



KPMG HEALTHCARE & PHARMACEUTICAL INSTITUTE

# Assessment of Key Risks for Hospitals and Healthcare Systems – Spring 2010

KPMG LLP



“In the past, we may not have paid much attention to the need for changing how we do things, but now it’s for real and we have no choice.”  
– Health System Executive

During March and April of this year, KPMG Healthcare conducted a survey of senior executives at major healthcare systems to gain their insights into the most significant risks facing their organizations in the near-to intermediate-term future.

This work was a follow-up to similar research done formally in 2005 and 2007. This paper provides a summary of identified risks, how they have changed over the past few years, and how the passage of healthcare reform will likely change the level of risk. (Note: at the time of most of the survey, healthcare reform legislation had not yet been

passed; passage of such reform was still viewed as unlikely by many survey respondents.)

The results of the 2010 survey are summarized in the following sections:

I. List of the 2010 risks by level, with a comparison to the ranking of these risks as identified in 2005 and 2007

II. Assessment of the impact that passage of healthcare reform would likely have on key top-level risks and an estimate of the amount of control a healthcare organization might have relative to that risk

III. Identification of potential “low probability/high impact” risks and combinations of risks that could create a “perfect storm” for a healthcare organization

IV. Primary tactics to mitigate the impact of the highest priority, top-level risks

V. Appendix: Discussion of key points made in describing the ten top-level risks and the potential for mitigating those risks

## Risk Levels

### 1. Top-Level Enterprise Risks

These risks were identified by all or virtually all of the respondents and are seen as meeting the following parameters:

- a. A current risk or one that is on the short-term horizon
- b. A risk that has a high likelihood of occurring
- c. A risk that is seen as having a significant impact on the healthcare system

### 2. Mid-Level Enterprise Risks

These are essentially “around the corner” risks as identified by the executives. They are generally viewed as having a lower likelihood of happening or a longer lead time. However, if the risk becomes a reality, it is viewed as having a significant impact on the organization.

### 3. Lower-Level Enterprise Risks

These risks meet one or more of the following parameters:

- a. Much lower likelihood of occurring or a longer timeframe for a healthcare organization to adjust
- b. Less impact on the system and/or a more manageable level of risk

# I. 2010 Top-Level Risks and Comparison to Previous Surveys



Healthcare Enterprise Risk Survey – Spring 2010

Top 10 Risks 2010	Level of Risk 2007	Level of Risk 2005	Percent of respondents who believe that passage of healthcare reform will increase this risk	Estimate of an organization's ability to control this risk
Payment increases consistently below medical inflation: potential for precipitous reductions in reimbursement as a result of state and federal regulatory changes	Top-Level	Top-Level	92%	Limited or none
Physician relationships: ability to control the direction and level of alignment of physicians and institutions	Top-Level	Top-Level	95%	Reasonable
Preparedness for clinical automation: inadequate information technology requiring investment in more sophisticated information systems	New in 2010	New in 2010	83%	Reasonable
An extended economic recovery or a return to a significant recessionary environment; unemployment increases and continues to remain high	New in 2010	New in 2010	No additional impact	None
Improving performance in the midst of accelerating regulatory and marketplace change	New in 2010	New in 2010	85%	Reasonable
Increased enforcement initiatives and governmental challenge of overpayment for services (e.g. RAC, MIC, and ZPIC audits, Stark anti-kickback statutes, false claims laws, antitrust, etc.)	Lower-Level	Mid-Level	89%	Some
Unfunded mandates for the provision of healthcare services	Top-Level	Top-Level	66%	Limited or none
Rebuilding the organization's balance sheet	New in 2010	New in 2010	73%	Reasonable
Increasing cost of capital and significant gap between capital needs and capital available from all sources	Lower-Level	Lower-Level	66%	Some
Significant reduction in employer-based insurance	New in 2010	New in 2010	77%	None

## Respondents to the 2010 survey of healthcare risks categorized ten risks in the top-level category.

As indicated in the table, only five of the ten top-level risks in this survey were also identified in previous surveys over the past five years. These risks are:

1. Payment increases consistently below medical inflation
2. Physician relationships
3. Increased enforcement initiatives and governmental challenge of overpayment for services
4. Unfunded mandates for the provision of healthcare services
5. Increasing cost of capital and gaps between needed and available capital

Shortage of clinicians was seen as a top-level risk in both the 2005 and 2007 surveys. This year, shortage of clinicians is viewed as a mid-level risk, possibly because the economic slowdown has led to deferred retirements and less movement from one organization to another.

Newly identified risks in 2010 include the following:

1. Preparedness for clinical automation: inadequate information technology requiring investment in more sophisticated information systems
2. An extended economic recovery or a return to a significant recessionary environment; unemployment increases and continues to remain high
3. Improving performance in the midst of accelerating regulatory and marketplace change
4. Rebuilding the organization's balance sheet
5. A significant reduction in employer-based insurance

Consistent with previous surveys, payment for services and physician relationships top the list of significant risks to healthcare systems and hospitals. Mitigation tactics for reducing these risks will be outlined later in this report. However, it is safe to say that the future success of any healthcare organization is probably most dependent on success in addressing these two top-level risks.



## II. Impact of Healthcare Reform on Top-Level Risks

As this survey indicates, the implementation of healthcare reform legislation is expected to result in a dramatic increase in the level of perceived operating risk that healthcare providers must take on. Key among those heightened risks are:

**Physician Relationships:** Ninety-five percent of respondents indicated that healthcare reform will further increase the risks associated with relationships between physicians and institutional providers of healthcare services. In particular, the combination of physician payment reform and various forms of bundled payments is seen as creating additional stress and pressure on the ability of physicians to control their own destiny. Healthcare systems can be seen by physicians as part of their problem and/or part of their solution, depending on the nature and structure of alignment opportunities presented and executed.

**Revenue:** Payments from Medicare, Medicaid, and other governmental programs have long lagged behind the cost of medical inflation. That lag has generally been offset by increased payments from commercial insurers. Ninety-two percent of respondents

expect the combination of reform and the economic environment to trigger reductions in payments from Medicare, Medicaid, and other programs. They also believe it's highly unlikely that providers will be able to increase charges to private patients and commercial insurers to offset the reductions.

**Regulations:** The pace of regulation and regulatory scrutiny continues to quicken. This results in a regulatory environment that is increasingly complicated, costly, and difficult to comply with, unless technology can be broadly used to automate compliance requirements. Without the ability to fully automate areas like coding, provider organizations will likely continually have difficulty with major automated data mining and audit programs such as RAC, MIC, and ZPIC audits (Recovery Audit Contractors, Medicaid Integrity Contractors and Zone Program Integrity Contractors).

**Implementation of Electronic Health Records:** The HITECH Act stimulus funding provides the opportunity for getting some governmental support for the development and implementation of electronic health records. However, achieving the increasing "meaningful

use" requirements on a timely basis will be a significant challenge for many providers, resulting in the loss of funding support. The ongoing penalties for not achieving meaningful use definitions could cost organizations as much as three-quarters of the market basket update funding annually, an amount that would be devastating for most healthcare organizations.

**Performance Improvement:** Improving organizational performance (effectiveness and efficiency) has long been a priority for healthcare organizations. However, it has not been viewed as a top-level risk until this year. Respondents report that the biggest challenge they face is the acceleration of both regulatory and marketplace change that requires them to step up their performance improvement initiatives. Many have stated they believe their organizations must improve their overall cost structure by at least 5 percent per year to combat the effects of reduced payments and increased cost of compliance with governmental regulation. From their perspective, healthcare reform initiatives only serve to exacerbate these challenges.

### III. Combinations of Risks That Could Create a “Perfect Storm”

Hospitals and health systems can usually withstand one or two significant challenges at the same time. However, three or four negative events in the same timeframe can have a devastating impact on the organization. Referring back to the summary table of healthcare enterprise risks, the two major risks over which organizations are seen as having the least amount of control are the general economy and governmental payments and regulatory requirements. These areas form the basis for most of the “perfect storm” scenarios identified by survey respondents. Other components of a potential “perfect storm” most commonly mentioned are (in order of perceived risk):

1. Loss of key physicians or groups due to operational issues, competitor intervention, or insurance contracts that move their business to another organization

2. State budget and/or taxation issues
3. Insurance-related issues such as a collapse of the commercial insurance industry or another malpractice insurance crisis
4. Failure of technology or inability to effectively meet the demands for a fully operational electronic health record
5. Removal of tax exemption/elimination of nonprofit status
6. Ineffective leadership/management as it relates to the ability to implement a successful performance improvement model and culture
7. Unionization of the workforce and/or a strike by a nurses union
8. Natural disaster



## IV. Primary Risk Mitigation Strategies

Executives responding to the 2010 survey openly shared the primary strategies/tactics they are using or intend to use to mitigate the top-level risks. There was broad-based agreement that mitigating the potential impact of the two critical areas, payment reductions and physician relationships, should be the top priority of all hospitals and health systems. Some of the basic approaches being utilized are the following:

### Revenue, Payment Reductions, and Other Financial Issues:

1. Work to achieve scale (get bigger through growth or acquisition) to reduce cost/unit and improve negotiating strength
2. Develop and consistently apply a performance improvement program using lean technology; identify and eliminate waste, redesign processes, measure results, and control variation

3. Adopt and fully deploy a real-time productivity system
4. Engage with policymakers and regulators at the local, state, and federal levels, both as an individual organization and in concert with others
5. Decrease the costs associated with overutilization of services
6. Target expense reductions to achieve a cost structure that can operate successfully at a reimbursement rate of Medicare plus 10 percent
7. Leverage market strength where possible; seek creative alignments with others to secure market strength; exit markets where market strength is unlikely to be achieved in a reasonable timeframe
8. Expand and standardize the compliance program as much as possible; implement coding accuracy software, broaden education and training, and

further expand monitoring efforts

### Physician Relationships:

1. Accelerate development of integrated and coordinated care delivery models (e.g. Accountable Care Organizations) with substantial physician leadership and engagement
2. Greatly expand the use of physician employment and/or medical foundations
3. Make more liberal use of joint ventures or other business arrangements (e.g. comanagement agreements)
4. Greater engagement of physician partners in quality and performance improvement initiatives
5. Support the implementation of electronic health records in physician offices where possible
6. Create and deploy a team focused primarily on business relationships with physicians



## V. APPENDIX: Discussion of Key Points Made in Describing the 10 Top-Level Risks and the Potential for Mitigating These Risks

1. Payment increases consistently below medical inflation: potential for precipitous reductions in reimbursement as a result of state and federal regulatory changes

Providers have generally fared well over the last several years as it relates to payment from Medicare and other key payors. Management has kept its eye on such payment trends in anticipation of the time when payment increases would no longer cover increased costs. Executives now believe that with increased economic pressures and regulatory reform, reimbursements from state and/or federal agencies could result in precipitous reductions in payment. Reform is also placing pressure on other contracted payment increases with key insurers. Providers are looking at dramatic cost reductions — often targeted toward Medicare payment levels. Such reductions are being achieved through lean or other

operational improvement initiatives with a focus on improving quality at lower cost through identifying and eliminating waste through redesigned processes.

## 2. Physician relationships: ability to control the direction and level of alignment of physicians and institutions

Physician relations continue to be one of the key risks facing providers. The ability to control the direction and level of physician alignment is key to the success of any health system. Alignment is being achieved through employment, joint venture or other business arrangements, and through extensive physician involvement in alignment or other key strategic initiatives.

In addition, executives recognize that, over time, many forms of bundled payments will become “real” and that hospitals must find ways to take and share insurance risk. While this was a failed experiment for most hospitals and systems back in the mid-80s to mid-90s, most will have to build or rebuild the infrastructure to become Accountable Care Organizations (ACOs) or the equivalent. Even systems that have learned to manage insurance risk know that they will have to deal with reduced or smaller payment increases.

## 3. Preparedness for clinical automation: inadequate information technology requiring investment in more sophisticated information systems

Another key risk facing providers is challenges with timely and effective implementation of electronic health

records (EHR). The risks and rewards surrounding EHR and the ability to meet “meaningful use” benchmarks are substantial. Executives are closely tracking IT investments and implementation programs to stay on track with effective and timely implementation requirements. IT expenditures are consuming an inordinate amount of the capital budget and are placing increased pressure on overall capital needs.

## 4. An extended economic recovery or a return to a significant recessionary environment; unemployment increases and continues to remain high

Executives have accepted that one consequence of the recent financial crisis and recession is an extended economic recovery with continued high unemployment. In response, greater focus is being placed on controllable cost-reduction initiatives that will allow the organization to preserve capital and strengthen the balance sheet. Many health systems have experienced strong recovery from the significant balance sheet deterioration suffered 18–24 months ago, but there is continued anxiety over any recurrence scenarios. Management has expressed the need for greater risk management in times of uncertain economic recovery.

## 5. Improving performance in the midst of accelerating regulatory and marketplace change

The pace of change is accelerating. Regulatory and reform factors, economic pressures, and other strategic factors have placed unprecedented pressures on operations. Such pressures are creating

new cultural paradigms, including much increased level of urgency around performance improvement.

Improved quality and continuous performance improvement have been focal points for a number of years. However, increasingly healthcare executives have come to the conclusion that this change is “real” and will only be further amplified by healthcare reform. Survey results indicate a level of commitment to rigorous performance improvement and change acceleration unlike anything we’ve seen before. One executive summed up the current environment by saying, “in the past, we may not have paid much attention to the need for changing how we do things, but now it’s for real and we have no choice.”

## 6. Increased enforcement initiatives and governmental challenge of overpayment for services (e.g. RAC, MIC, and ZPIC audits, Stark anti-kickback statutes, false claims laws, antitrust, etc.)

Both federal and state governments have increased regulatory scrutiny since technology can be much more readily used to automate compliance requirements. Executives have expressed concern that if regulators are using technology to monitor compliance, providers that are still using manual systems to comply with complex regulatory requirements are probably subjecting themselves to high rates of error and further regulatory scrutiny. The cost to comply in an increasingly regulated environment is increasing and the need for automation to comply with such requirements is increased. The risk of recovery resulting from RAC

and other regulatory audits is increased, resulting in the need for stronger audit and compliance functions.

### 7. Unfunded mandates for the provision of healthcare services

Providers have faced the risk of increasing unfunded mandates for a number of years. Increasing budget deficits for virtually all states resulting in significant program funding cuts, higher unemployment, and increased patient responsibility as well as other economic and social factors contributing to the increasing number of uninsured and underinsured have put constant pressure on increased charity and community benefit commitments. Although increased coverage of uninsured populations should benefit providers in future years, providers are contemplating the more immediate impact of payment reductions and increased taxes against future benefits of increased insured populations in anticipation that the net impact could result in greater pressure on operations.

### 8. Rebuilding the organization's balance sheet

Most healthcare organizations experienced significant balance sheet deterioration from August of 2008 through March of 2009. Primary factors contributing to balance sheet deterioration were losses in investment portfolios, declining values of swaps and other derivative instruments, increasing pension liabilities, and other negative market conditions. Over the next year, through improved market performance and implementation of difficult management decisions, many health systems were able to recover much of their losses. Others, of course, have not been as successful.

Whether fully recovered or not, management has gained an appreciation for the extent of financial devastation

that can be experienced over a very short period of time and the disruption it causes within the organization. As a result, there is a renewed focus on achieving and then maintaining a strong balance sheet that sustains the health system's credit worthiness and financial health.

Primary areas of focus on rebuilding and maintaining the balance sheet are continued financial prudence, capital spending restraint, formalized and ongoing cost reductions programs, and managing investment portfolio risk. The volatility of the past few years has also caused management to reassess necessary reserve levels and financial risk factors.

### 9. Increasing cost of capital and significant gap between capital needs and capital available from all sources

Capital appetites continue to be stretched with significant IT commitments as well as other investments in technology. Much-needed investment in facilities and other strategic investments have also pushed capital investment to unprecedented levels. Capital availability from all sources (operations, philanthropy, and debt capacity) is increasingly strained. Operating margins are pressured due to the costs and payment reductions associated with healthcare reform, philanthropy is down and not expected to recover quickly in a prolonged economic recovery, and demand for capital is expected to outpace supply in a few years. The combined effect of all of these factors is the increasing gap between capital needs and available capital.

As noted above, health systems will need to attain and maintain strong balance sheets to enable continued access to capital. Since capital will be more readily available and at a lower cost

to financially healthy providers, this will likely contribute to the "strong getting stronger and the weak getting weaker."

### 10. Significant reduction in employer-based insurance coverage

For years, employers have been seeking ways to reduce their exposure to increases in the cost of health insurance. The most common ways of accomplishing this have been to shift more risk to employees through higher co-pays and reducing the percent of the insurance premium covered by the employer. Many employers have offered catastrophic or high deductible plans that have much lower monthly premiums but also shift more of the out-of-pocket burden directly to the employee. Other employers, of course, have simply stopped providing health insurance to their employees.

This trend to reduced employer-based insurance coverage has been exacerbated by the financial crisis and the subsequent recession. With a continued recessionary environment, jobless recovery, and high unemployment levels, it is unlikely that health insurance coverage will be substantially expanded anytime soon.

While health reform holds the promise of providing insurance coverage to more people, it is unclear that expanded coverage will significantly offset lower payments to providers. A primary mitigation strategy being employed by successful hospitals and systems is a singular and focused improvement in payment and collection policies and procedures. Key elements of this approach are a rigorous tracking and documentation of patient co-pay requirements and improved collections practices including broad-based requests for advance payment by cash or credit card.

The American healthcare system across all segments — providers, payors, pharmaceuticals, life sciences, and government — is undergoing an unprecedented transformation, which is only further accelerated by the new healthcare reform laws. Employers and individuals across the country will all be affected by the changes.

Solving the complex equation for healthcare that balances cost, quality, and access is growing ever more difficult as the industry faces reductions in government reimbursement, an unknown demand curve from the newly insured, new intersections among the segments, and employers' insistence on moderating healthcare premiums.

This environment for business planning and operational execution has never been more dynamic or challenging. From the perspective of KPMG Healthcare, the industry should both acknowledge that this is a transformative time and that executing exceptionally against immediate mandates isn't discretionary. For example, meeting the meaningful use of healthcare IT standards and converting to ICD-10 are complex, multiyear programs that cannot be delayed nor denied.

At the same time, the industry needs to ensure that the deep business changes accompanying such mandates are institutionalized in a sustainable fashion. This is what we call "transformation sustainability" — a fundamental principle that informs today's healthcare landscape.

At this critical time, the professionals of KPMG Healthcare offer our clients and other industry leaders this distinct and deceptively simple point of view that shapes our approach to helping them develop and maintain transformation sustainability — **that healthcare is ultimately about the patient — a person who is at the center of an emerging healthcare ecosystem, which is increasingly integrated in new ways and defined by important intersection points among the key players in the industry.**

With deep experience in technical matters and full commitment to understanding this emerging environment in all its complexity, KPMG Healthcare now brings together more than 1,500 partners and professionals from our provider, payor, pharmaceutical, life sciences, and government practices, to serve the business of healthcare.

Importantly, KPMG Healthcare's services are informed by our view of this increasingly integrated ecosystem and its challenge to achieve sustainable transformation. The KPMG approach not only adds value to the industry dialogue but also links all of our industry-based services in end-to-end fashion — from independent audit, to tax compliance and consulting, in a broad continuum of healthcare advisory services.



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