

# Introduction

*Prediction is very difficult, especially if it's about the future.*

—Niels Bohr, 1949

## INTO THE STORM

Healthcare has had it pretty good for a long time. What other industry could stay in business without worrying about price or quality? Or, generally speaking, not even know what its actual costs were? Could you picture an automobile company or a computer company surviving for long in that environment? Wind the clock back 25 years, before prospective payments came into play, and you had a “cost plus” environment where providers were also paid to fix work that wasn’t done correctly the first time (readmissions).

Furthermore, why does the same procedure being delivered in Albany, New York, have costs dramatically different from those for the same procedure in Charlotte, North Carolina, even after adjusting for local labor differences? It’s simply because they’re done differently. That would be like General Motors having a different cost for a car built in Michigan instead of Tennessee. Would they then charge differently based on where it was manufactured? Good luck with that.

Yet that described healthcare in March 2010 when the Patient Protection and Affordable Care Act (ACA) formally became law. No wonder everyone had that puzzled look.

## A BRIEF HISTORY OF HEALTHCARE

Every once in a while we get reminded that healthcare is a regulated business. We don't mean regulated the way the Federal Communications Commission regulates communication, or the way the Federal Aviation Administration regulates the airline industry, or even the way the government regulates utilities. We mean regulated in all facets of how you conduct business. Regulated in how care is delivered (evidence-based medicine), regulated in how everyone gets paid (diagnosis related groups, or DRGs), and even regulated as to whom you can sell services (insurance). Fifty years ago healthcare was more or less unregulated and essentially delivered through the private sector. The private, not-for-profit hospital was either community based or faith based, and reimbursement was either self-pay or paid through private insurance. But in 1965, everything changed.

That, of course, was the year of the enactment of the Medicare and Medicaid programs. As a result of those programs, providers had to change the way they delivered services, not only to accommodate additional covered lives, but to do so in a growing public sector reimbursement environment.

Then, in 1985, with the advent of DRG reimbursement, everything was once again turned on its head, with hospital systems scrambling to adapt to the changed environment. Going from retrospective reimbursement (cost plus) to a prospective payment system challenged the financial capabilities of a large segment of the hospital universe.

In 1997, once again, regulation affected delivery of services, as the Balanced Budget Act dramatically changed the rural healthcare landscape with the advent of the critical access and sole community hospital designations.

Each of these laws had a major impact not only on the delivery of services and the reimbursement for those services, but also on the capital projects that followed.

Having lived through those three major regulatory ages when the ACA was enacted in 2010, healthcare professionals had every

reason to assume the industry was again going to undergo dramatic changes, changes that would affect the healthcare landscape in ways that we couldn't imagine. But in talking to industry leaders then, we found dramatic disagreement as to what was going on, what changes would occur in both delivery and outcomes, and most important to us, how the buildings that house healthcare activities would change. In all areas of capital project development, from planners and designers to project and construction managers as well as public and private sector providers, no clear concept emerged of what those changes would be.

In our opinion, we were witnessing what is called historical determinism—living through a historical event without realizing it. Many people said they lived through the 1929 stock market crash as if they were aware of its historical significance, but few truly understood its impact. In 2010, although numerous pundits were offering opinions and numerous sources of information, there was no one source from which to get a grasp of the new reform law, no oracle to predict its true implications and how it would affect not only healthcare delivery but the capital development projects that would accommodate the industry going forward.

## **ENTER REFORM**

This book attempts to look at reform and its implications for capital development projects through the eyes of the different participants in the industry, as well as within the context of a changed economic climate. We'll describe what the new paradigm is and why it exists, lay out a game plan for addressing that new environment, and identify what we believe the future will hold for capital projects. If you want to know why a bird flies, you don't examine the feathers—you look at the aerodynamics. We've done that with healthcare reform, concentrating on those components of capital development that will have the most impact.

While the ACA itself is comprehensive, this book is intended to address only that part of the bill that clearly affects capital development. We also examine related factors not specifically part of the bill that are forcing change. As Alan Yordy points out in Chapter 1 on the healthcare CEO's viewpoint, many of the issues being addressed in reform would've taken place without the ACA, although probably at a slower pace.

Although predicting the impact of the various dynamics within the reform bill is difficult, it is possible to discuss the potential for various outcomes. For example, coverage will be expanded, so we will look at both sides of this issue:

- With millions of additional people being covered, what is the potential that this covered population will enter old age in a healthier state, thereby lowering future development needs?
- Will state exchanges drive down reimbursements to the detriment of development, or will they support development resulting from broader access through affordable premiums?
- The potential exists for the loss of operating lease status. If all leases become capital leases, will they adversely affect a hospital pro forma and, ultimately, its bond capacity for new construction?
- With the dramatic shift from sick care to wellness, can keeping the population healthier add opportunity to development, or will it diminish use of facilities and therefore limit growth?

## **THE FINANCIAL CRISES**

We've always looked at healthcare capital development as running counter to the normal economic cycle. Unlike development in the

private sector, which is always tied to the strength of the private economy, healthcare development was a function of the twin pillars of demand and reimbursement, both independent of the economy. Or so we thought. On occasion, economic factors would affect healthcare development, especially when a strong economy led to rising interest rates. But even then, the availability of funds through variable rate products was always more important than rates, with the possible exception of double-digit rates in the 1970s.

The financial crisis of 2008–2009 challenged that thinking. A severe recession with dramatically high unemployment clearly affected healthcare as the unemployed not only lost their healthcare coverage, but the deleveraging that went along with the financial crisis put downward pressure on nonessential healthcare procedures and dramatically increased charity care. But the financial crisis challenged healthcare in another way through the tremendous pressure on the states as a result of lower tax revenues and higher social supports, such as unemployment payments and Medicaid. The states' mandates to have balanced budgets affected their ability to fund healthcare programs, such as Medicaid; Women, Infants, and Children nutritional support; and the Children's Health Insurance Program. So the thought that healthcare is immune to economic downturns is no longer valid.

Within that economic climate, enter the healthcare reform legislation of 2010. It's the most ambitious healthcare legislation since the advent of Medicare and Medicaid in 1965 and the introduction of DRGs as the basis of reimbursement in 1985. Notwithstanding the political ramifications of the reform bill, we believe the changes within the bill will impose a dramatic headwind to future capital development.

Although this book is meant to address the topic of reform, it's foolish to do it in a vacuum. We must consider what aspects of financing new development will change with reform as a result of a changing economic environment. The aging population, the lower workforce participation, and the widening income gap all put pressure on Medicare and Medicaid taxes, thereby putting pressure on

Medicare reimbursements. We've already seen what weaker economic growth can do to discretionary medical spending.

Thus the assumption that healthcare was countercyclical to the economy is no longer valid:

- The dynamics of the aging population seemed to have little to do with a slowing economy.
- Margin compression has occurred because of economic shifts primarily from unemployment levels.
- Philanthropy has dropped because of donor investment losses.
- The need to fund deferred capital improvements continues.
- Reimbursement has declined because of recent (and probably ongoing) federal budget cuts.
- Hospitals' nonprofit tax-exempt status has been challenged because of diminished charity care.
- Credit ratings have been downgraded because all of the reasons above are increasing costs and decreasing availability of capital.

Who was it that said the definition of despair is that it is always darkest before it goes black? We hope this book will show that all of the headwinds we mentioned can create opportunities for those who can see that there is much to gain on the other side of the ledger.

## **YES, WE KNOW YOU CAN'T PREDICT THE FUTURE, BUT . . .**

By looking at past regulations as a way of getting a peek into the future, we identified three recurring themes. First, *major consolidation* followed the enactment of Medicare and Medicaid, most likely because the financial pressures of lower reimbursements

were more dramatic than the offsetting of additional covered lives. DRGs exposed many hospitals unprepared to go from a cost plus (retrospective) environment to a prospective one. Once again consolidation solved the problem of the financially weaker hospitals.

We're already seeing the start of consolidation and acquisitions under the ACA. In 2013, the number of consolidations and acquisitions was more than double those in 2005. In fact, the consulting firm Booz & Company predicts that 1,000 of the nation's 5,000 hospitals will seek out mergers out of the next five to seven years (Creswell and Abelson 2013). The trend is all about efficiency. Despite some states' opposition to some of the mergers in fear of increased costs to consumers, for the most part the mergers continue unchallenged.

Second, we saw the *growth of investor-owned or for-profit hospitals and systems*. These barely existed before 1965, had substantial growth after that, and then saw a growth spurt after DRGs began. Although this book is not meant to provide the history of investor-owned systems, we do address them to the extent that their culture and delivery clearly flourish in a tighter reimbursement environment. And although these hospitals make up only 15 percent of the beds nationwide, they comprise 40 percent of the capital development dollars being spent. To ignore them is to look at only half of the market.

Third, *new legislation tends to evolve over time*, partially because new laws can be tweaked every two years with even a slight change in who is elected to Congress. Major legislation takes a long time to integrate into our lives to the point where it feels like business as usual. In spite of the 2012 Supreme Court decision (*National Federation of Independent Businesses v. Sebelius*), Medicaid coverage continues to vary state by state. Even though DRGs were enacted in 1985 with 467 different rate groups, the system has become more targeted over the years. The most recent International Statistical Classification of Diseases and Health Related Problems (ICD-10) addresses DRGs more strategically to allow for newer healthcare delivery methods and therefore lower reimbursement. We should expect the ACA to be no different.

To make matters more difficult, the ACA has established a series of pilot programs. These programs are tested nationally for a limited time. If found to be of monetary value, they can be inserted into the ACA without going back to Congress for approval. Currently 25 pilot programs exist, with 380 references in the ACA. Examples include the following:

- Tort reform (being tested in the Northwest)
- Bundled payments (which can ultimately include insurance)
- Payment for performance
- Increased payments for primary care physicians

Not only will the current law be modified through these pilots, but their inclusion will have substantial impact on reimbursements. Anticipating those outcomes adds to the challenge.

Clearly the ACA, with nine years to fully roll out (2010 to 2019), will undergo more changes. When you consider the fact that we attempt to design and build healthcare buildings meant to last 40 to 50 years, the importance of getting it right is critical, and that is the goal of this book. Nassim Nicholas Taleb (2005), in his wonderful book *Foiled by Randomness*, makes the argument that predicting anything with certainty is impossible. But it is possible to acknowledge change, anticipate the impact of that change, and embrace solutions that incorporate it. To do these things successfully, we must eliminate the preconceptions—conventional wisdom and confirmation bias—that we inherently possess.

## A CULTURE CHANGE

It's one thing to make changes to processes when it becomes obvious that changes are needed. But it's another thing to change the culture within which those processes are delivered. One of the

challenges all businesses face is how to grow while maintaining the company culture. Although approaches vary, some businesses choose to slow their growth so that it can occur organically and the company can avoid bringing new people in from the outside. For many companies, maintaining their culture is critical.

The ACA is challenging the very existence of our current health-care culture, and therein lies a major difficulty. Asking a hospital to participate in wellness programs when its survival is tied to treating sick people is a small example of a dramatic culture shift. Forming accountable care organizations and patient-centered medical homes can drive down occupancy rates in hospitals at the same time that funding existing bond programs relies on maintaining bed occupancy and related revenue.

The culture is also changing for the physician. Smaller practices can no longer exist with the conflicting pressures of lower reimbursement and higher costs for electronic medical records and information technology (IT) mandated by the ACA. The resulting integration into healthcare systems is changing provider obligations to meet care delivery goals as systems look to benefit from that integration. Physicians are also being introduced to a more collaborative world as IT opens up the benefits of shared information between providers. And physicians are adjusting to a more informed patient as the Internet expands education and options for patients and their families.

Today's culture is changing for the patient also. In the past, insurance was most likely provided by our employer, the physicians we saw were dictated by our insurance coverage, and the hospitals we went to were dictated by our physician. That's changing. The ACA is encouraging more employers to underwrite employees' health-care instead of providing it, thus driving them to the exchanges. In doing so, the choice of insurance is now in the patient's hands, and with that, the choice of physician. The patient must become his or her own advocate and be an active participant in the process.

And the culture is changing for the planning and design community. Sitting with the user groups to determine how they want

to deliver services, and then designing based on those requests, is no longer enough. The design community must be knowledgeable about how healthcare must be delivered today—to address value, not volume, with a declining reimbursement environment. Yes, we know “form follows function,” but as Winston Churchill (1943) said, “We shape our buildings, and afterwards our buildings shape us.”

Each chapter in this book addresses this change in culture from the authors’ unique perspectives. We’ve organized the book chapters in the chronological order we think a capital development project should occur, having nothing to do with the order of importance.

Throughout this book, Georgeann and Robert will attempt to tie thoughts together in boxes introducing each chapter and in key takeaways at the end of each chapter. When you see these boxes, you will know it is us speaking.

## REFERENCES

- Churchill, W. 1943. Speech to the House of Commons, October 28.
- Creswell, J., and R. Abelson. 2013. “New Laws and Rising Costs Create a Surge of Supersizing Hospitals.” Published August 12. [www.nytimes.com/2013/08/13/business/bigger-hospitals-may-lead-to-bigger-bills-for-patients.html?\\_r=0](http://www.nytimes.com/2013/08/13/business/bigger-hospitals-may-lead-to-bigger-bills-for-patients.html?_r=0).
- Taleb, N. N. 2005. *Foiled by Randomness: The Hidden Role of Chance in Life and in the Markets*. New York: Random House.