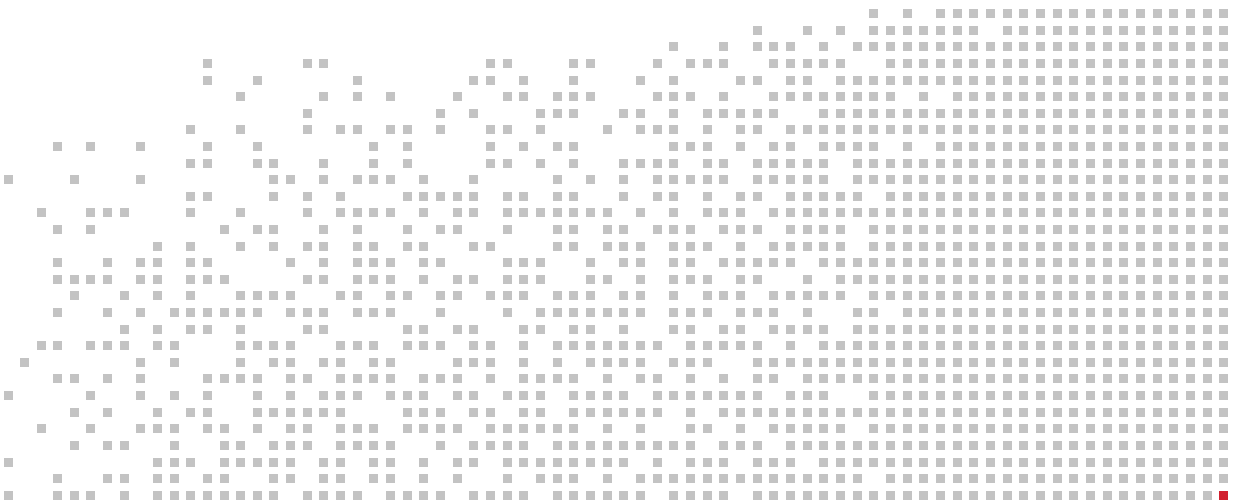


# Health System **Growth Strategy** for the Value-Based Market





# REINVENTING HOSPITAL GROWTH STRATEGY

## Hospitals **can't rely** on their existing growth strategies.

Hospitals and health systems have used a common set of proven growth strategies for decades. They have successfully grown—in size, scope, and revenues—by consolidating their market position, locking up referral streams, and demanding steep price increases from payers.

**But these same strategies will not lead to growth in the future.**

For one thing, annual price increases are no longer a reliable certainty, as the number of Medicare beneficiaries rises and purchasers become more active in managing cost.

But volumes, too, are harder to come by. Overall hospital demand is not expected to increase like it has in the past. And it's harder than ever before to consolidate for growth's sake. Existing markets are already concentrated, hospital mergers are drawing greater scrutiny, and capital for acquisitions can be scarce.

With softer overall demand and ever-fewer unaffiliated physicians, competing for physician referral streams won't be a recipe for growth either.

**So hospitals and health systems need a new playbook for growth.**

**Read on** to learn more about why the old drivers of growth will be insufficient for future success—and how to win customers in the post-reform marketplace.

# The hospital industry is facing an onslaught of **direct price cuts**.

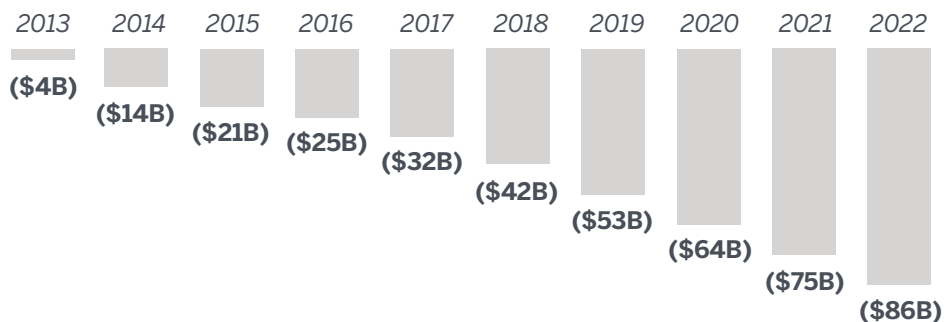
**While price increases** have supported health care industry growth for many years, those days are coming to an end, especially as health care providers confront massive cuts to pricing growth from their largest payer, Medicare.

Across the next decade, hospitals alone will absorb over \$260 billion in Medicare rate cuts from the Affordable Care Act. They will also lose another 2% from the sequestration process and \$56 billion from the reallocation of Disproportionate Share Hospital (DSH) payments.

These rate cuts will be even more painful for health care providers because, as the years go on, there will be fewer and fewer commercially insured patients who could potentially offset the Medicare cuts. As the Baby Boomers age, Medicare will account for a larger share of hospitals' payer mix each year.

## ACA's Fee-for-Service Payment Cuts

*Reductions in Annual Payment Rate Increases for Hospitals, Hospice, SNFs, and Home Health*



# Hospitals are also contending with **implicit price cuts.**

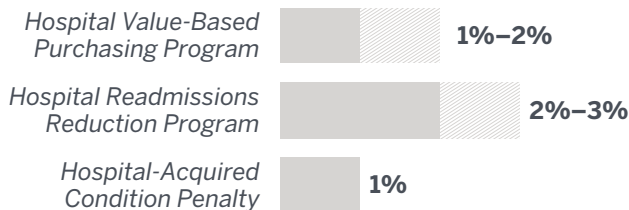
**The picture for hospital pricing** is even worse than it appears at first glance, because new pay-for-performance programs and regulatory changes will also have the effect of lowering hospital revenue per case.

While beneficial for some hospitals, pay-for-performance initiatives, such as the Hospital Value-Based Payment Program and the Hospital Readmissions Reduction Program, will lower Medicare reimbursement rates for others.

At the same time, the explosion of observation status is slashing reimbursement for millions of hospital stays nationwide. Many of these cases use the exact same clinical staff, bed, and technology as full inpatient admissions, but hospitals receive only a fraction of the reimbursement.

## Mandatory Medicare Pay-for-Performance Programs

Maximum Payment Penalty

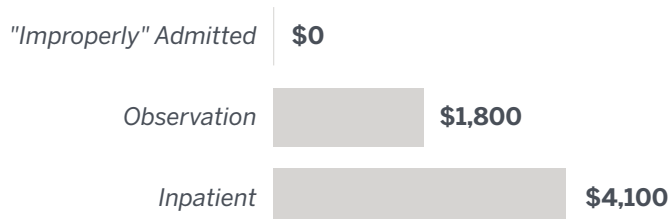


**25%**

Hospitals mandated to face hospital-acquired condition penalty

## Medicare Payment Rates

Potential Chest Pain Treatment Paths



**1.6M**

Observation stays nationwide, 2011

**69%**

Increase in number of Medicare beneficiaries under observation, 2006–2011

# All signs point to a structural— not cyclical—**volume slowdown.**

**Many health care providers** saw volumes dip in the wake of the economic recession. But even if the economy recovers in full, volumes are unlikely to return to pre-recession levels.

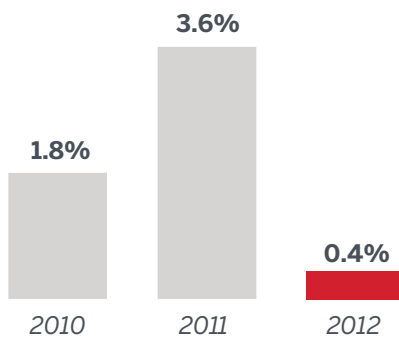
Consumers continue to enroll in high-deductible health plans, and employers aren't rushing to reinstate generous benefits. These actions are permanently changing health care consumption patterns. Their effects won't dissipate as the economy improves.

The most critical evidence of structural change is the slowdown in spending growth per Medicare beneficiary—virtually flat in 2012. Medicare beneficiaries don't face high deductibles or new cost-sharing tactics. But they're being readmitted less frequently and receiving better care management and coordination. Both deflate long-term volumes.

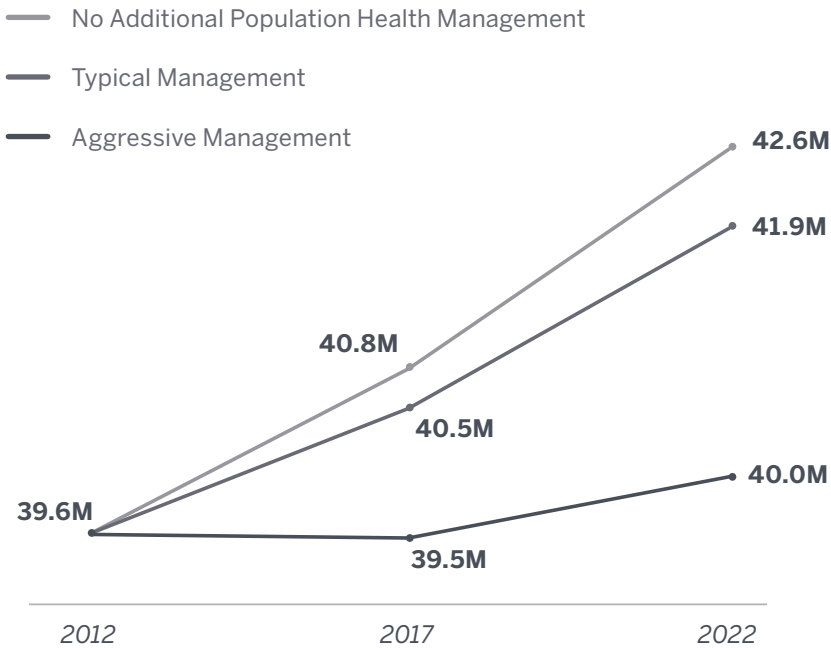
Providers themselves are further eroding volumes by becoming full-service population health managers. Our analysis suggests that aggressive population health management efforts could reduce inpatient volume growth by more than six percentage points over ten years.

## Medicare Spending Growth per Beneficiary

2010–2012



## Inpatient Volume Under Different Population Health Assumptions



### Quite a Difference

**7.6%** Total inpatient volume growth, 2012–2022, with no additional population health management effort

**1.1%** Total inpatient volume growth, 2012–2022, with aggressive population health management efforts

## Competition for high-margin procedural cases is becoming fiercer.

**Even if volumes begin** to rebound somewhat, there simply will not be enough profitable cases to go around. When Advisory Board researchers analyzed the long-term margin outlook for hundreds of hospitals in markets nationwide through the Medicare Breakeven Project, we found that many markets will still experience some organic volume growth—but rarely enough to sustain all of the local hospitals.

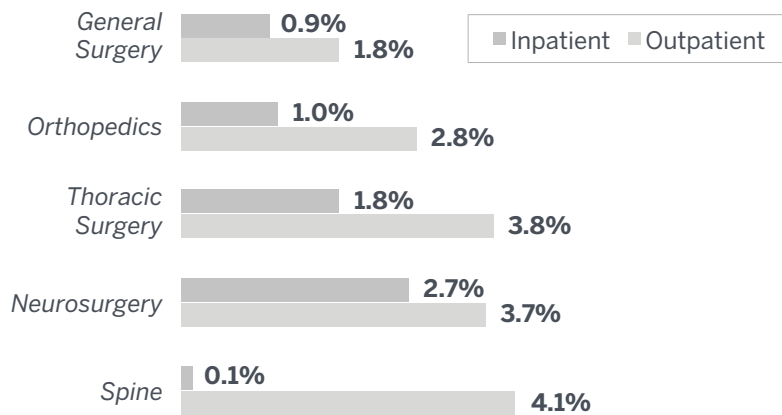
We still predict that certain procedural specialties will grow over the next several years: orthopedics, neurosurgery, and spine surgery among them. But this modest growth will simply not be sufficient to offset the pressure on per-case revenue across the industry.

On average, hospitals can expect organic growth to provide less than 20% of the surgical volumes they'll need to sustain margins in the long term. The remaining 80% of volume growth will need to come from capturing market share, **igniting a zero-sum game that will ultimately result in winners and losers.**

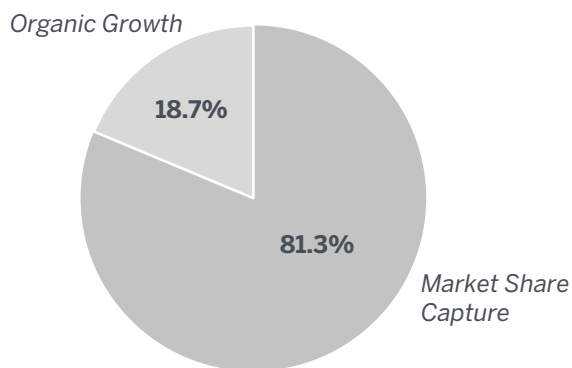


## Annual Service Line Growth Forecasts

2012-2017



## Sources of Surgical Volume Growth Needed for Sustainable Margins<sup>1</sup>



1) Based on analysis of 62 hospitals' margin projections using Advisory Board's "Pleasantville" model.

# To fuel future growth, hospitals **must win share** in the new value-based market.

Instead of, in effect, extracting growth from purchasers, hospitals need to focus on earning their market share, marking the shift from price-extractive growth to value-based growth. **Increasingly, hospitals will get bigger by being better, reaping the rewards of superior performance in a competitive marketplace.**

Embracing value-based growth will require notable changes, including new success factors, new targets of strategies, and potentially even some new leaders. It will also require a new outlook on the role of growth in hospital economics.

In the old era of price-extractive growth, hospital leaders often justified growth as an input, as a means to advance some larger end—securing access, funding innovation, or extending the mission.

But in the emerging era of value-based growth, where purchasers are selectively buying care in a competitive market, **leaders must reposition growth as an output rather than an input.** Hospitals will grow because they are providing services that purchasers want.

And what if hospitals remain stagnant, or even shrink? In a competitive market, that means purchasers are actively choosing someone else. Hospitals that don't grow are failing.

**In sum, future growth is an essential measure of success.**

	<b>Health System Strategy, c. 2003</b> <i>Price-Extractive Growth</i>	<b>Health System Strategy, 2013–2023</b> <i>Value-Based Growth</i>
<b>Description</b>	<b>Grow by being bigger:</b> Leverage market dominance to secure prime pricing, network status	<b>Grow by being better:</b> Leverage cost, quality, service advantage to attract key decision makers
<b>Key Success Factors</b>	<ul style="list-style-type: none"> <li>• Expand market share</li> <li>• Strengthen service lines</li> <li>• Exert pricing leverage</li> <li>• Solidify referrals</li> <li>• Secure physicians</li> <li>• Increase utilization</li> </ul>	<ul style="list-style-type: none"> <li>• Expand covered lives</li> <li>• Compete on outcomes</li> <li>• Minimize total cost</li> <li>• Assemble network</li> <li>• Offer convenience</li> <li>• Expand access</li> </ul>
<b>Target of Strategy</b>	<ul style="list-style-type: none"> <li>• Commercial payers</li> <li>• Government purchasers</li> <li>• Physicians</li> </ul>	<ul style="list-style-type: none"> <li>• Employers</li> <li>• Individuals</li> <li>• Population health managers</li> </ul>
<b>Performance Metrics</b>	<ul style="list-style-type: none"> <li>• Discharges</li> <li>• Service line share</li> <li>• Fee-for-service revenue</li> <li>• Pricing growth</li> <li>• Occupancy rate</li> <li>• Process quality</li> </ul>	<ul style="list-style-type: none"> <li>• Share of lives</li> <li>• Geographic reach</li> <li>• Risk-based revenue</li> <li>• Share of wallet</li> <li>• Outcomes quality</li> <li>• Total cost of care</li> </ul>
<b>Competitive Dynamics</b>	<ul style="list-style-type: none"> <li>• Service line competition</li> <li>• Centers of excellence</li> <li>• Referral channels</li> <li>• Physician loyalty</li> </ul>	<ul style="list-style-type: none"> <li>• Comprehensive care</li> <li>• Patient engagement</li> <li>• Clinical quality</li> <li>• Service quality</li> </ul>
<b>Critical Infrastructure</b>	<ul style="list-style-type: none"> <li>• Inpatient capacity</li> <li>• Outpatient imaging centers</li> <li>• Clinical technology</li> <li>• Ambulatory surgery centers</li> </ul>	<ul style="list-style-type: none"> <li>• Primary care capacity</li> <li>• Care management staff and systems</li> <li>• IT analytics</li> <li>• Post-acute care network</li> </ul>
<b>Key Leaders</b>	<ul style="list-style-type: none"> <li>• CEO</li> <li>• CFO</li> <li>• COO</li> <li>• CMO</li> <li>• CNO</li> <li>• Board</li> </ul>	<ul style="list-style-type: none"> <li>• CEO</li> <li>• CFO</li> <li>• COO</li> <li>• CMO</li> <li>• CNO</li> <li>• Board</li> <li>• CSO<sup>1</sup></li> <li>• CPE<sup>2</sup></li> <li>• CTO<sup>3</sup></li> </ul>

1) Chief strategy officer.

2) Chief physician executive.

3) Chief transformation officer.



## WHAT VALUE-BASED PURCHASERS WANT

Health care providers should think about their customers as ‘**wholesale buyers**’ or ‘**clinical shoppers**.’

**To capitalize on new growth opportunities**, health care providers—especially hospitals and health systems—need to appeal to the individuals and organizations that make market share decisions. We have identified two critical types of empowered decision makers, whom we’ve termed “wholesale buyers” and “clinical shoppers.”

Wholesale buyers are risk-bearing entities that purchase care on behalf of broad populations of patients. Examples include commercial payers, self-funded employers, and population health managers. By attracting or contracting with these wholesale buyers, hospitals can capture large segments of market en masse.

Clinical shoppers are individual stakeholders selecting discrete care services for distinct episodes of care. The key clinical shoppers are individual physicians and consumers. Many health care purchasing decisions are still made at retail level, so attracting these decision makers remains critical.

## WHOLESALE BUYERS

**Commercial payers** are looking to reduce unit prices, but also to limit avoidable utilization.

**Commercial payers have traditionally** served as the principal wholesale buyers, contracting on behalf of insured patients—and this will continue to be the case. But the hospital-payer relationship is evolving.

We are seeing commercial payers becoming more aggressive about price transparency, new payment models, and steerage as they try to retain employers as fully insured clients. Commercial payers are deploying a range of strategies that reduce the unit price of care and limit avoidable utilization.

### Sample Commercial Payer Cost Control Initiatives



#### Price Transparency Tools

- Health Care Service Corp. Benefits Value Advisor program
- UnitedHealthcare's myHealthcare Cost Estimator



#### Bundled Payment

- BCBS of Western NY, Kaleida Health cardiac surgery bundle
- ConnectiCare, St. Francis Hospital hip and knee replacement bundle



#### Narrow Networks, Steerage

- Harvard Pilgrim Focus Network
- Anthem BCBS Compass SmartShopper Program

### Results from Benefits Value Advisor Program

**90%** BVA<sup>1</sup> program participants eligible for savings by choosing alternative provider

**\$2K** Average savings per claim

1) Benefits value advisor.

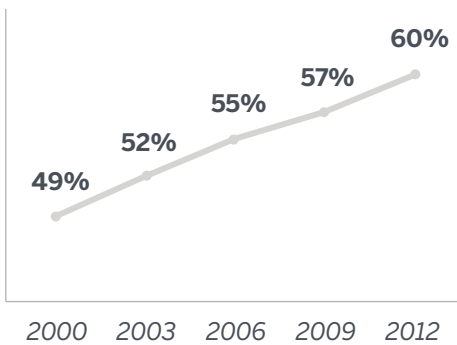
# Employers are becoming increasingly important—and active—wholesale buyers.

**Commercial payers are far from the only wholesale buyers.** Across the past decade, employers have steadily taken on full accountability for their health care spending. These self-funded employers are becoming increasingly sophisticated about working directly with providers—not just for typical worksite services, but for care coordination and management.

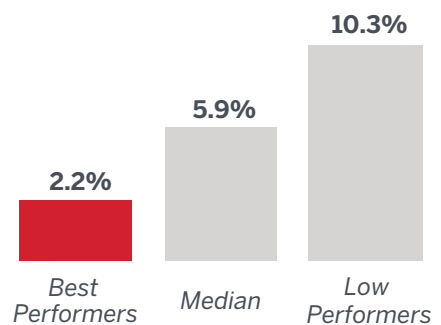
In fact, recent research suggests that the employers that have most successfully reduced their health care spending growth are the ones that collaborate the most with providers.

## Percentage of Self-Insured Employers

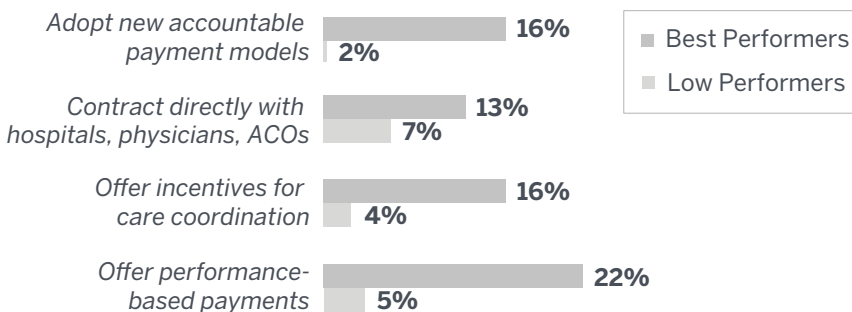
*Partially or Completely Self-Insured*



## Average Annual Employer Health Cost Growth



## Best Performers More Likely to Focus on Provider Strategies



# Large employers are seeking lower prices—even if they have to **pay for travel** to find them.

**As a starting place, activist employers** are demanding lower prices for high-cost services. Large employers such as Walmart, Lowes, and PepsiCo have entered into bundled payment contracts with providers, channeling their volumes in exchange for preferential pricing. Self-funded employers can even adjust benefit design to encourage patients to travel for their care, such as waiving copays and deductibles and paying for travel. These models have the potential to ignite national competition and shift massive market share. Walmart's new Center of Excellence Program includes more than 1.1 million covered lives.



## Walmart Centers of Excellence Partners

- Cleveland Clinic
- Geisinger Medical Center
- Mayo Clinic
- Mercy Hospital Springfield
- Scott & White Memorial Hospital
- Virginia Mason Medical Center



### Case in Brief

#### *Walmart Centers of Excellence*

- Walmart entered into bundled payment agreements with six health systems covering heart, spine, and transplant surgeries
- Program launched in January 2013; includes 1.1 million covered lives
- Providers selected based on convenience, quality, and potential for cost savings



CASE STUDY

# Intel's Partnership with Presbyterian Healthcare Services

**Some employers are turning to providers** to develop an even more comprehensive health care solution. In January 2013, Intel entered into a new partnership with Presbyterian Healthcare Services covering 5,400 employees in New Mexico. The partnership combines a number of strategies—narrow networks, shared risk, and customized care management.

The relationship is expected to save Intel between \$8 million and \$10 million across five years. And with half of the offered health plans composed exclusively of Presbyterian's providers, the system can potentially gain substantial market share.

## Key Components of Partnership



### Narrowing of Health Plan Options

Intel reducing number of health plan options from eight to four; two remaining plans are narrow networks of Presbyterian Healthcare Services providers



### Shared Accountability

Upside and downside risk for health care spending compared to projected target



### Customized Care Offerings

Addition of depression screening into customary provider workflow



### Infrastructure for Care Management

Conversion of Intel's on-site clinic into full service patient-centered medical home



## Case in Brief

*Intel Corporation*

- Large, multinational employer headquartered in Santa Clara, California
- Entered into narrow-network contract with Presbyterian Healthcare Services, an eight-hospital system in New Mexico, for employees at Rio Rancho plant

**5,400**

Covered lives in contract

**\$8M–\$10M**

Projected savings through contract, 2013–2017

## Population health management organizations are important new value-based purchasers—and will aggressively steer volumes.

### **Activist employers are not the only new wholesale buyers.**

Population health managers—many known as accountable care organizations (ACOs)—are launching in markets coast to coast. Of the more than 400 ACOs up and running, more than half are composed exclusively of physicians. And these risk-bearing entities are rapidly changing behaviors to manage their newfound financial accountability.

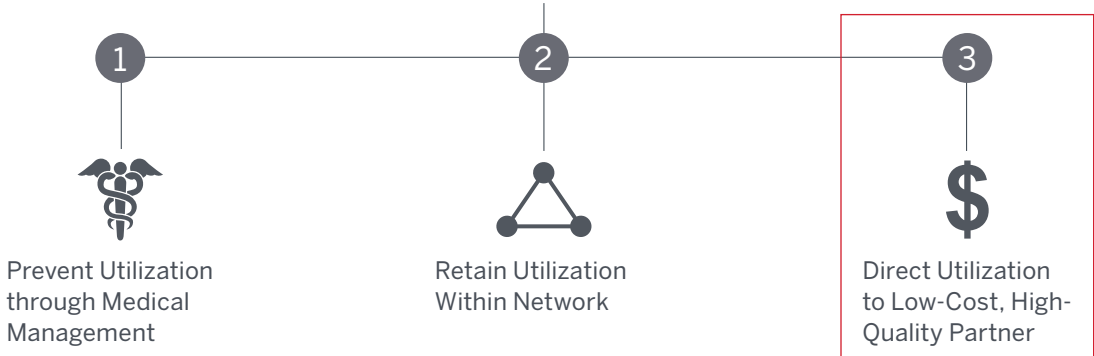
Population health managers have three direct levers for reducing spending on their patient populations. Most visibly, they are working to prevent avoidable utilization, taking steps to prevent admissions and reduce readmissions—especially those related to chronic conditions.

But their efforts do not stop at preempting avoidable utilization. Population health managers are also rethinking how to reduce costs for unavoidable care. They are focused on retaining care within their networks where possible. And for care that can't be retained, they are carefully directing utilization to low-cost, high-quality, collaborative partners. Hospitals can gain significant market share by becoming an ACO's hospital of choice.

## Three Ways for Risk-Bearing Providers to Bend the Cost Curve



Population Health Manager



**Example:** High-risk patient care management (e.g., medication management, care transitions management)

**Example:** Cost incentives to encourage in-network imaging referrals

**Example:** Volume steerage to high-value acute care providers

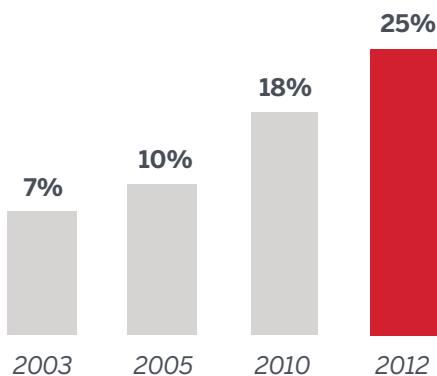
# Physicians aren't the only clinical shoppers anymore.

**Even if physician referral is still an important driver** of clinical referral decisions, patients are more actively engaging with their physicians when these decisions are being made. Patients have clear motivation to become more active consumers of health care services—they bear an increasing share of the total health care bill each year as deductible levels continue to grow.

And patients are demanding more involvement in making health care decisions. Activated patients want to be the subject of care, not the object. They want health care to become more participatory and less paternalistic.

## High-Deductible Health Plan Enrollment

*Percentage of Adults with Deductibles of \$1,000 or More<sup>1</sup>*

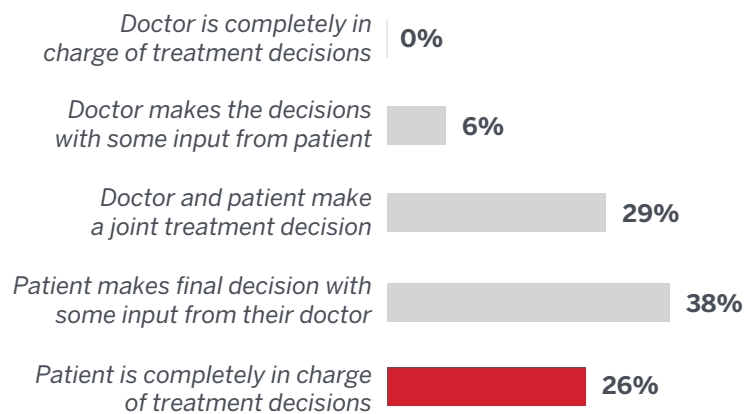


1) Insured adults age 19–64.



## Consumer Viewpoint on Role in Care Decision Making

n=2,071



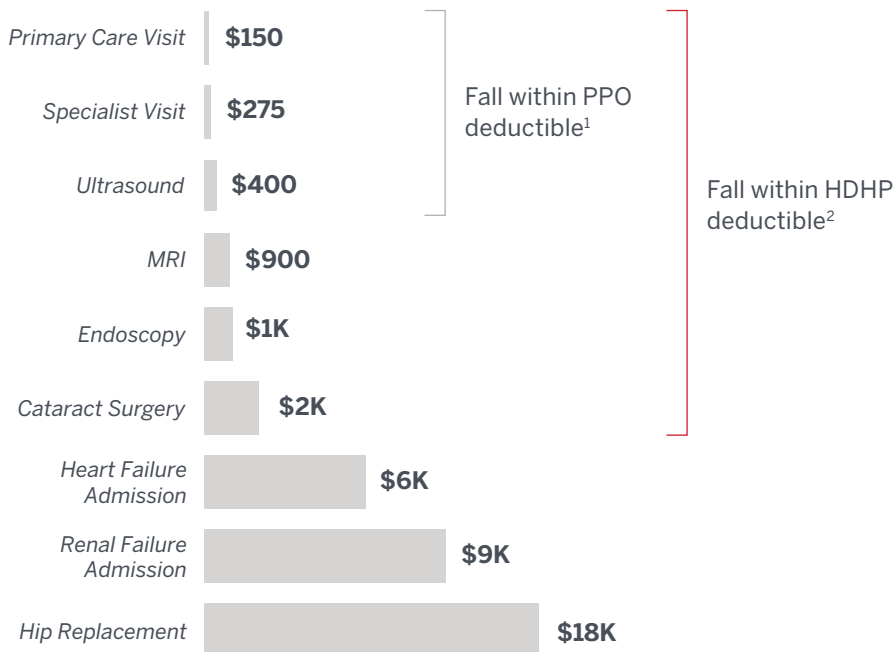
**33%** Respondents age 25 to 34 preferring fully active role in care decision making

# As deductibles grow, more health care services are becoming subject to **price sensitivity**.

**The steady rise of deductible levels** is rapidly changing care consumption trends. A host of new clinical services—physician visits, imaging, and even some outpatient procedures—are now exposed to the forces of consumerism.

Price transparency is adding fuel to the fire. As prices become more transparent, patients are quickly realizing the massive price variation that exists across providers. Paying for an MRI scan in Washington, DC, can cost anywhere from \$411 to nearly \$2,200. That's upwards of \$1,800 in additional—and avoidable—out-of-pocket spending for patients with high-deductible health plans.

## Consumers Paying More Out-of-Pocket



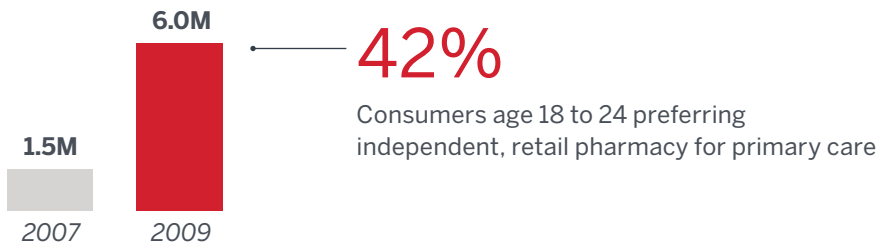
1) \$733; based on Kaiser Family Foundation report of average PPO deductible.

2) \$2,086; based on Kaiser Family Foundation report of average HDHP deductible.




# Patients are also demanding new **convenient care** options.

**Similar to the wholesale buyers**, price is just one of several factors influencing consumers' health care purchasing decisions. Time-sensitive patients prioritize convenience and extended access. As a result, retail clinic visits continue to grow. And new concierge practices—often offering same-day appointments, patient portals, and virtual visits—are flourishing in markets nationwide. These models directly answer consumers' increasing calls for convenient, accessible care options, and are steadily shifting market share and interrupting established referral networks.

## Rising Popularity of Retail Clinic Visits



## One Medical Group's On-Demand Services

-  Same-day appointment booking online, through mobile app
-  Physician email consultations for minor illnesses, ongoing management
-  Coordinated tests, treatments, specialist referrals, hospitalizations



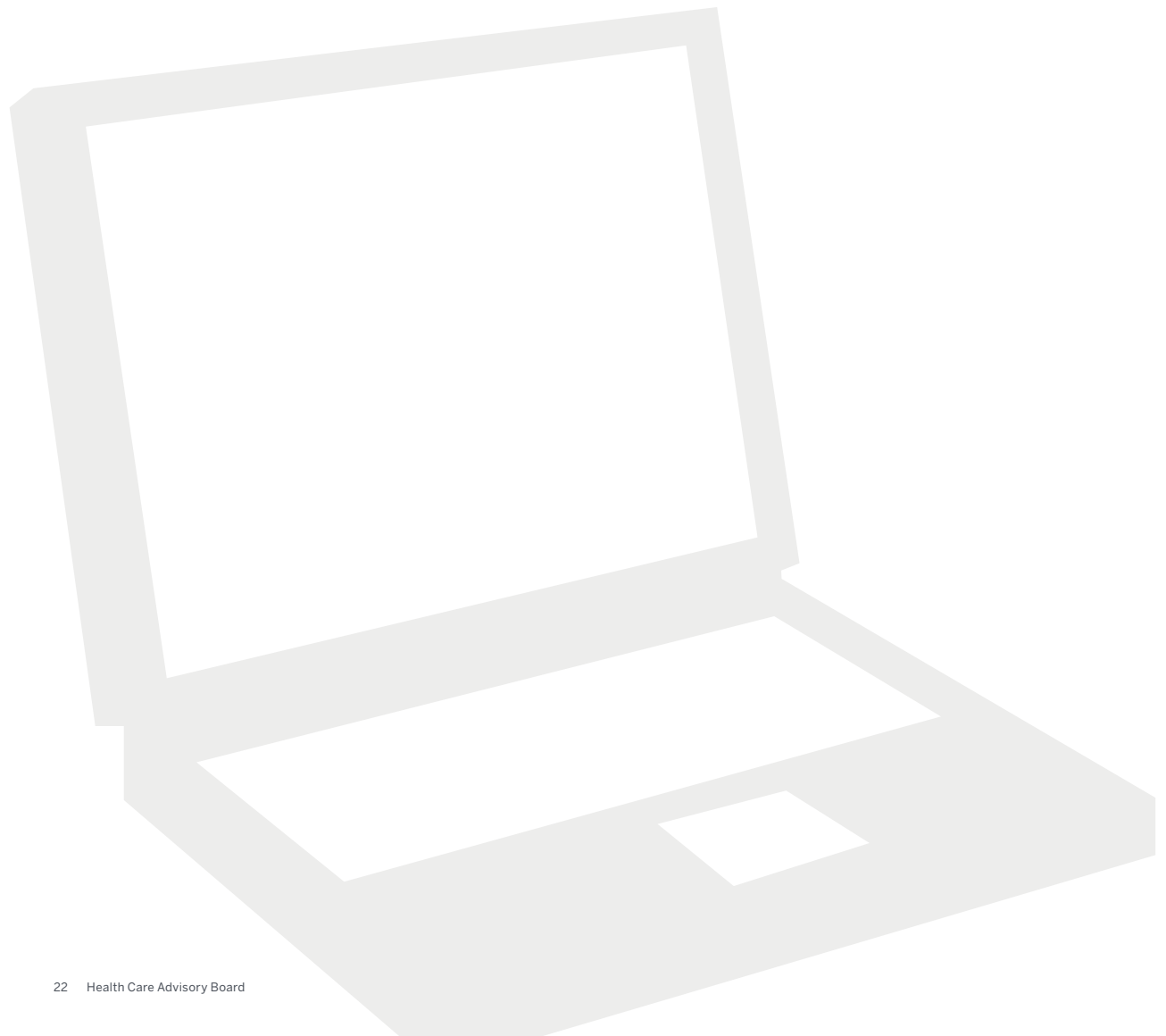
### Case in Brief

*One Medical Group*

- 90-physician network based in San Francisco, California
- Patients pay \$149 to \$199 for annual membership

## Patients are reading your online reviews. **Are you?**

**Finally, consumers consider clinical and service quality** when making their health care purchasing decisions. With limited clinical data available, however, patients turn to anecdotal data to guide their clinical shopping. Using websites such as Yelp, patients now find health care providers just like they find restaurants. Reputation matters to the activated patient. Just a handful of negative reviews can scare consumers away from physician practices and hospitals.





## Wave of Tools to Search Health Care Consumer Ratings

**Marcus Welby, MD**  
General Practice

★★★★☆

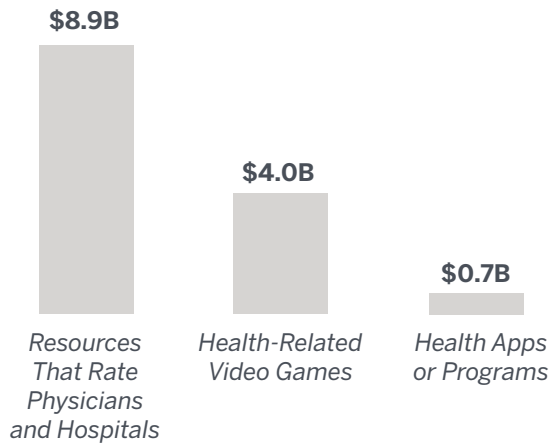
497 reviews (read below)

yelp

Other available apps, websites:

- Consumer Reports
- HealthGrades
- RateMDs
- Vitals
- ZocDoc
- PatientsLikeMe

## Consumer Willingness to Spend Out-of-Pocket for Health-Related Tools



**48%**

Consumers reading health-related reviews online

**33%**

Consumers using health-related online reviews to decide where to get care

## Successful hospitals will win share by embracing **new market identities**.

**Hospitals and health systems must reshape their strategies** to appeal to empowered decision makers, especially wholesale buyers and clinical shoppers. As part of developing their new competitive strategies, hospitals will need to evaluate potential market identities that can appeal to the new decision makers. Four dominant provider identities are beginning to emerge:

- 1 Best-in-class acute care destination**
  - Consistently delivers efficient, effective acute care episodes
  - Ensures reliable coordination, communication, data sharing across the care continuum
- 2 Consumer-oriented ambulatory network**
  - Maintains extensive network of outpatient care sites
  - Offers convenient primary care, diagnostic, procedural services at competitive prices
- 3 Full-service population health manager**
  - Assumes delegated risk from institutional purchasers
  - Prioritizes care management, coordination to limit avoidable demand
- 4 Financially integrated delivery system**
  - Assumes full risk by offering health plan to subscribers
  - Unifies care financing and delivery into single coordinated care enterprise

## The right identity depends on the intended purchaser—and payment model.

**The four emerging market identities are not mutually exclusive;** many organizations will effectively fill multiple roles in their market. But the four identities reflect different strategic priorities, infrastructure investments, and growth opportunities. They also attract different decision makers and rely on different payment mechanisms.

The best-in-class acute care destination and full-service population health manager appeal most directly to wholesale buyers. These identities are designed to help risk-bearing entities—commercial payers, activist employers, and ACOs—successfully manage their financial accountability.

Conversely, the consumer-oriented ambulatory network and financially integrated delivery system most directly attract clinical shoppers. These two models appeal to price-sensitive individuals when they're selecting sites of care or health insurance plans.

The best-in-class acute care destination and consumer-oriented ambulatory care network compete for share of volumes, so they're principally paid through episode-based payments. These can include traditional fee-for-service payments or a range of new bundled payment models.

The full-service population health manager and financially integrated delivery system compete for share of lives, typically accepting risk-based payments as part of the contractual relationship. The full-service population health manager typically signs shared savings or capitated contracts, while the financially integrated delivery system accepts the full risk of selling health insurance.

## IDENTITY #1:

Best-in-Class Acute  
Care Destination



IDENTITY #2



IDENTITY #3



IDENTITY #4

# Compete for share of appropriate inpatient demand through superior performance.

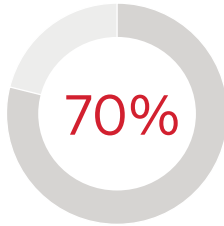
**The best-in-class acute care destination** is the epitome of an effective hospital, reliably providing high-quality, low-cost episodes of care. Remaining largely in the fee-for-service environment, this role appeals most directly to wholesale buyers that are managing risk for their patient populations.

Even if commercial payers, employers, and population health managers can effectively reduce avoidable utilization, they will still need high-value partners to treat their unavoidable demand—which research suggests is 70% or more of overall health care spending.

While most hospitals aspire to fill this role, only a few will successfully stand out among their peer institutions. Beyond delivering high-value care, the best-in-class acute care destination proactively demonstrates and communicates its superior performance to potential purchasers. To successfully embrace this identity, hospitals must prevent inpatient care from becoming a commodity by providing high quality and low episode cost—not just in-hospital cost.

### Key Imperatives:

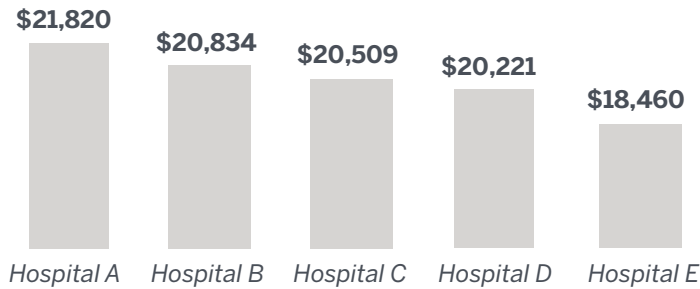
- Deliver superior episodic care outcomes
- Assemble reliable specialist and post-acute care network
- Ensure effective collaboration and communication with purchasers



Percentage of health care spending considered unavoidable

### Not All Hospitals the Same

90-Day Episodic Cost, Total Knee Replacement



**\$1,680** Potential shared savings to physician ACO per lower-cost referral<sup>1</sup>



#### Analysis in Brief

- Advisory Board analysis of five competing hospitals in major metropolitan area
- Compared total 90-day cost to Medicare for episodes beginning with DRG 470 (total knee replacement)
- Use of Medicare cases in single market controls for pricing disparities
- Statistically significant ( $p < 0.02$ ) difference between average episodic costs suggests real differences in utilization patterns

1) Assumes 50 percent shared savings.

# Build the high-performing provider network.

**To successfully emerge as the best-in-class** acute care destination, hospitals will need to develop high-performing provider networks that span the care continuum. Thus, hospitals embracing this identity will need to make partnership management a core competency.

Hospitals will start by building a premium physician network, paying special attention to the proceduralists and hospital-based specialists who collectively form an efficient acute-care enterprise. But next on the partnership list are the post-acute care providers, critical allies for reining in post-discharge costs. Hospitals will need to select the right clinical partners—and develop the right relationship models to ensure effective partnership and mutual accountability.

## Assembling the Comprehensive Specialist Network

Specialist Partners	Key Responsibilities	Evaluation Criteria
<b>Community-Based Medical Specialists</b> <i>e.g., Cardiology, Oncology, OB/GYN</i>	<ul style="list-style-type: none"> <li>• Medical management</li> <li>• Care coordination</li> <li>• Efficient consultation</li> </ul>	<ul style="list-style-type: none"> <li>• Cost accountability</li> <li>• Referral patterns</li> <li>• Patient follow-up</li> </ul>
<b>Proceduralists</b> <i>e.g., General Surgery, Neurosurgery</i>	<ul style="list-style-type: none"> <li>• Procedural outcomes</li> <li>• Standardized protocols</li> <li>• Care coordination</li> <li>• Quality improvement</li> </ul>	<ul style="list-style-type: none"> <li>• Error, complication rates</li> <li>• Readmissions rates</li> <li>• Procedure volume</li> <li>• Evidence-based practice</li> </ul>
<b>Hospital-Based Non-admitting Specialists</b> <i>e.g., Radiology, Pathology, ED Physicians</i>	<ul style="list-style-type: none"> <li>• Inpatient efficiency</li> <li>• Clinical outcomes</li> <li>• Prompt communication</li> </ul>	<ul style="list-style-type: none"> <li>• Care transitions</li> <li>• Compliance with care pathways</li> </ul>

## Three Elements of the Aligned Partner Network

1

**Rigorous Selectivity:** Partners are selected based on specific list of criteria related to cost, quality

2

**Compatible Culture:** Communication and training a focus for both owned and non-owned entities

3

**Collectively Managed Performance:** All network participants held accountable to performance standards

# Ensure best-in-class **collaboration and communication** with decision makers.

**Partnership management extends** well beyond the provider network. The best-in-class acute care destination collaborates and communicates effectively with purchasers too, evolving from a subcontractor to a force-multiplier.

Large purchasers, especially physician ACOs, need ongoing collaboration with their hospitals partners to perform at the top of their game. They want access to real-time data—especially the admissions, discharges, and transfers (ADT) feed. And they want to actively participate in care coordination throughout admissions.

Securing status as the best-in-class acute care destination means more than delivering superior clinical care—it means ensuring superior communication and collaboration along the way.

## Commitments to Delivering High-Value Care



### Data Sharing

- Real-time utilization feedback for PCPs; can dictate patient transfer to health facility
- Interoperability between physician, hospital IT systems



### Care Coordination

- Care managers on site, collaborate with floor RNs; responsible for care management, follow-up
- Mutually defined standards of care
- Preferred network honored

## Elements of Effective Partnership



### Discharge Planning

- PCP notified of patient discharge, collaborates on discharge care plan
- Care transitions based on patient history and preferred providers



### Strategic Alignment

- Dedicated seats for staff on multiple committees
- Co-investments for planning, development of service expansions

## Compete for share of **consumer-selected** outpatient volumes.

**The consumer-oriented ambulatory network wins share** by offering price-competitive, convenient care options directly to patients. Embracing this identity, however, requires facing new competitors, especially name-brand retailers such as CVS, Walgreens, and Walmart. It also means responding to the forces of consumerism, particularly demands for affordable prices, on-demand access, and tailored services.

### Major Categories of Consumer Preference



#### Affordability

- Reasonable price compared to similar options
- Clear pricing to streamline payment
- Guidance on which sites are most affordable



#### On-Demand Access

- Immediate availability
- Broad range of hours open
- Rapid completion of service
- Geographic proximity to home, work, errands



#### Tailored Service

- Comprehensive visit length
- Provider interaction matches expectation
- Delivery options tailored to specific need

### Key Imperatives

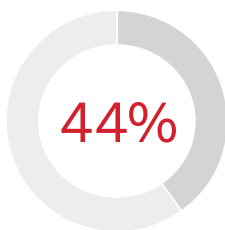
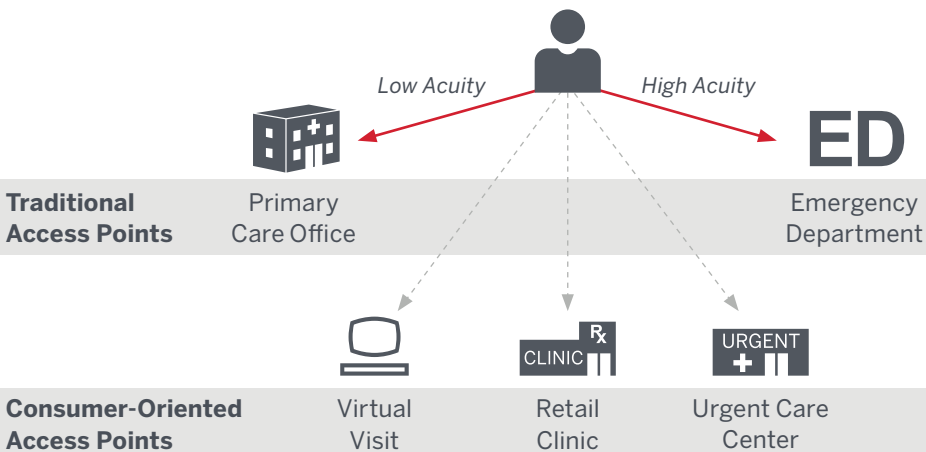
- Offer affordable options for consumer-selected care services
- Assemble network of convenient care options
- Explore premium-priced, expanded-access primary care models
- Convert initial ambulatory visits into lasting patient relationships



# Offer a variety of **convenient** care options.

**Hospitals and health systems choosing to compete** in the consumer-oriented ambulatory arena will need to dramatically expand their range of ambulatory care options. The two traditional ambulatory access points—primary care offices and emergency departments—don't sufficiently meet consumers' demands for affordability or convenience. So hospitals are investing in a range of consumer-oriented care access points, especially urgent care centers, retail clinics, and virtual visit capabilities. Unfortunately, each model comes with a set of pure play competitors. As a result, many hospitals are considering partnership with established providers in their markets.

## Consumer-Oriented Service Delivery Sites Filling the Gap



Retail visits occur when physician office is likely to be closed

# Attract price-sensitive consumers with competitive offerings.

**Having the right set of ambulatory services** available is just the first step. Next, hospitals need to price these services attractively. Without an effective pricing strategy, price-sensitive consumers will choose a lower-priced alternative—or delay care altogether. Hospitals want their ambulatory services to appear affordable, which means they're priced low enough to attract patients and are comparable to low-cost alternatives in the market.

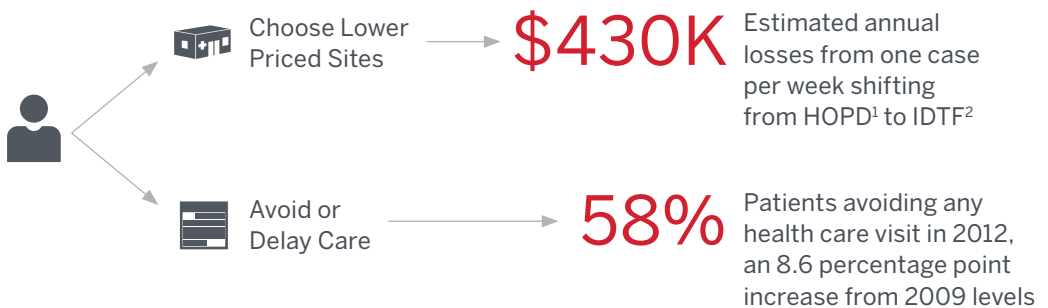
Hospitals have explored a range of models making their prices more attractive, such as implementing across-the-board price reductions and selling discount cards. But some providers are putting the pricing decision directly in patients' hands. For example, the CarePilot scheduling service offers steep discounts—upwards of 30%—if patients select off-peak appointment times. This makes selecting an imaging appointment similar to booking an airplane ticket.

## What does it mean to be 'affordable'?

1 Prices low enough to attract patients

2 Comparable to other prices in the market, particularly the lowest price

## Price-Sensitive Consumer Behaviors



1) Hospital outpatient department.

2) Independent diagnostic treatment facility.

## CarePilot Scheduling Service



- Patient searches for needed service
- Available appointments sorted by price, time

### Available Appointments and Prices

*CT Scan Without Contrast, Near Denver*

October 2013				
Mon	Tues	Wed	Thurs	Fri
7 \$543	8 \$472	9 \$543	10 \$543	11 \$472
14 \$543	15 \$472	16 \$543	17 \$543	18 \$472
21 \$543	22 \$472	23 \$543	24 \$543	25 \$472
28 \$543	29 \$472	30 \$543	31 \$543	



### Case in Brief

#### *CarePilot*

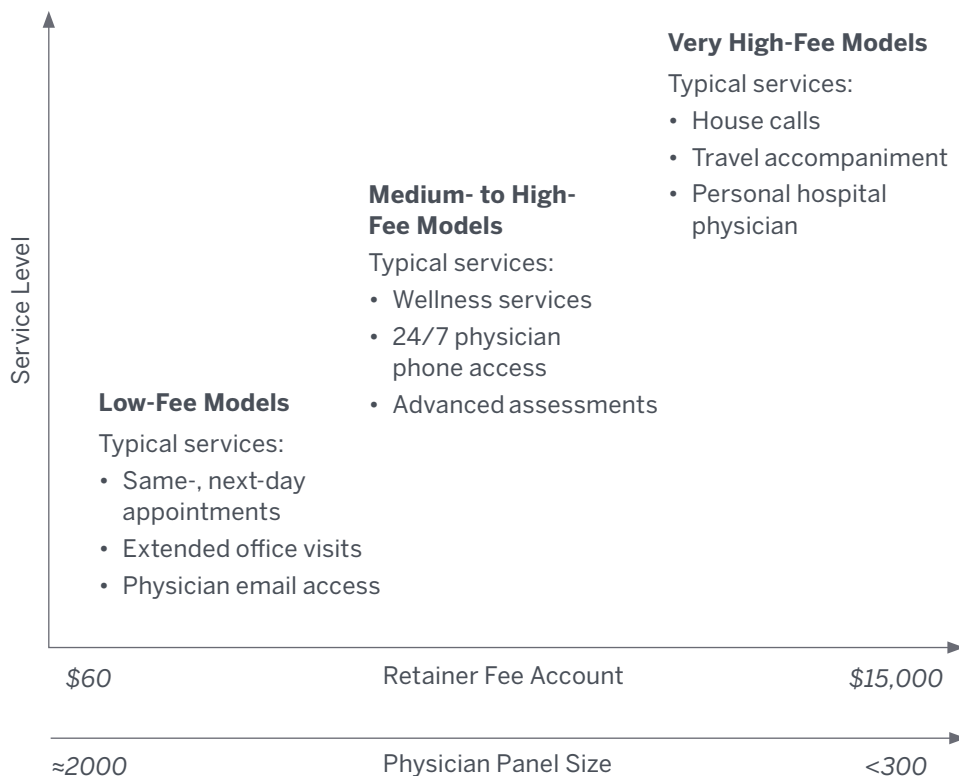
- Colorado-based company contracts with 300 providers to offer available medical appointments for variety of procedures
- Providers promote off-peak appointment times priced at 10% to 30% discount
- Patients must pay up-front through HSA,<sup>1</sup> credit card, or PayPal; may submit claim to insurance later

1) Health savings account.

# Consider premium payment models—even concierge medicine.

**But finding a low price** isn't always consumers' top motivation, at least not for all ambulatory services. On-demand access is a more important consideration for many patients—and they're even willing to pay a premium to get it. As a result, providers are exploring a range of concierge medicine models, offering different service levels at different price points. Hospitals can't afford to cede the patients seeking premium experience to the new competitors offering improved access and service.

## Landscape of Concierge Medicine



# Convert initial ambulatory visits into **lasting relationships**.

**Finally, hospitals embracing** the consumer-oriented ambulatory network identity need to capitalize on the prime advantage they have over pure-play competitors—their ability to form long-term relationships with patients. Hospitals need to develop a clear plan for connecting patients who access convenient care site visits with affiliated primary care practices.

Mercy Medical Center in Des Moines, Iowa, has developed an effective model for converting urgent care visits to standing relationships. They co-locate urgent care centers with primary care practices—and hardwire the referral protocols to ensure effective handoffs from urgent care to primary care. As a result, they’re able to increase new patient visits, decrease wait times, and improve patient satisfaction. And over time, these relationships will lead to future revenue too.

## Components of Timely Appointment Conversion at Mercy Medical Center

*Support on-demand care sites with accessible referral points*

*Secure next step with hardwired referrals protocol*



### **Advanced Access**

Most employed PCPs maintain same-day access slots for on-demand care



### **Multiple Site Options**

Mercy has 100 PCP providers at 35 locations, multiple urgent care centers in region



### **Referrals Protocol Control**

As clinic sole owner, Mercy controls operations, prioritizes in-network referrals for follow-up care



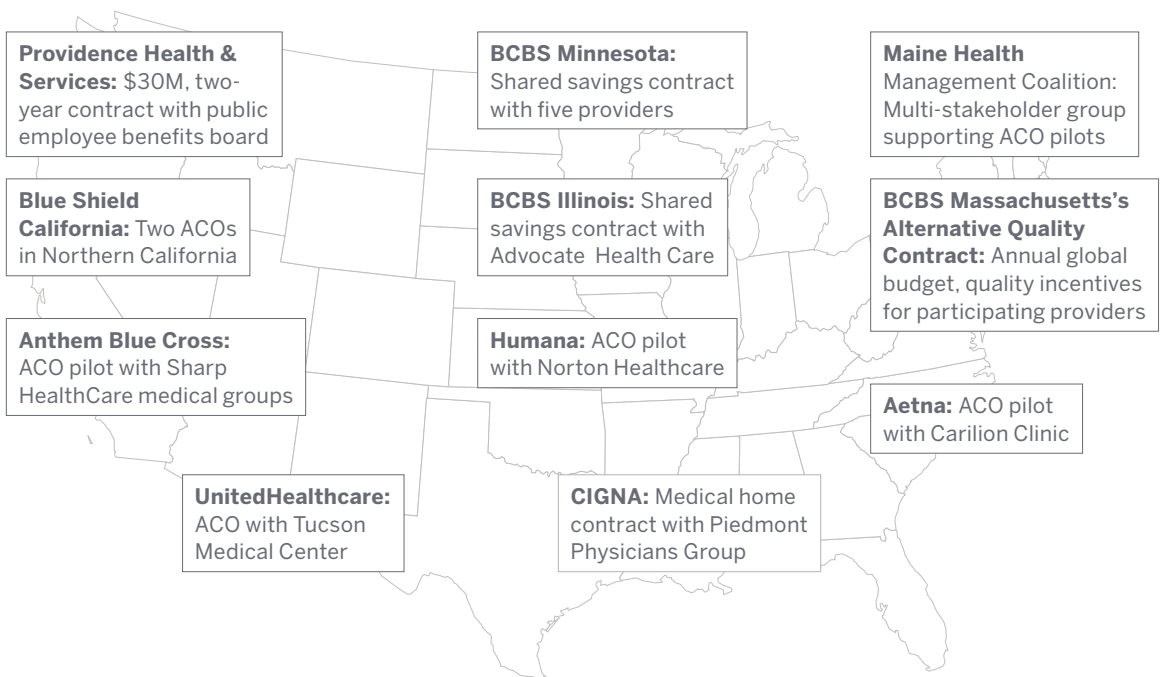
### **Staff Alignment**

Retail NPs staff employed physician offices one day per week to develop trust, reinforce network coherence



## Compete for **share of lives** by appealing to risk-bearing institutions.

**The full-service population health manager wins** share of lives by contracting directly with risk-bearing wholesale buyers. Commercial payers and activist employers are looking for new solutions to address their mounting health care spending—and they're increasingly willing to delegate their financial accountability to providers as part of the solution. As a result, providers and purchasers are entering into shared savings and capitated contracts, forming ACOs in the private sector. The full-service population health manager accepts this financial risk and effectively manages the total cost of care for its attributed patient population.



### Key Imperatives

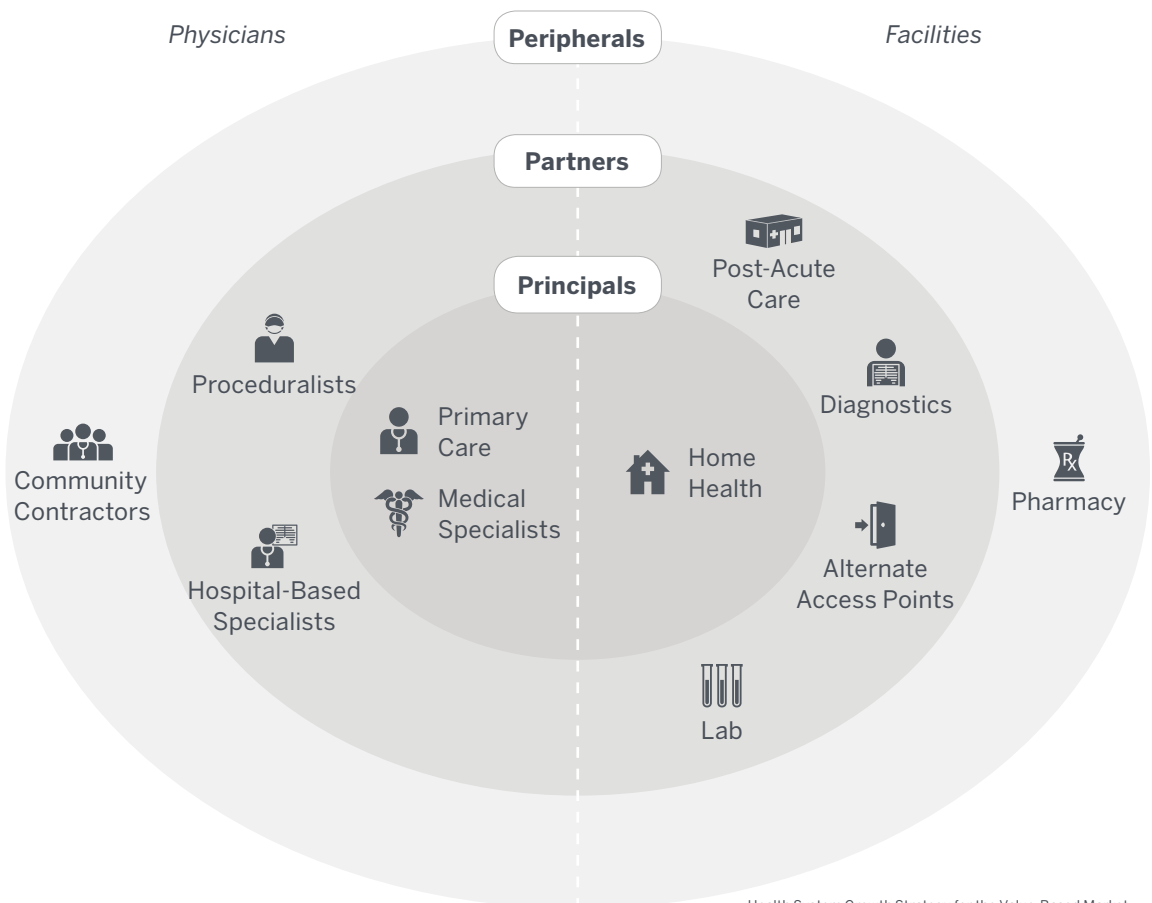
- Assemble comprehensive, convenient provider network
- Sign risk-based contracts with purchasers
- Segment patients based on clinical and psychosocial risk factors
- Deploy tailored care models to support specific patient populations

# Assemble a comprehensive—and appealing—full-service provider network.

**Hospitals and health systems embracing** the full-service population health manager identify must be able to attract wholesale buyers, and that means developing an appealing provider network. Employers and commercial payers want a turnkey solution, encouraging hospitals to assemble the full-service network capable of delivering hospital, physician, ambulatory, and post-acute care. And these providers need to be located near where potential patient populations live and work—convenience matters, especially to employers.

Hospitals don't need to rush out to buy all of these assets and providers. Leading organizations are forming partnerships to build out their networks. While full ownership, employment, or clinical integration may be necessary for certain "Principal" providers, looser affiliations and performance-based contracts are proving sufficient for "Partner" and "Peripheral" providers.

## Comprehensiveness Not Contingent Upon Ownership



# Sign risk-based contracts to **share in the rewards** of effective care management.

**After attracting potential purchasers** with comprehensive provider networks, hospitals can begin to negotiate risk-based contracts. These contracts are critical for aligning incentives around effective population health management. Risk-based contracts help offset the revenue hospitals would otherwise lose from effective care management—plus the initial investment and ongoing costs of operating new care management infrastructure.

But hospitals can't enter into shared savings or capitated contracts lightly. They must complete thorough analyses, especially around the patient population's risk profile, opportunity to reduce spending, and the ultimate impact on the hospital's cost structure.

## Three Must-Do Analyses

# 1

### **Dynamic Population-Level Risk Profile**

Ongoing tracking, analysis of trends, variation in aggregate measures including:

- Incidence of disease
- Prevalence of risk factors
- Typical utilization patterns

*Key Resources: Market-wide data set (or large representative sample); statistical analysis capabilities*

# 2

### **Evidence-Based Opportunity Assessment**

Objective comparison of current performance with feasible benchmarks

- What are realistic targets for average spending for a given condition?
- How likely is the best-case scenario? What about the worst-case?

*Key Resources: Validated benchmarks, actuarial modeling, clinical input*

# 3

### **Cost Structure Impact Projection**

Explicit analysis of impact of utilization reductions on provider expenses

- How variable are the expenses incurred for a given condition or treatment?
- What will the true dollar impact of utilization reduction be?

*Key Resources: Accurate cost accounting, understanding of potential to variabilize fixed costs*



# Deliver the right care to the right patients through effective segmentation.

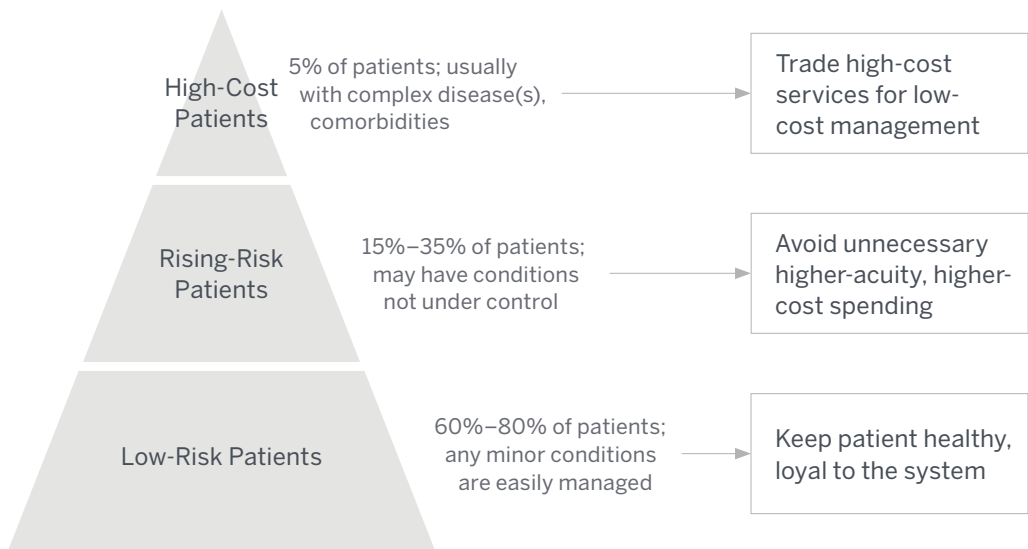
**With a risk-based contract in place**, hospitals embracing the full-service population health manager identity must next become effective care managers. Best-in-class population health managers carefully segment their patient populations—typically into high-cost, rising-risk, and low-risk strata—to ensure patients receive appropriate care and coordination.

*High-cost patients* need intensive support, often in the form of a high-risk care manager who works exclusively with the sickest patients. Models like the medical home just aren't sufficient for these vulnerable patients.

*Rising-risk patients* need effective chronic disease management to ensure they don't get sicker and graduate to the ranks of high-risk patients. Every year, nearly 20% of rising-risk patients make the leap to high-risk patients. For these patients, the medical home model—focused on chronic disease management and patient engagement—is the right approach.

*Low-risk patients* need less obtrusive interactions with the health care system. Hospitals want to keep these patients loyal and monitor their health status to keep them healthy. Leading population health managers are turning to patient portals and virtual visits to support low-risk patients.

## Managing Three Distinct Patient Populations



## Compete for share of lives in the **individual market.**

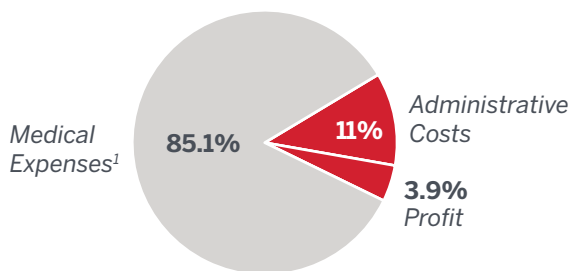
**The financially integrated delivery system builds** on the care management expertise of the full-service population health manager. But instead of accepting delegated risk from a payer or self-funded employer, the financially integrated delivery system sells health insurance directly to consumers and fully insured employers. Succeeding under this identity requires superior performance as both a care manager and health insurer.

There are clear benefits to becoming a financially integrated delivery system. This identity is the sole path to capturing the full premium dollar. And there are strategic benefits—especially control over benefit design.

But most important, the individual market is growing rapidly. Enrollment in Medicare Advantage plans continues to rise, and public and private health insurance exchanges are gaining momentum. More patients will be selecting their health plans—and the narrow networks attached to them—in the individual market each year.

### Allocation of Premium Dollar

*National Health Insurers, 2011*



### Benefits of Bearing Full Risk



Capture full premium dollar from subscribers



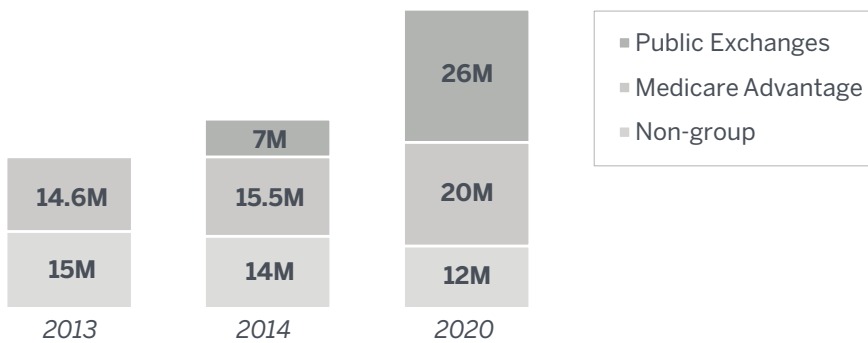
Manage utilization with benefit design, steer patients to owned or affiliated facilities and providers



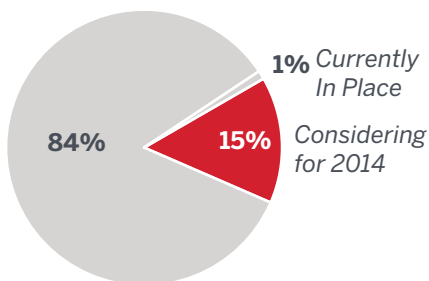
Present credible contracting threat to health insurance companies

1) Includes quality improvement expenses, rebates.

## Projected Individual Market Composition<sup>1</sup>



## Employer Participation in Private Health Insurance Exchanges



**6.2M**

Potential private exchange enrollees in 2014 if 15% of defined contribution firms subscribe

### Key Imperatives

- Develop health plan infrastructure and management competencies
- Attract consumers through competitive health plan offerings
- Ensure effective population health management

1) Congressional Budget Office projections for non-group, public exchanges. Advisory Board analysis for Medicare Advantage. Non-group refers to current, non-Medicare Advantage individual market purchasers.

# Health systems face **major barriers** to forming new health plans.

**While the financial and strategic benefits** of forming a health plan are alluring, hospitals and health systems embracing the financially integrated delivery system identity must fully acknowledge the substantial challenges before them. Forming a high-functioning health plan requires infrastructure and management capabilities that most hospitals currently lack. Hospitals would also need to navigate a host of complex regulatory requirements and allocate a large amount of capital to reserves.

## Challenges to Establishing Health Insurance Company



### Expanded Management, Analytic Capabilities

- Recruitment, retention of experienced executive management difficult
- Determining actuarial value requires vast patient data, pricing expertise



### Complex Regulatory Requirements

- Subject to product, financial, market regulations, consumer dispute protections, licensing requirements
- \$1.2B spent annually on state regulators; 342 licenses revoked or suspended in 2010



### Claims Processing Infrastructure

- Investment in claim submission, adjudication system required
- Verify benefits, address out-of-network services, adjudicate claims, submit payments



### Substantial Reserve Requirements

- Significant capital, surplus requirements for accreditation, vary by state (ranging from \$150K to \$7M)
- Median national capital, surplus retained by health insurers: \$15M



### Caveat Emptor

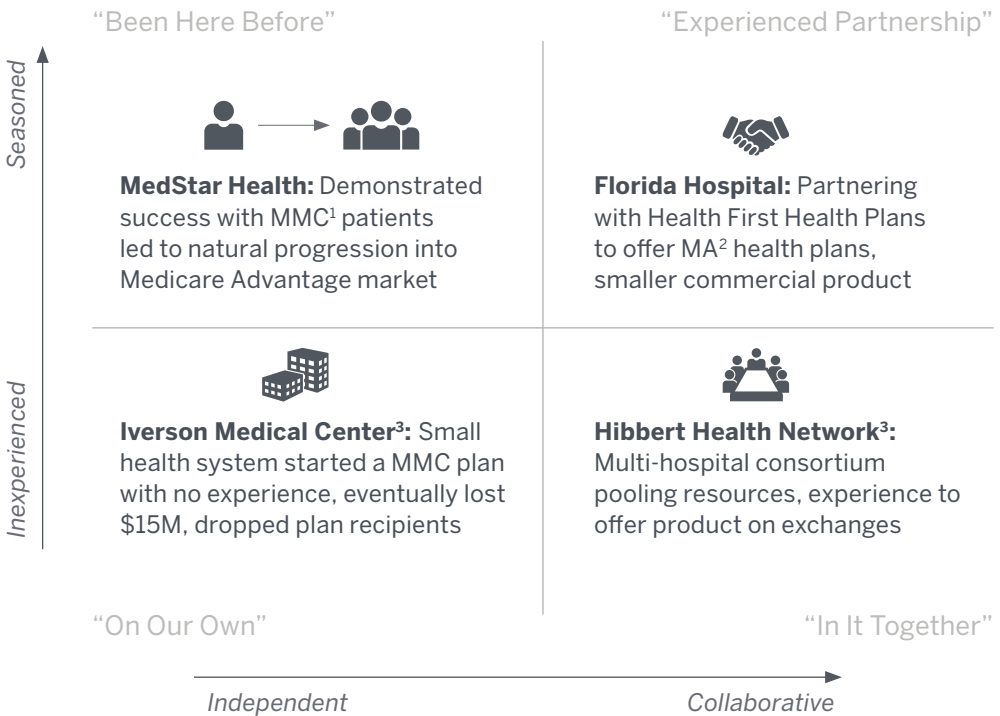
“We tried becoming an insurer in the 90s and found out that we didn’t know what the hell we were doing. Truth be told, we probably lost about \$120 million.”

*SVP, Large Health System*

# Explore partnership opportunities with established health plans.

**Given the host of challenges hospitals and health systems** would face in starting a new health plan on their own, some organizations are taking the partnership route. Hospitals and health plans are forming new partnerships and offering co-branded plans in insurance exchanges and the individual market. This path allows hospitals to learn the health plan business from seasoned veterans—and bypass many of the barriers to new plan development.

## Provider-Sponsored Health Insurance Plan Development Strategies



1) Medicaid Managed Care.  
 2) Medicare Advantage.  
 3) Pseudonym.

# Design competitive health plan offerings for the individual market.

**Regardless of whether hospitals** become financially integrated delivery systems through partnerships or on their own, they're going to need to attract consumers in the individual market. If results from the Massachusetts health insurance exchange are any indication, that means offering low premiums, especially in the Bronze and Silver benefit levels.

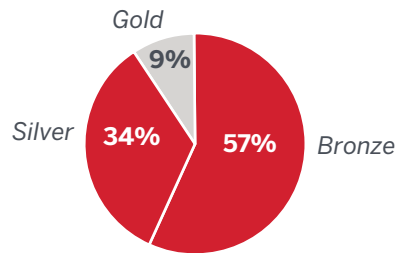
But hospitals becoming financially integrated delivery networks can't ignore the potential marketing power of their provider networks—especially as consumers increasingly choose among health plans that are all tied to narrow networks. A financially integrated delivery system must attract patients through both low premiums and a strong provider brand. Long-term success will then depend on the hospital successfully managing enrolled patients through its high-powered care management enterprise.

## Sample Monthly Premiums for Massachusetts Connector Plans

- Bronze (40%–50% AV<sup>1</sup>): \$225
- Silver (63%–75% AV): \$313
- Gold (80%–85% AV): \$390

## Plan Choice Among Massachusetts Exchange Enrollees<sup>2</sup>

2010



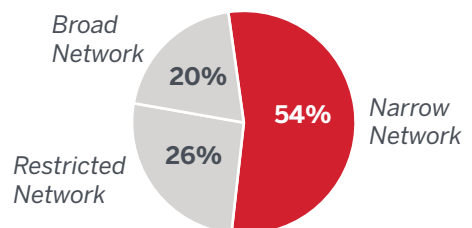
## “Premium More Important Than Brand

“Of course an employee visits the AMC if his employer is paying for it. But add \$150 to the premium for that network and the patient will gladly choose the lower-cost provider.”

*SVP, Health Plan Operations  
Large Health Plan*

## Projected Network Choices for Exchange Enrollees

All Metal Levels



1) Actuarial value.  
2) Excludes young-adult market.

## Additional Resources

- » **Sustainable Acute Care Enterprise: Radically Restructuring Costs and Operations to Break Even on Medicare**  
Explore near-term cost reduction opportunities and review 12 next-generation strategies to nurture employee innovation, capture shared value with suppliers, minimize unwarranted clinical variation, and realize the full value of systemness.  
[advisory.com/sustainacutecare](https://advisory.com/sustainacutecare)
  
- » **12 'Must Do' Strategies for Protecting Future Margins**  
Every health care executive's goal should be sustainable margins, not cost reduction. Here are 12 ways to adopt a broader view of margin management.  
[advisory.com/hcab/12marginstrategies](https://advisory.com/hcab/12marginstrategies)
  
- » **Consumer-Oriented Ambulatory Network**  
Few organizations understand how to profitably meet consumer demands for ambulatory care. Learn how to establish an attractive, coordinated, and high-performing ambulatory network that drives system growth.  
[advisory.com/hcab/ambulatorystrategy](https://advisory.com/hcab/ambulatorystrategy)
  
- » **Playbook for Population Health: Building the High-Performance Care Management Network**  
For aspiring population health managers, clinical and financial success depends on successful leadership and care model transformation. This study provides a comprehensive blueprint for that transformation.  
[advisory.com/pophealthplaybook](https://advisory.com/pophealthplaybook)
  
- » **5 Steps to Build the Advanced Medical Home**  
The advanced medical home is what's next in primary care innovation. Get five strategies for evolving the current model to scale care management across the health system.  
[advisory.com/hcab/advancedmedicalhome](https://advisory.com/hcab/advancedmedicalhome)
  
- » **Prioritizing Population Health Interventions**  
You don't need comprehensive data or world-class analytics to start making an impact on population health. Learn how to identify which patients are at risk, why they are at risk, and who would benefit most from intervention.  
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