Hospitals and health systems must re-think delivery strategies

New technology and patient concern for cost and safety draws competition and opportunities that never before existed

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EXECUTIVE SUMMARY

Hospitals have traditionally been the centerpiece of healthcare delivery in the United States but that is shifting. Big changes are afoot that will forever alter the landscape of healthcare delivery. Technology continues to facilitate the migration of more and more services to the outpatient setting and public view of hospitals is changing rapidly. One reason could be the fear of contracting an infection while in a hospital. The federal Center for Disease Control and Prevention recently revealed that one in every twenty-five patients visiting a hospital contracts an infection. The most frequent infection types (percentages of the total infections) are: pneumonia (21.8%); surgical site (21.8%); gastrointestinal (17.1%); urinary tract (12.9%) and primary bloodstream (9.9%).

Hospital costs represent one-third (the largest component of all healthcare sectors) of the $2.7 trillion spent on healthcare in the United States according to the U.S. government statistics. The average cost of a single day in a U.S. hospital is now five (5) times that experienced in a hospital located in any other developed nation.

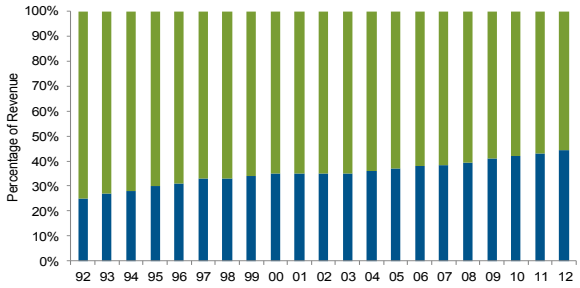
These factors have created pressure to develop alternative delivery models that are proving to be both viable and cost effective for consumers and their employers. It has been observed that large portions of hospital-based outpatient services are shifting to alternative delivery venues. Hospitals must begin to incorporate alternative delivery strategies into their existing models if they want to compete in this changing market. Failing to do so they will eventually be recast as cost centers and their size and scope will begin to fade. Those hospitals that have invested heavily in static facilities that require the patient to come to them will need to find ways to bring their services to the patients.

THE IMPETUS

New technology, coupled with the consumer's desire to be in better control of their healthcare is driving the movement. Patients' are increasingly frustrated with the lacking accessibility and the high cost of quality healthcare. Even in the face of significant cost reductions, hospitals have successfully raised their prices and shifted fees to private insurance payors and individuals, in answer to controlled pricing from Medicare and Medicaid.

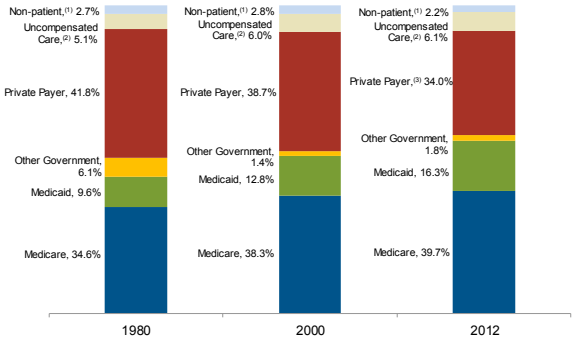
Inpatient revenues, though still the majority of a typical hospitals total revenue, do not represent a like portion of net income for hospitals and health systems. Outpatient revenues

now dominate the interests of hospital operators. The following chart provided by the American Hospital Association and Avalere Health, shows the steady increase in outpatient revenue as a percentage of the total hospital revenue.



Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2012, for community hospitals.

The chart below provides some insight into why hospitals need to sustain growth in outpatient revenue. Hospital operating costs associated with private payor classes have decreased from 41.8% in 1980 to 34.0% in 2012, Medicare and Medicaid have increased in combination from 44.2% in 1980 to 56.0%. What this means is that commercial payors are subsidizing the losing Medicare and Medicaid programs.



Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2012, for community hospitals.

(1) Non-patient represents costs for cafeterias, parking lots, gift shops and other non-patient care operating services and are not attributed to any one payer.

(2) Uncompensated care represents bad debt expense and charity care, at cost.

(3) Private payer formulas were updated in 2014 to account for the change in bad debt calculations, which is now reported as a deduction from revenue rather than a expense.

Competitors for inpatient services are limited while competitors for outpatient services are many and that is the challenge for hospitals and health systems. Examples include: radiology/imaging services, outpatient surgery services, laboratory, physical therapy, emergency department, physician services and urgent care. All of these services are lucrative revenue sources for hospitals. The growth in non-hospital competitors in all of these areas is great cause for concern by hospitals.

The practice of hospitals shifting the financial burdens of Medicare and Medicaid to commercial payors is unsustainable.

Commercial payors are reacting to these trends by shifting more and more financial responsibility to beneficiaries in the form of higher deductibles and co-payments. In doing this, consumers have begun to take a more active role in their medical decisions focusing on value and costs. They are looking for and finding alternatives to hospital services. By example,

commercial co-payments for a visit to the hospital emergency room are generally higher than those for urgent care centers and copayments for urgent care visits are generally higher than visits to both primary care and specialty physicians. This provides an incentive for patients to seek alternatives. Payors are generally holding on to the idea that patients need to have a primary care physician directing their care. Even in the face of increasing costs to patients in the form of higher co-payments, utilization of urgent care services and hospital emergency departments is on the rise. The steady increase in the number of Medicare and Medicaid patients is an ever-increasing part of the primary care patient portfolio. Medicare and Medicaid patients generally have lifestyles that are more accommodating of the schedules of primary care provider. Specifically, they have the time to schedule an appointment and wait. Commercially insured, non-Medicare and non-Medicaid patients do not. Their schedules do not afford them to wait and they certainly cannot schedule their illnesses. This means that the working population must seek and find cost effective care without the wait times that they encounter at primary care physician offices and without the cost of the hospital emergency department.

WHAT HOSPITALS ARE DOING TO ANSWER

Hospitals have answered the challenge presented by these changes by: integrating/opening urgent care centers/freestanding emergency departments of their own, acquiring diagnostic imaging centers, outpatient surgery centers and physician practices.

Though vertical integration like this is logical for hospitals and health systems, they are not solutions in themselves. In fact, some of the cost and access issues with these strategies are being exacerbated. Here are some examples of how:

- Many hospital-owned urgent care centers are designated as “hospital-based”. Hospital-based urgent care centers generally charge and get paid much higher rates than do freestanding/independent urgent care centers. These rates can be as much as 3 to 4 times the rates being paid to non-hospital-based urgent care providers. Payors (insurers) have provided for this in the agreements that they struck with hospitals and, in doing so, created the opportunity for hospitals to enter the market with an advantage that freestanding urgent care/freestanding emergency departments do not have.
- Diagnostic imaging centers being acquired by hospitals/health systems generally experience a post-transaction increase in revenue because, again, hospitals have provisions in their managed care agreements that allows them to charge and get paid higher rates than was the previous owner/operator.
- Fees paid for outpatient surgery are generally more lower for freestanding versus hospital-based units and thus hospital acquisition of freestanding surgery centers has not generally been as financially rewarding as other outpatient services, nonetheless, hospitals have engaged in the acquisition of these facilities as a means of collecting market share. Like with imaging and urgent care center, the fees charged and paid to hospital-based surgery centers are higher.
- The acquisition of physician practices has been increasing steadily over recent years. Though it sounds reasonable for hospitals to integrate physician practices, only a change in the delivery model makes it so. Hospitals acquiring physician practices with no plan or intention of adapting them to a broader plan of delivery generally only results in significant financial losses and more cost to the consumer. The best reason for hospitals to integrate physician practices is to align goals for the enterprise and to alter

the delivery model so as to capitalize on that re-alignment. Few health systems and hospitals do this. It has been proven time and time again that acquiring a physician's practice, with the expectation of any enhanced efficiency, is a fallacy. Most often the inverse is true; the high cost environment of the hospital becomes part of the otherwise cost efficient medical practice. Some may facilitate improved reimbursements but this does not translate into savings or enhanced efficiency for the consumer.

Each of these strategies, if done for the right reason and with a clear vision in mind can result in a successful overall health system strategy. The key is to engage them all in an organized manner to facilitate a population health strategy.

So what is a population health strategy and how does a health system engage resources to create one. This is what we will explore now.

WHAT HOSPITALS COULD BE DOING?

Hospitals and health systems need to step back and take a broader look at their market, their resources and ways to connect them. Earlier it was pointed out that acquiring physician practices could be a successful strategy if it is done to align objectives. The same can be said of all other acquired or developed resources. Taking a look at a health system's resources requires an objective look from someone outside the organization because those inside the organization tend to either embellish or under state the value of certain resources. For example, an integrated orthopedic surgeon may be the biggest revenue producer for the hospital but may also be the biggest liability for a large local employer or insurance payor due to case costs or outcomes. If so, sustaining that resource without adaptation to the employers'/payors' needs will surely be a short-term solution.

Imagine a health system with a large hospital, a large integrated physician network, two freestanding surgery centers, four urgent care sites and an overall market penetration of around 60% versus its competitors. One would expect that this health system is both healthy and satisfied with its position, regardless of what its competitors do. A closer look at what happens in this type of market is the larger local employers are becoming increasingly dissatisfied with the performance of systems like this in terms of cost and outcomes and, most importantly, focus on their needs as the payor for healthcare services. Having such large market share generally makes such a provider the focus of claims and healthcare costs by employers, weary and drained. Employers have proven to be more likely than not to pursue the opinions of those other than the local hospital when it comes to addressing the issue higher healthcare costs and some have decided to take matters into their own hands.

Price Waterhouse Cooper's (PWC) healthcare research team recently discussed the following topics:

Four factors deflate medical cost trend in 2014:

- Care continues to move outside costly settings such as hospitals to more affordable retail clinics and mobile health. Consumers value the convenience, and costs can be as little as one-third of the bill in a traditional healthcare site.
- Major employers such as Wal-Mart, Boeing, and Lowe's now contract directly with big-name health systems for costly, complicated procedures such as heart surgery and

spinal fusion. The employers are making the move to "high performance networks" far away from the home office in the belief that even with travel costs, these networks still deliver overall savings.

- The federal government's new readmission penalties take direct aim at waste in the health system, estimated to be as high as 30%. According to government data, hospital readmissions dropped by nearly 70,000 in 2012, and this trend is expected to accelerate through 2014 as hospitals focus on discharge planning, compliance and the continuum of care.
- Seventeen percent of employers in PwC's 2013 Touchstone survey today offer a high deductible health plan as the only option for employees. And more than 44% are considering offering it as the only option. When consumers pay more for their healthcare, they often make more cost-conscious choices.

Two factors inflate medical cost trend in 2014

- Until recently, widespread adoption of generic medicines helped dampen overall medical inflation, but the rise of expensive complex biologics will nudge spending trends upward. Approvals of new biologics now outpace traditional therapies, and that pattern will continue in 2014 as research efforts target complex cases such as cancer.
- Health industry consolidation has increased more than 50% since 2009—activity that is expected to continue through 2014. Higher prices are sure to follow in some markets. According to a recent report, hospital mergers can lead to price increases of up to 20.3% These price increases are especially acute in markets with one dominant system.

With these as a backdrop and continuing with our imaginary "health system" (the United States does not really have a single system), would it be wise for regional health system to engage local employers in meaningful discussion about issues/concerns and to focus on ways to cultivate win/win solutions or should they wait for the smaller local competitor to make a move and then react to it? What if the small local competitor was part of something larger? Just like individual "stand alone" hospitals are becoming extinct, so will regional systems if they don't connect nationally with other regional systems. The even bigger problem is that hospitals and health systems have built their business entirely around a consumptive product line; a fee-for-service model that requires more volume and maximum pricing. Though it is true that hospitals and health systems have little to gain from embracing wellness initiatives or changing the delivery models that define them, there is little doubt this model is unsustainable. Medicare shifted from a cost reimbursement model in the mid 1980's and is moving to a performance-based platform now, while most commercial payors are still paying providers based upon fee for service. Hospitals and health systems are naïve to think that it will remain so.

The short term pain that any health system will feel from their efforts to adapt new ways of delivery or new plans for payment that vest them in true population health initiatives can most assuredly be offset with the rewards of even greater market share and longstanding relationships with employers and their teams.

Medicare forced diagnosis related groups (DRG's) on hospitals in the mid 1980's but commercial payors are not taking the same kind of initiative. One might ask why? The answer is in the way medical claims are funded. Today, insurance payors are generally just processors

of claims and use the money of employers who self-fund their medical costs for their employees. Once again motivations come into play because there is little motivation for payors to control employers healthcare spend. It's ironic but true. Employers though are becoming restless. If history is any indication, insurance companies cannot be relied upon to solve the problem because they are simply claims processing agents. The answer lies in what kind of relationships providers forge with employers that are funding the costs for their employees. Presuming that this employer has, say, 30,000 employees located in six (6) distinct local markets with only one being inside of a single health system service area; does it make sense for the CEO of that local healthcare system to connect with his counterpart(s) in the other five (5) markets to come up with a plan to service the entire employer population and produce reports and data to help all of them enhance the health status of that entire employer population? The simple answer is absolutely yes. Further that health system and the employer should forge a sharing methodology that allows for each to gain in the successful management of healthcare outcomes and cost that are achieved in their execution. This could be an example of what the future of healthcare will look like.

Employers bear over 70% of the U.S. healthcare spend and they need to get it under control. They can only do it if the various healthcare systems work together in order to help address the issues that are costing these employers and their employees so dearly.

The bottom line is that providers are so busy competing that there is little collaboration and this has to change. The United States has a fictional "healthcare system"...in truth, we have a collection of healthcare systems and until they begin to work together in successful collaboration, employers will focus their attentions on changing benefit plans and creating their own provider resources in order to avoid hospital and health system interaction to the greatest degree possible.

GAME CHANGERS

There are a few game changers that are quietly facilitating alternatives that can reduce costs and facilitate improved access and quality:

Telemedicine: Telemedicine capitalizes on technology to facilitate better access basic healthcare at a lower cost. Telemedicine is generally thought of as speaking to a medical provider via the telephone. Video conferencing and coordinated other technology is changing that and will continue to do so. Telemedical services may become a significant mode of delivery in the future as primary care physician populations level off. A significant number of conditions can be treated successfully via this method of connection

Employer-Based Clinics: Larger employers have been adding medical services to their worksites for several years but they are refining and adjusting the models now to focus on wellness and prevention with the objective being to aggressively pursue lower costs and better production by workers.

Population Health Management: Chronic medical conditions are root causes for much of the total spend by employers on healthcare. Hospitals have not eagerly embraced the topic of population health management but are starting to. This refers to the assessment of a given population through surveys and basic health screenings with the objective being to identify potential health risks that could lead to downstream costly and debilitating health issues.

Generally, these programs involve the creation of both a telemedical as well as an employer based clinic presence. It is truly unknown how much of the healthcare spend can be prevented through deployment of population health initiatives but some case studies suggest that a significant cost savings as well as increased worker productivity can be achieved with proper deployment of a population health strategy. Nancy Beaulieu, David M. Cutler, Katherine Ho, George Isham, Tammie, Lindquist, Andrew Nelson, and Patrick O'Connor, collectively made a study of one managed care organizations population. What they found was this:

- 7% of the source population had diabetes
- The annual cost of management of the condition was $13,700/person
- They found that the cost could be reduced to $5,347 if a more proactive approach was taken

For an employer of 2,000 this could result in an annual savings of nearly $750,000.

Off-Shore Medical Tourism Services: Australia, China, Costa Rica, India, Israel, Japan, Korea, Mexico, Singapore and (the most popular of all) Thailand all offer robust medical tourism services and Americans are among the most targeted populations. What drives patients offshore? Price is the primary reason, followed by anonymity. A heart valve procedure in the United States will average about $150,000; the same procedure in an offshore environment could cost as little as $15,000. An increasing number of these destination hospitals are becoming accredited by the Joint Commission of Accreditation of Healthcare Organizations and their facilities are generally at or above the U.S. standard. Current estimates show approximately 750,000 patients per year traveling outside of this country for healthcare at these medical tourism destinations. There have been some warnings issued by groups discouraging this form of medical delivery, but the truth is that there is no concrete evidence to suggest that there any addition risk associated with going to one of these destinations as there would be going to hospital in the United States. None the less, these are examples of what they provide warnings of:

- Receiving care at a facility where you do not speak the language fluently increases the chance that misunderstandings will arise about the care.
- Doctors may reuse needles between patients or have other unsafe injection practices, which can transmit diseases such as hepatitis and HIV.
- Medication may be counterfeit or of poor quality in some countries.
- Antibiotic resistance is a global problem, and resistant bacteria may be more common in other countries than in the United States.
- The blood supply in some countries comes primarily from paid donors and may not be screened, which puts patients at risk of HIV and other infections spread through blood.
- Flying after surgery increases the risk for blood clots.

Nonetheless it is a good idea to screen to destination with the same diligence that one would and should when screening a medical provider here in the United States.

SUMMARY

Threats to the traditional U.S. hospital are prolific. Generally, hospitals have not demonstrated the capacity to adapt their models to meet these challenges. Hospitals have generally focused their attention on the in-market threats. Now that healthcare is becoming virtual, international and otherwise being delivered in non-traditional environments, competition is very often nowhere near their location and they have adapted no means of measuring the impact.

Because of all this hospitals and health systems are being forced to adapt to competition in the same manner as nearly all other business, beginning with better market and consumer research, setting a plan for alternative delivery and breaking down traditional barriers that prevented them from working with other hospitals, medical staff and others that they may have been considered competitors in the past. There will be many challenges. Since prevailing revenue model for U.S. medical providers is built on a fee-for-service form that encourages consumption without accountability there will be significant resistance to any change. The truth is, however, that our current system is unsustainable. It must and will change regardless of the amount of resistance encountered. The next ten years will certainly provide for some interesting evolutions.

Progressive health systems and hospitals must consider the following strategies in the face of emerging competition and paradigm shift:

Expand their reach beyond what they define as their markets: It's not nearly as difficult as it sounds; here are some examples:

- Incorporate telemedicine as part of their delivery process: Telemedicine is a natural reach agent for hospitals and health systems. It is very likely that the physicians that hospitals employ are already being compensated by telemedical providers outside of their employment agreements with hospitals. Hospitals should bring this business in as part of their model take control of the telemedical opportunities that exist within their market and expand their reach into otherwise unreachable markets. Let us say that a health system employs 200 physicians in a state and services a market of 100,000. This same group of physicians could reach additional markets with telemedical technologies in that state by connecting new technology that can deliver services to schools, employer worksites and even remote primary care providers. Physicians licensed in a state can service the entire population of that state with proper deployment of telemedical technology. Telemedical technology is a natural low cost market expander for the savvy regional medical provider.
- Address the needs of a large local employer that has many more employees elsewhere in the country: Hospitals must look beyond their local markets to understand the needs of employers. An employer of 30,000 likely has only a portion thereof in a single market. If that employer has that population spread over 30 different locations that doesn't lessen their value to the local hospital but it does lessen the value of the local hospital to the larger employer. Regional providers should identify and relate to the needs of such an employer and reach out to health systems in the other 29 sites whether this employer has staff and reach out to their counterpart health systems in those markets to create a winning solution for that employer and facilitate win/win relationships in the form of population health management.
- Engage third parties to design win/win engagements with employers: Employers rarely seek advice from the local hospital or health system in addressing their healthcare cost issues. Most define hospitals and health systems as part of the problem. They engage benefits managers to advise them on such matters but most are ill equipped to make wholesale changes in delivery that could result in significant improvement in their healthcare cost as well as the needs of the employees. Engaging a third party to review the medical costs of an employer and to recommend solutions that involve discussions

with the health system in conjunction with the employer is a non-threatening way of breaking the ice and delivers an unbiased opinion for engagement.

- Create a model for delivery of population health management services: Hospitals must facilitate a mechanism measuring, monitoring and improving the health status of defined populations. This includes identifying chronic conditions and designing mechanisms to deploy resources so as to improve outcomes and reduce cost. This is coming whether hospitals want it or not. Hospitals should embrace the process and begin to establish themselves at the point of the initiative. Eventually, someone will be required to take risk for the delivery of services to a population and having the experience and capability to do so successfully will define success and failure.

The United States has the most expensive healthcare system in the world, spending over twice as much on healthcare per capita as the next highest country. Even so, the World Health Organization ranks the United States 37th out of all developed countries relative to quality and outcomes. There is no need to spend more money when we have the capability and budgets to do so much with what are already spending.