The US Healthcare Provider Economic Model Is in Critical Condition

ECG's weBELIEVE SERIES

Part 1

HEALTHCARE'S NEW ERA WILL REQUIRE ACCELERATED CHANGE

ECG MANAGEMENT CONSULTANTS

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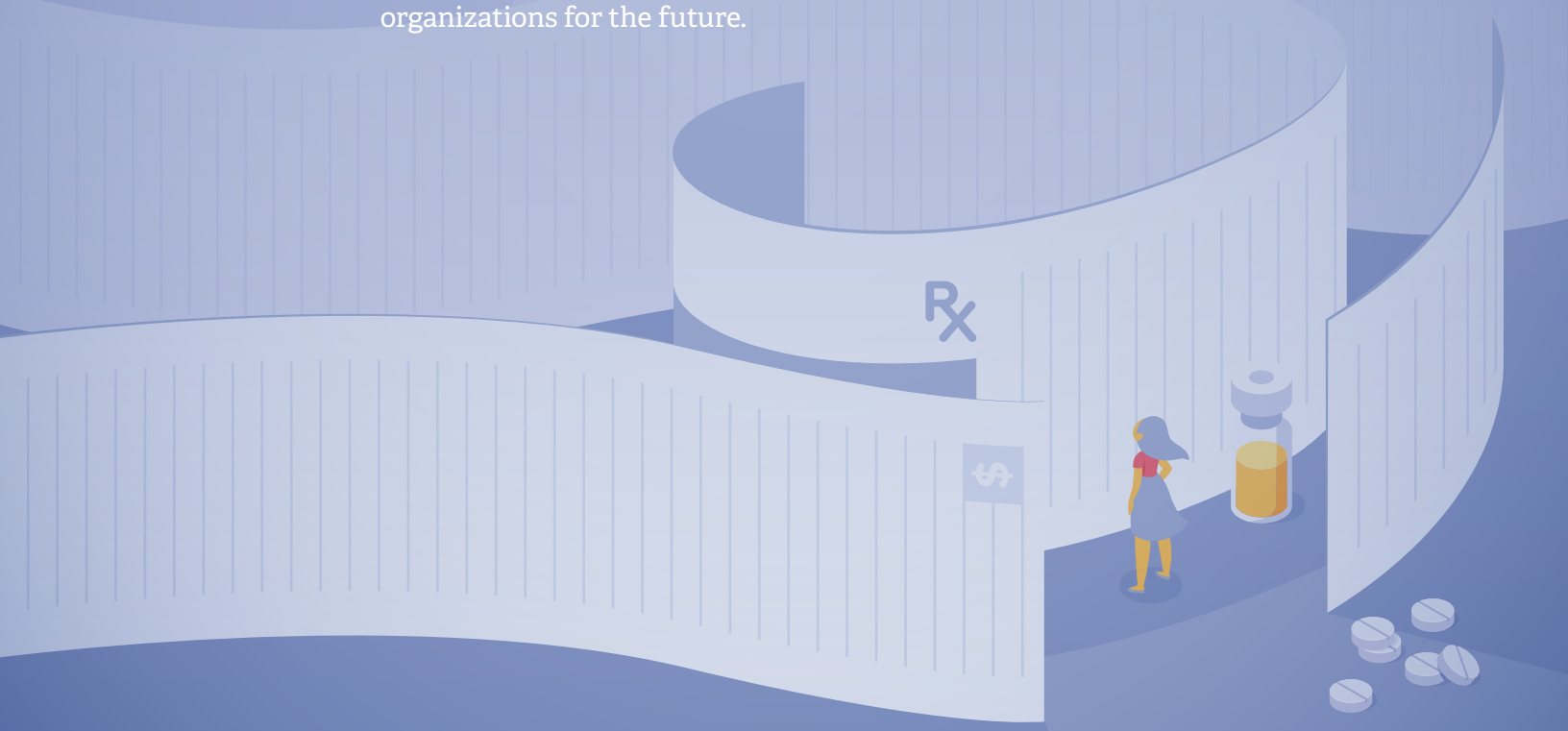
Abstract

The level of healthcare spending in the US has driven significant debate and served as the catalyst for the ongoing evolution of funding and care delivery models, from the advancement of the concept of the Triple Aim as an industry call to action to reform efforts such as the Affordable Care Act. While to date we have seen an industry embrace value-based care, we have not achieved any semblance of an industry-wide transformation. Health systems and provider organizations are experiencing significant financial pressure, exacerbated by the COVID-19 pandemic, which will impact healthcare delivery for years to come, while at the same time historical market forces continue to create serious challenges and pressures for provider organizations.

We believe the industry is too costly, too complex, and too fragmented—yet, a systemic reform solution likely will not occur in the near term, requiring health systems to reinvent themselves. We advance four key imperatives for health systems to improve their financial health and position their organizations for the future.



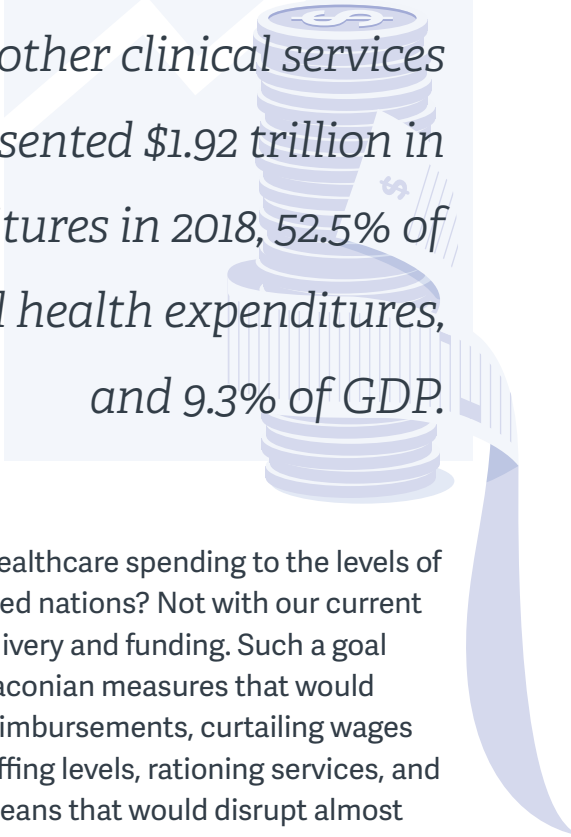
This paper is the first in a series of five ECG strategic perspectives on the changing dynamics of the US healthcare system.

What Got Us Here?

Healthcare expenditures in the US represent nearly 18% of the gross domestic product (GDP). Many take issue with the level of healthcare spending in this country based on comparisons to other countries. In the US, healthcare is the second-largest component of the federal budget behind Social Security, representing nearly 30% in FY 2020, and government sources fund 51% of all national healthcare expenditures. Further, the healthcare share of the federal budget is projected to increase significantly as the last wave of baby boomers enroll in Medicare.[1,2]

One could also take the position that this level of spending is not, in and of itself, a bad thing. The healthcare sector is an economic juggernaut. In addition to providing a clear societal benefit, hospitals, physicians, and other clinical services represented $1.92 trillion in expenditures in 2018, 52.5% of national health expenditures, and 9.3% of GDP. Retail sales of medical products, including prescription medications, represent another $456.3 billion, and 12.5% of national health expenditures.[3] In many communities, hospitals and health systems are among the largest employers. Physicians, other medical providers, and their employees across the continuum make up a significant part of every community's workforce. The sector added 2.8 million jobs between 2006 and 2016, the most of any industry. The US Bureau of Labor Statistics projects another 18% growth in health sector jobs between 2016 and 2026, and growth in national health expenditures is expected to continue to slightly outpace the general economy, reaching 19.7% of GDP by 2028.[4,5] That represents a 54% increase in spending over 2018 levels.

The healthcare sector is an economic juggernaut. Hospitals, physicians, and other clinical services represented $1.92 trillion in expenditures in 2018, 52.5% of national health expenditures, and 9.3% of GDP.



Can we reduce healthcare spending to the levels of other industrialized nations? Not with our current model of care delivery and funding. Such a goal would require draconian measures that would entail slashing reimbursements, curtailing wages and reducing staffing levels, rationing services, and a host of other means that would disrupt almost every aspect of how we access, provide, and pay for care—never mind the impact on the economy overall if the healthcare spending equivalent of even three to four percentage points were to disappear from the GDP. There are also cultural differences that impact the types of healthcare services available in the US versus other countries and how they are utilized. Even the Organisation for Economic Co-operation and Development (OECD), the entity that compiles country comparisons, acknowledges that data inconsistency and availability between countries may impact the comparisons. Where there seems to be clarity is that base provider costs—labor, pharmaceuticals, medical equipment, and supplies—in the US are simply higher.[6] The literature has many

examples of authors supporting either side of this debate.[7–11]

Politicians and policy makers, health systems and payers, employers, and consumers all have a vested interest in controlling the rate of spend in healthcare, or at least improving the value for what we do spend. There is little disagreement that the US healthcare system has significant amounts of inefficiency and waste in clinical care delivery and high administrative costs attributable to both regulatory burden and our private insurance model. Various studies estimate the total annual cost of waste ranges from $760 billion to $935 billion.[12] Some measures of quality, and quality of life, consistently fall below levels that we would aspire to achieve, and the US chronic disease burden and obesity rate being substantially higher than the rest of the world certainly affects health outcomes. Our underlying costs for a highly trained and credentialed clinical workforce that is in short supply and other key cost elements, such as pharmaceuticals, are higher than those of our counterparts in other areas of the world. Our infrastructure is asset heavy, expensive, and aging more rapidly than it can be replenished in many parts of the country. The industry has been a slow adopter of information technology (IT) and lags in the use of technology generally to drive innovations in access and care management.

Of course, the preceding discussion does not reflect the impact of the COVID-19 pandemic and the resulting US government infusion of trillions of stimulus dollars. The healthcare sector itself has been particularly hard hit, as the COVID-19 crisis has shone a bright light on the fragility of the provider economic model and its dependency on elective procedures, diagnostics, and admissions via the emergency department that have historically kept hospitals afloat with sufficient volumes to spread fixed costs. At the center of that bright light is a flawed reimbursement model. There will be no "post-COVID-19" return to business as usual, as the pandemic has sent the economy reeling, and most providers realize their business model will likely be forever changed.

Some might suggest healthcare is "too big to fail." That may be true, but it isn't too big to undergo transformative change.

As the nation grapples with its recovery from the coronavirus crisis and how to pay for the associated stimulus costs, healthcare spending and the entirety of the nation's public health and healthcare infrastructure will be in the spotlight. Some might suggest healthcare is "too big to fail." That may be true, but it isn't too big to undergo transformative change.

Reform: The Good, the Bad, and the Necessary

The Centers for Medicare & Medicaid Services (CMS) and private payers have advocated for pay-for-performance and pay-for-value reimbursements, commonly referred to as value-based care (VBC) models, since the early 2000s. The results have not been impressive. A number of studies indicate that these programs have neither demonstrably improved outcomes nor lowered the costs of care.[13,14] Only approximately 14.5% of all payments in the US healthcare system have some element of downside risk.[15]

The Patient Protection and Affordable Care Act (ACA), the largest, most comprehensive healthcare legislation since the introduction of Medicare and Medicaid, has become the poster child for a divided nation—largely along partisan and ideological lines—on the topic of healthcare. Obamacare, as it has come to be known, has much to its credit and a few hard lessons in policy stability learned along the way.

An estimated 20 million people gained coverage either through Medicaid expansion or insurance exchanges. In the decade since its passage, the ACA has faced numerous legal challenges and changes, and it will soon be before the US Supreme Court to review the most recent challenge to the constitutionality of the law. Hospitals in states that expanded Medicaid generally saw positive impacts to their bottom lines due to increased coverage, while states that didn't expand Medicaid had more hospitals experience financial distress and closures than in states that did have Medicaid expansion.

Now, six years into Obamacare, coverage gains are reversing in some states due to local changes to Medicaid enrollment criteria, costs of insurance products and deductibles (particularly those purchased on insurance exchanges), and the elimination of individual mandates—meaning the ranks of the uninsured could swell again in coming years. CMS's Office of the Actuary projects the uninsured population will increase by 20%, reaching 37 million by 2028.[16]

Of real concern is the estimated 44 million people who are characterized as "underinsured."[17] These are people who have health plans but whose deductible costs are 5% or more of their annual income. Indeed, consumer healthcare out-of-pocket expenses have become a burden for many families, with the employee share of employer-sponsored health insurance premiums plus deductibles amounting to nearly 12% of median gross income, with some experiencing much higher costs.[18] Unlike the concept of moral hazard—the idea that providing access without sufficient risk sharing may drive unnecessary utilization—we may now have the reverse situation, where people have access but cannot afford their share of costs to access care, so they avoid the system altogether.

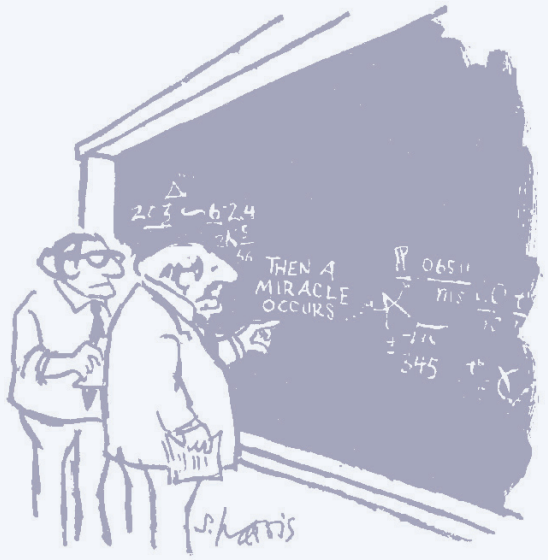
Like clockwork, the topic of healthcare reform resurfaces nearly every year upon CMS's release of the national health expenditure data; and in election years—this one included—it often becomes a platform issue. The US has a long history of healthcare reform efforts at the federal level and an exhaustive list of legislation that has been enacted over several decades. Similarly, many states have enacted their own efforts to ensure access and/or contain costs, notably Maryland with its CMS waiver and global budget revenue total-cost-of-care model and Massachusetts with its mandatory health insurance law. Other states, like Colorado, are exploring their own public option plans.

Healthcare has already become a political hot button as President Trump's administration moved to restrain the ACA and Republicans jockeyed to "repeal and replace" it, while during the Democratic primaries candidates sparred over various models, including proposals that strengthen the ACA, a federally run public option health plan, Medicaid buy-in, Medicare buy-in, primary care for all, and "Medicare for All." On the Republican side, options generally replace the ACA and shift and reallocate federal funding to the states in the form of block grants, while preserving Medicare. This politicking is somewhat interesting in that VBC is one of the only healthcare issues that is truly bipartisan. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was arguably the biggest and most important piece of VBC legislation in US history—and it passed the Senate 92–8 and the House of Representatives 392–37.[19] Healthcare and the economy will no doubt be signature platform debates in the 2020 elections and well into the first term of whomever is elected. Whether the next effort at reform is incremental or revolutionary remains to be seen.

Despite its real or perceived shortcomings, the truth is that our current model of government-funded healthcare and private insurance programs is so ingrained in our culture that a sweeping change will require a generation or two before it is fully operational and accepted—and even then, it is anyone's guess whether the model we move to will accomplish its objectives. Satirical cartoonist Sidney Harris would have no shortage of material in listening to the debates.

The reality is that our healthcare system is performing exactly as it was designed to do. The foundational principles that guide reimbursement, whether for hospitals or other care providers, are prominently tied to volume and complexity. Do more, treat more complex conditions, get paid more. CMS has adopted a rigorous approach to hospital payment by adopting guidelines based on prospective measures of anticipated complexity, resource consumption, and geographic differences in wages, with regular adjustments intended to track with changes in care delivery; it is a somewhat manageable process with just 740 diagnosis related groups, all designed to be clinically coherent (that is, of similar diagnosis or condition).

CMS's approach to physician reimbursement is far less sophisticated. Our current physician reimbursement system dates to the resource-based relative value scale (RVS) established in the early 1990s and is tied to a complex methodology initially designed around studies that measured effort for physician work and actual practice expenses adjusted by geography for the 10,000-plus CPT codes associated with the ICD-9 medical classification convention. The methodology has since been updated to include a professional liability insurance resource variable, as well as conversion to the ICD-10 medical classification convention.



"I think you should be more explicit here in step two."

CMS has effectively outsourced physician reimbursement guidance to the American Medical Association (AMA) through the RVS Update Committee (RUC). The RUC is composed of just 31 physicians and 300 medical advisers representing each sector of medicine, though it is decidedly specialist centric. We believe the intentions of both CMS and the RUC are good, but given that the RUC's approach is based on a straightforward sampling method, its ability to provide meaningful guidance on reimbursement across today's 140,000 or so codes is embarrassingly simplistic, at best. While the Medicare Payment Advisory Committee (MedPAC) has more recently begun to challenge a larger percentage of recommendations from RUC, the underlying mechanics of the system are essentially unchanged, and reimbursement models continue to be mostly structured around volume-based care, which impacts utilization in both hospital and private care delivery sites.

Until such time that placing limits on per unit capita healthcare spending becomes the foundation of structural reform, costs in the US will remain a significant issue. Such a model would require more aggressive risk sharing between payers and providers—and perhaps capitated payment models that cover the total cost of care across the continuum for defined populations. Premium tiers tied to health status, means testing for government-funded healthcare enrollees, and strict utilization and/or site-of-care controls could all be part of proposed solutions. This is the third rail of reform that no proposals have fully addressed, in part because it is almost a certainty that such measures will impact the compensation levels of many providers and support staff and quite likely result in the closure of many underperforming hospitals.

Until such time that reimbursement itself, and therefore what providers earn in income, becomes the foundation of structural reform, the issue of costs is likely to remain a significant issue.

Never Mistake a Clear View for a Short Distance

For the past two decades, or even longer, the narrative has barely changed: there seems to be a continuous chorus from industry leaders and critics alike to make the US healthcare system better, and cost less: improve access and coverage, improve quality and safety, "bend the cost curve," enhance the patient experience, make pricing more transparent and predictable, transform and create greater value. All of these are laudable goals, and in some of these areas we have seen meaningful progress. All of these objectives and many others fit nicely into the deceptively simple transformation concept of the "second curve" established by Ian Morrison,[20] and the adoption of that concept in healthcare around the industry transition from volume to value has served as the playbook that has guided hospital and health system strategy for many years. The American Hospital Association (AHA) adopted this framework as part of its education series for its members.[21,22] We reference this "first curve, second curve" paradigm in multiple instances in the balance of this paper.

When the Institute for Healthcare Improvement (IHI) advanced the Triple Aim in 2007 as an approach to optimizing health system performance, it set in motion an industry shift that continues to this day. The Triple Aim concept recognized that in most care settings, no one is accountable for all three dimensions of its goal: improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of healthcare. To help incentivize the Triple Aim, CMS and private payers have introduced various iterations of VBC models since the mid 2000s.

HEALTHCARE IN TRANSITION—FIRST CURVE TO SECOND CURVE

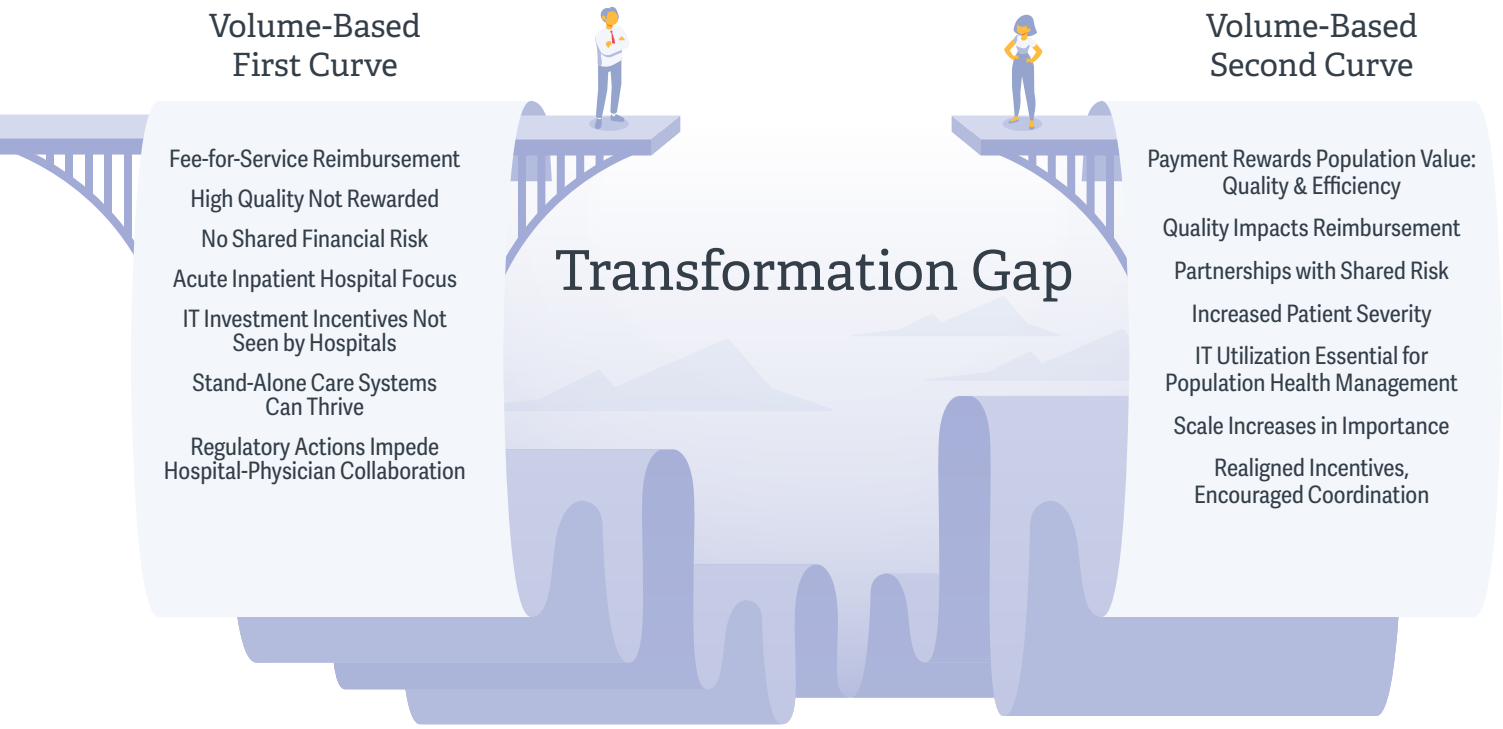


Figure 1: Healthcare in Transition—First Curve to Second Curve

Played out to the fullness of the second curve, we would see a healthcare model of highly integrated and networked providers—systems of care—responsible for managing the total cost of care for defined populations, while improving their experience and delivering better outcomes: population health in all its self-actualized glory. The foundational business model and driver of margins to reinvest in healthcare would have shifted from patient care to actuarial risk management and preventive health, backed by highly efficient management of acute episodes of care.

Some provider organizations have invested fortunes to scale up and organize their delivery networks and build the infrastructure to control the premium dollar and manage populations. Others have developed or entered into joint venture health plans, while some have structured partnership vehicles to manage risk for select patient populations, like Medicare Advantage. Employers prefer broader open access networks over modest cost savings, though some hospitals have traded rate concessions to be placed in a preferred tier or narrow network in hopes of securing greater volumes that were not realized due to insufficient steerage mechanisms or incentives to patients in the plan design. We have seen spectacular failures, though also some successes. But we have not achieved any definitive transformation of the industry.

In practical terms, such a complete transformation across the US healthcare delivery model is unlikely, though there is benefit to all stakeholders for adopting many of the second curve's principles.

Why has this pace of transition been so slow? In the simplest of terms, despite the challenges of today's healthcare business model, many markets and much of the healthcare industry itself are not ready. And if we are honest with ourselves. . . we kind of like the status quo. That is a truism for providers and payers alike. An axiom from futurist Paul Saffo is: "Never mistake a clear view for a short distance."[23] Indeed, the work of transformation can take time.

More often than not, payers are reluctant to share meaningful risk-based incentives with providers. Most at-risk, value-based contracts with commercial payers have historically been thinly disguised discounts. CMS's VBC models have placed very little of a provider's reimbursement at risk, with data limitations and interoperability cited as key barriers preventing adoption of performance-based risk-sharing arrangements by health insurers and other large payers.[24] Even the accountable care organization (ACO) model's impact on costs and quality has been relatively small, and the ACO model has been criticized for holding physicians at risk for utilization and costs incurred by patients whose care is not fully under the physician's control.[25] CMS's rollout of Pathways to Success in 2019, a major overhaul of the Medicare Shared Savings Program (MSSP), is intended to move providers more quickly to downside risk models. Other CMS value-based options set to launch in 2021, including the Primary Care First and Direct Contracting models, feature shifts away from fee-for-service payment toward population health.[26] How these new models will impact the pace of transformation remains to be seen.

We have seen spectacular failures, though also some successes. But we have not achieved any definitive transformation of the industry.

The transition to a fully value-based healthcare system has been complicated by the very structure of the US healthcare system and its complex, fragmented nature. Healthcare is an imperfect market; it doesn't look or function like other markets of supply and demand where Adam Smith's notion of "the invisible hand" enables the market to find its equilibrium without government or other interventions. All parties to any healthcare consumption in the US have contributed to the model's inefficiency:

- The US population is characterized by a high level of chronic and multichronic conditions exacerbated by lifestyle decisions, socioeconomic factors, and noncompliance with medical advice from physicians and other providers.
- Consumers are generally risk averse and thus place great value on access to insurance. However, the costs of premiums and deductibles are consumers' primary means of valuing a plan, much less so than the coverage itself. Accordingly, consumers have historically been removed from the total cost of care and remain highly desensitized to prices beyond their out-of-pocket costs.
- Employer-funded health insurance is not taxable income to employees, and for most large businesses, employer-provided insurance has become an expected part of the employer-employee compact and an important vehicle to attract and retain employees. Even today, although employers have implemented a higher degree of premium cost-sharing benefit plans whereby employees take on more financial responsibility for their insurance, employers generally still pay an increasing and disproportionately high percentage of the premium.
- Third-party payers and purchasers set the terms for coverage and therefore resource allocation, yet they are not directly accountable for ensuring efficient utilization of healthcare resources or for improving outcomes—that responsibility is shifted to the provider. Commercial payers bear little direct responsibility for managing the total cost of care and simply pass anticipated provider cost increases on to employers or other purchasers.
- Providers are characterized by a business model that is fragmented, disjointed, and heavily commoditized, and the problematic reality is that many organizations do not truly know the actual costs of delivering specific services. Further, hospital providers are beset with an unfunded mandate to care for patients that present in their emergency rooms regardless of their ability to pay.
- Provider pricing methodology is rarely tied to the actual costs of producing a service. For providers, the most desirable pricing (i.e., commercial reimbursement rates) is often set in relation to offset the least desirable pricing (i.e., Medicare and Medicaid reimbursement rates), plus some to generate a margin to invest and recapitalize the business.

Myriad other factors, such as an underdeveloped public health safety net, the US tax structure, and tort and patent laws, further complicate the situation. The combination of these dynamics results in a highly inefficient market.

Given the structure of the healthcare industry and the nontraditional economic relationship between consumers, providers, and payers, the results of efforts to move toward the second curve over the past decade should surprise no one: incremental improvements yet no real breakthrough solutions, little to no differentiation between provider organizations or between private payers, and a view of the future by many organizations that is too closely tied to annual budget cycles.

US Hospitals' Financial Health Likely to Worsen

ECG's financial and operational health index stratifies US short-term acute care hospitals based on the current year and a four-year trend of operational and financial metrics.[27] Our findings suggest that 35% of hospitals are marginal/at risk and another 27% are technically failing or at a high risk of failure, with the latter characterized by both negative operating and EBITDA margins on a year-over-year basis, at least for the past four years. An organization can survive on funded depreciation for only so long. The top 6% (peak performers) are characterized by strong double-digit operating and EBITDA margins, strong cash generation, and the ability to grow revenues much faster than expenses. The next 31% are steady performers and also perform well on these metrics, though at a level below the top tier. Our findings are not dissimilar from other studies over the years.[28,29]

HOSPITAL PERFORMANCE TIER	# HOSPITALS	% HOSPITALS
Peak	180	6.2%
Steady	909	31.3%
Marginal/At Risk	1,024	35.2%
High Risk for Failure	795	27.3%
	2,908	**100.0%**

Table 1: ECG's Financial and Operational Health Index of US Hospitals

Our findings suggest that 35% of hospitals are marginal/at risk of failure, and another 27% are technically failing or at a high risk of failure.

Every year, providers are faced with margin pressure driven by escalating costs and efforts by both CMS and private payers to restructure reimbursements into risk-based arrangements and move care into less costly outpatient environments. Managing the rate of expense growth is a significant challenge, and while we have seen a slowing in this rate, revenues have also been pressured.

Hospitals that are able to grow revenues faster than expenses—through volume and/or reimbursement rate growth—are likely able to maintain or even improve their position. For those that cannot do so consistently, trouble awaits. Providers should expect continued scrutiny on their costs. Large US employers' healthcare costs have risen more than 28% in the past five years, which is why the Leapfrog Group and other corporate coalitions are driving healthcare transformation.[30] As shown in figure 2, in the time horizon between 2010 and 2018, hospitals and professional services represented 74% of the increase in national healthcare expenditures on a per capita basis.[31]

As we look ahead, the economic equation for healthcare providers could become even more bleak. CMS projects Medicare enrollment to grow

SECTORS DRIVING GROWTH IN PERSONAL HEALTHCARE EXPENDITURES, PER CAPITA 2010–2018

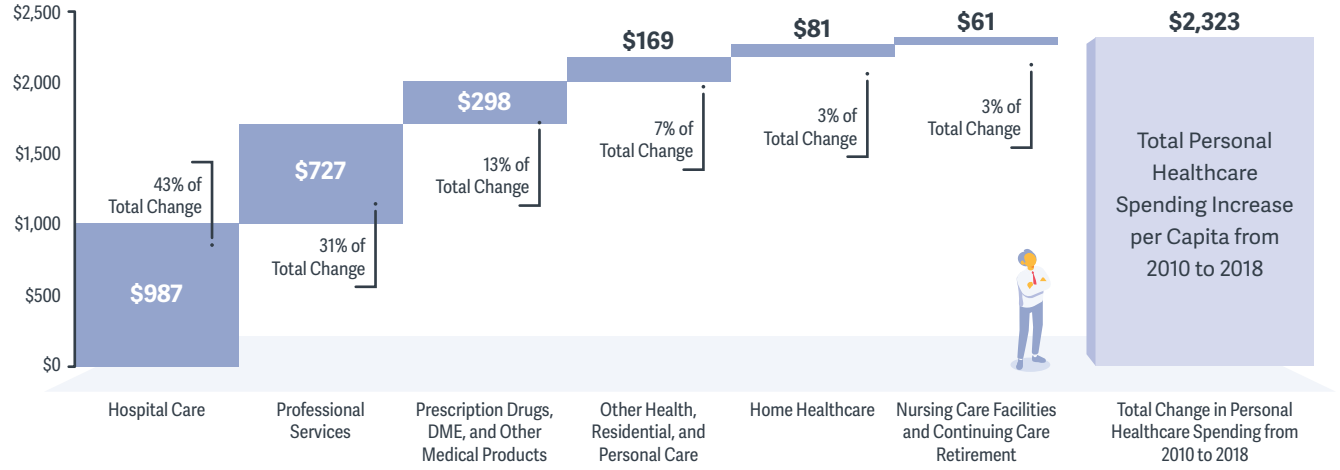


Figure 2: Sectors Driving Growth in Personal Healthcare Expenditures, Per Capita 2010–2018

by 25% between 2019 and 2029, reaching more than 77 million enrollees. And the percentage in private Medicare plans will rise from 37.5% to over 43.0%. As a result of this increased enrollment and anticipated acceleration in spending, the Hospital Insurance Trust Fund (HITF), which covers Medicare Part A, is projected to be depleted by 2026.[32] The AHA estimates that payment shortfalls from government programs to hospitals were nearly $78 billion in 2017, and that number is undoubtably higher as of this writing. Medicare shortfalls represented nearly $54 billion of this amount and Medicaid and other government programs the balance, which in aggregate means government payment shortfalls represent a payment-to-cost ratio of around 87%, down from nearly 100% at the start of the century. Conversely, private payer reimbursements to hospitals represent a significant cost shift and now equate to a national average payment-to-cost ratio of 145%, in large part to offset shortfalls from government payers, up from 116% in 2000.[33] This cost-shift "hydraulic" has been hotly debated for decades, and indeed it is a complex topic with several additional variables influencing the magnitude of the shift, which can vary dramatically by state and by market.[34]

Increased Medicare enrollment and payment-to-cost ratio trends have several implications for providers. First, in the next few years Medicare will represent an increasing share of the payer mix, which will add both reimbursement and cost pressure to providers. Second, in the face of an HITF funding deficit, the government has three basic options:

1. Increase taxes to replenish the fund.
2. Reduce utilization (likely through rationing or cutting off reimbursement).
3. Reduce reimbursement rates (or the rate of reimbursement increases) and/or continue to put more reimbursement at risk.

It may choose to employ all of the above.

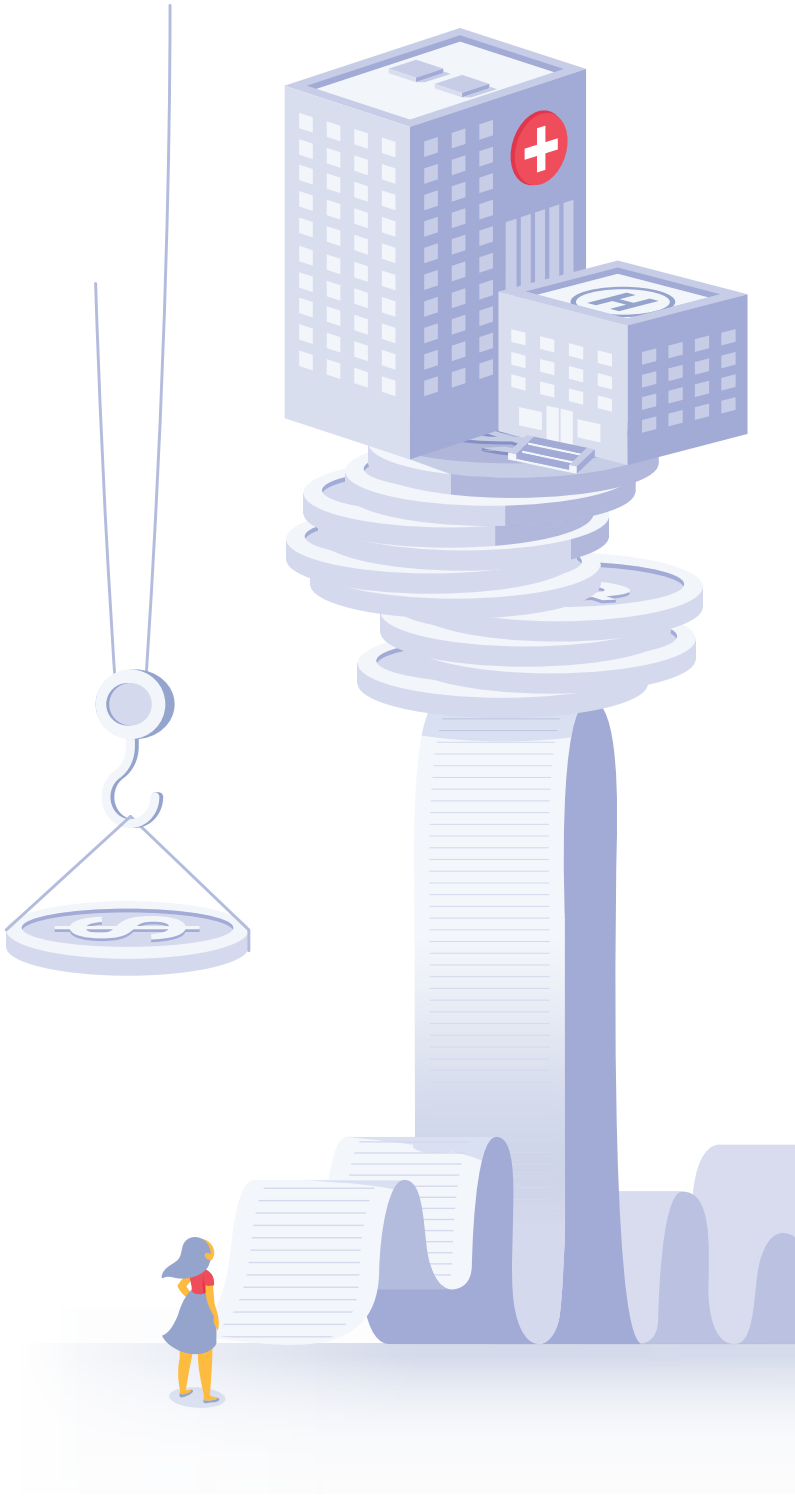
Third, commercial payers are already pushing back on the cost shift embedded into provider contracts, meaning providers will need to become more sophisticated in their contracting strategy and in negotiating rate increases.

Commercial payers have become weary of this cost shift, hence the introduction of narrow networks and tiers based on hospital prices (i.e., payments to providers) and an increasingly hard negotiating

position relative to rate increases. Further, benefit designs are increasingly structured to create incentives for members (enrollees), such as waiving copayments and deductibles, to utilize specific sites of service, particularly for ambulatory surgery and other ancillary service venues. As CMS continues to broaden the list of ambulatory surgery center (ASC)–eligible procedures, commercial payers will rapidly adopt these guidelines, as it is not unusual for the payment differential between a hospital and an ASC to be 100%.

The state of the US healthcare industry has created attractive market dynamics for innovation, disruption, and a resetting of the competitive landscape—and we have seen that where current providers and payers do not step in to drive change, others will. Walmart, Best Buy, Walgreens, CVS, Haven (joint venture between Amazon, JPMorgan Chase, and Berkshire Hathaway), and hundreds of technology and care delivery start-ups backed by billions in private equity funds are investing in healthcare. Mergers, acquisitions, and strategic partnerships that drive vertical or horizontal integration and scale are frequently in the headlines (e.g., CVS's acquisition of Aetna, Cigna's acquisition of Express Scripts, UnitedHealth Group's acquisition [through its affiliate Optum] of DaVita Medical Group and other large practices across the US, and Walgreens' strategic partnership with LabCorp).

These are businesses and investors that see healthcare as an arena in which to engage consumers to provide a differentiated care experience, establish linkages to other services, deliver care at a lower cost, and drive profits by reimagining the way healthcare is organized and delivered. These changes are no longer just on the fringes of the industry—they have the potential to become mainstream.



The future will be characterized by continued challenges for the US healthcare system. Revenue and cost pressures will mount. The economy and demographic shifts will impact healthcare utilization and payer mix. Industry disruption will continue. Margins and cash flow will be affected, and capital will become scarce. We will no doubt see calls for further, potentially massive reform across multiple sectors of the economy, including healthcare. And while the future may well be subject to these many points of uncertainty, one thing is certain: left unchecked, healthcare provider economics will remain in critical condition and perhaps worsen.

As we contemplate the implications of the forces affecting the US healthcare system, we cannot escape the realization that our current model is too complex, too costly, and too fragmented. Yet, until we establish a systemic solution, the pressures and challenges we face today will continue and quite likely escalate for the foreseeable future. The key question then becomes, how can healthcare providers optimize their business model to achieve a sustainable advantage and position themselves favorably for the future?

Healthcare's New Era Will Require Accelerated Change

We are in a new era, one in which we envision an acceleration of the VBC model, though focused more around the principles of cost, access, and convenience more so than population health. This new curve recognizes that the current healthcare funding structure of government and private payers in the US isn't changing dramatically in the near term, though the business model is being reframed to slow the pace of cost growth. For providers to survive, they must reinvent themselves and adapt to this new era that we believe will shift the organizational and delivery model away from a historically provider-centric model to one that is consumer centric. Those unable to do so risk being marginalized in their markets by other providers, or combinations of providers and payers, and potentially new entrants.

Access, convenience, and cost will become key drivers of choice. In this case, cost refers to consumer out-of-pocket costs in terms of premium share, copayments and deductibles, and cost to the payer (i.e., reimbursement rates to providers), which is largely attributable to site of service. These access, convenience, and cost variables will increasingly drive features of benefit plan design and preferred provider networks. To be clear, quality remains an important variable and will continue to be central to risk-sharing reimbursement arrangements. For consumers, quality will remain a threshold barometer; it will be assumed to be good unless there are publicly reported poor ratings tied to the patient experience and quality measures such as HCAHPS and from rating bodies like Leapfrog.

A NEW ERA OF HEALTHCARE—REDEFINING THE TRANSFORMATION CURVE

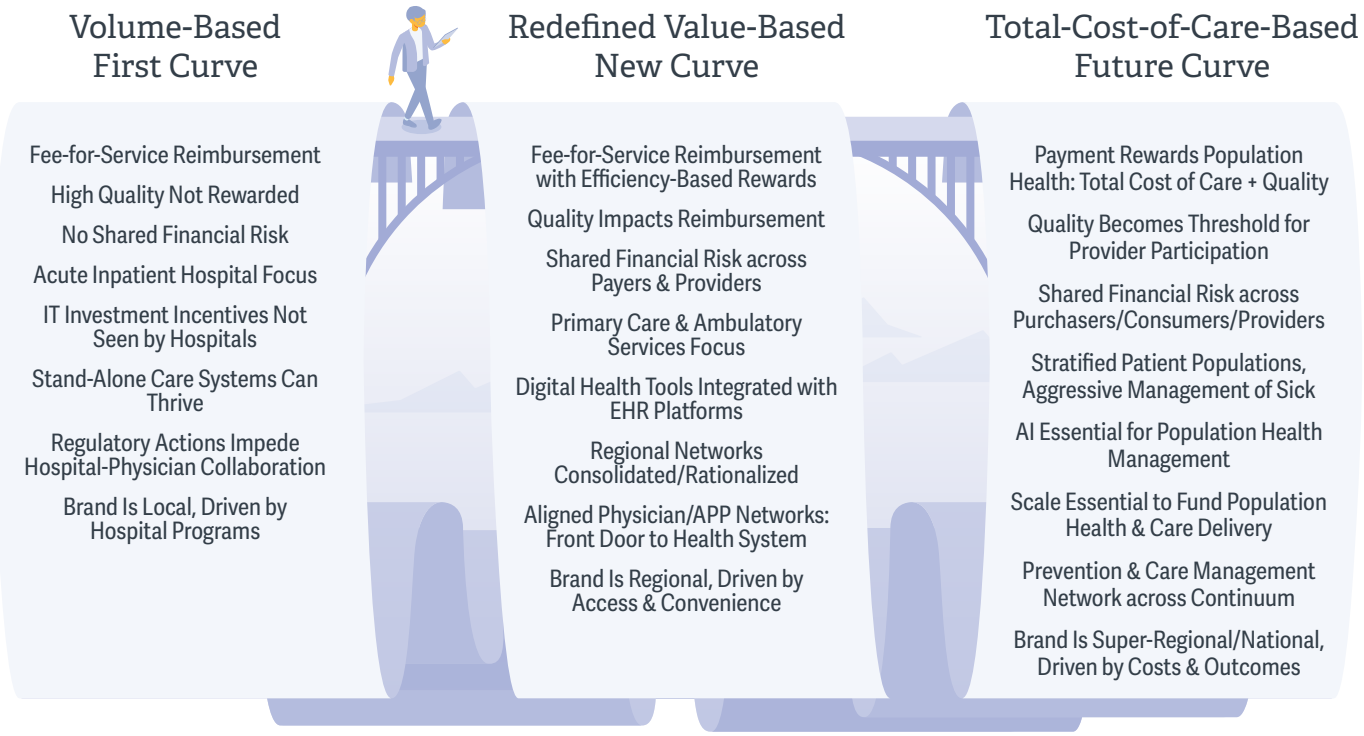


Figure 3: A New Era of Healthcare—Redefining the Transformation Curve

An even more transformational future curve is still within grasp for those few markets and delivery networks prepared to manage the total cost of care for defined populations under a capitated payment model—true population health organizations. However, we believe this total-cost-of-care curve will be elusive for most markets and providers, unless it becomes the foundational model of national reform—and should that occur, we posit we'll see much greater transformation in the provider space. A topic for another day.

In the near term, the strategies that hospitals and health systems employ to improve their financial health and ready their organizations for this new era will necessarily vary based on their market dynamics and the individual hospital/health system's strategic and financial position. On the face of it, the strategic imperatives that all providers must consider are not unfamiliar: cost structure, revenue structure, delivery network design, and consumer engagement. Some might say "been there, done that" or "this seems like that movie Groundhog Day." Perhaps so. Often the right strategy stares us right in the face, though we ignore it because current-state performance is stable. It is not uncommon for businesses in any industry to allow growth (through volume and/or price increases) and stability in operating margins to mask a host of operational flaws. Better yet, strong nonoperating income and investment returns make us blinder still to otherwise obvious market forces. In those environments, long-term strategy execution suffers in deference to annual budget cycles. Those that can't achieve desired bottom-line results are merged, acquired, or closed. Such has been the case for many healthcare providers in the past two decades.

In the first part of this paper, we made the case that the macro industry trends and outlook are not favorable for providers, and some market forces will be far less forgiving than in previous decades. The urgency for health systems to act is now. Those organizations that make bold moves to address these imperatives will be better positioned for the future. We outline below four key imperatives for health systems to reposition themselves, ready their organizations for the future, and improve their financial health today.

STRATEGIC IMPERATIVES FOR PROVIDERS

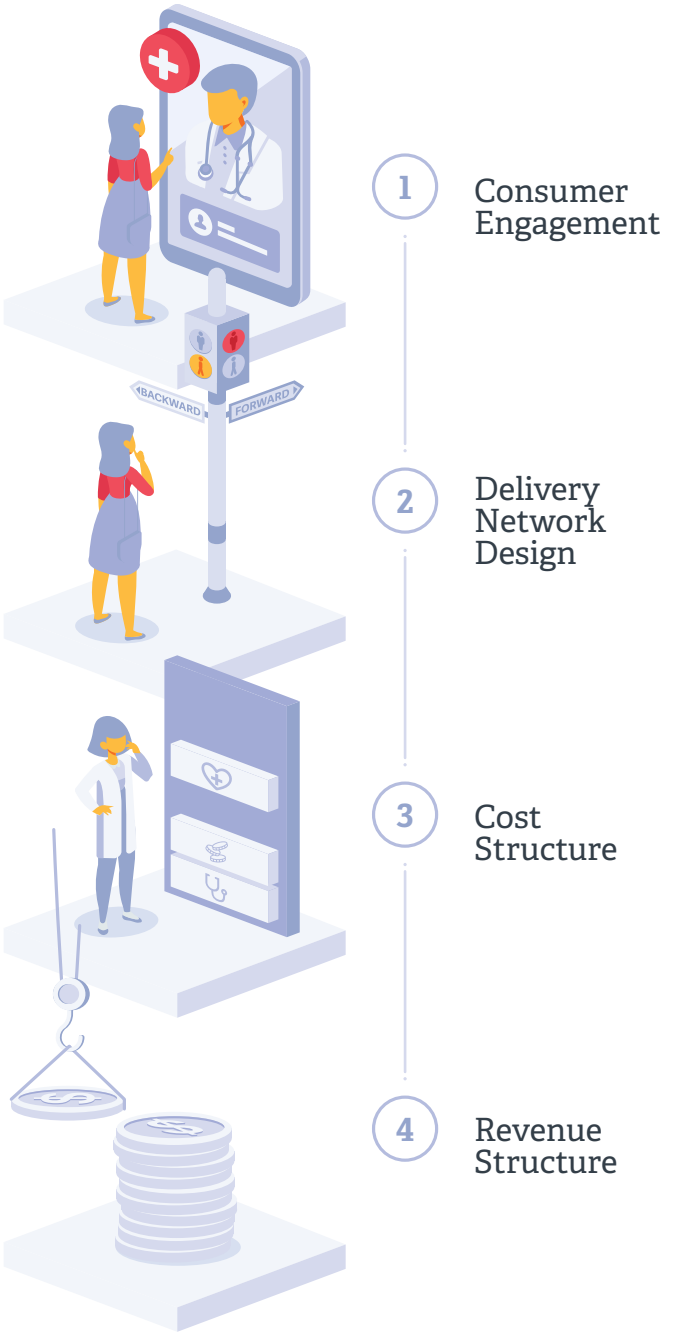


Figure 4: Strategic Imperatives for Providers

KEY IMPERATIVE 1:

Own the Consumer Relationship

The future of healthcare is digital—not just in digitally enabled care delivery such as telehealth and remote monitoring, but in the use of data as a strategic asset.

Healthcare has a complex marketing problem. Its customers can be defined as its patients, its physician network, affiliated hospitals and other providers across the continuum, payers, area employers, and the communities at large that it serves. The patient is the most critical, and we submit that the community at large, or the population base as a group of consumers, is the ultimate customer base that health systems must focus on in terms of owning the consumer relationship.

In healthcare, the principal relationship between provider organizations and consumers occurs at the patient level—that is to say, after a consumer has become a patient due to the presence of symptoms or a condition requiring diagnosis, treatment, and management. There is inherently a degree of trust on both sides of any patient encounter. Though, for many of these patient care episodes, the relationship is little more than what would be considered transactional, an exchange of some payment (or the potential for payment) for services rendered. Patient-centered care is often at the core of cultural transformation and caregiver philosophy, and that is a great achievement. The measure of success? A retrospective measurement of satisfaction typically measured by the survey question "I would recommend XYZ provider." Of course, health systems measure many other experience variables, conduct regular public perception and awareness surveys, and are highly engaged in their communities around health education, screenings, and prevention. By many measures, their level of consumer engagement might be seen as favorable or even strong.

However, few health systems can say they own the consumer relationship in the sense that leading service organizations think of their relationships with their customer base. Why is this important? Because much about the future of healthcare is digital, not just in digitally enabled care delivery such as telehealth and remote monitoring, but ultimately in artificial intelligence (AI)–enabled health management and precision medicine in care delivery. Health systems must appreciate that the rich data locked within their electronic health records (EHRs) is a strategic asset that can be used to strengthen the bond with consumers, though most organizations need to learn to utilize this information proactively as an engagement tool. This is the inherent advantage that health systems have over new market entrants and disruptors. The potential is huge to connect with larger segments of the population or even to expand the service area beyond traditional boundaries.

There is an actual race underway between payers and health systems to secure the consumer relationship. Insurers and other disruptors are investing large sums in digital health and consumer (or member) engagement, principally value-added member services to navigate the complexity of healthcare transactions, and this is becoming a feature of benefit design and a basis for securing longer-term relationships with purchasers. Health systems should be able to scale a consumer relationship strategy faster by providing omnichannel access to patients and consumers. However, many organizations are already late entrants to digital health and need to design or partner for digital solutions that secure consumer relationships. Health systems need a multifaceted consumer engagement strategy that encompasses the following considerations:

Digital Health: Health systems should develop a clear digital health strategy, recognizing that digital health is not an IT function: it is a care delivery and consumer engagement capability enabled by technology. For our purposes in this paper, digital health solutions—telehealth, remote monitoring, virtual care, and AI-enabled healthcare solutions such as precision medicine and predictive health analytics—are part of the delivery network design consideration discussed below. In terms of consumer engagement, the range of digital health solutions can

be daunting, and it is important to conduct research and understand the priority needs of your population base, particularly the preferences of younger and older populations; research indicates that all age levels have an interest in digital health, though the platform preferences differ.

The market is flooded with internet-based and mobile digital health applications associated with the management of health and wellness goals, self-service tools to navigate scheduling and healthcare transactions, and even self-diagnose, or just to gain access to information. Like any new market development, there will be substantial contraction

DIGITAL HEALTH ACROSS THE CONTINUUM

Digital Health

Patient Access Enhancement
Consumer Self-Service
Telehealth Virtual Provider Visits
Coordination of Digital Health Activities
Clinical Decision Support & Precision Medicine
Virtual Health Monitoring

Ambulatory Care

Wellness & Prevention
Cognitive & Developmental
Physician Office
Urgent Care
Diagnostics (e.g., lab, imaging)
Treatment (e.g., surgery, cancer care)

Post-Acute Care

LTC, Specialty Rehab, & Chronic Care
Outpatient Rehab, PT, OT, & ST
Home Care
Specialty Pharmacy

Acute Care

Emergency Services & Trauma
Hospital Medical-Surgical, NICU, & PICU
Inpatient Rehab & Behavioral

EHR
Omnichannel Communication + CRM
Revenue Management
Customer Service, Training, & Quality Standards

Shared Infrastructure

Figure 5: Digital Health across the Continuum

as the digital health market matures, though the sophistication of service offerings will likely become even more powerful, enabling providers to not just engage with consumers and their patient populations but also to reduce costs through operational efficiency and alternative means of care delivery.

Health systems should heed the experiences and lessons learned in other industries: start small and build a following, gain momentum and add features, and continuously enhance the core service offering and value equation to consumers. The scope of offerings should be tiered from including free services or nominal membership fees for additional value-added services (which may include limited virtual care services) to providing more robust concierge medicine–type services with access to primary care and specialty providers.

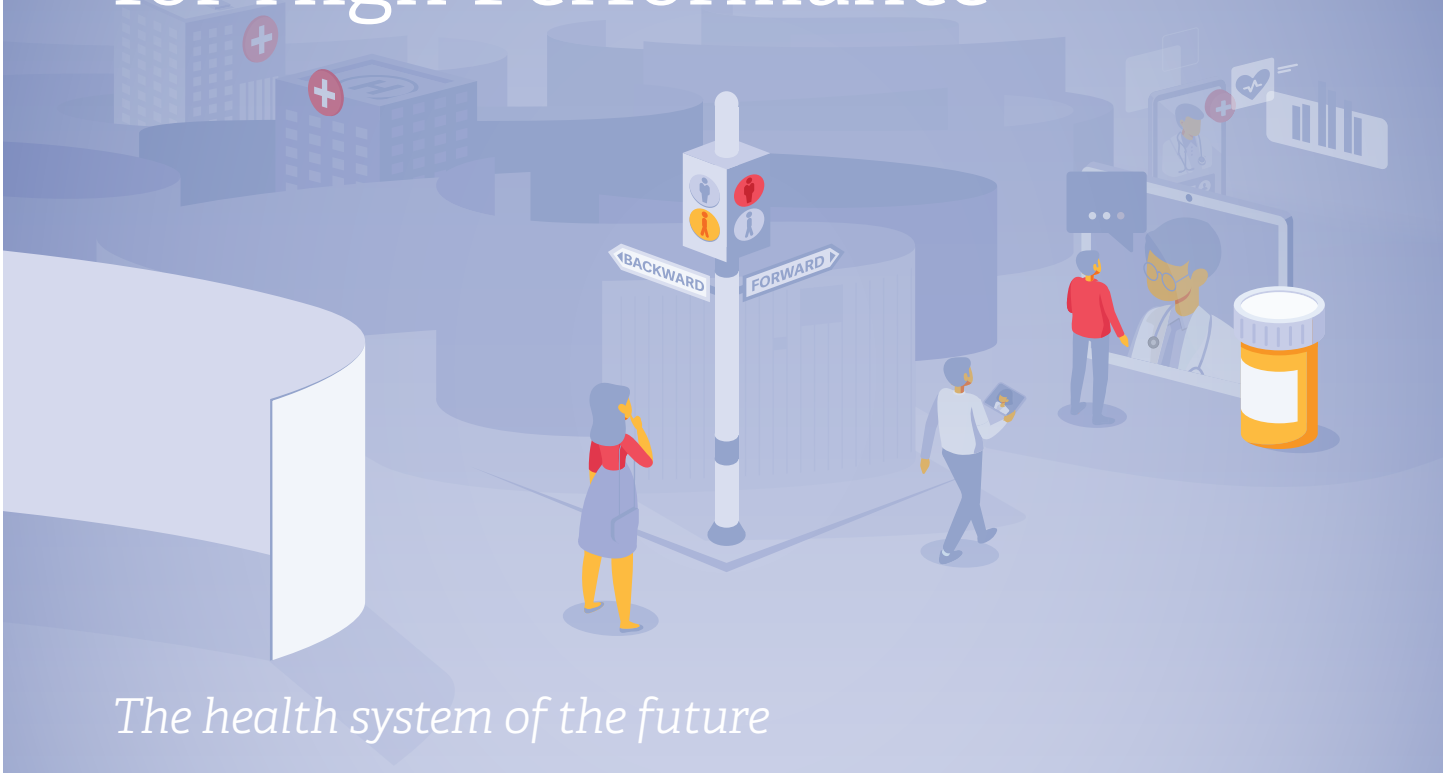
A digital health consumer engagement strategy will require several years' commitment to get launched. Health systems with scale have a clear advantage to mobilize and invest in this strategy, though they and smaller systems may benefit from strategic partnerships with businesses that bring the technological and consumer engagement expertise.

Customer Relationship Management (CRM): Investing in technology-enabled digital health consumer engagement platforms without a well-designed CRM strategy will leave the organization with communication portals that eventually become disjointed from the health system's overall strategy. CRM is the process of establishing and managing personalized relationships with an organization's customers—patients, physicians, and the general population—and using data about their needs to strengthen those relationships and build trust with the health system. A CRM strategy is built by extensive data mining of the health system's patient records, physician referral data, and other sources to categorize and eventually tailor interactions with unique individuals, and through both passive and active communications, direct them to an appropriate user channel within the health system. For instance, a user channel could be at the clinical level and employ an active communication, such as an appointment or prescription refill or the provision of results to the patient from a remote-monitoring device. Another channel might be at an educational level, employing a passive communication related to health education or a wellness offering that aligns with the patient's condition. The opportunities to strengthen the consumer relationship are all around.

At the end of the day, having patients agree to recommend a provider organization will always remain a good outcome. In addition, having an established long-term relationship with a consumer population whose mindset is "I wouldn't think of going anywhere else" becomes a market differentiator. The health system's brand must be managed to this end.

KEY IMPERATIVE 2:

Redesign the Delivery Network for High Performance



The health system of the future will be turned on its head and based around its digital health platform, ambulatory network, and physician network as the front door to the system.

The structure and design of the health system's delivery network, inclusive of the physician network, ambulatory services, hospital services, and nonacute services, must be better than just adequate—it must be indispensable to consumers and payers, and each component of the delivery network must be a high-performing business unit. The adoption of technology will change all facets of healthcare delivery and care management through the use of web-based applications, telehealth and virtual health platforms, and AI-enabled predictive health and precision medicine. The health system of the future will be turned on its head and based around its digital health platform, ambulatory network, and physician network as the front door to the system—with hospital services available when they are needed.

Hospitals: Historically the economic engine for a health system, and likely to remain so for at least a while, hospitals will come under great stress in the future as growth in ambulatory services continues and payment rates reach parity (or near parity) for ambulatory and ancillary services between freestanding and hospital-based sites of care. As margin pressures continue to mount, hospitals must become more focused on the performance of their clinical portfolio. Gone are the days of attempting to "be all things to all people"; hospitals simply cannot afford to offer a full range of services when many of them are underutilized or have poor financial performance due to high costs, inefficiency, and/or insufficient payment rates—particularly if quality and safety levels are poor or at risk.

For regional systems, duplication of high-cost services at multiple delivery sites can result in underutilization at each location, or worse, a demonstrably different patient experience and quality signature for the health system across its asset base. Health systems should employ a rigorous evaluation of their clinical portfolio, taking into consideration multiple variables such as market demand, referral and competitive dynamics, program scale, growth opportunity, financial performance, and quality. This management discipline is necessary to define clinical priorities for the organization; assess programs with a potential for investment; and discern potential programs for rationalization, consolidation, or potential elimination.

Ambulatory and Physician Network: In the longer term, we envision that the economic engine for many regional delivery networks will shift from the hospital to the ambulatory network and physician network. A health system's ambulatory network and its aligned physician network—either through a health system–owned physician enterprise, clinically integrated network, or other alignment vehicle—are the metaphorical front door to the health system. This is why cost, access, and convenience are so critical. Access and convenience relate to the ability to obtain an appointment within a reasonable time frame, through a process that is not burdensome, and at a location that is within a reasonable distance—in the eyes of the consumer. Provider organizations can manage consumer expectations, but they cannot discount or discard them.

A health system's ambulatory network design must be envisioned as a self-sustaining business. A range of ambulatory models will likely be required, meeting both local/neighborhood needs and others that serve larger population bases and draw regionally. They require sufficient scale and scope of services to be attractive, yet not so asset heavy that they lock in a provider to a given physical site for 40-plus years (as is the case for hospital buildings). The operational model must be efficient and at a cost structure that supports a sustainable business model. The nonacute (e.g., home health, therapy services) component of the business must be in place either through ownership of cost-effective and profitable business units or through strategic partnerships with performance requirements. The health system's payer

strategy (discussed further below) needs to balance the need for a cost-efficient model while affording sufficient margin to reinvest in the business.

Physician Enterprise: Many organizations have employed physicians placed in a "medical group" sponsored by the health system, often cobbled together through practice acquisitions or recruitment in response to various market or operational needs such as filling community gaps in primary care, supporting strategic specialty programs or bolstering scarce specialties, or directly supporting certain hospital-based specialties. Others have networks of contracted physicians via professional services arrangements. Some health systems will readily admit they never wanted to be in the business of physician practice ownership and have done so reluctantly. Others have been more deliberate and strategic and link the physician enterprise strategy to clinical integration and population health.

Many continue to operate their employed physician network as a loose federation of practices, and few have created a fully functioning integrated medical group model despite hiring professional leadership. The institutional subsidy of these practices has become a financial burden for many health systems, with the average annual "mission support" requirement of nearly $240,000 per provider FTE based on ECG's annual survey of health systems, and for some organizations the aggregate investment (i.e., operating losses) can amount to tens of millions of dollars per year. Many health systems target the median to 75th percentile as an acceptable level of performance but fail to realize that a comparison to a "peer group" of other underperforming physician enterprise organizations is hardly the right yardstick. In fact, the inability of many health system physician enterprise organizations to demonstrate a clear return on investment should stand as an obvious challenge to their strategy.

Hospitals and health systems rationalize these losses to meeting community need or retaining a key resource in the community, or point to the downstream economic impact on the hospital, despite the fact that in many cases those downstream revenues were in place prior to the physician's employment by the hospital or health system.

Addressing the investment costs and operating losses in a health system's physician enterprise can be a sensitive undertaking, and given competitive pressure from other health systems and payers that are building their own employed physician networks,

health systems need to be creative in designing solutions that have staying power. Every aspect of the physician enterprise should be reimagined: provider mix, size, and distribution; revenue streams; economic relationships with consumers; productivity and compensation; staffing levels and operations; organization and governance; even ownership structure. Revisiting strategic questions about why the physician enterprise exists and what the necessary scale is to achieve strategic objectives is the place to start.

Fundamentally, many health systems will find they need to rethink their strategy of employing physicians, advanced practice providers (APPs), and their staffs. Alternative business models may be required, potentially to include ones that create the necessary strategic alignment but also ensure the physician enterprise providers have skin in the game.

Select ancillary services may need to reside in the same P&L as the physician practices, and while those revenues cannot legally be part of the compensation model, they may create a more transparent view into performance of the business and at the same time shine a brighter light on hospital performance.

Health systems should evaluate opportunities for equity participation by the physicians and consider structural models that do not keep the physician enterprise or its employees from optimizing revenue and margin performance. Joint ventures of the operation, potentially even as part of a bigger strategic play with a payer partner, might drive stronger performance.

There won't be a one-size-fits-all solution, though it is clear the current physician enterprise model for many health systems is not sustainable.

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KEY IMPERATIVE 3:

Optimize Operations and the Cost Structure

Organizations that adopt a continuous process improvement business model strive to reduce unit costs through greater efficiency, lower-cost resources, and innovations in care.

A growing government-funded payer mix and continued movement toward risk-sharing arrangements, combined with an emphasis on further migration of services to the ambulatory arena, will require health systems to achieve greater levels of efficiency and cost management across their delivery networks. Regardless of market dynamics and the maturity of VBC and population health models in the market, health systems must continuously work to manage and improve the cost structure of their delivery networks and support infrastructure.

The process of optimizing an organization's operations and cost structure can be painstaking, though the results can be significant if approached in a sustainable manner. However, the efforts of many organizations to control or reduce their cost structure are often short lived. In most instances, this is primarily a function of a weak or absent performance excellence culture and/or the lack of a fully developed cost accounting capability—two areas that health systems must commit resources to in order to truly understand their patient care costs at a service or episode level and to instill the culture and process discipline necessary to achieve continuous improvement.

Operating Costs: The solution for sustainable cost reduction is not a wholesale "slash and burn" reduction in force that so many organizations have painfully experienced. Such approaches are akin to ancient medical approaches of bloodletting, trepanation, and mercury dosing—unproven and generally resulting in more harm than good. Managing cost increases to levels just below annual payer rate increases isn't good enough, nor is it even the right mindset. Organizations that adopt a continuous process improvement business model strive to reduce unit costs through greater efficiency, lower-cost resources, and innovations in care. Those operating under a population health model must go further and manage the total cost of care for the patient's entire episode of care, across the continuum. Organizations must focus on every aspect of their cost structure: fixed costs and asset management costs; labor and skill mix; high unit cost and variable cost items, such as blood products and pharmaceuticals; and of course, throughput and capacity management to drive substantially greater levels of operational efficiency. Perioperative services and bed management typically offer significant opportunities. Managing assets and capacity through longer operating hours will become essential as organizations pursue regional consolidations and closures of underperforming assets.

Fixed Costs: We have adopted a business model in healthcare where the best opportunity to manage fixed costs and overhead is to spread those costs over a larger revenue base. Still, fixed costs and overhead expenses account for a significant portion of total operating costs, and the percentage has grown for many hospitals and health systems as they have invested in people and support systems to help them navigate toward VBC and expand their scope of business to include the physician enterprise, ambulatory care, and other services across the continuum.

Because of the COVID-19 crisis, hospitals and health systems have been forced to take a hard look at their cost structure. Any fixed expense not contributing to direct patient care or positively impacting quality or safety has been closely evaluated, and while many hospitals have furloughed large numbers of employees (including clinical personnel) due to loss of volume, others have eliminated certain fixed costs—mostly support functions—entirely. Going forward, hospitals and health systems must hone their focus on overhead and fixed costs. In ECG's experience, the most significant areas of opportunity to impact fixed costs and overhead costs include:

- Reducing layers of management.
- Improving financial processes, including billing and collections.
- Eliminating noncore businesses or services.
- Scaling down the fixed asset base, including both leased and owned assets.

High-Cost Patient Populations: Organizations that can effectively manage high-cost, frequent utilizers can have a significant impact on a provider's ability to improve their financial health and sustain that improvement into the future. In order to do so, it is crucial to fully understand the different strata that patients can fall into and the impact of each stratum on healthcare costs.

The top tier (the 5% or 6% driving just over 50% of spending) represents a very complex range of patients, from high-cost episodic and terminal patients to those with irreversible and declining conditions. Some of these patient populations can be managed through lower-cost settings, but many will still experience episodic acute hospitalization at some point. Not much change is expected in the percentage of patients in this tier between now and 2030.

PATIENT STRATUM AND IMPACT ON HEALTHCARE SPEND

STRATUM	2015 % OF US*	2015 % SPEND*	2030 % OF US*	STRATUM DEFINITION
High-Cost Episodic Medically Simple	1.1%	12%	1.3%	Of the top 20 most expensive episodes of care, those that are often noncomorbid, such as AMI, joints, pneumonia, fractures, etc.
High-Cost Episodic Medically Complex	1.8%	12%	1.9%	Of the top 20 most expensive episodes of care, those that are complex to treat, such as sepsis, aggressive tumors, complications of procedures or care, NICU, etc.
High-Cost Terminal	1%	7.5%	2%	Patients with a high risk of death engaged in intensive short-term care for conditions such as cancer, dementia, heart disease, or lung disease
Irreversible Declining	2%	20%	2%	Patients with a longer (>1 year) life expectancy who require a palliative approach for conditions such as renal failure, late stage CHF, or late stages of polymorbidity
Progressive Multichronic	5%	15.7%	10%	Patients with 3–4 chronic and/or uncontrolled conditions: CKD, mood disorders, early-stage CHF, uncontrolled diabetes, uncontrolled high blood pressure with hypertension, polymorbidity
Stable Chronic	10%	18%	18%	Patients with 1–2 chronic conditions and/or controlled conditions: behavioral health issues such as depression and anxiety, controlled diabetes, CAD, hypertension, lipid disorders, obesity
Episodic Planned	18%	8.3%	18%	Patient with planned episodes such as procedures, diagnostics, minor surgeries, and courses of treatment (pregnancy, cosmetic, eye, GI)
Episodic Unplanned	12%	5.5%	12%	Patients with unplanned episodes of care (infections, unintended injuries and accidents, fractures, abrasions, viruses)
Well At Risk	-	-	15%	Patients who are mainly well but have been screened and are at risk for developing conditions (pre-diabetes, high blood pressure, etc.)
Well	35%	3%	15%	Patients utilizing short-term, routine care: prevention/wellness visits, physical exams, ambulatory episodes of care
Not Accessing Care	15%	0%	5%	Patients not accessing healthcare

*Based on ECG analysis.

Figure 6: Patient Stratum and Impact on Healthcare Spend

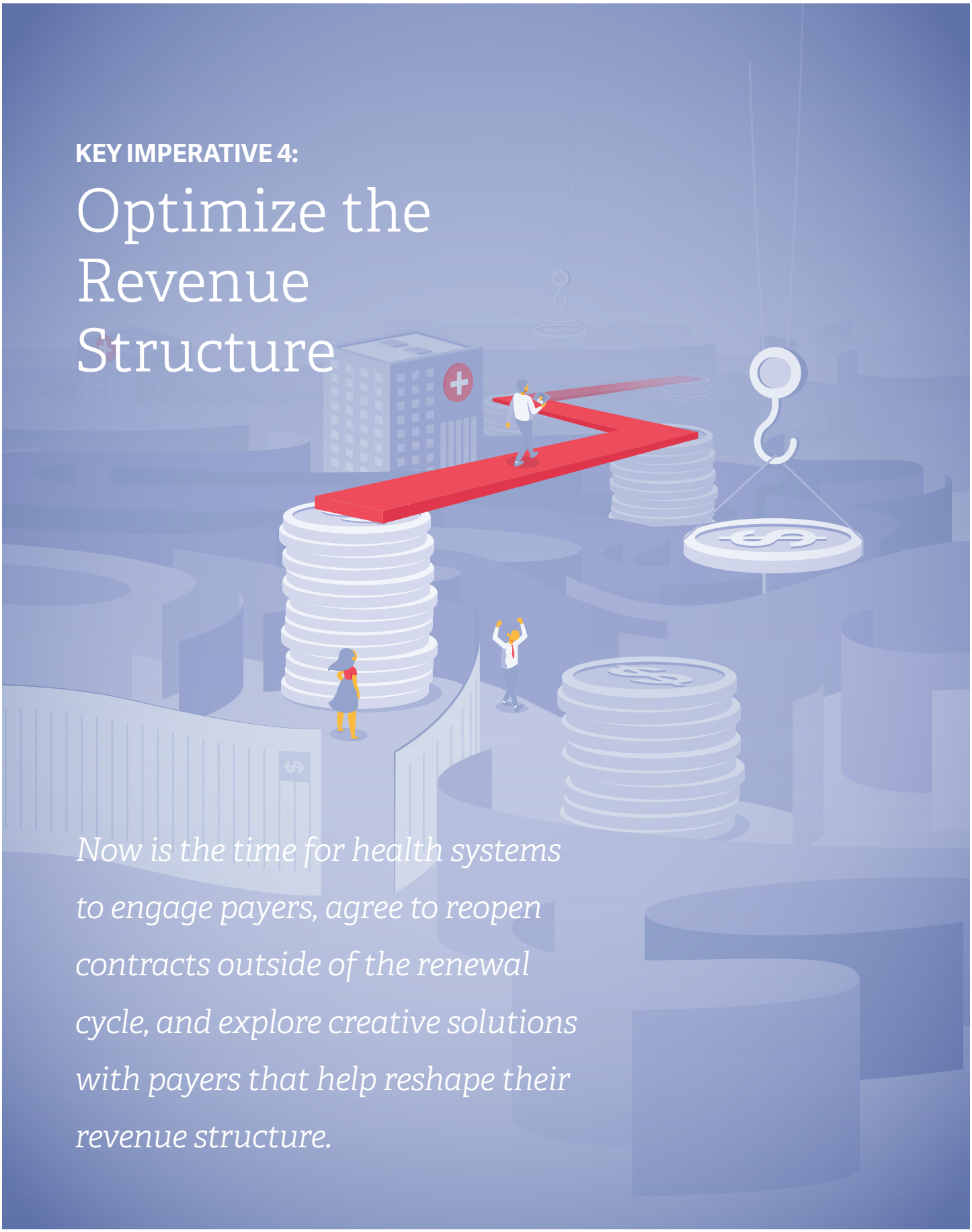
The tier to be most concerned about includes the progressive multichronic and the stable chronic, which together represent 15% of the current patient population but will grow to represent 28% by 2030—an 86% increase. If this tier currently makes up 34% of spending, that share of spending in the future has the potential to become massive if current ratios hold true. What makes the populations in this tier so important to provider organizations is that they can be managed if the health system has the clinical integration infrastructure to do so. Of course, this also requires patient compliance and perhaps acceptance of more financial accountability.

Managing these populations is a difficult task, but one that can lead to long-term financial health for the organization through reduced cost. The two major areas where these populations can be impacted are via an integrated delivery network throughout the care continuum and a strong care transformation model.

1. **Care Continuum Integration:** Achieving a meaningful impact with these patient populations requires a well-developed and integrated primary care and specialist network, the ability to manage patients prospectively through at-home visits and telehealth, efficient care delivery in the acute setting, and aggressive oversight of care in the post-acute environment to prevent readmissions or lapses in treatment or recovery plans.
2. **Care Transformation Model:** Providers attempting to manage these populations will need to have a strong care transformation model that aligns the proper resources for these patients. A robust program will allow providers to manage the redundancy in the system, allowing costs to stay low. In addition, well-structured risk arrangements can ensure that the reduced costs associated with the provider's efforts stay within the system instead of simply accreting to payers.

KEY IMPERATIVE 4:

Optimize the Revenue Structure



Now is the time for health systems to engage payers, agree to reopen contracts outside of the renewal cycle, and explore creative solutions with payers that help reshape their revenue structure.

The assumptions and models that have historically served as the basis for establishing rates, often through multiyear contracts, and the mix of services have been completely disrupted by the COVID-19 pandemic. This situation will provide ample opportunity for health systems and payers to engage in collaborative discussions to reset payment rates going forward. This new era of healthcare has the potential to create a further divide between health systems and payers if not carefully managed. As noted previously, commercial payers may be reluctant to negotiate with health systems—and in fact will push back harder if a system's sole strategy is to negotiate for future rate increases that require commercial payers to cover shortfalls from government payers. Health systems cannot afford to be shortsighted and focus merely on rate relief associated with pandemic-related loss of volumes. Now is the time for health systems to engage payers, agree to reopen contracts outside of the renewal cycle, and explore creative solutions with payers that align with select customer-centric concepts and help reshape their revenue structure.

As health systems redesign their delivery networks to emphasize ambulatory services and their physician networks, those organizations that have historically weighted reimbursements more favorably on hospital services will be in a tough negotiating position unless they are prepared to take on increased levels of financial risk sharing and work with payers and employers to structure and enforce meaningful steerage.

Providers should attempt to wrest every dollar in rates they can get from payers. Getting paid and managing the revenue cycle is an equally important component of ensuring the integrity of an organization's revenue structure. Revenue diversification may also present opportunities for some provider organizations.

Payer Contracts: As hospitals and health systems emerge from the initial onslaught of the COVID-19 crisis, and notwithstanding the impact of the CARES and Families First Coronavirus Response Acts, we estimate that providers will experience revenue shortfalls of roughly two years' worth of operating margin, with some faring much worse. Payers have not experienced the financial hardship that hospitals have. Providers should reopen contracts and pursue terms that address rates, care management fees, and payer investments in public health. Those payers making strategic plays to preserve membership will be staying close to employers and will need to stabilize their provider networks.

Renegotiating payer contracts can generate significant incremental revenue. Providers need to be wary of payer efforts to place them in tiers or narrow networks, often trading lower rates for the promise of a greater share of the payer's members. Do not settle for subpar rates. Provider organizations must become sophisticated modelers of payer contracts, and never underestimate the power of a data-driven discussion with payers in which market intelligence can effectively support not only payment-level requests but also other key provisions within payer arrangements.

As a longer-term consideration, health systems should partner with payers on commercial and Medicare Advantage products to secure more of the premium dollar in value-based contracts. The COVID-19 crisis has demonstrated the imperative of effectively managing at-risk patient populations and ensuring they receive preventive services and care in the most appropriate settings. Providers should share in those risks and rewards.

Revenue Cycle Management (RCM): A focus on RCM is imperative to improve cash flow and minimize bad debt. The back-end functions of billing, denials management, and collections have historically been the primary focus of RCM initiatives. Ample industry and best practice experience supports the fact that paying more attention to the revenue cycle on the front end of a patient's journey (i.e., days before their anticipated date of service) will have a profound impact on revenue and collections.

Considering all aspects of patient scheduling and registration—including insurance verification and precertification, financial counseling, case management, advance or time-of-encounter collection of patient financial responsibility, and the billing and collection process itself—offers significant opportunities to enhance revenue cycle integrity, reduce days outstanding in collections, and potentially improve bad debt. Special attention is warranted for payment compliance with payer contracts. The RCM process should similarly extend to clinical departments and medical staff to ensure appropriate documentation and charge capture.

RCM is not an event—it is a process of continuous improvement around any aspect of the patient journey that impacts a charge and the organization's ability to collect. Hospitals and health systems should ensure their RCM improvement teams include representation from scheduling and registration, ancillary and nursing clinical areas, IT, patient financial services, and case management. Opportunities for improvement range from lowering days outstanding by a week or more, increasing charge capture by up to five percentage points or better, and improving collections and payer payment compliance by several percentage points. The aggregate impact can be the difference in the survival of the organization.

STRUCTURED OPPORTUNITY ASSESSMENT FOR PAYER NEGOTIATIONS

Figure 7: Structured Opportunity Assessment for Payer Negotiations

Key Takeaways

The overall costs of the US healthcare system are staggering, though in the immediate term to midterm, we do not believe a healthcare reform scenario is forthcoming that will transform the underlying funding and care delivery model. Today's complex and fragmented model is here for the foreseeable future. For hospitals and health systems, many of which are on tenuous financial footing, the continued mandate to improve value combined with trends in demographics and escalating provider costs suggest that the healthcare economic model for providers will remain in critical condition.

We posit that few systems will make the full leap to population health, though most every provider organization must tread in these waters at some level as reimbursement becomes increasingly at risk. Most hospitals and health systems must double down on several foundational business imperatives to be competitive in this new era of healthcare, one that places value on cost, access, and convenience. These imperatives are not unfamiliar to the industry, though markets will be much less forgiving of organizations that fail to execute across these key areas:

- Delivery network design
- Cost structure
- Revenue structure
- Consumer engagement

Health systems must own the consumer relationship and create multiple pathways to their organization—for consumers, patients, referring physicians, transferring hospitals, and others across the continuum and in the community. There is no wrong door, though increasingly the front door will be through digital health channels.

Before a provider organization can transform to a future value curve model of population health management, it must first transform its current business model to one of a low-cost, continuously improving organization. And beyond seizing control of their cost structure and ensuring the integrity of their revenue structure, healthcare organizations must make bold decisions regarding their clinical portfolio and physician enterprise and prospectively manage defined patient segments to reduce utilization and episodic care events.

Navigating this path to improved financial health requires vision, strong leadership, a healthy respect for uncertainty, and a firm belief that if providers are not proactively driving change in the US healthcare industry, it will be done by others while they sit on the sidelines and are marginalized to vendor status in the process.

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ABOUT ECG

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