Kurt Salmon

SIX IMPERATIVES FOR FUTURE SUCCESS

Bringing Certainty to Uncertain Times

Current health care dynamics in America present critical challenges for providers. The cost of health care per person is increasing over five times faster than the average U.S. household income, and the U.S. has a higher per capita cost of care than any other developed country. Despite this higher spending, we lag behind many other industrialized nations in basic measures of health, such as life expectancy and infant mortality. Additionally, nearly 50 million uninsured Americans have limited access to health care and their unreimbursed care places strains on health care provider organizations.[i] Clearly, health care costs are growing at an unsustainable rate and represent a major source of future unfunded liabilities in the U.S. No one can rationally argue with the need to control costs while improving access and quality, yet unproven government reform efforts remain the topic of substantial debate, leaving the U.S. health care delivery system, and providers in particular, facing the greatest period of uncertainty in memory.

For many health care providers, this is a time of survival, and for others, an opportunity to lead. In either case, the path to a sustainable future involves the pursuit of fundamental changes required regardless of how reform-oriented policy options are resolved. Health care organizations cannot defer acting while waiting for policy decisions; we will not legislate our way to a certain future of greater efficiency and better quality. Providers are tasked with improving these elements while the government enables market-based solutions.

Key Premises Defining Our Future

Our current health care environment is rooted in several underlying premises that will both lead to change and can help inform the direction health care organizations need to take as they position themselves for a more sustainable future. Patient demand and market supply will continue to impact service offerings and patient access, while market pressures and reform efforts will lead health care organizations to transition from thinking about growth in total assets to maximizing returns on total assets.

Premise #1: Growth in Demand Will Exceed Ability to Control Utilization

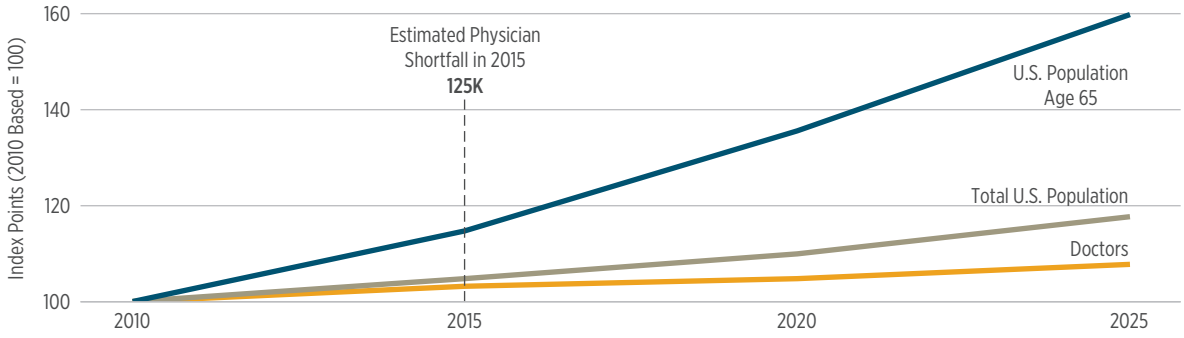
The U.S. population is expected to grow by 8.4%, or approximately 24 million people, between 2010 and 2020. (See Exhibit 1.) Population aging, chronic disease and increased access to care for the uninsured will drive dramatic growth in demand for health care despite efforts to manage utilization. By 2030, 20% of the population will be over 65, compared to 13% today.[ii] The rate of obesity has grown more than twofold since 1980.[iii] Continued advances in science, technology and treatments can add expense as they are prolonging life by turning what were once terminal conditions into chronic conditions. Diagnostic and treatment advances have moved many high-cost conditions from the inpatient to an outpatient or even home-care or self-care environment, and overall age-adjusted inpatient utilization rates are quite low in many communities. Indeed, much of the improvement in inpatient utilization rates has occurred among the 65+ population.

A legitimate question exists as to how much further utilization rates can be reduced. We have modeled in many communities that even a 20% reduction in overall utilization is not enough to offset the expected growth in demand due to the acceleration of other factors noted above. Except for unpopular options such as rationing care, on balance, we postulate that the combination of an increase in total population, aging, accelerating chronic disease and improved access will have a significant impact in driving up future demand within the U.S. health care system. While some communities will experience an overall decline in population and perhaps in health care demand, the net-net effect for the U.S. overall will be growth in demand.

Premise #2: Workforce and Capacity Constraints Will Limit Access to Care

The gap between the growth in demand for care and the availability of health care professionals will continue to grow. The rate of growth in the U.S. workforce will slow as the population ages and retires, and the U.S. has already reached its expected peak in terms of women in the workforce.[iv] We will see many jobs open due to retirements, yet potentially fewer qualified people available to fill them as current Gen-X and Millennials, and quite likely future generations, seek different career paths. The physician workforce will similarly see continued challenges. While the number of medical school students is increasing, it will not be enough to meet future demand. Further, it is understood that the supply of primary care providers faces an acute shortage, and this fact is not likely

EXHIBIT 1: Projected U.S. Population Growth (Indexed)



to change unless we address the underlying financial issues that presently serve as a major disincentive for physicians to enter primary care specialties. In the absence of dramatically changing productivity or utilization of health care services, we will face a significant workforce shortage within just a few years.

Hospitals in the U.S. are aging rapidly, and while organizations can conceptually increase capacity to meet demand, many are not even reinvesting at a rate to maintain current age-of-plant thresholds let alone add new capacity. As capital markets remain volatile due to continued economic uncertainty, rating agencies continue to place a negative outlook on the not-for-profit hospital industry due to erosion of the Hospital Insurance Trust Fund and as most U.S. hospitals are facing significant cost and reimbursement pressure. For many provider organizations, the ability to meet future demand in modern, state-of-the-art facilities will be elusive unless new sources of human and financial capital are identified or their need mitigated.

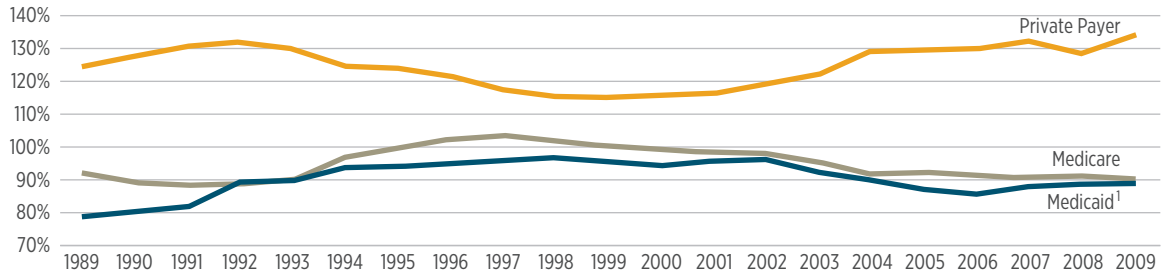
Premise #3: We Have Reached the Apex of Cost Shifting

Left unchecked, U.S. health care expenditures, presently at 17% of GDP, are projected to climb to over 20% by 2020. The causes are many, especially demand and utilization. Yet a unique aspect of the U.S. health care system has become an integral part of the industry's financing system, the "cost shift hydraulic,"[v] whereby provider organizations secure payment levels from commercial insurers and private payors to cover reimbursements considered deficient relative to cost from government payors. The American Hospital Association has found that Medicare payments to hospitals are approximately 90% of costs, and Medicaid payments are approximately 89% of costs, with corollary payment rates from commercial insurers at about 134% of Medicare payment rates.[vi] (See Exhibit 2.)

There is great debate in our industry as to whether cost shifting exists and, if so, to what extent it has driven up health spending. On one hand, most providers premise that government payors under-reimburse relative to costs. On the other, many payors premise that hospitals are merely cost-inefficient yet wield market power that drives surplus payments from commercial and private payors. We propose that, at least historically, both views are likely true to some extent, but what matters is the future. Faced with their own fiscal constraints, both government and private payors have sought to control the rate of growth in reimbursements, if not impose reductions. Anticipated spending controls from government payors associated with annual budgetary pressure and reform initiatives could effectively eliminate operating margins for many provider organizations.

Even if providers could rely on cost shifting more than they historically have, the necessary shift would be at levels that commercial and private payors, as well as employers, would not be willing to sustain even with increased premium shifting and higher employee copays. We calculate that the necessary cost

EXHIBIT 2: Aggregate Hospital Payment-to-Cost Ratios for Private Payors, Medicare, and Medicaid, 1989—2009



Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2009, for community hospitals.
[1]Includes Medicaid Disproportionate Share payments.

Six Imperatives for Health Care Providers

shift to cover an increasing Medicare population combined with potential future Medicare reimbursement scenarios and the potential shift of some sector of the commercial population to government rolls could be more than 160% to cover dollar-for-dollar "shortfalls." As commercial insurers have increasingly moved away from discounts on charges toward per diems and case rate payments to providers, and as hospitals face increasing competition not just from other hospitals but from physicians and other ancillary providers, the ability to cost shift to cover cuts in Medicare or Medicaid reimbursement may be limited. Simply put, the historic "cost shift hydraulic" must give way to a "payment downshift hydraulic," whereby providers focus more on cost management than revenue as the primary driver of their operating margin.

In the absence of an ability to materially cost shift, we are left with underlying cost structure and utilization as the primary levers of control. Providers will innovate and find creative solutions and new, more clinically effective and cost-efficient means of care delivery, and many will also rationalize services and seek the security of larger systems. This is not a new concept for most providers, though adopting it as an underlying business model for long-term sustainability will be a challenge for most organizations.

In light of these future conditions, health systems must learn to be ambidextrous organizations and will benefit from simultaneously pursuing strategies that exploit the present while exploring the future.[vii] For the near term, health care delivery will continue to be driven by market-based dynamics. As such, strategic positioning, volume, share position and revenues will remain important drivers of financial health and fiscal stability. Concurrently, and certainly over the long term, reimbursement will shift to even greater emphasis on performance and risk bearing by providers, intensifying provider focus on improving cost, quality and more efficient care delivery models, and reducing unnecessary utilization. Leaders will gain sustainable advantage by managing to several key imperatives.

Imperative #1: Strengthen Physician Alignment

Historically, many health care organizations attempted to increase physician alignment through economic models alone, including employment, professional service arrangements, medical directorships and emergency department call fees. But to create a leading provider organization ready to embrace the ambidextrous business model of selective growth and an increasing focus on cost, quality, and efficient and effective care delivery, physicians and hospitals must be aligned along three dimensions, as illustrated in Exhibit 3.

- **Alignment of purpose:** the correlation of vision, values and energies; creating a shared belief in a single vision/mission, a common culture and an active involvement in the organization's future direction.
- **Clinical activity alignment:** the correlation of the patient care approach, expectations of quality and service, and consolidation of activity in the diagnosis, treatment and rehabilitation of a patient.
- **Economic alignment:** the correlation of physician and hospital financial returns.

Only through alignment across all three dimensions can organizations truly act as a team and create a physician-hospital competitive advantage.

EXHIBIT 3: Physician-Hospital Alignment Triangle

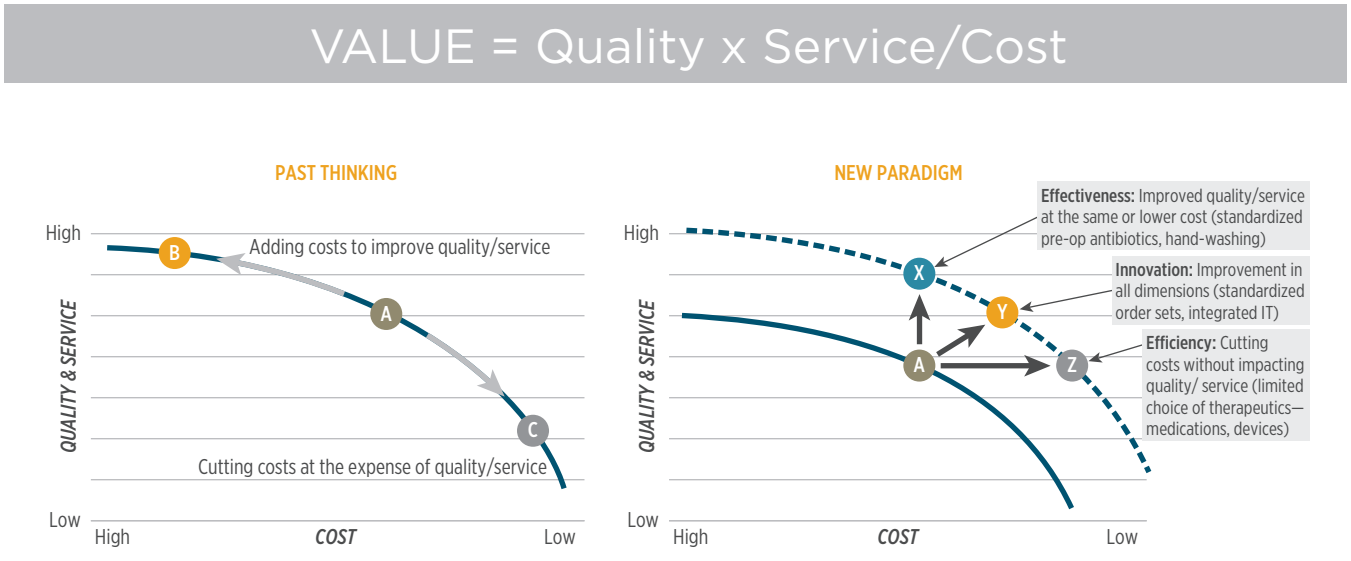
Imperative #2: Enhance Operating Performance—Cost and Quality

Facing the prospect of declining reimbursements, health care provider organizations must become more operationally efficient while continuing to provide high-quality care and exceptional patient service. This will require aggressive control of both labor and non-labor costs while concurrently improving clinical effectiveness and providing an environment where physicians want to practice and patients want to receive their care. (See Exhibit 4.) This is no small feat and, if managed poorly, providers may see the departure of both physicians and patients. Providers must embrace a value-based strategy and a culture of innovation, efficiency and effectiveness. At the same time, it's essential to integrate clinical and operational advances in a manner that creates more value for patients, insurers and physicians, as shown by Exhibit 4.

Imperative #3: Optimize Your Delivery Network

We do not believe that joining a system is the penultimate solution for improving health care delivery in the U.S., nor do we suggest that complex organizational structures overseen by federal agencies and designed to share savings among a delivery network are the optimal means to achieve longstanding improvement. However, we do believe that only strong partnerships among hospitals, physicians and other providers—whether wholly integrated or with strong clinical and economic alignment—are in better positions to shift the value curve.

EXHIBIT 4: Enhance Operating Performance—Cost and Quality



As financial pressures intensify, scale will become increasingly important. Consolidation among providers will accelerate, and many independent community hospitals will seek the safety of system membership. Concurrently, many systems will seek to expand their reach in order to gain purchasing power, achieve economies of scale, and expand their referral network to their affiliated subspecialists and their tertiary and quaternary medical centers. In locally concentrated systems, rationalization and consolidation of services will become important considerations as health systems seek to maximize use of their clinical resources and adopt a single standard of care across their delivery network.

As we move to an era of accountable care, even one premised on as simple a concept as shared savings, optimizing a health care delivery network will be no simple task. Many health care providers are challenged to find the right degree of centralization and standardization of services within a system, but these challenges will be simple compared to the task of achieving clinical alignment and integration across a network of providers with the objective of achieving higher levels of quality, access and more efficient care delivery models. Provider organizations that can navigate these dynamics will be far ahead in their ability to achieve long-term sustainability and strategic advantage.

Imperative #4: Grow Intelligently, Rationalize Selectively

Hospitals, historically originating as independent acute care providers serving distinct geographies or populations, have attempted to grow diffusely by trying to serve as much of their population as possible. This basic strategy is supported by the diffusion of technology and procedural capabilities once considered tertiary to primary and secondary hospitals. Reimbursement methodologies favoring high-tech and procedural services further exacerbated the trends. The result has been the institutionalization of cross-subsidies, whereby many hospitals have leveraged the financial benefit of select clinical services to support myriad programs and services that fare worse in an economic sense, if not along other metrics as well

But the new health care environment will not condone such a diffuse strategy to the extent present today. Provider organizations need to evaluate their clinical portfolio and determine against codified criteria which programs and services are essential, which are strategic and which are expendable. Selective rationalization of underperforming or undercontributing programs and services will be a necessary discipline for providers in the future. Historically, U.S. providers have not been able to make these tough decisions and it won't be any easier in the future. It will take strong leadership and improved physician alignment to make such disciplined decisions.

The rational deployment of resources will become essential. Providers must evaluate their clinical service offerings, patient migration patterns, physician availability and capacity to ensure patients are being treated at the right place, location and time, and by the right set of caregivers guided by the principles of optimizing value: costs, quality and patient experience. Regional referral sites with subspecialized services, advanced technology and high infrastructure costs should concentrate their available resources and may not be the best venue to support the provision of basic care that is more appropriately treated in less intensive provider settings. Several leading health systems have already initiated this approach to resource deployment.

The corollary rule is that health care providers must pursue intelligent growth, discerning market opportunity, patient needs and resource availability with return at or above defined threshold levels of performance in terms of contributions to margin, quality and community benefit. Few provider organizations will be able to support growth for growth's sake, and the days of being "all things to all people" are at an end.

Imperative #5: Improve Clinical Effectiveness

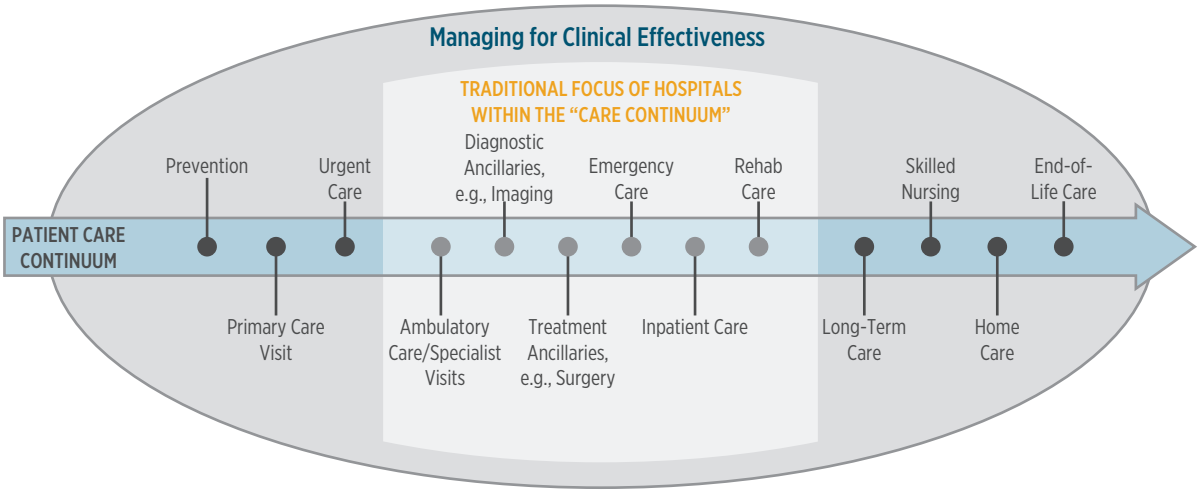
Optimizing effectiveness will require innovative models of care that improve clinical effectiveness, operational efficiency and the ability to manage patients across the continuum. Value will no longer be determined solely by what happens within the walls of the hospital, but on the outcomes of care along the continuum: from primary care clinicians and specialists working together pre-hospital, to post-hospital care, which meets the needs of patients in the most cost-effective setting—rehab facilities, skilled nursing facilities or at home. (See Exhibit 5.) Again, primary care clinicians will have an important role in assuring that patients are adhering to medications and that any deviations from planned recovery are managed in a timely way to prevent unnecessary read-missions or complications. The Asthma Initiative at Children's Hospital in Boston demonstrated that by applying basic care systematically outside the hospital using a combination of primary care, parent and community education, and an asthma care plan and access to medications, ED visits and admissions for asthma (the most frequent reason for admissions among children) were dramatically reduced over a short period of time. Efforts like these demonstrate that value can be achieved with the help of providers across the care continuum.[viii]

The challenge is implementing a model that will sustain value in health care across a broad range of diagnoses.[iv] We believe this can be done and that some components of this model will be structural, while others will be rooted in evidence-based clinical practice.

Patient-centered medical homes (PCMHs) are one vehicle for providing cost-effective care management. PCMHs have demonstrated their effectiveness at reducing unnecessary admissions and preventing readmissions. Using innovative care management protocols, they have also demonstrated their effectiveness in improving care outcomes and decreasing the cost of care per patient when one looks at the full continuum.[x]

As important as how care is organized will be that care provided is based on best practices and not always on the latest practices. For example, recent studies have shown that caring for diabetes with diet and generic medications can be just as effective as treatment with much more expensive new drugs.[xi] But despite these studies, aggregate diabetes drug expenditures increased by 87% from $6.7 billion in 2001 to $12.5 billion in 2007.[xii] This increase is due to a larger number of diagnosed patients, but also because many patients are using greater quantities of more expensive drugs.

EXHIBIT 5: Healthcare Continuum



Although numerous studies have been conducted on clinically effective management, more clinical effectiveness research needs to be encouraged. Nevertheless, translating study learnings into clinical practice will be critical in bending the cost curve and improving value provided to patients. Providers will likely implement best practices when well educated on the evidence and when they have an opportunity to develop care management protocols and to share in the savings achieved, demonstrating the benefit of rewarding care based on value instead of volume.

Imperative #6: Prepare for Population Health Management

While population health is being widely discussed in the context of reform and is a laudable goal, it will be difficult to achieve without considerable change to funding and behavior management among resident populations and providers. This is an important future issue but will require significant short-term investment and institutional learning to produce a long-term return. Population health management will be particularly important to providers who care for a large number of patients on Medicare and Medicaid, and these will be among the most difficult populations to manage given their typically complex health status. Academic medical centers and children's hospitals will have a particularly significant challenge ahead.

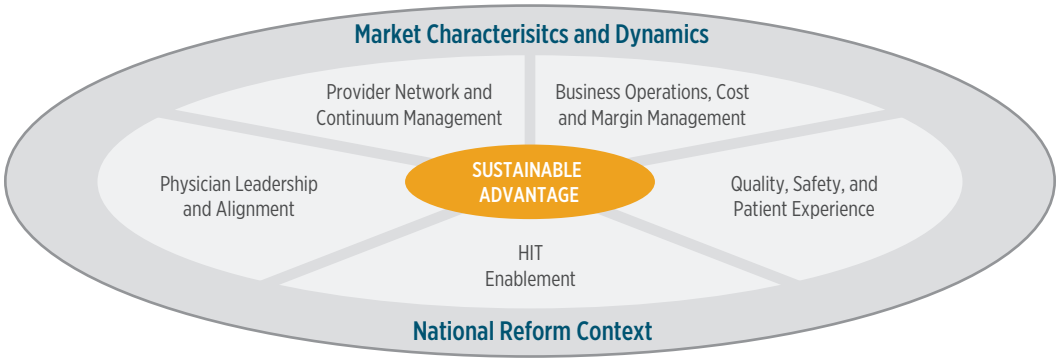
Because the concept of population health management is ahead of proven funding and reimbursement models, rather than get distracted with the pursuit of population health initiatives for patient populations who lack the personal accountability to change, we submit that providers can prepare for population health management by starting with their own employees. Many providers experience annual increases to their health benefits costs on par or in excess of the national average and, let's face it, many providers have an employee base representative of many of the worst health habits in the U.S. Providers that pilot programs with segments of their employee base with the right incentives for participation—be it those with CHF, diabetes or COPD—on a longitudinal basis with evidence-based preventive screening and treatment will learn the techniques to manage population health at large. The near-term payoff can be a healthier employee base and less cost to the organization.

Determining Readiness for Change

Any health care provider's need and readiness for change will depend on two factors: local market characteristics and dynamics, and the organization's positioning. Positioning encompasses several key factors: the degree of alignment and integration of the provider network and continuum; the effectiveness of its business operations, cost structure and margin generation; its quality, patient safety and service environment; the strength of its physician alignment and physician leadership; and the degree of health information technology as an enabler of managing the business, managing patient care and as a platform for managing change. (Exhibit 6.)

But regardless of readiness, the industry is quickly changing, and leading organizations will ensure they are ready to meet those changes in six key areas, positioning themselves for sustainable growth and viability in the future health care environment.

EXHIBIT 6: Determining Readiness for Change



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