Health System Winners in the Retail Revolution

Attributes of successful systems that prove it's not just about size.

BY BRIAN CONTOS

News of health system mergers and acquisitions dominates the headlines. Providers are scaling up to address financial, competitive, and care delivery goals. But size and brand prestige alone do not guarantee success, especially in the emerging era of health care consumerism. This article explores three core competencies that health systems must demonstrate to achieve market leadership.

CONSOLIDATION AND CONSUMERISM

The health care market looks a lot different these days. Massive regional and national health systems have emerged as a result of unprecedented consolidation. In 2013 alone, health systems involved in mergers and acquisitions represented $32 billion in revenue (Figure 1).[1] Physician practice acquisition is also white-hot, including both primary care and specialty physicians. Cardiovascular services have been the vanguards, and today, most comprehensive hospital cardiovascular programs employ specialists (Figure 2).[2] But these business transactions are happening in the backdrop of an even more profound change in health care: the retail revolution.

Although "retail" may be the buzzword of the year in 2015, this monumental shift is not just about CVS, Walgreens, and Wal-Mart investing in health care delivery models. Two underlying forces promise to be even more disruptive to hospital and health system economics: (1) the emergence of a new retail insurance market, and (2) the growth of retail shopping for care (Figure 3).[3] These changes were ignited by the launch of public and private exchanges that give individual consumers substantially more control in selecting health insurance coverage. No provider is insulated from these market forces, and only the savviest and most adaptable provider organizations will thrive.

Health systems are consolidating for a lot of reasons, including as a means to achieve scale to drive efficiencies and coordinate care. Although meeting the needs of the retail customer may not have been the primary trigger for consolidation, it is fast becoming a major consideration in decisions about what kind of capacity to bring on board and what kind of partnership deals to explore.

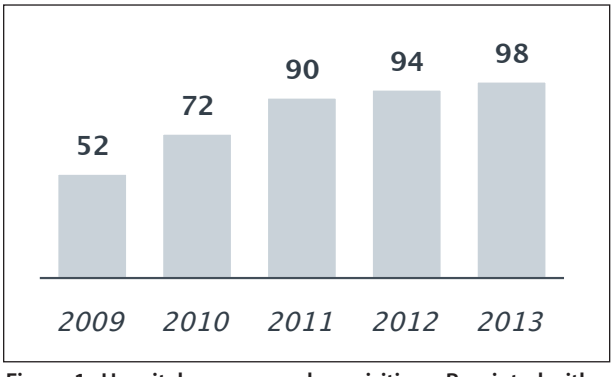

Figure 1. Hospital mergers and acquisitions. Reprinted with permission from the Advisory Board Company.

PICKING HEALTH SYSTEM WINNERS

Who will emerge as "winners" in this new retail market? As evidenced by unabated mergers, acquisitions, and other partnership strategies, many assume that

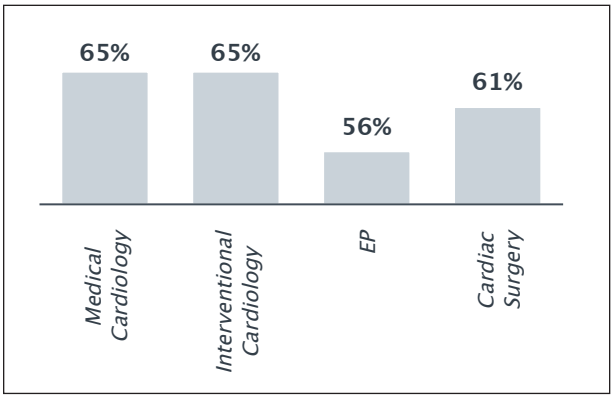

Figure 2. Comprehensive cardiovascular programs employing specialists, 2014. Reprinted with permission from the Advisory Board Company.

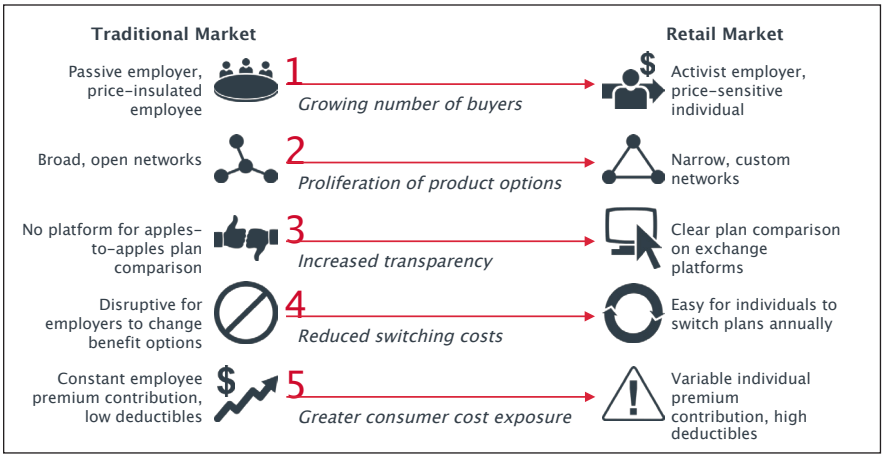

Figure 3. Characteristics of a traditional versus retail market. Reprinted with permission from the Advisory Board Company.

size and brand prestige are essential to winning in this emerging health care ecosystem, but that is not necessarily the case. Although size and scale may help health systems differentiate themselves to some purchasers and consumers of care, those factors alone will not guarantee success. Moreover, with market forces changing so rapidly, past performance is often an unreliable predictor of future success for health care providers. Indeed, less than one-third of hospitals in the top performing quartile based on revenue growth in 2010 were able to hold onto this position in 2013 (Figure 4).[4]

Yesterday's best-bet health systems are not necessarily tomorrow's winners. Winning health systems will come in varying sizes and locales, but they will all share three characteristics; more specifically, provider organizations able to thrive in the coming decade will excel at three competencies now coming to the forefront as business imperatives: (1) setting a clearly defined customer value proposition, (2) demonstrating success in mixing volume- and value-based contracts, and (3) developing a highly aligned network of care sites.

SETTING A CLEAR CUSTOMER VALUE PROPOSITION

After years of academic discourse about the rise of the health care consumer, the "retailization" of health care has become a reality. The urgency for providers to figure out how to win and retain these customers will only increase as performance-based payment, data transparency, and patient financial accountability escalate. Disruptive innovators, including nontraditional providers and companies focused on aiding consumer decision making, will challenge health systems to nail their consumer value propositions.

The first step for providers is to understand what consumers want and how they prioritize their expectations. A recent survey of 4,000 consumers about their primary care preferences revealed that convenience is king. Winning providers must prioritize immediate access. Six of the top 10 preferred primary care clinic attributes related to access and convenience were chosen as such based on ratings for access and convenience. Consumers also value up front cost information, as opposed to waiting for weeks until the bill arrives. Interestingly, in the context of clinic visits, respondents ranked attributes related to reputation surprisingly low (Figure 5).[5]

Providers that have historically focused on meeting referring physician preferences are coming up against new retail and virtual care competitors who are arriving

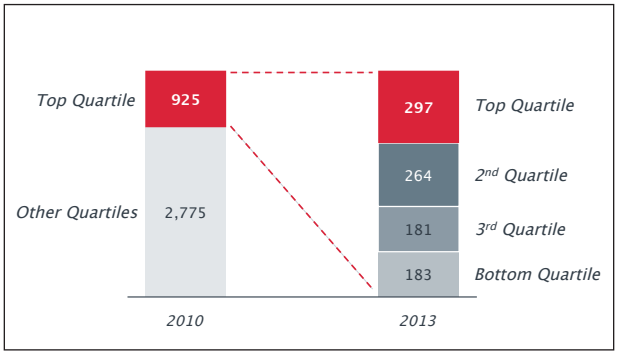

Figure 4. Hospital revenue growth by quartiles (n = 3,700 hospitals). Reprinted with permission from the Advisory Board Company.

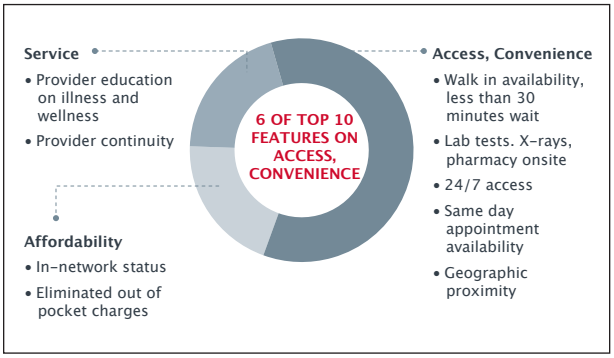

Figure 5. Top 10 preferred primary care clinic attributes by category. Reprinted with permission from the Advisory Board Company.

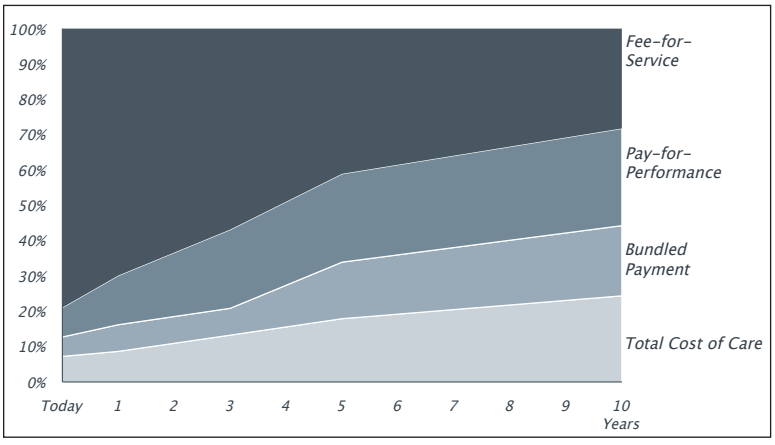

Figure 6. Projected growth in all risk-based contracting models. Average estimated hospital revenue breakdown (n = 88 hospitals). Reprinted with permission from the Advisory Board Company.

on the scene with much deeper consumer expertise. The rapid growth in retail clinics (such as those found in CVS or Walgreens) that offer convenient, affordable care and applications like Castlight and PokitDok, which provide cost and quality transparency and easy scheduling, make it clear that providers must consider these factors in their value proposition. Transparent, understandable, and competitive prices; same-day appointment availability; one-stop shop service offerings; and virtual care options signal that providers "get" health care consumerism.

The principles behind a robust customer value proposition are not limited to primary care. Endovascular specialists can contribute to meeting the evolving demands of today's health care purchasers. For instance, excellent patient outcomes are a primary advantage of image-guided interventions. Compared to more invasive procedures, endovascular therapies generally have quicker recovery times and lower infection rates, and they can provide a quality-of-life advantage over alternatives. Furthermore, these procedures can be cost effective because they do not require full operating room setups and general anesthesia, and oftentimes, they can be performed in ambulatory settings, with short recovery periods.

Endovascular specialists can also partner with health system executives to advance specific institutional goals by tapping into their specialty-specific experiences. For instance, radiologists can help with utilization management efforts based on their knowledge surrounding referring physician exam ordering. Cardiologists can assist their colleagues with implementation of appropriate-use criteria based on work done in the coronary arena.

MIXING VOLUME- AND VALUE-BASED CONTRACTS

The expectations of health care shoppers, including payers, employers, and patients, have increased in recent years. They are all looking for more affordable, high-quality, accessible care. One way to catalyze higher-value care is the adoption of performance-based payment models. Today, virtually every health care provider maintains a mix of traditional fee-for-service payer contracts and value-based arrangements that delegate cost and quality risk to providers.

The shift to accountable payment models is happening quickly (Figure 6),[6] and managing the business during this transition period can feel schizophrenic. Reducing demand for high-cost services is a key determinant of success under risk arrangements, which is the opposite incentive from traditional fee-for-service medicine. Providers must transform both their payment models and care models, ideally in a synchronized manner.

A provider's playbook of "no regrets" strategies must include tactics for eliminating avoidable spending without destroying the profitable fee-for-service business. To lower costs, most providers have taken to freezing or cutting budgets as the path of least resistance. Top sup-

Respondents Rating Attribute as "Very Important"

n=61 hospitals, 44 suppliers

Vendor Attribute	Hospitals	Suppliers
Help improving supply chain	#1	#9
Post-purchase service quality	#2	#5
Impact on LOS, readmissions	#3	#7
Bundled pricing	#4	#3
Individual item price	#5	#1
Ability to engage system on strategic issues	#9	#2
Hospital-supplier relationship	#13	#4

Figure 7. Top attributes driving hospital purchasing decisions. Reprinted with permission from the Advisory Board Company.

ply chain cost-cutting strategies look familiar, including product standardization and reducing physician preference items. But providers have been at this for a number of years, and some now realize these techniques alone will not suffice. In a recent survey of hospitals and suppliers, hospitals actually ranked things like help improving supply chain management and impact on length of stay and readmissions as more important to purchasing decisions than individual item cost (Figure 7).[7] These priorities indicate that hospitals have begun to appreciate the importance of reducing the total costs of care.

Options for eliminating avoidable health care delivery costs include care pathway redesign and use of value-added care substitutions (Figure 8).[8] These tactics can be organized around four principles in order by their relative disruption of traditional fee-for-service payment. First is the elimination of unnecessary services like redundant tests and low-value (clinically unproven) procedures. Second is the removal of clinical and process variation in care pathways such as the use of specific drugs or medical devices. The third approach relates to shifting care to lower-cost sites and providers (eg, inpatient vs outpatient). The final tactic is demanding substitution using cost-effective clinical alternatives like optimal medical therapy over invasive treatments.

DEVELOPING A HIGHLY ALIGNED NETWORK OF CARE SITES

Consolidation (eg, from mergers and acquisitions) alone does not guarantee a seamless care network. Often, providers in the same health system fail to successfully integrate operations and care delivery standards (Figure 9).[9] Misalignment is incredibly costly and can result in $25 to $45 billion wasted each year as a result of inadequate care coordination.[10] Yet, alignment is essential for accomplishing the two related goals of capturing covered lives (eg, patients within the network) and improving access and coordination.

Although a health system ownership stake in hospital, physician, and post-acute sites may be the typical approach to growing market share, integration can occur without balance sheet ownership. Nonequity models can foster collaboration and support population health management initiatives. For instance, innovative providers have formed partnerships to jointly develop the full continuum of care required for advanced therapies like transcatheter aortic valve replacement. Others have linked up to advance quality goals, such as standardizing care protocols for heart failure management across a network of providers.[11]

Successfully aligned networks improve access. To win customers, health systems must set up care networks that offer patients less hassle and more effective transitions of care. Of course, access can be defined in many ways. Winning health systems approach access as a comprehensive strategy to see the right patients at the right locations for the right services in a convenient, timely, and cost-effective manner. Compared to their peers, these

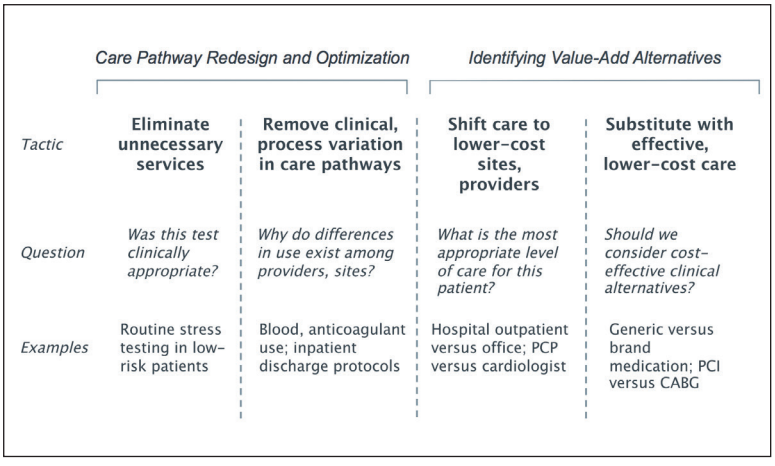

Figure 8. Options for eliminating avoidable health care delivery costs. Reprinted with permission from the Advisory Board Company.

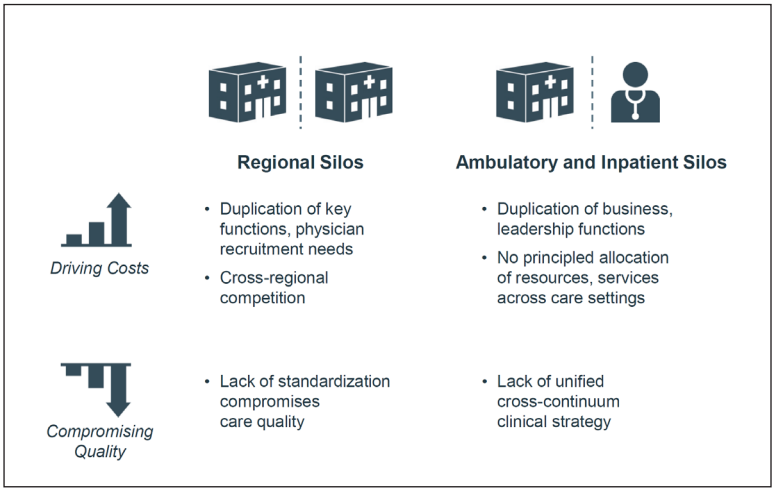

Figure 9. Access and coordination failures resulting from poor integration of health system providers. Reprinted with permission from the Advisory Board Company.

THE GROWTH OF ACCOUNTABLE PAYMENT MODELS

The shift toward new accountable payment models has been swift. Some of this risk is de facto where providers are subjected to conditional payment, like it or not. Examples include Medicare's Readmissions Reduction Program, Value-Based Purchasing, and the Hospital-Acquired Condition Reduction Program. Across these three programs, up to about 5.5% of a hospital's inpatient Medicare payment is at risk in 2015.[12]

Other arrangements reflect deliberate risk taking (ie, accountable care organizations [ACOs]). In December, the Centers for Medicare & Medicaid Services announced that 89 new ACOs joined the Medicare Shared Savings Program, bringing the total count to 424 ACOs. These ACOs serve more than 7.8 million beneficiaries.[13] Medicare's largest voluntary payment innovation program is the Bundled Payments for Care Improvement Initiative, which now includes more than 6,400 providers.[14] But value-based contracting is not limited to Medicare. Thirty-one percent of hospitals have contracts with commercial insurers that link reimbursement to quality metrics.[15]

The momentum behind value-based payment is picking up. In January, the Department of Health and Human Services announced ambitious goals for reforming Medicare payments for hospitals and physicians that would make 30% of payments through alternate payment models like ACOs and bundled payment by 2016.[16] To facilitate the transition away from fee-for-service care, the Department of Health and Human Services announced the formation of a Health Care Payment Learning and Action Network. The network will work with private payers, consumers, employers, providers, Medicaid programs, and other partners to expand alternate payment models into non-Medicare programs.

health systems invest disproportionately in the information technology, care processes, staff, and provider-industry partnerships needed to deliver on this ambition.

SUMMARY

Today, the question, "How big do we need to be?" is less relevant than the far more important question, "How good do we need to be?" Health systems that want to thrive in the coming years must excel at certain competencies. Winning providers will be able to articulate and deliver against a compelling value proposition aimed at the new era of health care consumers. These organizations will embrace new accountability-based payment and successfully transform their payment models and care delivery models in a synchronized manner. Finally, they will develop highly aligned networks of care sites that compete more effectively against traditional and nontraditional providers when it comes to winning over the health care consumer. ■

Brian Contos is an Executive Director for the Advisory Board Company, a global technology, research, and consulting firm partnering with 200,00 leaders in 4,500 member organizations across health care and higher education. Through its innovative membership model, the firm collaborates with executives and their teams to elevate performance and solve their most pressing challenges. The company provides strategic guidance, actionable insights, web-based software solutions, and comprehensive implementation and management services. He has disclosed that he has no financial interests related to this article. Mr. Contos may be reached at (202) 266-6715; contosb@advisory.com. For more information about The Advisory Board Company, visit www.advisory.com.

1. Budryk Z. Hospital mergers and acquisitions increased in 2013. Fierce Health Finance website. Available at http://www.fiercehealthfinance.com/story/hospital-mergers-and-acquisitions-increased-2013/2014-04-14. Accessed February 1, 2015.
2. The Advisory Board Company. 2014 Cardiovascular Roundtable CV Physician Alignment Strategy survey. The Advisory Board Company website. 2014. Available at http://www.advisory.com/cr. Accessed February 2, 2015.
3. The Advisory Board Company. C-suite agenda 2015: identifying winning health systems in the retail revolution. The Advisory Board Company website. Available at http://www.advisory.com. Accessed February 1, 2015.
4. American Hospital Association. American Hospital Association DataViewer. American Hospital Association website. Available at http://www.ahadataviewer.com. Accessed December 1, 2014.
5. The Advisory Board Company. What do consumers want from primary care? The Advisory Board Company website. Available at http://www.advisory.com/research/marketing-and-planning-leadership-council/expert-insights/2014/get-the-primary-care-consumer-choice-survey-results. Accessed February 3, 2015.
6. The Advisory Board Company. Accountable Payment Survey 2014. The Advisory Board Company website. Available at http://www.advisory.com/research/health-care-advisory-board/blogs/toward-accountable-payment/2014/01/proportion-of-risk-based-revenue. Accessed February 2, 2015.
7. The Advisory Board Company. What your hospital customers really want. The Advisory Board Company website. Available at http://www.advisory.com. Accessed February 3, 2015.
8. The Advisory Board Company. The cardiovascular playbook for avoidable costs. The Advisory Board website. Available at http://www.advisory.com/cr. Accessed February 3, 2015.
9. The Advisory Board Company. Building the integrated clinical enterprise. The Advisory Board Company website. Available at http://www.advisory.com/mgsc. Accessed February 3, 2015.
10. Health Affairs. Improving care transitions. Health Affairs blog. 2012. Available at http://healthaffairs.org/blog/2012/09/21/health-policy-brief-improving-care-transitions. Accessed February 3, 2015.
11. The Advisory Board Company. Blueprint for disease centered investments. The Advisory Board Company website. 2013. Available at http://www.advisory.com/research/cardiovascular-roundtable/studies/2013/blueprint-for-cardiovascular-disease-centers. Accessed February 4, 2015.
12. The Advisory Board Company. Medicare inpatient payment update final rule 2015. The Advisory Board Company website. 2014. Available at http://www.advisory.com/research/health-care-advisory-board/events/on-demand-webconferences/2014/medicare-inpatient-payment-update-proposed-rule-fy-2015-052714. Accessed February 4, 2015.
13. The Centers for Medicare & Medicaid Services. ACPOs moving ahead. The Centers for Medicare & Medicaid Services blog. Available at http://blog.cms.gov/2014/12/22/acos-moving-ahead. Accessed February 4, 2015.
14. The Advisory Board Company. Four reactions to the big BPCI expansion. The Advisory Board Company website. Available at http://www.advisory.com/research/care-transformation-center/care-transformation-center-blog/2014/08/four-reactions-to-bpci-expansion. Accessed February 2, 2015.
15. American Hospital Association. Trend watch chart book 2014. American Hospital Association website. 2014. Available at http://www.aha.org/research/reports/tw/chartbook/2014/14chartbook.pdf. Accessed February 3, 2015.
16. Department of Health and Human Services. better, smarter, healthier: in historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value. Department of Health and Human Services website. 2015. Available at http://www.hhs.gov/news/press/2015pres/01/20150126a.html. Accessed February 3, 2015.