McGUIREWOODS

HEALTHCARE STRATEGY 2015 — BACK TO THE BASICS: 12 KEY THOUGHTS

SCOTT BECKER, PARTNER
312.750.6016 | sbecker@mcguirewoods.com
77 West Wacker Drive
Suite 4100
Chicago, IL 60601-1818

January 2015
www.mcguirewoods.com

As one looks at the next couple of years and thinks about strategy, there are many different thoughts as to what is the right strategy. Increasingly, a number of these thoughts are untested and put forth by professors and consultants. The strategies resonate less and less with what is going on in the real world, what works and what is successful.

As I read articles like "The Strategy That Will Fix Healthcare," published in *Harvard Business Review* by Harvard Business School professor Michael Porter, PhD, and Thomas Lee, MD, CMO of Press Ganey Associates, one grapples with the mix of intelligent and ridiculous thought all put forth by the same brilliant strategic professor. A core challenge in reading some of the strategy papers is that the authors tend to imply that their ideas — as basic as case management, cost accounting and integrated delivery systems — have been historically absent from healthcare leadership.

This article, in contrast, embraces a lot of existing concepts. Here, as the world evolves, is the belief that one largely needs to return to the basics as a core starting point.

This article breaks down the core concepts as follows:

1. Build a dominant system and market position.
2. Know what drives your revenues and profits.
3. Constantly recruit and retain talented people.
4. Test new areas but double down on winning areas.
5. Apply the 80/20 rule to most opportunities, talent, revenues and cost areas.
6. Agitate to constantly improve on many levels.
7. Embrace owning practices.
8. Acknowledge that there is no single strategy, but define a few core plans and goals.
9. High deductible and consumer driven health plans are here to stay and will have a bigger and bigger impact.

The following 12 points expand on these thoughts.

1. Market power wins.

Like in most any business, the party with the greater market power tends to do better in healthcare, as is seen in most markets. Jack Welch, the celebrated longtime CEO of GE, positioned GE such that it only focused on markets where it could be a market leader. Being a market leader often provides pricing power, durability in challenging times, branding and recruiting advantages, purchasing power and other advantages. In healthcare and in business, the top one or two market dominant leaders tend to end up with the lion's share of profits.

The dominant organizations often have pricing power and/or cost advantages. Consumers do not think there are acceptable substitutes, and/or the health system receives better prices from suppliers. This concept seems to be as true or truer than ever in healthcare. Does it pay to proactively develop a dominant market position in whatever market you are in such that it is difficult for payers and patients to avoid you? Further, it has become more important as the top four payors have become more dominant in most markets; in fact, it is usually one or two of the four that really dominate any specific market.

Ideally, you want your organization to be so substantial that there is maybe only one other serious competitor. If you are not going to be a dominant party, you either must have a very low cost structure and can try and survive, or provide such a specialized service where your demand is always on the rise.

One of the most interesting discussions of power and monopoly I have read in a long time is set forth in the book titled *"Zero to One: Notes on Startups, or How to Build the Future"* by entrepreneur Peter Thiel. Other articles such as "How the Affordable Care Act Fuels Health Care Market Consolidation" by Christopher Pope and "Acknowledging the Elephant: Moving Market Power and Prices to the Center of Health Policy" by Robert Berenson, MD, are also worth reading, as is Jeff Goldsmith's blog piece for *Health Affairs*, "How Much Market Power Do Hospital Systems Have?"

2. Know your business.

A core concept of business management is the discipline to constantly understand and study where one's current business is coming from. What is your specialty and who makes up your customer base? A first effort is to constantly reinforce that customer base and those revenues. How do you continue to get those revenues? Are those revenues at risk? Are you allocating resources appropriately?

One of the fascinating refrains of the national healthcare system and many hospitals is the spraying of money and resources in several different directions. In a health system, as in any business, it is critical to understand where revenues are coming from, whether they are high- or low-margin revenues and whether a more targeted effort can be made toward the higher margin and higher revenue businesses. Further, can the system afford to abandon certain low-margin business?

As there is so much change and turmoil in healthcare, it is more apparent that hospitals have to go back to the old Boston Consulting Group paradigm of business management and development.

First, leadership has to understand their cash cows. Before reallocating to other areas, health systems must maintain and harvest cash in those businesses. Two successful community hospitals excel in orthopedics (a southern hospital) and neurosurgery (a Midwestern hospital). The leadership team knows the exact revenues and margins these specialties and practices meant to the hospitals. Each consistently doubles down to protect those revenues.

Second, leadership must devote a certain percentage of resources, maybe 25 percent, to new initiatives and areas that can become tomorrow's stars. This may be orientating part of the system to a more focused shared savings payment model, looking at different types of fee-for-service initiatives or creating and maintaining greatness in product lines. Here, while exploring new areas, there needs to be a constantly doubling back to three core questions: What is the system going to be great in, where does it make its money and who is its customer?

Many of the systems that continue to thrive and dominate are leaders in their markets. They can point to the specialties they are the best in, and they continue to double down on areas that work — even when the world around them is changing and moving. These systems keep track of the world around them. However, they are also very cognizant of where their revenues come from and the need to continually invest in and harvest these areas.

3. No single strategy, no static solution.

Some of the best discussions of healthcare strategy recognize the obvious. In essence, there is probably no single great strategy for the future. It all starts with a baseline of services. Then one needs a lot of smart, creative talent constantly looking to improve upon operations. There are countless examples of this and it takes a lot of energy. In one hospital I visited recently, the hospital is constantly applying for every state grant it can get. In another hospital, leadership supports constant outreach to gain patients in the area with the most patients. In one case, the outreach is at the largest church in the community every Sunday. At another place, the system is trying to work with payors to try new initiatives and new concepts.

Another hospital has a tremendous effort underway around better use of its electronic medical records and better development of systems to deliver after-care notes to patients. In other places, like Evanston, Ill.-based NorthShore University HealthSystem, a strategy might be constant talent development to grow the next level of leaders. There are no static solutions. In essence, it's often not, 'We simply do this and this works for the long run.' Rather, a high-performing system requires consistent, smart leadership that is always improving. Hence, one needs to constantly be looking to get better and have lots of talent in place to go after initiatives and make the system more successful. It is not that any one of these initiatives is perfect. Rather, it is more the concept of an agitating system constantly trying to get better.

The best businesses have a solid core and then constantly try to improve themselves. They constantly look to apply and test new ideas and concepts, and they do so with discipline and cohesion. With all the discussion of new and great concepts in healthcare, there is no substitute for this. There is not one brilliant concept from Dr. Michael Porter or any consultant that will save the day. Rather, there is a constant evolution to get better. It's closer, if anything, to a Jim Collins perspective of constant talent and team development. Essentially, every ability to pursue initiative depends on talented people.

4. There will still be a lot of fee-for-service. It's not the villain it's made out to be, and bundled payments are a type of fee-for-service.

One of the fascinating things I see is the constant attacking of fee-for-service. In one article, for example, the author bashes fee-for-service and sanctifies bundled care. Notwithstanding that it has become popular to bash fee-for-service, the reality is fee-for-service will persist at some level and someone will be paid for doing something.

When someone provides a bundled service, for example, someone within that bundle still receives fee-for-service payment to some degree. For procedures and costs of treatment over a certain amount, it clearly is a concept that may be worthwhile. No question this makes sense. Here, a provider needs to make sure it offers high enough quality and an organized bundle that they can deliver. It also needs to make sure there is a big enough market for their bundle that they can take share from others.

Further, if someone must travel to receive care under your bundle, savings and quality must be substantial enough that people are willing to actually travel for that bundled care. Cleveland Clinic, rated first in the country for cardiac care by *U.S. News & World Report* for a decade, was an attractive partner for Mooresville, N.C.-based home improvement giant Lowe's when the two finalized their

direct contracting arrangement in 2010. Prior to striking the deal, Lowe's observed variability in outcomes among its employees' heart care, as roughly a quarter of a million Lowe's staff throughout the country visited different physicians and hospitals. Cardiac surgery is a big-ticket procedure, which justifies Lowe's reimbursement for airfare and other travel costs.

Cleveland Clinic has similar agreements in place with Seattle-based Boeing and Bentonville, Ark.-based Wal-Mart Corp. In evaluating these bundles and relationships, Cleveland Clinic does not operate on the notion that every patient needs to travel. Rather, its team looks for services for which travel makes most sense.

In short, the bundled payment concept has been discussed a great deal and while it is a worthwhile concept, I think — like many of the recipes in healthcare — it is just one part of the solution and not a huge driver.

5. Dominant systems face pushback.

As hospitals get better at making shared savings and similar systems work and have a more dominant footprint to make sure their physician hospital organization or shared savings plan is the most important one in their area, the fascinating consequences of this are twofold.

First, you don't actually see costs dropping to the final payor or employer. Rather, you see the system having more leverage with the payor. Second, you often see the payor rebounding back to look for other options so they don't become so reliant on one provider. In either situation, you do not see a great deal of cost savings for employers, but you do see a reshuffling of power between providers and payors. Payors also push hard for market power. Market power provides payors with power with customers (i.e., employers and individuals) and providers (i.e., their suppliers).

In one fascinating example, a provider network became strong enough to be a key partner for a payor. Now that payor spends a lot of its time agitating to make sure it is not too reliant upon that provider network. The moral of the story as a provider network is to keep getting stronger and stronger so you have that kind of market power. However, you should understand that once the market power becomes high enough, it will get pushback from the payor. This plays out over and over throughout the country. The core question is how does one get better and gain market power?

6. To own or not own practices?

There is no question that a health system has to own practices. If you don't own practices, your fee-for-service volume goes elsewhere. Further, if you don't own practices, in the evolving managed care world, you don't have a total delivery system to provide. Part of owning practices is retaining fee-for-service volume. Another part of owning practices is being able to offer integrated packages of services. Finally, part of owning practices is maintaining dominance in an area so payors and patients are unable to go around you.

The real question becomes what kind of practices to own, how big a physician network do you need and how to manage it efficiently. In most places, you need the biggest physician network possible, you often want productivity-driven compensation and you want to constantly improve your physician network. One may not need to break even on their physician-owned network, but one needs to be close enough that the losses, if there are any, are not devastating to the system. Further, one has to be prepared and have contingency plans in place in case revenues drop.

7. Consumer-driven healthcare.

The only apparent long-term solution for really reducing healthcare costs is the greater use of high deductible and similar health plans. This is a useful strategy for the great majority of day-to-day healthcare costs. On bigger ticket healthcare costs, there will be a need for more care management teams and efforts to bundle, reduce and target costs. Day-to-day, however, consumer-driven plans — such as health savings accounts and high deductible plans — seem to be the best answer out there for the system as a whole.

For a provider who relies day-to-day on ordinary care for a great percentage of its revenues, this is concerning. The ultimate shift of costs to consumers is the best bullet for slowing down the growth in healthcare costs on a substantial percentage of the dollar. Here, this is where systems need to drive patients to their lowest cost provider, allow direction to advanced practitioners versus physicians, and get better at collecting upfront since collecting from patients later is very difficult. Hence, as a basic strategy, health systems need constant internal agitation to move costs to lower points of care and constant efforts to improve billing and collections at the point of service.

8. The best systems test new areas.

The best businesses are constantly recruiting and retaining the best talent, so they can constantly improve current operations and go after new initiatives. They also have a very clear definition of their customer. For example, is their customer the patient, the payor or some combination of the two? And if it is a combination, the system has clarity on how it is really targeting that customer. The best businesses are not static. They are constantly working at understanding and improving the core business, and then they devote time and attention to the allocation of talent to new initiatives.

Hospitals have to constantly look at how they maintain a cost and margin structure so they can attack different areas while refocusing on their core areas and patients. Hence, it is an interesting concept used by business consultant Jim Collins to put resources into different areas, but fire bullets as opposed to huge amounts of money. His school of thought is to test new areas but not break the bank.

One of the tensions I see is that between geographic expansion versus not too much expansion. Can you do a geographic expansion without investing a ton of resources? For example, a constant theme — and a disaster in many situations — is where a health system significantly increases its cost structure at a time of change.

A health system may invest a certain amount for outreach clinics, for example. It then faces a set of questions: Are those outreach clinics really successful, do they really generate revenues, do they really generate referrals back to the main hospital? Further, once a hospital seriously expands into another related market, does it need to have a more substantial presence there to be a more dominant player? For example, while Cleveland Clinic has maintained a dominant position in the greater Cleveland area, a great question is whether its national efforts are truly effective. Either way, its dominance in Cleveland allows it to test those other efforts. Increasingly, it seems like some of its expansion efforts are successful and some not.

9. Leadership and double-hatting.

There are huge differences between managing a large system and a small system. In a small system, one needs a tight executive leadership team, and it can be easier to assure everyone stays on the same

page. In an environment where there are 100 to 200 employees, it is a lot easier to do this with a small management team that is on top of its game. I have seen many small health systems and many small chains thrive with a great core management team of four to five "A" players and a terrific larger staff. In a small system, however, it can be harder to develop and afford the next level of talent.

In contrast, if you become a bigger system, there is an institutional concept that becomes more important. Great people must be in the lead of the various different units throughout the system. In general, you never want more leadership positions than you have great leaders. Increasingly, this may mean you have a great leader "double-hatting." I have seen a situation where a great CFO, for example, also serves as president of the medical group. While this isn't ideal, it is far better to have a single great leader with great discipline and drive captain two units instead of two mediocre people leading two different units.

10. Talent management.

Critical parts of any CEO's job are to watch the big picture, keep a baseline of cost in place, focus the systems' energy on having market power, dominate in certain niches and maintain clarity about who are their customers. A core effort critical to all of this is to be constantly putting the right talent in the right spots.

There is a great friction between keeping okay talent in place versus agitating and constantly changing leadership. There is a pace at which change can be made that doesn't overly disrupt an organization. In contrast, if it is in constant change, it results in cultural challenges. A leader needs to offset this concern with the cultural challenge of allowing greatness and not mediocrity to flourish in leadership positions. This is a constant challenge for health systems. There may be a certain gravitational pull toward leaving things in place rather than agitating for change. At the same time, organizations get stale, slow and ultimately grind in the wrong direction if they are not constantly agitating toward greatness and constantly developing and grooming leaders for different leadership positions.

In some ways, business today involves a certain amount of surfing. You want to have a great a team in place and focus on core priorities, but also be able to surf from opportunity to opportunity. It is less and less that any one leader can tell an organization, "This is where things are heading." Rather, the key is starting with a core baseline business and making sure great people are in place who can adjust as needed.

11. The great theorists are often wrong.

Notwithstanding the brilliance of Dr. Michael Porter, I am convinced that few of the theorists have the next great answer. They may have an answer that works for the next two or five years, but even that is very questionable. More often, if someone can understand who their customer is, where their revenues come from and start by really managing and developing those pieces of information — building upon the core of what works — they are more likely to succeed. For example, there is no question that inpatient volumes will continue to decline. There is no one great answer to this other than to keep costs in the system rational and to keep becoming dominant in those things where the system is making money and continually grow revenues in those areas. A system needs a clear plan to capture outpatient costs in place.

12. Cost accounting.

There is a concept of measuring costs and putting resources into place to track costs where revenues (and costs) are substantial enough that they are worth measuring. As I survey what is talked about in healthcare cost accounting, the literature seems to imply that the history of healthcare has been without health cost accounting. Thus, it is proclaimed in paper after paper and speech after speech that every cost must be measured. This almost assumes that hospital executives existed without cost management.

Here, I suggest that cost accounting be broken down at a few different levels.

First, the amount of resources needed to measure the cost of care for every individual patient without a significant condition often will outweigh any benefit of such granular measurement. Second, for any type of procedure, core treatment or mode of treatment where the cost is over a certain amount, it should be obvious that one needs to really understand the costs of care. A decade ago, the best outpatient surgical care providers started to very aggressively understand cost-per-case and take steps to reduce cost-per-case to where they could survive and be profitable under a certain payment method. Notwithstanding proclamations that providers must get better at measuring cost, I think providers must start by defining their overall costs and then measuring what is important.

In essence, if you are doing a lot of procedures that are expensive, of course one needs to study the cost-per-case. In contrast, if you are primarily serving primary care patients, you need to understand your cost structure to support the type of revenues that brings. Then, it is understanding whether there are outsized costs that can be normalized and whether patients can be moved to a lower costs means of service delivery.

Costs need to be measured, but the concept that they have not been measured to date is incorrect. Rather, the challenge is deciding what really needs to be measured and what doesn't need to be measured and allocating resources effectively.

Healthcare systems, like any business, must have a very good sense of actual total spending per year. Initially, most cost containment and management starts by asking, "What are the total costs? Are our total costs this year going to be $300 million versus $295 million last year, or $310 million versus $300 million, and where are we going to find the revenues to cover that?" Then one rebounds to the old adage as to how are we going to manage costs so that our revenues exceed cost?

63446247_7