NAVIGANT

THE PATH TO A SUSTAINABLE OPERATING MARGIN, MISSION, AND MARKET ESSENTIALITY

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Part one of a four-part series.

Leading health systems are undertaking extraordinary work to calibrate their margin, mission, market position, and operating model as the industry faces mounting margin pressure, which is now the "new normal." Key observations/takeaways from those efforts include:

- Transformation is change. Change is relative. Change is hard, and even harder if it involves thousands of people, done under duress, and is inadequately designed and resourced.
- For nearly all health systems, change or transformation must begin with a fresh, holistic look at its strategic plan, long-range financial plan, operating and capital budgets, cost and pricing structures and performance improvement plans, and whether the system has the scale and market essentiality to survive on its own.
- Health systems with strong fee-for-service (FFS) margins and market essentiality qualify to pivot to a per member per month (PMPM) or capitation-based margin and mission in the populations/customer segments seeking a new offering (e.g., Medicaid, Medicare Advantage). Unfortunately, some systems have dabbled in new payment and delivery models, without a sufficient assessment of customer-specific opportunities and internal readiness — which has resulted in considerable losses and created a bigger gap between margin and mission.
- Given the magnitude of traditional hospital FFS-based margin deterioration, now is the time for health systems to calibrate their margin, mission, market position, and operating model plans along a spectrum ranging between a "back to basics," hospital-centric operating model and a competitive network model responsible for managing a sustainable PMPM-based margin — and build its findings into its strategic plan, long-range financial plan, operating and capital budgets, cost and pricing structures, and performance improvement plans.
- Ultimately, all organizations need a clear, compelling, believable, and sufficiently resourced plan to guide their volume and value journey — particularly if their aspirations are greater than their ability and resources to reach their goals. The plan must capture their role in delivering the right care at the right place, time, and cost with the right staff — every time.

- Industry leaders also need a unified technology platform that a) aligns the strategic plan, long-range financial plan, operating and capital budgets and performance improvement plans; and b) streamlines, automates, activates, and proactively matches demand with much more affordable, productive, and reliable capacity — all in real time, whether that be in their hospitals or their periphery care network.

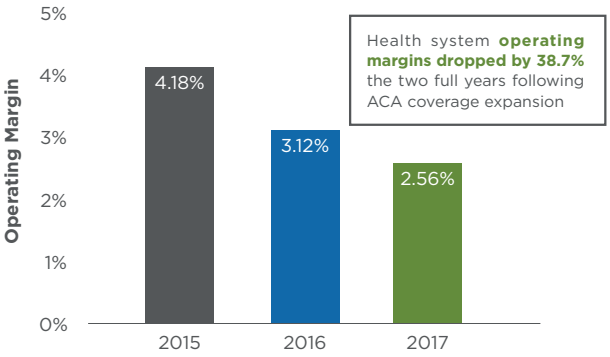
HEALTH SYSTEM TRANSFORMATION BACKGROUND

Declining payer mix, volumes, and unit reimbursement coupled with increased bad debt have accelerated health system margin deterioration, even as the overall economy has improved.[1]

A Navigant Consulting, Inc. analysis of 104 health systems composing 47% of U.S. hospitals[2] found broad-based deterioration of operating margins post-Affordable Care Act insurance coverage expansion. According to the analysis, from 2015 to 2017:

- The average operating margin decline for analyzed systems was 38.7% (Figure 1).

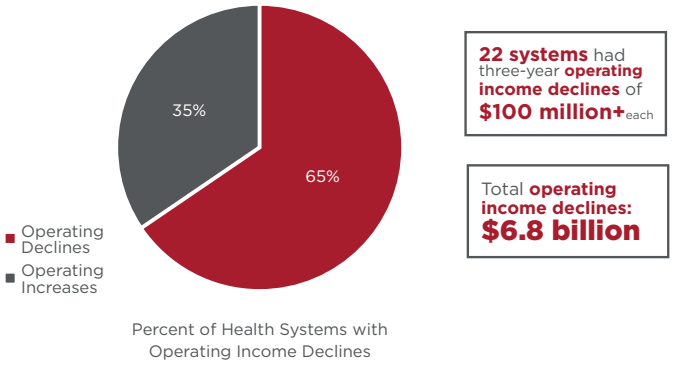
Figure 1: Average Operating Margin by Fiscal Year (2015-2017)



Source: Navigant

- 65% of systems experienced operating income declines totaling $6.8 billion (Figure 2).

Figure 2: Health System Operating Income Declines (2015-2017)



Source: Navigant

Despite traditional margin improvement initiatives in such areas as supply chain, throughput, clinical documentation improvement, and revenue cycle, margins continue to decline. FFS reimbursement cuts, both past and future, promise to cost the industry billions as entitlement reforms are addressed. Recent downturns in hospital inpatient and ambulatory volumes due to affordability problems have exacerbated provider margin gaps.[3]

Some health systems have attempted to diversify their margins through provider-sponsored health plans, but several have failed because of insufficient enrollment, planning, revenue, under-segmentation, significant losses, and/or competitive responses.[4]

Consequently, many health systems feel stuck between the "boat and the dock" and face the following options:

Return to the hospital "dock": Pursue a back-to-basics, hospital-and-physician-centric margin improvement plan to achieve a sustainable 3-5% operating margin, which puts sacred cows (e.g., the return on investment of information technology (IT), physician employment, and facility footprint) on the table.

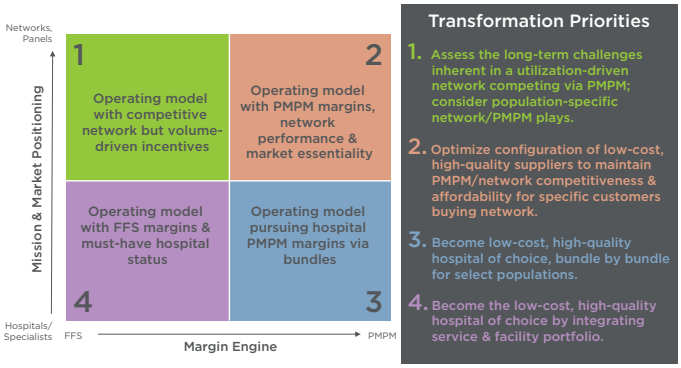
1. Tara Bannow, "Low reimbursement, high expenses contribute to poor 2018 not-for-profit healthcare outlook," Modern Healthcare, December 4, 2017, http://www.modernhealthcare.com/article/20171204/NEWS/171209962.
2. Jeff Goldsmith, Rulon Stacey, and Alex Hunter, "Stiffening Headwinds Challenge Health Systems to Grow Smarter," September 2018, https://www.navigant.com/insights/healthcare/2018/health-systems-financial-analysis.
3. "Health insurers' disruptive growth strategies threaten NFP hospital volume and margins," Moody's, February 21, 2018, https://www.moodys.com/research/Moodys-Health-insurers-disruptive-growth-strategies-threaten-NFP-hospital-volume--PR_379801.
4. "Hospitals find launching health plans remains an expensive experiment," Modern Healthcare, September 27, 2017, http://www.modernhealthcare.com/article/20170923/NEWS/170929947.

Jump in the network "boat": Organize to manage to a sustainable 3-5% margin across a competitive provider network at a competitive price point. This requires further recalibration in target markets, organizational structure, and a very deliberate balance between specialty and primary care, as well as inpatient, ambulatory, and post-acute footprints.

THE CALL TO ACTION

Fortunately, for many large systems, the "boat vs. dock" or "volume vs. value" decision does not have to be one or the other, but rather how much change and how fast. The ultimate call to action is for organizations to calibrate future margins, missions, and market positioning with their operating model and underlying technology platforms. Through this calibration exercise, we find health systems fall into one of four categories (Figure 3).

Figure 3: Calibrating Future Margin, Mission, and Market Position



- Systems in quadrant 4 will need to double down on being the low-cost, high-quality hospitals of choice. Traditional for-profit hospitals tend to fall into this quadrant.
- Systems in quadrant 3 will need to organize their delivery model, structure, and economics to sustain margins through more PMPM reimbursement. This requires a deeper focus on cross-continuum and bundled products, services, and reimbursement models targeting specific populations. Specialty hospitals often fall into this quadrant.
- Systems in quadrant 1 arguably face the most challenges as they've likely invested millions of dollars in becoming a network yet make the majority of their margins on volume rather than reducing total cost of care. These systems need to reassess their market, mission, and resources, and decide whether quadrant 1 is sustainable, or whether to move to quadrant 2 or 4 with a scalable, unified platform that improves the overall end-to-end experience. Many of the nation's largest health systems fall into quadrant 1.
- Systems in quadrant 2 need the leadership, operations, and measurement systems to continually optimize the configuration of low-cost, high-quality suppliers to maintain a competitive offering in the eyes of their target customers. Relatively few systems fall into this more enviable quadrant.

BEST PRACTICES TO NAVIGATE THE TRANSFORMATION

Regardless of margin/mission/market orientation (think quadrants), now is the time for systems to thoughtfully plot their plans. The personal and enterprise risk of "playing the middle" or "being all things to all people" is sizable.

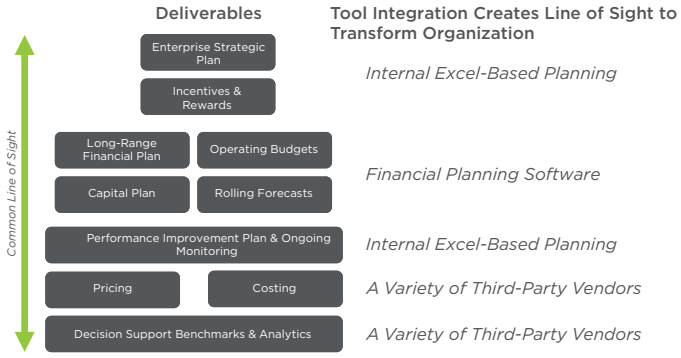
Following are four best practices we observe health systems pursuing as they sort through their "quadrant of choice." No quadrant is wrong, and organizations must determine where the probability of success is greatest based on unique goals and objectives.

Practice 1. Prepare for change: Leading systems soften the ground to prepare for the new normal in advance of major changes to enterprise goals, economics, and organizational structure. They carefully assess, debate, and commit to their sweet spot between the boat and the dock (i.e., their current vs. future quadrant, and the associated timing and magnitude of change). And the more change is necessary, the more time leaders must spend with constituents to ensure the "why" is clear, the "what" is compelling, the "how" is believable, and the "who" is sufficient.

Practice 2. Adopt a unified strategic, financial, and operations planning and monitoring approach to hold people accountable for results: Leading systems adopt a unified methodology, process, and/or language (e.g., Lean Six Sigma, Baldrige Excellence Framework, ISO-9000, systems thinking) and technology platform to simultaneously engineer cost reductions, revenue improvements, and affordability — all by population, practice, function, and project. This approach is particularly important if a system aspires to move quadrants. Equally as important is an enterprise technology platform that integrates multiple data sources and systems (e.g., electronic health records, claims, real-time tracking information, registry information, scheduling and staffing information, and health risk appraisals) in near-real time, to a) monitor and activate unwarranted practice and process variations across both the hospital and entire care continuum and b) align the strategic

plan, long-range financial plan, operating and capital budgets, and performance improvement plans, with a single line of sight (Figure 4).

Figure 4: Integrate Financial, Strategic Planning, and Performance Improvement Decision Support Tools



Practice 3. Deep dive cost management: Regardless of quadrant, leading systems also take a fresh, deeper-than-ever look at costs, including clinical/nonclinical, and labor/nonlabor costs vs. benefits. Leading systems also take a very close look at underperforming IT, population health, and physician arrangements, management layers, clinical variation/waste, and facility investments (in addition to traditional cost-management tactics). After all, the cost to consumers is directly correlated with the costs it takes a provider to deliver services.

Practice 4. Deep dive revenue management: Systems wishing to change margin, mission, and market orientation and switch quadrants by selectively or fully pursuing PMPM-based revenues and margins must be particularly mindful of how they restructure/align management, leverage technology, and employ a unified methodology. This must be done to appropriately calibrate pricing, operations, and positioning of their physician and virtual network's specialty/hospital footprint vs. their primary care and wellness footprint. Structurally, this may mean organizing the people and work into a primary care or network company that buys services from the hospital/specialty company, and underlying infrastructure/shared services from the provider/corporate parent.

The next article in this series will more closely examine four leading practices for health systems for sorting through their "quadrant of choice."

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