The New Margin Playbook

Maximizing Operating Income in an Era of Decelerating Reimbursement
Revenue Growth Barely Exceeded Cost in 2014

Ongoing Expense Reduction Expected to Be Challenging

Revenue and Expense Growth Rates for Non-Profit Hospitals

2009-2014 Medians, n=444

Prioritize Performance Improvement Opportunities

Use Customized Data to Develop a Margin Protection Plan

The Margin Improvement Intensive

Customized Data Diagnostic
Review key margin performance indicators to identify strengths and diagnose areas for improvement

Executive Management Workshop
Our presentation of “The New Margin Playbook”

Tailored Action Plan
Access a full complement of Advisory Board best practices and resources

Hospital Benchmark Generator
A One-Stop Application For Hospital Performance Benchmarking

Customized Access Portal
Instant Access to Critical Organization-Specific Analytics

Source: Health Care Advisory Board interviews and analysis.
The New Margin Playbook

1. Containing Cost Growth
   - Containing Labor and Benefit Cost Growth
     1. Instill Greater Employee Accountability for Costs
     2. Maximize Top-of-License Care
   - Curtailing Supply Expenses
     3. Enable Greater Self-Contracting
     4. Leverage Technology to Enable Reverse Auctions
   - Minimizing Unnecessary and Unreimbursed Utilization
     5. Prioritize Sources of Clinical Care Variation
     6. Reinforce Patient Intake Protocols
     7. Standardize Care Across Clinics and Sites of Care
   - Leveraging Systemness to Excise Structural Costs
     8. Optimize Shared Administrative Services
     9. Rightsize Services and Sites of Care

2. Maximizing Revenue Capture
   - Minimizing Denials and Underpayments
     10. Accelerate the Transition to ICD-10
     11. Implement Best-in-Class CDI Programs
   - Elevating Performance on Mandates and Value-Based Reimbursement
     12. Prioritize Risks from VBP and Other Penalties
   - Minimizing Avoidable Uncompensated Care
     13. Elevate Point-of-Service Collections
   - Increasing Returns from Philanthropy
     14. Develop a Major-Gifts Philanthropy Program
     15. Engage Physicians in Donor Development

3. Capturing New Sources of Growth
   - Becoming the Procedural “DRG Factory”
     16. Increase Transparency of Referral Patterns
     17. Engage Physicians to Strengthen Referral Network
   - Growing through Acquisitions and Partnerships
     18. Embrace Partnerships that Expand Competencies
   - Pursuing Risk-Based Reimbursement
     19. Build the Clinical Model for Population Health
     20. Choose the Right Business Model for Risk
   - Winning Share in a Retail Market for Health Care
     21. Capture New Patients with Convenient Offerings
     22. Expand Share with Tailored Service

Source: Health Care Advisory Board interviews and analysis.
1. Containing Cost Growth

2. Maximizing Revenue Capture

3. Capturing New Sources of Growth
Instill Greater Employee Accountability for Costs

Covenant Health’s Benefit Pricing Strategy

- Increasing
  - ED visits
  - Urgent care visits

- Decreasing
  - Generic prescriptions
  - Primary care visits (free)

Benefit Design Levers to Inflect Utilization Patterns

1. Change Price of Services, Products
   - Strategies to Consider:
     - Differentiate network prices
     - Raise emergency department copays
     - Tier pharmaceutical price structure
     - Reduce price of preventive services

2. Limit Access to Certain Services, Products
   - Strategies to Consider:
     - Remove certain brand-name pharmaceuticals from formulary
     - Require prior authorizations for imaging services

Case in Brief: Covenant Health

- Three-hospital health system based in Lubbock, Texas
- Already at risk for own employees
- Using employees’ health plan benefit design to encourage appropriate utilization of primary care, generic prescriptions to reduce costs

Source: Health Care Advisory Board interviews and analysis.
Maximize Top-of-License Care

Using Team-Based Care, Technology to Extend Clinical Reach

Three Elements to Enable Top-of-License Care Delivery

Element 1: Ensure Proper Task Allocation

Element 2: Broaden Range of Clinical Decision-Makers

Element 3: Leverage Technology to Extend Care Team

Source: Health Care Advisory Board interviews and analysis
Enable Greater Self-Contracting

Balancing GPO, Self-Contracting Advantages

Self-Contracting Opportunity Analysis

Available value through local sourcing
Available value through GPO sourcing

Directly sourced today
Currently left to GPO
GPO line today
Latent value
Cross-over point, direct no longer makes sense

PPI
Warrants direct approach

Commodity
Warrants aggregated approach

Category Type

Source: Health Care Advisory Board interviews and analysis.
Normalizing Supplier Offers to Remove Price Bias

**Supplier Bidding Process**
- Physicians, suppliers can compare blinded bids in real-time
  - Engages physicians throughout entire bidding process
  - Fosters competition among suppliers

**Physician-Led Contract Evaluation**
- Physicians compare normalized offers and determine final purchase
  - Provides equal, non-biased comparisons across products
  - Enables decisions based on total value of offer, not item-by-item price

- Final bids normalized around physician-defined parameters
  - Factors in changes to procedure process/time, personnel requirements
  - Accounts for variation in product quality, supplemental supplies required

- Supplier bids required to offer specific service terms for consideration
  - Incorporates specific physician preferences
  - Bids often bundle items together for portfolio-based approach

**Enabling Physicians to Make Informed Decisions Around Total Value**

17% Reduction in orthopedic supply expenses

Source: Health Care Advisory Board interviews and analysis.
Minimizing Unnecessary and Unreimbursed Utilization

Prioritize Sources of Clinical Care Variation

Running Toward Zero-Defect

Four Components of Reducing Clinical Variation

1. Advanced Enterprise Analytics
   - Gain access to comprehensive, real-time performance data
   - Identify key variation opportunities with multidisciplinary team

2. Reengineered Workflow Design
   - Engage care teams in structured workflow redesign
   - Foster front-line team implementation through competition

3. Evidence-Driven Clinical Compliance
   - Drive practice patterns with peer-to-peer clinician meetings
   - Enable compliance with advanced technology
   - Promote adherence through expert support and surveillance

4. Scalable Standardization Structure
   - Create matrixed accountability structure
   - Embed change as part of routine operations
   - Foster transparency within and across departments, services, and sites

Source: Health Care Advisory Board interviews and analysis.
Reinforce Patient Intake Protocols

Early Sepsis Detection: Good for Patients, Good for Efficiency

Kaiser’s ED Sepsis Screening Tool

- Screen for Sepsis
- Identify at triage if suspected infection and 2 SIRS (Systemic Inflammatory Response Syndrome) criteria
- Suspected Sepsis
  - Temperature $>38.6$ or $<35.8$
  - HR $>90$
  - RR $>25$
  - WBC $>12$ or $<4$
  - O2 saturation $<90$

- CBC, Lactate, BUN, Creatinine, Platelet

Early Identification in ED

Sepsis Diagnoses per 1,000 Admissions

- July 2009: 35.7
- May 2011: 119.4

Better Outcomes

Sepsis Mortality Rate

- 2007: 24%
- 2011: 10%

Faster Discharge

Observed/Expected LOS

- July 2009: 1.08
- May 2011: 0.8

Standardize Care Across Clinics and Sites of Care

Two Ways of Looking at Variation ROI

First Step: Outlier Reduction
Strategy Drives Early ROI

- Reduce outlier cases by targeting smaller number of physicians with practice patterns that fall outside facility norm
- Provides faster impact, but diminishing returns over time as outliers are eliminated

Second Step: Shifting the Mean
Drives Long-Term Results

- Need the majority of providers to make continuous, minor tweaks to their practice that improve care and reduce costs
- Takes longer to do, but offers consistent returns over time (constant evolution)

Immediate Behavior Change from Few
Gradual Behavior Change from Many

Source: Crimson Continuum of Care data and analysis; Health Care Advisory Board interviews and analysis.
Seven Elements of Clinical Standardization

A Comprehensive Approach to Transformation at Banner Health

Adopting Care Reliability as the Central Clinical Strategy
1. A Defined Vision of Reliable Care
2. Physician Value-Vision Alignment

Building a Clinician-Centered Infrastructure
3. Clinician Defined System-wide Standards of Care
4. Physician Support Structure

Aligning Medical Staff Management
5. Cultural Fit Assessment
6. Physician Leader Pipeline Development
7. Accountability for Clinical Standard Adoption

“A System Approach to Transforming Clinical Culture: Case Study of Banner Health System”, Advisory Board Company’s Physician Executive Council


Source: Banner Health, Phoenix, AZ; Health Care Advisory Board interviews and analysis.
Optimize Shared Administrative Services

Evolution in the Benefits of Shared Services

Centralizing Disparate Functions
- Less duplication of services across system
- Savings from reclaimed space, headcount reduction
- Efficiency from economies of scale

Building a User-Focused Model
- Improved service quality, efficiency
- Incorporated SLAs\(^1\)/KPIs\(^2\)
- Streamlined cash management
- Facilitated enterprise growth

Capturing Next-Generation Benefits
- Scale-enabled specialization
- Enhanced business intelligence capabilities
- Elevated competitive advantage

Scale of Benefit

Scope of Benefit

Service-Specific

System-Wide

Source: Health Care Advisory Board interviews and analysis.
## Rightsize Services and Sites of Care

### Evaluating Each Service Against Five Strategic Considerations

#### Strategic Considerations for Rationalization of Services

- **Matching access and capacity** to historical volumes
- **Opportunity for growth** in new and existing service lines
- **Regulatory issues** with FTC, State Attorney General, CMS
- **Culture** of clinical and non-clinical staff constituencies
- **Religious directives** for Hospital at Saint Raphael (Catholic Church)

#### Rationalization Actions Based on Strategic Considerations

- Analyzed OR procedural volumes to determine appropriate locations
- Invested in services with high forecasted demand to create care destinations
- Required zero duplication of new services or technologies at two sites
- Created single medical staff, evaluated clinical need at sites
- Respected Ethical and Religious Directives for Catholic Health Care at Hospital of Saint Raphael

Source: Health Care Advisory Board interviews and analysis.
1. Containing Cost Growth

2. Maximizing Revenue Capture

3. Capturing New Sources of Growth
Minimize Denials and Underpayments

Accelerate the Transition to ICD-10

**DRG Change for Negative Claims**

- **-$3,511**
  - Average Change in Payment Per Claim

- **-$8,470.40**
  - Average Change in Payment Per Claim

**DRG Change for Positive Charts**

- **$3,822**
  - Average Change in Payment Per Claim

- **$9,978**
  - Average Change in Payment Per Claim

**DRG Change for Positive Charts**

- **$5,174**
  - Average Change in Payment Per Claim

Source: Health Care Advisory Board interviews and analysis.
Implement Best-in-Class CDI Programs

1. Clearly Defined Mission
   - Reimbursement or quality focus?
   - Reporting structure matches mission

2. Optimally Staffed Program
   - Productivity standards used to determine staffing
   - Engaging with other departments take time away from charts

3. Efficient Process Flow
   - Well-integrated electronic queries
   - Clear escalation policy in place for unresponsive physicians

4. Established Intra-Department Relationships
   - Ongoing training and data sharing
   - Physician champions used effectively to gain buy-in

5. Performance Accountability
   - Expectations are explicit and well-understood
   - Program performance data shared with relevant parties

Source: Financial Leadership Council interviews and analysis.
Prioritize Risks from VPB and Other Penalties

Reimbursement Increasingly Tied to Performance

Mandatory Medicare Pay-for-Performance Programs

Maximum Payment Penalty

- Hospital Value-Based Purchasing Program: 1%-2%
- Hospital Readmissions Reduction Program: 2%-3%
- Hospital-Acquired Condition Penalty: 1%

Medicare Payment Rates

Potential Chest Pain Treatment Paths

- Inpatient: $4,100
- Observation: $1,800
- "Improperly" Admitted: $0

RAC Reaction Spilling Over to Volume

- Observation stays nationwide, 2011: 1.6M
- Increase in number of Medicare beneficiaries under observation, 2006-2011: 69%

Elevate Performance on Mandates and Value-Based Reimbursement


80%

Percent of hospitals expected to see reduced reimbursement in FY 2015 due to CMS P4P programs
# The Future of Uncompensated Care?

Shifting Coverage Increases Uncompensated Care, Decreases Net Payment

## Impact of Commercial Shifts on Bad Debt, Net Charity Discounts

*Assumes 15% Discount Off Commercial Rates*

<table>
<thead>
<tr>
<th>Year</th>
<th>Bad Debt</th>
<th>Net Charity Discounts</th>
</tr>
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<tbody>
<tr>
<td>2013</td>
<td>$11.9M</td>
<td>$9.3M</td>
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<tr>
<td>2014 Full ACA Implementation</td>
<td>$12.4M</td>
<td>$7.5M</td>
</tr>
<tr>
<td>2014 Opt-Out of Medicaid</td>
<td>$12.6M</td>
<td>$8.7M</td>
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<tr>
<td>2014 Full ACA, 10% Shift to Exchanges</td>
<td>$14.3M</td>
<td>$7.6M</td>
</tr>
<tr>
<td>2014 Full ACA, 20% Shift to Exchanges</td>
<td>$16.2M</td>
<td>$7.8M</td>
</tr>
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</table>

### Margins

<table>
<thead>
<tr>
<th>Operating Margin</th>
<th>Net Payment</th>
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<tbody>
<tr>
<td>2013</td>
<td>$220M</td>
</tr>
<tr>
<td>2014 Full ACA Implementation</td>
<td>$222M</td>
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<tr>
<td>2014 Opt-Out of Medicaid</td>
<td>$221M</td>
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<tr>
<td>2014 Full ACA, 10% Shift to Exchanges</td>
<td>$219M</td>
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<tr>
<td>2014 Full ACA, 20% Shift to Exchanges</td>
<td>$217M</td>
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</tbody>
</table>

Margins are effectively erased with a 20% shift to exchanges.

Source: Financial Leadership Council interviews and analysis.
Considerable Delta Between Average and Strong Collections

**Total Annual Point of Service Collections**

*Medium-Sized Hospital (Net Patient Revenue: $450 M)*

<table>
<thead>
<tr>
<th>Practice</th>
<th>Total Collections</th>
<th>% of Net Patient Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Typical Practice</td>
<td>$1.8 M</td>
<td>0.4%</td>
</tr>
<tr>
<td>Strong Practice</td>
<td>$8.1 M</td>
<td>1.8% - 3.0%</td>
</tr>
<tr>
<td></td>
<td>$13.5 M</td>
<td>1.8% - 3.0%</td>
</tr>
</tbody>
</table>

Source: Health Care Advisory Board interviews and analysis.
Develop a Major-Gifts Philanthropy Program

Focus on Major Gifts to Maximize Return

Revenue at Mayo Health System

- 85% Patient Revenue
- 2% Philanthropy
- 13% Other

Income at Mayo Health System

- 65% Patient Income
- 21% Philanthropy
- 14% Other

Philanthropy Return on Investment, by Fundraising Strategy

<table>
<thead>
<tr>
<th></th>
<th>25th Percentile</th>
<th>50th Percentile</th>
<th>75th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special Events</td>
<td>0.81</td>
<td>1.18</td>
<td>1.67</td>
</tr>
<tr>
<td>Major Gifts</td>
<td>1.66</td>
<td>3.49</td>
<td>6.71</td>
</tr>
</tbody>
</table>

Engage Physicians in Donor Development
Physicians the Most Productive Source of Grateful Patient Donors

Time to Major Gift and Average Gift Size at Virginia Mason

- **Board referrals**: 6.9 months, $242K
- **Patient prospects**: 4.2 months, $49K
- **Physician referrals**: 2.9 months, $455K

Source: Virginia Mason Medical Center, Seattle, WA; Health Care Advisory Board interviews and analysis.
1. Containing Cost Growth

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Increase Transparency of Referral Patterns

Homing In on Leakage Problems, Hardwiring Regular Referral Tracking

**Stralian’s Referral-Monitoring Structure**

- EMR field outlines referral steps
- Physicians required to fill field, highlight need for patient follow-up
- Service line leaders pull, evaluate data monthly
- Intervene as necessary to improve efficiency, decrease referral leaks

**Percent of In-Network Referrals**

<table>
<thead>
<tr>
<th>Historic</th>
<th>Current</th>
</tr>
</thead>
<tbody>
<tr>
<td>76%</td>
<td>88%</td>
</tr>
</tbody>
</table>

**Case in Brief: Stralian Health**

- 500-physician multi-specialty group affiliated with large health system in the South
- Ties portion of physician compensation to use of EMR for referral data entry

1. Historic and current data compared, showing a 12-percent increase in in-network referrals.
Engage Physicians to Strengthen Referral Network

Opening the Books and Teaching the Financial Impact of Referrals

New Hire Orientation

- Physician leader presents profit margin data on IP procedures
- Compares number of PCP patient visits needed to generate same margin; makes the case that PCP referrals are integral to financial health of the organization
- Demonstrates impact of referral leakage on hospital margin to new physician recruits

Case in Brief: Hepworth Clinic

- 600-physician multi-specialty clinic in the Southeast
- Physician leader discusses referral management during new-physician onboarding
- Organization reports an increase of in-network referrals by several percentage points in recent years; leaders attribute growth to enhanced transparency around referral impact
Addressing Individual Limits in Geographic Reach

Partnering to Expand Geographic Scope

Neither Organization Able to Offer Adequate Geographic Coverage Alone

Case in Brief: Healthcare Solutions Network

- Joint venture collaboration between Cincinnati, Ohio-based TriHealth and Edgewood, Kentucky-based St. Elizabeth Healthcare
- Offers health insurers access to a unified, high-quality, low-cost network that covers the entire Tristate region
- Both organizations offering the network to their current employees and dependents

Source: Health Care Advisory Board interviews and analysis.
Three Key Investment Decisions for Care Management Infrastructure

1. Leverage Analytics to Drive Value from Care Management IT
2. Develop a Preferred Partner Network
3. Invest in Flexible Care Management Workforce
Choose the Right Business Model for Risk

Attaining Financial Returns from Care Transformation

- Assemble the Low-Cost Network
- Identify and Secure New Lives for Management
- Operate Performance-Based Care Network

Successful business model facilitates new growth

Building the Network | Acquiring Lives and Managing Care
Winning Share in a Retail Market for Health Care

All Signs Point to a Retail Market

New Dynamics Unfamiliar in Health Care, But Not in Broader Economy

### Traditional Market

- Passive employer, price-insulated employee
  - Growing number of buyers

- Broad, open networks
  - Proliferation of product options

- No platform for apples-to-apples plan comparison
  - Increased transparency

- Disruptive for employers to change benefit options
  - Reduced switching costs

- Constant employee premium contribution, low deductibles
  - Greater consumer cost exposure

### Retail Market

- Activist employer, price-sensitive individual

- Narrow, custom networks

- Clear plan comparison on exchange platforms

- Easy for individuals to switch plans annually

- Variable individual premium contribution, high deductibles

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Source: Health Care Advisory Board interviews and analysis.
Selectively Engage Price-Sensitive Patients

Reduce Prices for Only the Price-Sensitive

Attracting Price-Sensitive Consumers with Competitive Offerings

How do we identify and segment price-sensitive patients from price-insensitive patients?

What services do we offer at a reduced price to attract that consumer subset?

How do we selectively market these lower-priced options to price-sensitive consumers?

Source: Health Care Advisory Board interviews and analysis.
Capture New Patients with Convenient Offerings

Markets Responding to Unmet Needs

Consumer-Oriented Service Delivery Sites Filling Traditional Gaps

Traditional Access Points
- Primary Care Office

Consumer-Oriented Access Points
- Virtual Visit
- Retail Clinic
- Urgent Care Center
- ED (Emergency Department)

Driving Provider Questions:
- Should we partner to establish **retail clinics**?
- Should we **build or expand** our urgent care footprint?
- Is **virtual care** something that we should provide?
- When should we enter into **partnerships** to meet patient demands?

44% Retail visits occur when physician office is likely to be closed

Source: Mehrota A et al, "Visits To Retail Clinics Grew Fourfold From 2007 To 2009, Although Their Share Of Overall Outpatient Visits Remains Low," Health Affairs, August 2012; Health Care Advisory Board interviews and analysis.
Expand Share with Tailored Service

Referencing the Principles of Supply and Demand

Demand Outstripping Supply For Primary Care Services

Current supply not meeting patient demand for primary care services

Current price below what consumers are willing to pay for primary care services

Price

Market Price

Current Price

Supply

Demand

Quantity

Two Ways to Address a Primary Care Shortage

1. Embracing Premium Payment Models

2. Accommodating Excess Primary Care Demand

Source: Health Care Advisory Board interviews and analysis.
Redefining the Value Proposition

Delivering Desirable Network Attributes at Low Cost

Four Imperatives for Health Systems

<table>
<thead>
<tr>
<th>Low Cost</th>
<th>Desirable Network Attributes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Competitive Unit Prices</strong></td>
<td><strong>Strategic Imperatives:</strong></td>
</tr>
<tr>
<td><strong>Avoid reactive position vis-a-vis price cuts, transparency</strong></td>
<td>• Match service portfolios, footprints to target purchasers</td>
</tr>
<tr>
<td><strong>Radically restructure cost structures to sustain lower unit prices</strong></td>
<td>• Explore partnership strategies that strengthen market presence</td>
</tr>
<tr>
<td><strong>Total Cost Control</strong></td>
<td><strong>Strategic Imperatives:</strong></td>
</tr>
<tr>
<td><strong>Develop population health model to control cost trend</strong></td>
<td>• Present unimpeachable clinical credentials to wholesale buyers</td>
</tr>
<tr>
<td><strong>Clearly communicate total cost advantage to potential purchasers</strong></td>
<td>• Emphasize access, experience advantages to individual consumers</td>
</tr>
</tbody>
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Source: Health Care Advisory Board interviews and analysis.