

## The Emerging Healthcare Business Model

COMPELLED BY THE urgency to rein in costs and improve quality and access, US health policymakers and consumers are demanding greater accountability and demonstrated value from healthcare providers. These forces are fundamentally altering how care is financed and delivered, in turn transforming the business of healthcare delivery.

Historically, healthcare organizations succeeded by performing more and more services to an increasing number of patients. Hospitals and health systems leveraged their brand and expanded services to attract more patients. Revenues grew with increases in patient volumes. When revenues exceeded operating costs, healthcare organizations could reinvest gains into equipment and facilities, invest in human capital, and build brand recognition in the markets they served. Absent a disruption to this cycle—a drop in patient volumes, uncontrolled operating expenses, or adverse quality events—healthcare providers could continue to prosper.

Over time, the old volume-driven, fee-for-service model has resulted in medical cost growth that has far outpaced general inflation. Medical consumers, including patients, health plans, and employer groups, have paid increasingly higher costs with limited means to measure outcomes and value. Recent healthcare policy reform, new payer strategies, and the forces of consumerism are

poised to bring greater information and control to consumers while requiring greater provider accountability and transparency than has been seen in healthcare in the past. These forces represent a fundamental challenge to the traditional healthcare business model.

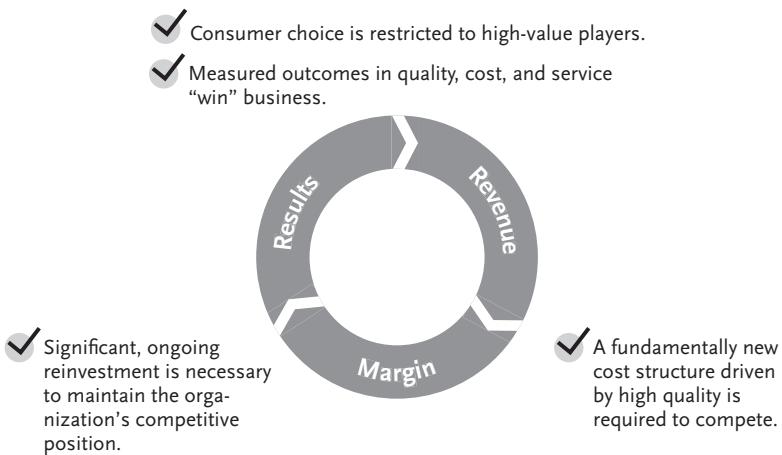
## HOW HEALTHCARE'S BUSINESS MODEL IS EVOLVING

Faced with these challenges, healthcare providers must adapt to this new environment by adopting a new success model. The emerging business model in healthcare (exhibit 1.1) is based on the requirement of providers to produce demonstrated, measurable results for the services they provide at a cost that is affordable to consumers.

The model is made up of three primary components: results, revenue, and margin, as discussed in the following paragraphs.

---

### Exhibit 1.1: The Emerging Business Model for Healthcare Organizations



## Results

Providers must produce consistent results that meet the needs of healthcare consumers. In this context, results are the outcomes and value a healthcare entity or practitioner delivers to the patients served. These outcomes are a composite of three performance dimensions, which align with the Triple Aim of the Institute for Healthcare Improvement as explained by Berwick, Nolan, and Whittington (2008):

- *Clinical quality.* The organization provides high-quality, evidence-based clinical services that ensure patient safety and consistently achieve high-quality outcomes.
- *Service quality.* The organization provides excellent customer service through streamlined, patient-centric processes that facilitate access and efficient care that is reflected in high patient satisfaction scores.
- *Cost performance.* The organization provides cost-effective care that is market competitive and produces high value to patients and the communities served.

Increasingly, providers are required to track multiple metrics along these performance dimensions and share results with patients, payers, and the public. Armed with this information, consumers will increasingly migrate to high-value providers. This trend will, in turn, create mandates for competing providers to improve their performance.

## Revenue

Fee-for-service reimbursement for healthcare services represents a shrinking portion of payments for those services. Increasingly, a healthcare organization's revenues will be based on the results they

produce. A variety of payment programs now reward providers on the basis of their performance, including the following:

- *Medicare accountable care organizations (ACOs)* are intended to drive the coordination of care for Medicare patients, particularly those with chronic conditions. ACO payments include bundled payments that combine hospital and physician service remuneration. ACOs share in the savings that accrue through the program (CMS 2017a).
- *Medicare's Hospital Value-Based Purchasing program* withholds a portion of participating hospitals' acute care reimbursement and rewards or penalizes organizations on the basis of their quartile ranking in multiple clinical and service performance measures (CMS 2017d; AHRQ 2017).
- *Case- or episode-based payment arrangements* have been established for high-volume, high-cost services such as joint replacement surgery and usually bundle the hospital and physician professional fee. Providers are financially motivated to provide care at lowered costs.
- *Direct contracting mechanisms* are used by many large employers to obtain care for their employees. These arrangements usually have negotiated pricing, including case-based payment.
- *Capitation* sets a fixed amount that healthcare organizations are paid per month to provide for the total healthcare needs of patients.

Each of these payment methodologies places greater financial risk on providers than in the past and requires organizations to adopt new systems and learn new competencies to manage costs and improve quality performance. Hospitals and physicians must work together to coordinate and deliver high-quality, cost-effective care for patients. For low-performing health systems, payment

reform will result in anemic or declining revenues for facility and professional services.

## **Margin**

Organizations must generate operating margins for reinvestment in medical technologies, information systems, facilities, and new programs and services. Organizations that cannot generate sufficient operating margins are unable to pursue new markets, improve existing services, or enhance the organization's brand in the community.

As reimbursement pressures build, organizations will need to focus increased attention on reducing operating expenses to maintain sufficient margins. The new reimbursement systems will require new or reimagined operating structures that deliver quality care at substantially reduced costs. For most providers, this expectation creates significant disruption to current health system organization and management.

## **OPERATIONAL CHALLENGES IN THE NEW HEALTHCARE ENVIRONMENT**

The emerging business model has profound implications for healthcare organizations and how care will be organized and delivered in the future. Pursuing value improvement requires providers to transform old operating systems and create new models of service delivery that lower costs and ensure increasingly high-quality outcomes.

To lead this transformation, healthcare executives must first confront significant operational challenges common to most health systems. These include the following:

- The rising costs of medical care resources
- The need for improved and integrated information systems

- The costs of building and sustaining ambulatory services
- The challenges of health system consolidation
- The shift from acute care hospitals
- The challenges of performance-based population health management
- The implications of increased consumer engagement and consumerism

## **The Continued Rise of Medical Care Resources and Costs**

The rising costs of healthcare in the United States are driven largely by the ever-increasing operational expenses required to run healthcare systems. For many provider organizations, operating costs are increasing at rates that exceed revenue growth, resulting in small or negative operating margins, which are unsustainable over time.

Several operational components contribute to medical cost inflation, such as labor, supplies and capital, and facility operation.

### ***Labor Costs***

Healthcare delivery is a labor-intensive business, so providers continuously face challenges associated with

- wage inflation due to shortages in key skilled positions, including registered nurses, pharmacists, physical and occupational therapists, and numerous others;
- rising benefit expenses, particularly for employee health insurance coverage; and
- increased costs resulting from high staff turnover and recruitment expenses.

### ***Supplies and Capital Equipment***

Nonlabor expenses often represent the highest growth component of a healthcare system's operating expenses. Medical supplies represent

20 percent or more of a healthcare system's operating budget. High-growth, high-expense supply categories include the following:

- Surgical supplies associated with implants, biologics, and other devices
- Invasive cardiac supplies and devices
- Oncology drugs and other specialty pharmaceuticals
- Imaging and laboratory supplies and equipment

### ***Facilities***

Many health systems operate with outdated facilities and equipment that need renovation or replacement. The substantial investments required for these upgrades, or to service the debt associated with them, must ultimately come from philanthropy or through operating margins.

## **The Role of Information Systems**

Information systems represent an ever-growing portion of a healthcare organization's capital investments. Significant funding is required for a wide range of applications, including the following:

- Electronic health records
- Electronic prescribing and order entry
- Clinical and operational decision support systems
- Decision support systems for population health management
- Health information exchanges
- Telemedicine

Leaders must fully leverage information technologies to streamline business processes and reduce costs. An information infrastructure is critical for healthcare systems seeking to maintain integrated and seamless processes and data flow across the enterprise. Organizations

without sufficient margins will not be able to maintain the informational platform required for the future.

## **The Cost of Integrating Physician Services**

Many healthcare systems have made substantial investments in purchasing physician practices, specialty clinics, urgent care centers, and other related ambulatory service providers. These investments are the centerpiece of a healthcare organization's drive to build integrated delivery systems that bring together hospital-based and physician office-based healthcare services. Hospital systems have many reasons for pursuing physician practice ownership, including the following:

- It provides new sources of ambulatory-based revenues.
- It preserves a hospital's primary care referral network.
- It builds physician alignment with and loyalty to the healthcare system.
- It facilitates joint business ventures between hospitals and physicians, such as comanagement agreements, bundled payment strategies, and population health management.
- It provides a foundation for cooperation in clinical and cost improvement initiatives.

Although the business case for integration is often compelling, many systems find the payback period on these investments to be much longer than originally envisioned. Healthcare systems may experience financial challenges with their physician enterprise, including

- gaps in leadership experience and competencies in managing complex, multidisciplinary physician organizations;
- lingering practice subsidies from high compensation levels and, in some cases, lower-than-planned physician productivity;



- continued leakage of patient referrals to competing organizations;
- lower-than-planned net revenues resulting from slow practice growth, payment reforms, and revenue cycle challenges;
- difficulties in consolidating practice support and administrative services; and
- challenges in blending hospital-centric cultures with physician service cultures.

The new business model will require healthcare systems to greatly improve the cost and revenue performance of their physician services enterprise and fully leverage the potential benefits of integration.

## **Hospital Consolidation into Large Healthcare Systems**

With increasing frequency, hospital systems, through mergers and other affiliation agreements, are joining with other hospitals in their region or large national systems. Many markets today are dominated by a few large, integrated health systems.

Hospital mergers and consolidations are pursued to achieve the following goals:

- Enable joint contracting for managed care business
- Build scale and operational efficiencies
- Increase purchasing leverage for supplies and services
- Provide a broader portfolio of patient care services
- Reduce duplicative services and programs
- Expand the organization's geographic service region

Despite the many advantages of affiliation, multihospital systems are often slow to reap the full benefits. Many systems experience protracted delays in

- standardizing processes and systems to ensure consistencies in patient care services and create a unified brand;
- centralizing services beyond purchasing, patient accounts, and other support services;
- pursuing management consolidation across care sites;
- implementing clinical services consolidation to reduce duplicate programs; and
- reducing clinical practice variation across care sites and medical groups.

These delays occur most often in the early phases of system formation. During this period, individual sites and leaders frequently resist integration, preferring autonomy and retention of legacy processes and systems. Underlying these preferences are cultural norms and practices that vary across sites and are difficult to change and unify.

With increased revenue pressures, health system leaders need to focus attention on achieving the savings and revenue synergies that are possible in a multi-institutional healthcare system. For many health systems, achieving this aim requires executives to lead large-scale operational changes that are difficult to implement but necessary for the organization's future success.

## **The Shift from Care Delivery at Hospitals**

Hospitals have long been the centerpiece of healthcare delivery. Most hospital facilities and programs have been designed primarily to support acute care services. As the most expensive component of healthcare, inpatient service utilization is a primary target for cost improvement from payers and population health initiatives. Advances in medical technologies are driving the shift of services even further from acute care to ambulatory or home care settings.

The shift from acute care has profound, long-term implications for how health systems are organized and structured, and healthcare leaders face numerous challenges as they guide organizations through

this transition. For example, hospitals need to dramatically reduce inpatient bed capacity and redeploy resources to other components of the care continuum. In some cases, hospitals will eliminate acute care entirely and repurpose facilities for ambulatory care and other services.

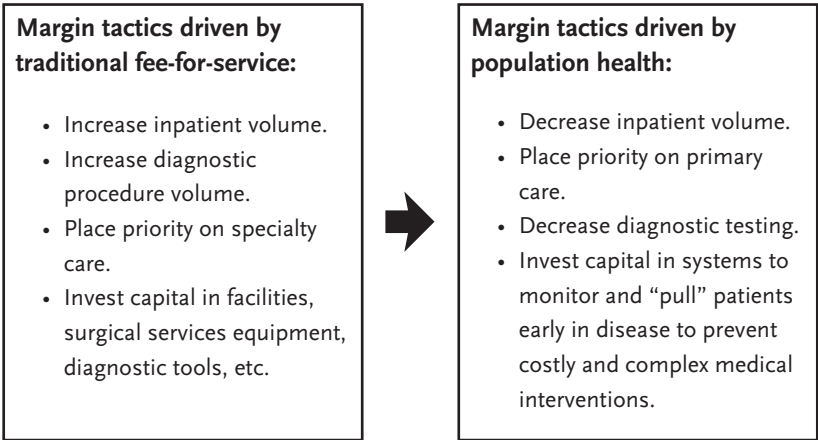
During this transition, hospital organizations must build competencies in case management, improve inpatient throughput, and lower length-of-stay rates. Simultaneously, leaders must continuously adjust staffing and bed capacity to match reduced census levels.

## Performance-Based Population Health

The shift from acute care will accelerate as the industry migrates to risk-based population health management and commensurate reimbursement. Healthcare systems must transform operations, invest in new systems and skills, and create new programs and services. The push toward population health is altering the traditional notion of margin generation for provider organizations (exhibit 1.2) and the incentives that drive provider behaviors.

---

### Exhibit 1.2: Margin Strategies—Fee-for-Service Versus Population Health



To succeed at population health, health systems need to adopt the following approaches (Medicare.gov 2017):

- Expand clinical programs, through partnerships or acquisitions, to provide coordinated services across the full continuum of care.
- Create new medical programs designed to address the care requirements of patients with specific chronic conditions and disease states.
- Build clinically integrated networks with physicians to jointly coordinate and improve care delivery.
- Invest in information technologies, personnel, and expertise to support utilization management, health information exchanges, population analytics and predictive modeling, patient registries, and other programs.
- Implement processes and systems to support the patient-centered medical home models (AHRQ 2017).

## **Increased Consumerism and Consumer Engagement**

Healthcare consumerism has risen in recent years out of growing public concerns and frustrations with the chronic problems plaguing the industry—rising costs, safety issues, wide variations in clinical outcomes, restricted access, and others. Consumerism continues to be fed from two primary sources: consumer-led trends and movements, and the consumer-based initiatives of government agencies, employers, health plans, and other organizations seeking to empower consumers.

In the past, a hospital's brand was formed largely on a community's subjective perceptions and the influences of physicians and advertising. Today's consumers are better informed than in the past about hospital and physician quality and cost because of the increasing availability of public performance data. The emphasis on transparency in hospital clinical and service performance measures has led to the creation of systems, such as the Medicare Hospital

Compare platform, that enable consumers to evaluate competing hospitals on the basis of multiple measures of quality, service, and cost (Medicare.gov 2017). Reported outcome data represent “brand in fact” and remove some of the subjectivity from rating hospitals. Equipped with this type of data, payers and consumers are making informed decisions in their selection of medical providers.

Increasingly, healthcare providers must institute processes, systems, and services to build engagement with medical consumers. The extent to which consumers engage in their healthcare varies, representing a progression of patient and family involvement.

### ***Experience***

Healthcare providers must enhance processes and facilities and train staff to consistently provide customer-responsive care and services. To be responsive to consumer needs, healthcare organizations need continuous feedback on programs and services through patient satisfaction surveys and focus groups. In addition to measuring satisfaction levels, healthcare systems require consumer input when planning new services, designing new facilities, or improving processes.

### ***Engagement***

Providers must engage consumers in their own care and health management. Clinicians can improve patient engagement by educating patients on their medical condition and available treatment options.

### ***Shared Decision Making***

Beyond informing patients and family members, providers should involve consumers directly in decision making related to care alternatives. Physicians and clinical staff should support efforts that engage patients in major care decisions.

### ***Activation***

Patients who are actively involved in their health management achieve better clinical outcomes than do those who receive care in a passive manner (Hibbard and Greene 2013). Effective population

health management requires informed patients who are motivated to take care of their health. Providers should inspire patients and communities to take responsibility for their health status.

## **IMPLICATIONS FOR PERFORMANCE IMPROVEMENT**

The emerging healthcare business model reflects the new link between performance outcomes and revenues. To thrive, healthcare organizations must continuously improve in each performance dimension: cost, quality, and service. Slow, incremental improvements, while important, are not enough to transform healthcare systems to the new model. To sustain and improve operating margins, performance improvement (PI) initiatives must focus on issues that substantively reduce expenses and increase revenues. These changes must occur quickly to reposition the organization in an evolving marketplace.

The market challenges identified earlier in this chapter have substantial implications for performance improvement in a healthcare system. These implications may necessitate revisions in an organization's PI plans, priorities, and approaches. As shown in exhibit 1.3, each challenge is accompanied by specific PI issues and approaches to consider.

Health systems must reset their PI priorities and focus attention on high-impact opportunities that promise long-term benefits. While traditional operational interventions—labor productivity, revenue cycle, supply chain improvement, and so on—are still necessary, organizations increasingly need to focus attention on disruptive, high-impact changes, including

- portfolio management,
- cross-entity business process redesign,
- clinical utilization improvement,
- off-quality improvement,
- system-level consolidation, and
- growth acceleration.

## Exhibit 1.3: Implications of Industry Trends for Performance Improvement Strategies

Industry Trend	Performance Improvement Implications
Costs of medical care resources continue to rise.	<ul style="list-style-type: none"> <li>• Focus on process improvement and other levers that most affect labor productivity.</li> <li>• Institute comprehensive labor management and control systems to keep staffing levels in line with workload demand.</li> <li>• Optimize supply chain processes, and reduce supply variation across providers.</li> <li>• Continuously evaluate and drive down the costs of purchased services.</li> <li>• Scrutinize return on investment for large investments.</li> </ul>
Information systems are foundational to the emerging healthcare system.	<ul style="list-style-type: none"> <li>• Leverage information technologies to streamline key business processes and reduce operating expense.</li> <li>• Use real-time data to improve clinical and operational decision making.</li> <li>• Build systems to continuously monitor key performance metrics.</li> <li>• Employ predictive analytics to anticipate demand and risk.</li> </ul>
Physician services integration is costly.	<ul style="list-style-type: none"> <li>• Employ improvement levers that have the greatest application to ambulatory services.</li> <li>• Build alignment and solicit physician involvement.</li> <li>• Apply portfolio management principles when making investments and service line management decisions.</li> </ul>
Hospitals are consolidating into large healthcare systems.	<ul style="list-style-type: none"> <li>• Use system-level levers to achieve available cost synergies.</li> <li>• Focus initially on management restructuring and consolidating administrative and support functions.</li> <li>• Build consistencies into processes and service levels across the system.</li> <li>• Build an integrated culture focused on quality performance and value improvement.</li> </ul>

(continued)

(continued from previous page)

---

### Exhibit 1.3: Implications of Industry Trends for Performance Improvement Strategies

Industry Trend	Performance Improvement Implications
Healthcare is shifting from hospitals to external locations.	<ul style="list-style-type: none"><li>• Focus on acute care utilization improvement, including length-of-stay management and throughput.</li><li>• Resize inpatient capacity to match changes in demand.</li><li>• Apply portfolio management principles when making investments along the care continuum.</li></ul>
Performance-based population health will transform healthcare delivery.	<ul style="list-style-type: none"><li>• Institute information systems and expertise to manage medical risk.</li><li>• Realign investments and operations to support an expanded care continuum.</li><li>• Use portfolio management to determine make-or-buy decisions on service provision.</li></ul>
Consumer engagement is transforming healthcare services.	<ul style="list-style-type: none"><li>• Build systems to measure consumer satisfaction and perceptions.</li><li>• Include consumer input in the design of new systems.</li><li>• Focus attention on processes that most affect patient satisfaction.</li><li>• Train staff on sound customer service principles.</li><li>• Engage consumers in their own healthcare.</li></ul>

---

These initiatives often bring high levels of change to healthcare systems and can be challenging for some leaders, physicians, and staff. This work requires new resources, expertise, and management systems support. For some organizations, these changes require a new leadership framework and PI approach.