ARE YOU MAINTAINING YOUR MARGIN AS REIMBURSEMENT DECLINES?

CUTTING COSTS MAY NOT BE THE ANSWER

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Nationally, reimbursement for most health systems has been and continues to be in decline. And that decline, coupled with declines in patient volume, is understandably the source of much anxiety in the C-Suite. Many systems are responding to reimbursement declines with more and more draconian cost cutting measures. However, the reality is that more and more systems are discovering -- often in a very painful way -- that even if their cost structure matches the highest benchmark levels of performance, this level of performance will not be enough to close the gap.

The key is to manage margin, not cost. While managing your cost structure is a vital and necessary component of any margin plan, focusing on margin opens additional options that may be used to maintain desired levels of performance.

Our Accelerated Healthcare Transformation (AHT) process focuses on three major levers to maintain or grow margin:

- Cost structure
- Portfolio assessment
- Clinical utilization

Through this process, you are able to confront the current reality of a situation, confirm the current and projected margin operating at status quo, choose the desired level of operating margin and conclude with a "glide path" that describes in tactical detail what must be done, by whom, by when, to get the desired results. This work can be accomplished with high levels of buy-in through a seven-meeting process. In seven meetings, strategic decisions for the future are translated into measurable tactics and the ideal intersection of a long-range view coupled with tactical activities can begin immediately in order to achieve rapid results.

"CLOSE THE GAP BY MANAGING EXPENSE" - AVOID THE TRAP

Many health systems react to declines in margin in a very predictable way: Cut costs and keep a tight control on expenses. There is a good reason that cost cutting efforts, like driving labor costs to desired benchmark levels, are embraced. Expense cuts are more predictable than other strategies. But driving labor costs to benchmarks in order to cut costs comes with sharp awareness about the impact on staff lives. Reductions in labor are a pragmatic, predictable response with benefits flowing to the bottom line as progress is made against easily understood and measured targets. While difficult to impose on an organization, the notion of driving labor to benchmark levels is also a widely understood organizational tactic, not just for healthcare organizations, but for other industries as well. What usually happens is that once the revenue target is selected -- typically Medicare breakeven or Medicare minus 5% -- financial models show that even if an organization builds a model assuming success achieves the highest levels of benchmark e.g. 90th percentile, it's still difficult to meet the margin target.

The other moment of discovery is when experienced leaders and teams consider what it's going to take to reach the 90th percentile of cost performance. Teams know that it will be a challenge to reach these benchmark levels without seeing a deterioration in either patient satisfaction, provider satisfaction or quality. There is a reason that only elite performing organizations can successfully operate at the highest levels of performance. Experienced leaders know that reaching 50th percentile level of performance is relatively easy because operating at the 50th percentile of performance does not often require the radical reengineering and rethinking of processes that is an absolute requirement for organizations operating at the 90th percentile.

It is essential to re-state that cost reductions are an essential part of any plan that assumes successful operation with revenue at Medicare or Medicare minus 5%.

MANAGING CLINICAL UTILIZATION

Clinical utilization strategies are often messy, sometimes contentious, undertakings. First, it requires a thorough understanding of what is driving the cost of any given clinical process. For example, if a hospital is rigorously reviewing DRG performance and comparing total cost to total revenue on the top variant DRGs, many things can be driving up the cost. Cost might be driven up by individual physician practice patterns. Cost could also be driven up when Length of Stay (LOS) is extended because of difficulties securing Skilled Nursing Facility (SNF) or rehabilitation beds when these are required for discharge. Surgical costs may also be driven up by the supply cost, either because of inadequate/poor contracts or because physicians have not agreed to adhere to the short list of agreed upon implant alternatives. The point is that predictably reducing variance in clinical utilization is a much more complicated undertaking, both analytically and tactically.

The other barrier that prevents many organizations from successfully engaging in a focused effort toward better management of clinic utilization is reluctance to engage physicians. Many incorrectly believe that engagement with physicians around more efficient clinical utilization is essentially an exercise in confrontation. While it is true that these types of efforts often engage, and spotlight the most variant performance, the reality is that if your key cohort of physicians is genuinely interested in the health of the organization, they will sincerely engage in these efforts. Remember also that some of your findings about cost drivers, using available SNF and rehab beds for discharge as an example, may be their frustration as well. Engaging physicians in a holistic, real effort directed at improving clinical utilization can be a mutually beneficial process.

The good news is that there is an organized, predictable way to construct an organization's glide path to include predictable reductions in clinical utilization. More discussion will follow on the "how" later in the article.

MANAGING YOUR PORTFOLIO EFFECTIVELY

A rigorous portfolio assessment is an essential component of a realistic, predictable plan for operating at reduced revenues. Every health system or hospital has three categories of service:

- **Margin** services, those programs that generate revenue after covering fully loaded expenses. Fully loaded expenses include both direct costs and allocated costs. An example of a margin service is Cardiac Surgery.
- **Volume** services cover their contribution margin but don't generate any margin of revenues over these expenses. Volume services do exactly what their name implies, these are the programs that often drive volume into margin services. An example of a volume service is a hospitalist service. While this service rarely makes any margin, it is a major driver of volume into higher margin services like Cardiac Surgery.
- **Brand** services do not cover either their direct or allocated costs. Since these services don't cover direct or allocated costs, they offset margins generated by margin services. An example of a "Brand" service is blood pressure screenings outreach program held in various community settings.

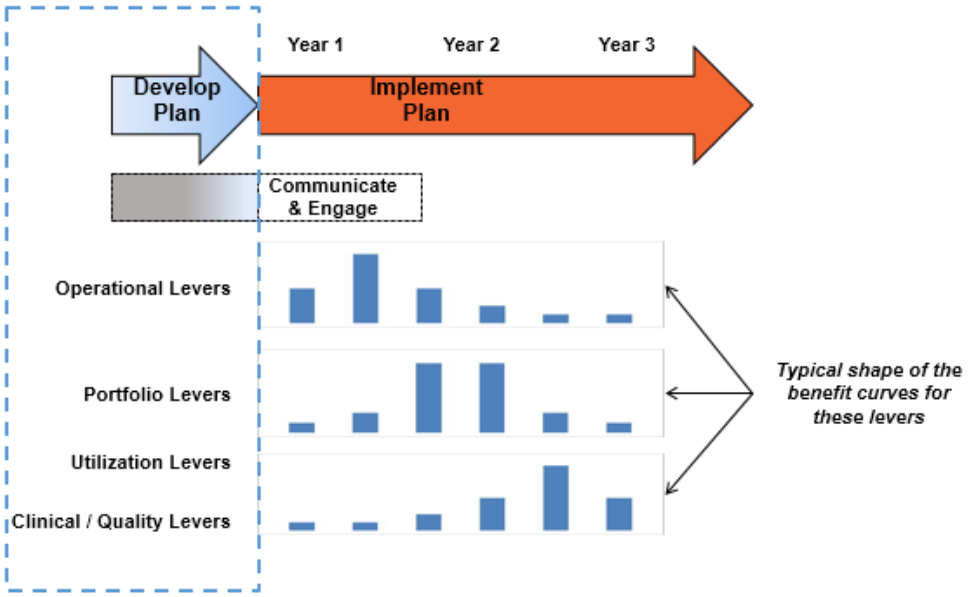
Ideally margin, brand and volume services work together and create a synergy. For the Cardiac Surgery service to continue to have a predictable flow of patients, there needs to be a reputation in the community that a health system or hospital cares about the population. This is where the screening or brand service come in to play. Later, if a patient needs to be referred to Cardiac Surgery by a volume service, the decision is made based on their impression of the system or hospital, perhaps formed by community outreach efforts, to use and trust the Cardiac Services offered. The margin service then generates the margin that is necessary to support both brand and volume services so that the cycle can continue.

The problem for most health systems and hospitals is that there is an imbalance in the portfolio. Everything can't be a margin service or there would be an absence of patients in the queue for margin services. Likewise, everything can't be a volume service, or the health system or hospital will be unable to have a margin. Last, it is obvious by now that everything can't be a brand service, because there would be no financial underpinnings to allow the organization to sustain itself.

Effectively managing your portfolio is an essential step in operating in the new world of reduced revenues. If there is an imbalance in your portfolio with a slant towards brand and volume services, cost cutting can't help you reach adequate margins. Therefore, it is essential to rebalance your portfolio as part of your journey towards operating at Medicare breakeven or Medicare -5%.

FOCUS ON OPERATING AT REDUCED REVENUE

There are two distinct parts of our AHT process. The first step in the process is a planning component that leads to the development of a detailed plan or glide path document. This glide path becomes the map for implementation and the plan against which progress will be measured.

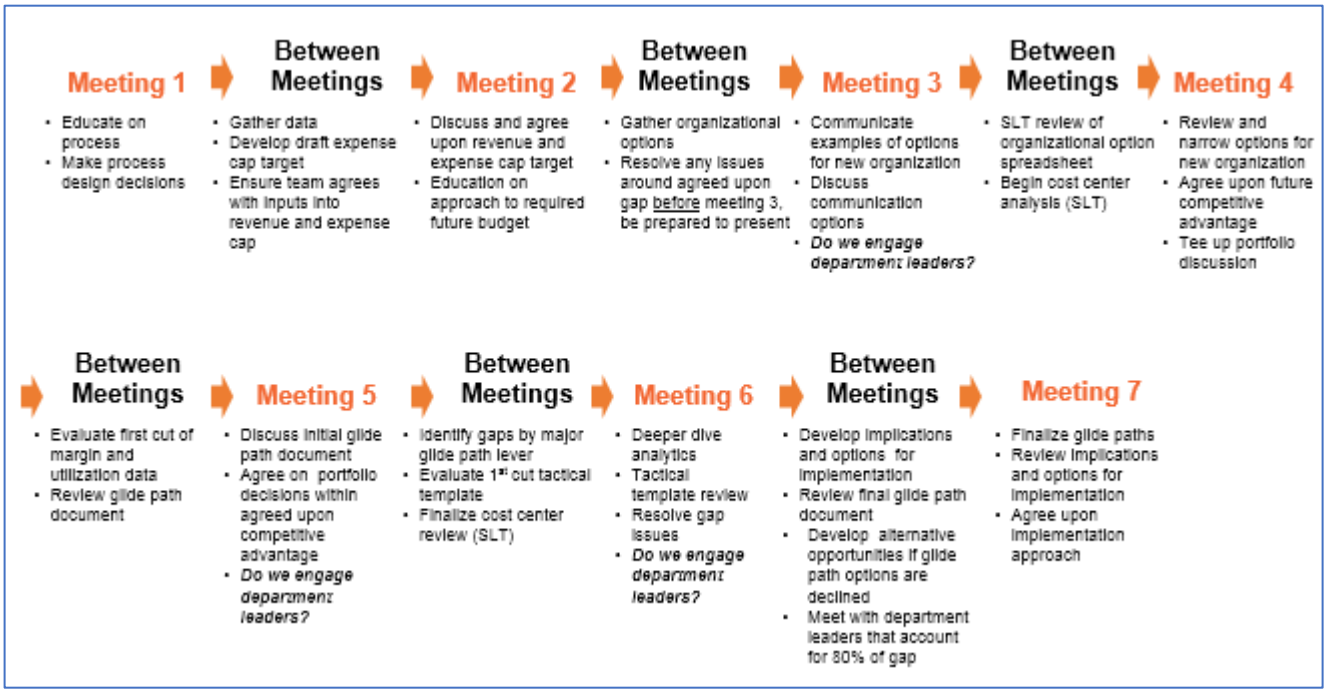


You will note that this is a three-year plan and that each of the major levers has a different timeline for completion. Operational levers, those that include typical expense management tactics like managing labor, have the shortest implementation time lines. Portfolio decisions generally have a longer tail. While the decision for what ideally belongs in the portfolio can take place fairly quickly, portfolio changes often take time to implement because proposed changes may involve communication with the community, board or other important stake holders. Clinical utilization/quality changes take the most time. Installing the appropriate analytics, those that are credible to physicians and leadership, require both time for implementation and vetting with those involved in this effort. It is only after this data foundation has been built that a detailed, tactical implementation plan may be developed and implemented, carefully focused on the right physicians in order to have the most impact.

The implementation of the plan may be accomplished with or without outside help. Often teams engage the Galloway team to help with the clinical utilization and portfolio work so that our proven tools and techniques may be transferred seamlessly to internal staff, equipping them to continue the process of

improvement. This is an example of a deliberate “consultants fade into the sunset” structure that several clients have requested. In some ways, the “fade into the sunset” model combines the best of both the outside help and in-house support worlds. In-house teams are often ill equipped or not equipped at all to take on in-house responsibility for driving a plan to completion. The critical element often missing is the design of the implementation structure and the necessary equipping of in-house staff.

The AHT planning process has been carefully designed to be as efficient as possible without omitting the times that teams must take along the way in order to fully assimilate, commit and engage in the development of both the overall plan and the glide path tactics. The process centers around seven meetings, with requirements that must be met at each meeting in order to be prepared for the next meeting in the sequence. The seven-meeting process, including brief descriptions about what happens at each of the meetings is found below:



The leaders typically involved in this process are the CEO and the C-Suite team, key SVPs, a financial analyst (who will help model and put vetted numbers in front of the team) and a Galloway Advisor.

MEETINGS 1-4 SET THE STRATEGIC FRAMEWORK

The first four meetings of the process focus on the many strategic issues that must be agreed upon before the tactical glide path is constructed. Revenue targets are selected and vetted, portfolio discussions take place and there is much discussion around where the organization should place itself in the multi-linked value chain of the many health care activities that comprise our medical care system. At the conclusion of meeting four, there is agreement around a decision between two basic organizational options.

The first organizational option is the “focus factory” construct, meaning an organization would deliberately choose (or re-affirm) to focus intently on a small set of options along the value chain of health system options. A typical organizational choice made within the framework of a focus factory might be to provide only inpatient hospital, outpatient diagnostic and treatment services. One of the margin managing activities that comes out of making the clear, focus factory decision is that business units that aren’t part of the core strategic choice will each undergo though program evaluation to determine organizational fit.

The other organizational option, the "general contractor" model, is a choice generally requiring an insurance plan and ownership or contractual relationships with most of the elements along the health care value chain, from a risk taking entity all the way to primary care physician practices. Tight management of the spectrum of the entire set of activities is necessary in order to manage "risk" for a population that uses care all along the value chain. A typical organizational choice made within this framework is to determine that being an ACO is that way to maximize value from the current environment. It is easy to see that reaching agreement on such an organizational view is essential to the development of a detailed, integrated and tactical implementation plan. The ACO view causes foundational shifts in how various entities along the health care value chain are viewed and operated. For example, in the ACO view of the health care delivery world, inpatient services are no longer profit centers, but instead are now steps along a treatment journey that should be minimized. In the stand-alone Hospital Entity world, increased hospital admissions are good. In the ACO world, admissions are bad. This fundamental shift in strategic thinking will affect how capital is allocated and organizational planning is accomplished.

MEETINGS 5-7 SET THE IMPLEMENTATION FRAMEWORK

Once the foundational strategic building blocks of the plan are established, the remainder of the work of the team focuses on the construction of a "glide path" document, a detailed implementation plan that uses all levers, including cost management, to establish a predictable, detailed and measurable plan. The team reviews everything from summary lever level information on areas of opportunity to "deep dive" planning within each of the tactical areas. An example of a team based summary document is found below:

AHT Improvement Lever	Number of Initiatives	Economic Impact (Risk-Adjusted)	FY 2013 Impact	FY 2014 Impact	FY 2015 Impact
Operational- Labor	33	$16,439,177	$16,439,177	$16,439,177	$16,439,177
Operational- Supplies	117	$4,336,576	$3,817,069	$4,336,576	$4,336,576
Operational-Other	37	$1,721,841	$1,552,734	$1,697,081	$1,697,081
Portfolio	14	$2,465,165	$1,232,583	$1,848,874	$2,465,165
Utilization	16	$16,617,908	$8,308,954	$12,463,431	$16,617,908
Quality	7	$796,559	$398,280	$597,420	$796,559
TOTALS:	**224**	**$42,377,227**	**$31,748,797**	**$37,382,559**	**$42,352,467**

Team members understand that without a more detailed, tactical understanding of the plan to reach identified targets, the Plan is well, just a plan. The AHT team also reviews the detailed tasks that are necessary to take place in order to predictably implement any given initiative. AHT teams generally assess 200 or more opportunities that collectively tie back to the overall identified targets.

Client Success

A large, multi-hospital system in the Western part of the United States made the necessary adjustments to their cost structure to enable them to meet targets under the current reimbursement structure. What concerned the CEO was the ability to not just survive, but thrive, under an anticipated reimbursement structure that was based on Medicare rates.

Each of the system hospitals participated in the AHT 7-meeting process to agree upon both strategic direction as well as agree upon a detailed, tactical understanding of the many activities that would comprise construction of a successful plan under the new reimbursement reality. The hospitals leadership teams agreed to margin improvement plans that **totaled $231 million dollars**. These plans were integrated into monthly financial planning and allowed the system to track progress on the many margin activities implemented.

AHT CREATES AN ENVIRONMENT FOR ACCOUNTABILITY AND THRIVING UNDER MEDICARE REIMBURSEMENT

The AHT process establishes such meaningful, substantive dialogue around strategic direction and corresponding tactical plans, there is automatic buy in among the C-Suite and other team members around the "glide-path" or implementation document. This makes the glide path documents a logical fit with other key monthly financial documents that system Leadership use to manage and project the financial health of the organization(s). What this also means is that there is built in buy in and accountability for the many changes that must take place for an organization to successfully adapt to the new reimbursement climate.

MEET OUR EXPERT

Jay Zerwekh is Executive Vice President at Galloway Consulting. He brings to his clients a broad range of senior management and consulting experiences from a variety of healthcare settings. Mr. Zerwekh has expertise in improving partnerships and increasing Health Systems' alignment with independent physician practices, system/hospital owned medical groups and physician organizations. In his more than 25 years of operational experience as a healthcare executive in medical group, health plan and hospital settings, both for-profit and not-for- profit, Mr. Zerwekh unfailingly achieved results; improved practice environment for physicians, increased profitability, improved customer service and increased staff satisfaction. His operational expertise, coupled with 12 years of consulting experience with health systems, hospitals, tribal clinics, health plans, medical groups and physician organizations throughout the country, provides the foundation to guide clients to practical, effective and predictable solutions.

Mr. Zerwekh has a Master of Health Services Administration from the University of Michigan and a Bachelor of Arts from Clark University.

Various colleagues from Galloway contributed to the thought leadership and approach outlined in this paper.