



# Charting a Clear Course in Rough Seas

## *A New Perspective on Hospital and Health System Strategy*

---

# The healthcare ecosystem is witnessing unprecedented volatility, transformation and innovation

More Bang  
for the Buck

Just Getting  
Started

Tectonic  
Plates  
Colliding

Busier But  
Poorer

Safety in  
Numbers?







Identity  
Crisis

Leap of  
Faith

Different  
This Time  
Around?

# Hospitals and health systems – from community hospitals to major AMCs - are showing signs of distress

## 2012: Major Hospital Cost Reductions and Layoffs

 Boston Children's Hospital	<ul style="list-style-type: none"> <li>▪ 255 jobs eliminated</li> <li>▪ Aims to take out \$150MM in 2013</li> </ul>
 UMassMemorial <small>www.umassmemorial.org</small>	<ul style="list-style-type: none"> <li>▪ 290 jobs eliminated</li> <li>▪ Aims to take out \$80MM in 2013</li> </ul>
 Northwestern Memorial Hospital	<ul style="list-style-type: none"> <li>▪ 230 jobs eliminated</li> <li>▪ Plans to cut costs by 25% by 2017</li> </ul>
 SUMMA Health System	<ul style="list-style-type: none"> <li>▪ 110 laid off since 2011</li> <li>▪ Plans to save \$966MM over next decade</li> </ul>
 Cooper Green Mercy Hospital	<ul style="list-style-type: none"> <li>▪ Laid off 200 of 528 staff (including CEO)</li> <li>▪ Transitioning to urgent and primary care only</li> </ul>
 WESTCHESTER MEDICAL CENTER	<ul style="list-style-type: none"> <li>▪ Laid off 400+ before merging with Sound Shore</li> </ul>

**5,512**

Number of hospital employees laid off in Q1-3 of 2012 – compared to 4,474 in Q1-3 of 2011

**\$20B**

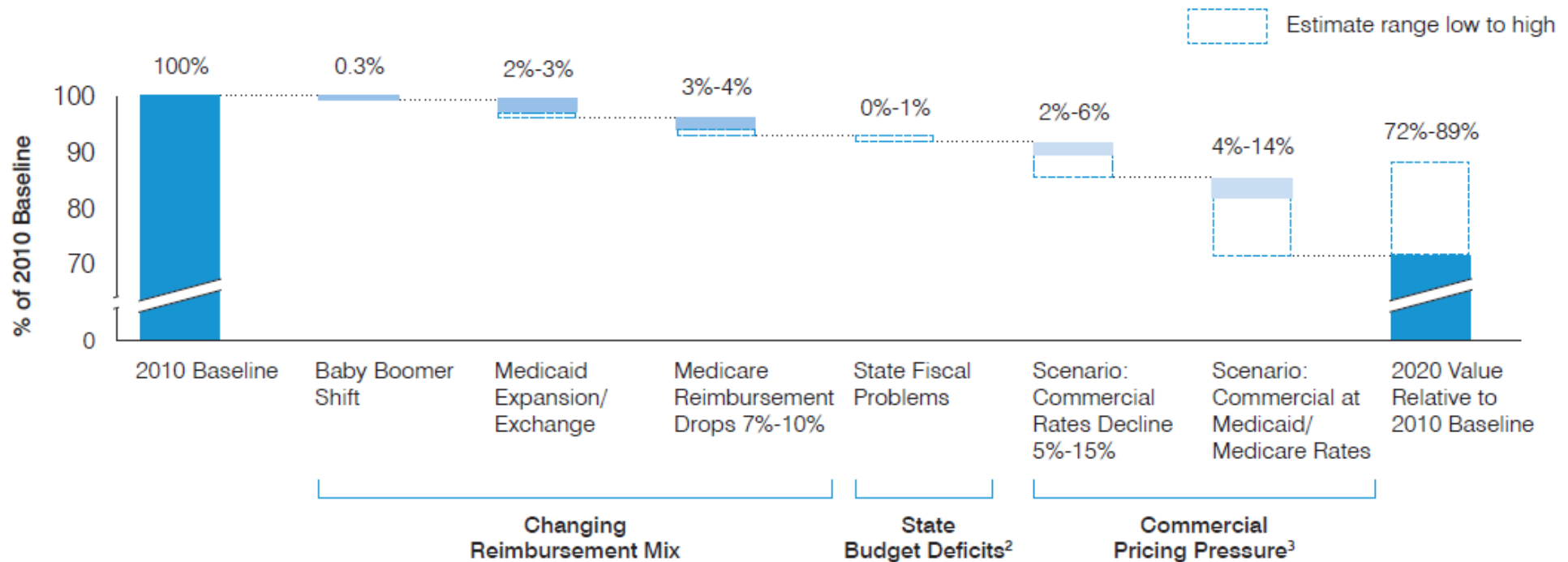
Amount of non-profit hospital debt downgraded in 2011 – record high since metric was set up in 1995

**50%**

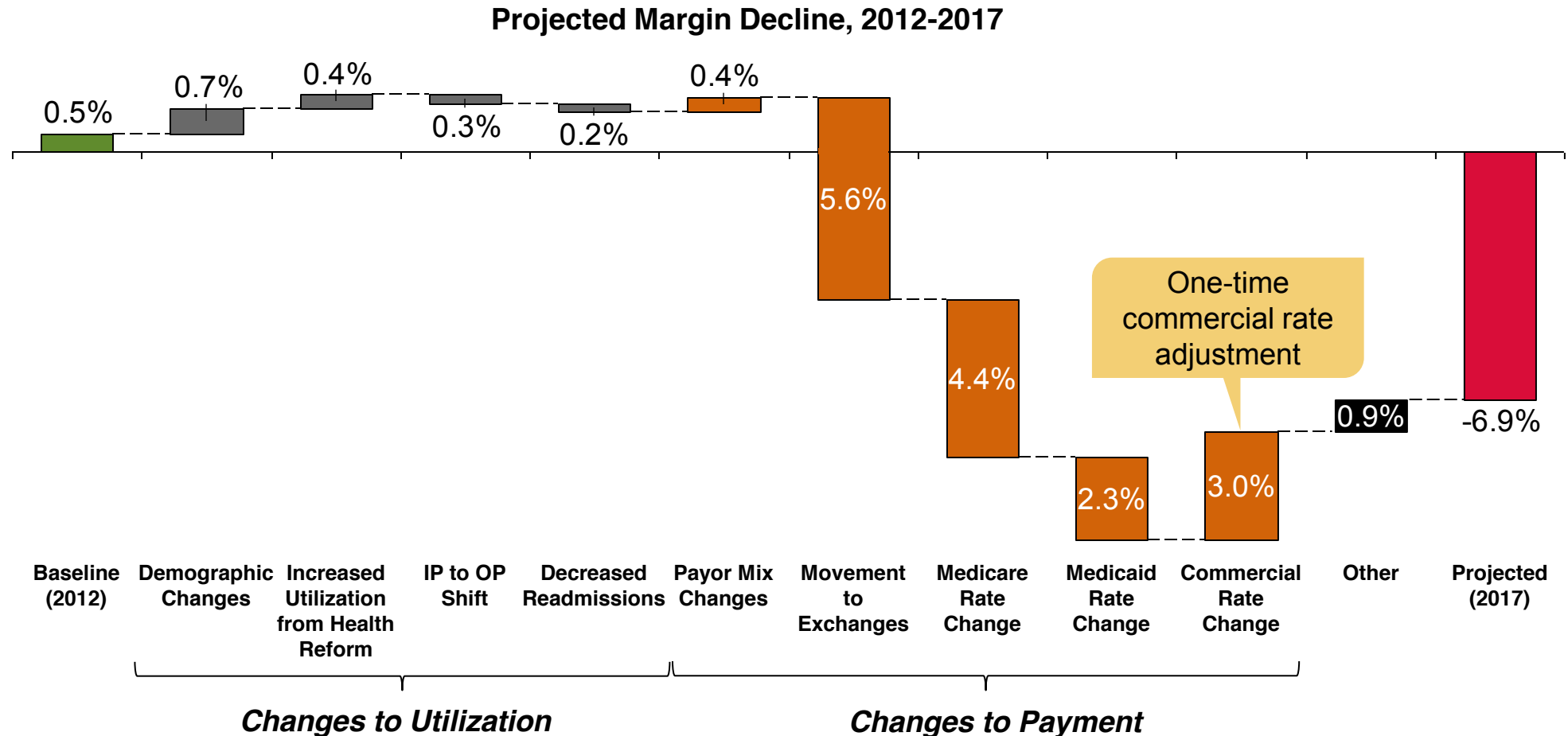
Percentage of stand-alone non-profit hospitals at BBB or “speculative” credit rating

# In summary, we project that hospitals face ~10-30% decline in reimbursement yield over the next decade

## Net Hospital Yield (Payments as a Percentage of Charges) Changes 2010 - 2020 with Scenarios for Commercial Insurance Reimbursement Changes



## Example: Midwestern Community Hospital projects an unsustainable margin decline



1. *Journal of Management Studies*, 1997, 34, 1, 1-14.

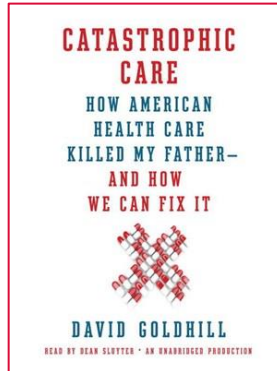
## Increasing Transparency and Pricing Pressure

Price for hip replacement highly variable, hard to obtain

### Many hospitals unable to provide estimates

BY: JENNIFER BROWN | 2013.02.11 | 11:07 AM

A "secret shopper" study conducted by researchers with University of Iowa Health Care and Iowa City VA Medical Center reveals the difficulty consumers face when attempting to obtain prices for a common surgical procedure.



Updated: 8:12 p.m. Saturday, July 21, 2012 | Posted: 8:11 p.m. Saturday, July 21, 2012

## Patients take frustrating, labyrinthine journey to uncover hospital costs


By Mary Ann Roser

Walter Simonds went to the emergency room on a Saturday night in February with a stabbing pain in his right side. After two hours at Seton Medical Center Austin, Simonds learned he had a large kidney stone.



## Economix

## Explaining the Science of Everyday Life

March 29, 2013, 6:00 am |  156 Comments

## U.S. Health Care Prices Are the Elephant in the Room

By UWE E. REINHARDT



### Patient's chemotherapy charges top \$145,000

Carolinas Medical Center-Northeast, in Concord, billed one patient a total of more than \$145,000 for six cycles of rituximab, a drug used to treat lymphoma and leukemia. The patient and his employer, a N.C. university, paid more than \$130,000. The average sales price for the amount of the drug: less than \$40,000. Following is an excerpt from one of the six bills.

### A hefty markup

The hospital billed the patient more than **\$24,000** for ten units of rituximab. The patient and his health plan wound up paying most of that amount. The average sales price for that quantity of the drug: less than **\$6,500**.

258	NS 500ML INJECTION	1	85.00	85.00
259	NS 1000ML INJECTION	1	85.00	85.00
636	RTTUSOMAB 100MG/10ML VIAL	10	2420.19	24,201.90
636	PACICICIMAB 200MG/20ML SML IN	1	611.25	611.25
636	CYCLOPHOSPHAMIDE 200MG/10ML SML IN	19	69.92	1,328.45
636	FLUOROURACIL 150 MG IN	1	1,000.00	1,000.00
351	ADM CHEMO IV PUSH 1A ADDL DRUG	2	172.20	344.40
351	ADM CHEMO IV SQD UP TO 1HR	1	181.40	181.40
	<b>TOTAL RADIATION-CHEMO THERAPY</b>			<b>1,821.15</b>

## Hospital Billing Varies Wildly, Government Data Shows

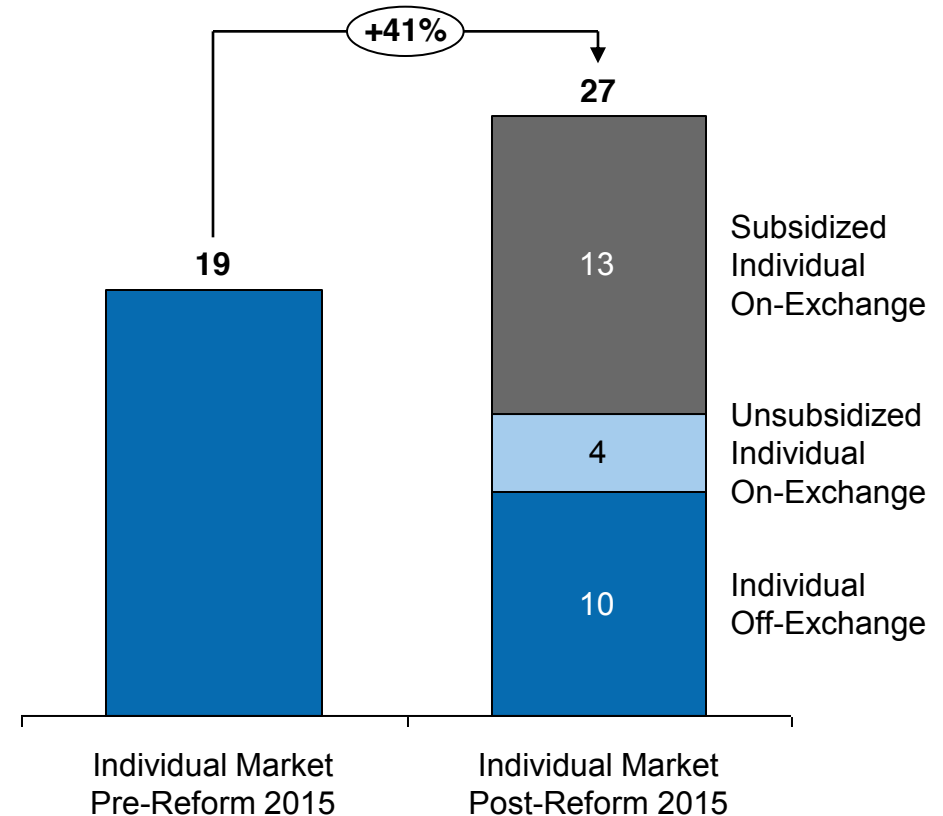
By **BARRY MEIER**, **JO CRAVEN MCGINTY** and **JULIE CRESWELL**

Published: May 8, 2013 | 708 Comments

a total of more than **\$1,800** for the work that went into injecting his health plan paid most of that. Medicare would have paid less. services, National studies say that efficient hospitals are able to bursement.

## Individual Market Projections Pre- and Post-Reform

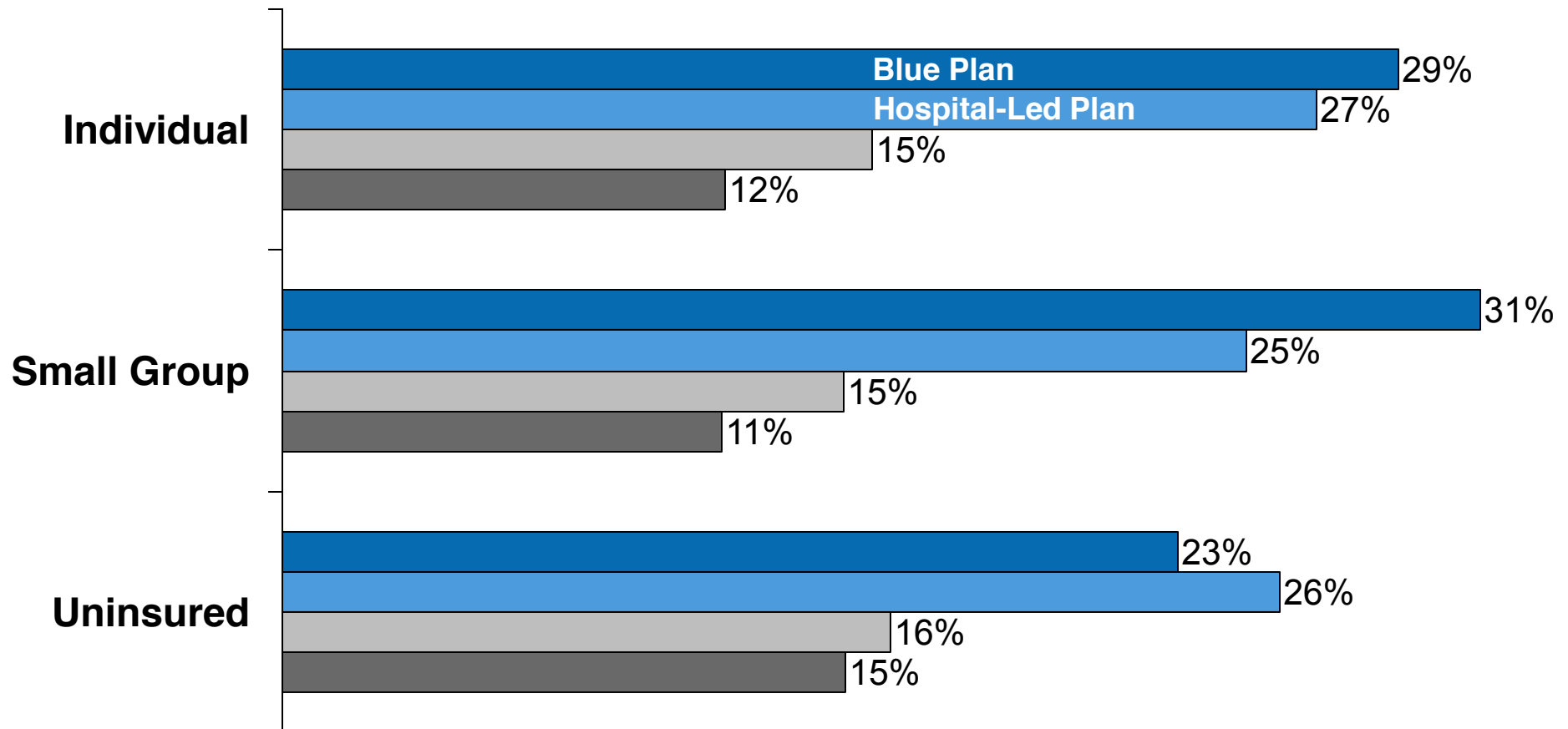
### Booz & Company Projections for Individual Market (2015)



---

**In particular, hospital-branded limited-network plans could appeal to them...**

**Top Choice Brand in Exchange Simulator by Current Insurance Status**



# In response, health systems are taking a number of actions – the more transformative ones require greater strategic clarity

## Health Systems Actions and Management Decisions Required

### Incremental Optimization

- Cost reduction
- Service line portfolio rebalancing
- Increased marketing
- Payor renegotiation and new payment model experiments
- Opportunistic M&A

### Right-Sizing | Expansion

- Network- and scale-driven M&A and partnerships
- Integration across care continuum

### Transformation

- Care model innovation
- Business model innovation (e.g., franchising, assuming risk)
- Operating model innovation (e.g., hub and spoke)
- Capability-driven M&A and partnerships

### Key Management Decisions

- What are the near-term priorities and tradeoffs?
- What capacity am I going to deploy and where in the continuum?
- What markets will I serve?
- What customers am I going to target and how will I differentiate?
- What will my growth engine be?
- How much risk should I assume?

Increasing risk, disruption and need for strategic clarity



# Given the limitations of the traditional approaches, we expect health systems to get more strategic in their actions...

## New Requirements for a Hospital Strategy



	Current State	Future State
<b>Strategy</b>	Rooted in the past, limited to vision and mission	Forward-looking, market-driven, disciplined and concrete
<b>Value Proposition</b>	“All things to all people”	Differentiated value proposition for consumers, public and private payors
<b>Basis of Competition</b>	Volume, pricing power, breakthrough research	Value for a given quality and access level
<b>Clinical Focus</b>	Illness   Hospital-based Care	Illness and Wellness   Retail, mobile and home health
<b>Key Capabilities</b>	MD affiliation, capital access, revenue cycle, acute care operations	Informatics, care redesign, population + risk management, patient experience
<b>Role of Quality and Process Excellence</b>	Differentiator	Table stakes

# This will mean non-trivial changes to the three most common types of hospitals and health systems

	Current State	Next Steps
<b>Community Hospital</b>	<ul style="list-style-type: none"><li>▪ Created to provide care in the area that had none</li><li>▪ Finding itself less relevant, facing higher-performing, better-capitalized competitors</li></ul>	<ul style="list-style-type: none"><li>▪ Need to compare service offerings with community needs and competitors' performance to ensure the institution is still relevant</li></ul>
<b>Academic Medical Center</b>	<ul style="list-style-type: none"><li>▪ Academic mission requires AMCs to charge a higher price to cover the costs of the medical school – “AMC Tax”</li><li>▪ However, for the majority of patients who do not require cutting-edge care, AMCs may not deliver the best value</li></ul>	<ul style="list-style-type: none"><li>▪ Need to have a broad enough catchment area to justify the “AMC tax” – and a set of “simpler” network assets for less complex care</li></ul>
<b>Multi-Hospital Health System</b>	<ul style="list-style-type: none"><li>▪ More multi-hospital systems emerge – in an effort to gain market power or cost “synergies”</li><li>▪ However, having multiple hospitals in a system does not automatically translate into higher performance –many transactions have destroyed value</li></ul>	<ul style="list-style-type: none"><li>▪ Need to have the right operating model to take advantage of scale, innovation and market leadership – and achieve “system-ness”</li></ul>

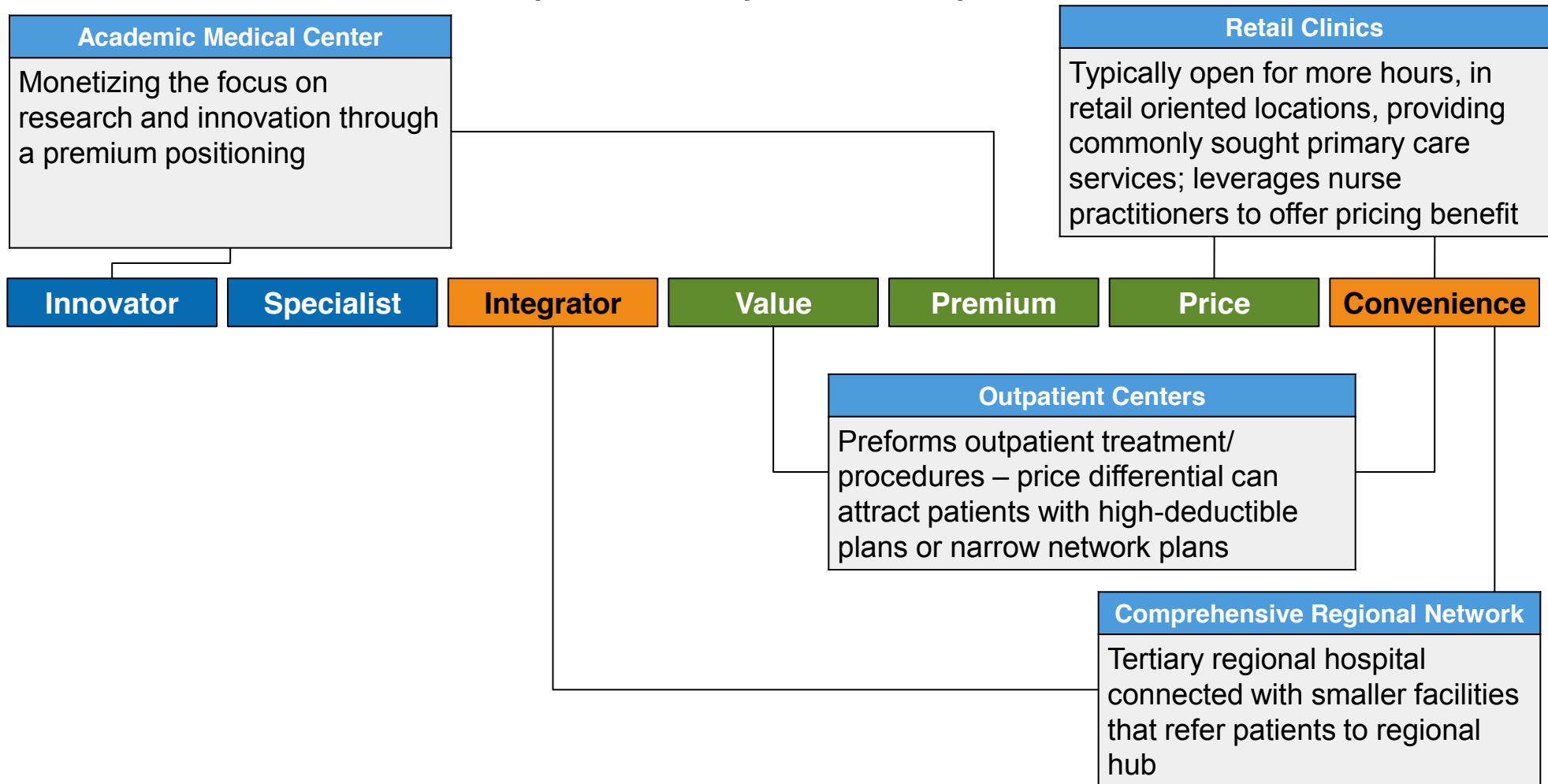
# Hospitals and health systems will look for ways to differentiate themselves – they can choose from a set of pure-tone strategies...



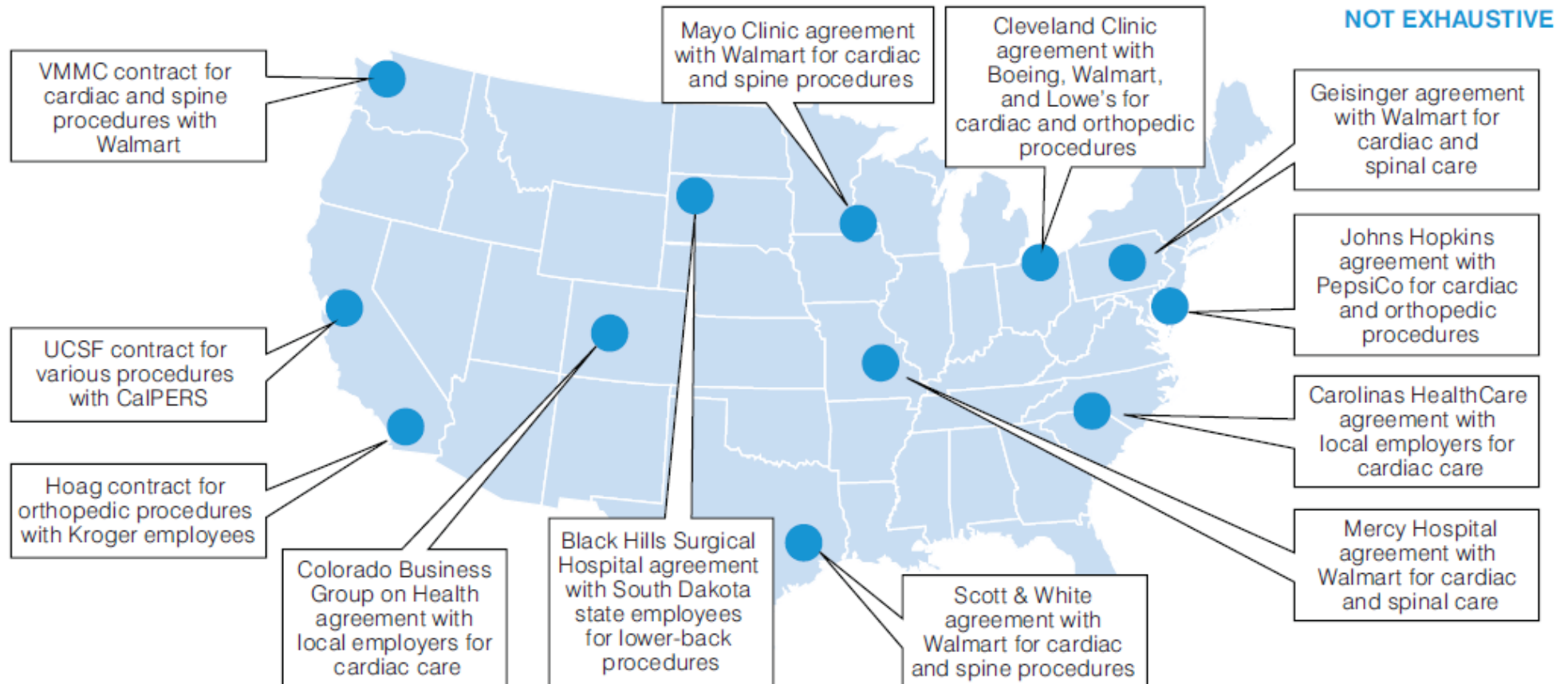
 <b>Payor Value Proposition</b>	 <b>Consumer Value Proposition</b>
<b>Access</b>	
<ul style="list-style-type: none"> <li>▪ Must-have Network</li> <li>▪ Convenient Alternative</li> </ul>	<ul style="list-style-type: none"> <li>▪ Convenience King</li> <li>▪ Integrator</li> </ul>
<b>Care</b>	
<ul style="list-style-type: none"> <li>▪ Segment Specialist / Population Manager</li> <li>▪ Clinical Specialist</li> </ul>	<ul style="list-style-type: none"> <li>▪ Innovator</li> <li>▪ Specialist</li> </ul>
<b>Cost</b>	
<ul style="list-style-type: none"> <li>▪ Risk Manager</li> <li>▪ Must-Have Brand</li> <li>▪ Value Maximizer</li> </ul>	<ul style="list-style-type: none"> <li>▪ Premium Property</li> <li>▪ Price Cutter</li> <li>▪ Value Maximizer</li> </ul>

...as well as from a range of hybrids – some will be more coherent than others

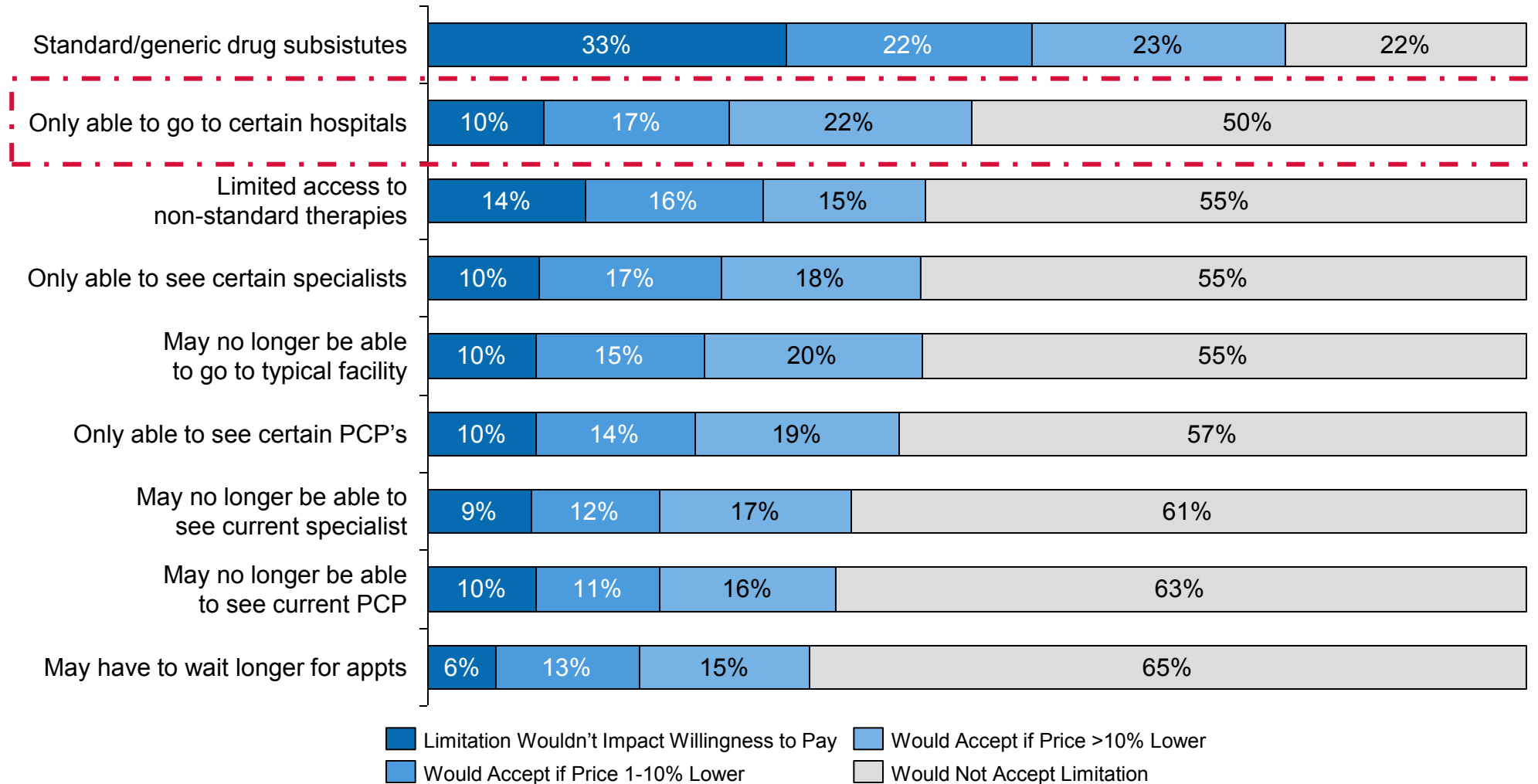
### Sample Coherent Hybrid Value Propositions












# We expect healthcare bundles to serve as an important engine of differentiation



# In fact, half the consumers we surveyed are willing to change hospitals for low-cost bundles



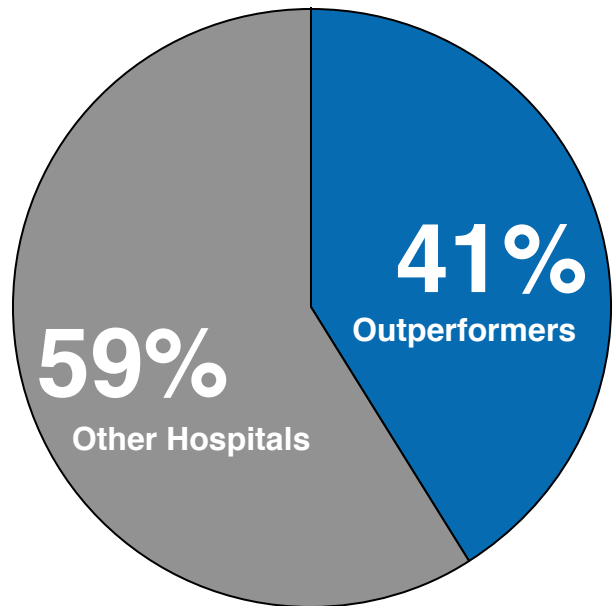
# New strategies will also require health systems to rethink their operating models

<u>Operating Models</u>	<u>Value Creation</u>	<u>Examples</u>
<b>Scaled Portfolio</b>	<ul style="list-style-type: none"> <li>Apply superior operating model to undervalued assets, benefit from efficient, replicable operating model</li> <li>Tend to be geography-agnostic (growth/income preferred)</li> </ul>	 
<b>Geographic Cluster</b>	<ul style="list-style-type: none"> <li>Build concentration in a reasonably contiguous regional market (typically outside major urban centers)</li> <li>Benefit from market power, lower-cost model and reduced leakage</li> </ul>	  
<b>Hub and Spoke</b>	<ul style="list-style-type: none"> <li>Expand footprint to drive central, tertiary hub, often an AMC</li> <li>Benefit from increased tertiary/quaternary volumes</li> </ul>	 
<b>Clinical Innovation</b>	<ul style="list-style-type: none"> <li>Apply innovative care delivery model to non-adjacent geographies</li> <li>Monetize intellectual property and brand globally</li> </ul>	
<b>Fully Integrated</b>	<ul style="list-style-type: none"> <li>Leverage owned assets and labor to create value; Fully risk-bearing</li> <li>Focus typically in dense markets</li> </ul>	

# Building out the right operating model will often rely on M&A – however, our research shows that synergies often prove elusive

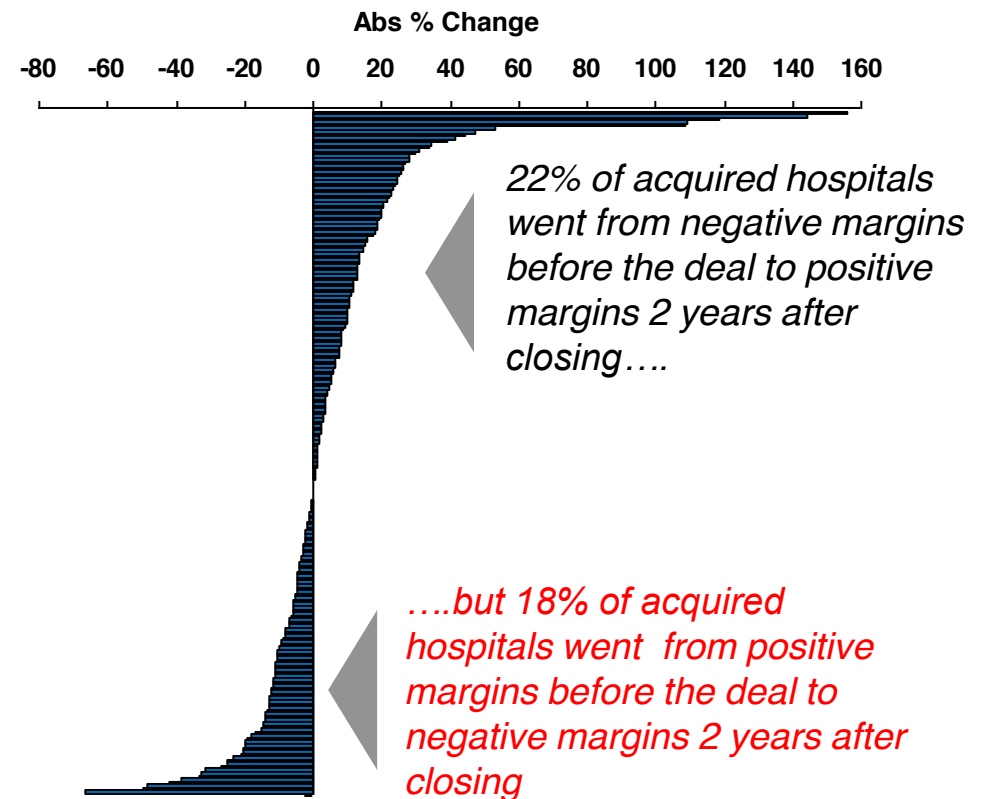
## % Hospitals with Superior Relative Operating Performance Improvement<sup>(1)</sup>

No. of Acquired Hospitals = 219



## Distribution of Operating Margin Change Between Y-2 and Y+2 from Deal Closing

No. of Acquired Hospitals = 219



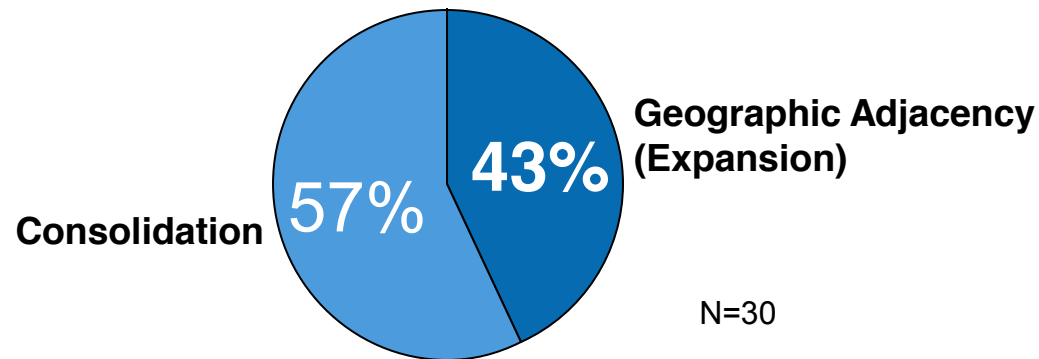
Source: Capital IQ, AHD Database, Booz & Company analysis



# However, intent and capabilities do matter – we saw above-average returns in deals with stronger capability fit

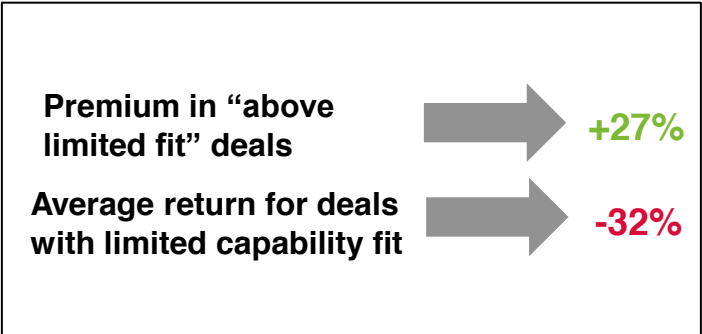
## Deal Intent

30 Large Publicly Traded Health System Deals (1998-2010)



## Capability Premium Results

Largest Public Health System Deals (1998-2010)



*Our experience suggests that these findings apply to not-for-profit health systems as well*

Examples of Deals included:



---

# Contact Information

## **Gary Ahlquist**

Senior Partner, Chicago

1.312.578.4708

Gary.Ahlquist@booz.com



## **Sanjay Saxena, MD**

Partner, San Francisco

1.415.263.3729

Sanjay.Saxena@booz.com



## **Igor Belokrinitsky**

Principal, Chicago

1.312.578.4808

Igor.Belokrinitsky@booz.com

