The opportunity in disruption
What’s the smart bet for a CFO?

“‘It’s a buckdancer’s choice, my friend. Better take my advice. You know all the rules by now, and the fire from the ice.’”
— Robert Hunter, “Uncle John’s Band”

Chief financial officer: tough gig. Seriously. Whether for a payer or a health care provider, the CFO’s job is the exact point where the smiling faces on the billboards meet the double entry, the financing, the payer mix, the debt structure. And it all has to work out in the black. It has to do that sustainably, not only this year but next year and five years from now. Best guess? It’s going to get a lot tougher, with shifting revenue streams, market boundaries, new technologies, growing consumer expectations and uncertain politics.

Raise your hand if you can tell me the significance of these names: Univac, Control Data, Burroughs, Digital, Honeywell, IBM, NCR. These companies dominated the computer world in 1980. As of 1990, all but IBM were gone, bankrupt, subsumed into some other company, or just out of the computer business. The one that survived, IBM, is the one that said, “Maybe we should at least get a toehold in this new personal computer game, even though it is risky for our main revenue streams.” All the others went poof. A number of factors — radical new technologies with vast potential, ramifying customer frustration, shifting user base — are coming together to put health care today at exactly the place the computing world was in 1980.

Health care: A beautiful system in danger
The U.S. health care system is in many ways a beautiful system. We can be proud of our world-leading technology, gorgeous physical plants, and a vigorous sector fairly fountaining the best jobs.

In many ways, the system is doing really well at what it is designed to do. But we have to ask: What is it designed to do?

The medical care system and the clinicians who work in it are focused on curing people, keeping people healthy, fixing them where they are broken.
The health care system that now envelops, manages and pays for all that wonderful work is designed for a different aim. No one person or group designed it this way. It is a complex adaptive system with many interacting parts that developed over the last half century or so. It is, in a sense, self-designed.

An economic market that works brings together health care consumers with providers who can give them what they need at a price they can afford.

The fee-for-service system is working at cross-purposes to the needs of consumers, employers and other buyers. Health care costs far too much, is far too wasteful, and still can’t seem to take care of everyone.

The U.S. system has almost exclusively a single financial input: code-driven, incident-focused, insurance-supported, fee-for-service payments. Its other key inputs are not financial but human: the needs of patients, and the commitment and passion of the clinicians and caregivers.

The problem expressed in the iron tongue of financials is: How do we close the gap between our customers’ and clinicians’ real needs and the financial engineering of our systems? How do we shift from the current single-input model to new models that will bring us closer to our customers and help us do the job we are here to do? What are the new dynamics? Who are our new partners and allies? No one does this alone.

First, let’s take a closer look at the current dynamics.

The shape of today’s system
CFOs must look at the environment in which their system lives: Over the last 20 years, wages have risen barely faster than inflation, while the costs of health care that an American family of four pays directly have more than doubled to over $12,000 per year. This long, continuing rise in the costs along with the continuing and increasing unreliability of the system (“Will it actually be there for me when I need it? Will it bankrupt me?”) create unyielding disruption.

Instability: omens
I am no fortune teller, but here are some things we can see right now that give us a sense of what’s coming.

• Political shift: Public opinion has shifted. When polled about actual policies, health care has been cited repeatedly as the top concern of voters across the country. Voters’ top concerns are cost, the risk to patient protections in the ACA, and threats to “reform” Medicare by weakening it. The popularity of “single payer” proposals is a direct result of the cost and uncertainty of health care, a simple cry to “Do something!”

Under this pressure we are more likely to see drastic solutions proposed and passed at the federal and state levels or embodied in regulatory changes and lawsuits against industry practices.

• Public awareness: Health care is intensely personal, visceral. It’s crazy-making. Surprise bills, balance bills, other bills slipped through loopholes in the fine print or even in unwritten industry practices — what the industry considers standard operating procedure, the customers view as aggressive and financially difficult.
• **Restive buyers:** The percentage of buyers — such as employers, unions and pension plans — telling various polls that health care costs were a major problem for their business has more than doubled in the last five years and is now a majority. Buyers are pushing for choices to control costs and manage quality. They are beginning in greater numbers to demand reference pricing tied to Medicare rates, direct access to competitive bundled prices, and price transparency through centers of excellence, high-performance networks and accountable care organizations. Some 64% of employers plan on implementing direct primary care in on-site or near-site clinics by 2020. Buyers are increasingly willing to take their beneficiaries elsewhere if your business can’t meet their demands.

• **New entrants in the marketplace:** In response we are seeing a thousand new flowers bloom in the health care marketplace. We are seeing never-before-seen congeries of insurers and providers, of insurers and retail pharmaceutical chains, with CVS buying Aetna and CIGNA buying Express Scripts. The Blues are bankrolling Sanitas primary care centers in multiple states. CVS Health, Walgreens Boots Alliance and Walmart are already eating into hospital volume with their in-store health centers, and Amazon’s new chain of grocery stores will have a health care component as well. UPS is even partnering with Merck to launch an in-your-home vaccination project. The high-tech giants all have plays offering to straighten out the kinks in the system. The new virtual/direct primary care company 98point6 is off the ground with 50 companies signed up. Multiple new primary care chains (Zoom+, Iora, ChenMed, OneMedical), free-standing emergency centers, and enhanced urgent care centers with overnight stays, infusion and other services are popping up, almost all with different business models, workflows, efficiencies and pricing structures. It’s classic capitalism: If you fail to meet the needs of your customers, someone else will show up who can do the job better. In the end, the only opinion that counts is the buyer’s opinion.

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Where will the combination of new market entrants and the more militant buyers take us? The clearest direction is toward:

1. A more fluid market
2. New ways of paying for health care such as various population health management packages, direct-pay primary care, bundled payments, and medical tourism — all of which shift the risk onto the health care provider to get the price and offering right.

• **New transparency:** All HIPAA-covered entities are now required to have digital interfaces to give patients the full and free access to their medical records, and the patients are free to share that information with any other entity. This is a great step for the patient. For health care organizations, it can have revolutionary effect. In your organization, you may think of the EMR database as “your” records, but any new competitor in any particular niche can get those records just by asking the customer for them. And yes, there will be apps for doing that.
• **Shifts in pricing and reimbursement:** Currently, a physician’s office performing an X-ray (for instance) bills at one level, while a hospital bills at a significantly higher level, and often adds on “facility fees” and other fees. It is not uncommon for a bill for the same service — even using the same machines and personnel — to be ten times as much coming from a hospital as from a physician group working in the hospital. This practice has been one major driver of the vast consolidation we have seen over recent years. CMS has announced that this practice will end. Reimbursement in the future will be “site agnostic.”

Similarly, CMS has announced the end of accountable care arrangements in which health care providers do not actually take on any risk. In the future, providers will get a risk payment only if they can show that they have actually reduced overall costs — a demand that itself calls for a whole new level of metrics, of transparency, of financial infrastructure.

• **Limits of “value” arrangements:** Over the past decade the response by providers to the spiraling costs has been to attempt a shift from “volume to value” through a variety of market experiments.

  Increased value to the customer means either giving the customer the same product at a lower cost, or giving them a better product (more complete, more appropriate, more reliable) at the same cost.

  The fact that the cost of health care has continued to rise represents an enormous market opportunity for any organization that can offer true value in health care: actual reduced costs for standard products, or product that is greatly enhanced in reliability, appropriateness and quality at the same cost. This is the huge business awaiting whoever can put it together.

• **New tech:** Finally, we are seeing more and more technologies arising that can enable greater efficiencies in health care, from the clinical to the administrative to patient engagement. Every medical tech conference I have gone to for years has featured one or more bits of tech whose proponents proclaim, “This changes everything!” Every time, I feel, “No. Not by itself. But it will help when the time comes to change the fundamentals.” That time is near.

**Shape of things to come:**

Picture, if you will, a health care sector that **costs less**, whose share of the national economy is more like it is in other advanced economies — let’s imagine 9% or 10% rather than 18% or 19%.

A big part of this drop is a **vast reduction in overtreatment**, because non-fee-for service payment systems are far less likely to pay for things that don’t help the patient. Another part of this drop is the greater efficiency of every procedure and process as providers get better at knowing their true costs and cutting out waste. The third major factor is that new payment systems and business models actually drive toward true value for the buyers and health care consumers. This includes giving a return on the investment for prevention, population health management, and building healthier communities. This incentive would reduce the large percentage of health care costs due to preventable and manageable diseases, trauma and addictions.

Picture, if you will, a health care sector in which **prices are real, known and reliable**. Price outliers that today may be two, three, five times the industry median have rapidly disappeared. Prices for comparable procedures have normalized in a narrower range well below today’s median prices. Most prices are bundled, a single price for an entire procedure or process, in ways that can be compared across the entire industry. Prices are guaranteed. There are no circumstances under which a health care provider can decide after the fact how much to charge,
or a health insurer can decide after the fact that the procedure was not covered, or that the unconscious heart attack victim should have been taken to a different emergency department farther away.

Picture a well-informed, savvy health care consumer, with active support and incentives from their employers and payers, who is far more willing and eager to find out what their choices are and exercise that choice. They want the same level of service, quality and financial choices they get from almost every other industry. And as their financial burden increases, so do their demands.

Picture a reversing of consolidation, ending a providers’ ability to demand full-network contracting with opaque price agreements — and encouraging new market entrants capable of facilitating a yeasty market for competition. Picture growing disintermediation and decentralization of health care, with buyers increasingly able to act like real customers, picking and choosing particular services based on price and quality.

Picture an industry whose processes are as revolutionized by new technologies as the news industry has been, or gaming, or energy. Picture a health care industry in which you simply cannot compete using yesterday’s technologies — not just clinical technologies but data, communications and transaction technologies.

True value

Other industries define their “value proposition” as: How do we succeed by bringing the customer greater real value, with products and services that have some combination of lower price, greater reliability and more functionality? The question is: “How do we get the job done better at a reasonable price?”

That would be a radical redefinition for health care. It is simply not what today’s structures are built for. The fee-for-service model by its nature cannot drive toward true value for the customer. Yet this radical redefinition is exactly what all of health care’s customers and buyers and all of the new disruptive entrants in the health care market are pushing for. Their question, getting more and more urgent by the moment, is: “How do we get what we pay for in health care?”

Will we succeed? Do we really have to adapt ourselves to this radical redefinition? Or can we count on the basic underpinnings of the market staying mostly the same for the foreseeable future? Obviously, we can’t know. The shifts above suggest that the market is moving in a new direction, but that move has not yet reached a tipping point.

But the real question to ask is not whether it will happen or not. The right question is:

What’s the smart bet for a payer or provider CFO?

/// The smart bet is to act as if this radical redefinition of our value is going to happen, and shift your strategies to account for it.
Here’s the argument for why this will happen:

- The shifts in the marketplace, new entrants and enabling technologies indicate that **at least some significant portion of your market is going to be able to find their way to this new value proposition.**
- The strategies that providers and insurers and new entrants are testing are **not mere tweaks,** not small programs for particular customers, but systemic changes and strategic shifts across the entire system.
- Developing the ability to partner, to know your real costs, to tough-love bargain with suppliers, and to create bundled offerings at the right price will put you in a stronger market position whether the market shifts a little or a lot. Developing new revenue streams and new organizational capabilities never hurts.
- Betting that this market shift won’t happen enough to affect you leaves you dependent on the single insured fee-for-service revenue model. You’re like a farmer with a single crop in a market with only a few buyers. Your guess about the future had better be right.

### What are the key strategies for managing this turbulence?

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<th>Success strategies for provider CFOs</th>
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| OVERTREATMENT AND WASTE | **OVERTREATMENT AND WASTE**
Do a deep and honest analysis of how much of your book of business is actually not effective, not necessary, does not deliver value or satisfaction to the customer — because that book of business is likely to wither away under alternative financing arrangements. Keep in mind that among various studies, the low estimate of how much of health care delivers no real value to the customer (an estimate by doctors about their own specialties) is 20%. The high end (in a PricewaterhouseCoopers study) is 54.5%. Most studies and estimates cluster around 35%. |
| ABANDON MONOPOLISTIC PRACTICES | **ABANDON MONOPOLISTIC PRACTICES**
An “all system” fee-for-service contract hidden from public scrutiny is **smart, but not wise.** It may help this year, maybe next year, but in the longer run it creates vulnerability to political attack, legislation and lawsuits, and also to shifts in the market. A semi-monopoly position allows you to charge a premium for your products, but it locks you into that ability to charge a premium. As the market shifts and finds ways around paying high prices, you will be forced to compete at the lower prices, but you will not have developed the partnerships, the strategies and the product lines to do that. If there is no competition in your area, then compete with yourself to forestall lower-cost competition developing. |
| BIRTH YOUR COMPETITION | **BIRTH YOUR COMPETITION**
The growth area in the new health care competition will be: “How to cut into the hospital’s bottom line by keeping people out of the hospital.” The most competitive business models in health care will be in the business of cutting off hospitals’ revenue streams upstream. |
| Get into this business model, even if you are a hospital. Especially if you are a hospital. Get into this business and get better at it than any potential competition. Create high-performance bundled programs with deeply managed costs well below the industry median. Get into contracts with large buyers for particular niches in which you give financial and quality performance guarantees. If you can’t guarantee that you can drop the cost and improve the quality, you will lose that business to someone else who can show that track record and give that guarantee. | **Get into this business model, even if you are a hospital. Get into this business and get better at it than any potential competition. Create high-performance bundled programs with deeply managed costs well below the industry median. Get into contracts with large buyers for particular niches in which you give financial and quality performance guarantees. If you can’t guarantee that you can drop the cost and improve the quality, you will lose that business to someone else who can show that track record and give that guarantee.** |
| Put yourself into all the business models that are disrupting you, such as outpatient clinics, community clinics, mobile vans, mini-hospitals, stand-alone emergency departments, on-site clinics, personalized management of complex cases, direct-pay primary care and others. Make these businesses able to compete for market share by unshackling them from hospital pricing and facilities fees. | **Put yourself into all the business models that are disrupting you, such as outpatient clinics, community clinics, mobile vans, mini-hospitals, stand-alone emergency departments, on-site clinics, personalized management of complex cases, direct-pay primary care and others. Make these businesses able to compete for market share by unshackling them from hospital pricing and facilities fees.** |
| Risky? Sure, but you do not want to end up being just the super-expensive job shop at the end of the line that every single customer and buyer is making every effort to avoid. | **Risky? Sure, but you do not want to end up being just the super-expensive job shop at the end of the line that every single customer and buyer is making every effort to avoid.** |
Success strategies for payer CFOs

**READ THE LIST OF STRATEGIES** that health care providers have to go through to survive and serve their market. Think through all the assets, connections and information that you have, and ask yourself two questions:

1. How can we help providers succeed at those strategies?
2. How can we foster competition against them in all those strategies?

**HEAD TOWARD TPA**

Employers are frustrated and headed toward disintermediation. So be in the business of helping them realize the full potential of self-funded health care. Third-party administration (TPA) can help employers, unions, pension plans and other buying agents to reduce their costs and then push that savings directly toward increased value for their health care consumers.

**AGGRESSIVELY PUSH ALL SOLUTIONS THAT ARE NOT FEE-FOR-SERVICE**

Use your research expertise and bargaining power to bring bundled services, medical tourism, full capitation, mini-capitation, reference pricing, on-site and near-site direct-pay clinics, as well as the innovations mentioned above.

**HELP PROTECT THE FINANCIAL SECURITY OF YOUR CUSTOMERS**

It does not help you if your customers feel like they are in an adversarial relationship with you, that you and the health care providers are lying in wait to catch them out and cost them vast sums. Today, most of your customers fear exactly that. If your customers know that you will defend them vigorously against surprise billing, balance billing, and hidden out-of-network costs, you have a superior product. Get aggressive in your negotiations with providers to get contracts that prevent them from using these egregious practices on your customers. **Go to bat for your customers.** Honor your contracts. Honor the promise of the happy, healthy faces on your billboards, not the “gotcha” traps in the fine print.

**FUND POPULATION HEALTH AND HEALTHY COMMUNITIES**, in cooperation with existing health care providers, but even in competition with them if necessary. If you put yourself in a position to do better financially if your covered population is healthier, then the opioid crisis, rampant diabetes and other population health problems turn into huge opportunity spaces. We can already see this happening in various emerging Medicaid programs that are becoming more responsive to the social determinants of health. In a number of states, Medicaid Managed Care Organizations are required to build their plans not just on providing medical care, but by in one way or another offering help for housing, transportation, nutrition and access to healthy food, social contacts — a whole range of the things that we know make a huge difference to our health.

**WORK WITH THE DISRUPTIVE NEW ENTRANTS**

Bring your data analytics to the next level and use those analytics, your customer base and your financial power to catalyze the disruption that is coming.

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Strategies of coopetition

*Both health care providers and payers*

**ALIGN INCENTIVES IN THE CONTRACTS**

Health care providers must be able to engage performance agreements that give at least some of the bottom-line risk to them. Work with third-party companies that can actually audit organizations’ abilities to perform consistently over time.

**ESCHEW EMBIGGENING**

Size per se is not a safe harbor from risk. There are few economies of scale in health care. Concentration within a given market can be essential to success in offering a true range of services, well supported, at a lower price, customized to the regional population, the provider mix, the state laws and the local economy.

And **size does not help the customer**. There just are no examples in the history of health care in which size alone has returned greater value to the patient, the consumer, or the buyer, whether lower cost, greater reliability or higher quality.

**EXPAND THE DEFINITION**

Widen the “medical services” that you fund and offer to include services such as functional medicine, chiropractic, acupuncture and various other modalities that have been shown to be highly effective at far lower cost. There are ways to do this within licensing requirements.
INTEGRATE BEHAVIORAL HEALTH
Find ways to fund behavioral health and addiction treatment. Integrate behavioral health directly into the patient experience, triaging at the door to the Emergency Department and in every primary encounter. Find local innovators that can help preempt costly crises. Partner with community health, housing and nutrition advocates. Helping people change their habits, manage their lives and get beyond their addictions is far less expensive than fixing them over and over.

RETRAIN CLINICIANS
Physicians and other clinicians are heavily trained to create and document reimbursable events. If you change the economics so that the system finds ROI in promoting health, preventing disease, managing population health, producing cures and reducing suffering as efficiently as possible, those very same clinicians will need to be retrained. Most of them will be deeply grateful, because they, like you, genuinely want to bring real value to the customer. In fact, if you do this you could end the physician shortage and the nurse shortage. People will flock back to do what they became a doctor or a nurse to do: Help people.

None of this easy. It is extraordinarily difficult and fraught with risks. But so is the future looming before you. Doing things the same old way doesn’t lower your risk, it raises it. There is no quick way out of this pickle. Health care CFOs have a chance to help their organizations survive this looming transformation, but only by embracing change, building new kinds of relationships, shifting financial dynamics and looking for opportunities within the disruption.

“"I don’t know why,” musical revolutionary John Cage is said to have said, “people are so afraid of new ideas. I’m afraid of the old ideas.”"