2018 State of Cost Transformation in U.S. Hospitals and Health Systems: Time for Big Steps

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Introduction

The Healthcare Environment: Pressures accelerated for the nation's hospitals and health systems during the past year. Multiple forces, including competition, consumer expectations, payment pressures, and regulation, are expected to cause a decline in demand and revenue for core inpatient services. This trend increases the imperative to reduce costs to alleviate shrinking hospital margins. New approaches to care delivery, such as retail clinics and telehealth, have emerged to offer consumers high-volume services at lower prices and more conveniently than hospital outpatient facilities. Powerful new players, such as the venture formed by giants Amazon, JPMorgan Chase, and Berkshire Hathaway, are on the scene, with the intellectual and capital investment capabilities to overhaul significant pieces of the health/healthcare business.

Such forces have the potential to minimize or eliminate the role played by legacy healthcare organizations. “The specific future for legacy hospitals and health systems may be hazy, but we know its direction,” notes Kenneth Kaufman, Chair of Kaufman Hall. “Meaningful actions can and must be taken immediately.”

Why This Publication? This report is the second annual in-depth look at the priorities and progress healthcare executives are making in reducing organizational costs. The 2017 State of Cost Transformation in U.S. Hospitals led with an urgent call to leadership teams to accelerate action on the cost-transformation front. This 2018 report examines progress to date, noting the pressing need to add focus on transformative cost initiatives. The results indicate:

- Some progress has been made on some fronts, but overall, the progress has been limited.
- The latter is particularly the case with initiatives that will yield transformative reductions, including service rationalization, clinical/care redesign, physician enterprise management, and the reduction of unwarranted clinical variation.
- Key challenges continue to include lack of accountability for goal setting and achievement, lack of reliable data, and lack of tools to identify and monitor cost improvement efforts.

Cost transformation remains an urgent need in most organizations. In addition to the related survey findings, we offer five strategies that can help organizations set and achieve cost-transformation goals.

About the Report

This report presents results of an online survey completed in June and July 2018 by senior executives of U.S. hospitals, health systems, and other healthcare organizations. It is the second such annual report; the 2017 report was published in September 2017.

As with the survey last year, the goal of the 2018 survey is to gauge where industry participants stand with regard to transforming the cost of care:

- **Nearly 190 senior executives** from hospitals and health systems participated in the 2018 report, up from 173 in 2017.
  - 21 percent were from health systems with 10 or more hospitals
  - 15 percent were from health systems with 5-9 hospitals
  - 24 percent were from health systems with 2-4 hospitals
  - 24 percent were from a single hospital
  - 16 percent were from other organizations, such as a health plan or medical group

- **70 percent** of participants were in executive leadership or finance roles; the remaining 30 percent were individuals in operations, strategy, quality, clinical management, and other areas.
Top Findings and Related Strategies to Initiate Progress

**Top Forces:** The three top forces cited by executives as spurring cost transformation efforts are

1. The need to be proactive in refining the organization’s cost structure during the transition to a value-based model (70 percent)
2. The need to remain competitive amidst traditional and non-traditional competitors (67 percent)
3. The need to generate capital to fund strategic growth initiatives (61 percent)

Other forces, each capturing a 59 percent response, include the need to close a gap between the financial plan and current operating performance and the need to participate in making care more affordable for all consumers.

- **Strategy 1:** Ensure all top disruptive forces are on leaders’ radar screens and driving cost transformation.

**Accountability:** Executives in nearly a third of organizations (32 percent) say that goal setting for cost reduction is absent in their organizations, and modest targets (1 to 5 percent) exist in about a quarter of represented organizations (22 percent). More than half of executives (57 percent) say their organizations set cost-reduction targets solely at the enterprise level, not at the vice president, service line, or department level, where the operational cost reduction work takes place. Forty-two percent of executives say their organizations do not have processes and structures in place to hold leaders accountable for performance for cost transformation goals.

- **Strategy 2:** Put in place the structures and processes required for cost transformation accountability, and hold leaders accountable for setting and achieving transformative cost-reduction goals.
Top Findings and Related Strategies to Initiate Progress (continued)

**Priorities:** Traditional priorities dominate attention for cost reduction, with 72 percent of executives citing labor cost/productivity and supply chain and other non-labor costs as a key focus area. Areas that will contribute to changing foundational cost structure, such as service rationalization and physician enterprise management, are not being addressed at a similar pace (29 percent and 45 percent, respectively). Physician engagement in cost-transformation efforts appears limited. The top-cited strategy to engage physicians in cost transformation is to regularly deliver to them reports on quality, cost, and patient experience, but this was cited by less than half of respondents (42 percent).

- **Strategy 3:** Focus on all initiatives that can contribute to transformative cost improvement, such as reduction of unwarranted clinical variation and service line rationalization.

- **Strategy 4:** Focus on the physician enterprise.

Traditional and transformative cost reduction effort should be additive, not mutually exclusive.

**Roadblocks:** The top-cited impediment to cost transformation is “lack of good data and insight into costs and where savings opportunities exist” (22 percent). More than 70 percent of executives indicate that they lack confidence in the accuracy of results from their existing cost accounting solution or have no tools or only rudimentary tools in place.

- **Strategy 5:** Use high-quality data, analytics, tools, and processes to drive improved decision making in clinical and business domains, and the tracking of improvement progress across transformation areas.

Executive teams can spur cost-transformation progress by addressing the roadblocks, as recommended.

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3. A “check all that apply” option was available.
4. Respondents were asked to supply one response only.
The State of Cost Transformation:
Detailed Survey Findings and Relevant Strategies for Transformative Cost Reduction
The Cost Transformation Imperative

The forces driving the need for significant cost reduction remain pressing.

70% of executives cite the need to be proactive in lowering the organization's cost structure during the transition to a value-based payment model (down from 77 percent in 2017).

67% of executives cite the need for their organizations to remain competitive amidst traditional and non-traditional competitors (up from 61 percent in 2017).

61% of executives cite the need to generate capital/capital capacity to fund strategic growth initiatives (up from 51 percent in 2017).

A smaller (but still large) proportion of respondents this year cited preparation for the value-based model as a factor driving their cost-reduction efforts. Many organizations might have made investments that are longer term, and achievement of expected targets related to such investments may remain a goal. Competition and funding for growth initiatives are motivating a greater proportion of executives to lower their organizations' cost position.

Factors Driving the Need for Cost Transformation

- To refine our cost structure as we transition to the value-based model: 70%
- To remain competitive in our service area: 67%
- To generate capital to fund strategic growth initiatives: 61%
- To close the gap between our financial plan and current operating performance: 59%
- To participate in making care more affordable: 59%

Note: A “check all that apply” option was available.

Takeaway: Competition and the need to generate capital to fund an increasing numbers of strategic growth initiatives are driving the cost-transformation imperative in more organizations.
The Cost Transformation Imperative (continued)

Not all important forces are considered imperatives at many organizations.

41% do not cite “making care more affordable for all consumers” as important to their cost transformation efforts.

Lessons from Amazon, retail, and other disruptors apply in healthcare today and tomorrow. These competitors seek to carve out the segments of healthcare with the lowest fixed costs and the highest volume and pass on the savings of operational efficiencies as lower prices for customers.

With “skin in the game” due to higher deductibles and co-payments, and through consumer-engagement technologies, healthcare consumers are increasingly price sensitive. They will be incentivized to look beyond hospitals and hospital outpatient facilities for non-emergent, elective services.

Health systems often have significant volumes of “bread-and-butter” outpatient services, such as imaging, labs, and elective surgeries. These same services are squarely in the bull’s eye of consumers and competitors. Hospitals should ensure:

- Cost-efficient, high-quality patient care
- Pricing transparency
- Competitive pricing for ambulatory services they wish to retain

According to results from a new consumerism survey, only 5 percent of organizations rated in the top tier for aggressively pursuing pricing strategies and price transparency, while an overwhelming 74 percent are low-end performers in this regard.

Consumerism, payers, and employers will continue to put pressure on providers to reduce costs and be more efficient.

Strategy 1. Ensure all top disruptive forces are on leaders’ radar screens and driving cost transformation.

Accountability

Improvement is needed in the structures and processes required to transform costs organization wide.

The cost transformation imperative is well-recognized, but the processes and structures for accountability need to be developed and implemented in many organizations.

86% say cost transformation is a “significant” to “very significant” need for their organizations today, but . . .

42% say their organizations do not have processes and structures in place to hold leaders accountable to performance for cost-transformation goals or do not know whether this is/is not the case.

Reduction targets should extend to levels beneath the enterprise level and be distributed across the organization.

57% say improvement targets have been set at the hospital level only—and not at the vice president, service line, or department level.

27% say their organizations do not distribute targets across the organization or are not sure whether this is/is not the case.

Takeaway: Executives should be transparent about the need to reduce costs with all key stakeholders, including physicians, staff, and the community at large. Transparency of processes, responsibilities, and targets helps ensure communication and dissemination of relevant cost-reduction information.
Accountability (continued)

Improvement is needed in the structures and processes required to transform costs.

32% of executives say no cost-improvement goal has been established in their organizations for the next five years (up from 25 percent in 2017). A five-year cost-reduction goal is entirely absent in nearly 1 in 3 organizations, meaning the organization is not trying to lower cost in an organized and deliberate way. This puts the hospital or health system at high risk for diminishing financial performance resulting from inflationary pressures and slowing or declining revenues.

22% have a cost reduction goal of 1 to 5 percent.

25% have a cost reduction goal of 6 to 10 percent.

21% have a cost reduction goal of 11 percent or more.

Takeaway: Financial realities make cost transformation an imperative for healthcare organizations and their leaders. Significant improvement is needed in organizational commitment to goal setting that will build organizational agility through more extreme lowering of costs (beyond 1 to 5 percent) and into double-digit levels that can transform cost structures.

A close study of survey data indicates organizations that hold leaders accountable for targets are more likely to report progress in most cost-reduction priority areas described later.
81% of executives cite that some type of incentive is in place for leaders to improve operational cost.

**Use of Incentives to Improve Operational Cost**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Progress toward individual/department goals is built into the performance review process</td>
<td>59%</td>
</tr>
<tr>
<td>Leaders can earn financial rewards for the attainment or improvement of individual/department goals</td>
<td>40%</td>
</tr>
<tr>
<td>Leaders report on their progress regularly in front of their peers</td>
<td>38%</td>
</tr>
<tr>
<td>No incentives are in place</td>
<td>19%</td>
</tr>
<tr>
<td>Other</td>
<td>6%</td>
</tr>
</tbody>
</table>

**Takeaway:** A structured, comprehensive approach to cost transformation is paramount. The approach includes clearly defined roles, accountability and reporting, goal setting, and ultimately, incentives tied to sustainable cost control. While financial incentives are helpful, they are not sufficient without an engaged management team.

**Strategy 2.** Put in place the structures and processes required for cost transformation accountability, and hold leaders accountable for setting and achieving transformative cost-reduction goals.
Where Are Organizations Focusing?

Traditional priorities dominate attention, while areas that will contribute to changing foundational cost structure are not being addressed aggressively.

72% cite traditional “labor cost/productivity” and “supply chain and other non-labor costs” as a key focus area

But . . . . .

Among physician enterprise and service line initiatives:

71% do not cite service rationalization as a key focus

55% do not cite physician enterprise management as a key focus

52% do not cite service line efficiency as a key focus

Among clinical redesign and workforce initiatives:

62% do not cite reduction in inappropriate clinical variation as a key focus

60% do not cite clinical workforce redesign as a key focus

55% do not cite clinical redesign (workflow and/or model) as a key focus

**Takeaway:** A new mindset is required for the kind of extreme shift and lowering of costs that will distinguish an organization into the future. That frame of mind is characterized by a willingness to focus on the full cost transformation agenda. This will require overcoming entrenched incrementalism and political sensitivities to make progress with the hardest cost-reduction work—namely business and service line rationalization, physician enterprise management, clinical redesign, and workforce redesign.

**Strategy 3.** Focus on all initiatives that can contribute to transformative cost improvement.
Where Are Organizations Focusing? (continued)

Focus of Current Cost-Transformation Efforts

- **Labor cost/productivity**: 72%
- **Supply chain/other non-labor**: 72%
- **Service line efficiency**: 48%
- **Overhead/shared services synergies**: 45%
- **Physician enterprise management**: 45%
- **Clinical redesign**: 45%
- **Clinical workforce redesign**: 40%
- **Inappropriate clinical variation**: 38%
- **Merger synergies**: 31%
- **Service rationalization**: 29%

Note: A “check all that apply” option was available.

Executive quote: “We are in the fourth year of a five-year cost-reduction/revenue enhancement effort. It has become increasingly harder each year. This fourth year has created a lot of pushback, as there are only the ‘tough’ items left to take on.”
Engagement of the physician enterprise in cost transformation is limited, at best.

The top-cited physician engagement strategy is to regularly deliver reports on quality, cost, and patient experience, but this was cited by less than half of respondents.

In our experience, organizations that are able to engage their physicians typically are the organizations with stronger strategic and financial performance. Most physicians want to improve their performance. Regularly providing physicians with relevant data and enabling a view of their performance in the context of peer performance helps them to identify improvement opportunities that can be pursued.

The identification and engagement of strong physician sponsorship in a chief medical officer or other physician leader are critical to obtaining buy in from other physicians in the organization. Benchmarks provided to clinicians should be directional in nature (i.e., normalized based on an understanding of the relevant operations) and applied in the context of the system as a whole. Reporting on progress should occur regularly in medical staff meetings. All of the surveyed engagement strategies, as presented in the graph, should be used by organizations.

**Strategies to Engage the Physician Enterprise**

- Reports (quality, cost, patient experience) delivered to physicians regularly: 42%
- Physician leaders are members of cost transformation steering committee: 39%
- Physician advisory council: 25%
- None of the above: 22%
- Cost improvement targets built into physician contracts: 17%

*Note: A “check all that apply” option was available.*

**Strategy 4. Focus on the physician enterprise.**
A large proportion of organizations (44 percent) cite no progress with the physician enterprise during the past year.

Many hospital and health system C-suite leaders and board members are asking about the size of their organizations' investments in physician practices and whether the physician enterprise is optimized to meet organizational goals, now and going forward (see Sidebar). The development and implementation of a clear rationale for the number of employed physicians in specific specialties and a thorough approach to improving efficiency and collaboration within the physician network would benefit hospitals and health systems.

For example, a thorough analysis of one organization's primary care enterprise suggested that, with improved operational and clinical efficiencies provided by non-physician providers, and as physicians increase their panel count capacity, costs would decrease by $8.6 million to $9.9 million in salaries and benefits savings alone.7

Questions to Ask Related to the Right Number of Physicians

Source: Kaufman, Hall & Associates, LLC.

- Which services are expected to grow, and which likely will shrink?
- Where is geographic growth or attrition expected?
- In which markets and with which services does the organization have a distinct competitive advantage?
- As community needs are identified and benefit assessed, might service lines in two health system hospitals be combined? Might some services be contracted to third-party providers or reduced?
- In which services can non-physician professionals increase the efficiency of delivered care, reducing the number of required physicians or extending physician panel size?
- What are the implications of call coverage and training requirements?
- What is the current mix of primary care physicians relative to specialists, and how will this mix change?

Cost-Transformation Progress

Less than one in five executives cited cost reductions of more than 5 percent in any priority area.

Top progress was achieved in supply chain and other non-labor costs.

64% of executives cited a reduction of 3 percent or more, with 17 percent of these citing a reduction of more than 5 percent.

Lowest progress was achieved in service rationalization.

61% of executives cited no progress in this area.

How much cost have organizations removed in specific areas during the past year?

<table>
<thead>
<tr>
<th>Area</th>
<th>No Progress</th>
<th>1-2% Reduction</th>
<th>3-5% Reduction</th>
<th>&gt;5% Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labor Cost/Productivity</td>
<td>27%</td>
<td>46%</td>
<td>21%</td>
<td>5%</td>
</tr>
<tr>
<td>Supply Chain and Other Non-Labor Cost</td>
<td>6%</td>
<td>30%</td>
<td>47%</td>
<td>17%</td>
</tr>
<tr>
<td>Overhead/Shared Service Synergies</td>
<td>32%</td>
<td>32%</td>
<td>23%</td>
<td>14%</td>
</tr>
<tr>
<td>Physician Enterprise Management</td>
<td>44%</td>
<td>28%</td>
<td>16%</td>
<td>12%</td>
</tr>
<tr>
<td>Service Line Efficiency</td>
<td>33%</td>
<td>44%</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>Service Rationalization</td>
<td>61%</td>
<td>22%</td>
<td>6%</td>
<td>11%</td>
</tr>
<tr>
<td>Clinical Workflow and/or Model Redesign</td>
<td>21%</td>
<td>47%</td>
<td>26%</td>
<td>5%</td>
</tr>
<tr>
<td>Clinical Workforce Redesign</td>
<td>20%</td>
<td>40%</td>
<td>35%</td>
<td>5%</td>
</tr>
<tr>
<td>Inappropriate Clinical Variation</td>
<td>46%</td>
<td>25%</td>
<td>17%</td>
<td>12%</td>
</tr>
</tbody>
</table>

Takeaway: The area where the highest proportion of executives cited no progress—service rationalization—has perhaps the greatest potential for transforming cost structure. Forward-thinking healthcare leaders are evaluating all aspects of their business in light of requirements for future success. They are concentrating resources in services that will result in long-term relevance and sustainability and consolidating or divesting services that are not expected to add value going forward.
Cost-Transformation Progress (continued)

Executives in many organizations cite zero progress in the hardest-to-achieve cost-transformation areas.

- 61% cite no progress with service rationalization.
- 46% cite no progress with reducing inappropriate clinical variation.
- 44% cite no progress with physician enterprise management.
- 33% cite no progress with service line efficiency.

Executives of organizations with more than 10 hospitals cited no progress more frequently that did executives of smaller hospitals:

- 60% for reduction of inappropriate clinical variation
- 57% for physician enterprise management
- 60% for service line efficiency

**Takeaway:** Many larger health systems appear not to be achieving progress toward the economies of scale available through physician enterprise management, service line efficiency, and reduction of inappropriate clinical variation. Mergers have occurred, but true operational synergies may not have been realized in many cases.
Cost-Transformation Progress (continued)

Numerous findings indicate some progress is being made.

Evidence of Progress

- Distribution of targets: 73 percent say improvement targets have been distributed across the organization, up from 53 percent last year.
- Accountability: 58 percent say their organizations have processes and structures in place to hold leaders accountable to performance for cost transformation goals, up from 46 percent last year.
- Clinical care: 56 percent say their organizations make effective use of clinical pathways, protocols, and guidelines to develop a common approach to treatment, up from 47 percent last year.
- Care delivery network: 49 percent say their care networks are efficient and aligned with the needs of served populations, up from 39 percent last year.
Cost-Transformation Progress (continued)

Other findings show lack of progress or movement in the wrong direction.

Lack of Progress or Movement in the Wrong Direction

- **Cost-reduction imperative:** 86 percent say cost transformation is a “significant” to “very significant” need for their organizations today, down from 96 percent last year.

- **Cost-improvement goal:** 32 percent indicate their organization have set no cost improvement goal, up from 25 percent last year.

- **Target setting:** 57 percent say improvement targets are set at the hospital level only and not at the vice president, service line, or department level, up from 35 percent last year.

- **Roadblocks:** 24 percent cite the lack of good data and insight into costs and where savings opportunities exist as the most significant impediment, about the same as last year (25 percent), when this was also the top-cited impediment.

- **Physician engagement:** 22 percent say their organizations have not engaged their physician enterprise in cost transformation (not a focus of last year’s survey).
Addressing Roadblocks

Top-cited impediments remain entrenched.

1. Lack of good data and insight into costs and where savings opportunities exist (24 percent)
2. Political sensitivities of savings opportunities prevent their pursuit (22 percent)
3. Difficulty maintaining focus and realizing savings opportunities once they are identified (18 percent)
4. Lack of understanding of the organization’s future financial needs to provide context for the cost-transformation effort (9 percent)
5. Inability to sustain improvements once savings are achieved (8 percent)
6. Inability to simultaneously monitor the many cost initiatives underway across the organization (6 percent)

*Results were consistent from 2017 to 2018.*

Other impediments cited by executives (13 percent) were:

- **Competition**, which requires using all people resources for new and expanded services
- **Bandwidth** to simultaneously achieve the many cost initiatives underway across the organization
- **Lack of a true partnership** to pursue cost transformation with the physician group’s leadership
- **Cost reduction not made a priority**
Addressing Roadblocks (continued)

Top-Cited Impediments to Achieving Cost-Transformation Goals

- We lack good data and insight into our costs and where savings opportunities exist: 24%
- Many savings opportunities are too politically sensitive to pursue: 22%
- We have trouble realizing savings opportunities once they are identified: 18%
- Other: 13%
- We lack a strong understanding of future financial needs to give cost transformation a context: 9%
- We are unable to sustain improvements once savings are achieved: 8%

Note: Respondents were asked to pick one of six listed impediments or to provide a “write in.”
The challenge related to absent or unreliable data, analytics, processes, and tools could account for the low cost-reduction goals set by organizations and limited progress toward achieving such goals. To succeed in reducing an organization’s cost structure, executives need a rich set of accurate data that gives them insight into their current costs and allows them to make informed decisions on how to reduce costs going forward. The data and analytics must extend beyond financials to include clinical and other operational data sets. Reporting of cost and profitability trends should be broad to support strategic decision making. Executives want to do more to leverage data and analytics to improve insights and decision making. Reliable cost data, analytic insights, decision making, and monitoring are required to transform costs in a sustainable way.

Executive Survey of Use of Data, Analytics, and Insights


- **90%** think their organizations should be doing more to leverage financial and operational data to inform strategic decisions.
- **95%** experience increasing pressure to have greater insight into how financial results impact business strategy.
- **48%** cite no or a very limited distribution and use of cost and profitability reports to support strategic decision making and influence financial and tactical planning.
- **58%** indicate that that these enablers are not available or don’t know whether they exist.

The reporting of cost and profitability trends is limited.

Data, tools, and processes for managing such initiatives as inappropriate clinical variation are lacking.
Addressing Roadblocks  
(continued)

Current cost-accounting systems lack credibility in a wide majority of organizations.

71% of executives do not have a high degree of confidence in the accuracy of results from their existing cost accounting solution.

Takeaway: A reliable cost-accounting tool is critical to cost transformation. Such a tool offers robust data and analytics, is integrated with the organization’s strategic-financial planning software, and delivers the right information in an actionable format.

Survey data indicate executives that have confidence in the accuracy of their cost accounting data are more likely to report progress in areas such as labor costs and clinical variation reduction.

Strategy 5. Use high-quality data, analytics, tools, and processes to drive improved decision making in clinical and business domains, and the tracking of improvement progress across transformation areas.
The State of Cost Transformation:
Strategic Considerations for Healthcare Organizations Going Forward
What Should the Cost-Reduction Goal Be?

Many leadership teams are asking this question. The answer varies by organization depending on factors such as current financial performance and cost structure, competitive position in the marketplace, payer mix, differentiated acute and non-acute offerings, physician enterprise and integrated networks, coordinated care models, strength of leadership and management teams, past progress with cost-reduction efforts, and data, analytics, and tools in place to drive cost improvement.

That being said, Kaufman Hall believes organizations should establish and work toward the goal of reaching Medicare breakeven, at a minimum. However, Medicare breakeven is only a good place to start, but likely not a sufficient long-range goal for cost restructuring for most organizations. Continuing to reduce costs by double digits will be needed by many hospitals and health systems.

Medicare breakeven: Sixty percent of executives say their organizations have set a goal of achieving revenue/expense breakeven with Medicare or believe their organizations should consider that goal. One executive noted the size and nature of the task: “We need to transform care delivery to be viable on a Medicare reimbursement platform.”


Notes: A margin is calculated as payments minus costs, divided by payments; margins are based on Medicare-allowable costs. Overall Medicare margin covers acute inpatient, outpatient, hospital-based skilled nursing facility (including swing beds), hospital-based home health, and inpatient psychiatric and rehabilitation services, plus graduate medical education and electronic health record incentive payments and payments for uncompensated care.
What Should the Cost-Reduction Goal Be? (continued)

As illustrated in the previous page, overall Medicare margins, released by the Medicare Payment Advisory Commission in March 2018, show that hospitals averaged a -9.6 percent margin in 2016, down from +5.5 percent in 2001. This means:

- A $2 billion healthcare organization with 50 percent of its mix in Medicare revenue, running at the national average of -9.6 percent loss on Medicare, would need an 8.8 percent reduction in costs to achieve Medicare breakeven.
- A $500 million healthcare organization with 55 percent of its mix in Medicare revenue, running at a 20 percent loss on Medicare, would need a 16.7 percent reduction in costs to achieve Medicare breakeven.

The sidebar provides details.

Given the importance of Medicare payment to hospital revenue, the goal of achieving Medicare breakeven is a “no-regret strategy.” Timeliness of data will continue to be a major challenge, so new sources for data and analytics will be helpful.

### Calculations for Getting to Medicare Breakeven

<table>
<thead>
<tr>
<th></th>
<th>$2 billion organization (50% Medicare)</th>
<th>$500 million organization (55% Medicare)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare payments</td>
<td>$1,000,000,000</td>
<td>$275,000,000</td>
</tr>
<tr>
<td>Costs</td>
<td>$1,096,000,000</td>
<td>$330,000,000</td>
</tr>
<tr>
<td>Margin</td>
<td>$(96,000,000)</td>
<td>$(55,000,000)</td>
</tr>
<tr>
<td>Margin %</td>
<td>-9.6%</td>
<td>-20%</td>
</tr>
<tr>
<td>Cost Reduction % to Breakeven</td>
<td>-8.8%</td>
<td>-16.7%</td>
</tr>
</tbody>
</table>
Moving to a Transformed Cost Structure

As noted in this report, core strategies for achieving transformative cost improvement include the following:

- Ensure all top disruptive forces facing the nation’s healthcare organizations are on leaders’ radar screens and driving cost transformation.
- Put in place the processes and structures required for cost transformation accountability, and hold leaders accountable for setting and achieving transformative goals:
  - Set specific and ambitious goals and distribute targets enterprise-wide
  - Put in place incentives for achieving cost-transformation targets
  - Hold leaders accountable for the achievement of performance-improvement goals
- Focus on initiatives that can truly yield transformative improvements: physician enterprise management; inappropriate clinical variation reduction; service rationalization; service line efficiency; and redesign of the clinical workflow/model and workforce.
- Use high-quality data, analytics, tools, and processes to drive improved decision making in clinical and business domains and the tracking of improvement progress across transformation areas:
  - Ensure access to information through broad report distribution and other approaches

To reconfigure their businesses for a much more cost-competitive future, healthcare leadership teams must ensure a “profound refocus” on lower-forever initiatives as well as traditional initiatives and their enablement through reliable data, analytics, processes, and tools. Lower-forever initiatives permanently remove or reshape capital-intensive structures, models, and processes. They do so by redesigning care, rationalizing/right-sizing services, and reducing unwarranted clinical variation to continually remove utilization from the system. Physician engagement is critical to these more transformative initiatives.

Leadership teams must be willing to tackle the more politically sensitive opportunities. The core strategies above require strong resolve, but they are necessary to truly bend the cost curve. If implemented correctly, organizations will begin to see the year-over-year benefit sustained over time.

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Lance Robinson is a Managing Director of Kaufman Hall and leader of the firm’s Performance Improvement practice, which includes individuals with deep expertise in labor, non-labor, productivity, supply chain, contracted services, overhead, clinical service mix, and revenue cycle management. Mr. Robinson works with hospitals and health systems nationwide to redefine the way healthcare leaders view performance improvement by providing data-driven insights and solutions for achieving widespread and sustainable results.

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About Kaufman Hall

Kaufman Hall provides management consulting and software to help organizations realize sustained success amid changing market conditions. Since 1985, Kaufman Hall has been a trusted advisor to boards and executive management teams, helping them incorporate proven methods into their strategic planning and financial management processes and quantify the financial impact of their plans and strategic decisions to consistently achieve their goals.

Kaufman Hall services use a rigorous, disciplined, and structured approach that is based on the principles of corporate finance. The breadth and integration of Kaufman Hall advisory services are unparalleled, encompassing strategy; financial and capital planning; cost transformation; treasury and capital markets management; and mergers, acquisitions, partnerships, and joint ventures.

Kaufman Hall software includes the Axiom Healthcare Suite, providing sophisticated, flexible performance management solutions that empower finance professionals to analyze results, model the future, and optimize organizational decision making. Solutions for long-range planning, budgeting and forecasting, performance reporting, capital planning, and cost accounting deliver decision support, reporting, and analytics within an integrated software platform. Kaufman Hall’s Peak Software empowers healthcare organizations with clinical benchmarks, data, and analytics to provide a higher quality of care for optimized performance and improved patient outcomes. kaufmanhall.com