Building Consumer-Driven Ambulatory Businesses

By David G. Anderson, PhD

Executive Summary

Ambulatory health care is growing rapidly. Hospitals and health systems grabbed an early lead in building ambulatory services because of their market prominence and favorable reimbursement. Few health systems, however, have demonstrated the ability to operate ambulatory services efficiently and effectively, and they are now facing stiff competition from independent, well capitalized ambulatory care companies, medical groups, and payers. Growing ambulatory services will require dealing with major internal barriers as well as external competition. To compete successfully, health systems need to:

1. Reorganize ambulatory services to give them greater stature and access to resources;
2. Enhance the ambulatory consumer experience;
3. Develop rigorous product costing and pricing models;
4. Take consumer marketing to a new level;
5. Develop a culture that supports and expects innovation;
6. Strengthen business development capabilities.

Success in growing ambulatory services will enable health systems to maintain or increase their share of total health care dollars and build core skills required to manage population health.

Background

While overall health expenditures have moderated, ambulatory services continue to grow at a healthy clip. Since 1995, hospital outpatient visits per 1000 have grown 1.5% per year, while inpatient admissions declined 0.6% per year. In that same period, overall ambulatory service revenues grew 6.2% per year, while inpatient revenues grew only 4.4% per year.[1]

The shift from inpatient to outpatient care has been a fifty-year trend, as shown in Figure 1.

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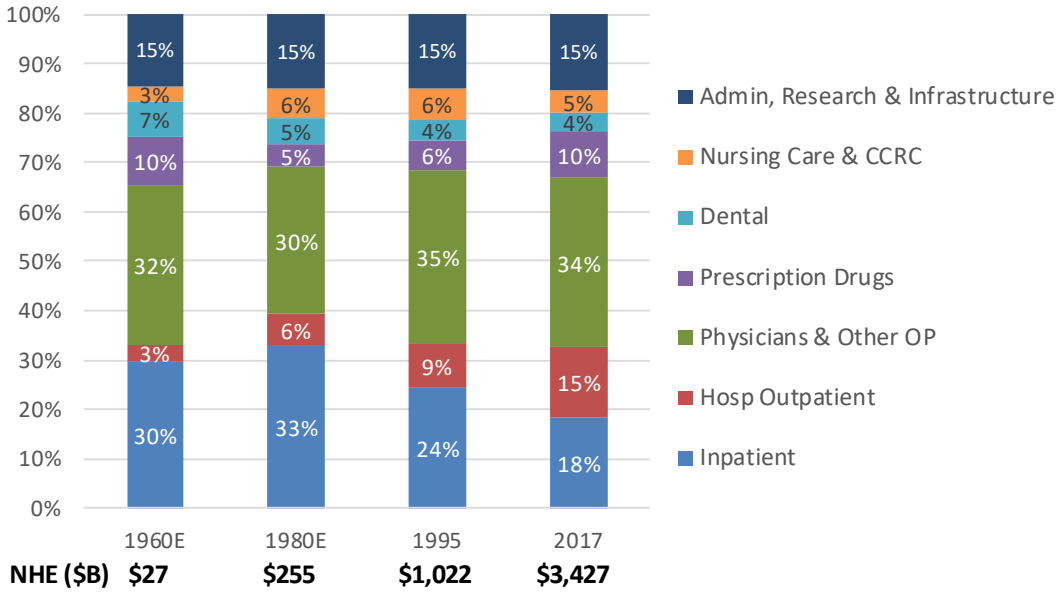
Figure 1. Estimated Composition of National Health Expenditures, 1960-2017

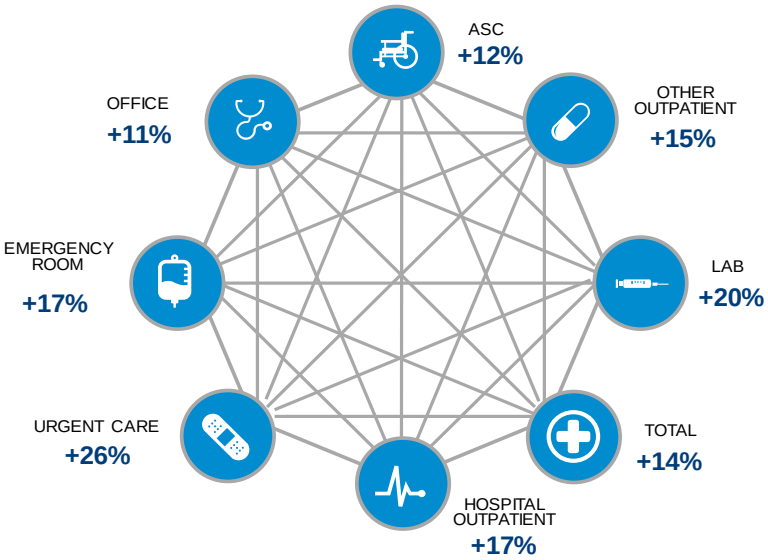


Source: CMS.gov National Health Expenditure Data; AHA Trendwatch / Chartbook, 2018; IAHC analysis.

Since 1980, the portion of health care expenditures spent on inpatient care has shrunk from 33% to 18%, while the portion spent on ambulatory services has grown from 36% to 49%.

Going forward, outpatient services are likely to grow even faster. The growth of digital medicine, coupled with population growth, aging, and expansion of Medicaid and health insurance exchange coverage, will fuel substantial growth in demand, particularly in ambulatory settings where consumers' preference for convenience has emerged as a major driver of where they select care. For one BDC Advisors client, Truven Health Analytics projected that outpatient procedures will grow 2.7% annually over the next five years, as shown in Figure 2.

Figure 2. Projected Outpatient Procedure Growth by Site of Service (2017 to 2022)



Source: Truven Annual Outpatient Procedures 2017 to 2022 for all Clinical Service Categories for a BDC Advisors client. Projections based on reform trended procedures, which assumes full continuation of ACA and current diagnosis and treatment trends.

So far, hospitals have maintained their share of total health care dollars by employing physicians and building outpatient services. For the average hospital, outpatient charges are on track to equal inpatient charges by 2020.[2] Several factors have contributed to their success: (1) motivation – a critical need to replace flat or declining inpatient revenues; (2) access to capital; (3) physician relationships, and (4) government and commercial subsidies.[3]

Health System Challenges

Markets for ambulatory services are significantly different than markets for inpatient care, as summarized in Figure 2.

Figure 2. Inpatient and Ambulatory Market Characteristics

	Inpatient Markets	*Ambulatory Markets*
• **Capital intensity**	High	Varies, but mostly low
• **Barriers to entry**	High	Low*
• **Market concentration**	High	Low*
• **Pricing**	Pricing based on cost, purchasing volume	Pricing based on competition, demand elasticity
• **Input labor markets**	Guild-like, unionized	Flexible, non-union
• **Product development**	Provider-driven, long life cycles	Consumer-driven, short life cycles
• **Government regulation**	Prime targets	Diffuse, difficult to regulate

* In metropolitan areas. Rural markets may be quite concentrated.

Inpatient markets are heavily intermediated, twentieth-century, provider-driven markets with relatively stable products and well-defined competitors. In contrast, ambulatory markets are dynamic twenty-first-century, consumer-driven markets with rapidly evolving products and chaotic, unpredictable competition.

Given these differences, it is not surprising that health systems have been challenged to operate ambulatory services efficiently and effectively. Typical errors health systems make include:

- *Locating ambulatory services adjacent to hospitals, rather than optimizing their locations for consumer access.* Hospital campuses may be convenient for physicians who want to go back and forth between inpatient and ambulatory activities (a shrinking group of doctors), but most are terribly inconvenient for consumers (crowded, confusing, parking problems, etc.) As every retailer knows, site location often makes the difference between a profitable and unprofitable outlet. Many health systems, however, adopt a "build it and they will come" approach to siting ambulatory services rather than providing the ease of access consumers expect.
- *Raising the cost of ambulatory services to inpatient levels.* The clearest example of this is applying inpatient staffing models to ambulatory services. One large health system purchased a chain of ambulatory centers and within a few months had replaced nurse practitioners with physicians because "margins on physician visits" were higher. At the same time, they also replaced the existing salary and

benefit structure with the hospital's higher salary and benefits for all the centers. Overall, these changes raised costs to uncompetitive levels and reduced EBITDA by 22%.

- *Imposing inpatient pricing methodologies on ambulatory services.* Inpatient prices are built up from rudimentary cost analysis and protected by high market concentration and barriers to entry. Most health systems use similar pricing methodologies for ambulatory services, and, as a result, most hospital-owned ambulatory services are overpriced, relative to competitors. Overhead allocation provides the clearest example: Health systems have large overhead structures that must be paid for, and internal pressure to allocate overhead equally across inpatient and outpatient activities is powerful. The fact that ambulatory services are competing with physicians and independent ambulatory providers with much lower overhead is underappreciated, if not ignored entirely.
- *Delivering sub-standard customer service.* For inpatient services, customer service is driven largely by the quality of interaction patients have with their providers. Because patients are sick and care is customized, patients are willing to put up with inefficient systems if they are treated by kind, understanding nurses and confidence-inspiring physicians. On the ambulatory side, however, customer service is much more system-driven. Efficient intake processes, timely appointments, and organized, knowledgeable office staffs are keys to exceeding customer expectations. Problems occur when inpatient customer service mores are imposed on ambulatory services. One well-known health system created a large, impersonal waiting room with more than 100 chairs for its ambulatory clinics and announced patient names over the PA system when doctors were ready to see them. This approach would embarrass departments of motor vehicles in most states.

Health systems' financial and organizational commitments to their inpatient business are significant obstacles to growing ambulatory businesses.[4] Most large health systems are organized geographically around their hospitals and still operate like *multi-hospital* systems, rather than true *health* systems. There are good reasons for this. Inpatient care requires larger capital investments and generates more revenue than ambulatory care. In addition, because inpatient care is so capital intensive, it poses greater risk for health systems. A drop in inpatient census catches everyone's attention because it can have drastic implications for system profitability.[5]

These economic realities translate into political clout within health system organizations. Chief Medical Officers, Chief Nursing Officers, and Chief Operating Officers spend most of their time managing the inpatient business. In teaching hospitals, most teaching occurs on inpatient units (although the Liaison Committee on Medical Education – LCME – is trying to change that). Management attention and capital investment are skewed significantly to the inpatient business. For health care executives, running ambulatory services is still viewed as a stepping stone to the real business of running hospitals. One large academic health system we worked with owned two tertiary care centers and six community hospitals distributed across a wide geography. Even though the system changed the title of its hospital CEOs to "market CEOs," two years later the CEOs were still career hospital CEOs, and they were still managing these markets as extensions of their hospitals.

Health systems have another disadvantage in building ambulatory businesses: conflicts of interest. For years, hospitals were cautious about building outpatient services because their main priorities were keeping their inpatient beds full and running outpatient services at high capacity to maintain profitability. Not surprisingly, this opened the door for physicians to build competing services, which they did extensively in the 1990s. An apochryphal story was related to us by one client's chief of gastroenterology who offered the hospital an opportunity to buy a 50% interest in an endoscopy center that he and his physician colleagues wanted to build. Hospital management declined, saying it was against their policy to JV outpatient services with physicians. The chief of gastroenterology said "OK," obtained financing, built the center, and moved all its outpatient endoscopy business out of the hospital, leaving the hospital with a half-empty, money-losing endoscopy lab.

Conflicts of interest that leave "empty spaces" in markets invite physicians and other competitors to compete in ambulatory care. Resistance to building ambulatory surgery centers that would compete with hospital outpatient surgery suites created a ready market for independent ambulatory surgery chains. Hospitals protecting their emergency department business created a market for independent urgent care centers. This pattern has played out in multiple specialties.

Another obstacle health systems must deal with is regulation surrounding their not-for-profit status. The capital required to develop new ambulatory ventures is most readily available from private capital markets. However, law and regulations limit how much for-profit business public charities can do. In addition, physician participation is critical to success in managing ambulatory services, and most physicians want to have equity in these activities. Regulations like the Stark Law and anti-kickback statutes make structuring joint ventured activities with private physicians more complex. On the other hand, there are ways around most of these regulatory obstacles if health systems are committed enough to find or invent them. For example, not-for-profit health systems can always set up independent for-profit companies that attract outside capital and provide distributions and other benefits to their not-for-profit investors.

Given their first-mover advantage, if health systems had been less inpatient-driven and more aggressive about building ambulatory care 20-30 years ago, they could have owned more of these markets outright. Now, however, even health systems that overcome these barriers will have a tough time staying in the driver's seat. Capital for building ambulatory services is plentiful. Physician relationships are dividing along inpatient and outpatient lines, and many doctors who aren't employed by hospitals are less dependent on them. CMS' new site-of-service regulations have reduced government subsidies and paved the way for private insurers to cut reimbursement for hospital outpatient services.[6] As a result, independent ambulatory companies are growing rapidly and beginning to dominate many product segments, as shown in the sidebar.

Insurance companies are also getting into the ambulatory care business by buying up physician practices. With the purchase of HealthCare Partners and other medical groups, UnitedHealth Group's Optum subsidiary has become the largest employer of physicians in the country. Even once-stodgy Blue Cross Blue Shield plans are buying up physician practices to gain control of health care costs.[7]

Health System Success Factors

To compete successfully in ambulatory care, health systems must break the chains anchoring their ambulatory business to their inpatient businesses. In addition to accelerating growth, there are other good reasons for this. Ambulatory services are closer to consumer experiences, which means building ambulatory businesses can give health systems a jump-start in becoming more consumer-driven, a goal for many. Also, delivering efficient ambulatory care is critical to population health management, since ambulatory services comprise almost half the health care $ [Figure 1]. It is difficult to imagine how health systems can "cross the crevasse" and manage population health unless they can provide consumer-driven, cost-effective ambulatory services.

But how do health systems create the focus, free up the resources, and guide the development of ambulatory services so they can compete and grow? Here are six key organizational steps they can take, each of which is discussed below:

1. Reorganize ambulatory services to give them greater stature and access to resources
2. Enhance the ambulatory consumer experience
3. Develop rigorous product costing and pricing models that learn from experience
4. Take consumer marketing to a new level

5. Develop a culture that supports and expects innovation
6. Strengthen business development to execute partnerships and alliances

Health system leaders need to take a careful look at their markets, assess their capabilities, decide on their goals for ambulatory care, and plan strategies and tactics to achieve them. As a quick self-diagnostic, CEOs, COOs, and CFOs should check their calendars to assess what portion of their time is spent developing these skills in their organizations.

1. Reorganize Ambulatory Services to Give Them Greater Stature and Access to Resources

The first step health systems should take to strengthen ambulatory care is to restructure their organizations to enhance the stature of ambulatory services and ambulatory leaders. One way to accomplish this is by creating a multi-divisional management structure, with separate ambulatory and inpatient divisions, that can insulate ambulatory care from the dominant inpatient business. This can be done at the individual hospital, system level, or both. As with any change in organization structure, unique factors will determine how this change is implemented in different health systems. But all will need to address some common design issues:

- *What relationship should ambulatory services have with employed physician groups?* Many health systems have developed separate organizations for their employed physicians because of differences in hospital and physician reimbursement systems. Integrating responsibility for ambulatory and physician services has some significant advantages: (1) It immediately enhances the stature of ambulatory services within the organization; (2) It gets physicians invested in making ambulatory care successful. Medical groups across the country have demonstrated the ability to manage ambulatory operations when given the opportunity (e.g., KP's Permanente Medical Groups).
- *Should the ambulatory organization manage only off-hospital-campus activities, or should it also manage selected campus-based ambulatory services?* Given most health systems' hospital-centric cultures, the idea of a hospital's ambulatory surgery center being managed by a separate ambulatory division is, of course, profoundly counter-cultural. Nevertheless, in some cases, placing an on-campus ASC or urgent care center under ambulatory leadership could result in a higher-performing center.
- *What role should the ambulatory organization play in managing population health?* BI Lahey Health, a new health system formed by the merger of BI Deaconess Health System and the Lahey Clinic, has appointed a new EVP and Chief Population Health Officer and given her line responsibility for managing the system's ACOs, behavioral health, and continuing care businesses, most of which are ambulatory.[8]
- *How should ambulatory organizations be organized internally?* Most large health systems organize hospital operations geographically. While this an option for ambulatory divisions (and linkages with local hospitals are crucial), different ambulatory services have vastly different economics, geographic reach, and product development strategies. Consideration should be given to organizing the ambulatory division by product lines – e.g., primary care clinics, surgicenters, cancer centers, eye centers, women's health clinics, multi-specialty "big box" ambulatory centers, etc. These ambulatory product lines can also be inked programmatically to inpatient service lines through "independent practice unit (IPU)" structures, as described in Section 3 below.[9]

Large health systems with hospitals scattered across broad geographies will have to manage the relationship between local market leaders (usually hospital CEOs, as in our academic health system example) and the ambulatory division. There are various ways this relationship can work effectively. The further away and the more isolated the market is, the stronger the argument for the local CEO to control both inpatient and

ambulatory care as part of the care continuum. The closer and more populous the market, the greater the potential for managing different ambulatory product lines separately as distinct system activities.

Reorganizing ambulatory and inpatient services is a necessary step, but it is not sufficient. The goal of restructuring is to allow the ambulatory business to develop its own operating systems, staff, and cultural values that reflect the market requirements shown in Figure 2. This is true organizational transformation, and not only does it require sustained commitment from top leaders, but it also needs the support of the health system's governing board. This can be a tough sell, since board members of not-for-profit health systems usually identify with the hospital, not a sprawling, diverse network of ambulatory centers. Failure to educate the board, however, can easily set up management for failure when margins shrink or inpatient investments must be deferred.

2. Enhance the Ambulatory Consumer Experience

Ambulatory markets are highly competitive, and whenever consumers have choices, *access* and *convenience* are important decision criteria. No matter how knowledgeable and understanding hospital clinicians and administrators are, hospitals are simply too complex and intense to provide exemplary customer service.[10] But ambulatory care is less complex, and, as a result, consumers have higher expectations. Health systems that are serious about building ambulatory care must invest resources building an exceptional customer experience function. This starts with a patient-centered call center and an easy-to-navigate, highly functional web site. Penn Medicine, University of Pennsylvania's health system, created two video vignettes of a patient-centered call center interaction that captures management's aspirations for their customer experience.[11]

Most health systems underinvest in core customer service functions, which puts them at a disadvantage in ambulatory markets. One medical school that has placed consumers squarely at the center of ambulatory care delivery is the new Dell Medical School at The University of Texas in Austin.[12] Dell's Design Institute for Health designed its specialty clinic space around Integrated Practice Units (IPUs), interdisciplinary team-based structures responsible for the full cycle of care for defined medical conditions. In addition to providing space for interaction between IPU team members, Dell's specialty clinics were designed to place the patient in the center of the clinic experience by:

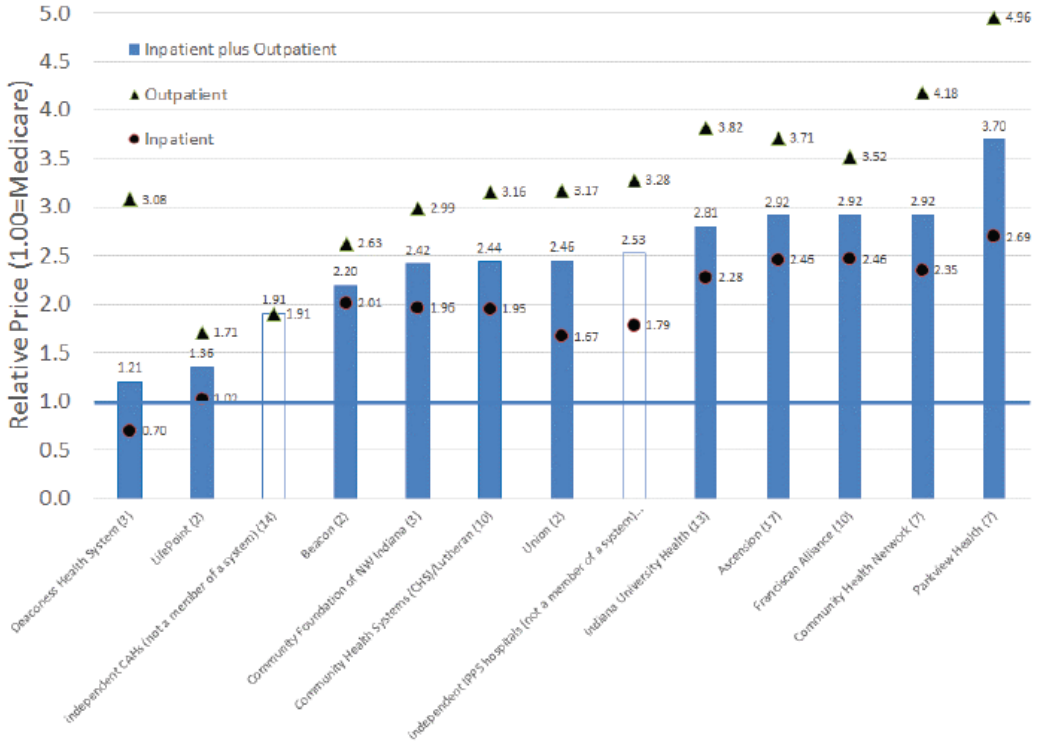
- Assigning care rooms to patients for the duration of their stay and rotating specialists and other clinicians through these rooms, rather than moving patients around to different providers' exam rooms or waiting areas.
- Organizing as many interactions with multiple providers as possible for patient visits. (This maximizes efficiency for the patient by reducing multiple trips, similar to the way the Mayo Clinic in Rochester and the Cleveland Clinic organize patient visits for out-of-town patients.)
- Eliminating waiting rooms and letting patients who are not seeing providers in their care rooms choose where to spend their time.

Health systems should also consider developing segment-specific customer service strategies, tied to segment marketing. Medicare consumers, for example, have common service needs that health systems can help address. Unlike commercial patients who can get advice from corporate benefits departments, Medicare patients are often confused by the web of insurance coverages they participate in and need help understanding their coverages and financial responsibilities. Most health systems today provide little help beyond impersonal and vaguely threatening telephone calls with business office staff.

3. Develop Rigorous Product Costing and Pricing Models

As consumers bear more and more of the cost of ambulatory services through higher co-pays and deductibles, pricing of ambulatory services is becoming more important. Most health systems, however, consider prices and costs to be under the purview of the finance department, and marketing is not even invited to the party. This results in pricing of ambulatory services which can be way out of line. Figure 3 shows results from an analysis conducted by the RAND Corporation for a coalition of Indiana employers representing about 225,000 covered lives, who were concerned about the prices they were paying Indiana hospitals for services. "Relative Prices" are the actual payments by health plans and patients (including co-pays and deductibles) for specific hospital services relative to what Medicare paid for the same services. As this chart shows, most hospitals priced outpatient services between 200% and 500% of Medicare, while most priced inpatient services closer to 200% of Medicare. This pattern reflects a CFO-centric view of pricing: Use market leverage to get the highest prices you can and be willing to give away some margin on stable or declining inpatient business if you can recoup it on growing outpatient business. This negotiating pattern is common in many health care markets, and the strategy has worked so far, but its days are numbered.

Figure 3. Relative Prices of Indiana Hospital Groups, 2016[13]



For most consumer services companies, pricing is a complex strategic undertaking involving activities like:

- Understanding average and marginal product costs
- Determining price elasticity for core consumer segments
- Analyzing competitive prices and pricing strategies
- Developing predictive models of consumer behavior, revenue yield, and profitability
- Testing and refining predictive models based on experience

Consumer product and service companies invest heavily in these strategic pricing activities.[14] Health systems that are serious about ambulatory care need to view pricing as a critical element of the marketing mix and develop the tools and capabilities they need to understand the needs of consumers at least as well as the payers they are negotiating with.

It goes without saying that successful product pricing depends on understanding product costs – certainly your own, and preferably also your competitors'. Fortunately, because ambulatory care is much simpler than inpatient care, it is much easier to understand the true costs of ambulatory services. This doesn't mean that most health systems make it easy, however. Because ambulatory care has been so closely tied to inpatient care, many health systems have used the same costing approaches – e.g., "ratio-of-costs-to-charges – RCC"- based costing. Few systems understand the actual average and marginal costs of their ambulatory services.[15] Because of this, most ambulatory divisions will have to build their understanding of the true cost of ambulatory encounters from the ground up.

In addition to developing "retail" and "wholesale" pricing strategies for key ambulatory services, health systems need to develop discounting and rebate policies. Both are widespread in consumer products marketing, and both have an important role to play in pricing ambulatory services. Advanced imaging, for example is a service that is often discounted based on up-front payments, same-day appointments (when capacity is available), and for self-pay patients, whose price elasticity is greater. Web-based companies in Los Angeles and San Francisco broker same-day MRI appointments at multiple centers at significantly discounted prices to fill unused capacity.[16] Some health systems have tried offering time-of-day discounts on high-cost procedures to spread out demand and increase equipment utilization, and while these have not all been successful, it seems likely that some discounting formula exists that can achieve this goal.

Competitive factors should also be factored into pricing decisions for ambulatory services. If you know that a medical group or ambulatory company is planning on building a center in your market, you may want to sacrifice some margin and reduce prices to get them to think about building elsewhere. If hospitals had taken this approach thirty years ago, they might have retained more of this business for themselves.

4. Take Consumer Marketing to a New Level

By now, almost all health systems' marketing functions reach out beyond their own patients to consumers they don't now serve but could target in the future. However, few have attained the level of sophistication needed to stand out in crowded, chaotic ambulatory markets. Since ambulatory services are inherently more consumer-driven, health systems that are serious about building ambulatory services need robust consumer marketing functions. This includes, at a minimum:

- *Strong market analysis and research capabilities* to define key market segments, determine how consumers in these different segments make health care decisions, and identify the sources of customer value, including the transient value of fashions. Specialized healthcare analytic companies like evariant, OptumIQ, and Simplify Compliance have evolved to support more sophisticated consumer marketing. A strong market research function is also critical for assessing the impact of marketing efforts and initiatives, so that health systems can learn from experience, promote successful approaches, and restructure or eliminate underperforming ones.
- *Digital marketing.* Because almost all health care services have both physical and informational components, call centers, web sites, and social media are crucial to marketing these services effectively. One highly specialized pediatric service provided by Children's Hospital of Philadelphia attracts over one-third of its patients through its web site.

- *Service line marketing* that integrates the "4Ps" of the marketing mix[17] for key ambulatory services. While ambulatory product lines are not identical to inpatient service lines, many are closely related and can be linked through IPU organization structures.[18] For example, distributed eye clinics and/or eye surgery centers may be linked with a hospital's ophthalmology service line. Baskin Palmer Eye Institute at the University of Miami, which *US News* rates as the #1 eye center in the nation, epitomizes the synergies this type of relationship can produce. Similarly, inpatient GI service lines can be linked with endoscopy centers, and cardiovascular service lines can be linked with outpatient cardiac diagnostic or rehab centers, as long as the "links" aren't so strong that the inpatient service lines drive the ambulatory businesses.
- *Segment marketing* that reaches out with segment-specific product variations, promotion, pricing for ambulatory services for seniors, families, or other groups with specific sociographic profiles. Understanding how different segments make tradeoffs is critical to product design and pricing decisions and can provide a window on transient fashions that can create significant opportunities to capture share. Social media are also important vehicles for reaching deep into specific segments.
- *Brand marketing* to build consumer awareness and help extend health systems' "platform" presence.[19] Scale is critical to capturing consumers' "share of mind" in today's information-rich, short-attention-span environment.

5. Develop a Culture That Supports and Expects Innovation

New product development is much more important to success in ambulatory markets than inpatient markets for many reasons: (1) Ambulatory markets are larger and much more diverse; (2) They are more consumer-driven and thus subject to changing consumers tastes; (3) Most ambulatory products are less capital-intensive, which encourages new entrants; and (4) Product life cycles are shorter. While innovations in inpatient services are usually driven by long-term technology trends (e.g., PTCI, joint replacement) or regulation (e.g., CMS incentives to reduce readmission rates), innovations in ambulatory services are driven by consumer need and can come from anywhere. For this reason, health systems serious about growing ambulatory services need internal product development resources who can scan the environment for high-potential innovations, evaluate them, pilot them as appropriate, and plan their development and implementation.

Developing successful new ambulatory products is not just a matter of adding a few people with ambulatory experience and product development skills. It requires investment of time and capital and a level of risk-taking that is uncommon for inpatient-centric health systems. In other words, it requires a significant shift in cultural values to encourage innovation in traditionally risk-averse organizations.[20] Recognition of this is critical. Cultures don't change without leadership, and health system leaders must step up and support these activities aggressively or they will be overwhelmed by tradition, vested interests, and constrained resources. At the same time, health systems must also develop the disciplines required to make judicious new product investment decisions. They have to be willing to terminate pilots that aren't delivering sufficient value and scale up ventures that need to grow.

Fortunately, over the past few years many health systems have made substantial investments in venture investing, which has given them a window on this world.[21] Experienced venture teams, such as those at Kaiser Permanente, Ascension Health, the Mayo Clinic, UPMC, the Cleveland Clinic, and other health systems are the closest models we have for building product development teams that can succeed in the diverse, chaotic world of ambulatory care.

6. Strengthen Business Development Capabilities

Ambulatory care is an entrepreneurial world full of partnerships, joint ventures, affiliations, and alliances. There are many reasons for this: partnerships are needed to surmount skill deficiencies, fill in service gaps, burnish credentials, build scale, preempt competition, accelerate growth, and many other reasons. Your ultimate goal should be turning your health system into a "platform" that others will invest in and organize around. [22]

To succeed in this world, health systems need ambulatory leaders who are themselves entrepreneurs. They also need effective systems for identifying the need for potential partners, seeking them out, structuring partnerships to deliver "win-win" outcomes, assessing partnership performance, and restructuring them as conditions change.

Since physicians are the experts in delivering care, most of these partnerships need to involve physicians, and physicians often prefer to be equity partners in these arrangements.[23] Health systems that are serious about building ambulatory care must therefore be adept at structuring deals with physician entrepreneurs.[24] This requires building a capable internal business development function with finance, consulting, project management, and legal resources, as well as rich external relations with leading community physicians, entrepreneurs, and investors. As with new product development, the most fertile source of these business development skills may be in health systems' venture investing units, for systems that have them.

Building all these capabilities internally is a tall order for any health system. One alternative to internal development is acquisition. Few not-for-profit health systems, however, have flexible enough missions, access to sufficient capital, and the management skills needed to acquire large ambulatory players and grow them successfully. Dignity Health (now merged with Catholic Health Initiatives in CommonSpirit Health) acquired U.S. HealthWorks, an operator of occupational health and urgent care centers, in 2012, owned it for five years, and then sold it in 2017 to Concentra, a division of Select Medical Holdings, for cash and stock.[25] Around the same time period, Dignity also bought a majority interest in SimonMed Imaging, a chain of outpatient imaging centers, but these companies parted ways in 2017, too.[26] During the time they owned U.S. HealthWorks, Dignity had at least one opportunity to grow the business substantially, but management wasn't willing to make the "big bet" capital investment required to make this happen.

In today's hot ambulatory market, a more productive strategy for health systems may be collaborating with companies that have already demonstrated success in "coopetitive" – cooperative and competitive – relationships.[27] United Surgical Partners International ("USPI"), the country's largest ambulatory surgery company and now a division of Tenet, has developed joint ventures with health systems across the country. GoHealth, an urgent care company backed by Texas Pacific Group, has developed joint ventures in urgent care with Dignity Health in California, Legacy Health in Portland, Northwell Health in Long Island, and Mercy in St. Louis, among others.[28] Joint ventures with insurance companies are also possible: Blue Cross Blue Shield of Minnesota just announced a joint venture with North Memorial Health to build a network of 20 primary care clinics in the Twin Cities.[29]

One health system that has made a major commitment to building ambulatory care is MemorialCare, an integrated Southern California health system with separate hospital and physician divisions, a Medi-Cal health plan, seven different ACOs, and risk relationships with several health plans and large employers. Their experience is described in the sidebar.

Manage the Continuum or Build Ambulatory Care?

Ironically, health systems' vision of delivering integrated care may be an obstacle to building ambulatory services. The integrated care vision underlies Great Britain's National Health Service and has been an important rationale for consolidation and growth of not-for-profit health systems. Over the years, health systems pursuing this vision have been called "health maintenance organizations," "integrated delivery systems," "accountable health partnerships" (Clinton-era health reform), and "accountable care organizations" aimed at "managing population health" (Obama-era reform). The integrated care vision has not changed. Key features of this vision include financial responsibility for all medical costs, centralized clinical information (via EHRs today), unified care protocols and guidelines, seamless and consistent patient experience, and a distinctive system-wide brand.[30]

While this vision has been successful for Kaiser Permanente, Geisinger, a few other health systems, and some medical groups with experience taking global capitation, it has proved elusive for most.[31] Nonetheless, many health systems with no immediate desire to take risk are consolidating to pursue an "integrated care – light" vision called "managing the continuum of care." This vertically integrated vision has also been challenging. Systems that have attempted to own the continuum of care have discovered that many parts of the continuum are not very profitable and/or that they are not well suited to running them efficiently. Systems that have pursued loose affiliations with independent players along the continuum have discovered that these relationships are only as strong as the value they produce today and can go away tomorrow.[32] And systems that have consolidated without integrating have often raised the cost of care.[33]

At its core, the continuum of care vision treats ambulatory care as a means to an end. The end may be filling hospital beds via "hub and spoke" referral arrangements or managing population health, but either way, this vision devalues the pursuit of ambulatory businesses for their own sake and can divert them from doing what it takes to succeed in these consumer-oriented, entrepreneurial markets.

Ambulatory markets demand products that create value and seize transient advantage. An inevitable side effect of building focused ambulatory businesses may be greater fragmentation than exists within Kaiser Permanente, Geisinger, the Veterans Health Administration, or Great Britain's National Health Service. But the broader market may be fragmenting, anyway. Some new national physician practices, for example, have developed their own EHRs because the major health system EHR vendors aren't attuned to their needs and/or cost too much.[34]

Will fragmentation in ambulatory markets raise health care costs? Or will it stimulate innovation that improves quality and service and reduces cost? Historically, innovation and entrepreneurship in health care have focused more on improving quality (which generates revenue) than on reducing cost. But, that is not true in other industries where true consumer-driven price competition exists – e.g., airlines, autos, telecommunications, oil and gas. Process innovations in these industries have had dramatic effects on cost. If we can stimulate competition and make reducing prices and costs essential to gaining share, there is every reason to believe we will generate many more ambulatory innovations like vaccines and telehealth that reduce health care costs while improving quality of care. Health systems that lead the way could find themselves in the enviable position of being platforms for investment by others…unless Amazon beats them to it, which they apparently intend to try to do.[35]

Sidebar: Selected Ambulatory Competitors

Types of Companies	Examples
Ambulatory care providers	• USPI (ambulatory surgery) – now owned by Tenet • Da Vita, Fresenius (dialysis) • GoHealth (urgent care) – owned by Texas Pacific Group • Twentieth Century Oncology (cancer centers) • CVS Health, Walgreen's, Walmart (in-store clinics) • Heal (house calls and telephonic visits)
National and regional medical groups	• OptumCare (multi-specialty care, mid-level & nursing care) • One Medical (primary care) • Parsley Health (primary care) • VillageMD (multi-specialty care) • US Oncology (cancer) • Mednax (pediatrics, neonatology, anesthesiology, radiology) • VitalMD (Florida-based multi-specialty group founded by the "Femwell" OB/GYN group)
Disease management companies	• Omada Health (diabetes, hypertension) • Ginger.io (behavioral health) • Thirty Madison (male pattern baldness, branded as "Keeps")
Health tech "solution" providers	• SnapMD, American Well (telemedicine) • Medtronic, iRhythm (cardiac monitoring) • Connected Home Living (home care monitoring) • MD Revolution (chronic care monitoring) • HyperMed Imaging (remote imaging) • Apple mHealth, Samsung, Garmin (wearables)

Sidebar: MemorialCare's Ambulatory Joint Ventures

Over the past decade or so, MemorialCare of Los Angeles and Orange counties in Southern California has implemented joint ventures with a number of independent ambulatory companies, including RadNet (outpatient imaging), Surgical Care Affiliates (SCA), now part of Optum (ambulatory surgi-centers), and Fresenius (outpatient dialysis). The health system is currently negotiating a JV with an independent physical therapy provider and is considering moving into other outpatient services (e.g., outpatient infusion centers). MemorialCare's JV with RadNet combined 10 of its own outpatient imaging centers with 25 RadNet centers and consolidated two, resulting in a network of 33 centers today. The MemorialCare / SCA ambulatory surgicenter model shares ownership between local physicians, MemorialCare, and SCA, with MemorialCare owning the "majority of the majority" – i.e., about 26% of each center.

Overall, MemorialCare now has over 200 ambulatory centers, many of which are joint ventures, and the proportion of health system revenues attributable to its physician and ambulatory divisions (excluding hospital-based outpatient services) has grown from 3% in 2011 to 27% today. All its JV partnerships are exclusive in their geographies, so competitors cannot duplicate them with the same partners.

According to Barry Arbuckle, MemorialCare's CEO, replacing hospital-based outpatient business with joint-ventured non-provider-based ambulatory business has reduced annual health system net income by $30 million. Nonetheless, the joint venture strategy is a key component of the health system's commitment to move aggressively into value-based contracts. Besides cutting health care costs for patients, employers, and insurers (the primary beneficiaries to date), this approach has several strategic advantages for MemorialCare:

- It makes the health system much less vulnerable to Medicare's "site neutral" payment rules and "location management" by commercial payers. This is important, since in Southern California both Anthem and United HealthCare pay for advanced imaging in hospital-based facilities rather than lower-priced community-based facilities only when patients have a clinical reason to be there.
- It improves MemorialCare's performance on risk-sharing contracts. Currently, 60-65% of revenue from its hospitals, 90% from its physician division, and 30% from its ambulatory division are subject to risk-sharing.
- It attracts referrals from capitated medical groups and IPAs, which control a significant amount of health care business in Southern California. One particular IPA, Monarch, is owned by Optum, creating additional impetus to shift volume to the surgicenters they own jointly with MemorialCare.

Unlike many other health systems, MemorialCare has chosen ***not*** to brand their ambulatory JVs, in order to reduce the risk of driving off business from competing systems.

Early on in implementing MemorialCare's ambulatory JV strategy, Arbuckle was concerned about how rating agencies would react to the investments required and their impact on system operating margin. So far, however, the agencies have fully understood and supported the strategy, and MemorialCare's ambulatory market share is increasing as hoped. As a result, the health system has been able to maintain its AA- rating.

References

[1] CMS National Health Expenditures; 2018 AHA Chartbook; IAHC analysis.

[2] 2018 AHA Chartbook; IAHC analysis.

[3] CMS has subsidized hospital outpatient services for many years through "provider-based" technical reimbursement that is not available to physicians. In addition, when outpatient procedures were a relatively small part of health care expenses, many commercial health plans also paid hospitals higher rates than community-based centers, assuming that ambulatory procedures performed at a hospital were more complex than those performed by physicians in the community.

[4] There are some exceptions. Kaiser Permanente, Geisinger, and HealthPartners of Minneapolis, are members of a small set of fully integrated health systems. KP, the largest, is organized by regions that include health plans, hospitals, and medical groups. For KP, revenue is top-line premium revenue, and hospitals cost centers, and medical groups are delivery partners and cost centers.

[5] For health systems that own health plans, financial risk on the health plan side can be even greater than for inpatient care, as some health systems have discovered. In order to manage this risk, large health systems like Intermountain Healthcare, Henry Ford Health System, Sentara Healthcare, and Providence St. Joseph Health operate their plans mostly independently of their hospital networks and hire experienced health plan executives to lead them. While this approach limits potential synergies they could achieve by "managing to a single bottom line," it has been effective in containing financial risk on the plan side, as long as the plans are big enough. The performance of provider-sponsored health plans, however, is another matter. A recent RWJ Foundation report found that the vast majority of provider-sponsored plans lose money for their owners: See A. Baumgarten, "Analysis of Integrated Delivery Systems and New Provider-Sponsored Health Plans," RWJ Foundation, June 2017, https://www.rwjf.org/en/library/research/2017/06/analysis-of-integrated-delivery-systems-and-new-provider-sponsor.html.

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[7] S. Livingston, "Texas Blues insurer to open primary-care clinics," *Modern Healthcare*, April 8, 2019. https://www.modernhealthcare.com/care-delivery/texas-blues-insurer-open-primary-care-clinics .

[8] J. Bartlett, "Beth Israel Lahey Health announces new organization for five-hospital merger, *Boston Business Journal*, Jan. 18, 2019, https://www.bizjournals.com/boston/news/2019/01/18/beth-israel-lahey-ealth-announces-new-organization.html.

[9] M.E. Porter & T.H. Lee, "Why strategy matters now," *New England Journal of Medicine, 372* (April 30, 2015), 1681-1684.

[10] Some get close. The Mayo Clinic and the Cleveland Clinic are often cited for their convenience as well as their excellent care. But customer experience is still very challenging. See M. Solomon, "Customer Service in Healthcare," Interview with Dr. James Merlino of Press Ganey, *Forbes*, May 11, 2017. https://www.forbes.com/sites/micahsolomon/2017/05/11/delivering-customer-service-in-healthcare-patient-satisfaction-and-the-patient-experience/#1d156bc23a7b .

[11] See https://www.youtube.com/watch?v=XLIJKQT27DM and https://www.youtube.com/watch?v=3QnlxatX8Zg .

[12] S. Chang, "Nobody wants a waiting room," *NEJM Catalyst*, February 6, 2019, https://catalyst.nejm.org/nobody-wants-waiting-room/ .

[13] C. White, "Hospital prices in Indiana: Findings from an employer-led transparency initiative," Santa Monica: RAND Corporation, 2017. https://www.rand.org/pubs/research_reports/RR2106.html .

[14] For a provocative example of the emphasis one consumer services company places on pricing, see American Airlines' position description for Yield Management / Pricing Analysts: https://www.linkedin.com/jobs2/view/12436487 [downloaded 3/31/15, but still relevant].

[15] The realization that understanding true costs is important has led to a resurgence in interest in "activity-based costing - ABC". HealthCatalyst recently published a case study of its work with UPMC to improve UPMC's understanding of product costs (https://www.healthcatalyst.com/success_stories/activity-based-costing-in-healthcare-service-lines-upmc). UPMC used ABC mostly to identify ways to reduce clinical variation and average costs, but knowing true costs is critically important in pricing ambulatory services.

[16] www.bestpricemri.com and www.affordablescan.com, respectively

[17] 4Ps: Product, Place, Price, Promotion

[18] M.E. Porter & T. H. Lee, *op cit.*

[19] D. Michelson, Strata Decision Technology *op.cit.*

[20] Innovative cultures also have a strategic side – the pursuit of what Rita Gunther McGrath calls "transient advantage." Achieving transient advantage requires bringing new business initiatives to scale rapidly, managing short life cycles to maximize near-term benefit, and unsentimentally "disengaging" when life cycles start trending down. See S. Weylandt & D.G. Anderson," Launching 1,000 ships? Time to refocus your strategy on creating value," *hfm Magazine*, March, 2016, and R.G. McGrath, *The end of competitive advantage: How to keep your strategy moving as fast as your business*, Boston: Harvard Business Review Press, 2013.

[21] See D.G. Anderson, M.J. Potter & D.E. Morris,, *op cit*.

[22] D. Michelson, Strata Decision Technology, "The No. 1 takeaway from the 2019 J.P. Morgan Healthcare Conference: It's the platform, stupid," Becker's Hospital Review, ASC Communications, 2019. https://www.beckershospitalreview.com/hospital-management-administration/the-no-1-takeaway-from-the-2019-jp-morgan-healthcare-conference-it-s-the-platform-stupid.html .

[23] This could change as more physicians are employed by health systems and available to be assigned to business development roles. However, with the ready availability of venture capital, it is hard to imagine institutionalized product development displacing entrepreneurial physicians pursuing their own dreams as owners of ambulatory care ventures.

[24] As discussed above, this can be tricky for not-for-profit health systems, given current regulatory restrictions.

[25] Dignity Health earned a sizable return on its investment in U.S. HealthWorks. See C. Rauber, "Dignity Health's acquisition of U.S. HealthWorks Quietly Closes," *SF Business Times*, August 15, 2012; Concentra, "Definitive agreement to combine Concentra and U.S. HealthWorks," October 23, 2017, https://www.concentra.com/resource-center/press-releases/definitive-agreement-to-combine-concentra-and-us-healthworks/

[26] American Bankers Association, "Dignity Health Taxable Bond Offering of October 7, 2014,"p. A-5; CourtListener, "SimonMed Imaging v. Dignity Healthcare Inc: Joint stipulation and order for dismissal with prejudice," April 19, 2018.

[27] Over the past 5-10 years, more and more health systems have been investing in many of these ambulatory spaces through internal venture funds and activities. See D.G. Anderson, M.J. Potter & D.E. Morris, "Improving Performance & Enhancing Investment with Venture Investing," HFMA online journal, March, 2018.

[28] M. Evans, "Private-equity backed urgent-care developer taps Dignity Health for California expansion," *Modern Healthcare*, February 9, 2016.

[29] P. Minemyer, "Blue Cross Blue Shield of Minnesota, North Memorial Health launch joint primary care venture," *FierceHealthcare*, June 26, 2019, https://www.fiercehealthcare.com/payer/blue-cross-and-blue-shield-minnesota-north-memorial-health-launch-joint-primary-care-venture .

[30] A recent summary of this perspective can be found in J. Goldsmith, "What a 'Health System' Is and Isn't," HBR Digital Article, January 24, 2019. https://hbr.org/2019/01/what-a-health-systm-is-and-isnt/

[31] Given the Affordable Care Act's focus on accountable care and population health, and the efforts CMS and some private insurers have made to shift risk to providers, one might think that at-risk or capitated top line revenue is driving health system decision-making. So far, however, few health systems have built up significant books of risk business. With growing incentives to take risk and significant investments in structures and tools to manage risk, this will probably change. For now, though, fee-for-service, and especially inpatient care, still drives most health system decision-making. Some provider groups have, in fact backed away from taking risk. One leading West coast medical group that was about 50% capitated for professional fees in the mid-1990s is now 90% fee-for-service again because they found it was more profitable.

[32] Interestingly, HCA and Tenet, the two largest for-profit health systems, have focused more on running profitable hospitals than on managing the continuum of care.

[33] As Austin Frakt recently pointed out, citing research by Martin Gaynor and others, the evidence so far indicates that health system consolidation raises costs and lowers quality. See A. Frakt, "Hospital mergers improve health? Evidence shows the opposite," *The New York Times*, Feb 11, 2019.

[34] Even insurance companies are getting into the EHR business. UnitedHealthcare has also announced plans to launch its own EHR by the end of 2019. See E. Sweeney, "UnitedHealth plans to roll out a new EHR offering for consumers and providers by the end of 2019," *FierceHealthcare Online Journal*, Oct 16, 2018. https://www.fiercehealthcare.com/tech/unitedhealth-plans-to-roll-out-a-new-ehr-offering-for-consumers-and-providers.

Fortunately, new connectivity approaches such as FHIR are also emerging that enable diverse EHRs to exchange low-level clinical and transactional information, potentially mitigating some effects of fragmentation.

[35] See Haven's web site: https://havenhealthcare.com/