Reform Readiness

Healthcare reform has become such an overused term that healthcare leaders are almost numbed by it. It encompasses so many changes—from the way healthcare is paid for to how it’s accessed—that it calls into question almost everything leaders think they know about how to best run a hospital, health system, or physician group practice. The term also references a multi-year change, so leaders are doing the best they can to break down strategies necessary to survive and thrive under new rules into more easily digestible steps. In October, we held a roundtable with some of the industry’s top strategists to discuss findings in the latest HealthLeaders Media survey on reform readiness and to come up with several sharable insights into how to frame and enact many of the strategies that will ensure survival in the turbulent environment to come.
HEALTHLEADERS: Many are predicting that funding for the Patient Protection and Affordable Care Act will be short or that parts of the law will be repealed. How does that affect how you prepare?

PETER BRUMLEVE: Regardless of whether it gets repealed or funded, private market forces will still act in trying to fix the fundamental issues in healthcare. So we look at the act as a stalking horse for what we eventually have to do as a system. We’re a large group practice that has hospitals and clinics, and we have roughly a thousand salaried physicians. Our single biggest granular concern is about the cuts in Medicare payments to physicians surrounding the sustainable growth rate formula.

HEALTHLEADERS: What about issues with the congressional debt commission? Are you preparing as though it will fail to find enough savings, thereby instituting automatic cuts across the federal budget?

ANNETTE WALKER: We’ve had some discussions about whether or not automatic cuts would be less painful than if they actually implement specific cuts. As Peter alluded to, we are very concerned about automatic cuts in physician reimbursement. But the primary discussion we’re having around reimbursement is how we prepare to survive on current Medicare rates. The reductions are significant enough that it’s a most pressing issue. When we saw the world was changing well over a year ago, we started working on solutions to these types of challenges.

MARTY MANNING: Our best-case scenario as an industry might be if the [congressional] debt commission failed because we would then presumably only be subject to the same kinds of across-the-board cuts that everybody else would be. The real problem is on the utilization side. So we’re very much looking at the ACO models as the way to get back some of the savings that would be otherwise taken out by drops in utilization.

BRUMLEVE: While we break even or even make a little bit of margin on Medicare today, any cuts are a game-changer because we’re right on the line now. Also, in Texas, we just took an immediate 8% cut on Medicaid, so we’re going to be running out of room. And of course the private payers are unwilling to continue to subsidize. Then you add some estimates that 30% of employers are going to be dropping healthcare and giving vouchers to their employees to go into the exchanges and they’re getting out of the healthcare business. We get all that.

WALKER: Those big game-changers are going to be seismic alterations to the landscape. We’ve been through Medicare cuts before, but not accompanied by such significant decreases in the commercial market.

HEALTHLEADERS: What contingency planning can you make for those issues?

BRUMLEVE: We’re not worried about quality or transparency because that’s what we should do anyway on the patient’s behalf. But in terms of the reimbursement rates coming down, we think we can continue to blunt that through our essentiality in our local market. There really is no way that a commercial payer who wants to continue to be in the business can market health insurance to employers or individuals without us in the network. But it doesn’t mean the pressures aren’t constant and real in terms of, well, Medicare did it, so we’re going to do it. So in fact, we’re trying to entice some of the commercials to enact some of the metrics in terms of quality and volume and bundled payments and payment for episodes of care.

HEALTHLEADERS: What’s your sense about employers and whether they will be dropping coverage in order to force people into the exchanges?

MANNING: It’s a little murky yet what the reaction will actually be. The groups that go to the exchanges first are the small employers and individuals, and that’s even harder to get a pulse on because there’s so many of them. But in our discussions with payers, getting ready for the exchanges is a big motivator for them. One of the things we’re trying to do is shift the terms of the debate and how they even look at the problem, from one focusing exclusively on unit costs to a focus on total cost per member per year. The way payers and employers purchase the product today is still based on a discount-from-charges mentality wherein a deeper discount is
better, but there’s not a lot of sophistication yet in looking at the total care that they are buying. So we’re trying to move our payers in that direction.

**WALKER:** In California, we’ve seen rapid movement to narrower networks, which is the precursor to exchanges. Payers are moving to narrow networks to get a more reasonably priced product. Very quickly, large numbers of patients are moving into exclusive, narrow networks and, although our organization has been successful in getting into some, you can’t be in all of them. We’re also rapidly engineering ourselves to be able to participate in the exchanges. It’s a struggle. If price is the determinant of how patients access you, it doesn’t matter how exceptional your care is. And if you fail to make yourself accessible to your community because you’re too expensive, how are we really meeting our mission?

**HEALTHLEADERS:** Sounds like we’re talking about accountability. So let’s talk about ACOs. What are some of the forces that are acting upon you in that regard?

**MANNING:** We’ve already entered into a shared savings or ACO-like arrangement with our largest payer. ACO is a politically loaded term, so we try to finesse that a little. We now have 215,000 attributed PPO lives through that contract, plus about 150,000 at full risk—commercially insured HMO patients—so we’re getting to the critical mass necessary to transform the way we organize the delivery of care and get paid for it. It’s about a fourth of our total business, maybe a little more. But to this point about living in the two worlds, we’re going to be doing something like this with our own employees starting January 1. Foundationally, we will have one approach to the care delivery model. So it doesn’t really matter which specific contracts plug into that model—there may be slightly different rules about attribution or the percent of shared savings, but it’s the core infrastructure that we’re focused on developing now.

**WALKER:** We know we need a structure different from what we have now. It will be a transformative—not incremental—change, with the objective of creating something much more efficient, with less waste in the system. We’re more interested in the commercial ACO market, and there’s a lot of activity putting deals together with different insurers. Our concern is how the insurers are going to translate the savings into premium rate reductions. The market will adjust in the long run, but in the short run we’ll experience the reductions with little benefit on the employer or patient side.

**BRUMLEVE:** We think we have an additional advantage in that we have our own health plan component to help administer all of this stuff. You really have to consolidate providers in order to do it, and it becomes a particularly unique problem in rural areas, which we cover a lot. Receiving preapprovals from the [Federal Trade Commission] and [Department of Justice] is obviously a concern for us. So it would be glib or cavalier to say that we’ve got this figured out. It would be a gross overstatement even for an organization that’s highly integrated like ours.

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It should be something that focuses on outcomes and gives healthcare providers a real opportunity to realize their mission of caring for the community. Ultimately, when we will maximize the value of what we provide to patients, we will have led a critically important transformation.

HEALTHLEADERS: What are the missing pieces to your respective ACO strategies?

BRUMLEVE: We feel like we pretty much have all the pieces already—everything from wellness programs to outpatient, acute, and postacute settings and home health. But looking at the Medicaid population, that’s going to require completely different models, as we’ve all identified. We’re working much more closely now with [Federally Qualified Health Centers], partially because they’re the darlings of reimbursement. And those are delicate situations because FQHCs are allowed to not just take care of what they were purposed to do, but now they can take any and all commercial payer contracts and actually compete for and deliver care to patients that we would like to have come to us. We try to work cooperatively with them. The point is, we are all going to create new collaborations.

WALKER: Historically, the hospital business has been great at building hospitals. Now, we obviously need to make some other investments. It’s a hard mind-set to shift from the hospital mentality to the continuum mentality, but we’re making that change. We’re going to find a different way to use the assets that we have and maximize their capacity, because I think probably every hospital has excess capacity, whether it’s space or expensive equipment. We’re clearly beginning to make decisions differently on any future capital investments. New partnerships are also important, such as flowing patients through skilled nursing in ways we haven’t done before. There are new relationships, too, with community and healthcare sectors that really aren’t yet on the radar. Also, we have to look at the IT support that’s going to better facilitate moving information with the patient. As other organizations are going to look toward us as part of a partnership, IT will be probably one of the first things on the table.

MANNING: The game now is not about managing silos; it’s about managing the transitions of care. It’s a whole paradigm shift. With skilled nursing, for example, we’re going through an RFP process to determine our preferred partners. We’ve actually been pleasantly surprised by the responsiveness of these skilled nursing facilities and their willingness to come to the table and share their quality data and talk about improving medical management.

WALKER: We have expertise that skilled nursing facilities and others have never been able to afford. As a community partner, we can help them with these needs.

BRUMLEVE: Even in a system like ours where we own everything, we’re going through a full portfolio analysis, which we’ve never done. We’re well aware of a couple of things. There is so much cash out there and investors in niches who do some things better than we do. We’re now looking for ways to monetize some assets from a balance sheet perspective and, where appropriate, sell some of those assets off to strategic partners who actually know...
how to provide specific services better. That is, as long as they can integrate with our medical record, use our brand appropriately—all the performance criteria that you would rely on in any strategic partnership.

MANNING: Even if you are not integrated financially, the model of care we are developing is actually more integrated clinically, because right now the care delivery system has a lot of silos that don’t talk to each other.

WALKER: We’re the consolidators and the integrators.

BRUMLEVE: Some systems, even in the billion, billion-and-a-half [revenue] range, are going to become part of something bigger. Watching the leadership in some organizations go through that turmoil, particularly with long, proud histories in their markets, is going to be tumultuous to say the least.

HEALTHLEADERS: Does that make you nervous, to offload care processes, given that the accountability goes to you?

BRUMLEVE: Yes. Performance and use of our brand are two of the things we will be concerned about. And a third is obvious: Potentially offloading some of the human capital, not just the buildings, in a system that has so much heritage in the markets that it operates in would not be a fun thing to do.

WALKER: I see us as the quarterbacks of these systems of care. Most likely, these systems will have our names on them. But there’s another variable in the market that I find interesting. For instance, when the insurance company is buying the physician groups, do the payers become the quarterbacks? What dynamic is that going to create in the market and how will it change relationships?

BRUMLEVE: The biggest fear from a strategic and a margin perspective is that the entire category, not to mention our organization, does become commoditized. Insurance is already a commodity. So when providers become part of insurance entities, it’s still an insurance entity. And I think it’d be tragic from my personal point of view to see providers, physicians, hospitals, and everything else included become so commoditized that the only point of differentiation is price. So I think even with quality metrics and everything else, as marketers and as stewards of the brand for the next generation in these organizations we run, the question is, how do you best position and differentiate yourself if the consuming public is really just looking at price?

MANNING: I’ve been observing the acquisitions of practices by insurance companies. I think this will be a short-lived phenomenon. The direction we need to go is pushing care down to mid-level providers, doing things with telemedicine, using technologies, engaging patients through benefit design and self-management and education.

WALKER: I understand the model, but I’m not sure it will work in this circumstance. Particularly, will physician providers find it satisfying to be under the insurance umbrella, as opposed to the provider umbrella?

HEALTHLEADERS: Back more generally to reform, our survey shows that many would like to repeal parts of PPACA.

But at this point, with many large organizations trying to change based on the guidelines in this law, is planning already too far along?

WALKER: This law was a catalyst that set into motion irreversible trends in the market that are not going to reverse, no matter what the government does. It could be repealed today, and this train isn’t going to stop. There are aspects of our healthcare system that need to be refined and improved. For instance, the financing mechanism is pretty frail at best. Regarding the individual mandate, there’s really very little incentive to have or maintain insurance. But we should be focusing on how to make it work, not how to repeal it, because the present system is undeniably ripe for change.

MANNING: The things that are going to really make it work and drive out the excess utilization will be coming out of the [Center for Medicare and Medicaid Innovation]. We’re just starting to see that now, so it’s almost premature to comment on that definitively.

BRUMLEVE: I concur. I think the train has left the station. As I said earlier, I think even if this thing were to be repealed in its entirety, the private market forces are already working on it. However, there are clearly aspects that should be significantly changed, refined, or repealed that I think they’re worthy of note. One that’s already been identified is that the financial penalties for employers or individuals who opt out of insurance are clearly not weighted correctly. Another is the independent payment advisory board. As a 501(c)(3),
we could not take—and did not take—a position on repeal or passage of this act, but clearly we think the independent payment advisory board is fundamentally flawed.

WALKER: The large influx of new patients on a broken system is concerning because it’s doubtful whether the infrastructure can support this influx without having fixed utilization, outcomes, and value equations. The potential exists to exacerbate the situation by driving up costs further because we haven’t got those elements in place yet.

MANNING: To underscore that last point, the law is very heavily consumer-focused, and there is little in it about benefit design change or patient responsibility because that’s a political third rail. That’s really the missing piece. And it’s still basically an open checkbook to get whatever service you want on demand wherever you want it.

WALKER: Yes. There’s not enough skin in the game. I’ve always thought that HMOs did a great disservice to this country by making everybody think every service should be $10. People developed a mentality of entitlement that grew under HMOs. There are still not clear incentives for keeping yourself healthy. Everybody just gets an across-the-board higher premium. Employers are starting to provide some personal incentives, which is positive, but we still have a long way to go.

BRUMLEVE: There’s another huge issue that needs to be addressed. As an academic medical center, we have the same three-part mission as any academic medical center: to provide outstanding clinical care, research, and education. The lack of real attention in the act to bringing along the next generation of doctors and other providers is simply stunning. Even if we could find 30% waste in the U.S. healthcare system, the baby boom is coming on like a freight train. We are not dealing with physician or other provider supply in an effective fashion in this act. A reduction in [Indirect Medical Education] funding through Medicare to an organization where more than half the residency slots are already fully funded by us will be extremely challenging.

WALKER: Healthcare has looming human resource issues. The students want to get into the universities to train, but the programs don’t have capacity. Those in school aren’t being trained to meet the needs of the future. And at the hospitals, we aren’t being efficient enough to maximize the capacity of our personnel right now. Compound this situation with the problem of clinical work force age demographics, and it’s a perfect storm.

BRUMLEVE: Our take on it as we watch our most senior physicians retire is that it takes 1.5 to 1.6 new physicians to fill in that void just from a work habit perspective.

MANNING: The other issue is that there are a lot of small private practices. While the employed groups are growing, a lot of the smaller practices are just not backfilling—creating their successors. They’re just going to go away.

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