# Perspective

# HEALTH CARE REFORM:

## Don't wait for the Specifics; the Fundamentals are Clear Enough

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As the "clouds" of health reform gather on the horizon, providers, community hospitals and physicians ponder and debate the impending specifics. The argument here is the specifics are relatively less important; the fundamentals appear sufficiently clear, straight forward and are enumerated here. The more important issue is the potential for related delivery-side mandates; i.e., "under the most likely reform model(s), how must community health systems and physicians prepare?" The underlying assumption here is that the more traditional and conventional models of community health services delivery, the independent medical staff and community health system models to be specific, will be challenged by economics and reimbursement models deriving from a reforming U.S. health care environment.

**The Likely Fundamentals of Reform**

While no one can prescribe with certainty (at least not now) the specifics of health care reform, the "most likely" characteristics are, however, discernable:

1. **Reimbursement Experimentation:** Payment for services from third parties will take a range of forms departing from the "pay for piece-work" traditions. Payments will be bundled and packaged. They will carry contingencies based upon performance. Future financial risk will be transferred to organized providers and services available for immediate downward price pressures will be identified for reductions; e.g., imaging services, ambulatory procedures and pharmaceuticals. The question here is not "will funds flow to providers" but rather, are providers organized to accept funds flow by new models and methods? How does a community hospital and 250 physicians in independent practice access and distribute packaged, bundled or risk-based payments?

2. **Specialty Revenue Stream Exposures:** Independent specialty medical groups are at-risk for focused reimbursement reduction strategies—especially from the governmental payers. Specialty medical practices that rely upon a very few clinical services to fund physician incomes (such as ambulatory procedures, lab and imaging diagnostics) are vulnerable to reimbursement reductions resulting from payer strategies that reorganize the opportunities to reduce payments for specific clinical services. Sufficient margins on these pressured services will be available only to high volume players with economies and scale potential.

3. **Risk Transfer to the End-User:** If more out-of-pocket risk exposure is transferred to the end-user (the patient), they become price and value shoppers. "Consumerism" takes hold. This is the likely case under any reform models that allow for "portability" of coverages or if employers rejigger incentives to shift risk to curtail the employee benefits inflation rate pressures; inflation pressures that, to a significant degree, wrecked the U.S. auto industry.

4. **Requirements of Care Practice; Quality and Value through Electronic Access:** Here accountability is demonstrated by way of sophisticated results analyses made available to the "customer" by way of electronic reporting, e.g., the ability to demonstrate care effectiveness for 10,000 diabetics, 2,000 heart failure patients and 1,500 child and adolescent asthmatics. "Value shoppers" (including payers) will demand reporting of results for acute and chronic illness management.

5. **The End of Cross-Subsidization(?):** Payers are aware of the strategies of community health systems to subsidize the costs of community services missions (and competition) with the margins on a small handful of clinical service lines. The question payers and policy makers ask (or should ask) is "to what extent should payments for specific clinical conditions disproportionately carry the costs for self-stylized missions and competitive strategies of private, not-for-profit community health care systems?" Health system financial performance is especially vulnerable here.

6. **Evidence-Based Clinical Interventions:** Private physicians and community hospitals, for the most part, are not held to evidence-based standards of care. Said otherwise, they're paid for care and care practices that may not pass muster if presented before a qualified group of peers. While many in the professions would debate and challenge rigid applications of evidence-based standards of care on grounds of specific patient "need" and clinician judgement, the realities of unexplained geographic variation in care practices argues for evidence-based payment as one facet of any universal reform plan. Who wants universal coverage for inefficient and unnecessary clinical practices?

**So, How Might the Reform Fundamentals of Health Care Affect (and challenge) Our "System" of Health Care Delivery in the U.S.?**

1. The small private medical practices (and perhaps the larger as well) experience daunting challenges to their business and economic models; physician incomes are exposed. The "price" of independent practice goes up; physicians who value independence above all else will experience challenging practice economics ahead.

2. The Autonomy of the Professions is challenged; at least, autonomy that allows any style of practice with expectation of payment by any and all who underwrite healthcare costs.

3. Demonstrative and transparent value as an essential requirement of a viable, enduring business model. The customer demands an available and transparent ongoing "resume" of results and costs. The customer becomes a more sophisticated shopper. They'll demand answers to cost, access, quality and value related questions.

4. The financing of broad, community missions by a very few "marginable" clinical service lines is significantly curtailed; the margins on heart surgeries are no longer sufficient to fund uncompensated community care, mission-based negative margin programs, or expensive, competitive market strategies.

5. Access to affordable capital becomes restricted to the strongest balance sheets tied to organizations with the greatest potential for business model viability into the future.

6. Scale and scalability become a requirement of doing business; especially for an asset base exposed to compressed depreciation curves (i.e., acceleration of technology obsolescence and innovations). If more of the population is "covered" in a reformed environment, but payment "per unit" of service is reduced, then improved operating economics from volumes and scale become an essential operating requirement. Scale interacts with reductions in process variation to enhance operating and financial results.

7. The need for division of labor, subspecialization and labor leverage become pronounced. The prevailing clinical care and business models must display

organizational design characteristics that facilitate concepts of operations and management that are mundane among industries outside health care. The economics of the business models must support such characteristics to their highest levels of performance. Effective process management becomes essential.

8. Organizational culture, attitude and operating systems must embrace the active consumer at the most fundamental levels; e.g. the person ordering the MRI should know the charge; or, at least, the services price list is published along with the organization's track record with the services it sells. Primary care physicians may need to become health economics advisers to their patients, especially if out-of-pocket payment levels rise, answering such questions as "how do I best spend my $5,000 deductible this year?"

**The Most Likely Effects and Delivery Model Reform**

If the U.S. healthcare marketplace responds rationally to the pressures at hand, the most likely supply-side response to demand-side driven reform is accelerating consolidation resulting in the founding of fewer, larger, integrated health systems with the integrated models of care hospitals and physicians operating from unified clinical care and business models[(1)]. These models are designed to accept payments in any form[(2)] and present a unified and efficient asset base and balance sheet to access capital from debt and equity markets[(3)]. Competition between and among providers within the model is eliminated (or at least minimized). All operate from a common information systems platform (including a common electronic health record) and integrated business strategies are more easily and effectively devised and executed[(4)].

Governance and management designs adapt accordingly.[(5)] Physicians integrated with the health system serve as directors alongside qualified community members. Capital is accessed by traditional and non-traditional methods, including "off balance sheet" methods and models. Health system trustees become more discerning regarding community missions and related costs.

[1] Zismer, D.K., Integrated Health System Design; If you're Heading There, It's Best to Have a Map; Boardroom Press, The Governance Institute, Vol. 20, No. 4, August 2009.

[2] Zismer, D.K., Person, P.E., McCullough, J., Renier, C., Knutson, D.; Integrated Health System Economics: Are Specialty Physician Services Revenues Reliable Predictors of Community Health System Financial Performance? Physician Executive, Vol. 35, Issue 3, May/June 2009.

[2] Zismer, D.K., Person, P.E., McCullough; Integrated Health System Economics: Understanding the Revenue Drivers in Fully Integrated Community Helath Systems, Physician Executive, Vol. 35, Issue 3, May/June 2009.

[3] Cain Bros; Farewell to a Time of Plenty: Health Plan Strategies for Growth in a More Challenging Market, White Paper, Strategies in Capital Finance, February 2008.

**Summary**

If healthcare provider markets behave at all rationally in an environment of reform, wholesale change in the clinical and business models is inevitable. The risk is change comes too late for some providers and health systems. What does "too late" mean? In this context, too late means one or all of the following: the organization doesn't have sufficient balance sheet capacity to afford provider-side integration, the essential elements are no longer available (e.g., the right physicians, especially). Competitors have won the race to the best opportunities and/or the best "customers" have moved on to the better organized provider systems.

Why would savvy health care leaders wait too long? They're waiting for too much clarity, too many specifics, too much detail to point them in the right direction. They may be missing the forest for the trees. The forest is sending a strong message:

- The U.S. annual healthcare cost inflation rate is unaffordable now.
- The fractious nature of the delivery model(s) cannot afford the capital and operating inefficiencies they yield.
- The independent medical practice model is at risk.
- Despite U.S. per capita, healthcare spending is at over twice the rate of other industrialized countries. We rank far down the list on many, if not most, key health status measures.
- Congress questions whether tax breaks for not-for-profit community health providers should continue.
- Credit markets are less sanguine regarding the financial productivity of community health systems.[(6)]
- Two-thirds of our economy is driven by small business. This large segment simply can't afford annualized, double-digit, healthcare cost inflation rates. Health coverages for employees are reduced or eliminated.

So, while some argue that we just don't know enough about what health care reform looks like, others are making educated wagers on the future; betting that in markets where demand-side pressures accelerate, the supply side looks to consolidation, scale, capital efficiency, smart allocations of labor and increasing leverage on the "manufacturing" model.

[4] Zismer, D.K., Person, P.E.; Aggarwal, R., Finding Economic Leverage in the Fully Integrated Health System Model, Group Practice Journal, May 2009, Vol.58, No.5.

[5] Zismer, D.K., Will the Invisible Hand Work in U.S. Healthcare? A Challenge to non-profit Boards"; E-Briefings, The Governance Institute, June 2009.

[5] Brueggemann, J.G., Zismer, D.K., Physician Autonomy in Integrated Health Systems, Group Practice Journal, October 2008, Volume 57, No. 9.

[6] Understanding Hospital-Physician Alignment, Corporate Finance, Fitch Ratings, Oct. 2007

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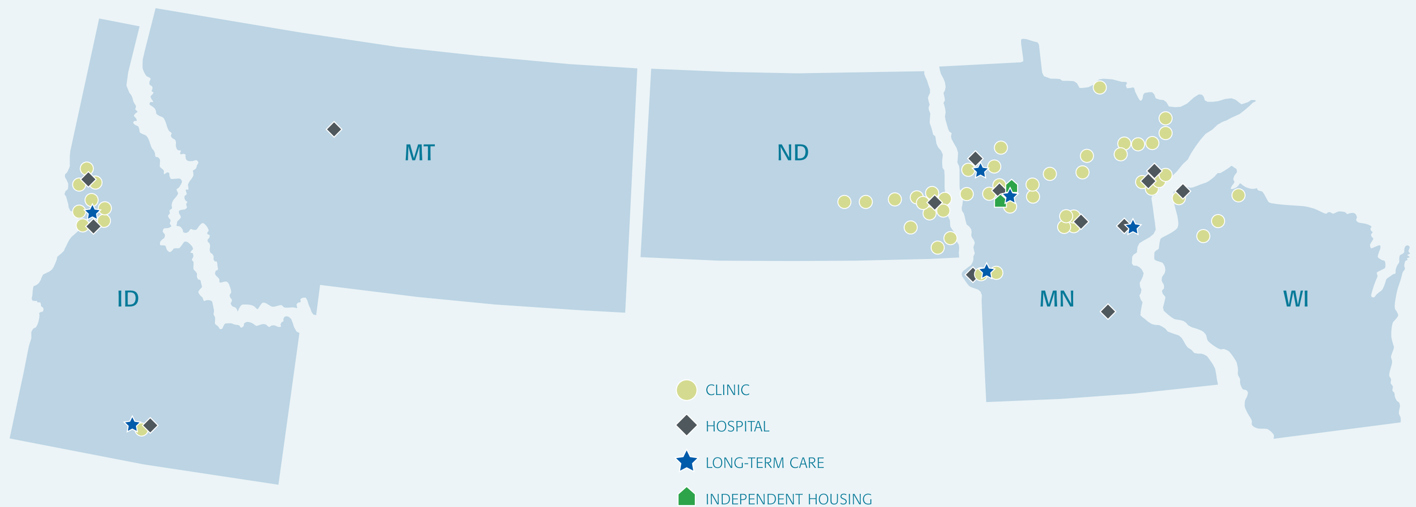


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