

Changing Economics in an Era of Healthcare Reform

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As health systems prepare for healthcare reform, they are focusing significant resources on developing accountable care organizations and medical homes and on preparing for bundled payments and population-based reimbursement. However, current economic trends combined with an analysis of the impact of key healthcare reform initiatives will require health systems to take significant cost out of their systems to maintain positive financial performance. Few organizations have the culture or the expertise to implement a cost-reduction effort of this magnitude.

THESE ARE THE GOOD OLD DAYS (FOR COST SHIFTING)

Since the late 1980s the hospital industry has subsidized losses from Medicare and Medicaid by demanding premium rates from commercial payers. In 2008, the hospital industry's aggregate payment-to-cost ratio from Medicare was 90.9 percent; from Medicaid, 88.7 percent; and from commercial payers, 128.3 percent (AHA 2010). The impact of cost shifting will be diminished as a result of the new healthcare reform law, the aging of the population, continued compression of government and private reimbursement, and increased patient responsibility. This change will require most health systems to reduce their current operating cost structures by 10 to 15 percent.

CHANGE IN PAYER MIX

Over the next five years there will be a significant shift in health plan enrollment. Fewer people will be covered by highly profitable private health plans, while more people will join deficit-generating government-sponsored plans. Expanded coverage for the uninsured will not be sufficient to mitigate the negative impact of this shift. CMS estimates that by 2016, as a result of the Patient Protection and Affordable Care Act (PPACA) and the aging of the population, the number of beneficiaries covered by relatively high-margin private insurance will decline by approximately nine million. These profitable patients will be lost to government-sponsored plans with non-negotiable provider rates (i.e., Medicare, Medicaid, exchanges). The financial benefit of providing coverage for the 25.3 million uninsured, most of whom will receive government-funded insurance, will not be sufficient to offset the deleterious effects of the shift away from commercial health plans (Foster 2010).

DECLINING MEDICARE AND MEDICAID MARGINS

Future payment increases from Medicare and Medicaid will not keep pace with the historical trend in hospital cost inflation. This will further suppress the margin contribution from government-funded reimbursement, raising the cost-shifting

hurdle for private insurance. In their 2010 *Report to Congress*, MedPAC acknowledged that since 1996, hospital margins from Medicare have declined by approximately 1 percent per year (MedPAC 2010). Their data show that the average hospital lost 7.2 cents of every dollar of care provided to Medicare patients in 2008. (Note: MedPAC's methodology is different from AHA's.) Even before the \$155 billion hospital payment reduction through PPACA, MedPAC expressed its intention to force hospitals to operate more efficiently by continuing to provide updates to hospitals at rates that are significantly below cost inflation. MedPAC believes that it is possible to provide quality care and break even on Medicare:

Medicare margins are low and are expected to remain negative... however... a set of hospitals has been able to maintain relatively low costs, while maintaining relatively high quality of care. Roughly half of these providers are [currently] generating a profit on their Medicare business (MedPAC 2010).

With respect to Medicaid, the Kaiser Family Foundation reports that for fiscal year 2010, 33 states restricted hospital payment rates: 14 states froze rates and 19 states reduced rates. For FY 2011, 17 states plan rate freezes and 13 states plan cuts (Smith et al. 2010).

LIMITED ABILITY TO COST SHIFT

As patients are forced to pay a greater percentage of their healthcare costs, higher provider charges will result in increased bad debt and lower utilization rather than increased income. The fastest growing component of bad debt in hospitals is unpaid copayments and deductibles from patients with insurance (Pellathy and Singhal 2010). One health system featured by Pellathy and Singhal reported that their unpaid balance for patients with insurance was growing by 30 percent per year, much faster than bad debt from patients without insurance.

Enrollment in high deductible employer-sponsored health plans climbed from 9 percent in 2009 to 11 percent in 2010. Low-income families with high deductibles are more likely to "delay or indefinitely postpone medical procedures" (Steenhuysen 2010). The increase in patient financial responsibility and the poor economy have contributed to the year-over-year decline in physician visits (Stagg Elliott 2010) and an unprecedented decline in admissions to not-for-profit hospitals (Goldstein 2010).

DOWNWARD PRESSURE ON PROVIDER RATES

The healthcare reform environment has not been kind to private insurance companies. A number of states have enacted or are preparing legislation to enable their insurance commissioners to block or reduce proposed premium increases. In addition, PPACA gives the secretary of Health and Human Services the authority to regulate excessive rate increases. Last year in Massachusetts, when proposed rates of increase in private insurance premiums were rejected by the Department of Insurance, the insurance companies proposed freezing or reducing payments to hospitals and large physician groups (Kowalczyk 2010).

THE COST OF PHYSICIAN INTEGRATION

The mad dash toward the development of accountable care organizations (ACOs) will only exacerbate the cost issues in most health systems. The infrastructure costs associated with forming and operating a high-functioning ACO are significant, and return on this investment is uncertain at best. PPACA stipulates that ACOs will be rewarded for improving quality *and* reducing cost. The majority of these cost reductions will come from reductions in the volume of specialty consultations, high-end procedures, and hospital admissions. There is no evidence that the health system's "shared savings" payments from its ACO efforts will offset the infrastructure costs, the loss in volume and revenue, or the political capital being invested in this effort.

SAME ACTION, SAME RESULTS

Many health systems continue to operate as though cost-shifting will remain a viable strategy in the long term. Their primary focus is fiddling with ACOs as their organizations begin to bend under the stress of flat to declining revenues. A new, radically intense focus on the cost of care is essential if a health system is going to succeed in the future. Getting in shape for 2016 will require health systems to do the following:

1. Define efficiency targets and stick to them. Leadership is critical for setting the course.
2. Engage physicians and hospital staff in discussions about the need to significantly reduce the cost of care.
3. Hold all members of the organization (including medical directors) accountable for maintaining non-negotiable, performance-based cost budgets based on industry best practices and for attracting profitable growth in their service lines.
4. Develop a plan to reduce the cost structure of the organization to break even on Medicare rates. (Note: Private payers will continue to pay at rates above Medicare, but the ability to absorb declining Medicare margins through cost shifting will be limited.)
5. Rationalize your portfolio of services and facilities, eliminating duplication and divesting services that generate deficits the organization can no longer afford to absorb.
6. Workforce reductions will not generate sufficient savings. Employ established redesign methods such as Lean to eliminate waste and unnecessary variability of care.
7. Use objective critical analyses to ensure optimal performance of IT, revenue cycle, supply chain, and clinical documentation systems. This usually requires an audit by an independent third party.
8. Using physician leaders, create a culture within the employed physician group that is aligned with the objectives of the health system.
9. Begin a process of true clinical integration with your physicians, focusing on the basics of redesigning the delivery of care, but don't try to be an ACO by 2012.

Most health systems will not be ready by 2012. The only thing worse than not having an ACO is operating an ACO that fails to achieve desired results. Eventually every health system will be held accountable for their cost and quality on a per episode or per capita basis, but most current models of clinical integration involving retrospective review will not be sufficient. Becoming an effective clinically integrated organization will take time, discipline, and ultimately a cultural change among members of the medical staff. Critical success criteria for clinically integrated delivery systems include the following:

- a. Physicians in critical specialties must participate and be willing to standardize their clinical practices based on the best science.
- b. All providers must be able to share an EHR that includes hardwired point-of-care protocols.
- c. Primary care capacity must be sufficient, using extenders as the first line of care.
- d. Engaged physician champions must drive the process.
- e. A programmatic approach to chronic diseases such as diabetes and chronic heart failure must be taken.
- f. Hospitalists, intensivists, and other key physicians must be trained in the latest care delivery techniques and evaluated based on cost, quality, and service metrics.
- g. Physicians who do not meet key cost and quality metrics must be sanctioned.
- h. The infrastructure must be able to manage the delivery system, monitor metrics, and report outcomes.

The healthcare delivery system will not change overnight. Organizations that begin repositioning today can phase in the cost reduction strategies necessary to succeed under the post-reform environment. Transforming a health system will be expensive. Healthcare leaders will need to optimize income in the fee-for-service delivery system in order to fund long-term investments in their physicians, IT systems, process redesign, clinical integration, and other improvements. The irony is that the primary source of the dollars to fund this transformation will come from cost-shifting—get it while it lasts.

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