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Bracing for the Failures of Incremental Health Care Reform

By Nathan Kaufman

Hospitals must begin preparing for the inevitable "fixes" to our post-reform health care system.

Nathan Kaufman

The U.S. health care system needed to be reformed, but we did not need a patchwork of disconnected compromises between legislators and special interest groups that fail to address the fundamental flaws. Now that health care reform is the law of the land, it is probable that many of these reforms will accelerate the crises rather than solve them, resulting in new legislation to "fix" the underlying problems in the system. If Wayne Gretzky is correct—that greatness requires one to skate where the puck is going to be—then one must (1) anticipate the true consequences from the recent reform legislation, (2) prepare for the disequilibrium that will be created in the market and (3) begin positioning for the inevitable legislative "fixes" that will be implemented by mid-decade.

How History Will Repeat Itself

The government's primary response to escalating costs has been (and will continue to be) to reduce payments to providers. Since 2001, the government has programmed rate increases for Medicare so that the average hospital's Medicare margin will decline by 1 to 2 percent per year. Medicaid reimbursement is far worse than Medicare and is based on each state's fiscal condition. Today, the average community hospital is losing approximately 12 cents on every dollar spent caring for Medicare patients and 35 cents per dollar of care for Medicaid patients.

While physician practice expenses have increased by 3 to 5 percent per year over the past decade, their payments from Medicare have increased by less than 2 percent, and the meager payments to physicians from Medicaid have remained unchanged at best. It is expected that the 20 percent-plus reduction in the Medicare fee schedule will be patched with a negligible increase. However, many specialties including cardiology, endocrinology and radiology will face significant reductions in payments from Medicare as a result of the adjustments implemented in the 2010 fee schedule.

The government demonstrated that it does not have the appetite to deal with many of the fundamental factors that have contributed to the rapid escalation of cost, such as appropriateness and effectiveness of care, personal responsibility, the inability to easily align incentives between physicians and hospitals, the health insurance industry's antitrust exemption and excessive pricing by pharmaceutical and device manufacturers. One of the few certainties of the new reform legislation is that most hospitals and physicians will be paid less and expected to provide more care with better outcomes.

We can all learn from Massachusetts where, to compensate for expanding Medicaid enrollment, the state reduced Medicaid payment rates to hospitals from 82 percent of cost to 70 percent of cost. Then, recognizing that these incremental payment reductions were having little effect on controlling

cost, a special commission recommended that the state phase out the fee-for-service payment system and move to capitation. The data from Massachusetts does not support the theory that expanding coverage will not negatively impact providers or accelerate costs. Since the implantation of universal coverage in 2006, statewide hospital census has not increased, 43 percent of the non-teaching hospitals are operating at a deficit, and several hospitals are suing the state for underfunded rates from Medicaid. Even with the new insurance exchange (aka "connector"), average private insurance premiums are increasing by 6 percent per year, and according to the Massachusetts Division of Health Care Finance Policy, "Premium growth would have been greater…had it not been for employers reducing the richness of the benefits they offer." (See DHCFP Massachusetts Health Care Cost Trends Part 2, February 2010, page 7.)

Financial Problems from Incremental Reform

Historically, hospitals have compensated for their deteriorating Medicare margin and underpayments from Medicaid with investment income and cost shifting to managed-care payers. However, the economic downturn has limited the contribution from investments, and the negotiating power of the health plans will remain strong:

- There will be no viable alternative to commercial insurance companies in the near term other than Medicare and Medicaid.
- The antitrust exemption for health insurers was not repealed, providing these companies with unprecedented market power.
- Insurance companies will attempt to offload the costs associated with the new reform law, e.g., preexisting conditions, onto the providers in the form of lower reimbursement.

Physicians have compensated for the underfunded Medicare reimbursement by seeing more patients, closing their practices to all Medicaid and new Medicare patients, and investing in profitable office-based ancillary services that were formerly provided by the hospital. These compensatory tactics are having limited impact on stabilizing physician incomes as fee schedules are cut for physician services.

At the exact time that hospitals can least afford the new cost of stabilizing physician incomes, physicians are demanding increased payments from hospitals in the form of ED call pay, joint ventures and employment. Given the undersupply of physicians, hospitals cannot afford to underinvest in their physicians. Nor can they afford to invest in physician engagement strategies without expecting an incremental return on the investment. This will require a new collaborative relationship between hospitals and physicians in which the funds that are used to stabilize physician incomes are generated from improvements in the efficiency of care.

While Medicare and Medicaid continue to reduce the rate of increase in payments to hospitals, the costs associated with recruiting and retaining a workforce, as well as acquiring medical device and pharmaceutical supplies, continue to grow exponentially.

Redesigning Strategies

Traditional means of subsidizing the underfunding (investments and cost shifting) will not be sufficient for a health system to achieve optimal performance. The impact of theoretical models such as consumer-directed health care, medical homes and deployment of information technology, may actually add cost over the next five to 10 years (per the Congressional Budget Office). Thus hospitals must begin resizing their "cost chassis" to approach breakeven on Medicare.

The auto industry is on the verge of extinction because it ignored the realities of the market. At the same time, Apple has demonstrated American ingenuity at its best by revolutionizing the music industry. The economic and market conditions impacting health care providers are of the magnitude that have impacted the financial and automobile sectors. In their recent industry downgrade, Moody's states, "Sound management decisions about operating costs and capital investments, coupled with skilled oversight and direction from hospital boards, will be of special importance." Health care providers must embrace innovation and redesign to provide more and better care at much lower

costs.

These strategies include:

Investing in cost management and process redesign to approach breakeven on Medicare reimbursement. Use best practice benchmarks to set performance expectations. Review and redesign all processes to eliminate waste and unnecessary duplication/variation.

Maximizing and rebalancing payer contracts. Set a minimum target for commercial reimbursement at 135 percent of cost (160 to 180 percent of Medicare). Ensure that profit margins for inpatient and outpatient services are equivalent. Overdependence on outpatient profits can put a health system at a disadvantage as health plans can steer these patients away upon contract termination.

Investing in coding and revenue cycle management. Many hospitals are excellent at providing care but poor at documentation and/or payment processing, and thus they do not receive the reimbursement they deserve. Outside expertise is usually necessary to correct this problem.

Employing and collaborating with physicians to add value. Improvement of clinical efficiency must be driven by strong physician leadership. Thus the roles of the chief medical officer and physician-service line leaders should be elevated. In addition, employment seems to be one of the few safe harbors that enable a hospital to recruit and retain physicians. The investment in physician employment can be recouped over the long term if the employed physicians are organized and become recognized as a premier multispecialty group.

Investing in the components of clinical integration: IT, hospitalists and bundled programs. At some point CMS will have to change the current fee-for-service system. In anticipation of bundled payments for outpatients and declining rates for inpatients, many hospitals are digitally connecting to their physicians, developing evidence-based protocols, and delegating the delivery of care to the most appropriate provider—e.g., hospitalist, critical care specialist, physician extender, etc. By creating an organized care system that is "clinically integrated," the physicians and hospitals may gain the benefit of negotiating as a single entity for managed care contracts.

Health care providers must begin today to prepare for the disequilibrium that will be created by the new health care reform legislation, and the ultimate restructuring of the payment system. Befriend the inevitable or it will become your worst enemy.

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