

## *Three “Brutal Facts” That Provide Strategic Direction for Healthcare Delivery Systems: Preparing for the End of the Healthcare Bubble*

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In August 2005, David Lereah, then chief economist of the National Association of REALTORS, stated, “All of the doom-and-gloom forecasts of a housing debacle are not only irresponsible, but downright wrong” (Shilling 2010). Lereah was not alone; economists from Goldman Sachs, National Association of Home Builders and the Mortgage Bankers Association all expressed similar opinions. Wall Street firms such as Lehman Brothers and Bear Stearns bet their companies on the strength of the housing market. Eventually the lack of financial sustainability inherent in subprime mortgages burst the housing bubble and the industry collapsed.

The lack of acceptance of the housing bubble by industry leaders is a clear case of cognitive dissonance, in which “the more we are committed to believe something is true, the less likely we are to believe its opposite is true, even in the face of clear evidence that shows that we are wrong” (Goldsmith 2010). Refusal to recognize new market realities is a fundamental strategic flaw that has led to the demise of many organizations. As Admiral James Stockdale noted in his discussion with Jim Collins (Collins 2001, 85):

You must never confuse faith that you will prevail in the end—which you can never afford to lose—with the discipline to confront the most brutal facts of your current reality, whatever they might be.

The passage of the Patient Protection and Affordable Care Act (PPACA) (also referred to as the Affordable Care Act, or ACA) has created uncertainty about the future of the nation’s healthcare delivery system. Regardless of how the ACA is implemented, funded, or modified, there are certain brutal facts regarding the future of healthcare delivery in the United States. In order to prepare for the ultimate impact of these brutal facts, healthcare organizations must begin today to modify their core beliefs and clinical practices. By focusing strategy on new market realities (regardless how brutal they may be), a healthcare organization can begin to position itself for success in the future.

### **1: OUR HEALTHCARE BUBBLE WILL EVENTUALLY BURST**

In their open letter to the American people published in November 2010, several months after the ACA became law, the Bipartisan Debt Reduction Task Force stated:

The federal budget is on a dangerous, unsustainable path. Federal debt will rise to unmanageable levels, which will push interest rates up, endanger our prosperity, and make us increasingly vulnerable to the dictates of our creditors, including nations whose interests may differ from ours.... we must take immediate steps to reduce the unsustainable debt that will be driven [in part] by the aging of the population and the rapid growth of healthcare costs.

Even the Congressional Budget Office (CBO) appears to be skeptical about the ACA's ability to reduce the deficit as was reflected their original baseline projections. As a result, the CBO produced an "alternative fiscal scenario" using the more realistic assumptions that (1) tax revenues would remain at historical levels (i.e., 19 percent of GDP) and (2) cost control features of the new law would only have a moderate impact (Frakt 2011). This more realistic scenario further supports the task force's assertion that healthcare costs will contribute to the destabilization of the economy.

Richard Foster, the chief actuary for the Centers for Medicare & Medicaid Services (CMS), supported this concern when he testified before Congress that the new law will increase the nation's overall spending on healthcare by \$289 billion through 2019 (Daly 2011).

The state budgets are in no position to absorb the cost of PPACA. According to Lanhee Chen of the *Wall Street Journal* (2011),

PPACA puts cash-strapped states in a tenuous position, forcing them into one or more unattractive policy choices: cut spending in crucial areas, such as public safety and education, to compensate for the additional healthcare costs, raise taxes to fund the new spending, or borrow money to pay the bill and sink further into debt.

That we are in an economic healthcare bubble that will eventually burst is a brutal reality. Out of necessity, both state-funded and federally funded healthcare programs will intensify pressure on providers to reduce the per capita cost of care. In the immediate term this pressure will take the form of draconian reductions in fee schedules (as we are currently seeing from some states Medicaid programs). Over the longer term, government-funded healthcare will move from the fee-for-service reimbursement methodology to either bundled/episodic or population-based payments. Given the historical pace with which government implements changes in payment methodologies, one can expect these new payment systems to phase in between 2016 and 2018.

## **2: NEITHER THE SHARED SAVINGS ACO PROGRAM NOR FIRST-GENERATION CLINICALLY INTEGRATED NETWORKS WILL PRODUCE DESIRED RESULTS**

PPACA established a shared savings program for Medicare fee-for-service patients in which accountable care organization (ACO) providers would share in cost savings should the ACO meet certain quality and cost benchmarks. The ACO concept has been pilot tested under the Physician Group Practice Demonstration Project (PGP). Ten of the nation's most integrated medical groups participated in the PGP

demonstration. The demonstration provided groups the “opportunity to earn performance payments derived from savings for improving quality and efficiency of delivering healthcare services through better coordination of care and investment in care” (CMS 2010).

After four years, the “all star” group practices in the PGP achieved a 40 percent success rate—during the first year, only two groups received a shared savings payment. By the fourth year, five groups received a payout. Ultimately, over the four years, only sixteen shared savings payments were distributed out of a possible 40 (10 groups multiplied by 4 years). Among the brutal facts from the PGP demonstration project:

1. It is difficult for even the most integrated medical groups to generate significant savings on Medicare fee-for-service patients
2. When a group received shared savings payments, the magnitude of these payments were not sufficient to cover the infrastructure cost associated with operating an ACO.

A report from the National Institute for Health Care Reform (Lake, Stewart, and Ginsburg 2011) notes, “the economic and market rewards [for ACOs] may not materialize for a long time, if ever... None of the organizations [in the PGP] indicated positive return on investments related to improvement activities.”

There is little hard data documenting the primary source(s) of the cost savings that generated the shared savings payments. According to Robert Berenson (2010), vice chairman of MedPac:

the year 2 evaluation report documented that the essential reason for the overall savings across the 10 sites of about 1 percent compared with the control group was from diagnosis coding changes the PGP sites initiated that produced different risk-adjustment scores for their patients. In effect, the coding pattern changes produced apparent savings that resulted in shared savings payments to some of the demonstration sites, but not actually fewer dollars spent.

Any savings probably came from reductions in both admissions and high cost procedures such as imaging. It is a brutal fact that ROI for the “successful” PGP participants was negative even before accounting for the loss of admissions and procedural revenue. Financially, the PGP participants would have been much better off not participating in this ACO-like demonstration. From the PGP experience it appears that the only parties who will receive financial benefit from the establishment of a Medicare ACO are the lawyers and consultants retained for this purpose—buyer beware!

Many physicians and hospitals have formed clinically integrated networks that they believe will evolve into ACOs. While these networks have noble goals and some have positive results, few have demonstrated the competency to significantly lower the cost of care. Even Advocate Physician Partners, a joint venture clinically integrated network in operation for more than 15 years, could not document “medi-

cal cost savings" in real dollars but stated that improvements in the cost of care are "inferred" (Shields 2011).

One could argue that even though it is unlikely that ACOs and first-generation clinically integrated networks will fail to achieve cost-saving benchmarks, these ACOs will eventually evolve into an effective delivery model. However, as the noted futurist Jeff Goldsmith (2011) points out, the track record for past similar efforts for physician-hospital collaboration has been "dismal," and there is no reason to assume that this time it will be different.

Based on the brutal fact that ACOs and first generation clinically integrated networks will not generate sufficient cost savings to be relevant, healthcare organization leaders would be wise to skip the first-generation models, avoid the knee jerk reaction to rush to become an ACO as soon as possible and begin a slow thoughtful journey toward the creation of second-generation clinically integrated networks capable of managing risk and targeting the 20 percent of the population that incurs 80 percent of the cost. Reschovsky and colleagues' (2011) research on reducing the per capita cost of treating Medicare patients concludes:

Health reform policies currently envisioned to improve care and lower costs may have small effects on high-cost patients who consume most resources. Instead, developing interventions tailored to improve care and lowering cost for specific types of complex and costly patients may hold greater potential for "bending the cost curve."

Rather than pilot test an ACO model on Medicare or commercial fee-for-service patients in which reductions in admissions will affect the revenue of the health system, these networks should cut their teeth on the self-funded pool of hospital employees and dependents, where a reduction in admissions and costs results in savings for the organization.

Critical elements for a successful second-generation clinically integrated network include primary care-based medical homes, digitally connected electronic medical records with point-of-care protocols, disease management programs, relationships with post acute providers, and a culture committed to improving the cost and quality of care for patients rather than to maintaining individual provider income and autonomy (Kaufman 2011).

### **3: PHYSICIAN AUTONOMY AND THE ORGANIZED MEDICAL STAFF WILL BECOME LESS RELEVANT**

On January 13, 2011, CMS published the proposed rule for a value-based purchasing program for Medicare inpatient services (VBP). Starting October, 1 2012, hospitals can earn incentive payments based on the care they deliver to Medicare inpatients. These incentive payments will be funded by a 1-percent reduction in the base DRG payment. Thus, hospitals that underperform will see a relative reduction in their Medicare payment rates. The VBP incentive will be based on adherence to clinical processes (e.g., aspirin prescribed at discharge for heart attack patients) and patient

experience (e.g., communication with doctors, responsiveness of staff). CMS will eventually also include mortality-related measures in VBP. In addition, as part of the National Patient Safety Initiative, early information indicates that by 2015 9 percent of a hospital's Medicare reimbursement will be "tied to public reporting of errors and provision of safer, more reliable care (with a particular focus on hospital acquired infections and avoidable readmissions)" (CMS 2011).

Traditionally, medical staff had the responsibility for monitoring and maintaining high quality care within a hospital. While hospitals have always borne the financial risk for the cost of care ordered by their physicians, VBP now puts hospitals' revenues at risk contingent on their physicians' clinical practices and communication skills. Geisinger, ThedaCare, and Virginia Mason are exemplary HCOs that show that standardizing care through thoughtful process redesign can improve efficiency, quality, safety, and patient satisfaction (Kenney 2010).

It is a brutal fact that hospitals can no longer afford to delegate the responsibility and accountability of the cost and quality of care to an independent medical staff of physicians practicing and promoting the traditional autonomous, highly variable model of care. Hospitals will have to develop a work with the members of their medical staffs to

1. modify bylaws to require conformance to patient safety, patient satisfaction, process, and quality metrics as a condition of keeping hospital privileges, and
2. develop the clinical infrastructure with a new breed of physician leaders in which medical directors will have the authority and accountability for cost, quality, and patient satisfaction in their service lines.

### **Not If, But When**

The rate of healthcare spending in the United States is unsustainable. As with the housing bubble, the fundamental economics cannot support the status quo, and yet many healthcare thought leaders and politicians dismiss claims of a healthcare bubble as "doom and gloom." Others choose to ignore the possibility that ACA may exacerbate the cost crisis rather than moderate it.

Those who recognize the existence of a bubble and prepare for its brutal realities can benefit when the bubble bursts, as was the case during the housing bubble, when Michael Burry and his investors earned hundreds of millions of dollars betting against mortgage-backed securities (Zuckerman 2009). Healthcare organizations that believe in the brutal realities of the healthcare bubble can also position themselves for success when the bubble bursts. These organizations will dismiss the incremental approaches such as Medicare Shared Savings ACOs and first-generation clinical integration. Instead, prepared organizations will focus on meaningful transformation into a provider system comprising data-driven, digitally connected, physician-led teams consistently delivering evidence-based, patient-centered healthcare. These teams will be able to treat higher volumes of patients at lower predictable costs per

episode, demonstrating measurable high quality and providing an exceptional patient experience. As Donald Berwick states, "Healthcare is hungry for something truly new, less a fad than a new way to be" (Kenney 2010).

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