Six Steps for Success in the Reform Market

Rick Wesslund, Founder and Chairman; David Anderson, Managing Director; Fran Kelleher, Principal; Larry Garcia, Senior Advisor; and Dudley Morris, Senior Advisor; BDC Advisors, LLC

Now that the major clouds of uncertainty about the constitutionality of the Patient Protection and Affordable Care Act (ACA) have been lifted, and the key implementation dates of reform grow near, the pace of healthcare reform will accelerate.

In the near term, the focus of reform will shift to the states, where the future of Medicaid Expansion and the organization of Health Insurance Exchanges will be played out: CMS has promised to have exchanges in all 50 states by 2014. This creates an impetus for progressively managed organizations to adapt now, and focus on how their revenue picture will change as a result of a redesigned insurance landscape. In three years time, the expansion of coverage mandated by the ACA and the accompanying changes already occurring in the commercial sector means few regional markets will look like they do today. Delaying action until after the November election may be a tactical choice, but the market changes that are occurring now are here to stay and will likely accelerate.

Reform is Still a Market Issue

In 2011 we wrote that it is market forces (not ACA) that create the driving catalyst for change. In our view, healthcare reform is primarily a market issue. Employers and commercial insurers are demanding better value and an end to runaway premium costs. There has also been broad (although far from unanimous) public support for the expansion of coverage for individuals and families who have not been able to qualify for or afford health insurance on their own. Medicaid costs were stressing state budgets, and Medicare, until recently, would have become insolvent as soon as 2015. Government as well as private reform efforts has been driven by these market forces.

---

Since the publication of that article, commercial health plans have moved rapidly to adopt what looks a great deal like Elliott Fisher’s and Donald Berwick’s “Accountable Care” reforms that form the core of the ACA as their own. To do that, they are developing models of care that drive cooperation among the insurer, physicians, and hospitals. These cooperative business models are providing new opportunities for providers to move from traditional “Distant Neighbor” relationships to “Effective Accountable Care Partnerships.” Starting in California, a new wave of narrow, tailored or high performance networks and defined benefit products are emerging in response to employer demands for lower premium increases and better insurance value for employees.

Where the ACA is driving the market is with the medical loss ratio. To succeed under these new rules Aetna, WellPoint, UnitedHealthcare, the Blues and other plans recognize that they need physicians to take the lead in reducing costs and making medical costs more predictable. They are developing cooperative partnerships with many of their formerly distant provider neighbors, and developing new shared-risk or global-risk contracts. This is transforming the commercial market in several states.2 Fee-for-service reimbursement is not dead, but the value-based risk contracting market is expanding rapidly.

With the constitutionality of the ACA reaffirmed, the government’s reform efforts can proceed in harmony with the reforms the private market has adopted. Since the private sector initiatives do not require government approval, they will continue regardless of the results of the November election. The genie is out of the bottle on health care reform, so to speak, and it will be impossible to get it back in.

**Six Steps to Stay Ahead of the Curve**

The post-ACA decision marketplace requires providers who are flexible and fast enough to respond to a new market that is driven by employer demands for improved value and more predictable premiums. At the same time providers must understand and be prepared to thrive under Medicaid expansion, health insurance exchanges, and CMS’ multiple initiatives for reform. Now that the Supreme Court has upheld most of the Act, CMS’ position is likely to change from one of encouraging innovation to a faster roll out of reform. Within this framework, BDC believes that surviving in the new “Reform Market” will require well managed health systems to focus in six key areas.

1. **Rethink Revenue Strategy to Fit “Reform Market” Circumstances**

   Understanding where patient growth will be coming from, predicting how these patients’ reimbursement will affect the system, and deciding which strategies to use to respond to them, is the first order of business now that the ACA has been upheld.

---

One thing is for sure: provider organizations must be prepared to deal with a greater volume of patients at a lower average reimbursement. The ACA, according to the Congressional Budget Office, includes billions of dollars in reductions to Medicare payouts in the next decade. Commercial insurers are likewise seeking to reduce premium costs. Rates for the new Medicaid expansion patients will be meager and the payment rates for the Insurance Exchange products will likely fall between Medicare and commercial rates. The system needs to analyze how health reform will reshape the local insurance landscape and how this will disrupt utilization, revenues, and operating margins.

As reform takes hold, every provider organization will need to re-compute where their future revenue will come from. As basic fee-for-service reimbursement declines, earning revenue through quality and efficiency bonuses, risk-sharing on total costs or taking on more insurance functions to “move up the premium revenue stream” will become more important. Each organization will need to determine the size of the population they need to manage, and the amount of risk they need to take in a market, in order to maintain an appropriate share of the premium dollar. Figure 1 illustrates the range of options open to health systems as they consider redefining their revenue strategy.

**Figure 1. Provider Business Redefinition Options**

![Provider Business Redefinition Options Diagram]

Progressive organizations have determined that survival in the “Reform Market” requires aggressively shifting significant portions of business to risk arrangements,
by either partnering with established HMOs to earn a greater share of healthcare reimbursement revenues, or by forming their own health plans.

- Do you have a clear picture of where your organization’s revenue will come from in the expanded “Reform Market”, and where you will need to position your organization in terms of its revenue-to-risk profile?

2. **Double Down on Primary Care**

When universal health insurance was implemented in 2006 in Massachusetts there was an immediate shortage of primary care physicians, which created access and cost control challenges. Providing health benefits to the uninsured through either Medicaid expansion or health insurance exchanges will similarly create more demand for primary care. The Medicare ACO shared savings program is predicated on the belief that all Medicare beneficiaries will be assigned to a primary care physician. Similarly, most of the Accountable Care experiments funded by commercial insurers have similar requirements. Given the critical role played by primary care physicians in improving quality and efficiency, we would expect to see the continued blurring of the lines between payers and providers in selected markets. Acquisitions such as WellPoint’s recent purchase of CareMore, Humana’s acquisition of Concentra, or UnitedHealthcare’s acquisition of various IPAs in the West are likely to continue in response to the anticipated increase in demand caused by the expansion of Medicaid and launching of HIEs. The entry of drug store chains and Wal-Mart into the retail clinic business adds further competition for primary care resources and revenue. A recent survey by the Commonwealth Fund indicates that physician led Accountable Care Organizations are the second most common governance model, far exceeding payer-led models, “highlighting an encouraging paradigm shift away from acute care and toward primary care.”

- Have you locked down a plan for an adequate primary care network to effectively serve the newly insured Medicaid and HIE markets, and the emerging narrow, tailored, and high performance networks, and Accountable Care partnerships being rolled out by commercial insurers?

3. **Plan for “Strategic Asset Repositioning”**

In many markets, potential reimbursement rates for the new members insured through HIEs will fall somewhere between Medicare and Medicaid rates, and it is not yet clear whether these new rates will balance out the cost of care already provided,

---

3 The Commonwealth Fund, Issues Brief, “Hospitals on the Path to Accountable Care: Highlights from a 2011 National Survey of Hospital Readiness to Participate in an Accountable Care Organization,” August 2012
or simply add to the deficit. While the new government supported business will provide needed relief for hospitals’ charity care burden, it is likely that a portion of the newly insured may have a pent up demand for health services that will require costly care not fully covered by the new rates. Since Medicare rates are likely to rise more slowly than inflation no matter how the November elections turn out, it is certain that many hospitals will need to focus on gaining additional expense savings as well as new revenue sources to maintain their profit margins. As a leading industry analyst predicted, health systems need to be “taking apart the fundamental basic building blocks of patient care and recreating them all over again in a more efficient manner.”

We expect that strategic asset repositioning will once again be high on the agenda of many providers, regardless of how health care reform plays out in the next year.

- Do you have a strategy for addressing rising cost pressures in place?

4. **Pay Real Attention to Prevention and Wellness**

The ACA contains a strong emphasis on prevention, and many think that wellness, or the lack of it, is a major driver of health care costs. Now may be a good time for hospitals and health systems to address this issue. CMS will establish significant penalties for unnecessary Medicare admissions and readmissions in 2013, and in 2015 will add similar penalties for hospital acquired conditions. Many health systems are testing out various value-based payment systems which tie an increasing portion of reimbursement to outcomes. With average reimbursement rates trending downward and capitation on the rise, the management of wellness may eventually become as important as the treatment of disease.

---

4 Moody’s Investors Services, March Report, 2012
5. Get the Infrastructure Working to Produce Results

During the past two years, many healthcare providers invested heavily in building the infrastructure to be ready to participate in value-based contracting or the Medicare shared savings program. Now it is time to demonstrate how these structural changes can deliver their theoretical promise of better care at lower cost.

It is wonderful to say – we have a large group of employed doctors – but the new market will demand that they function as a high-performance multispecialty clinic. It is wonderful to be “innovative” – but innovations often fail. The ACA has already triggered a wave of innovation in developing more effective ways of delivering and managing care, and innovation is not part of most healthcare providers’ DNA. Since only the largest organizations generally have the resources to support significant pilot programs, most delivery systems will be better off by becoming fast followers, adapting and improving on new best practices, than early stage innovators. Implementation, not innovation, should be the first item on most organizations’ agendas.

The investments made by the Pioneer and early Accountable Care Organization applicants to build clinically integrated delivery networks will only be validated if these new entities are able to deliver measurable improvements to care while also bending the cost curve. Changing incentives under new “fee-for-value” contracts...
doesn’t necessarily change behavior. Institutional inertia, silos, and fragmentation may not dampen experimentation, but they pose huge obstacles to implementation.

- Is your infrastructure primed to deliver results, or are there still some organizational roadblocks to be addressed along the way?

6. **Look for the Right Strategic Partners to Create Value and Facilitate Growth**

The era of shared savings, accountable care, and population health management has created the opportunity for effective new partnerships between the formerly “distant neighbors.” Providers will increasingly need to address a “make versus buy” decision to identify the need for strategic partners to work with in developing their ACOs, value based contracts, or even their own private label health plans.

There are currently 154 organizations participating in the Medicare Shared Savings Program authorized by the ACA. In 2013, CMS expects an additional 400 organizations will apply for ACO designation. The challenge is that many of these emerging ACOs will lack the infrastructure and predictive modeling tools necessary to take on financial risk and to manage population health. Many may look to new Accountable Care Management groups, such as UnitedHealthcare’s OptumHealth division or Aetna’s Strategic Diversification Group, to offer the necessary back office and risk management expertise to succeed in the new value-based market.

While many organizations may seek to grow market share through joint ventures with their traditional competitors, some providers may find it easier to grow market share through acquisition – not only of other hospitals, which has been a traditional avenue of growth, but of independent Medicare Advantage plans, TPAs or organized medical groups.

- Have you evaluated whether your organization will need outside strategic assistance to reach your goals in the new “Reform Market”, and do you know who your most effective partners are likely to be?

**Conclusion**

Healthcare reform has always been a “wicked problem” – messy, hard to organize, financially complex, with no easy solutions. However, healthcare professionals want to be “part of the solution” and most support the need for reform. While there is a long road ahead, it appears that many of the current reform efforts are beginning to make a

---

5 Wesslund, Rick, and Morris, Dudley, “Payers and Providers: Distant Neighbors or Effective Partners,” BDC Advisors, LLC., 2012
6 The Commonwealth Fund, Issues Brief, “Hospitals on the Path To Accountable Care, Highlights from a 2011 National Survey of Hospital Readiness to Participate in an Accountable Care Organization”, August 2012
7 Gawande, Atul, New Yorker, June 28, 2012
difference in meeting the goals of improved quality, reduced costs, and achieving a better patient experience. Since the tools to reform are out there, this is not so much the time for innovation as it is a time for effective implementation. Now is the time for action and to be sure your organization has the necessary building blocks in place for success.