HEALTHCARE STRATEGY IN THE YEAR OF UNCERTAINTY

Even amid significant legislative ambiguity, reform remains a market-driven issue.

By Aamer Mumtaz, Alan London, MD, and David Fairchild, MD

Authors’ note: To understand how providers are navigating the unsettled and evolving environment around healthcare regulation, BDC Advisors is having ongoing conversations with CEOs and chief strategy officers (CSOs) from major health systems and academic medical centers (AMCs). Recent conversations have included a dozen leaders from California, Florida, Massachusetts, Maryland, New Jersey, Pennsylvania, Arizona, Louisiana, and Ohio. We will continue these conversations as discussions around repeal and replacement of the Affordable Care Act (ACA) evolve. This is our first report.

In 2011, after passage of the ACA, we wrote that the driving imperatives for change in the provider space were not legislative mandates but market forces—especially the quest of employers and consumers to have access to high-quality, affordable care. A similar statement holds true in the current environment.

At the time this article went to press, GOP leaders in the House had finally managed to pass a version of the American Health Care Act of 2017 (AHCA), which would repeal and replace key parts of the ACA. Regardless of the bill’s fate in the Senate, where there is considerable opposition to many of its provisions even among Republicans, the passionate disagreement around healthcare regulation is certain to continue. As one executive told us, the continued tensions around the AHCA demonstrate the inability of political factions to come together—creating greater uncertainty, not less, going forward.

Among the dozen C-suite leaders from leading health systems and AMCs in nine states who we interviewed over the past two months, most believe that the healthcare market has many of the same characteristics and challenges as it did in 2011: Cost growth is an issue, quality and value are ongoing concerns, and breaking even on government programs is a challenge. With some critical caveats, the appropriate short-term provider response thus will not be fundamentally different from the past seven years:

- The search for value will continue, with clinical integration, care coordination, and high-quality care still the paths to get there.
- Scale will become even more important as systems look for ways to reduce the per unit cost of care.
- Commercial insurance will remain the main engine of growth for providers, with Medicare Advantage the most attractive government program financially.
- Medicaid and the ACA marketplaces are wild cards. What happens in those spaces will be felt disproportionately by systems serving high numbers of underprivileged patients, including systems operating in rural areas.
- The move toward quality will continue despite the potential waning of government support for innovation.
- Speed to market for new initiatives in the pipeline will be important.
- Cost reduction and asset redeployment will be essential in an increasingly cash-strapped environment.
CONCERNED ABOUT ‘NO REGRET’ MOVES
Concerned about the current state of uncertainty, providers are, in the words of one executive, “hunkering down.” That is, they are continuing down existing paths while slowing major capital investments.

The focus, for now, is on what one executive called “no regret” strategies that address fundamental economic forces: the relentless pressure on costs, the rise of consumerism, the shift from inpatient to outpatient care, and the growth of population health management and other forms of value-based payment mechanisms.

For example, the CSO of a leading not-for-profit integrated organization sees no reason for the organization to rethink its broader strategy. As before, “There will be less money in the system,” so the organization will “need to become more cost-effective and demonstrate value.” With a sizable Medicaid business in an expansion state, the organization is “most concerned” about a potential move to block grants. Despite these concerns, the organization expects to continue down the path to value, even if the speed at which it implements its strategy may change as things evolve in Washington, D.C.

Other executives indicated a similar approach of continuing down existing paths.

DELAYING NEW CAPITAL OUTLAYS
Organization leaders generally expressed a need to wait and see how things evolve before making any significant capital outlays. One CEO observed that most organizations “are hitting the pause button on a lot of things,” including programmatic growth, new hospital construction, and major capital purchases.

Most executives told us that they have not built any significant changes into their budgets and are going to wait to see what happens in the midterm elections. An exception is a nationally recognized public health system in the Midwest that is looking at the current environment as a brief window of opportunity, before they lose critical sources of funds, to quickly get initiatives to market. Unlike others, they are increasing their capital investment, for example by raising $1.3 billion in April for a campus transformation project that would help replace aging outpatient facilities.

CUTS TO MEDICAID AND THE MARKETPLACES
If Medicaid expansion ends and the ACA marketplace subsidies are eliminated, hospitals could lose up to $30 billion in revenue, or roughly 3 percent of the estimated $1 trillion spent on hospital services every year.2 That is a large but manageable impact on the industry’s financial health. One East Coast AMC executive with less than 3 percent of patient volume in the marketplaces told us that “repealing without effective coverage replacement would be bad politics. But whether it would be bad for [our] bottom line is questionable.”

However, the impact on individual providers will vary significantly. In particular, providers serving a disproportionate share of vulnerable populations face a far greater degree of risk. This includes safety-net organizations serving disadvantaged populations in inner cities and organizations operating in struggling rural areas.

Leaders from the Miami-Dade and Los Angeles County markets, which have high concentrations of Medicaid and ACA marketplace business, expressed strong concerns, for example. In Massachusetts, which expanded Medicaid while gaining additional funding in the form of a Medicaid waiver for accountable care organization (ACO) development, a Boston-based AMC with about 20 percent of its business in Medicaid calls the impact of ACA repeal “big numbers [that will] hurt everybody.” Another expansion-state executive described the numbers “as so huge, you can’t even plan for them.”

Ironically, states that did not expand Medicaid under the ACA may do so under a waiver from the Trump administration. For example, given that Florida may accept block grants from the administration to expand eligibility, the CEO of a system with 12 to 15 percent of its business in Medicaid says, “It is just as likely that what happens at the federal level is good for us as it is that it’s bad for us.”

OUTLOOK FOR CARE COORDINATION AND QUALITY IMPROVEMENT
Although providers are convinced that the shift to value largely is going to continue, several pointed out a concern: If an organization has not made progress on innovations promoted by the Center for Medicare and Medicaid Innovation (CMMI), the current uncertainty may suggest that it should not start now.

‘NO REGRET’ MOVES
Providers are focused on moves that transcend the ongoing legislative and regulatory uncertainty and instead address more fundamental economic forces. Such moves include:

- Achieving scale through partnerships and alliances
- Commercial market growth (e.g., through targeted ambulatory expansion)
- Continued focus on Medicare Advantage
- Aggressive cost control
- Partnerships with health plans to share more risk
- Building the clinical network
- Slowdown or halt on long-term investments
As one executive says, “If innovations have a shelf life of one to two years, and you have not gotten into bundling, narrow networks, Next Generation ACOs, etc., then you are better off not starting now.” Another executive pointed out that because health care “doesn’t have double-digit margins” as other industries do, providers don’t have the financial cushion to experiment with innovative models in the face of uncertainty. Recent signals from Washington, such as a delay in the expansion of CMMI bundled payment programs, may reinforce this conclusion.

Combined with a general slowdown and the “hunkering down” among organizations, these issues point to the possibility of a slowing, in some areas, of the momentum created by the ACA toward care coordination and value-based care.

ECONOMICS OVERSHADOWS POLITICS
Our preliminary discussions with leaders from major health systems around the country have confirmed that healthcare reform remains driven primarily by market forces as opposed to legislative initiatives. As one West Coast executive told us, “The challenges facing health care are more economic than political.”

Just as in 2011, imperatives to reduce costs and to achieve profitable growth through the delivery of value remain key. In fact, cutting costs, improving clinical integration, and addressing quality and customer service needs—all while focusing on profitable markets for growth—arguably will be even more important strategies in 2017 and going forward than they were in 2011.

The organizations facing the biggest challenges in this tough environment will be providers with significant Medicaid and ACA marketplace business. In a low-margin industry, those organizations will struggle to manage profitable growth.

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FOOTNOTES: