Perspectives on a selected key topic

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Today’s Topic

“Is there a trend or issue for 2020 that could potentially have a significant impact for healthcare stakeholders that might be flying under some organizations’ radar?”

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Those of us working in healthcare are burdened with our own unique “original sin.” We are reminded of it constantly: US healthcare per capita costs are about double the costs of the next nearest industrialized nation, and our quality is worse.

We are told that this “original sin” is the result of providers being paid for each unit of service they deliver, and if only incentives could be aligned, health systems reorganized, and a new form of payment instituted, lower costs and higher quality would ensue. In the 1990s everyone talked about the whole industry becoming like Kaiser. In the past decade Obamacare has focused increasing industry attention on the goal of population health as the antidote for original sin of volume-based fee for service.

Much good work has been done - for example better integration of physicians, and better care of patients with chronic conditions – but the dramatic shift to population health (now sought for over 30 years) has not arrived. Our industry rhetoric about population health simply does not match the reality of our market situation: studies show that fewer than 15% of health systems in the country are getting more than 10% of their revenues from risk. After 30 years of talk—and lots of effort--- we are still largely a system based on fee-for-service.

Insurers have been unwilling to part with risk, because they believe that they can reduce costs of care, and thus keep that arbitrage for themselves, or they simply do not believe that health systems will be effective at managing risk. Instead of risk, we see much more of a move to “value-based payments.” Payment to the provider is still “fee-for-service,” but layered on top are added bonuses and penalties designed to improve quality or penalize excessive costs. The fee-for-service payment is the cupcake. The bonuses and penalties from value-based payments are only the frosting. Most of the money comes from an additional unit of service. A tiny fraction of the money comes from the bonus. If you have a 5% penalty – you can get that penalty for 20 patients – and make up for it with just one new admission.
Winning bonuses and avoiding penalties requires a different system than pure fee-for-service, but it is also quite different from managing global risk. Value based payment (which looks a lot more like the traditional fee-for-service model than risk) seems to be a signpost on the road to population health—if that is where our system is truly heading.

We need to start matching the reality to the rhetoric so we can be clear about how to win in an era of consumerism and transparency. As one board member mentioned to me, “At our board meetings we spend most of the time talking about population health—until we get to the finance report. Then it is all about profits from inpatient procedures.” Health systems need the capabilities for “winning the frosting” of value based payments, and should look into specific populations to manage (Medicare Advantage is a great start), but with a recognition that the cold, hard reality is that the vast majority of our revenue comes from fee-for-service, and will likely do so for a long time.

There is a lot of talk in the industry about “straddling the two canoes of fee-for-service and risk-based payment.” Turns out that most providers are still firmly planted on the fee-for-service canoe (though it is morphing into value-based payment), and are just gingerly dipping a toe into the risk-based canoe. Many are not even doing that.

By and large health insurance companies are paid for “managing a population” and health systems are paid for treating individual patients. For many systems winning in today’s market is less about population health and more about the fundamentals of lower cost, better care for each patient who presents to us. Systems should not be ashamed of pricing aggressively when they can, increasing market share, and giving patients all the treatments that they need. We want to win the bonuses and avoid the penalties (and we need new capabilities to accomplish that), but more importantly we want to serve patients, lots of them, and get paid appropriately for each service we provide.

In other words, we need to match our rhetoric—and actions— with the market reality.