The Changing Face of Healthcare Delivery: What to Expect Over the Next Ten Years

Observations and analysis

By: **Joe Flower**

Venue: **9th Annual Orthopedic, Spine and Pain Management-Driven ASC Conference**
Chicago IL, June 10, 2011

The reform is not the change. The transformation in healthcare now underway is far larger and more fundamental, driven by demographics and economics, not legislation.

Biggest transformation driven by employers. Because of political and size constraints, we will see the most vigorous, daring, and creative transformation in the private market, largely driven by employers, with some health plans eager to implement. Some states will try vigorous experiments (e.g. Massachusetts, Vermont).

Expect rapid structural change in markets, more rapid than you have ever experienced.

Change in business models: All healthcare providers, willing or not, will shift from what has mostly been a single business model (insurance-supported fee-for-service) to multiple, more complex business models.

Core idea: redistribution of risk. The key characteristic of the shift: Risk is being re-distributed. Previously all the financial risk of any transaction was taken by the insurer. ASCs have been operating in an atmosphere of relatively minimized financial risk in the transaction, with payment guaranteed at certain levels by insurance, and ability to effectively offload non-paying or low-paying clients to hospitals and the larger health system. In the new models, the consumer will take some financial risk, and all providers will be at greater financial risk for outcomes, effectiveness, and efficiency.

Changing risk changes behavior. As risk is redistributed, the behavior of all actors will shift, and shift again in reaction to other actors' changed behavior.

Profit is based on risk. You will not be able to avoid taking on more risk, in various ways. Survival and profit will depend on the astute management of the risk.

Specialized model, changing ecology: The ASC is a highly specialized model, not only clinically, but in its business model. It depends upon narrow assumptions about what particular procedures it will provide, where its customers come from, how it will be paid, by whom, in what increments, as well as who its competition is, and what their clinical and business environment is.

In a changing environment, any specialized, rigid design is vulnerable. Ecology: When a species has optimized itself to a narrow niche, and the climate becomes drier or colder or with different vegetation, that species dies out, or gets bigger or smaller, or adapts in some other way. Most successful species (e.g. humans) are not the largest, the fastest, or the strongest, but the most adaptive to change.

Rush to build: A lot of ASCs are being built, in some places in a rush (e.g. New Jersey recently imposed a moratorium, and over 100 applications to build were filed before it came into effect). Yet few are being built taking even the present evidence-based design in mind, none for the flexibility needed for a future with rapidly-changing needs.

Consumer-like behavior: Expect far more consumer-like behavior (shopping for value) on three levels:

1. **Actual consumers** motivated by consumer-directed health plans
2. **Payers** (especially employers, and health plans now strongly competing for the business of highly motivated employers)
3. **Associations of payers,** organized to procure better value for their members

Competition is not just other surgeries: In this more consumer-like market, you will not be competing against other places to get the same surgery (such as the local hospital, or hospitals in other countries). You will be competing against **other ways of solving the consumer's problem**. These ways are primarily:

1. **Medical management**
2. **Doing nothing at all**

The competition does not have to be better than what you do to beat you. It does not even have to be as good as what you do. It only has to be "good enough, and a whole lot cheaper." Your medical opinion as to what is "good enough" will not weigh as heavily with your potential customers as it did in the past.

Details of change

Payers will focus on:

- **Comparative effectiveness research** (limiting or ending payment for any surgeries that are not strongly medially indicated, or that have "good enough" alternatives at lower cost)
- **Paying for outcomes** and for measurable quality markers
- **Aggressively advising individual clients and employers** about what works and doesn't, what is most cost-effective.

Consolidation and diversification: The transformation of healthcare, with its greater demands for capital and technical capacity, will greatly encourage the ongoing consolidation of the industry. Major health systems will continue their move toward consolidating and buying up capacity. The sweet spot in the new healthcare economy will be the ability to offer a comprehensive menu of services at the highest quality and the lowest cost under a single financial umbrella.

Systemic cost savings: In this atmosphere, major health systems will increasingly be forced to get costs down systemically rather than either through efficiencies (doing the same things at lower cost) or through simply cost-shifting. The gap between Medicare/Medicaid reimbursements and private payers will decrease.

Cost advantage of ASCs likely to narrow: As payers of all kinds squeeze health system reimbursements, the cost advantage of ASCs will narrow significantly.

Types of savings: There exist within major health systems three ways to save money:

1. **Cost efficiency** through "lean manufacturing" and similar models: Doing the same things using fewer resources
2. **Cost coordination**: Avoiding duplication, or treating at a higher-than-necessary level of acuity
3. **Cost avoidance:** Avoiding doing expensive and unnecessary things at all.

Biggest bucket of savings: Of these three types of savings, by far the largest potential lies in the third. For an unconsolidated hospital in a fee-for-service environment, avoiding unnecessary procedures means cutting their own revenue. For an integrated health system in an at-risk environment avoiding unnecessary procedures means significantly greater profit.

ACOs will not become common. ACO's are not an obvious answer to health systems' problems, because:

- An ACO is not a business model (it is not really a revenue stream).
- An ACO is a way to (possibly) recoup (some) lost revenues.
- It is a fee-for-service concept, not risk-based, so the health system cannot actually earn more money by avoiding unnecessary procedures and tests
- ACOs have heavy requirements, and compliance is assessed well after the expenses for meeting them are incurred.
- An ACO is not a contract, but a rebate paid after the fact.

- Getting the rebate is unpredictable, and the rebate is limited.
- Patients' revenues are assigned to the ACO only after the fact, so you cannot set up a special organization to drive value for your ACO customers.
- The rules exclude (for purposes of calculating the rebate) the beneficiaries of Federally Qualified Health Centers — and FQHCs are a primary way of corralling and driving down the unnecessary expenses of a poorly-reimbursed population.

Only integrated systems: ACOs will likely only make sense for well-grounded systems already well along in integration and digitization. They will not be the major engine of change themselves. So ACOs will increase differentiation in the hospital/health system market, giving some advantage to those who already furthest ahead in integration, efficiency, and effectiveness.

Major health systems take on more risk: Major health system will take on more risk-based contracts, bundles, and measurement-based compensation (such as "pay for performance"). Implications:

- Patients covered by risk-based contracts likely to be unable to "go out of plan" unless they want to pay for it themselves. Watch how popular they become. If they become very popular in your area, they are likely to greatly cut into your market
- ASCs can strongly compete on bundles. They can offer lower price, guaranteed outcome, guaranteed timing, greater flexibility on using new techniques (less invasive, for instance).
- ASCs can likely also strongly compete on measurement, such as safety (infection control) if ASCs take it on. It is harder for hospitals and large health systems to deal with these complex safety issues.
- ASCs can also sub-contract on hospitals/health systems bundles and risk-based patients, to help the risk-based health systems meet their cost and safety goals. **Your biggest rivals could become your best customers**.