Healthcare leaders such as Randy Moore, MD, president of Mercy Virtual, are taking steps to ensure their workforces evolve to meet the demands of value-based care. See page 6.
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PERCENTAGE CHANGE IN INSURANCE COVERAGE FOR AGES 18-64, 1997-2016

This exhibit shows the percentage of U.S. adults ages 18 to 64 who were uninsured or had public or private coverage between 1997 and September 2016. The total number of uninsured among all age groups as of September 2016 was 28.2 million, or 20.4 million fewer than in 2010. Data are based on household interviews of a sample of the civilian noninstitutionalized population.

PREPARING THE HEALTHCARE WORKFORCE FOR VALUE

Encountering obstacles but seeking creative solutions, stakeholders across the healthcare industry strive to enhance the ability of workforces to provide value-based care.

By Karen Wagner

Ted Wymyslo, MD, has a tough task. As chief medical officer of the Ohio Association of Community Health Centers, his central role is to enhance the workforce at the state’s 49 federally qualified health centers and to expand use of the patient-centered medical home (PCMH) model of care.

“What’s my biggest challenge? It’s finding primary care providers,” Wymyslo says. “It’s the weak link in this whole chain. All these great ideas, new care models, and payment reforms don’t turn into anything if primary care workforce needs aren’t met. And providers are much more effective if they’re practicing comprehensive primary care.”

Indeed, as the healthcare industry continues to shift from volume to value, the workforce has to evolve as well, particularly with cost and care quality in mind. New models of care and payment, a focus on population health management, a growing emphasis on behavioral health, and an aging, more diverse population are changing workforce requirements, necessitating the development or repositioning of traditional roles in primary care.

In addition to the challenge of providing appropriate education and training for healthcare professionals, healthcare organizations also face issues with clinician shortages (see the exhibit on page 7) and funding that may hamper their ability to optimize their workforce. Organizations can use various strategies to prepare their workforce for value, but stakeholders say long-term solutions involve improving collaboration across the spectrum of health care, including among providers, health plans, state and federal agencies, and educators.

CONNECTING THE WORKFORCE

The drive to lower costs while providing better care and meeting the needs of a diverse group of patients has required a reengineering of care. Value-based care models such as the PCMH are designed to provide seamless care via teams of providers who coordinate care along the continuum.

Processes and tasks that once were the domain of physicians only or were not part of primary care at all are being delegated to physician assistants and nurse practitioners, along with case managers, clinical care managers, and relatively new roles such as patient navigators, health coaches, and community health workers.

Physician assistants and nurse practitioners. These roles have become more prevalent as providers seek ways to enhance the quality of care and patient satisfaction in addition to making care more cost-effective. According to the Bureau of Labor Statistics (BLS), nurse practitioners (grouped with nurse anesthetists and certified nurse midwives) and physician assistants are among the fastest-growing occupations nationwide, with expected growth between 2014 and 2024 of 35 percent and 30 percent, respectively.

Patient navigators. This role has become more prominent at both primary care and specialty practices as a resource for patients winding their way through an often complex and confusing healthcare system.

“The most important characteristic of a patient navigator is the ability to effectively serve as a broker between the patient and the system,” says Mandi Pratt-Chapman, MA, associate center director of the GW Cancer Center, part of the GW School of Medicine and Health Sciences at The George Washington University in Washington, D.C. “Your ideal navigator would be someone who understands the culture of many of their patients, what their lives are like, and also understands the needs of the healthcare team.”

Although registered nurses fill many patient navigator roles, non-licensed staff are becoming a more significant part of the care team, especially for logistical coordination, patient advocacy, and support. At the GW Cancer Center, patient navigators help identify insurance plans and co-pay assistance for eligible patients, arrange transportation to appointments, obtain missing information on referrals so patients are not turned away, and smooth the authorization process for patients to receive necessary treatments.

Other patient-support roles. These roles include health educators, who teach and promote community wellness; and community health workers, who work on health issues with specific populations or communities. According to BLS, the number of health educators and
The Association of American Medical Colleges projects the national physician shortage to reach as high as 94,700 by 2025.

Source: Association of American Medical Colleges. Used with permission.
every level who actually are trained in a team-based model,” she says.

As an example, Carlevale says, nurses are generally trained in a specialty such as psychiatry or geriatrics. “But these newer models are demanding that you understand chronic diseases and the patient’s needs as they move through the continuum of care,” she says.

That may leave the education of care coordinators to the provider organizations. “Health systems have taken on a commitment to the education of providers, including nurses—specifically targeting the skills that are needed to work in this new kind of environment, where performance is linked to a series of patient-related quality metrics and ultimately to payment,” says Bobbie Berkowitz, PhD, RN, NEA-BC, FAAN, dean of Columbia University School of Nursing, New York City.

Perhaps the issue felt most acutely across healthcare organizations is how to fund these new roles and approaches. Breaking down the silos of FFS care to deliver care across a continuum may improve quality, but it also leaves a funding gap. Many of the new roles have no billing codes associated with them and are not reimbursed.

“I don’t advocate for billing piecemeal for those services,” Pratt-Chapman says. “I don’t think going back to a fee-for-service model where volume is rewarded is the way to go. But I do think we need to pay attention to research results showing the impact of patient navigation, the impact of patient-centered care. It does save money and improve the quality of care. Creating adequate bundled payments or global payment structures that compensate providers for the real costs of patient navigation and care coordination is what we need to ensure sustainable infrastructure for value-based care.”

THINKING OUTSIDE THE BOX

Staffing, training, and funding may present considerable obstacles to securing a value-ready workforce, but healthcare organizations are pursuing various strategies for surmounting those obstacles.

A telehealth workforce may solve some of the clinician shortage issues. Mercy Virtual employs “electronic” sitters who monitor patients across multiple locations. One trained technician can monitor four to 10 patients virtually as opposed to a single patient at the bedside, Moore says.

“We believe as the market goes toward value that our ability to really drive significant increase in efficiencies and effectiveness is going to go up significantly, as is the impact of each team, which may significantly mitigate what people see as the looming shortages in different areas,” he says.

The use of advanced practice registered nurses such as nurse practitioners can help relieve the shortage of primary care physicians, Berkowitz says. Utilizing nurse practitioners to the full scope of their license can improve patient outcomes and optimize the healthcare workforce, she says, but the state-by-state approach to regulating scope-of-practice remains a challenge.

Pratt-Chapman says using non-licensed healthcare workers also can help clinicians work at the top of their license and produce more cost-efficient care. She references a study recently published online in JAMA Oncology showing that nonclinical navigators used by the University of Alabama Health System’s Cancer Community Network for geriatric patients saved the system about $780 per patient per quarter, for an estimated $19 million in annual savings. “At GW Cancer Center,” Pratt-Chapman says, “our patient navigators often identify insurance products that patients do not know they are eligible for, reducing uncompensated care for the cancer center and putting treatment within the reach of patients.”

Ensuring that patient navigators are trained to effectively serve as brokers between patients and the healthcare system has been a top priority for Pratt-Chapman. “These allied health professions, these support roles, are critical to help make physicians and nursing roles more efficient, but they need training. For patient navigators, we developed free competency-based training that anyone with Internet access can complete to ensure their foundational knowledge as a patient navigator,” she says.

COLLABORATION IS KEY

Addressing the root of the problem, however, most likely requires innovative collaboration among providers, health plans, academic institutions, and state and federal agencies.

On the health plan side, Humana provides physician practices with support in areas such as care coordination, value-based capabilities, wellness, care delivery, and behavioral health, says Mike Funk, vice president for thought leadership in the Provider Development Center of Excellence at Humana.

“We have been focused on a number of initiatives to assist physicians and their office staff in meeting the demands of today’s workplace,” Funk says. “While it may still appear very disconnected, there is a tremendous amount of work taking place to develop a more connected, seamless, efficient, and effective healthcare system that simplifies and integrates healthcare delivery.”

For example, Humana reimburses telehealth services under certain plans in some rural areas and some areas that are experiencing clinician shortages.

Carlevale strongly advocates incorporating interdisciplinary team-care training at medical schools and in other clinical educational and training programs. She also supports the idea of establishing a consortium integrating multiple stakeholders to address the need for value-based training and the funding of such training and roles in the clinical setting.
“I would really encourage everyone to think outside the box,” Carlevale says. Wymyslo used a $2.68 million state subsidy to fund training for medical and other clinical students who work at Ohio community health centers that are also qualified PCMHs. In the first year of the subsidized program, 900 students were trained at 35 health centers, Wymyslo says.

“Students are getting the chance to see comprehensive team care provided to patients that considers their biological, psychological, and social needs,” says Wymyslo, a former director of the Ohio Department of Health and a practicing physician who ran a family practice residency program for about 20 years. Medical students in the training program work not only with physicians but also with advanced practice nurses, dentists, social workers, and even front- and back-office staff to attain a holistic understanding of the clinical and operational aspects of a practice, he says.

Wymyslo says the next step is for graduate medical school education to incorporate comprehensive primary care training.

Berkowitz says graduate-level nursing education, the focus of nursing education programs at Columbia, often encompasses such training. The school of nursing has recently developed a tailored master’s program for its partners at NewYork-Presbyterian. The program is designed specifically to focus on evidence-based nursing practice and on preparation for care coordination, team-based care, and care transitions.

“Those partnerships are really ideal because we can work together to make sure we’re creating clinicians who are relevant to current practice,” she says. “It’s a challenge, of course, but I think it’s a new direction that is essential.”

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Interviewed for this article: Bobbie Berkowitz, PhD, RN, NEW-BC, FAAN, dean and professor, Columbia University School of Nursing, and senior vice president, Columbia University Medical Center, Columbia University, New York City (bb2509@columbia.edu); Jean Carlevale, RN, program support, Commonwealth Medicine, UMass (University of Massachusetts) Medical School, Shrewsbury, Mass. (jean.carlevale@state.ma.us); Mike Funk, vice president, Thought Leadership, Provider Development Center of Excellence, Humana, Louisville, Ky.; Randy Moore, MD, MBA, president, Mercy Virtual, Chesterfield, Mo. (randall.moore@mercy.net); Mandi Pratt-Chapman, MA, associate center director, Patient-Centered Initiatives & Health Equity, GW Cancer Center, GW School of Medicine and Health Sciences, The George Washington University, Washington, D.C. (gwci@email.gwu.edu.); Ted Wymyslo, chief medical officer, Ohio Association of Community Health Centers, Columbus, Ohio (twymyslo@ohiochc.org).

FOOTNOTES:
OPTIMIZING THE PREAUTHORIZATION PROCESS

In the Healthcare Challenge Roundtable, healthcare finance, clinical, and health plan leaders discuss ways to collaborate on solutions to some of the industry’s biggest issues. This month’s topic: preauthorizations.

By Kathleen Vega

Healthcare providers often expend significant time and money on obtaining prior authorizations for services. Although the effort can present a substantial burden for clinicians and staff, it is important from a payer perspective to ensure proper payment and to avoid duplicative or unnecessary services (in the context of preauthorization, payer may refer to commercial health plans, Medicaid, and/or Medicare Advantage).

In this edition of the Healthcare Challenge Roundtable, senior provider and health plan leaders examine the difficulties associated with preauthorization and offer strategies for how stakeholders can collaborate to optimize the process. Participating are Jeffrey Hankoff, MD, medical officer for clinical performance and quality, Cigna; Sarah Knodel, system vice president, revenue cycle, Baylor Scott & White Health; Soujanya Pulluru, MD, medical director, DuPage Medical Group; and Krishna Ramachandran, chief administrative officer, DuPage Medical Group.

How can providers and health plans work together to improve the efficiency of preauthorization?

Sarah Knodel: There is a huge struggle right now regarding this topic. Baylor Scott & White Health has added technology over the years to streamline the insurance verification and preauthorization process. However, payers continue to implement more restrictions and requirements, and we’re starting to lose some of the efficiencies we gained a few years ago through automation.

It seems like each day I receive an email from our managed care department saying there are new authorization requirements from various payers, and staying on top of these changes can be daunting. Trying to ensure our technology stays updated with the latest requirements and that our Access Services staff and clinicians are aware of constantly changing requirements that differ by payer can be challenging. As an industry, we must find the balance between limiting the administrative load and making sure that the proper care is provided with the highest level of quality and at a reasonable cost.

To address some of these challenges, we should bring all stakeholders to the table. The good news is that we are starting to see and hear about this level of collaboration. For example, we were recently approached by a company representing a top commercial payer, and they asked us to work with them to review and reduce the administrative burden associated with determining inpatient versus observation status. It was exciting to see the payer initiate this dialogue in an effort to revamp the process. When both sides clearly understand each other’s pain points and what each one is trying to achieve, that is a solid first step. I feel confident that with everyone working together, we can figure out a better way to do this while also protecting the interests of both sides.

Krishna Ramachandran: The biggest disconnect we see at DuPage Medical Group involves making sure we’re on the same page with patients’ expectations. It can be challenging when a patient calls a payer and gets the impression that a certain procedure or medication is approved by the plan but then comes to us and we indicate there are clinical guidelines that need to be taken into consideration,
and those guidelines preclude the patient from receiving the treatment. This disconnect is a pain point on all sides of the equation—for patients, providers, and payers.

As such, I would say that clear expectation setting across the board would be helpful, especially regarding what’s covered, what’s not covered, what may be covered, and what may be concerning to the network.

Soujanya Pulluru: The lack of consistency is definitely a problem. When patients call their insurance providers, the message that they seem to be receiving—I don’t know what’s conveyed—is much more diffused and broad-based as far as what services are initially available. In other words, they are hearing mixed messages on what the first level of service is, causing a frustrating disconnect.

For example, if I as a primary care physician refer one of my patients to orthopedics, I would tell the person, “We have a great orthopedics department with plenty of choice. You are welcome to choose based on what you want, but here are the doctors I recommend.” Oftentimes, if the patient decides to see another doctor somewhere else for whatever reason, and the patient calls his or her health plan, there seems to be a different message from the payer. The patient is told that he or she can choose any physician as long as the doctor is contracted. It leaves us in a bit of a quandary. Again, this may not be the intention of the payer, but it appears to be the message that many of our patients are getting.

Jeffrey Hankoff: To make progress, it is important that we all appreciate each other’s perspectives and pain points. From our vantage point, preauthorization involves a balancing act. For 85 percent of our clients, we handle administrative services only—we administer their company health plans. As such, we have a fiduciary responsibility to make certain our client’s employees and their dependents receive evidence-based care.

Even though preserving clients’ interests is our primary focus, we acknowledge that the preauthorization process is a drain on providers, and we are trying to address that. The major reason that we see services being denied before ultimately being approved is that we don’t have the information we need for approval by the time we have to make the initial decision. Likewise, the major reason that a denial ends up being reversed on appeal is that the information we require becomes available. We’re ultimately dependent upon providers pushing data to us.

One of the ways we’re looking to reduce this dependency is by employing technology that automatically pulls information from electronic health records so we don’t have to rely on office staff or someone else in the provider organization to send the appropriate material. Although this is new for us and we’re still reviewing potential issues, such as obtaining the right HIPAA clearances and not inadvertently gaining access to information we shouldn’t have, it may solve a lot of problems if we can work through the logistical hurdles.

As an industry, we must find the balance between limiting the administrative load and making sure that the proper care is provided with the highest level of quality and at a reasonable cost.

— Sarah Knodel, Baylor Scott & White Health

What shared data or information is necessary to improve the process?

Ramachandran: There is a tremendous opportunity to have more up-front clarity about the guidelines and requirements. It would also be helpful if things were consistent across payers. Right now there is a significant amount of variation, which can be confusing and add layers of complexity.

Also, payers should make sure that all the various arms of their entities are communicating the same message. We’ve noticed that when we call our payer partners, the information we receive from the customer service representative is often different from what might be listed on the website or in the portal. When there is a disconnect, it sets up the entire team for failure—not just the provider and patient, but our payer partners as well.

Without having more clarity and consistency, we will always be swatting flies instead of closing the window. Every time there is rework or our doctors have to take time out of their busy schedules to call a medical director on the payer side, that’s an indication of process failure. If we know up front what information is necessary and can collect and package it to make the case for approval, then that is a “shutting the window” opportunity.

Hankoff: Cigna has publicly posted coverage policies that outline the criteria for virtually every procedure or service for which we require preauthorization. The key is getting the critical information needed for approval more quickly. If we don’t have to spend time chasing after details, it’s going to benefit the provider, the patient, and us. The more we improve our abilities to automatically share information, the more we will ultimately advance the process.

Knodel: Although certain payers are good about posting their requirements and having detailed information available in their web portals, not all are as robust in providing up-front guidelines as others, and that hinders the process—making it more time-consuming and manual. I think if payers consistently implemented best practices around guideline transparency, it could make things better. When more complexity is added to the preauthorization process, it naturally leads to less automation and to the need for us to call a payer for detailed
information to ensure we are financially securing an account. That process increases administrative costs for both sides because it involves human intervention.

That said, it would also be helpful if clinicians were more consistent in providing timely and complete medical documentation. If my department doesn’t have thorough information about what a physician has done up to the point of requesting a service, we can’t provide that information to the payer and obtaining preauthorization becomes more difficult, resulting in more delays and possibly requiring involvement from the physician to ensure the authorization is obtained for the service.

What if any sorts of exemptions from preauthorization requirements are fair?

Ramachandran: DuPage Medical Group has many contracts for which we are at some level of financial risk. It would be ideal to be exempt from the preauthorization process in instances when we’ve demonstrated that we are in a risk-sharing arrangement and using decision-support tools.

For example, at the point of ordering, our physicians use a tool from the American College of Radiology that asks the doctor a series of questions, such as “Have you tried these lower-cost, equally efficacious alternatives?” By taking on a risk-sharing arrangement and using decision-support tools, we are clearly on the hook for total-cost-of-care reduction and are already focused on keeping costs in check. Removing the burden of preauthorization in these circumstances would be helpful.

Hankoff: We frequently receive requests for what’s called “gold carding”—basically a free pass for organizations or individual providers that repeatedly demonstrate top performance and low costs. We have experimented with gold carding before with groups and individual providers that seem to have a history of good utilization. However, we have found that excellent performance tends to slip.

The one exception is when the provider is accepting some form of risk and physicians have an incentive to manage utilization. In these situations, the dynamic changes. Providers then manage their own preauthorization and work more collaboratively with each other. As they accept more risk, providers police themselves because it’s in their interest to do so. Over time, the preauthorization process shifts away from asking payers for approval and more toward seriously considering whether the available evidence supports the service being requested.

What can be done to help patients understand their role in managing healthcare costs, which, in turn, can expedite the preauthorization process?

Hankoff: More than ever before, patients are coming into their doctors’ offices with preconceived notions about what’s best. In many cases, they have the impression that they need something they don’t. For example, most low back pain will resolve on its own through either time or conservative medical management. Yet patients may come into the office and demand an MRI because they’ve read that an MRI is the best diagnostic tool.

Bottom line is we have a much more knowledgeable and empowered population, but that knowledge is not always accurate and that empowerment sometimes leads to pressure on physicians to order tests or procedures that they don’t think are going to be in the patient’s best interest. When the provider has no risk, it may be easier to check a box and send a request even though the provider may not agree that the patient needs the test. On the other hand, when the provider shares some of the risk, it does change the dynamic.

Both providers and payers have a responsibility to educate patients and help them understand that doing more is not always better. In fact, performing unnecessary testing often uncovers incidental things, which leads to further testing—and these procedures may have complications that introduce more risk.

Pulluru: Patient education is critical. Many people feel that because they have health insurance, there is a host of tests and labs that they should receive automatically. However, given that medicine is practiced by evidence-based guidelines, both providers and payers should educate patients that if a specific test is not medically warranted based on evidence, it will not occur—even if that test is technically covered by insurance.

Imaging is an area where these types of conversations frequently come into play. Patients may say, “I want a CT because my neighbor had cancer.” I tell them that it’s my job to assess risk versus benefit. Most patients receive this conversation well, but it is helpful when they also hear it from their insurer.

Both sides must be aligned on clinical appropriateness and evidence-based care. If the provider is saying, “Yes, you should get this done every year,” and the payer is saying, “You don’t need to have it done until the five-year mark,” then that can be confusing for the patient.

What technology can expedite the preauthorization process and make it more seamless?

Ramachandran: DuPage Medical Group has made investments in technology over the years, including systems focused on referrals and preauthorization. We’d love it if more of our payer partners would test these solutions with us. It would be great to take data that already exists in our electronic health records and send them in real-time to our payer partners, allowing us to immediately know whether the procedure was approved, denied, or in need of further information.

If you had asked me 10 years ago whether this was possible, I would have said it is a pipe dream. However, my thoughts on that are changing. We now have ways of checking payer benefits when our physicians place orders. We can determine in real time whether patients are eligible for insurance and what their copay is. There are lots of opportunities to get more out of these systems,
and I hope in the future we can better collaborate with our payer partners to move the process forward.

**Knodel:** Even though there have been advancements in technology over the past few years, preauthorization solutions still aren’t quite where they need to be. However, as these solutions are continually refined, I would expect the industry to start making progress in this area. I think progress will require continued innovation on the part of revenue cycle vendors and more transparent, robust, and actionable data and authorization requirements from payers.

A difficulty for us at Baylor is that we currently live in two worlds. For our employed physicians, we are responsible for initiating and obtaining preauthorization for services. Conversely, the independent physicians who refer patients for care at our facilities are acquiring their own approvals, and our role is to make sure they have done that in a timely and effective way prior to the rendering of services at one of our facilities. To be truly beneficial, preauthorization solutions are going to have to be flexible and meet the various needs of providers.

**Hankoff:** The more we can automate and leverage the electronic health record, the more we can reduce reliance on faxes and other manual processes. As we become more proficient at the automated parts of this, we should see fewer and fewer bottlenecks.

**How feasible is widespread implementation of real-time preauthorization at the point of care?**

**Ramachandran:** With all the investments healthcare providers have made in technology, we should be able to figure out a way to exchange preauthorization information. We can exchange medical records and engage in e-prescribing. We have shared platforms, so the time is right to leverage our technical capability and improve the preauthorization effort. We would certainly be amenable to a pilot if there were such an opportunity.

**Pulluru:** Absolutely, and there is low-hanging fruit we could address during a pilot—things like repeat testing, chronic conditions, and chronic medications that don’t require as much scrutiny.

**Knodel:** Real-time preauthorization is feasible, but only if the payers want it. The reason I say that is most of our managed care payers have 48 to 72 hours to respond to an authorization request. These delays, which are built into the payer’s workflow, are anxiety-provoking for the patient and physician. In limited instances, we even have some payers that make us wait up to 29 days to receive an authorization.

In these cases, the preauthorization delay is not because we haven’t started the process or provided the necessary information, but simply because of the administrative timeline that they’ve built in to their workflow. Although I think real-time authorization is possible, it’s a matter of whether all the stakeholders are willing to pursue it.

If we don’t have to spend time chasing after details, it’s going to benefit the provider, the patient, and us. The more we improve our abilities to automatically share information, the more we will ultimately advance the process.

—Jeffrey Hankoff, MD, Cigna

**Hankoff:** As I mentioned before, we’re looking at new technology that will allow us to pull in information. If we can agree on ways to exchange data, then we may be able to avoid some of the traditional back-and-forth.

Often a provider depends on a front-office staff person who doesn’t have any clinical training to submit the preauthorization.

The staff person may not know what information to send or which data are especially critical. In these situations, there is a lot of wasted time communicating back and forth trying to get all the appropriate details. If we could automate the process by which we receive the information we need up front, it would make everyone’s life easier.

Our medical directors are the only ones who can make adverse medical-necessity determinations—nurses and nonclinical staff cannot issue medical-necessity denials—and medical directors are not incentivized to deny services.

What we’re trying to do is minimize the time needed to get to approval of coverage of the best possible care. If something should be approved, arriving at that decision faster is in everyone’s best interests. On the other hand, if it’s not an approvable service, we want to minimize the time to reach that answer as well.

If we have all the information up front, we can arrive at what we feel is the right answer as quickly as possible. We believe that’s the fairest approach for the patient and the provider.

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**Interviewed for this article:** Jeffrey Hankoff, MD, medical officer for clinical performance and quality, Cigna (contact via Mark Slitt, mark.slitt@cigna.com); Sarah Knodel, system vice president, revenue cycle, Baylor Scott & White Health (sarah.knodel@bswhealth.org); Soujanya Pulluru, MD, medical director, DuPage Medical Group (soujanya.pulluru@dupagemd.com); Krishna Ramachandran, chief administrative officer, DuPage Medical Group (krishna@dupagemd.com).
NO EASY CHOICES: WHAT LIES AHEAD FOR HEALTHCARE REFORM

An examination of the options for replacing the Affordable Care Act shows why authors of the next chapter of healthcare reform face such a complex challenge.

By Timothy Stoltzfus Jost

On March 9, two House committees approved the American Health Care Act (AHCA), the legislation put forward by Republican leadership to partially repeal and replace the Affordable Care Act (ACA). Although the legislation still had to clear additional House committees and be approved by the full House and the Senate as of the publication of this article, some form of repeal-and-replacement bill could be passed by Congress as soon as this spring. So what will repeal-and-replace look like?

First, it is important to understand that repeal of the ACA in totality is not possible politically and probably not practically. As often has been noted, the ACA is hundreds of pages long and addresses virtually every aspect of our healthcare system, including payment fraud and abuse, preventive care, approval of biosimilars, and training for healthcare professionals. The ACA also amended numerous Medicare and Medicaid provisions, such as closing the Medicare prescription-drug doughnut hole and embracing Medicare payment and quality improvement initiatives. Some Republican proposals have bravely asserted that they will repeal the ACA entirely, but the AHCA limits itself to Title I, the insurance reforms; the Medicaid expansion provisions of Title II; and, significantly, the taxes that Title IX imposed on wealthy Americans and healthcare providers. (It repeals $300 billion in Medicare taxes over the next 10 years for taxpayers earning more than $200,000 a year.)

Although it was thought initially that Congress might proceed quickly to repeal some parts of the ACA but delay implementation of the repeal provisions until a replacement bill could be passed, it has become increasingly clear that this is not a viable strategy. Repeal without a replacement would cause 20 to 30 million Americans to lose coverage, according to the Congressional Budget Office, while repeal-and-delay could cause as many as 18 million to lose coverage by 2018.

That’s because insurers need to have a good sense of the replacement before repeal occurs. Insurers are reluctant to return to the individual-insurance market for 2018 until they know what that market will look like. Because the individual-insurance market represents a small share of revenue for large national insurers, they see little need to risk losing more money in it. And if they do not come back, the entire individual market collapses. Thus repeal is moving forward with provisions intended to replace parts of the ACA in the hope of reassuring health insurers.

THE ARGUMENT FOR “REPAIR” OVER “REPEAL”

As the Republican House leadership has moved forward with repeal-and-replacement, the Trump administration has argued that what they are doing is “repairing” damage caused by the ACA. The administration argues that the ACA individual market was completely broken, but this is not necessarily the case. Some insurers raised premiums dramatically for 2017, but there were indications that the premium increases were sufficient to stabilize the market going forward.

Talk of repeal itself, however, has caused a great deal of damage and has aggravated the effects of steps that Congress has taken in the recent past, such as defunding the risk corridor payments for 2014 and 2015 and suing to end cost-sharing reduction payments. Some “repair” initiatives are, therefore, in order.

In the first instance, the Trump administration is moving forward with regulatory measures intended to build insurer confidence in the future of the market. The Trump administration has proposed a “market stabilization” rule, which would further restrict special enrollment periods, allow insurers to sell plans with lower actuarial values, shorten the open enrollment period for 2018, and roll back other regulatory requirements. The rule will likely be finalized in late March.

A CLOSER LOOK AT REPLACEMENT

The proposed AHCA would go much further than those regulatory steps, as a look at some of the key provisions makes clear.

Continuous-coverage requirements and high-risk pools. First, the AHCA would repeal the unpopular individual and employer mandate penalties and replace them with a continuous-coverage requirement. If consumers maintain continuous coverage, they can move from one insurance plan or market to another and be subject only to the limits that apply to normal open- and special-enrollment periods. If an individual has a gap in coverage of 63 or more days, however, the individual’s premium will be increased by 30 percent for the next 12 months.

Breaks in coverage are common for low-income consumers or consumers with health problems. Cancer patients, for example, often have to stop working while receiving treatment, losing coverage in the interim. Moreover, as a practical matter, the continuous-coverage
penalty will discourage healthy as well as unhealthy people from enrolling. Whereas the individual mandate penalizes people for remaining uninsured, the continuous-coverage requirement penalizes people when they attempt to enroll in coverage.

The nonpartisan Congressional Budget Office apparently doesn’t think this requirement and other provisions will make up for the loss of the mandate to have insurance—it projects 24 million fewer people will be insured by 2026 under the AHCA compared with the ACA.

The AHCA also gives $100 million to states over the next nine years to use for various purposes, including reinsurance and high-risk pools. The ACA offered reinsurance to individual-market insurers for high-cost cases during its first three years, but the program phased down far too quickly. The AHCA’s fund, if used wisely, could provide some stability to markets going forward, particularly if supplemented by state funds.

High-risk pools are more problematic. Two-thirds of the states had high-risk pools before the ACA was adopted. The pools had limited capacity and offered costly and limited coverage that often excluded preexisting conditions. High-risk pools would likely work only with federal support exceeding that which is being offered in the AHCA.

**Fixed-dollar, age-adjusted tax credits.** The AHCA would repeal the ACA’s means-tested tax credits and swap in fixed-dollar, age-adjusted credits, which phase out only at relatively high income levels. The tax credits offered by the AHCA are more generous than the ACA’s tax credits for young and higher-income people, but will simply leave premiums unaffordable for older and lower-income enrollees. Having more young and higher-income enrollees will benefit the insurers, but millions who were covered by the ACA will lose coverage.

**Health savings accounts (HSAs).** The AHCA, like most other replacement plans that Republicans have put forward, promotes HSAs, a longtime Republican health policy panacea. In particular, the bill would increase the maximum tax-subsidized amounts that can be contributed to HSAs to the amount of the out-of-pocket limit, allow both spouses to make catch-up contributions to the same HSA, and allow HSAs to cover medical expenses incurred up to 60 days before HSA coverage begins.

HSAs are a great tax shelter for higher-income Americans—they shield from taxation deposits in an HSA, investment income on funds held in an HSA, and healthcare expenditures made from the HSA. There is also evidence that account holders reduce healthcare utilization—not always wisely—because they are effectively spending their own money when they purchase services from their HSA. But low-income consumers lack both discretionary income to deposit in HSAs and the tax incentives to make such deposits.

Any strategy that makes coverage cheaper will also diminish the value of the coverage. Higher deductibles, for example, will essentially impose a permanent additional cost on individuals with high-cost chronic conditions.

**Cheaper coverage.** Finally, the AHCA includes a couple of provisions intended to make coverage more affordable, particularly for younger people. It would allow insurers to charge older enrollees five times as much as younger enrollees (the ACA allowed only a 3-to-1 ratio) and would remove the ACA’s actuarial-value rules that require insurers to offer health plans with comparable cost-sharing levels. Unlike earlier proposals, the AHCA does not remove or reduce requirements regarding essential health benefits or allow the sale of insurance across state lines. And the ACA’s out-of-pocket limits remain in place, limiting the ability of insurers to increase cost sharing and, in turn, to reduce premiums.

Any strategy that makes coverage cheaper will also diminish the value of the coverage. Higher deductibles, for example, will essentially impose a permanent additional cost on individuals with high-cost chronic conditions. But finding ways to reduce the cost of coverage would allow Republicans to claim that more individuals have access to coverage, disregarding how protective that coverage is.

**RAISING THE POLITICAL STAKES**

Each of these provisions is likely to alienate certain constituencies. Increasing age-rating bands will disadvantage older consumers, for example, while penalizing gaps in coverage and instituting fixed-dollar tax credits will harm low-income consumers.

The ACA itself has been unpopular with many Americans, of course, and it is not possible to find a reform proposal that will please everyone. In the coming weeks and months, however, Republicans in Congress and the Trump administration will have to decide which constituencies they are willing to alienate. Their decisions may well decide the shape of future electoral battles, much as the ACA has arguably disadvantaged Democrats with respect to certain constituencies for the past six years. +

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Independence Blue Cross, Penn Medicine, and Dreamit Health are working together to bring innovative solutions to health care.

By Laura Ramos Hegwer

During the past four years, leaders at three Philadelphia-based organizations—Independence Blue Cross, Penn Medicine, and the venture accelerator Dreamit Health—have helped launch more than 75 healthcare startups. Such collaboration is essential if health plans and providers truly want to transform health care, says Tom Olenzak, managing director of the strategic innovation portfolio and director of corporate development and innovation at Independence.

“There really isn’t an Uber or a Facebook for health care,” Olenzak says. “Because the healthcare system is so complex, it doesn’t lend itself to complete outside disruption. You need collaboration.”

**WORKING WITH AN ACCELERATOR**

For the past four years, Independence and Penn Medicine, along with other organizations, have sponsored and supported Dreamit Health’s accelerator program.

“During a typical cycle at Dreamit Health, we will have approximately 400 startups apply from three dozen countries, and only six to 12 will get in,” says Steve Barsh, the accelerator’s chief innovation officer. Leaders at Independence and Penn Medicine work with Dreamit Health to interview and select the companies during the two cycles hosted each year. “They help us pressure-test assumptions and make sure the startups have a solid go-to market strategy,” Barsh says.

Each startup that is selected to participate completes a 14-week curriculum in which it has access to customers, coaching, legal counsel, and other resources that can help launch the business. But the startups are not the only participants learning from the process. “It’s an opportunity for us to get involved and learn from these entrepreneurs to see how they are thinking about health care,” Olenzak says. This insight gives Independence and Penn Medicine a fresh perspective on using new strategies, including emerging technology, to solve pressing problems.

Working with Dreamit Health also has helped leaders at the health plan develop a framework for an ongoing relationship with Penn Medicine. “This has helped us think about how we work collaboratively to improve health,” Olenzak says.

Roy Rosin, chief innovation officer at Penn Medicine, agrees. “With Dreamit, not only do we get to partner with our largest payer, Independence, but it is also a way that we can bring in people with a completely different skill set that may not be represented in a health system,” he says.

Among such participants are entrepreneurs who may not have extensive industry knowledge but may be motivated to solve a healthcare problem because of a personal or family member’s experience. “We find most of our Dreamit companies, typically digital health and medical device companies, are started because of a personal need,” Barsh says.

**FINDING COMMON GROUND**

“Everyone is interested in high-value care—that is the intersection between payer and provider interest,” Rosin says. Health plans and providers also are aligned when it comes to engaging patients in their care. “Most determinants of health happen outside of the few hours that we spend with patients during the year,” he says. “Patient engagement for us is about understanding how we can appropriately become part of the patient’s life to get better outcomes for them.”

One startup that exemplifies this alignment of goals is TowerView Health, which was developed by a group of Duke University students after one of the cofounders was diagnosed with leukemia during his first year of medical school. The entrepreneurs, who were part of Dreamit Health’s 2014 class, created a “connected pillbox” with prefilled trays designed to help patients manage multiple medications and to track patient adherence.

The pillbox, which is being tested at Penn Medicine with Independence members, can alert the patient, a family member, or a member of the care team via text if a dose is missed. It also alerts the Penn Medicine research coordinator when patients have missed their medication consistently.

With TowerView Health, it was important to Independence that they fund the research and it was important to Penn Medicine that we craft and create the clinical access and allocate researchers to the pilot,” Rosin says.

The TowerView Health program has achieved strong adherence in early trials, with compliance with complex medication schedules improving to more than 90 percent.

“With traditionally low medication adherence driving
both avoidable costs and suboptimal patient outcomes, it appears to be an example where all parties win,” Rosin says.

Another company that has grown out of the collaboration among Penn Medicine, Independence, and Dreamit Health is Tissue Analytics. The company created a smartphone app to objectively and automatically measure chronic wounds and other skin conditions—an improvement over having wound care nurses use wooden rulers to measure lesions when visiting patients’ homes. Rosin says the software, which can be used in a variety of settings, has shown the potential to cut in half the time that many wound care patients require home care services because a more accurate wound assessment allows for more effective treatment.

LESSONS LEARNED
Leaders at Dreamit Health, Penn Medicine, and Independence offer the following advice for healthcare organizations seeking to collaborate for innovation.

Define your success criteria. All parties involved in innovation should share the same definition of success, Barsh says. Specifically, all stakeholders need to define the outcomes they hope to achieve and establish clear endpoints for trials.

Understand what an accelerator can do. “Most of the providers that we work with don’t lack startups knocking on their door,” Barsh says. “If they have an innovation office, they are getting emails from startups every single day.” For this reason, many providers choose to work with a venture accelerator that can help curate the field.

Providers and health plans also need to be clear on what they hope to gain from getting involved with an accelerator. Goals might include finding solutions that dramatically improve care delivery and outcomes for their patient population, attracting physicians to their organizations by giving them a channel for innovation, or finding partners for potential mergers and acquisitions as well as pilot programs. Barsh says the accelerator gives health plans and providers “a detailed look under the hood” at startups and can better guide potential partners in moving forward if they choose to do so.

Select passionate leaders. “Finding projects where you have engaged senior leaders as executive sponsors is important, but so is having passionate and engaged clinical champions,” Rosin says. Executive champions might be department heads, the chief medical informatics officer, or business leaders responsible for service lines. Clinical champions should be front-line clinicians with access to the target patient population and setting and the relevant care team. “You need people to be excited about what they are doing,” Rosin says. “You want to find people for whom solving this problem is already a top priority and a personal passion.”

Embrace payment reform. “As you innovate on new products and services, you often need to have a new way of getting paid,” Rosin says. “That is why payer-provider collaborations are so interesting. If you’re sitting on the same side of the table with aligned incentives, mutual wins become possible.”

In a fee-for-service environment, advances that are better for patients and the community will tend to negatively impact either the health plan (if more costly) or the provider (if fewer services are used). Breakthrough innovations require a parallel effort focused on appropriate payment structures.

“Payment changes have probably driven more productive innovation than almost anything else, but where those payment reforms have lagged behind, you need to move business model innovation forward with product innovation,” Rosin says.

Make a long-term commitment to collaboration. “You can’t sign a partnership agreement and be done,” Olenzak says. “It is important to invest in building relationships and developing trust, because with innovation you are taking risks. Not everything is going to work, and you need to have a relationship that can sustain that. Obviously, that takes time.”

However, the benefits of collaborating on innovation can be significant. As Olenzak says, “The potential impact is much greater when you work together than when you try to do things in your own silo in the healthcare system.”

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ONE-STOP SHOPPING FOR HEALTHCARE SERVICES

Leading health systems are reorganizing and consolidating their services to make it easier for consumers to stay healthy.

By Lola Butcher

When Lee Health Coconut Point opens south of Fort Myers, Fla., next year, patients will be able to visit a physician, undergo a cardiac stress test, and get an ultrasound on the same day—without moving their car or registering for each service separately.

They can pick up prescriptions at the retail pharmacy on their way to the Healthy Life Center, which offers education about medical conditions and help with physician referrals for outpatient surgery and rehabilitation.

Focusing particularly on South Florida’s seniors, many of whom have multiple health conditions, Lee Health seeks to replace “fend-for-yourself” medicine with proactive assistance that allows patients to make wise use of healthcare resources.

“Even though this service is provided in a retail setting, we will have schedulers on-site to actually help people gain access to care versus leaving them to navigate the system for themselves,” says Kevin Newingham, Lee Health’s chief strategy officer.

Meanwhile, in Kingston, N.Y., primary care, behavioral health, and other support services—including health-oriented retail, educational programs, and community events—will coalesce at a medical village being developed by HealthAlliance of the Hudson Valley and its parent, Westchester Medical Center Health Network (WMCHHealth). Joshua Ratner, WMCHHealth’s senior vice president for network strategy, likens the project to a shopping mall designed to make healthy living easy.

“If you are in the local community, you’ll have the ability to walk to our medical village, see your primary care physician, maybe pick up a healthy shake, and have access to all sorts of support services,” he says.

While the two projects differ in many ways—Lee Health is reacting to demand for healthcare services in a fast-growing community; HealthAlliance is repurposing a hospital building—they both are responding to consumers’ desire for “one-stop shopping” for healthcare services.

CATERING TO THE CUSTOMER

As consumerism gains traction in health care, many health systems are beginning to borrow the imperatives of the retail industry, including convenience and customer service, to remake their operations. It can’t happen fast enough to suit Jon Burroughs, MD, MBA, president and CEO of the Burroughs Healthcare Consulting Network.

For the most part, he says, “everything still revolves around the needs of the physician and the hospital, despite all the patient-centered rhetoric.”

Using a suspicious breast lump as an example, he rattles off the many steps—a visit to a primary care physician; referrals to various specialists; multiple images ordered by multiple physicians, with the patient often relaying information from one provider to the next—before a treatment plan gets started. No one can call it consumer-friendly.

“Convenience means different things to different people—available when I need it, easy to get to, other people handle the complexity, no worries about records getting lost,” Burroughs says. “What it does not mean is going to a lot of different providers and being billed by each one.”
HEALTHY LIFE IN FLORIDA
Clustering services in a compact space is one step toward consumer-oriented convenience, Burroughs says, and Lee Health Coconut Point is putting that approach into practice.

“This is taking it beyond co-location of services to coordinate services in a different way than we do now,” says Dave Cato, Lee Health’s chief administrative officer for outpatient services.

Anchored by an emergency department and urgent care center, the 163,000-square-foot facility will include units for observation, outpatient surgery, radiology, laboratory, and rehabilitation, along with a breast health center and a pharmacy. Both primary care and specialty physicians will be on hand.

The Healthy Life Center at Coconut Point, already in operation, will be relocated to the new facility to serve as a hub that supports healthy lifestyles, early detection of disease, and chronic disease management. The center provides screenings—cardiovascular, memory, balance, and fitness, among others—and educational programs on nutrition, integrative medicine, sleep, and other topics.

“We don’t just see ourselves as providing sick care,” Newingham says. “One of our big areas of focus is the overall health and wellness of our population.”

The concept for Lee Health Coconut Point came from extensive interaction with community leaders in southern Lee County, which has experienced significant population growth that is expected to continue during the next 10 years. Because of that, Lee Health expects the project to generate a positive ROI on its own, without counting referrals that will be made to the organization’s hospitals.

The community leaders originally expressed interest in a new hospital, and the project is designed to possibly accommodate one in the future.

“We pulled together a group comprised of internal folks, but also community representatives and physicians from a wide number of specialties, to talk about what they would want to see in the new center, in terms of how it might function differently from traditional healthcare facilities and the types of programs and services to include,” Cato says. “It was through that collaborative process that the project that we’re pursuing emerged.”

HEALTHY COMMUNITY IN NEW YORK
In the Hudson Valley, HealthAlliance is also using community input to plan its medical village in Kingston. That project, stemming from a merger of two hospitals and the need to reduce unnecessary inpatient capacity, offers the opportunity to think about health in a much larger context.

“We’re taking this investment that’s come from the state and really leveraging it to elevate the overall health of our community,” Ratner says.

He’s referring to nearly $89 million HealthAlliance received, through a competitive process, from the state Department of Health as part of its Delivery System Reform Incentive Payment program. That money will support the renovation and expansion of HealthAlliance’s Mary’s Avenue hospital and the redeployment of its Broadway Campus into a medical village that includes primary care, behavioral health services, outpatient rehabilitative care, and other support services.

By grouping the services that outpatients need, the medical village will facilitate care navigation.

“If I were to go to the third floor and see a primary care physician, and then I need to go to the first floor for physical therapy, there can be a ‘warm’ hand-off so I’m not starting from scratch when I go from one to the other,” Ratner says.

Other tenants are expected to flock to the high-profile location near Kingston’s city center. Ratner believes the area’s federally qualified health center, which occupies space in the hospital, will expand its footprint, with community-based behavioral health service organizations also joining.

“Many of the behavioral health patients that we see in our emergency department really should be seen in a primary care physician’s office or in an outpatient behavioral health clinic,” he says. “This will be a better environment for those patients—it’s less expensive, and it’s really the right way to deliver care so that we can coordinate care more closely around behavioral health services.”

The medical village will be built out over several years as the Mary’s Avenue hospital expansion and renovation creates space for the inpatients currently cared for at the Broadway hospital. Ratner sees other entities wanting to be part of a medical village because they look at health holistically.

In fact, the county government has expressed interest in placing some services, such as a transportation hub and job training and placement services for at-risk individuals, in the village. Both jobs and transportation access are associated with improved health status, thus fitting in with HealthAlliance’s vision for a health-oriented village.

“And we’re looking to expand access to healthy foods,” Ratner says. “So we’re really looking at a full spectrum of offerings.”

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HOSPITAL ACQUISITIONS OF PHYSICIAN PRACTICES: PUT PEOPLE FIRST

Keeping the human component in mind can help the merging entities handle issues involving referrals, physician satisfaction, and compensation.

By Ed Avis

Physicians and hospitals go together in patients’ minds like chefs and restaurants—they are both part of the same operation. But hospital executives and physician practice leaders know that the reality can be different. When hospitals and physicians join forces, especially when health systems acquire physician practices, complications often arise.

“The success rates of hospital acquisitions of physician practices are quite variable,” says Peter Angood, MD, the CEO and president of the American Association for Physician Leadership. “The success stories arise when both sides of the arrangement have been up front about setting their expectations for the relationship. Those that are less successful make a lot of assumptions.”

The unexpected consequences of physician practice acquisitions can be costly and disruptive. But, experts say, those consequences often can be avoided, and remembering the “people” side of the transaction is key.

REFERRAL COMPLICATIONS

Referrals are the source of some of the most common issues that occur when a health system acquires a physician practice. Naturally, the promise of increased referrals is a key reason for systems to acquire practices, but the reality doesn’t always meet that promise.

For example, if the acquired physicians have solid relationships with specialists who are not part of the system, they may prefer to retain those referral relationships rather than switch loyalties to the health system’s specialists. And the health system cannot compel them to do otherwise.

“Hospitals and universities cannot force referrals, and they have to be careful not to put too much pressure on physicians to make referrals,” says Debra Phairas, president of Practice & Liability Consultants, LLC in San Francisco. “I’ve had three physicians [clients] leave hospital foundations because they felt pressured to keep referrals within the hospital.”

The reason health systems cannot compel their physicians to refer within the organization is liability, Phairas explains. If a patient dies after being referred to a specialist, for example, and the patient’s family learns that the physician felt compelled to refer to that specialist despite not thinking that specialist was the best choice, a lawsuit could ensue.

So how can a health system persuade its doctors to voluntarily refer within? It should make sure the best specialists are part of the system, of course. It should make the referral process as easy as possible. And it should discuss the expectation of referrals early in the acquisition process.

“Hospitals need to drive revenue from these physicians,” notes Katharine Halpin, principal of The Halpin Companies, a mergers-and-acquisitions consulting firm. “If the physicians are referring patients to other facilities for tests or treatments, the forecasted goals and metrics cannot be achieved. The reasons vary, but typically they relate to poor quality of the services, weak structures that make referrals difficult for the physicians, or simply a lack of awareness by the physicians of this key expectation.”

But even when health systems have excellent internal referral procedures and the expectations are clear, the system should recognize that compulsion is not an option.

“If the community has a mix of employed and independent physicians, the referrals all come down to relationships,” Angood says. “So there’s no guarantee that if a hospital buys a practice, it will get all the referrals. In some cases the physician says, ‘OK, I’m comfortable referring to your physicians,’ while others say, ‘No, I prefer referring outside the system.’ This should be a point of discussion during negotiations but not a contractual obligation.”

DISSATISFIED DOCTORS

Another potential issue with physician practice acquisitions is job satisfaction among newly employed physicians. Physicians are accustomed to being in charge and to commanding respect when they own a practice.

“Physicians often enter hospital employment because they want to decrease their bureaucratic burden, focus on patient care, get better compensation, and have a better work-life balance,” Angood says. “They may make the mistake of thinking they’ll get all of that and still maintain their autonomy and decision-making power. So it’s a shock when that doesn’t happen.”

Halpin concurs. “If leaders could engage the physicians at a granular level before the acquisition and build not only a shared vision and a commitment to
agreed-upon expectations but also routine methods for consistent, honest communication, the success rate of these acquisitions could skyrocket,” she says.

Health systems should discuss expectations early, offer leadership positions to the acquired physicians, be transparent in decision making, and treat physicians with respect.

“It’s important to understand that the approach with the physician can’t be the same as with any other employee—you need an equitable partnership with them,” says Adhi Sharma, MD, chief medical officer of South Nassau Communities Hospital in Oceanside, N.Y. “You have to make sure they are partners, not simply drones.”

Monty Porter, JD, a member of the Health Care and Finance Practice Group at law firm Jackson Kelly PLLC, says one key is ensuring physicians still have a voice in their future.

“It’s obviously important to try to make physicians feel involved, and that they have a voice that can be heard and will allow them to continue to have some influence as to what happens to them going forward,” Porter says. “I think they understand that many final decisions rest with the hospital, but it serves the hospital well to realize that this is a big change for physicians.”

One way health systems can help physicians make the transition from being practice owners to being employees is by ensuring they have convenient and regular access to hospital leaders. Physicians may be uncomfortable having to follow a long chain of command to discuss a potential problem.

“If physicians feel they have access to the people who are higher up, and those people will hear their concerns, it will go a long way toward a successful transition,” says Heather Delgado, JD, a partner with the law firm Barnes & Thornburg who handles many physician practice acquisitions.

Providing a path to leadership roles and listening to concerns are important approaches, but little things also matter.

“I had a physician tell me that one of the things he loved about us was that our parking lot was less than a minute’s walk to get into the facility,” Tony Tedeschi, MD, the CEO of the Chicago market for Tenet Healthcare and CEO of Weiss Memorial Hospital, said in December at a panel discussion of hospital executives. “For physicians, those are precious moments—they’re moments that take them away from their family, they’re moments that take them away from patient care. Everything we do, we try to really do with a recognition of the importance and the respectfulness of that relationship.”

The location of the parking garage may not be something a hospital executive can change, but other small issues can go a long way toward demonstrating respect to physicians. For example, the time physicians need to spend documenting care these days can be draining; a $20-per-hour scribe could lighten that load.

Naturally, the ultimate result of unhappy physicians is turnover.

“Employed doctors do not have the same emotional and financial stake in their practice as independent doctors,” says Travis Singleton, senior vice president of physician search at consulting firm Merritt Hawkins. “For doctors, it’s a seller’s market. If you don’t like the way things are going, it is not too difficult to find greener pastures elsewhere. That’s why any acquisition program must have a strong retention element.”

COMPENSATION CONCERNS
Physicians may seek employment with a health system in large part for the opportunity to have a steadier income. But the cost structure of a health system is different from that of an independent physician practice—systems frequently lose money on their physician organizations—and granting physicians a pay increase following a merger is not always feasible.

“If you look at a hospital’s balance sheet, a lot of times physician practices are not huge money makers,” Delgado says. “They do provide physician integration into the system and increase the physician network, so there’s a lot of good that comes from an acquisition. But if you acquire a primary care practice and you pay the physicians and their staff a competitive salary and benefits, ramp up their electronic health record (EHR) system, and buy new equipment to get the practice up to hospital standards, you have a lot of costs.”

Some of the costs may not be obvious, Delgado notes. For example, the health system may need to lease new space to accommodate the practice, or it may find itself on the hook for insurance overpayments to the practice that took place prior to the acquisition.

The result is that physicians are sometimes unhappy with their new income, while health systems may feel they are not getting enough value from the physicians. Establishing a transparent compensation program, with incentives, is key to avoiding disappointment on either side.

Commonly, employed physicians are paid a base salary that represents a percentage of the median salary for that specialty—as determined by the Medical Group Management Association or physician compensation consulting firm Sullivan Cotter—combined with a bonus based on the number of RVUs the physician achieves above the corresponding percentage of median RVUs.

“For example, say the median work RVUs for internal medicine is 4,795 and the median salary is $222,000,” Phairas says. “If they set the base salary at 80 percent
of that, the physician would have to achieve 3,836 work RVUs for the base. Anything over that base is going to be paid at a dollar amount per work RVU to incentivize them to be productive.”

Phairas says the bonus should not be capped—physicians who are highly productive should be highly compensated.

“I looked at one agreement in which the [physician] foundation capped the bonus at 10 percent over baseline,” she says. “I asked the hospital CEO, ‘Why would you do this? You are encouraging the doctor to do no more than he has to. The hospital loses and the doctor loses. You want them to be as productive as they can be.’”

However, the work RVU formula is designed for the fee-for-service world. The need to evolve the model as value-based compensation takes hold adds a new layer of complication to physician practice acquisitions.

Value-based payments encourage different activities from providers, of course. Rather than aiming for a greater number of procedures, hospitals and physicians theoretically aim for healthier overall patients. But that can be hard to measure, and consequently it’s hard to motivate caregivers in that direction.

Phairas has worked with healthcare organizations on value-based compensation programs. For example, she prepared one package in which 70 percent of compensation was based on the work RVU formula, 20 percent on quality metrics, and 10 percent on good citizenship, such as willingness to participate on committees.

WHERE TO FOCUS
Perhaps the best advice on making physician practice acquisitions work is simply to pay close attention to the human components.

“Because the focus of most due diligence processes is the legal and financial aspects of any merger or acquisition, the most important components are omitted,” Halpin says. “Without the right people in the right roles, focused on the right projects, no transaction will be successful. The key to success is to address the people side of the transaction.”

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Health care is inherently complex and continually evolving. Rising pressures on care delivery systems include employee shortages, an older workforce nearing retirement coupled with an aging patient population, rapidly changing finance models, shifting delivery systems focused on value, limited access to behavioral health services—and so many others. All the while, physician employment models are becoming much more prevalent.

Collectively, these issues align to make physician workforce planning and engagement an immediate priority. Emotional equity in the organization grows among all physicians when their peers are seen and engaged as leaders. This equity, in turn, correlates with increases in productivity and referrals, reductions in costs, and improvements in quality.1

Amid the current industry tumult—from both an administrative and a political perspective—organizations have even greater incentive to place physicians in leadership roles. The profession remains among the most trusted by the public, and society continues to view all physicians, at some level, as leaders. Physicians are natural stewards of the clinical delivery enterprise—and the primary managers of health for populations—and thus are best-suited to lead adaptive initiatives, innovative strategies, and novel campaigns designed to improve health care.

In fact, when a physician is the CEO for a delivery system, outcomes on established quality metrics improve between 25 and 33 percent.2 Physicians in other leadership roles, meanwhile, can draw from clinical and managerial experience to assist the C-suite in anticipating results of new initiatives. They can gauge how efforts might be perceived and adopted by personnel and patients (generally, physician leaders are very effective at networking in communities).

Another timely argument for physician leadership is the change in priority from disease-focused care and physician-centric business practices to population health management and patient wellness. Leading organizations are engaging physicians and redefining historical relationships to achieve better strategic alignment in pursuit of these goals.

OVERCOMING BARRIERS

The historical evolution and wide variability of medical staff models, taken together with volume-driven payment, is one dynamic that makes physician engagement a complicated issue. Another involves the traditional stereotypes of expected physician behavior and the tendency of the current medical education system to perpetuate those stereotypes of autonomous, independent decision makers. These factors make it imperative for all to consider different approaches.

Physician engagement and collaboration hinge on having well-educated and well-trained physician leaders. Mentoring and continued professional development are needed at every level and stage of physician leadership development and career progression. In turn, physicians with ambitions of serving in leadership roles must recognize the need to seek additional education and experience.

By working collaboratively, physician leaders and nonclinical leaders build effective relationships that facilitate bidirectional learning.

A MORALE-BOOSTING APPROACH

Physicians’ knowledge base, level of training, and practical experience command the respect and admiration of colleagues, patients, and the communities and systems in which they serve. Fellow physicians generally see these leaders as peers, thereby establishing a network of support and encouraging physicians throughout the organization to influence outcomes, whether by contributing to organizational care teams, adopting practice reforms, or spearheading improvement initiatives. These physicians themselves may subsequently make the transition from practice to leadership, driving business results, patient satisfaction, wellness, and safety.

With physician demand increasingly outpacing supply, the corresponding rise in employee mobility places organizations at greater risk of turnover. Compensation notwithstanding, physician engagement and leadership promote retention and help physicians feel respected, appreciated, and valued as part of a productive team.

Working together at the organizational level, administrators and physician leaders can lay the foundation for the industry-wide improvements that our patients and their families deserve.

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