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The New Era of Healthcare

Practical Strategies for Providers and Payers

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Emad Rizk, MD

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Emad Rizk, MD

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About the Author



Emad Rizk, MD, is president of McKesson Health Solutions, a division of McKesson Corporation, delivering unique solutions that enable payers, providers, and patients to come together to transform the business and process of healthcare.

Rizk is a world-renowned expert in the healthcare industry, with more than 25 years of experience working with payers, physicians, hospital systems, and pharmaceutical organizations. He is a thought leader on transformational strategies and operational execution for healthcare organizations.

In his previous position as the global director of Deloitte, Rizk led medical cost and quality management practice across all industries. He also spearheaded the largest redesign of care management and delivery models among health plans and providers nationwide.

Rizk is sought after for his knowledge of the healthcare industry. He has served on many healthcare boards, including the National Clinical Advisory Board and National Quality Review, and currently serves on the boards of DMAA: Care Continuum Alliance, National Association for Hispanic Health, University of Miami, University of North Texas, and *Managed Care Magazine*. Rizk is a senior scholar professor at Jefferson Medical College in Philadelphia and has an extensive portfolio of published journal articles and books, including *The Wisdom of Top*

Health Care CEOs, a collection of interviews published in 2003 by the American College of Physician Executives.

In 2008, Rizk was named one of the “50 Most Powerful Physician Executives” in the United States by *Modern Physician* and one of the nation’s top 25 leaders in disease management by *Managed Healthcare Executive*.

Rizk lives in Chicago with his wife Fadia and sons Antony, Michael, and Andrew.

Introduction

This is not an easy time for healthcare. Costs are up. Physician morale is down. Despite our growing medical knowledge, we seem unable to contain the burden of chronic disease. The cost, in dollars and human health, is astounding.

The most striking assessment of our healthcare system comes when we look abroad. The United States spends far more per capita on healthcare than any other country in the world. With that, we should have the world's top-rated healthcare, right? Unfortunately, we do not. While our costs have soared, our outcomes are not commensurate. Looking solely at mortality rates, many countries that spend a smaller portion of their gross domestic product on healthcare do significantly better.

So, it may surprise you that I am optimistic about the potential to improve the state of the U.S. healthcare system and the health of its patients. This improvement can be achieved through practical steps that focus largely on bringing together two critical constituents in healthcare: payers and providers.

For the past 20–30 years, payers and providers have been at odds with each other. Each move by insurers to control costs has been met with countermoves by hospitals and physicians to maintain their decision-making authority and payment levels. Our many strategies and models—from preferred health organizations, to health maintenance organizations to preferred provider organizations—have put payers and providers into every contorted relationship except as allies. No model yet has squarely addressed the critical relationship that must exist between payers and providers to ensure effective and cost-effective healthcare. The result is a system full of inefficiencies, redundancies, disconnects, and mistrust. These are some of the reasons that our healthcare system is in such distress.

But this dysfunction also opens a great window of opportunity. Payers and providers now have the incentive to put aside their old antagonisms. It is clear that the old ways of doing business cannot continue. Payers and providers face a shared challenge. Leaders on both sides are starting to see the fundamental need to work together toward mutual goals of healthcare efficiency and quality.

The term I use for this coming together is “alignment.” My dictionary defines alignment as “the process of adjusting parts so that they are in proper relative position.” Fortunately, we have the tools at hand to forge this alignment in the healthcare system. Payers and providers each have data that can drive better decisions and better care. Technologies exist that can bring all this data together. And each day brings new innovation—be it improved software to send real-time data from providers to payers, or a new device that enables a nurse to read biometric measures from a patient at home, miles away.

Will we have the motivation to master and use these technologies? Will we have the vision and road map to take the first steps?

In the pages that follow, I share my vision for healthcare. My goal is to help you look at your own region and your own sphere of influence differently and see the opportunities to bring about alignment. Whether you are a payer, provider, employer, or any other interested party, you can take steps toward a more efficient, productive health delivery system.

We need not wait for a master plan that will work for the entire country. I doubt such a thing exists. Experiments at the local level will show us what works and what does not, and will lead to models for the next round of experiments. This is how science moves forward. The same principle can apply in healthcare business innovation.

Introduction

For the past 25 years, I have worked elbow-deep in the financial realities of healthcare and am intimately aware of the complexities. As a physician executive, I have experienced, implemented, and observed the many strategies and economic models that have come into play. I have stood at the juncture where interests meet (and sometimes compete) in healthcare—mostly between the payer and provider, but also between the employer and employee/consumer. I have seen what has worked and what has not. And I am certain that every model tried so far has been less than optimal because it failed to address the critical relationship that must exist between the payer and provider.

I embarked on writing this book to share the big picture from where I sit. My strategies for alignment present practical ideas to change the way that payers and providers interact. These strategies create a means to improve quality and manage costs. I hope you will recognize ways in which you can apply some of these ideas to your own challenges.

As a physician and an executive, I see how healthcare is at the center of our future prosperity. Personal health is key to maintaining productivity for each individual. And for companies throughout our economy, healthcare expenditures go right to the bottom line. How we fix healthcare is critical to so much of the economic health of our country, and our global competitiveness.

Any solution must create a situation in which all parties benefit. Alignment is critical. I invite you to join in building a new paradigm for the payer-provider relationship. If we combine forces, we can take on and successfully solve the issues plaguing healthcare.

Chapter 1

Why Payers and Providers Are Disconnected



Two major stakeholders—the providers of healthcare and the entities that pay for it—affect the cost, quality, and outcome of healthcare delivery in the United States today. Yet, for nearly three decades, these two groups have been at odds. As healthcare and the way we pay for it have evolved, each group has adopted tactics to manage costs and leverage its own assets in ways that seemed reasonable. But the tactics of each group have increasingly alienated the other and widened the gulf of mistrust.

Over these same decades, we have witnessed great progress in diagnosing and treating disease, for which the medical community can be justifiably proud. On the payer side, insurers have innovated new products and technologies that help to manage the costs associated with the rapid expansion of medical technologies. However, we find ourselves with a healthcare system that costs more than ever, delivers less quality and efficiency than we would like, and lags behind most other developed countries in key indicators and cost. Therefore, it is time to refocus the energies of payers and providers on working together toward collaborative accountability.

Understanding the Disconnect

To understand the disconnect, let's look at how it evolved. Private health insurance and employer-sponsored healthcare emerged in the 1930s and 1940s, and put in place a fee-for-service model that dominated for 40 years. Under this indemnity system, patients paid all costs out of pocket up to a deductible (typically \$2,000) and then a percentage (typically 2%) of all subsequent costs. Increasingly, technological and expensive care led to the rise of managed care, in which employers, insurers, and medical providers sought to contain costs, improve performance, and increase coordination of services.¹ We have seen an evolution in managed care from health maintenance organizations to preferred provider organizations to point-of-service plans and, most recently, to consumer-directed products.

Managed care—defined as any system that manages care with the aim of controlling costs while satisfying medical quality standards—should have brought about an alignment among employers, insurers, and providers. But because payers and providers did not cooperate to find solutions, that did not happen. Instead, each party was looking after its own interests rather than exploring ways to work together.

With each new iteration of managed care, payers developed new tactics to control costs, some more successful than others. Payers instituted tools that either managed or controlled access to care. Through contracting, fees for some services were reduced. Capitation, a fixed payment to care for patients regardless of how intense their medical needs may be, shifted the financial risk to the provider. The gatekeeper role of the primary care physician (PCP), ostensibly to ensure appropriate use of specialists, quickly took on a negative connotation to patients and physicians who perceived the PCP as limiting access to care.

Meanwhile, hospitals were penalized with denials—for example, if a patient was readmitted within several days of discharge. Such penalties were intended to deliver more value by making hospitals and providers more efficient and effective. However, because most hospitals did not have the appropriate processes in place to improve care, the payers' actions were perceived as squeezing providers. And although hospitals and providers have become significantly more efficient, these changes have not led to the results we need to transform healthcare.

What nearly all of these tactics have in common—perhaps with the exception of the emerging consumer-directed movement—is that they are not aligned with provider incentives. Providers have responded with strategies of their own. Individual hospitals consolidated into hospital systems and sole practitioners into physician groups. Although many factors drove this process, one clear impetus was to increase the bargaining power of providers with payers. Providers, especially hospitals, applied rigorous review to their contracts. Contract negotiation became ever more arduous, often with nine months spent bargaining for a 12-month contract. With the advent of new technologies, providers drove innovation in tools to improve the billing cycle. In essence, providers, primarily hospitals, became fixated on revenue optimization when they could have focused on delivering more value to patients and becoming more efficient.

The lack of alignment between providers and payers has led to distorted behaviors. Managed care plans, when seeking to trim their expenses, tend to look at line items that cost a lot of money, particularly high-volume procedures such as cataract and cardiac procedures, and reflexively lower physician reimbursement. In response, many providers attempt to maintain their income by increasing the volume of procedures they perform.

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Physicians can increase volume in two ways. First, they can expand their patient base, which is not a feasible option for most. The second is to increase the number of procedures performed within the same patient pool by adopting more liberal decision-making. Consider the example of cataract surgery. Although there are clear guidelines recommending when a cataract should be removed, significant latitude and judgment can be applied when cataract disease is evident and the patient's vision is at stake without intervention. Therefore, some ophthalmologists looking to increase their procedure volume may become more aggressive in their treatment.

Managed care's most recent attempts to manage costs have come in the form of cost and quality rankings of physicians and hospitals. Plans use rankings within their markets to create tiers of physicians based on cost and quality data, and then use financial penalties on lower-tier performers. For example, plans charge consumers higher copayments for lower-tiered physicians. No managed care tactic has elicited a stronger organized response from physicians, who have not largely been consulted about how rankings were devised or imposed. More mistrustful of managed care than ever, physicians have rallied against these new programs. In Massachusetts, for example, the state medical society sued the state's Group Health Insurance Commission, charging that lower-ranked doctors were defamed and consumers who paid more for lower-tier physicians were defrauded.²

A Changing Universe for Physicians

Delivery of care ultimately is managed directly by providers. This is true no matter what program or practice standard is put in place and no matter what name it is given. The physician orders the tests, decides whether to admit a patient, and recommends one course of treatment over another. It is the physician who ultimately has the greatest influence over the quality of care, and, less directly, its cost.

To understand the environment of managed care—and to make any important changes—we need to take into account how the ground has shifted for physicians as a profession.

The past few decades have seen enormous disruption to physicians. The average income for a physician in the United States, adjusted for inflation, dropped by 7.1% from 1995 to 2003.³ PCPs saw their inflation-adjusted income drop the most—10.2% on average—while the income of surgical specialists dropped 8.2% and that of medical specialists fell 2.1%. Meanwhile, during the same period, salaries for other professional and technical workers increased by 6.9%.⁴

While their own income was slipping, physicians were acutely aware of a rising class of hospital and health plan administrators and executives with salaries exceeding their own. Perhaps more than the salaries, physicians were bothered by what they perceived as the emergence of medical managers who threatened to eclipse physician autonomy in decision-making.

Throughout the 1980s, the principles of industrial engineering were newly applied to many businesses, including healthcare. It was evident that the concept of “total quality management” and other approaches to improving quality and efficiency could be very useful in healthcare settings. But as administrators imposed these policies, physicians felt their toes were being stepped on. Part of the change was the rise in clinical guidelines, which first emerged from specialty physician groups. Increasingly, these guidelines—soon to be known as evidence-based medicine (EBM)—became part of managed care organizations’ requirements. Although there is now universal embrace of EBM as a hallmark for quality (as I’ll explain in the next chapter), the early move toward clinical practice guidelines was viewed by some physicians as “cookbook medicine” that usurped their judgment and experience.

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This new attention to efficiency occurred because medical care had become episodic, in a way that was not best for the patient, the provider, or the payer. For example, a patient might see a new doctor about chronic headaches. And the workup might lead to an expensive MRI, an important test to eventually rule out a brain tumor. But if that physician had a record of the patient's history showing a prior condition that could be contributing to the headache or that the patient had repeatedly visited other physicians with complaint of headache and perhaps already had an MRI, the physician might have taken a more effective—and less expensive—course of action.

There are many reasons we have reached this degree of episodic care: changes in reimbursement practices in the past 30 years, the rise of specialists, and simply the way doctors are trained to think and practice. This trend toward episodic care has had all sorts of implications for the cost and quality of care. It also has made the practice of medicine less satisfying for physicians, who have lost the personal connection to patients that typically develops over time and across multiple medical issues. The challenge now is to bring back continuity of care for physicians and their patients.

A physician's career satisfaction is difficult to measure over time and varies by specialty and setting. But according to a study of physicians from 1997 to 2001, the factors most strongly associated with satisfaction levels were threats to physician autonomy, physicians' ability to manage day-to-day patient interactions and time, and their ability to provide high-quality care. Declining income was not as strongly associated with changes in satisfaction.⁵

If physicians were not already feeling under siege, the past decade has brought a spate of much-publicized reports regarding medical errors, patient safety, and physician misjudgment. A well-known report from the Institute of Medicine in

1999 suggested that as many as 44,000–98,000 people die in hospitals each year as a result of medical errors and that medical errors cost \$37.6 billion annually, with approximately \$17 billion of these costs associated with preventable errors (about half of which are for direct healthcare costs rather than administration).⁶

More recently, we've seen reports of physician decision-making that resulted in underuse and overuse of medical services. In 2006, the RAND Corporation looked at the 30 acute and chronic conditions that constitute leading causes of death and disability and found that patients received about 55% of recommended care.⁷ In the same year, another study reported that overuse of three diagnostic tests during routine health exams—urinalysis, x-rays, and electrocardiograms—cost between \$47 million and \$194 million annually.⁸

Among many efforts to rein in costs of preventable errors and mistreatment, the government initiated a program to penalize providers for poor care. Hospitals, in particular, are feeling the squeeze from this initiative. In 2007, Medicare instituted a policy of not reimbursing for preventable medical problems among patients who already were hospitalized.⁹ Private insurers are beginning to follow suit and have adopted similar measures.

For physicians, changing employment trends reflect—and in some areas are driving—the working life of physicians. In coming years, we expect an increasing number of physicians to be employed by a hospital system; by some estimates, it may be up to 60%. The percentage of female physicians rose from 11.6% in 1980 to 26.6% in 2004.¹⁰ By 2006, women made up more than 48% of medical school graduates.¹¹ The desire to balance work and family has led an increasing number of physicians, both male and female, to seek more predictable work hours than their demanding profession has traditionally required. More physicians are also

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seeking part-time work. A recent study showed that four out of 10 pediatric residents seek part-time employment after graduation and two out of 10 find and accept part-time jobs.¹²

Those of us in the business of bringing technology to physicians also see a generation gap between more seasoned physicians and their younger peers. The physician leadership, who make decisions on behalf of their profession, may not be in sync with their younger colleagues, who generally are more fluent users of the newer technologies of connectivity. Younger physicians as a group adopt new technologies easily and fully expect to use such technologies to diminish their administrative burdens, whereas some seasoned physicians remain skeptical or unmotivated to embrace technology. Despite the difficulties posed by the generation gap, health-care leaders have an opportunity to work with physicians who are early adopters of technology to drive new efficiencies and collaboration.

Traditionally, the managed care industry's behavior toward physicians has been based on the incorrect assumption that providers are motivated primarily by financial incentives. This fallacy is one reason why so many attempts to manage care have not met their hoped-for results—and instead have fueled the cycle of mistrust. No doubt that finances matter, but there is much more to physician behavior than just money.

True alignment with physicians requires understanding the realities of their work life—their frustrations, their expectations, and their aspirations. The truth is that physicians feel great responsibility toward their patients, and are motivated primarily by the desire to do what is medically best for those under their care. So there is an enormous opportunity to focus on what is truly a shared goal: keeping patients healthy and restoring them to health when they fall ill.

Physicians also like efficiency, at least in concept, and solving problems. Reaching out to physicians and engaging them on a nonfinancial level is essential. I will address this further in Chapter 2 and throughout this book.

Many Players on One Stage

We cannot consider the payer-provider relationship without touching upon the other constituencies and trends that influence our healthcare system. These include:

- **Employers.** Employers are the drivers of health insurance, with increasing involvement in controlling costs and maintaining a healthy population. Large employers and business consortiums such as the National Business Group on Health have driven much of the innovation we've seen in recent years.
- **Patients.** The consumer health movement that began in the late 1960s, with patients playing a larger role in healthcare decision-making, has exploded in the last decade with the availability of health information on the Web. In a twist on patient empowerment, one of the most recent cost-control measures by insurers and employers has been consumer-directed products that shift costs to consumers. The intent of these plans is to motivate patients to seek out the most cost-efficient and high-quality care. But do consumers have the right information to make these decisions? And how do individual patients balance questions of cost and quality? Whether consumer-directed programs truly manage care has yet to be proven.

- **Government.** Government is a huge player, accounting for half of all healthcare spending in the United States, and creating policies that affect all payers. But it is the private sector that will drive the innovation needed now.
- **New health challenges.** Although a subset of the population may be in better health than ever, other health challenges have emerged—particularly in the areas of obesity, diabetes, asthma, and HIV. Most far-reaching of these challenges, perhaps, is the increasing number of patients without insurance or with inadequate insurance. These patients increasingly turn to hospitals for primary care, and hospitals must absorb the financial burden.

Entire books could be written about each of these factors in the healthcare system. However, this book will focus on the relationship between payers and providers—and how improving that relationship will bring benefits to all.

Where Do We Turn Next?

Continuing “business as usual” is not an option. Among those involved in healthcare, there increasingly is talk that the system as we know it cannot continue. Everywhere you look, there are dour assessments of the state of healthcare in the United States: discouraging measures of health outcomes dropping amid the highest healthcare costs in the world, painfully slow adoption of new technology, and a high percentage of the population without adequate primary care. And we are right to sound the alarm about healthcare as an industry. From 2006 to 2008, the medical loss ratio (the percentage of a health plan’s revenue used to pay for medical services) for large public plans rose from 81.7% to 83.7%. This drove an erosion of market value for those plans by \$70 billion in just the first half of 2008.

As an industry, we have shifted costs in every direction we can. We have done everything possible—except initiate the kind of changes that will get to the heart of the problems and create long-term benefits. It is time to stop shifting costs and instead align payers and providers around their common goals. Now is the time to bring together the two major constituents that affect cost, quality, and outcomes. Payers and providers must collaborate in a meaningful way to truly manage the care and costs for our patients. And it all comes down to the need for alignment in three basic areas: clinical, economic, and administrative.

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