DAVID VS. GOLIATH:
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Pittsburgh Business Group ON HEALTH

By: Tonic Advisors

The healthcare landscape is consolidating through a series of mergers and acquisitions across both healthcare financing and delivery. CVS and Aetna, Cigna and Express Scripts, even Walmart's overtures to Humana…have generated newspaper (do they still print those?) headlines nationwide. These mergers create economies of scale and "verticalize" and integrate care and financial incentives.

Vertical integration of healthcare is not entirely new. Integrated Delivery and Financing Systems (IDFSs) such as Kaiser Permanente have been around for a long time. What's an IDFS? Basically, it's just a fancy term for a system in which the health insurer is financially joined at the hip to the hospitals and doctors that provide care. Though not explicit, in theory, the providers in such a system are not compensated based on traditional measures of productivity such as Medicare Relative Value Units (RVUs are points for the number of procedures and office visits a provider does). The belief is that such entities can offer higher quality care at a lower cost. Duplicative tests, unnecessary procedures and unnecessary office visits can be reduced by sharing data, eliminating superfluous activities that don't enhance patient health, and using telemedicine (phone, data, voice, video) to provide certain types of care. Physicians and hospitals are graded and paid based on outcomes and satisfaction, not "widgets" or Relative Value Units produced.

The role of independent physicians and hospitals is in question as the industry consolidates in order to achieve the benefits of scale, data, analytics, and incentives alignment to provide quality of care rather than quantity.

What are the challenges facing independent providers compared to IDFSs?

1. Health Insurers who have captive provider systems, want to minimize "leakage" out of that captive provider system as much as possible.

A. Money spent (care delivered) at other providers is pure "loss." Money spent within the system feeds the integrated system.

B. Its own captive provider, when properly incentivized is focused on providing the most value possible, not on ensuring that the most revenue is generated.

C. The captive provider's approach to quality and outcomes is most aligned with the insurer's.

D. External providers, even those with "value based" contracts that reward quality, are still focused on optimizing their revenue. Over time, captive providers can become agnostic to revenue generation and the things that have historically gone with it such as RVUs and other productivity measures (procedures, office visits, etc.).

E. Non-captive providers, in particular those with limited value based compensation, cannot viably pattern their clinical behaviors on a value based methodology. They will suffer financially because their Fee for Service (FFS) payers will pay only for traditional services. For example, in a pure value based model a provider can be agnostic whether communicating with a patient via phone, text or face to face. In most cases in a fee for service model, they only get paid for the face to face office visit.

2. Independent providers are comparatively resource challenged. Access to money and resources provides:

A. Access to excellent people (both high quality physicians and administrative leadership)

B. Standardized processes, and ways to measure quality and cost across the system

C. Significant investment in technology (including electronic medical records)

D. State of the art equipment and resources

E. Ability to align financial incentives

F. A focus on the health of patients across all levels of care

3. Health Care Providers that are standalone will always have to focus on activities that generate revenue more than activities that improve health; this will make them inherently more costly and thus anathema to insurers who will strive to limit access to them through network restrictions, cost sharing burdens etc.

In anticipation of the push back, please note we are NOT suggesting that independent providers are greedy, ill intentioned, or corrupt. Businesses, for profit or non-profit, must have revenue to survive. It is the nature of such businesses, actually it is the obligation of such businesses to ensure that there is sufficient revenue to pay staff, fund operations and fulfill the mission. The comparison is purely based on the model of care.

In a true IDFS, somewhat surprisingly, the provider end of the organization does not generate revenue. It is purely a cost structure. The revenue is generated by the insurance arm, and in theory, what the insurance arm is selling is "a mechanism to keep us healthy, to help heal us when we are ill, and to do so in as painless, seamless, and pleasant a way as possible." As a general matter, the more the providers have to do, the more the system costs, and usually the less pleasant it is for the patient. No one ever paid more for an insurance policy because it offered twice as many colonoscopies as were necessary.

Non-integrated providers get paid to do things, Providers in an IDFS get paid regardless. If the system gets to be so efficient that fewer cardiologists are needed then the system hires fewer cardiologists which lowers the cost structure of the system. Non-integrated providers do what they need to in order to survive and they find ways to boost revenue.

The Battle to stay Independent

As with most things, there are excellent community hospitals and physicians, and some that are not as excellent. IDFSs do have an advantage in that if a physician is of poor quality based on available data, she or he can be removed from the system fairly easily. Outside of an IDFS, it's hard to remove a physician from the network, and as long as the physician generates revenue they will still be out there providing lower quality care. As the healthcare market evolves and consolidates, maintaining independence will become more challenging. Increasingly the question will become one of whether staying or being independent is actually good for the community?

Historically, reasons for hospital consolidation were more financial than clinical. Economies of scale, a struggle to stay afloat as the economics of healthcare delivery became more challenging, and the ability to provide more care integration and sophisticated technology were some of the driving factors. The ability to have greater leverage in contract negotiations with insurers/payers are some of the others. The reasons for consolidation ran the gamut from pure added quality and value, to "just more revenue."

Those same hospital systems often expanded into insurance, in part to further leverage in their markets but also in part when they realized that when they integrated with the financing side of the system, every dollar in saving on care delivery (and there was a lot of opportunity there) was an opportunity for added margin. If they were only providers, a dollar savings, was just a dollar not earned.

In a market such as Pittsburgh, in which IDFS competes with IDFS (UPMC and AHN/Highmark), it's pretty tough to stay independent because the efficiency of each IDFS depends in part on the ability of the IDFS to stay as self-contained as possible.

This isn't to say that there are not good reasons to stay independent or that competing IDFS are always optimal. There are challenges that occur when there are no independents as well.

1. Duplicative services. IDFSs must provide complete geographic coverage for their members. This means that all `essential health services must be available within a fairly tight radius of all of its membership. There is thus the potential for duplicative services in every community. A community needs to have cardiology available. Even if the aggregate demand in that community is only enough for one cardiologist, if there are two competing IDFSs, there will be two cardiologists serving that community.

2. Inefficient facilities. An IDFS needs to have inpatient beds in every community. If a community already has a hospital and it belongs to the other system, then the IDFS has to put up a hospital, probably a small one, to meet its constituent's needs. This makes for a generally inefficient facility because while bigger is not always better, very small facilities are generally not as efficient, and they cannot handle severe complications should they arise. The addition of a new small facility will also necessarily draw patient volume from the other hospital, making the old hospital less efficient.

3. Independent community hospitals can-- in theory--serve more than one IDFS and be a neutral party. The challenge for an independent hospital would be its ability to integrate its operations and incentives more than one integrated system. Different IDFS may have differing philosophies and approaches towards delivering care as well as different IT systems, metrics and incentives in place.

From a global health policy and system wide perspective, the question is really one of whether the efficiency losses from duplicative services and sub-optimally efficient facilities are greater than the inefficiencies of revenue focused non-integrated providers.

The answer will of course vary by circumstance and community. The variables are:

1. What is the population density of the community? New York City can have two hospitals on the same block from different systems and still not have a problem with excess or duplicative services because there are so many people so close to those hospitals. Rural Pennsylvania is a different story.

2. How cooperative and reasonable will the two competing IDFSs be? Are they willing to compromise and allow a little bit of sharing for the most esoteric of services (pediatric neurosurgery and experimental procedures or drug trials) and how accessible are alternatives in surrounding communities?

3. How reasonable are state regulations? Emergency Departments must see patients regardless of Insurance Status. Will the state allow ED's to gouge patients from non-integrated insurers or will there be limits?

4. How well do the hospitals that want to stay independent perform? How closely can they achieve efficiencies and quality associated with truly integrated providers?

How does this affect your insurance decision-making?

There was a time when the use of limited networks was just about discounts for volume and risk selection of members. Briefly, insurers negotiated steep price discounts with providers with the promise of a lot of patients coming through their doors—essentially bulk pricing. In addition, insurers knew that products with narrower networks would attract healthier populations so they could be priced lower. If you were seeing a cardiologist already and that cardiologist was not in the narrow network product, you would not choose it, since most people don't like to switch doctors. Odds are if you are already seeing a cardiologist your probably high risk. Fewer cardiologists in network equals fewer high risk members.
Today, some of that still holds, but as systems morph into IDFSs, it's about integrated care and alignment of incentives. Narrower networks are not about limiting choice for discounts and risk selection, it's about integrating care, eliminating non value generating activity, and creating a more seamless and fulfilling experience. Limiting choice of provider is now about creating a select provider network that is aligned with the goal of providing high quality, cost effective, convenient, and minimally intrusive care. Instead of giving patients free choice of any provider regardless of quality and regardless of efficiency, IDFSs offer a curated choice of providers that are screened, monitored and paid based on meeting quality and care metrics.
As employers and individuals making a choice of insurance carrier to team up with, you are increasingly choosing your health care provider at the same time. This is not necessarily a bad thing, it can actually be very positive. There are many efficiencies to be gained, and the migration of independent community hospitals to IDFSs is not necessarily a negative. The things to watch out for in the long term will be doing whatever can be done to ensure that the negative effects of consolidation are mitigated, through equitable sharing of the scarcest resources, and ensuring that EDs cannot gouge patients and insurers through unreasonable charges when circumstances are exigent.

Picking an insurance product and therefore the set of accessible health providers for your employees is only the beginning. As an employer you cannot abdicate further responsibility. Equally important is to monitor outcomes and satisfaction to ensure both that you and your employees are getting the most value possible. You may have dedicated people internally monitoring this, you may be relying on your consultants, or brokers. However, if you're not paying attention to these issues, if you are not aware of what your advisors are doing, then it's time to make some calls and open up a discussion. Understanding this will help you make changes to your plans year over year to ensure you are getting the most juice from your squeeze.

As always, the PBGH is available to provide perspective, and access to resources and expertise to help you understand the challenges of healthcare and how to make that information actionable for the betterment of your employees and the community.