REACTING TO REFORM

Health care change is coming, regardless of politics

BY KEVIN GALE

CRITICAL CONVERSATIONS AN ONGOING SERIES

This conversation, which occurred before a live audience at the Bankers Club of Miami, has been edited for clarity and brevity. Senior reporter Brian Bandell asked initial questions, and the audience asked three questions at the end.

Q: How will the Affordable Care Act impact the health care sector you work with?

A: Jerry Fedele, Boca Raton Regional Hospital: The pressures of the health care business are so much that it doesn't really matter whether it is passed or not. Now is the time, over the next generation, where we will start dealing with those issues.

Pressure to reduce expenses is coming from the Medicare system, which will have $150 billion in cuts over 10 years. This is the second time in the last three years Medicare has cut rates. [BRRH has a high percentage of Medicare patients and relatively few uninsured patients compared with many hospitals.] Your costs aren't going down. Employees want more money and equipment [costs are] going up.

Steven G. Ullmann, University of Miami School of Business Administration: A lot of students are applying to medical programs. We are dealing with a very unique market place in South Florida. There are 600,000 uninsured people in Miami-Dade County. We are the most expensive place for health care in the world.

I'm constantly being teased at conferences. They are constantly saying we are so weird down here.

Dr. Fernando Valverde, FIU HealthCare Network: If you don't have the infrastructure to provide health care, the infrastructure will change. We need to make more physicians and have 300 physicians being trained. Nurse practitioners and nurse extenders will be taking a larger role, especially in preventive care.

Brian Keeley, Baptist Health South Florida: I think we are the largest health care system in South Florida, with seven hospitals and 30 outpatient centers. I'm glad the Supreme Court made the decision, because it provides more certainty in an uncertain world. Another uncertainty, though, is what the president and the joint committee will do.

The worry is we will bankrupt the country. We can't be the most costly health care system – 50 percent greater in cost than the second most expensive system, which is Switzerland.

PHOTOS BY CARLOS CHATTAH

Above, attendees at the Critical Conversations event. Below, Sande Kaskel of Kaskel & Associates asks the panel a question.

The changes will be marketplace driven – coming together with the physicians, the hospitals and payers and saying: "Come on guys, we've got to figure this out."

Medicare reductions are a Herculean task. There is a lot involved in physician integration.

We need to get away from fee-based, volume-based medicine. We are spending a huge amount of money in information technology and need to give all the information that physicians need to have.

There is a reason we became committed to working with the FIU Medical School: There

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THE DETAILS

Parts of Medicare

- **Part A:** Hospital insurance that helps cover inpatient care in hospitals, skilled nursing facilities, hospice and home health care.
- **Part B:** Charges a premium to help cover medically necessary services such as doctors' services, outpatient care, durable medical equipment, home health services and other medical services. Part B also covers some preventive services.
- **Part C:** These are commonly called Medicare Advantage plans, which are offered by private companies approved by Medicare. The plans provide Part A and Part B coverage, and may offer extra coverage such as vision, hearing, dental and/or prescription drug coverage. Each plan can charge different out-of-pocket costs and have different rules, such as whether you need a referral to see a specialist or go to doctors, facilities or suppliers that belong to the plan for non-emergency services.
- **Page D:** Offers prescription drug coverage. Those who do not get drug coverage through Part C can get it through added coverage.

Some are anxious about how the changes will be implemented

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is a huge shortage of family practice physicians in this country.

For our business, we are also focusing on wellness. We have 15,000 employees and the health care tab is more than $100 million.

Lee Lasris, Florida Health Law Center: We are seeing a lot of consolidation in the health care market: Hospitals acquiring smaller physician groups and larger practices getting smaller practices. We are seeing a focus on controlling costs.

We are seeing compensation numbers being pressed down a bit. There is more emphasis on bonuses for productivity – not how much business you bring in, but being efficient, how long does it take to generate medical reports and respond to patient questions.

We're seeing a lot of angst out there about the changes in the health care system nowadays.

There are arguments back and forth about the ACOs and the changes in direction. [ACOs are accountable care organizations, which seek to tie reimbursements to the quality of care.]

We have to change things because it is too expensive out there and it's going to bankrupt the country.

How do you make the change? People get stressed when you deviate off the path. People get angry and start arguing and bickering.

Managed care didn't happen overnight. I heard doctors saying they would go kicking and screaming. Now, they are banging on doors trying to get that coveted HMO contract.

Is everything perfect? No. The ACA is a reality and is a definite thing. It's not perfect now, but it is just the keel to the ship, and that keel has to be built now.

Jeffrey B. Kramer, Goldstein Schechter Koch Accountants and Consultants: We provide tax and auditing services and work with a lot of physician groups. The smaller physician groups are finding all these changes to be stressful and are asking for advice.

Much of the merging in physician groups is because of this stress. Electronic medical records (EMR) is one of the challenges.

Some of the physicians are just tired, have too much on their plates and have trouble dealing with all the change. Some don't have the expertise to deal with HMOs and hospitals. They can't afford the MBAs and CPAs to help them. They feel like it is not a level playing field, to a degree.

Our clients are seeking to be more profitable and, hopefully, enjoy practicing medicine again.

Entrepreneurial physicians – the ones who can find ways to get paid beyond traditional pay – are doing better. An example is the dermatologist who can give cosmetic treatments.

The larger groups are doing well because they have the resources and capitalization to deal with the changing environment.

Mike Segal, Broad and Cassel: I've spent the last 25 years putting together practices – growing small practices into large ones in South Florida, around the state and sometimes outside. About all been specialty groups, which now have a lot of issues because the new focus is on primary care.

I agree with everyone who says this is market driven. If there were no ACA, a lot of the things you see happening would still be happening. Fee for service, at some point, will be a thing of the past.

There is a lot of consolidation all over the country. You see payers buying large networks and large medical practices.

About 60 percent of physicians do not practice solo. Most of them work in hospitals.

I am heavily involved in ACOs: two have gone live, two I've given advice to and two more are on the way in January.

The three states that have the most are New York, California and Florida, each with 14. Of the 14 here, none of them are based in Miami-Dade or Broward. The closest ones are two in Palm Beach, one of which we represent.

This is a sea change. The Affordable Care Act is only a part of it.

Medicare is broke; everyone knows it. Republicans know, Democrats know. A lot of changes have to happen that sectors aren't going to like.

Penny Shaffer, Florida Blue: ACA was really about access. The interesting thing is that the terminology is the Affordable Care Act, but when you look at what it will do, it will be difficult to afford. You have the pressure of 30 million to 40 million coming into health care insurance. But, if you introduce it the way we use it today, it will increase the GDP by 20 to 22 percent.

Comprehensive health care reform encompasses access, quality and cost. This law absolutely embraces the access, but doesn't embrace the cost and quality that we must take on. If we are going to bend the curve on health care and keep that access, it has to be affordable. Baptist and Florida Blue will have an ACO.

CARLOS CHATTAH

Jim Sink of assurance and tax consultancy McGladrey LLP addressed the panel regarded several issues.

THE DETAILS

Nurses help and get help

Nurse practitioners can perform some of the duties of doctors by assessing patients, ordering and interpreting diagnostic tests, making diagnoses, and initiating and managing treatment plans – including prescribing medications.

Nurse extenders, or assistive health care workers, have the skills to carry out selected technical, less complex and more routine duties typically performed by nurses.

Q: Will the Affordable Care Act be a positive or a negative for the job market?

A: Ullmann: If you are not providing insurance and have more than 50 employees, it will drive up costs. The global perspective on costs is that those who aren't insured will come into emergency rooms. A lot of facilities pass costs along to insurance providers and pass it to Penny over there, and she has to pass it along to employers.

Keeley: The health care industry will be a growth industry for the next 20 years, driven by demographics, the baby boomer tsunami. Medicare recipients use health care twice as much as those under 65. This will be the No. 1 growth industry in the United States.

The ACA, if done right, will result in fewer going to the ER and more going to primary care.

Shaffer: As pervasive as the cost of health care insurance is, it is not so super pervasive as to restrain growth in business. Attorneys may find ways to segment legal entities, so the company that is on the tipping point of going over 50 employees may restructure their company. I don't think it will restrain overall business.

In the health care sector, we will see growth because more people will be eligible. EMRs still have a long way to grow.

Ullmann: There is a need for 240,000 people in health care right now.

Kramer: Many large employers already provide health insurance and that group is not going to be severely impacted.

Segal: Will some companies decide not to provide insurance and let employees go to exchanges? In a geographic area, if one company decides not to, it could cause a trend that increases rates. I think a lot of them will take the exchange.

Q: How will insurance companies have to change their practices to get in line with the Affordable Care Act, especially considering the individual mandate, insurance exchanges and the acceptance of patients with chronic conditions?

A: Shaffer: I guess the good news is our company has been compliant and lived with many of the provisions that have been law.

With exchanges, we don't know the status in Florida of whether they will be federally run. We don't know how it will work. Knowing is important.

We watched the Supreme Court decision carefully. Guaranteed issuance of policies only works if you have everyone in the pool, not if the only thing you get is those who are sick or sign up on the way to the hospital or in the emergency room.

Valverde: A lot of compromise was made in the ACA. At the end, there was agreement the equation has to be balanced. Insurance companies would accept the 85 percent ratio [on medical care vs. administration] if they got the volume flow of patients.

The mandate was approved, but the state didn't approve Medicaid expansion. Insurance companies thought they were going to get more patients through Medicaid expansion. What remains to be seen is how insurance companies will adapt under this scenario.

I think only the very large companies can deal with 85 percent. Smaller ones will have to merge or go out of business. Exchanges can lower the cost for several years to get competitors out of the marketplace.

Shaffer: Florida has an Office of Insurance Regulation, so you have to back them up with appropriate contracts so that you can meet those rates and they are sustainable. There is a check and balance trying to protect against any deep predatory behavior.

Fedele: Cost will be the focus, and bringing the physician industry into health systems and building bigger health systems. But, frankly, I think it's just the beginning. Western Pennsylvania has consolidated in-

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Accountability plays key role in trimming future expenses

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to two aggregated large providers that each have an insurance provider. The market is 100 percent integrated on the physician side.

The focus on ACOs will eventually lead to that outcome. If you are a health care provider, you will say you need to be bigger to spread costs and be more efficient. I expect three to five years of very intense consolidation in the provider market as a precursor to consolidation between providers and insurers.

Q: Medicare spending is expected to reach $1 trillion in 10 years, which might be too much for the government to handle. What should be done to ensure the long-term survival of Medicare?

A: Ullmann: Long-term survival is predicated on significant cuts in physician reimbursement. That has been postponed, year after year. The longer that is postponed, the quicker Medicare goes broke. It would be broke in 2017. Congress has chosen to have blinders on. It is beyond several re-elections in the House, so no one is dealing with it. This is a disaster coming toward us, and it will be draconian unless it is dealt with.

Medicare is always like a defined benefit. The Ryan plan would change to defined contribution over the next decades. Many people believe we can't sustain any defined benefit over time. If I knew the answer to how we could conclusively fix Medicare, I wouldn't be on this panel today. I'd figure out a way to get super rich.

They will wind up with something mixed, and I don't know what it will be.

Lasris: There will definitely be reduced reimbursements to health care providers. Putting money in a big pot like an ACO is the way they will go, and also cutting out some of the waste and going after some of the fraud and abuse in the health care system.

The Office of Inspector General has reviewed Part D and criticized CMS for not implementing the type of oversight that needs to be done. That's going to be a stopgap in the interim to extend the life out for Medicare until the ACA kicks in.

Valverde: Less than 50 percent of health care costs go to doctors. Lowering reimbursements is not the answer. Essentially, Medicare patients have been given a card with no limits. You might have a patient see two or three cardiologists and two or three rheumatologists without each of them knowing. You need some form of managed care and ACO that monitor the dollars and quality of care. Otherwise the consumer will continue to use their credit card.

Ullmann: Life expectancy was 67.8 years in 1965. The concept was you would retire at 65 years, live 2.8 years and fall dead. Now, people are living till 79.

Kelley: The good news is people are living longer. The bad news is people are living longer.

Shaffer: People have to be better consumers.

Fedele: For the first time in 25 years, I'm not really sure where we are going. We've multiplied Medicare 15 times since it was enacted. Linear accelerators didn't exist in the mid-1960s. We've spent $20 million on them.

The question at the end of the day is: Will we get down to rationing? No question that there could be 25 or 30 patients in the hospital at the end-of-care stage and, if the family had to pay $100 a day, they would be pulling the plug so quickly it's not funny.

Lasris: Remember when MRIs came in? We had more MRIs than all of Canada, and a lot of referrals for MRIs that weren't necessary. Maybe they were pushed into it by litigators. We need a more holistic approach so we won't be rationing. Not only using technology smarter, it's going to be smarter about how we use the whole human body. It starts in your own home.

Doctors are now afraid they might miss something. Some radiologists say: "I only want to see the little thing I'm supposed to be looking at. I'm going to get sued if I miss that little lesion."

Everyone has to be smarter with better guidelines.

Q: What are the alternatives under Medicare or the HMO programs and private pay to handle those chronic disease issues that will be back and forth in the hospitals, and will providers be fined?

A: Segal: That's one of the main focuses of ACOs. The average person over 65 in Medicare has four chronic care issues. Are they being medicated, mixing medications, taking their medications timely? There are massive amounts of fat in the system.

ACOs make money by saving costs and, at the same time, providing measured quality care. Dealing with chronic diseases is right at the top of the list to prevent too many hospital and emergency admissions.

Advocate Health Care in Chicago has a partnership with Blue Cross in Illinois. It's private pay and covers 275,000 lives. The initial announcement is they are doing well and one of the areas they are focusing on is chronic disease.

Lasris: Under the act, there is the concept of the medical home.

Shaffer: There is a pilot program to put physicians in the home to monitor care immediately after the hospital stay to avoid readmission. Many times, the return to the hospital results because to safely transport the patient, you have to put them in an ambulance and, if you do so, you are going to transport them to a hospital.

Keeley: The ACA addresses chronic disease in a forthright fashion. We don't get paid for readmissions. We will incur a huge cost and get zero compensation. The focus is keeping people out of hospitals – and that's a unique statement for the CEO of a hospital system to make.

The law kicks in big time in 2014, so we have a little breathing room right now.

Q: My mom is 91 and went into the ER and got great care. Then she was admitted to the hospital and saw a number of doctors.

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MEET THE PANEL

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Many hope for better continuity among service providers

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Her doctor is not part of the hospital. The ER doctor did not pass on information, so the physician on her floor who saw her had no idea what happened to the results of her tests.

She went to a rehab center. That was awful. They didn't know what happened. There was such a duplication of effort. Forget about the quality of her life throughout this experience.

She is on Medicare and her insurance is going to pay for most of this. What does this say about the insurance company that is going to be double- and triple-billed for all the procedures she had done?

Fedele: The ACOs will drive toward better continuity and communication. South Florida is way behind the rest of the country in physician integration.

A: Lasris: Don't expect a lot more integration until physicians sign onto EMRs. It will happen more fluidly when exchanges are set up.

Valverde: In fee for service, no one is accountable. In an ACO, a coordinator would have been coordinating. In Medicare fee for service, no one is accountable. No one is really monitoring the store.

Q: If there were one thing to add to health care reform, what would it be?

A: Fedele: End-of-life care and tort reform are two critical items we need to come to grips with.

Segal: I think to sell products

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Cost, quality and access must be parts of the new system

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multistate. I think there are some real potential advantages to that, and it should be pushed more.

Shaffer: It's got to be a three-legged stool: cost, quality and access.

Ullmann: Addressing the overcapitalization of health care, which tends to drive up the cost of care.

Q: What tools and technology do you see coming that enable health care systems and their participants in the ACOs to more effectively control overutilization with patients?

A: Segal: The idea with electronic health records is that providers start to get penalized by Medicare if they don't have it. Medicare and CMS help with money to create it if you meet certain standards. Not everyone has the same records, and we need exchanges for them to talk with each other.

We need protocols for medicine and evidence-based care. The concept in general makes sense and we have had demonstration projects and organizations looking at it for many years.

Shaffer: There will still be lot of choice – many choices to be made along the way. We need to heighten the true cost of care. It's not just a $5 copayment. We have to look at the world in a completely different way, with health at the center of it.

Keeley: Patients have to have access to credible health care and good outcomes.

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