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The Aftermath of Federal Health Care Reform: The Challenge for States and the Private Sector

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Congress has been consumed with the effort to "reform" health care. At the time of writing this article, legislation has passed both the House and the Senate but its future remains in doubt. And yet, while development of federal reform legislation is important—indeed, it is a moral, public health and economic imperative—the cost of reform will weigh heavily upon the states and healthcare providers. Legislative enactment is only the first step, in a very long, arduous and complicated road, to truly reform health care.[1]

In point of fact, terming the federal efforts "healthcare" reform is a misnomer, as little change is likely to occur in the processes and delivery of health care. More accurately, the effort is best pegged as health *insurance* reform, as this is where the most important changes occur. While the proposed federal law will assuredly increase access to health insurance, it will not necessarily increase accessibility to care. The reason for this is quite simple: The law significantly expands the Medicaid ranks, yet does nothing to increase provider reimbursement or undertake any other systemic reforms which make the Medicaid population more attractive to providers. Accordingly, the number of Medicaid beneficiaries will swell at the same time that states' abilities to fund this care remains highly challenged.[2] It is

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1. Currently, the Senate bill passed on December 24 is over 2,000 pages long. Conservatively estimating five pages of regulation per page of statute, we can expect the development of approximately 7,500 – 10,000 pages of "official" implementation and clarification guidance from CMS, and similar amount in Manual provisions, provider instructions and the like. Each page represents an area of crucial import to a particular provider(s), meaning that the reform efforts have a long way to go and significant change can occur during the regulatory process. And with the legislation not calling for implementation of many of the reform provisions until 2013 or 2014, there is ample time to negotiate the regulations. Further, the President's goal of "bending the cost curve" has in many significant ways vanished from the legislation.

2. The National Conference of State Legislatures projects state budget deficits this fiscal

probable that reform will create a significant bottleneck effect in care,[3] with emergency department visits increasing as newly Medicaid- eligible beneficiaries seek care at the E.D., having failed to secure office visits and no longer hesitating to seek care due to lack of insurance.

Further, political pressure will likely rise on hospitals and physicians to accept more charity care (yes: it won't go away) or Medicaid patients through changes in tax-exemption standards, state licensing laws or other avenues. While anticipated cost savings in the legislation are extremely unlikely to be fully realized, it is a near certainty that the coming decade promises to strengthen the trend toward declining provider reimbursement in an era of increasing costs of care and ever-rising consumer expectations. With the federal budget deficit soaring, it is inconceivable that the federal government will be able to bail out the states on soaring Medicaid costs. Given this environment, the question becomes what must states and providers do to adjust to, if not thrive in, this new health care world. Below, I provide a roadmap.

I. STATES

While we focus largely on the federal government as the driver of health care, in fact state governments shoulder a significant load. In 2008 state governments share of Medicaid expenditures totaled $310.9 billion; in 2009 the state share is estimated to have swelled to $335.3 billion, a 7.8% increase.[4] Growth in healthcare spending is inexorable, with the constant advent of new technology and treatments. No one expects cost to actually decline—rather the focus is on slowing the rate of growth. To do this states have to realize that federal legislation is not really ushering in a new world of health care delivery. However, the incentives to do the same things—offering the same program in the same way—will markedly change. States will have to be more creative and efficient in their health care dollars than ever before. Specifically, some or all of the following must be done:

A. Medicaid Waivers

States must restructure their Medicaid programs to take advantage of every opportunity to lower costs while incentivizing the provision of high quality, accessible care. Funded demonstration projects involving medical

year of $174.1B, followed by deficits of $55.5B in the coming fiscal year. Gerald Seib, *In 2010, Economy Again to Crowd Domestic Stage*, WALL ST. J., Jan. 4, 2010.

3. SHARON K. LONG & KAREN STOCKLEY, URBAN INSTITUTE, EMERGENCY DEPARTMENT VISITS IN MASSACHUSETTS: WHO USES EMERGENCY CARE AND WHY? POLICY BRIEF 2-5 (Sept. 2009), *available at* http://www.rwjf.org/files/research/48929.pdf.

4. NAT'L. GOV. ASS'N AND NAT'L ASS'N OF STATE BUDGET OFFICERS, THE FISCAL SURVEY OF STATES 10 (2009), *available at* http://www.nasbo.org/Publications/FiscalSurvey/tabid/65/Default.aspx (click on 'fiscal survey of states, fall 2009 download').

homes, managed care, payment of physician extenders, contracting with "minute" clinics and other avenues need to be fully explored. New payment standards, encouraging bundled payments and incentivizing patient responsibility for care, must be developed.

B. Health Planning

Sophisticated health planning may be given new life, as states encourage providers, especially in urban areas, to collaborate. For too long institutional success has relied on geography. It is time that all providers shoulder their fair share of caring for our less privileged. "Second generation" (planning focused) certificate of need laws may be developed and, coupled with creative use of the state action doctrine, financially sustainable systems of quality care developed. Charity care standards might be revisited to assure that tax-exempt institutions are meeting their obligations to provide accessible care.

C. Governance/Management Resources

Expert management matching private industry capabilities must be instilled throughout state payment and provider systems. For too long state agencies and providers have been subject to the political winds, leaving them without the mix of resources needed to deliver, track and pay for quality care.

D. Technology

The opportunity to tap into federal funds through the HITECH Act, to develop electronic health record systems, represents a watershed moment for states desiring the creation of a statewide system of care. The direct patient care advantages of these systems—an always-accessible patient record—are routinely touted. In fact, the far more significant advantages to these systems come from their ability to facilitate cross-institutional linkages, enabling data sharing, local/regional best practice standards, joint resource planning and development and a myriad of other collaborative arrangements. This truly is a once in a lifetime opportunity for states to reshape the delivery of health care in their communities.

II. PROVIDERS

For providers, reform does not really represent a new world either, as the delivery of healthcare services is largely unaffected. But, continued reimbursement pressure will challenge even the strongest institutions and medical providers. Success—the delivery of high quality, accessible care in a cost effective manner leading to strategic and financial strength for the

provider—will depend upon providers being exceptionally sophisticated about how they structure their business and the choices that they make to confront the future.

A. Key Attributes

The "big 3"—The Mayo Clinic, the Cleveland Clinic and Geisinger Health System—are routinely touted as the gold standard for hospital and medical care. And deservedly so. However, few hospital and physician groups are likely to replicate these systems anytime soon. Key concepts from these systems, however, can be emulated: tight linkages between hospital and physicians; shared institutional/physician reputation; aligned payment between institution and physician; a strong teaching and research component; a high standard for quality; a relentless pursuit of efficiency and systemic improvement; scale; "best practice" use of technology; strong national advocacy; and a culture of strong lay and physician leadership.

B. Institutional Leadership

Non-profit institutions should be the leaders in inculcating the key attributes from these market leading organizations into their own communities. As charitable institutions, they have an unfettered focus on serving their communities. For too long many non-profit Boards have misunderstood their fiduciary duty, "protecting" the local hospital rather than striving to position it to best enhance the delivery of community health services. In hospitals' earliest years, the most important function that a Board would perform was to assure the financial stability of the organization. This remains crucial, of course.

Yet today, fulfillment of this duty is not nearly enough. Assuring the strategic positioning of the hospital in the community is today's number one job. Sometimes this may mean an alignment with a competitor, joining a larger system or recognizing that the need for the institution no longer exists and that its assets are better redeployed to address an unmet community need. While the "right" strategic positioning is, of course, market dependent and highly subjective, moving toward the key attributes of market leading organizations is *the* guidepost that Boards should be using in fulfilling their fiduciary responsibilities of service.

C. Physicians

Physicians will find themselves increasingly challenged as a profession and as individual providers. Over time states are likely to expand licensing prerogatives of non-physicians, shrinking the unique services that medical doctors can provide. Physician groups, many owned by health systems, will continue to gain in size, with growth likely to rapidly expand for the same

reason that institutions will seek larger size: scale is important. Groups will require expensive technology to understand and adjust to new payment mechanisms (bundled payment, for example), and also the sophisticated management and staff support to model payment alternatives. The investment in strong management and strategic skills in physician leaders will become paramount for success. Finally, leading organizations will find that strong physician governance and management will be crucial.

III. CONCLUSION

The provision of high quality, accessible care is a moral imperative. Fair or not, state governments and, in turn, health care providers are going to be compelled to shoulder significant costs associated with health reform. Anticipating the challenges likely to be faced, and acting now to prepare for them, is absolutely crucial.