Leading Managed Care in the Healthcare Reform Environment

Healthcare reform is driving new creativity on the part of providers as they face unprecedented pressure to control spending. Many hospitals and health systems have already made significant expense reductions and are now challenged to find additional ways to manage the negative impact of a weak economy. High unemployment, diminished expectations for personal income and changes in access to private insurance combine to reduce discretionary healthcare purchases. As employers reduce their own expenses by raising co-pays and deductibles, or dropping employee health coverage altogether, patients are less inclined to schedule elective or non-emergency procedures.[1] This means providers are contending with lower volumes and reduced revenues.

More is happening outside the hospital walls as well. There are looming new costs mandated by healthcare reform and changes in reimbursement. The result is that hospitals and health systems are looking for new responses to an urgent need to become more sophisticated in the area of managed care. Leaders are exploring and adopting strategic approaches that include new organizational structures, creative provider-payer collaborations, and broadened requirements for the skill set of managed care executives. The change to a strategic point of view that incorporates multiple external factors may be challenging for current leaders, who likely developed their strengths in a traditionally more isolated hospital environment.

Healthcare reform looks back to the future.

Steve Kratz, Witt/Kieffer Vice President and Managed Care Practice Leader, sees an environment today that looks a lot like that of the mid-'90s — with a twist.

"Most providers have shed the health plan organizations that they established 20 years ago," Kratz says. "Now, partially in response to employers trying to reduce costs, we're seeing our provider clients take another look. They feel pressure to develop greater expertise in managing all the elements that affect the cost of care so that payers aren't holding all the cards. As a consequence, providers are considering resurrecting and improving plans or starting new ones in partnership with payers. The big change is built-in quality measurement. The buzz words now are 'clinical integration' and 'accountable care organization.'"

Quality and outcome tracking that were not a focus for older PHOs (physician hospital organizations) and IDS (integrated delivery systems) are critical to the success of these new collaborations.

New expenses challenge smaller, less integrated systems.

Although much is yet to be determined about the evolution of healthcare reform, it is clear that future regulations will favor larger, more integrated systems. There are four primary reasons why:

1. Some players in the marketplace have consolidated, leaving smaller providers with little leverage to successfully negotiate higher payments from insurers and larger discounts from suppliers. This provider consolidation trend is accelerating, putting those providers who are unable to form advantageous partnerships at increased risk for survival.
2. Medicaid is expanding. Some estimates put Medicaid growth as high as 20 million new patients over the next several years while the commercial market is contracting.

3. The cost of adopting electronic health records is expected to increase information technology spending by $20B over the next five years. The ability to collect data electronically and, even more important, mine it for critical utilization and trend information will give providers new tools to help them negotiate with payers. This, along with enhanced quality tracking capability, is a critical piece of the growth in sophistication that providers seek. However, these changes may simply cost too much for many smaller providers.

4. Despite unresolved questions about how healthcare will ultimately be financed, we are moving back toward some version of capitation. Virtually all models will shift away from fee-for-service reimbursement with its implied incentive for use of specialized services. Newer models of global payment are based on per-person spending targets with shared risk when targets are exceeded and shared rewards when spending is reduced.[2] Systems with larger revenue bases and greater geographic diversity are better positioned to absorb risk and reap rewards.

Demand will favor managed care executives with broad-based skills.

Many current managed care leaders hold vice president titles and have expertise in contract negotiations. In fact, until recently, the conventional wisdom was to recruit managed care leaders from among the ranks of payer executives in pursuit of this particular skill. However, reentry into PHO and IDS models requires greater management capability.

Astute executives with a broad view of the market who can position the organization from both a provider and a payer perspective will play a larger role in hospital strategic initiatives. As the managed care landscape continues to combine expense pressures with low revenue growth, leaders who are willing to explore innovative programs and creative partnerships for healthcare delivery and financing will be in demand.

Managed care executives also need to work well with physicians. Although the final version of the accountable care organization is still being developed, the trend is to put primary care physicians at the center, with responsibility for coordination of care and outcome measures.[3] In previous fee-for-service models, primary care physicians served as gatekeepers, directing patients to high-revenue specialty care. Today's executives will need the ability to guide system integration and, at the same time, recast physicians into roles that reach beyond the one-to-one patient-centered relationships.

New thinking has providers looking for managed care executives who can adopt an integrated approach that combines contracting ability with strength and experience in marketing and branding, finance, customer service support, data analytics, and care management.

About Witt/Kieffer

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1 Spielman B (2011). Negative outlook for U.S. not-for-profit healthcare sector continues for 2011. Moody's Investors Service Outlook Report, #131016 February 3, 2011.
2 Chernew M, et al (2011). Private-payer innovation in Massachusetts: The alternative quality contract. Health Affairs, 30(1):51-61.
3 Ibid.

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