Six Bold Predictions About The Looming Health Reform

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Dr. Marc Bard of Navigant

On Tuesday, Dr. Marc Bard, chief innovation office in Navigant's health care practice, explained five key points about the Accountable Care Organization, the coming thing in Massachusetts health care if the Patrick administration has its way. Today, Marc makes six bold predictions about what will happen as the state attempts its next major phase of health care reform:

1. New partnerships will sweep across the landscape.

The academic medical centers lack the primary care base they need to provide fully integrated care, and of course community health systems lack the high-level tertiary care; neither one of them can be a complete system of care. So the first thing you're going to start to see is more consolidation. You're already seeing it on the insurance side with Tufts and Harvard Pilgrim merging, and you're going to start to see it with providers. And that's going to call into question restraint of trade and get the attorney general involved, because some of these systems are going to look closer and closer to monopolies.

2. More tension in the system

In today's' environment, for the most part, providers of care are contractually pitted against payers of care. They're a little like dogs and cats. They've never gotten along terribly well for obvious reasons, and they generally didn't mind battling each other.

Now, what is being proposed in Massachusetts creates somewhat of a zero-sum game, doctor against doctor and doctors against hospitals; and that's a less comfortable battle. And, it's potentially going to be even less comfortable because with the ACO, there's going to have to be more support for primary care, and if you're operating with a fixed global payment budget, that means that the high-end providers, the high-end physicians and hospitals, are going to take the greatest haircut. That's reality.

And by the way, I'm a strong advocate of capitation. Of all the payment strategies that have been used over the past decades, the one that truly fostered innovation was capitation, because it required the invention of new ways to deliver care on a fixed budget. So I like responsible

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capitation, it's just that I'm realistic enough to appreciate that introducing it in Massachusetts is going to be very difficult.

Think of a bell-shaped curve. There are people at one end who absolutely need the high-end procedure and no one would dispute that. At the other end, I don't need a total hip replacement. But there are a lot of people in the middle of the bell-shaped curve. The real question is: Do they need the procedure and do they need it now? And those kinds of borderline cases are going to come under much greater scrutiny. Who really needs a stent? Who really needs a bypass? What's the data to support bypass vs. stent? The best example is Prostate Specific Antigen testing for men. There are going to be long-term studies that ask the question, who really needs surgery or radiation and if so, when?

3. The Massachusetts reform will go a major step farther than federal health reform on ACOs.

On March 23 last year, President Obama signed the Patient Protection Act into law. It is 2200 pages, and I've had the privilege of reading it twice. The ACO part of it is exactly four pages long out of 2200. And in those four pages, because of fear of 1990s-style Managed Care that locked people into restricted systems of care, the act specifically says that in an ACO, you're free to go anywhere you want for your care.

That is where it might be tricky to honor that level of freedom in a global payment system as proposed in Massachusetts. If one hospital is getting paid for your care, you can't go to another hospital and say, 'I want my care here.' Essentially, you're going to have to select a system of care, because we have to pay somebody for your care and somebody's got to own it.

The good news is that we have great places of care. It's just that unlike Kaiser Permanente, the Cleveland Clinic or the Mayo Clinic, I'm not sure we have the best systems of care. And that's what we're going to have to invent very quickly. We've got some very powerful institutions, and if we use the creative power of these fabulous enterprises to design and build systems of care, then it will work.

4. Greater division of labor: Tertiary means tertiary

I suspect that more and more, hospitals set up to be tertiary — handling the most complex care — will really need to be doing tertiary care, and not secondary level care. My hunch is that they're doing a fair amount of secondary level care today. If they are, they're either going to have to figure out how to create low-cost delivery systems inside of themselves, or there's going to be a reallocation of where patients are cared for.

Let me remind you that when United built the airline Ted, and Delta built the airline Song, in order to compete with Southwest, neither survived because they were never able to reduce the cost per passenger-mile to come anywhere near Southwest. The parallel: How likely is a high-end tertiary hospital, with all its economic overhead burden around research, teaching and everything else, to be able to deliver secondary level care at the cost of some community hospitals?

5. A downward glide for costs.

The cost of delivering care will not go down precipitously; it's going to be a glide path.

6. Massachusetts medical culture will change to be more team-oriented.

Eastern Massachusetts health care is physician-focused rather than system-focused. We focus on doctors, we train them, we teach them, we develop them, rather than teams. And we're going to have to move to a much more team-oriented approach, which means we'll have to start really valuing the role of care coordinators and other disciplines rather than putting the burden on the doctors. So I think what we'll also see is that it's going to affect some academic pursuits: We're going to have to move to training more primary care doctors, and that is not something that Boston historically has focused on.

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