HEALTHCARE ROUNDTABLE

The Experts Discuss the Current Healthcare Landscape

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As the various sectors within the healthcare industry continue to evolve and adjust as a result of healthcare reform, many questions remain regarding the state of the industry and how our businesses and local population are affected. To help answer some of those questions, the Los Angeles Business Journal turned to a diverse group of experts with various perspectives, including some of the most knowledgeable and active participants in the regional equation. Below is a series of questions the Business Journal posed to these healthcare and financial stewards of Southern California and the unique responses they provided - offering a glimpse into where healthcare stands today - from the perspectives of those in the trenches, financing, delivering and facilitating health services for the people of Los Angeles.

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MICHAEL HUNN

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RUSSELL MOORE

◆ How has Covered California impacted providers?

Juniper: There have been tremendous challenges due to start-up problems, and the need for providers and payers to become familiar with the new system. Narrow networks have presented difficulties; hopefully, those problems will be resolved in the future. However, Covered California also presents some terrific opportunities for providers and payers who, faced with over 1.4 million newly insured consumers and the increased number of Medi-Cal beneficiaries, will be forced to become more efficient and find innovate ways to operate and deliver care.

Hunn: It's too early to measure actual impacts on providers, but one thing we do know is that the Affordable Care Act cut the number of uninsured residents in California by half to 11 percent. More than 1.2 million are newly insured, with the largest gains in the comparatively healthy 19- to 34-year-old age group. We expect the new access to affordable health care to increase the number of primary care visits to physicians that are health exchange providers. It also will increase the number of referrals to specialty care. Moreover, we expect to see more patients coming in for health screenings such as mammograms and colonoscopies.

◆ What changes are occurring in the small business health insurance marketplace this year?

Patton: Small businesses have more options to give their employees greater control over their coverage, making it easier to choose plans that employees will use. This year, Covered California is introducing a dual-tier model for the Small Business Health Options Program (SHOP) marketplace, allowing employers to provide employees with more choices to pick coverage that meets their needs. The dual-tier option is available for coverage starting on or after October 1, 2014. With this new option, employers select their contribution level and reference plan as before, but now they can pick two metallic tiers to offer their employees instead of just one. The employee decides which plan from the two tier options provides the best coverage at the most affordable price. Because employees have the opportunity to compare health plans at a variety of price points, the result is greater employee choice and coverage that is more closely tailored to individual needs, all without additional cost to the employer.

Hunn: Small and large employers alike are looking at the cost of health care for their employees and continue to evaluate the best options for their businesses. Employers are looking for year-over-year 'cost-predictability'. We reach out to employers routinely to advise them on how best to keep their employees on the job and safe – for the good of the individual and to benefit the productivity of the business. We encourage employers to meet with health system representatives, just like they do with providers of health plans, to better understand how to manage both the health coverage and costs of providing employer sponsored insurance. We encourage the business owner to participate in the dialogue along with human resources – the owner, CEO or president must be involved to make the best decision. The employees are counting on all of us to get this right.

◆ How will SB 1446 affect the small business community? What new opportunities will this bill create?

Patton: SB 1446 allows small businesses with less than 50 employees an extra year to find coverage that is compliant with the ACA. Over the coming year, the bill gives small businesses the opportunity to renew their existing coverage, regardless of whether that coverage meets the ACA "essential benefits" requirement. All non-ACA compliant plans will now expire at the end of 2015. Small businesses are not currently required to offer health insurance; however, if an employer currently provides and chooses to continue offering coverage, they will have an additional year to find options that are ACA compliant at a cost they can manage. Ultimately, SB 1446 offers small businesses a longer transition period with more time to research coverage options and a chance to better prepare for the future. Covered California's Small Business Health Options Program (SHOP) is interested in reaching the 300,000+ currently uninsured small businesses that are not affected by SB 1446. These are businesses that do not currently offer health coverage to employees but may be considering SHOP coverage to take advantage of federal tax credits and/or to recruit and retain industry talent. Covered California SHOP will also be prepared to assist those small businesses that are seeking ACA-compliant coverage in 2015 when existing plans expire.

◆ How can physicians survive and increase their revenues as reimbursement is reduced?

Moore: As with any form of business, it is important for medical-focused businesses to understand revenue streams and concentrations, and recognize how those might be impacted by new legislation, advancing technologies, and other challenges and opportunities. Knowing where and how you derive your revenue and what factors could impact future revenue is essential to the long-term success of your business. A knowledgeable banker can provide tools and expertise that assist in managing cash flow to maximize revenue as you identify those income streams. If you're like most companies today with a growth strategy, you're planning to make significant investments in technology, training and equipment, and you will want to finance some of that investment. Your banker should know your plans and proactively guide you toward funding options that are right for your situation. It's our job as bankers to help you succeed and that includes working hard to earn your trust, understanding your business and offering customized solutions.

Juniper: First and foremost, physicians need to focus on their own quality improvement, cost-saving efficiencies and electronic data systems, to survive in today's marketplace. Delivering high quality care efficiently through mechanisms such as well-developed case management systems will give providers better leverage in negotiating the best payer contracts. Collecting and analyzing their patient and cost data are critical to these efforts. Physicians can also consider other revenue enhancing mechanisms such as direct employer contracting, management services organizations and owning their own health plans and coordinated care companies. Finally, all providers should be thinking about delivering care based on the lessons learned by retailers: provide service in convenient locations, during non-business hours and with great customer service.

Hunn: Physicians must be open to innovative change to stay ahead as government and health plan reimbursements are reduced and or when new reimbursement methods include rewards for managing the care efficiently. Partnerships and affiliations with medical groups and health care organizations are surging as physicians see the value in shared management services, equipment and overhead. Providence has two affiliated physician groups – Providence Medical Group and the Providence Facey Medical Group, serving over 350,000 patients a year here in Los Angeles. Providence also participates in accountable care initiatives to better manage care of populations and to coordinate care between physicians and health delivery networks.

◆ How is the Affordable Care Act changing the way hospitals, clinics and employer groups work together? Are the benefits to consumers "as promised?"

Hunn: Employers, hospitals, clinics and physicians all desire the same thing, excellent care at an affordable price with a patient experience that is second to none – the ACA has definitely highlighted and prompted a robust dialogue among the key stakeholders to achieve these goals. Those dialogues have also resulted in a renewed focus on wellness and prevention. It has encouraged employers to educate themselves on how best to craft employee benefit plans to help workers adapt to higher deductible insurance plans and co-pays. And it has created a new urgency by the employee/patient/consumer to better manage their care through health savings accounts (HSAs) and health reimbursement accounts (HRAs). By creating select networks and other customized options, health care providers are strengthening their consumer bases. For Providence that means continued growth, more capital to keep up with the latest technology in diagnostics and treatment and the ability to sustain a workforce of approximately 15,000 in the Los Angeles Area. Consumers are benefiting on a variety of fronts – primarily because hospitals are competing for the newly insured and know they must provide the best possible patient experience. Health care reform also has

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CHRIS PATTON

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brought a new transparency to the industry and consumers can make more informed choices.

◆ **What are the predominant legal issues that physicians need to focus on when entering into managed care contracts today?**

Juniper: Providers need to scrutinize compensation and tiering provisions and understand the products and networks in which they will be participating. Payers are increasingly demanding value-based compensation where providers participate in shared savings, incentive plans and risk pools based on quality outcomes and cost reductions. The devil is in the details and providers need to be crystal clear about how and what data will be collected and then used to calculate incentive payments for each product and network, the degree of control they have over the delineated goals (whose performance will be measured), and how they can challenge inaccurate data. Where contracts are tiered, payers need to be held accountable and provide full disclosure, giving providers the right to challenge their tier placement.

◆ **Where do health care entities need to focus their limited resources in today's market?**

Hunn: Forming strategic partnerships, seeking innovation, inspiring employees and embracing young talent are key. Many of the larger hospitals offer high-level specialties that others do not. For example, Providence Saint Joseph Medical Center has a very successful neuro-interventional program, one we share via a telehealth network with four other hospitals in the San Fernando Valley, three of them unaffiliated with Providence. At Providence Holy Cross Medical Center, a team of oncologists from City of Hope brings that center's expertise to our community. By sharing rather than duplicating we find all of our patients are better served. Oftentimes, suggestions for improving upon excellence come from our employees, inspired to play larger roles. We must nurture that to ensure we sustain our ministry of health care into the next generations.

Juniper: Aside from good strategic plans, health care entities need first, to focus on their quality improve-

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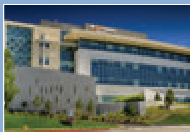

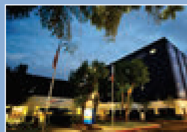

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ment programs, data infrastructures and systemic efficiencies. These are the basics that entities need to meet today's (and future) demands and to ready themselves for the new business opportunities and regulations (such as ICD-10). Second, entities need to cement collaborations with other entities that might provide resources to help them achieve their goals, improve their coordinated care and population health management and participate in other health care initiatives. Third, they must ensure that their operations and any new ventures they may structure, are legally compliant so as not to violate federal and state anti-kickback and referral laws or California corporate practice of medicine laws. Unknowing violations of these and privacy laws can lead to enormous penalties, legal fees and other costs, much less exclusion from government funded programs.

◆ Has the role of agents changed since the implementation of the ACA?

Patton: The implementation of the ACA has put greater emphasis on the role of the agent in assisting consumers with acquiring health coverage. Consumers now need more trusted advisors, particularly because many consumers are either purchasing health insurance or navigating multiple coverage options for the first time. Agents help consumers navigate plan costs and options, help consumers find the right coverage, file and submit consumer applications and assist consumers with application or coverage changes. Agents are equipped to help make applying for coverage as quick and painless as possible, particularly in the Covered California marketplace. Covered California's Certified Insurance Agents have received training on our system and products, which builds upon their own industry experience. Certified Insurance Agents help take the guesswork out of the process. They are there to provide assistance, at no additional cost, to employers and individuals navigating the new health insurance marketplace.

◆ We are reading a lot about health systems working to give individuals, employers and employees more options. In light of this, what should consumers be looking at when making healthcare decisions?

Hunn: The most important thing consumers can do is to work with their physicians to determine the best health care options for their particular needs. Age is important, as are pre-existing conditions. Then they must pay careful attention when choosing their insurance plans. Ask questions. Make sure your preferred physicians, clinics and hospitals are a part of the plan you choose, and double-check copays, premiums and prescription drug coverage.

Patton: Employers should be looking at health care models that are simple, cost-effective and give employees the most options. We encourage consumers to reach out to certified Covered California experts—free of charge—to walk them through a process and manage much of the paperwork involved. Covered California offers employers free support through the help of a Certified Insurance Agent or service center representative to help choose a plan that works for them within their budget. Their employees can also easily choose from multiple coverage options that meet their needs at the right price.

◆ Today more than ever before, businesses and practices in the healthcare industry are challenged with accounts receivable, including patient co-payments and reimbursements from a range of insurance providers. Are there any innovative ways companies can master cash flow management to overcome this challenge?

Moore: A recent study by Greenwich Associates found that the top two issues that keep the leaders of small and mid-size businesses up at night are achieving

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revenue or sales growth and cash flow concerns. This includes healthcare-based businesses, whose unique mix of compensation and often delayed reimbursements make this a critical issue. I like to remind clients that the banking industry has evolved, too. Gone are the days when only the largest businesses have a dedicated team of bankers to help them reach long- and short-term goals. You can expect your banker to offer solutions featuring elements like sweep accounts to leverage cash flow, interest rate swaps to mitigate risk on long-term borrowing and remote deposit capture to decrease float times—and eliminate trips to the branch. Experienced bankers are accustomed to working with businesses with varied cash flow and are ready and willing to dig into the details as a part of understanding your business, then offer a range of solutions suited to your needs.

◆ With the advent of electronic medical records, what are some emerging issues that consumers should be aware of?

Hunn: The positives far outweigh the single negative, but it is the latter that is of most concern to the health care industry. EHR systems can be subject to computer hacking, so Providence has been vigilant about system security now and in the future. EHRs improve quality of affordable care by allowing for better coordination by care teams and by giving patients access to their records. Providence believes patients should be partners in their care and is pleased that by the end of July, we had registered 123,000 patients in MyChart, Providence's online electronic health record system for patients. We will continue to promote this program, encouraging patients to access their records.

◆ Outside of the usual suspects (benefit structure changes, wellness programs), what other tactics are employers using to reduce their healthcare expenses?

Juniper: Some large employers are entering into direct contractual relationships with physicians and non-physicians to establish clinics and provide care on their worksites. Although these business arrangements need to be structured carefully, employers and physicians think that direct contracting can reduce employers' healthcare expenses: employers and employees would benefit through lower provider fees, less employee time away from work and better preventative health. Other employers are investing in mobile health devices that they give to employees to assist them with managing their health care.

◆ What strategies can self-insured employers implement to effectively manage their healthcare spend?

Hunn: The single best strategy for all employers is to encourage a work-life balance and to stress preventive care. A healthy, happy workforce is an effective work force. Providence has hosted Weight Watchers meetings, provided employees with pedometers to encourage walking both on and off the job and stressed the importance of family as part of its wellness focus. The organization also provides financial incentives for all employees to have annual physicals and provides basic health care checks annually.

◆ What issues do health care providers need to address as they become more retail-minded? Are there any specific issues that health care providers who partner with retailers need to be aware of?

Juniper: Becoming more retail-minded may mean establishing a retail presence, collaborating with other retailers and providers, or using tools long associated with retail success, particularly marketing and advertising. Health care providers who increase their marketing efforts need to review state professional laws, unfair and deceptive advertising laws and fraud and abuse laws that may prohibit consumer incentives (gift cards, discounts) or other typical marketing devices used by non-health care entities. Where a provider is collaborating with a corporate entity, the arrangement must be structured so as not to run afoul of California's ban on the corporate practice of medicine, fee-splitting and certain relationships among professionals. Compliance training that extends into the field, where retail managers often engage in their own local marketing efforts, are a must.

Hunn: Shared dedication to quality is the No. 1 issue as health care providers expand to new methods of delivering care by partnering with retailers. These partnerships lend the expertise of health care professionals to the retail enterprise, providing for intriguing options for consumers. For the not-for-profit, mission-focused Providence, we must carefully discern whether we are comfortable with the reputation, values, employee relations and community standing of any potential partners.

◆ Should large physician groups create their own managed care entities?

Juniper: This decision depends upon the group's culture, resources, degree of integration and strategic business plan. A California health plan structure can benefit a physician group by helping it to: (1) increase reimbursement by taking global risk and accepting delegated tasks from other payers; (2) expand networks and direct referrals within them; (3) contract directly with large employers; (4) create innovative products; (5) achieve clinical integration and quality improvement; (6) align financial goals and streamline operations; and (7) centralize data for better data collection, analysis and reporting, particularly with regard to quality measurements. Before proceeding on the path of managed care, though, a physician group needs to calculate whether these advantages outweigh the costs of start-up and ongoing compliance. If so, assembling a solid project team is essential for establishing the managed care organization in the shortest and least expensive manner.

◆ How is concierge medicine affecting the health care market? Might concierge medicine be an alternative for physicians who wish to avoid today's market pressures and reduced reimbursement?

Juniper: Concierge medicine allows physicians to control their patient load and increase revenues while delivering increased medical attention to patients. With the paucity of primary care physicians, this takes more physicians out of the population delivering care to others, including government funded patients. Due to legal limitations in how the practice must be structured, most concierge medicine practices cater to those who have the financial means to afford the care.

◆ With all the new clinic options for consumers, such as Walgreen's, CVS, Zoom and Minute Clinics, what should consumers be aware of when visiting these clinics?

Hunn: Quality, price, delivery of care, medical history and much, much more. These new retail clinic options provide for convenient care and less of a wait as some communities see declines in primary care physicians. Some of the concerns that have surfaced, however, including a disruption in a patient's continuity and coordination of care when these clinics are not connected with the patient's primary care doctor. Consumers also should be cautioned to check their insurance coverage because often times preventive care, such as a flu shot, is free from their physicians, but not retail clinics.

◆ Where do allied health/non-physician providers fit into today's health care market?

Juniper: Non-physician providers are well-positioned to be bigger players in the medical delivery system. The passage of AB 1000 increases the ability of professional corporations to employ other licensed persons, allowing for less restrictive professional business arrangements. Health care providers are using their non-physician providers to cut costs and allow physicians to see more patients. The growing shortage of primary care physicians has resulted in efforts

to expand the scopes of practices of non-physician providers. The extension of Medi-Cal managed care benefits to include vision and dental care will benefit optometrists, dentists and optical dispensers. Under the Affordable Care Act and California law, health insurance plans must include benefits that recognize non-physician providers like acupuncturists and chiropractors. In addition, allied health professions often found in retail settings, such as optometrists and dentists, are in positions to partner with other health care entities.

◆ Can non-physician providers help reduce costs and fill the gap with the insufficient number of primary care physicians?

Juniper: Yes, health care providers are using their non-physician providers to the extent possible to cut costs and allow physicians to have increased patient volumes. Efforts to bridge the gap created by the growing shortage of primary care physicians include the expansion of the scopes of practices of non-physician providers. The extension of Medi-Cal managed care benefits to include vision and dental care will benefit optometrists, dentists and optical dispensers. Under the Affordable Care Act and California law, health insurance plans must include benefits that recognize non-physician providers like acupuncturists and chiropractors. In addition, allied health professions often found in retail settings, such as optometrists and dentists, are in positions to partner with other health care entities.

◆ What should a physician, health professional or health industry business owner look for in a bank when establishing or expanding a private practice, care facility or health-related business?

Moore: Healthcare is an ever-evolving industry. That requires a banker who is on point and always available to you, not just when your line or loan is up for renewal—think of it as anytime access to free expertise. Above all, your banker should be willing to earn the right to become your trusted advisor. If you ask business owners in healthcare and other fields if they know the first name of their banker, often the answer is "no." That's disconcerting. Your banker should show the initiative to get to know you and the unique needs and goals of your business. Only then can he or she serve in a true advisory capacity and offer meaningful guidance to help you achieve your long- and short-term financial goals.

◆ What are effective models to analyze hospital departments for revenue enhancement?

Hunn: Hospital leaders must recognize the contributions and talents of the "boots on the ground" in the constant quest to improve upon excellence. Physicians and employees throughout Providence are urged to voice their suggestions on how to make our services more valuable and more efficient. They are our eyes and our ears, talking daily with consumers and seeking to understand their needs.

◆ How will transparency and the disclosure of costs and quality ratings affect the health care industry?

Hunn: Quality ratings based on patient surveys and patient outcomes will increase as forces in driving patients to – or away from – health care providers. Consumers have so many choices within reasonable distances. It is up to providers to ensure they are providing the best possible experiences from admission to discharge because deviations in quality will be part of the public record – and, more importantly, because it's the right thing to do. Disclosure of costs is a far more difficult issue. Hospital pricing is very complex and we as an industry are trying to simplify it, but the truth is hospitals must cover extensive overhead, maintain top quality equipment and, in the case of faith-based organization, to care for the poor and vulnerable in our communities.

Juniper: One of the most underplayed aspects of the Accountable Care Act – the transparency provisions – is slowly expanding, and the disclosure of costs and quality ratings will inevitably affect the health care market's dynamics. Putting new information into consumers' hands is a classic means by which to increase competition and lower prices. It is unclear how consumers will decipher and act upon information about provider costs and quality, starting with the cost information that CMS will release, but these disclosures clearly will change things: the way providers market themselves and provide care; the way patients choose their providers; and payers' choice of providers for their networks. Whether or not this will lead to price reductions and greater competition as seen in other markets, is yet to be seen.

◆ How are the quality and review websites (Healthgrades, Yelp, etc.) influencing consumers today? Are these sites delivering on the promise they make to consumers? How can consumers really know if the sites are providing accurate information?

Hunn: There is a wide range of these websites, and Healthgrades and Yelp! are at opposite ends of that spectrum. Healthgrades is strictly devoted to health care and uses data collected by regulatory agencies to rate hospitals and physicians. Yelp! features oftentimes anonymous reviews from participants commenting on everything from cupcakes to open heart surgery. Consumers have come to understand as more and more review sites pop up that some provide fair, balanced and professional recommendations. Nevertheless, regardless of the sources, reviews must be recognized as a public voice and thus a tool to help us continue to improve upon the quality of the patient experience we provide.

Juniper: Consumers clearly check and often rely upon these sites for anecdotal evidence of a provider's customer service and sometimes, costs. These sites provide recommendations and not qualitative evidence or surveys, however. As government, insurers and other rating websites gain access to and publicly disclose cost and quality data generated by new data collection and reporting requirements, those websites are expected to be much more influential in changing consumer behavior.

◆ What types of issues do businesses in the healthcare sector experience that are similar to or different from those of other businesses when it comes to managing growth or expanding into new markets?

Moore: Almost all businesses need access to working capital as well as capital to fund purchases of new equipment or property. The healthcare field, in particular, is faced with rapid technological advancements, changing patient needs and ever-evolving income streams. The impact of an aging population is particularly noticeable in healthcare, as providers work to accommodate the needs of older Americans, many of whom are intent on remaining as mobile, independent and youthful as possible for as long as possible. We're seeing markets emerge and expand as a result, in areas such as adaptive technologies and in-home services. So in order to compete, businesses need to remain flexible and responsive to those types of changes and view them as opportunities. By working with your banker year-round, you'll have a plan in place so you can move quickly when it comes time to replace aging equipment, modify or expand a facility, or acquire advanced technologies.

◆ Are there laws specific to California that restrict the growth of business and innovation in the health care industry?

Juniper: Many, many health care businesses established in other states who want to enter California with existing or innovative services and products, abandon or delay their plans after learning about the nuances of California's health care laws. Those laws often require that companies create complex and costly business structures in order to comply with corporate and commercial practice laws, professional laws and consumer protection laws. For instance, corporate practice of medicine laws, preclude non-professional corporations from employing or engaging in certain relationships with physicians and other professionals. Optometry laws prohibit national opticians from renting space on their premises to optometrists to provide eye exams. While some of these professional laws do preserve physicians' clinical judgment in certain situations, in others they may serve as barriers to entry, higher costs to consumers and loss of business to California.

◆ What expertise has your organization sought out (outside of your company) that has helped you make notable strides in growth/expansion? Do you continue to have outside professionals that you consider to be key members of your "team" that provide you with useful guidance/counsel?

Moore: From our unique lens, we see tremendous advantage to the business owner when he or she assembles a team of experts and pairs them with their internal team—professionals who are equally committed to the business' success. It is not uncommon for us to sit at the table with a client alongside that company's attorney, accountant and business manager. Together we offer a consultative approach with free anytime access to helpful advice. For businesses looking to grow or expand, or even those who want to thrive in an ever-changing arena, I encourage them to look outside their organization to augment their specialized healthcare expertise. We appreciate that you chose the healthcare field because you have a desire and ability to help others. When you have the right banker he or she can offer solutions that free-up time from day-to-day operations, so you can focus on what you do best—help so many Californians.

◆ What do you think will be the "new frontier" in health care for the future?

Juniper: I think that routinely delivering personalized, genomic-based medicine to consumers while getting consumers, including me, to change their behavior and take control of their health care, is the next new frontier. When health care practitioners can look to our DNA to tell us what we need to do to stay healthy and what treatments each individual needs to combat his or her diseases, then we will have the critical information we need to take control of our health care. The question is whether the social media and mobile tools used to prod us in this process will be sufficient to get those of us with lackluster behaviors to do so.

Hunn: Telehealth. Most larger hospitals have signatures specialties – stroke care, pediatric, interventional cardiology, substance abuse, psychiatry and more – and it isn't feasible to entrench communities with those services. Partnerships that allow shared expertise via telecommunications technology are part of the future. Today, specialists can diagnose and treat patients by robot at distant hospitals, helping to limit costs and improve outcomes. This will be especially important for hospitals in rural communities that don't have next-level care nearby. For example, a NICU specialist at Providence Tarzana can use this technology to save the life of a newborn in stress hundreds, if not thousands, of miles away!