Panel 3

"Moving Forward: The Drive Towards Clinical Integration"

Jim Barber, President and CEO of the Hospital Association of Southern California
Donald Crane, President and CEO of California Accountable Physician Group
Bill Gil, CEO of Providence Health Network, Southern California
Moderator: John Edelston, President of HealthPro Associates, Inc.

The final panel of the Symposium focused on the industry's future, with moderator John Edelston, president of HealthPro Associates, capping off the event by congratulating its organizers, Pepperdine and the Graziadio School, on the diverse audience they had assembled, including pharmaceutical and supply side professionals. "Bringing these people together is going to result in more disruptive innovations, more changes and greater cost containment and quality of care," Edelston declared.

The last three presentations and panel tackled clinical integration, consolidation and alignment, the continuing appeal of physician groups, and the role of pharma and the supply side going forward, specifically how these segments of the healthcare industry can be re-engaged by the rest of the industry.

Jim Barber has been president and CEO of the Hospital Association of Southern California for 21 years, an organization with more than 170 members spanning six counties (Los Angeles County, Orange Country, Ventura County, Santa Barbara County, Riverside County and San Bernardino County) that provides advocacy, industry representation, health policy development and products, services and educational programs for its members.

"I was asked at an investors' conference, if they had $300 million to invest in healthcare, where should they do it?" Barber recalled during the panel discussion on the shape of the industry going forward. "And I said: 'Costco.' Anybody who has diapers next to Depends understands the continuum of care.

"But I do think that you don't hire a chef to fry a couple of eggs; I think that the healthcare industry is going to be fragmented and the high-acuity, high-complexity work will be done by physicians and hospitals. And regarding the third of care, at least, that is low-complexity and ready-access, the pharma industry—CVS, Costco—is going to pick our pocket based on lower price, higher accessibility, more comfort.

"We are an industry that has done a very good job at being scientifically brilliant and self serving and providing poor access and there are people who make a living out of providing good access and they're going to pick the low-acuity work and take it away from us and we're going to be in the severe high-acuity business, not in healthcare, unless we incorporate that into our solution," Barber concluded.

Donald Crane, president and CEO of California Accountable Physician Group (CAPG) and a board member of Northridge Hospital Medical Center, observed nonetheless during his talk that "the march of coordinate, accountable care is really happening across the nation."

CAPG, an organization devoted to promoting the interests of physicians practicing accounting care, is comprised of nearly 200 members, mostly multi-specialty medical groups, but also IPAs based mostly in California, as well as 30 states and Puerto Rico. The medical groups cover 18 million members.

"The thing that distinguishes our members is that most of them derive most of their revenue from prepaid capitation," Crane explained. "Many, many of them made the move from volume to value two decades ago. And now, you have the legislative branch and the executive branch pushing the United States full tilt towards the movement from volume to value as it plays and, of course, we think that the end game there will be prospective population-based payments, aka capitation."

Bil Gil, CEO of Providence Health Network, Southern California, oversees the integrated healthcare system's medical group operations for over 300 physicians in the region and is responsible for developing his organization's vision and strategy for its health plan, having previously served as COO for UniMed Management Company.

"Clinical integration is chaotic," Gil declared. "It's very disruptive. It demands transparency. It forces physicians and hospitals to come out of their shell and play together in the sand box. It's very complex. You're now accountable for the continuum of care from preventive care through the episodic care through end of life. And so, that complexity challenges our clinical integration.

"This idea that health systems are trying to create alignment along the lines of the hospitals and the physicians and the health plans requires a level of trust and transparency and commitment that we should not expect great results on the short end," he said. "But if we don't do it, we can continue on the track that we're in, which is do more and get paid less per unit. And at some point, you're going to be very busy and get paid nothing. So, doing what's right in a capitated environment with clinical alignment is the key to success," he concluded.

Aligning the multitude of forces delivering healthcare is difficult in any state, given the changing landscape, though in high-population states like California, it can be particularly challenging.

As Gil noted during the panel's talk on local healthcare, "Providence is the second-largest health system in the state next to Kaiser and we barely cover 10 percent of the population, and not much more of the geography."

The shifts in the payment model and the increasing consolidation that has come to characterize the industry, along with new performance incentives offered by both the ACA and local programs, have required shifts in perspective on the part of physicians in terms of day-to-day care delivery, too.

"Under California's Pay for Performance (P4P) program, my members are graded on pharma use now, whether they have pharma risk or not, because what's being viewed here is the total cost of care," Crane stated. "So, all of a sudden, our pay will vary up and down depending upon what the total cost of care is, including a professional physician component, hospitals and then also the pharma risk. That's now all blended. Groups are now measured on that. So, they're very interested in pharma, very interested in outcomes, as will pharma be, as we move now towards greater consideration concerning not just process measures, but total outcomes."

"At bottom," continued Crane, "what still counts are the physician groups. And that is why hospitals have purchased them. They need them in order to be accountable for capitation and to take care of patients across the whole continuum. "The value of the physician group in the picture has probably risen because that's where you get organized systems, where there's some ability to manage the pen, which is the thing that writes the orders for admissions, discharges, prescriptions and the like—that ever-important pen in an era where affordability is key. That pen gets controlled in a physician group. Physician groups have high value. That's why hospitals want to buy them, and health plans want to buy them. I think we're going to see that trend continue. That's where the Pentium chip in healthcare lies."

In response to Edelston's last question about what the system might look like in 15 years, Barber predicted, "I think the future is going to be eight or ten large integrated delivery systems in California having the majority of the market share and in an area like Los Angeles, it could literally be four or five big systems with 80 percent of the market share in this region."

In terms of how the industry structures itself going forward, Gil said, "I think that we're going to sort of meet at the middle, where there's going to be a lot of strategic partnerships so that you can still go to market with a reasonably priced product, but you have the geographic coverage to do that. We're seeing it in New Jersey and we're seeing that in the South; I think that Los Angeles is probably the hardest town to do that."

"I think that when you go into Medicare, managed care or Medical managed care, you can run a health plan because you have default safety net rates. When you get into commercial business, you're flapping in the wind," explained Gil. "And so in order for us to go to market with a

commercial product, it would require a collaborative virtual network of health systems that would have to act like Kaiser."

With these shifts in models, focus and business strategies, a more philosophical shift may also be required on the part of both patients and care providers in order for U.S. healthcare to move forward under this new system, which the ACA has played a major role in shaping, even with the act's challenges and flaws.

"We're still talking about, in this country, things like who pays?" Barber observed during his presentation. "Should it be federal government? Should it be state governments? Should it be the employers, which we've had all these years? We're still talking about do they deserve it? Is my care going to be compromised if they get it?

"We support Obamacare, we support ACOs, we support a lot of pilots, and a lot of the payment reform in that piece of legislation," Barber said. "But still, after the five-year anniversary, after the ACA's been implemented and millions of people now have coverage that didn't have it before, the majority of Americans poll unfavorable toward the ACA. The last poll I saw had 46 unfavorable, 40 favorable and 15 undecided. And we're going through another Supreme Court decision that we hope comes out in favor of the current plan, which is to allow subsidiaries to be provided by federal exchanges because we don't want to go backwards at this point."

Indeed, moving forward is a complicated process but one that is well underway through the innovations in care delivery, focus and telehealth that have arisen in response to the ACA and system-wide changes, which will continue to challenge industry members across the spectrum, ranging from hospitals and physician groups to healthcare systems and plans to the patients themselves, to expand and adapt their vision in the service of quality medical care.