



## The Fiscal Cliff, Health Care Impacts and the Need for Operational Efficiency



*Integrated Oncology Consulting Solutions  
And Cancer Care Center Planning*

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Once again, the fiscal environment for health care is changing! Congress and the President just passed legislation to avoid the “fiscal cliff” that included essential items that impact health care. One of the most critical stops the 26.5% reimbursement cuts for physicians seeing Medicare patients. As in previous years, this fix is unfortunately just for one year and the money to pay for it, in part, comes from decreased reimbursements to hospitals that take Medicare patients. The projected cuts to hospitals are almost \$11 billion, with an additional reduction to disproportionate share hospitals of around \$4 billion, over 10 years. The additional \$15 billion to support the continued physician payments would come from other sources, including Medicaid payment reductions. Other sectors of the healthcare industry are also facing cuts that threaten financial performance. In all, it is estimated that 25-30 health and Medicare related sections are addressed in the current legislation passed by the Senate and the House of Representatives. Sequestration, the automatic spending cuts that would have gone into effect if legislation had not passed, protected Medicaid but imposed a 2% automatic cut to Medicare reimbursement. These automatic cuts were only postponed for two months, meaning that additional discussion must emerge in the coming weeks to prevent these and other drastic measures from being implemented. If these cuts are not postponed past the initial two months, other government agencies such as the National Institutes of Health and the National Cancer Institute, will be severely impacted leading to questionable funding situations.

While it seems that Congress and the President are at least communicating, healthcare reform talks will continue for many years to come as the goal is to control the escalating cost of health care over time. President Obama has made it clear that Medicare must be available for future generations by controlling the upward trajectory of costs. With the incredible downward pressure on reimbursement in the coming weeks, months and years, how are hospitals and physicians expected to survive? Hospitals face external demands for cost savings from both government and private payors, while struggling with internal constraints such as rising supply and technology acquisition and labor costs. Physician practices are threatening to quit seeing Medicare and Medicaid patients. In our consulting practice, The Oncology Group is seeing hospitals trying to conserve cash and physician practices begin to question who they will accept as patients going forward. The issue becomes how to continue to provide quality patient care when there are fewer and fewer dollars available to pay for care provided.

This is the point in time, regardless of future healthcare reform impacts, to explore measures to improve productivity and decrease costs without sacrificing quality and without using scarce resources inappropriately. Operational excellence is a major strategy to deliver a positive return in a time of increasing fiscal pressures. Cost control efforts are not new. The advent of the prospective payment system (PPS) in 1983 was the first attempt to control rising costs by changing incentive behaviors. A free-market approach to care has been seen as the answer to controlling costs, since competing on price and quality of service adjusts the market so that facilities with tighter cost controls, higher quality, lower costs of care and higher efficiency thrive.

In 1983, the development of the PPS in the U.S. was an initial attempt to control the rising cost of healthcare with the goal of making quality care available at a lower cost to everyone. The purpose of PPS was to change behaviors by changing the incentives of care reimbursement. The late 1980's brought competition to the forefront of cost control. As new payment schemes were initiated such as Ambulatory Payment Classifications (APC), hospitals and physicians adapted with varying degrees of success. Fostering a free-market economy was seen as the answer to controlling costs. Competing on

price, service and quality adjusts the market, and facilities with higher quality, lower prices and efficient care thrive. But today, uninsured patients, a downward pressure on rates, increasing technology and labor costs, an aging infrastructure and work force, and the uncertainty of the Affordable Care Act impacts are stressing hospital and practice administrators like never before.

In a recent article by Chris Conover for Forbes entitled [The Cost of Health Care: 1958-2012](http://www.forbes.com/sites/chrisconover/2012/12/22/the-cost-of-health-care-1958-vs-2012/) (available at <http://www.forbes.com/sites/chrisconover/2012/12/22/the-cost-of-health-care-1958-vs-2012/>), he states that per capita health expenditures in 1958 were \$134. Per capita spending on health care in 2012 was \$8,953. Goods and services as a percent of income decreased from 1958 to today, but healthcare costs quadrupled. He goes on to discuss whether the consumer of health care today is getting value for the dollars spent. Probably the most interesting point he brings up is that only 11% of health expenditures are paid out of pocket leading to no real consumer pressures to control their personal acquisition of health service. The Institute of Medicine went on record saying about 30% of health spending, or approximately \$765 billion, was wasted in 2009. Bottom line, the growth in costs, unnecessary services, and other unfocused health spending leading to massive expenditures is not sustainable...and that is the challenge before the President, Congress, payors, providers, employers and consumers.

So what are providers expected to do today to protect their sustainability? We know that extensive lobbying efforts are underway to convince Congress of the need to protect the healthcare industry from cuts so deep that survival is threatened. We also know that there are relatively few avenues open to providers to reduce their costs to sustain their margins. With external forces specifying what they will pay providers for services rendered, raising rates is almost futile. The acquisition costs of supplies and technologies continue to increase as everyone attempts to capture as many healthcare dollars as possible to protect their own margins. Controlling expenses with department level budgets is routine, but is it really effective? Setting what you need in a budget is difficult because so few providers have true cost determination capabilities. Ultimately, operational efficiency is the only truly controllable strategy a provider has...and of course, operational efficiency is the most difficult to achieve!

Developing efficiency measures in a cancer program is complex. Measures must determine the cost to provide a service or produce an outcome, all while maintaining quality patient outcomes. Reengineering processes to enhance productivity and developing action plans to manage labor, supply and technology costs require a level of sophisticated analysis and forward thinking. The Oncology Group, with our extensive consulting engagements with the best cancer programs and physician practices across the country, has seen a variety of measures that deliver savings. Facilities and practices that empower staff to seek savings, understand the economic operating climate, use a cost-determination team, evaluate purchased services carefully, strategically plan, and reengineer processes to meet the needs of the work flow are successful in maintaining both quality and margin in their cancer services. Realistically projecting market penetration and numbers of available and potential patients is crucial. Assuming that increased volume will drive increased margin is a fallacy when each unit of service is losing money. A better market understanding leads to more powerful decision making for the future.

For a cancer program or physician practice to survive and thrive going forward, a better understanding of the current environment of 21<sup>st</sup> century cancer care must also occur. Aligned incentives, practice acquisition, clinical affiliations and other arrangements to deliver patient-centered, quality care are just a few of the keys to success. Using a leveling strategy approach to bring staff and physicians to the same understanding of cost efficiency, educating staff and physicians to why cost control and operational efficiency is crucial and reassuring staff and physicians that operational efficiency is a positive approach

for the future will mitigate resistance to implemented measures. Because of the lack of trust evident in some facilities between administration and staff and between facilities and physician practices, a neutral moderator is often the best way to bring consensus. If there are aligned incentives and a strong bond within and between facilities and practices, assign an individual to monitor the fiscal and therapeutic cancer care environment and serve as facilitator for ongoing discussions of identified efforts.

The future of cancer care is in the hands of individuals willing to aggressively address the external and internal challenges presented on a daily basis and define strategies necessary to prosper. The Oncology Group is committed to assisting our clients with all their efforts to provide even better care for their cancer patients. While this is a challenging time in health care, it is also exiting as we move into the next chapter of cancer care delivering quality outcomes!