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HEALTH CARE

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MODERATOR**Dr. Kennard Brown**

Executive Vice Chancellor/
Chief Operations Officer,
The University of Tennessee
Health Science Center

Brown holds the responsibility of coordinating the day-to-day administrative operations and the effective management of the campus central administration. Brown has been with the Health Science Center for 17 years and began his university service in the Office of the General Counsel.

He previously served as the director of the Office of Equity and Diversity, Office of Employee Relations and Center on Health Disparities. He serves as the Assistant Professor in the College of Pharmacy, Department of Surgery in the College of Medicine.

PANELISTS**Prof. Amy Campbell**

Associate Professor of Law;
Director of the Institute for
Health Law and Policy,
Cecil C. Humphreys
School of Law

Campbell serves as adjunct faculty in the Center for Bioethics and Clinical Leadership of the Union Graduate College-Mount Sinai School of Medicine Bioethics Program. Campbell received her law degree from Yale Law School, master's in Bioethics from the University of Pennsylvania, and B.A. in History and Peace Studies from the University of Notre Dame.

Campbell serves on the Executive Committee of the Health Law Section of the Tennessee Bar Association and on the Board of the Memphis Bar Association's Health Law Section.

**Paul Hopkins**

CPA/Partner,
Dixon Hughes Goodman LLP

Hopkins has more than 20 years of experience as a certified public accountant working primarily in the health care industry.

He is an assurance partner for Dixon Hughes Goodman LLP and has been with DHG since 2004. Within the health care industry, he serves hospitals and related entities, physician practices, skilled nursing facilities, independent and assisted living facilities and continuing care retirement communities.

With more than two decades' experience in health care, Hopkins brings skill and industry insight to his clients.

**Jimmie Mancell**

M.D,
Methodist Le Bonheur
Healthcare

Mancell is the chief of medicine and associate dean for Clinical Affairs at Methodist University Hospital and UT Methodist Physicians in Memphis.

In addition, he is an associate professor in the Department of Medicine at the University of Tennessee Health Science Center.

He is currently a team physician with the Memphis Grizzlies and is a member of the Strategy Committee and Cardiac Subcommittee of the NBA Physicians Association, and he is a consulting physician for the University of Memphis Athletics and the Memphis Redbirds.

**Ron Rukstad**

Chief Executive Officer,
The Village at Germantown

Rukstad has 40 years of experience in the field of senior housing and services, and has served as the executive director of The Village at Germantown for the past four years.

Prior to that he was the executive vice president of operations for CRS, a Memphis-based firm that specializes in the development, marketing and operation of life plan communities in 17 states. While in this capacity, his corporate staff oversaw the opening of many retirement communities and served as manager for 25 communities.

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Navigating changes and challenges in health care

Kennard Brown: As hospitals struggle with their bottom line, is it possible for a hospital to go out of business?

Jimmie Mancell: Unfortunately, this is the reality for some small community hospitals as well as regional hospitals. Their health care margin is so narrow; they have to be very good stewards of their resources to stay in business or change their business model. If they do not adapt to the changes in health care, they cannot survive. We have seen evidence of this within our own community.

Brown: In the past, hospitals were incentivized for volume. Today, they are incentivized on the quality of care. How is this changing hospitals?

Mancell: Even if paid less, one could just increase the volume to make up the difference. This is no longer the case. Now, hospitals and clinicians will be rewarded for the increased quality of care they provide and penalized if they do not meet set quality goals. Additionally, hospitals and clinicians are incentivized for preventive care as well as efficiently transitioning care from the inpatient to the outpatient setting.

Brown: How do physicians feel about payers setting the paradigm on the standard of care? How are they responding to those standards, such as the set time frame for readmissions?

Mancell: With a certain degree of anxiety and apprehension. However, these standards are not going away, therefore clinicians must be willing to collaborate with payers to agree to best practices to which we will hold ourselves accountable. As to the time frame for readmissions, it would seem straightforward, but this is not the case. Clinicians and hospitals can be penalized for a preventable complication causing readmission. This would seem to be a reasonable expectation. However, there are complications and/or medical events completely unrelated to the initial episode of care that require readmission. The hospital and clinicians would be penalized adversely for this readmission as well, which does not make sense.

Brown: There are challenges with the transparency and understanding of health care costs. How do we better understand health care costs and the unpredictability of hospital costs?

Paul Hopkins: It's a conundrum. We're getting a lot of calls about where health care is headed and how hospitals are going to be paid in the future. With the new value-based payment system, hospitals need to be able to become more risk-capable. This means taking on greater responsibility for the care of a defined patient population. Under a risk-capable payment model, providers are penalized or given a bonus for the quality of care they provide – and those payment models come in different forms. In the future, that transparency about the varying costs will become clearer as payments are made to treat an entire episode of care from start to finish. This puts hospitals and providers in riskier situations. So, at DHG Healthcare, we analyze the costs and help hospitals plan financially so as to not affect their bottom line.

Brown: The Affordable Care Act (ACA) can be confusing and complicated. What is expected to happen in health care with the new administration? Will the 'policy dust' ever settle?

Amy Campbell: It is very complex. And a lot of the complexity was also happening before the ACA, so some of these policies are more reactive, while others are proactive. The ACA addressed the complexity but also created more complexity. We have to figure out what law's role is in all of this. There are so many layers and unintended complexities. We must determine if the laws should be put in place to nudge a system toward wellness and out of the hospital and whether policies and laws should be reactive or proactive. And we have to figure that out by looking at both the negative and positive aspects we're seeing in health care.

Ron Rukstad: In retirement communities, we've been looking at how to prepare. We're going to get sicker people sooner and must take care of them in a patient-centered, state-of-the-art health care setting. As part of our partnership with Methodist Hospital, we are working on and preparing for that. This is partly because of the changes in health care reimbursement. The average a patient would stay at a rehab facility after a hip or knee procedure was 22-23 days. Now, the normal stay is seven days. So, we also have to change the way we manage patients and prepare them to be independent and ready to go home in just seven days as opposed to 23. Our focus is on rehab and doing it well and as quickly as possible.

Brown: Can you please explain what the seniors' Life Plan Community is?

Rukstad: Things have changed in senior housing. When I began work in this field, the entire emphasis was on convenience – seniors would not have to take care of a yard or cook meals or do housekeeping. Today, our residents expect a comprehensive plan of wellness and programs that will help them live longer with a higher quality of life. So, the focus is now more on wellness and related programming. In addition, the emphasis for retirement communities used to be on seniors' care when they were sick. If their health declined, we'd help take care of them. Today our Life Plan Community program focuses on the positive and takes a holistic approach to wellness to help them live at the highest quality of life. In a traditional nursing home, people think that once they enter the facility, they are there to stay. We want to rehabilitate at the highest level possible – with 87 percent of the seniors returning to highest level of functioning. The whole approach has changed – Life Plan focuses on the positive and staying healthy, not simply taking care of you while ill.

Brown: Where does the health care responsibility lie – with the federal government or on the state level?

Campbell: It's not an either/or situation. We rely on and depend on the state's ingenuity and how they respond to local resources, conditions and needs. States also have more flexibility than the federal government. But the federal government can be supportive to states by showing

them how to invest and also by sharing best practices. Think of this as a two-legged stool: It might get off-kilter, but we do need interaction from both. And that also creates challenges of which is more dominant – states or feds? We have to value that health is as a state issue, but there is a role for the federal government. We have to find the balance, which is an ever-present challenge.

Brown: Should the payers devote more resources and pay more for populations with the poorest health or those who are sick more, such as geriatric and pediatric patients – or focus on trying to keep populations healthy?

Campbell: Historically, we've always paid more for the sick, and we've focused on a higher level of care for someone in the hospital. So, as we shift our policies, we still need to devote our resources to those ill populations, but we have to figure out how to do it more efficiently and effectively. Payers are realizing that it's not just the health system's job anymore, we have to help keep kids well and out of the ER. We could address mold in a household, for example. It's an odd health charge, but it will save health costs down the line. Payers also need to think about how what makes someone healthy isn't just about what happens in a hospital; they have to think in broader terms.

Hopkins: Employers are driving reform, too. Their health care costs have skyrocketed. So, they want to help their employees stay

healthy, keep them out of the hospital and help manage their chronic care – doing so helps keep the employers' costs down.

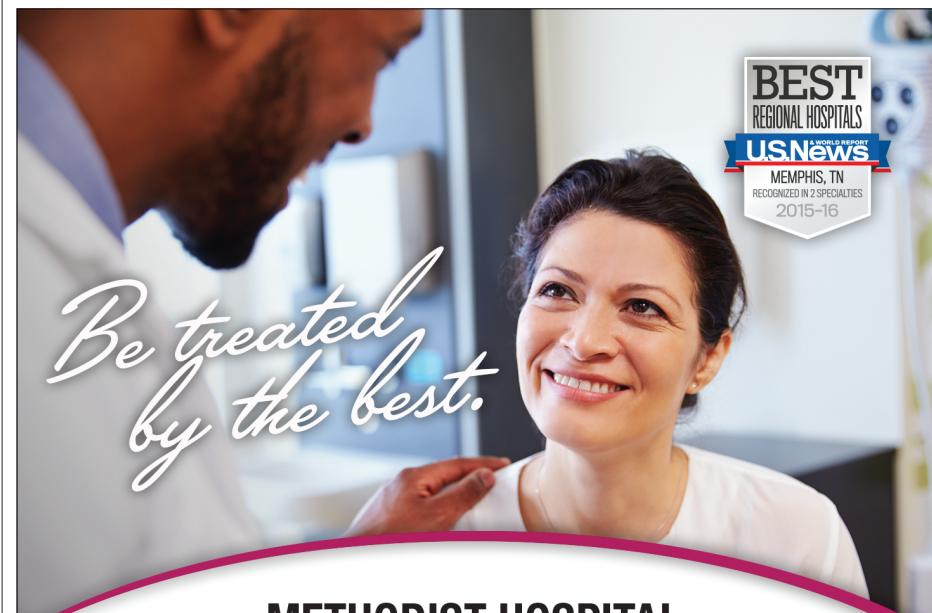
Mancell: Employers are investing in prevention and wellness because this affects the health and subsequent productivity of their employees, creating savings for them. Insurance companies, as well as the federal and state payers, should have strategies around preventive care and wellness for specific populations and communities. There was a time when medical insurance would only pay for a visit if there was actually something wrong with the health of the patient. This mindset has to shift in the discussion of population health.

Brown: Should health care and insurance be attached to employment?

Campbell: I say no. With the ACA exchanges, there are trends where employers want to get out of that line of business. Historically, it's been an employer-based benefit. It's so complex for employers, they'd want to be rid of that responsibility; so, they are interested. But, we have to figure out what fills that vacuum. Is it public or private? State or federal? What we have is not working – so, what's the fix? That's the challenge.

Brown: You know the saying "First in cost, last in outcomes." How do we make people come to grips with this reality?

Hopkins: There's continued pressure for the



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health care industry to do more and to do better with less and with a finite amount of money. The ACA ignited industry reform, where everyone is questioning this now and saying, "We want better outcomes, but we don't want to pay as much." That's the challenge. So, we need more best practices. For example, in the past, we'd always discharge patients to a nursing home and they'd stay for an extended period of time. Now, to reduce some of the financial waste, we're looking at home health care or rehab when appropriate to help reduce costs. This takes everyone working together. Employers and the government are driving this — the "do more with less" attitude — by funneling it down at an accelerated pace.

Rukstad: We have to change traditional mindsets to be more efficient with less. How can we deal with new quality-centered reimbursement systems? We need to rethink how everything works. Working with Methodist has been a great experience, because we are working together as partners to identify procedures, to provide efficient health care to seniors.

Mancell: In the changing health care landscape, we are going to have to provide value by increasing quality while decreasing cost. Essentially doing more with less. At Methodist LeBonheur Healthcare, we are doing this by removing inefficiencies and waste. Some of this is through better use of technology, including the electronic medical record. However, there continues to be obstructions such as HIPAA. Due to occasions of over-interpretation of this law, there can be an inability to get medical records with vital information, test results or procedural reports, which forces clinicians to sometimes repeat unnecessary tests. This reality has to change.



Jimmie Mancell and Amy Campbell

ELLEN COLLIER | MBJ

Campbell: I tell my students, the HIPAA law is an intervention in many ways as a lived experience; as a practice, it does frustrate and stifle conversation and that wasn't the intent — but that's how it's being interpreted, used and applied. Law's responsibility is to work and navigate, so the law is achieving the intended result not creating barriers. This is an opening — address HIPAA and those kinds of laws.

Brown: Should we deal with tort reform? What risk are physicians in in terms of legal culpability and malpractice?

Campbell: There is a role for litigation and addressing serious errors. And there is a role for tort reform as we have more team-based care, where the physician has the prominent risk, but the physician isn't the

only one with the risk — the liability is on a team, not just the doctor. Tort reform is for enhancing the quality of care. So, we have to figure out: How do we make sure the intent behind the law is being achieved?

Brown: To reduce hospital admissions and length of stays, wellness programs are being incentivized. Should entities take on more proactive measures to help to mitigate costs downstream?

Rukstad: New reimbursement systems are going to drive that, which is the expectation of payers and partners. The biggest incentive we have is to be in a preferred provider relationship, as we are with Methodist, Campbell Clinic, and MSK, which is a benefit to us. Wellness programs right now are only private pay. Our residents have access to our pool, track, therapists — they're part of the Life Plan Community. They have access to those things by being residents of the community. We are looking to expand that platform to our larger senior community.

Hopkins: Wellness becomes more important from the employer standpoint. By offering health club memberships and helping manage chronic conditions, employers are attempting to keep their employees healthy and total health care costs down, as well. Wellness programs will continue to expand to keep costs down. The benefit is reduced insurance costs to the employer. There should be some financial incentive because of the reduction in health care spending on the backend.

Brown: What can be done to orient the frontline physicians with the reality of the costs and economics of the medical industry?

Mancell: Physicians are going to have to become more actively involved in setting the standards for increasing the quality of care. This will require a better understanding of the costs associated with the care they provide. As we become more responsible for this cost, we are going to have to collaborate with each other as well as hospital management. At Methodist LeBonheur Healthcare, we have started this collaborative effort between hospital management and the medical staff by forming clinically integrated networks.

Brown: Should we indoctrinate medical students about the economics of the industry earlier — during medical school?

Mancell: Yes, we should. I have given a medical economics lecture to medical

residents and students regarding the cost of what we do. During the lecture, I ask them to write down the costs they believe are associated with certain tests, X-rays and procedures they order. Then, we go over the actual cost of all of these items, which becomes a rather sobering moment. I believe teaching medical students early the costs associated with what they do will certainly improve the quality of care while reducing these expenditures.

Hopkins: It can be challenging for hospitals to tell you their true cost for an episode of care, but they know what they're going to get reimbursed. There must be transparency. But, there is confusion because hospitals can show what the charges are, but they don't necessarily show the contracted amounts they will be paid. The industry only works like this because of third-party payer involvement.

Brown: How can costs for the same procedures be so different at various hospitals? Is there any intent to set a standard for charges and reimbursement to establish predictability in the costs?

Hopkins: Some reimbursement variance is due to different markets, but sometimes it just says something to the skill of contract negotiators to get a higher reimbursement rate for their hospital.

Campbell: We should have consistency and less variation. Health care is a business, and we have some knowledge of what it will cost and reimbursements based on what we're providing. We all agree there are problems, but we're not changing. The ACA created some changes, but we still need more understanding, consistency and clarity. Would we be better off with just one payer that we negotiate across systems? Even from a business and accounting perspective, that would have benefits.

Rukstad: Medicare covers a growing segment of the population. There is Medicare A, Medicare B, supplemental insurance, long-term insurance — it is all a challenge to navigate. There are few geriatricians. We are fortunate at The Village at Germantown to have doctors and staff who understand Medicare and how the system works — they deal with it every day. There is a real need within the industry to understand the Medicare system and how to navigate it. It is extremely complex.

Brown: So, where do seniors go for help with the system?



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Rukstad: At The Village at Germantown, we have a social services staff to help navigate that. In conjunction with Methodist, we want to use our platform as a basis to provide education to the community, so we offer people access to the full extent of services they may need — hospice, home health, companion programs and education on how to use Medicare. Our goal is to provide care coordinators for seniors who take advantage of the new program we envision: Seniors will be able to pick up the phone and tell the coordinators what's happening and ask who to be in touch with regarding a specific issue. We want them to be able to say, "I'm concerned about this, who can help me?" We want to be a resource for seniors because so many experience that difficult problem: What do I do?

Brown: What does the medical industry's economic future look like?

Hopkins: That's difficult, because the health care industry is always changing. I'd say we're going to see more alternative payment models and more risk pushed from payers over to providers. Providers who are ready for it will thrive, others will fail in that system. The time to look at it is now. We are close to that tipping point of when it occurs. If we can get some of the waste out of the system, that will take some of the pressure off.

Mancell: We will continue to have to improve managing costs associated with all patient populations, including insured, underinsured and uninsured patients. One of our solutions has been providing preventative services through our Congregational Health Network, especially in the 38109 ZIP code, which has improved care in the outpatient setting and decreased the high cost of hospital utilization. All health care systems will have to be proactive using different and unorthodox methods to improve the health in our community.

Brown: Is the magnitude of the underinsured and uninsured population still significant?

Mancell: The magnitude does remain significant. In addition, we have to recognize the increased out-of-pocket expenses incurred by the insured population with high-deductible plans, many of whom are one significant illness away from bankruptcy. Now the burden includes patient populations without insurance as well as populations with insurance having to pay an increased out-of-pocket expense. This increases the magnitude of financial risk.

Campbell: The ACA had built-in assumptions that states would expand Medicaid and the presumption that we wouldn't have uninsured people, and it altered how health systems would be reimbursed. We didn't expect we'd still have uninsured people and that rates would change with out-of-pocket costs. Health isn't just a Methodist Hospital or a Baptist Hospital — it's the health systems like Congregational Health Network. We have to be thinking, what can schools do to promote health, what can be done about transportation? So many things impact health and health systems. Our communities need to know what their roles are in maintaining health.

Brown: States can create unintentional competition. When a medical helicopter from Mississippi flies a patient to a medical facility in Memphis, are communities



Paul Hopkins and Ron Rukstad

ELLEN COLLIER | MBJ

expected to incur the costs of people who are not from that community? Are health systems and communities being negatively impacted by being a regional hub? And, who assumes financial responsibility for undocumented patients?

Campbell: This is another part of the state vs. federal roles. But, for certain trauma care and specialized care, which are necessary, it makes sense that there are just a few centers of excellence, rather than middling facilities. Memphis is a place that has centers of excellence and bears the burden of the cost of care from other communities, not just from within our own community. There can be a role there for the federal government to help ensure Memphis doesn't lose out because it did the right thing and served someone from Arkansas or Mississippi. We shouldn't have a system that says, we can't afford this. The federal government needs to help by playing a role with a fund to draw from to help offset those costs, for example.

Mancell: We experience this all the time. Being a regional referral center, we accept complex cases from multiple outlying communities. Whether they are insured, underinsured or uninsured, we can have significant difficulty returning them to their community. They may have limited family support or resources. This leads to very prolonged hospitalization with a high cost, for which we are typically not reimbursed. There are challenges unique to different states regarding the provision of care for patients from their communities and efforts to return them to those communities.

Brown: Where is the line drawn when cost is passed on to the health system? Who foots the bill for bad behavior such as eating fast food meals every day or choosing not to wear a helmet while riding a motorcycle? What about when cities pass laws banning 64 oz. sugary soft drinks for health reasons?

Campbell: We have to be careful here: How much can the law do and where does the law fit in? Does it come before or after issues? With value-based insurance, if you don't do certain things, you have to pay more, and you'll pay less each month if you do those things. How much is willfully bad and how much is systemic? How can we address the environment — if someone can't join a gym because it's expensive, but they could exercise outside — can we put the responsibility on the person? If so, we have to be careful. How much is it the individual's clear, obstructed choice and how much is environmental? The law has to address those barriers that impact

health. Policy is shifting to say that, with these value-based insurance plans, if you engage in behaviors that lead to unhealthy outcomes, you will pay more. If you smoke, for example, you'll have a surcharge. Within certain limits, surcharges are allowed.

Brown: Is a penalty for not having insurance okay?

Campbell: I'm okay with that — as long as we structure it correctly. For those who really can't afford it, can we craft ways to make sure the copays are affordable and the coverage is appropriate? There is a lot of focus on this idea: As an individual, I have rights when I get sick; I have needs. I think there has to be a shift in understanding that health is collectively felt and impacted. The system works best if we can figure out how to get everyone insured, perhaps by offering a sliding scale to make that mandate affordable.

Brown: Should the role of law be more embedded in the creation of health care legislation? Once a law is created, is the interpretation of the law up to the hospital, payers and providers? What if they have different interpretations rather than a common understanding? There should be more emphasis on how these laws are interpreted. The bastardization of HIPAA is a good example.

Campbell: I agree. When we're thinking about legislation or regulation, we should have doctors, CEOs, accountants — all people should be involved in an evidence-informed process. Law doesn't come from nothing. It's to address issues where it makes sense. We can't think of it as: Once we pass the law, we're done. Once it's passed, we must educate our health care partners about what the law means and the differences between a statute vs. a regulation. And we have to listen. If we hear or see there are problems, we have to think how we can fix the educational aspect or the actual law. There must be interdisciplinary collaboration in crafting, implementing, evaluating and amending as needed.

Brown: How do we keep young, bright people in the health care industry despite the challenges of policies and economics?

Mancell: We keep them interested by reminding them of the ultimate reward and satisfaction achieved by caring for our fellow man. It truly is a calling. There are going to be frustrations and challenges, as there are with most things in life, but to care for and improve the quality of life

for our patients and their families is a true gift. We have to prepare them for these challenges to minimize their frustration.

Brown: From doctors to policy makers and social services, health care has a framework based on community. Would you say that we, as a community, have to be more involved in our health care system and industry?

Mancell: We have to be more involved to address the health care disparities we have in a significant portion of the communities we serve. We know the majority of our community wants good health, we just have to find ways to remove the barriers keeping them from achieving good health. We have to be mindful of the financial barrier contributing to poor health. For example, the cost associated with the therapy of some chronic conditions such as diabetes is more than the monthly rent or mortgage for several of the patients in our community.

Brown: If you could change one thing about health care, what would it be?

Rukstad: Our nurses are amazing — they input chart information into the computer; what they did with the patient; why they did that; the care plan — all to ensure everything is compliant. These nurses want to care for these patients but spend much time in documentation. We need compliance, but it is to the point of being difficult to provide the hours on care required and expected.

Mancell: Sensible accountability. Physicians and health care systems should be held accountable for the quality of care they provide and any preventable complication associated with that care. Currently, though, physicians and hospitals are held accountable for unrelated complications as well as readmissions for medical problems completely unrelated to prior episodes of care based solely on a predetermined period of time, 30 days. This absurdity is what continues to perpetuate pessimism and the reluctance to participate in meaningful change within payment systems. As a whole, we must be more engaged than ever to remove these arbitrary penalties and drive sensible accountability.

Hopkins: From an accounting and CPA standpoint, health care is highly regulated, and a lot of dollars are spent on compliance that could be spent on patient care. To make health care better, one thing I'd change is to find a way to effectively operate the industry as it should, but not spend so many dollars on compliance.

Campbell: When I'm working with students, I tell them that law does not operate in a vacuum. Law is a service profession of open dialogue with all the players in the system with the right balance of policy regulation and a spirit of humility. Early on, we need to start training people to think about how we can be more collaborative and do more listening. What's the problem I'm hearing that law could help with? Law should be more of a flexible partner than in a fixed state. It's hard to change laws without unintended consequences. We need law advancing health — its purpose is not an impediment to health. How do we get a unified mission to advance health, and what's the role of law: as informing; being a firm hand; to nudge; to be a silent partner when it needs to be? How do we strike that balance? It has to start in law school by opening our doors and learning alongside businesses and health systems and all the players. What is this system, and what's the pivot point for law?