MEET THE PANEL

KEITH ALGOZZINE
Title: CEO
Company: United Concierge Medicine

JANE BELLO BURKE
Title: Partner
Company: Hodgson Russ

CHRIS DEL VECCHIO
Title: President & CEO
Company: MVP Health Care

PAUL MILTON
Title: President & CEO
Company: Ellis Medicine

BRIAN O'GRADY
Title: EVP & Chief Marketing Officer
Company: CDPHP

JULIE SHAW
Title: CEO
Company: OrthoNY

Industry ROUNDTABLE
HEALTH CARE

PRESENTED BY:

Is there anything on the horizon that's going to disrupt health care in a major way? What is your hardest job to fill? What would be the effect of a single-payer system on your organization? Law firm Hodgson Russ and the Albany Business Review hosted a discussion to answer these questions and more. Melissa Mangini, editor of the *Albany Business Review*, moderated the discussion.

How has what you do changed over the last 10 years?

KEITH ALGOZZINE: Ten years ago, I was working clinically and running brick-and-mortar emergency medicine practice. Today, ironically, I run a virtual ER. I focus on keeping people out of that same ER that I ran for 10 years.

What I did 10 years ago was take care of patients within the four walls of a hospital. Leveraging that emergency medicine expertise today, we're trying to reverse engineer that system and try to bring that same emergency medicine expertise to patients before they ever get to the hospital.

BRIAN O'GRADY: From an organizational perspective, what we're doing now is basically the same thing. We have the same purpose we had 10 years ago, in trying to facilitate access to high-quality health care for our members and improve the health of our overall community.

The way we go about doing that is a little bit different. As the delivery system has changed, we're trying to develop more partnerships that bring incremental value to not only CDPHP and our members, but to those partners as well.

JULIE SHAW: OrthoNY has changed a lot in the last 10 years. Specifically, in the last five, we got a lot bigger. We went through a merger with Saratoga Orthopedic Associates in 2013, and then in July of 2014, we brought on the Schenectady Regional Orthopedic Group.

What's changed for us in the past 10 years is the way we make money. We used to be reliant on insurance companies and the federal government paying us for our services. But by becoming larger, we have some negotiating power, not just with insurance companies but also with vendors.

CHRIS DEL VECCHIO: A lot has changed for MVP over the 10-year period. In the last five years, there's been this acceleration of change in how we work, how we think about business, how we think about our members and creating value because I think that is where the puck is going. We're trying to align with the provider system and we expanded into the Affordable Care Act market in a big way.

We acquired a Medicaid-managed care plan in Westchester County to expand our footprint, and we significantly increased our market share in the state of Vermont as a hedge against the global changes in the market. We were pretty much concentrated as an employer group company with some Medicare, and now we have this balanced portfolio that we're trying to manage across our footprint.

PAUL MILTON: Particularly over the last five years, we've become more outward in what we do. Not to say we were inward before, but with all the collaborative efforts, we've become more outward-looking and trying to do things with folks, whether it's OrthoNY or the insurance providers.

If you look at how we take care of certain populations, whether it's the Medicaid population or the Medicare populations, we're in these collaboratives. We try to work together to take care of that segment of the population. We're still a kind of brick-and-mortar place for the most part. We have core content of what we do as a provider of service; hasn't changed that much.

JANE BELLO BURKE: What we see is there's been an increased focus on keeping individuals out of the hospital. There's been advances in the use of technology to communicate both internally and externally. And there are a host of legal issues that fall out of that.

There's also an increased focus on affiliation and alignment. And so, we see across the provider spectrum, from hospitals to nursing homes to home care to individual providers, an increased focus on making those affiliations work.

Julie touched on this: How has what makes money changed in recent years?

O'GRADY: It's still the same. Our job is to manage risk and make sure our members get the care they need. The challenge for us is trying to estimate what that care is going to cost, and so as technology has kind of infiltrated the delivery system, as

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Standing: Chris Del Vecchio, left, Brian O'Grady, Paul Milton, Jane Bello Burke. Seated: Julie Shaw, left, Keith Algozzine.

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new methodologies and new treatments have been developed, we need to keep up with that.

At the end of the day, as a not-for-profit health care company, we're looking to make a 1% to 1.5% margin. It gets back to those partnerships. If we can partner appropriately, you've got to believe that higher-quality care with improved outcomes is going to lower overall costs. That's where the entire community benefits.

ALGOZZINE: Most people who will read this are people who have margins in their businesses that are 10%, 15%, 20%. And we're working off of 1% or 1.5% in a good year. The tightrope we walk is a matter of just one or two transplants. Or one or two drug therapies that run $2.5 million a year whereby you're getting a cure that impacts that predicted model and also trying to estimate costs in the market.

What is the hardest job to fill within your organization, and how is hiring in the tight labor market?

SHAW: The hardest job to fill in our organization is physicians. The most challenging thing I have ever dealt with is recruiting an orthopedic surgeon to upstate New York. Right now, the only chance we have of getting one is if they have some tie here or their spouse has a tie here. There's a shortage of orthopedic surgeons, we're being told.

We're competing with the world here and we're doing everything we possibly can from the traditional advertising in all the journals to using a head hunter. We're starting now to travel to conferences. Our COO, Michele Brinkman, is bringing herself and the OrthoNY roadshow to conferences and setting up a table and she's created some great marketing tools.

MILTON: The physician piece is difficult, but it is doable. I interview a number of folks and they go, "I don't want to be in the city. I want to get in where there's a different lifestyle."

Some folks like the whole upstate thing, so it is sellable.

Nurses are always at the top of our list. Nurses have a lot of choices now and nursing inside a hospital is a very difficult job. We haven't done it yet, but we are exploring going international because there's just not enough of a supply.

Our other issue is high turnover. People don't talk about it as much, but the techs are really critical in what we do. They're high turnover jobs.

BURKE: One of the things happening in health care today increasingly is more and more regulation. Health care providers need people who are trained in understanding the regulations, how they work together and in monitoring what's going on. What we see across provider types is difficulty in filling the compliance officer position. It's a required position. It's the person who is in charge of saying, "No, you can't do that." It's a hard position to have and it's complicated.

ALGOZZINE: From our perspective, we actually have no problem recruiting the professionals such as emergency physicians, PA, nurse practitioners, probably because it's new, it's innovative, and it's being part of something different and change. We can offer you a new emergency medicine experience, and actually have no problem filling those roles.

It is actually the lower role – the $16- to $20-an-hour care coordinator that I need to figure out a way to create a career path for them. Otherwise, it's just a job and then it's turnover. I wouldn't say that it's hard to necessarily recruit and get them, but I am actually for the first time in our five-year history seeing some turnover. We're looking very carefully at how we create career paths for the people that don't necessarily have an obvious one.

DEL VECCHIO: We have 140 openings. They span the gamut. There are some at the lower end, but it's sort of the data scientists, the statisticians, the technology people that are helping you lean-out your organization or create tools for helping members use their benefits or to simplify those things underneath.

We recently hired three individuals out of the Chicago market who are staying in Chicago and commuting one week a month to be a part of the culture, but it was accessing some really specific skillsets and talents to be able to do that. A fourth one did come to Albany. He came with his wife and we learned that she was into dance and brought them to SPAC and they have a whole collaborative there. He's into the arts and he's a part of Albany Pro Musica. We found enough things to match them up and he made the move.

Is there anything on the horizon that you think will disrupt health care in a major way?

ALGOZZINE: When you think, could Amazon, Google, Apple, really disrupt health care? I actually see a little bit of divergence happening. And I think it creates opportunity. Health care is personal and health care is local. The idea of health care scaling too much, to get a doctor to solve every-

HODGSON'S TAKE

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JANE BELLO BURKE, Jane counsels hospitals, health systems, physician groups, skilled nursing facilities, assisted living facilities, home care agencies and other health care practitioners and providers on a broad range of regulatory, reimbursement, transactional, litigation and compliance matters. She helps providers navigate the complex network of health care laws and regulations so they can focus on what they do best: providing care and services to the individuals they serve. Jane advises on hospital-physician affiliation and integration issues, including physician recruitment and joint ventures.

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HODGSON'S TAKE

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JANE BELLO BURKE, Partner at Hodgson Russ

thing digitally like a lot of other industries have done, I think, is a little bit of a fallacy. And while you could lower the cost curve with some of those things, I think the true quality in health care and some of the greatest disruption is going to actually happen at a local level.

DEL VECCHIO: I do think there is this acknowledgment by those big disrupters that they've got to get local. I just don't know that they can come down into the sweep of the market the way they think they can without creating duplication of what we do.

What effect will technology, AI and automation have on your organization, and how will it change jobs?

O'GRADY: Some of the positions we have difficulty hiring for are some of those more technology-based positions. And we really utilize those positions in some part to not only push additional information and tools out to our members, but also review our own internal processes and where can we become more efficient and where can we streamline.

It's also an opportunity for us to look at how is care being delivered. And how do we communicate care and how do our care teams communicate? How do our care managers communicate with our members as well? In health care you've got the health plan involved, you've got the provider involved, and we want the member involved. How can we involve the member and the member's family in being a part of that care team? We can use technology to solve some of those problems. We look at it as an opportunity to get closer to the member and bring that personal aspect into health care and help them participate in their health care.

MILTON: I would think in the reasonable future – three, four, five years – maybe upwards of 10% to 20% of those folks who are inside the hospital are going to be treated someplace else in a very good place, whether it's in the home or someplace else.

But I would underscore how good it is that the insurance companies are local. For the most part, the hospitals are all local. Businesses are local. You could really work together to do some fun stuff to create the 'new thing.' We're not dealing with big national organizations for the most part.

There have been a lot of mergers and affiliations over the past few years. Is that a good thing, and does it do anything to move the needle on health care costs?

MILTON: I think the literature will say the costs go up.

SHAW: It depends on what you read and what you look at. There's so much information out there that's conflicting. From our perspective, our costs went up in the beginning. They absolutely did because it depends on how you do it. When we merged, we didn't take all the people. We kept duplicate positions, for example. Again, because it was local and the idea was to kind of let it all fall out, on a very small scale, for us, we keep using the model that mergers take recovery time. It takes time to recover from that.

DEL VECCHIO: Because we do business into the downstate area, in every instance where there was a merger of a hospital system, costs for us went way up. In the local market, not so much. When you see the affiliations locally, costs have been relatively flat. We acquired a health plan down in Westchester. It was about a $1 billion company. We were able to take $30 million of costs out in synergies, out through the back, but it took about two years to get there through that transition. It does definitely take time.

O'GRADY: Anytime there's a merger or an acquisition, whether it be on the payer side or the provider's side, you're changing the leverage equation. So, what used to be maybe equal negotiating partners, you've created kind of a disparity in the leverage that one has over the other. In some markets,

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and even geographies within this market, those equations change county by county. If you go to a county where there's only one hospital, it's tough to negotiate that hospital against no other hospital. Right? They're in a pretty good position from a leverage perspective.

It depends on what each party at the table wants during the negotiations. Any time you disrupt that leverage equation or the equilibrium that sometimes we try to create in that leverage equation, you're going to have costs going up for someone or it's going to be a revenue hit on the other side of the table.

What's driving telemedicine's growth and is it meeting demand?

ALGOZZINE: It's economics and business 101. How huge is the problem? The problem is huge, so therefore the demand for the solution is huge. The problem of quality and cost and accessibility in health care is huge and it continues to grow. Therefore, the demand for solutions that provide lower cost, higher quality, more accessible care is growing. That's really what's fueling it.

Is it meeting the demand? I don't even know if supply and demand is the right way to think about it. I really believe what you will see five, 10 years from now is that greater than 50% of the care will at least be started digitally or electronically in some way. We're just getting started.

What can be done to ease the overcrowding and long waits in emergency rooms?

MILTON: There are just too many patients who really don't need to be in the ER. The ER's a complicated place with highly-trained people, and the acuity level for many of them, it just doesn't justify being in that place. It's reforming the system so that you get, probably, half of those patients at times, out of the ER and in a better place. Leave the really sick ones for the ER when you really need it because we've got all the training, the consultants, everybody to take care of that patient when they're really sick. But we've got to get the other ones in a safer place to be taken care of.

SHAW: We feel that place is in urgent care. Specialty groups are starting to focus on doing urgent care and, unfortunately, we are seeing that even our orthopedic urgent care is starting to become a bit of a triage. We're seeing the same patients who are just using us as if their situations are really urgent. We're not turning anyone away right now, but it's becoming the argument of, "Well, that's not urgent. You've had back pain for the last three months." But it's access and they can get in, whereas they can't see the spine surgeon for six months or they can't see the pain management doctor for eight months. So, they think, "Well, I've got an appointment three months down the road, but my back's been killing me for six months. I'm just going to come and sit in your ER or your urgent care."

Urgent care is what we've done in terms of trying to respond to that opening up the access and alleviating the hospital ERs and leaving them for what they're really there for.

DONNA ABBOTT-VLAHOS

How would a single payer system affect each of your companies?

DEL VECCHIO: Whether it's single payer, which Vermont tried and failed for a number of reasons, or Medicare for all or any of that, the only thing we're talking about is changing who finances it. We're not really changing health care in the conversation yet. We're not investing in the change in that argument that's happening in Washington or New York. And that's kind of the disappointing part because in the private sector, we are talking about how we invest in the change. We're all trying to put our money where our mouth is. We're all taking risks. We're talking a lot about leveraging our local collective power to be disruptive in the market. I feel that wouldn't happen because no one is saying, "Well, let's invest it in this change."

Medicare isn't free today and I think that is not being talked about in the media. There's a premium you pay if you're in the Medicare program and there are deductibles in that program and I think that's just lost in the argument, and it's sort of an unfair argument to put out there in the debate.

MILTON: I feel pretty strongly against it. Having said that, in our business, we're 68% government in terms of our revenues, so between Medicare and Medicaid from the government, it seems to be getting close to a one-government payer. And it'll probably inch up a little bit every year.

Having said that, I actually feel that single-payer is almost like taking the easy way out. This is complex, hard work, and the innovation and the ideas that come with it are what's really valuable. If we went to something like full government type models, I think you lose all that innovation and energy that goes into taking care of New Yorkers or Americans. And that's the hard work to do.

SHAW: It seems unfathomable. I can't imagine how it would ever get done, especially given what's going on in the political climate. Obviously, from a medical practice, I think it would greatly impact our ability, just like it would a hospital, but we don't have as high of a ratio. Employers maybe would somehow save on the expense side from the lack of premiums, but somebody's paying for it. It's being paid for by taxpayers.

O'GRADY: There's a voice that's missing here. You heard both Chris and I say we're hoping in a good year we make a 1% to 1.5% margin. You heard Paul say the same thing, so the margins aren't in the people at this table. I think we really need to look at that and look at health care reform. The Affordable Care Act was health insurance reform. We didn't do anything to address the cost of health care, whether it be the delivery of medical procedures, whether it be the pharmaceutical costs. That was all avoided for many reasons that we don't have time to get into now, and it really became health insurance reform legislation.

We really need to go back and look at health care reform. The system that was put in place in 2014 was a great foundation and now we do need work around the edges to make it even better, both from an access and from a cost perspective.

COMING UP

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January 15
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