

RAM: I recall the old saying, 'May you live in interesting times.' How interesting are these times for you with so many health reform and budget issues to deal with?

Hazel: Exceptionally interesting. We have a lot going on. It is not unusual to have budget difficulties, which the state has faced for several years. So to come into the office with a new government at a time when economic development and jobs creation are an issue and a priority makes it more challenging to deal with some of the issues we have.

The first is the economy... When employment goes down, uninsured and Medicaid rolls go up, and so it puts more pressure on us. We end up doing more with fewer resources. The government revenues are down, so we have less to work with. There become a number of challenges: the first is the eternal challenge of trying to become more efficient and effective with the government services. The opportunity for us is frankly to try to organize ourselves better, to work better between the departments, to do more case management and social services. The point is -- even though you're dealing with a physician public -- the job isn't just about health care.

RAM: OK, what is it about?

Hazel: Well, we have 13 agencies in the secretariat ... we have somewhere under 17,000 employees. We spend about a third of Virginia's money... it's a tremendous challenge.

RAM: How do you get your hands around so many things?

Hazel: First of all, fortunately I'm not entirely new to the health care part. ... The social service part is where I've really had to dig in and learn. Social services are not altogether different than health care services -- they're fragmented; we have different groups that don't talk to one another; we don't have the ability to share records easily; we don't have the ability to do case management. These are the things people are complaining about in the health care delivery system as well.

RAM: How does that affect physicians?

Hazel: On the health care side of the things -- and to get more to what your audience is probably most interested in -- health system reform is

obviously the big thing in domestic policy right now, outside of national security and the budget.

We have been charged with a series of things for health system reform that have to be in place by January 1<sup>st</sup>, 2014. I just spent two days in Washington at a National Governors Association meeting ... on just these topics. The theory is that January 1<sup>st</sup>, 2014 is tomorrow for us (laughing). It's almost like we don't have the time to do the things we need to do.

You start with the goals of the national health bill – expand coverage. We won't get to universal coverage with this expansion, but we'll get a significant number of people in the system. The good news and the bad news -- half of those probably go into the private sector, but about half will go into Medicaid.

So we're looking in Virginia already in the next budget cycle of having a billion-dollar-a-year deficit in Medicaid. And in 2014, we're expecting to add a minimum of probably 275,000 people to the Medicaid rolls, and possibly up over 400,000. So that's anywhere from a 25 to 50 percent increase in our Medicaid rolls. That creates three problems for us:

Number one is: Who's going to take care of them when we're already having workforce issues in Virginia?

Then we have to figure out who's going to pay for them, and then we have this little issue of how do you process it? How do you have the staff in place to do the eligibility and all of these things?

And while we expand the Medicaid rolls, we have this whole issue of the health insurance exchange that we're supposed to have in Beta testing in January, 2013. The Massachusetts Health Connector is a version of this, and it took them about five years. I explained yesterday to the staffers in the House and Senate that this is a little bit like what the moon shot was – it's something that just hasn't been done before on this scale. We're going to have to do it and do it right ... The good news in all this I tell the governor is that we can leave in January, 2014 so we turn it on and turn over the keys in a matter of two weeks (laughing).

RAM: So taking it one problem at a time – how DO you process 275,000- plus people?

Hazel: You can't start with processing 275,000 people. You have to start with how we do it now. How can we do the business process to make it as effective and efficient as possible? And then how do you put the surge capacity to deal with the bolus that comes through at the time?

Currently, we're not particularly effective. It's largely a manual process. We are looking at this challenge as an opportunity to upgrade our business processes and upgrade our information technology.

RAM: Is it mostly going digital?

Hazel: Well, I think we'll have to do that. We'll have to have Web-based services; we'll have to have more opportunities to get their data entered without our staff helping them; it's going to have to be a more automated process for us to handle this. Now that's good business for us anyway.

The message I have is that by becoming more effective and efficient and using technology appropriately it gives you the opportunity of either reducing your costs, or doing more, or some combination of both. That's basically the operating philosophy we have.

RAM: So for the forward-looking RAM member reading this...

Hazel: ... They frankly probably frankly won't care about how we do the internal side. What they're going to be worried about is how that impacts delivery in Virginia, and how they get care.

RAM: With more doctors declining to take on new Medicare and Medicaid patients, given the massive logistical problems you're facing right now, how do you avoid exacerbating that problem?

Hazel: We have 7.8 million people in Virginia, we are estimating upwards of 600,000 will come into insurance, with the combination of new programs, and if we're already having problems with capacity ... it's going to be exacerbated. We know that people who have been uninsured for periods of time, when they come into a system, they use services at a rate greater than normal – probably 220 percent. I think was the Indiana experience with the Healthy Indiana Plan. So it's going to be a big hit for us all at once unless we can smooth it out a bit.

But there are number of things we are doing: Reforming Medicaid, for us, means better care coordination and long-term care. It means behavioral health; it means community-based services instead of institutions, where appropriate... And in places where we don't have coordinated care – for instance, we don't have managed care in Southwest Virginia versus acute care – we're going to have to look at how we can do a better job of case management. I don't like the term "managed care," but it's case management to try to get the right treatment, right place, right time.

This year our challenge includes a lot of reforms of insurance. Some of these things seem obviously good, like expanding coverage to dependent children to 26; eliminating rescissions of policies; evaluating the medical loss ratios of insurance. These things are sold on the surface as very good, but they're not necessarily inexpensive things to do, and they're not without consequence. So we have to determine how in Virginia we want to do that, and then we also have to look at how we set up the health insurance exchange. There's a lot of policy involved in that. Is it going to be a mechanism like Utah uses to try to bring individuals and small businesses into some situation where they can get the federal tax deductions for purchasing health insurance, which you can only do if you're employer-based now? Or is it going to be really fundamentally changing the insurance markets? How does it tie into Medicaid?

Then we get to the delivery reform. I think it's pretty clear in this country, with the cost questions and the issues of cost containment, that the same systems that we're using now probably are not going to result in the savings that people are looking for. I tell my colleagues that people aren't buying what we're selling at the price we're selling it.

The fault, to me, has been a result of the federal fee schedules – price control for a large portion of the population that then sets a pattern of business that everybody follows. That means you don't pay primary care physicians what they feel they deserve to keep going. Price controls don't work.

RAM: That relates to Medicaid.

Hazel: It does. It's Medicaid and Medicare. When the federal government pays for more than 50 percent of health care in this country, and you have a fee schedule, they're dictating to a large extent what people

can do in terms of delivery. If you look back over the years, we've had great progress in medical technology, and health information technology capability (not implementation) and we've had progress in pharmaceuticals. But our delivery hasn't improved much at all. And the reason is you don't get paid when you do things innovatively.

(For example), the Virginia Mason Clinic found a way to save money in terms of treating patients for back pain. It turned out it cost their clinic more money than they saved. The reason is the providers get paid the same way no matter the value of the service they're providing. And so we have to break the stranglehold of the federal fee schedule.

RAM: Can you do that at the state level?

Hazel: It's going to be hard. I've got some thoughts about how we might do that, but that's a topic for another day.

RAM: When will you present those thoughts?

Hazel: Once I figure out whether they make sense or not (laughs). Somehow we've got to break the stranglehold for physicians. The hard part is they're going to be asked to deliver things. There's going to have to be some transparency in pricing. There's no doubt in my mind that part of this will be to give up the illusion of 'usual, customary, and reasonable' and you'll have market-based pricing... the problem you get into now, quite honestly, we send out a bill with the billing requirements, a patient gets (a bill) for \$3,000, when you know that at the end of the day, with all the adjustments and things, your contract is for \$800, the bill is cycled through the insurance managed care organization, and the patient gets an explanation of benefits that you've got charged with \$3,500 and you're happy with \$800. They're re going to say, "Well the doctor didn't get his bill, but thank God I've got the insurance company."

You got to compete – that bill should be what it is. We've got to break that system up, too.

RAM: So should physicians be getting ready for this, in terms of market-based pricing?

Hazel: Well I think they're going to have to think about it. And I think physicians are going to have to demonstrate their value. What we've only

had to do thus far, and we hate it, is the documentation... But I think we're going to see a national move away from paying for volume and documentation to payment for some sort of value. And how we define that value going forward is important, so if physicians are able to get in front and set the market and define the value, it's going to involve some change in thinking, but that's what has to happen.

RAM: Do they need to think more like marketers. Do they need some sort of professional advice?

Hazel: Well they may or may not. But the hard part is we're going ... into the blue ocean. You can get your choice. We can try to do a top-down approach which sets up the new paradigm for you – which in a few years will become the old paradigm and need to be changed again – or we can try to set up a paradigm where there is room for innovation, and creativity, and bundling of services and bundling of payments, and hopefully, providing better value.

RAM: That's one set of problems. What else?

Hazel: We have to look at scope-of- practice issues. Traditionally we've been very territorial with scope-of- practice, and when you start getting into the workforce problems, and the increased demands, and the need to reorganize, we have to look at it honestly. Not what we would like it to be, but what it is, and decide, "OK who gets to do what, and under what circumstances?" As the book 'Good to Great' (by Jim Collins) says, you get the right people on the bus, and you acknowledge the harsh realities.

And the harsh reality is that people believe ... that we're not getting our money's worth for the system -- in quality, safety, coverage, access, the whole nine yards. I think they are systems issues more than individuals. I'm not criticizing professions, but this is going to happen. And the question is whether we will be drivers of the improvements or whether we'll be pulled along.

RAM: You've mentioned workforce issues. Could you be more specific?

Hazel: There's a feeling now we don't have enough primary care doctors, general surgeons, and generalists... There's no button in my office to turn out more, and the one in the governor's office isn't working because there's no money to do it. So we're going to have to figure out how to

squeeze more out of the workforce. The question is how can we utilize it more efficiently? Doctors do doctor things, and others do other things, and we work in teams, we use different level of providers to deliver services...

RAM: So the doctors are going to have to become more creative with their management?

Hazel: Well, either they will and demonstrate value and get paid for it, or someone will tell them what that's going to be. That's the problem.

RAM: I hear you saying go for the innovative solution.

Hazel: I think it works better.

RAM: Does that fit mean physicians must become businessmen or businesswomen?

Hazel: Well, physicians are not uniform. If I've learned anything, there are some physicians in today's world who are very happy to go to work for an organization and to provide their service and their value and to get paid for it. And there are others who really are entrepreneurial, and there's probably going to be room for both.

RAM: How do you get the hospitals on board with this?

Hazel: The hospitals are actually ahead of physicians to an extent. If nothing else they tend to have more infrastructure to support them and more resources to use. They, too, are hamstrung by our payment paradigms. And that's going to be a real key to this – again, breaking up the stranglehold of the federal fee schedule.

RAM: But that cycles back to Washington, doesn't it?

Hazel. (agreeing) Isn't it interesting I spent the last two days in Washington?

... If we (think) we're going to get a lot more money, that isn't going to work. But if we organize (prepare) to get the same amount of money and organize it differently, to be more efficient, then I think we have a chance.

RAM: So what do we look for next?

Hazel: We'll convene a group, hopefully in August, that will start looking at what we want the outcomes to be on health system reform...

There will be a RAM member in that group. Then we set up outcomes that we want... provider satisfaction will be one to look at. We all think about patient satisfaction, but provider satisfaction may be important in this. Because if we want this to work, I believe the providers – the doctors, the nurses – have to find this a very rewarding environment in which to work. .. What is the adage – “happy cows make good milk?” If we want to have good health care, it’s better if we have happy providers. It sounds trite, but I think it’s true.

RAM: Are you involved in the Attorney General’s suit against the health care law?

Hazel: It will be several years possibly, we don’t even know if the suit has standing right now ... So we have a law which we are charged with implementing. We move ahead to do what we believe is prudent. We start with the premise that not all is wonderful in the state of Virginia. We have over a million uninsured; we have about 837,000 on Medicaid. My lapel pin on my jacket says, “Commonwealth of Opportunity.” And that’s predicated on being economically competitive internationally, and you can’t do that with, from an employer’s perspective, insurance premiums for employees that are out of control. So there is reason for Virginia, in and of itself, without any federal bill, to look at what we can do better.

RAM: What would you say to our members who want to prepare for this reform?

Hazel: This is obviously a challenging time for physicians, and change is always stressful and difficult. What we will try to do as best we can is to try to make this change manageable. Now, the transitions will be hard, and I am hopeful that at the end of this, four or five years from now, we’ll have a system that works a lot better for doctors as well as patients.

... Physicians really have to look at the transparency of their practice, particularly the bills that go out. You can’t compete in a marketplace with bills that don’t reflect some sort of market value; and to uphold the illusion of ‘usual, customary, and reasonable,’ we pay the expense of a large managed care industry.

I think that people will have to begin to show what it is they do in a positive way. There's no doubt that we aren't all perfect, and we worry about that being public, but the more data that gets to be public, the more people will realize what the reality is, and we'll have to address that...

... As we go into this, we look at outcomes for Virginia, we're going to have to look at the health status of Virginia, that's a new job I have, as opposed to my old job of seeing patients every day. We're going to have to look at the access to care; the cost of care; the patient satisfaction. But one of the elements that I think will be important is good provider satisfaction. I think that without a physician community, a hospital community, a nursing community that's engaged and actually feels that there's a good role, a positive role, this all falls apart.