

# Regulators extend their reign

Once again, administration officials and members of Congress top the 100 Most Powerful as the rollout of reform dominates the dialogue

By Rebecca Vesely

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This year, call it “regulation domination.”

*Modern Healthcare's* ninth annual ranking of the 100 Most Powerful People in Healthcare—as decided by the magazine's readers—is topped with people who are spearheading implementation of the sweeping new healthcare reform law and pressing forward with other big regulatory changes.

President Barack Obama leads the pack, followed by HHS Secretary Kathleen Sebelius and leading members of Congress. House Speaker Nancy Pelosi and Sen. Max Baucus of Montana, both Democrats, come in at Nos. 3 and 4, respectively.

Also high on the list are executives running large not-for-profit health systems, including Sister Carol Keehan, Sister Mary Jean Ryan and Joel Allison.

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A few names might be switched around if voting were held today as opposed to several months ago. Peter Orszag came in at No. 6 on the list, but the 41-year-old economist stepped down from his influential post as White House budget director on July 30.

And Donald Berwick landed at lucky No. 13. Berwick, a regular on the list because of his work leading the Institute for Healthcare Improvement, would likely have moved up had he been formally selected as incoming CMS administrator before voting closed on June 25. Obama put him in the post on July 7 through a recess appointment. At No. 16 is California Gov. Arnold Schwarzenegger, even though he will leave office in January.

## **Two in a row**

This is the second year in a row that Obama has grabbed the No. 1 spot—the first time that somebody has been named to the top spot for two consecutive years. It's also the second year that Sebelius came in just behind him at No. 2. Considering that both have been moving full force to push their healthcare agenda to improve access to care and make changes to the delivery system, their continued reign should have been expected.

But politicians didn't always dominate the highest echelons of the list. Just three years ago, Steve Case was named the No. 1 most powerful person in healthcare, as private-sector changes dominated the conversation. Case, the founder of AOL and Revolution Health Group, isn't on the list this year.

Coming in second and third place in 2008 were Google CEO Eric Schmidt and Bill Gates, Microsoft Corp. co-founder, respectively. This year, Gates ranks No. 8—probably more for his commitment to improving public health worldwide through his \$34 billion foundation than for his tech clout. Schmidt fell off the list entirely.

Carolyn Clancy, director of the Agency for Healthcare Research and Quality, stood at No. 31 on the list three years ago. This year, just as in 2009, she holds the No. 7 spot.

Clancy's clout has risen with the agency, which was created 20 years ago to support and conduct healthcare outcomes research. Today, thanks to the Patient Protection and Affordable Care Act of 2010, as well as the American Recovery and Reinvestment Act of 2009 (better known as the stimulus law),

AHRQ's profile is higher than ever.

"The role of improving quality and linking science to policy is a much stronger feature of the Affordable Care Act. It's all over the act. We're incredibly excited" that Congress understands that, Clancy says.

AHRQ was allocated \$300 million in the stimulus law to conduct comparative-effectiveness research, and is also managing the \$400 million allocated to the HHS secretary for this effort, Clancy says. With help from a 15-member council, AHRQ and related agencies will decide how to spend this windfall. Clancy calls the funds a "down payment" for quality improvements in healthcare.

Soon, AHRQ and coordinating agencies will release more information on what kinds of research on comparative effectiveness these dollars will fund. "We are wrapping up the details," she says. Priorities will include patient- and data-centered outcomes research, she says.

"We will be making investments in activities like patient registries," Clancy says, citing an example of safe surgery practices at the Veterans Affairs Department.

"It's all about collecting data, and taking a hard look at outcomes and becoming best in class," she says. "We have to involve people in the front lines of care."

Every year, AHRQ documents statistically significant improvements in quality. "The challenge is to accelerate the pace of improvements," she says. "I think we are well-positioned as a nation to do that."

While some fear that comparative effectiveness research could lead to rationing of healthcare, or curtailing physicians' ability to make treatment decisions, Clancy says that's not the agency's intent.

"We want to help physicians take the best science and tailor it to the individual," she says. "We stop where the evidence stops."

Comparative effectiveness is an opportunity to further the dialogue about best practices in patient care, Clancy says. "We hope this is a basis for informed discussions," she says. "Clinical care and decisionmaking are pretty nuanced."

## **Leading the change**

Managing all the changes coming fast and furious from Washington is top of mind for those who made it onto this year's 100 Most Powerful list.

Scott Armstrong, president and CEO of Group Health Cooperative in Seattle, debuted at No. 38. Group Health was in the national spotlight last year as Congress pondered whether to replicate the health cooperative model in other states through the healthcare reform bill. The idea of setting up co-ops across the country to compete for health insurance business did not ultimately gain traction, but Group Health earned new admirers for its ability to improve quality while reining in costs.

"The question is how we implement it and make this real," says Armstrong, who was also recently appointed as a commissioner to the Medicare Payment Advisory Commission. "I run a company that is demonstrating how to make this possible."

Armstrong called the Patient Protection and Affordable Care Act a "great first step," by expanding access to the nation's uninsured. "But it really is only a first step," he adds. "It sets us up to get into a whole body of work on changing the care delivery system."

Group Health has 26 primary-care centers across Washington state, and no inpatient facilities. About two-thirds of patients are cared for in a group practice, while the rest use contractors. The co-op is experimenting with payment models besides fee-for-service, and working to increase quality.

For instance, partnering with community hospitals, Group Health has managed to lower hospital 30-day

readmission rates by 9.5% over the past year, saving at least \$50 million annually. Group Health did this by standardizing the patient experience as patients transitioned from a hospital to an outpatient setting, Armstrong says. The readmission rate overall hovers around 14%. Rolling out a medical home to 400,000 patients at all 26 care centers is also reducing hospitalizations. One pilot study of this program showed a 29% reduction in hospital days, according to Group Health.

As the CMS and private insurers stop paying for hospital readmissions that happen within 30 days, payers and providers need to up the ante, Armstrong says. "We have to look at other ways to drive change," he says. Halting payments for readmissions "forces change, but it doesn't answer the question, 'How do you change?' We have to look at the underlying critical-care process."

That's the challenge for those in the delivery system: Staying ahead of all the new regulations coming down the pike while excelling in the current system. It's a topic that came up again and again in interviews with those on the Most Powerful list this year.

Nearly two years ago, Joel Allison, president and CEO of Baylor Health Care System in Dallas (and No. 23 on this year's list), created a seven-point vision for 2015. The vision included a patient-centered model of care and a new information technology system to provide a more seamless patient experience and improve quality and efficiency.

Like many other large systems, Baylor has set itself up as an accountable care organization called the Baylor Quality Healthcare Alliance, with a patient-centered medical home and more focus on pay for performance, wellness and outcomes. The health reform law authorizes Medicare to contract with ACOs, which are networks of providers that agree to work together to improve quality and reduce costs.

"It's a tall order, but it's also a huge opportunity," Allison says.

Right now, Baylor is working to come up with specific requirements and commitments from partners outside of Baylor that will participate in the ACO, such as home health companies, Allison says. These Baylor requirements include 12 "must-haves," such as that all aspects of the organization must be devoted to serving patients.

While building an ACO, Allison says he worries about the rising costs of care until 2014, when many of the reform law's benefits kick in. "The high cost of care has to do with the fragmentation of the system," he says.

Straddling the current system while preparing for what's coming is critical, and tough right now, agrees Dan Wolterman, president and CEO of Memorial Hermann Healthcare System in Houston, and No. 36 on this year's 100 Most Powerful list.

"We have to continue to do well in the current fee-for-service environment while preparing to jump to another environment," Wolterman says. "We've got to manage both camps right now."

There are ways to do both. Last year, Memorial Hermann won the National Quality Healthcare Award, sponsored by the National Quality Forum in partnership with *Modern Healthcare*. Wolterman says the system improved quality by, in part, spending \$20 million to train all employees in best practices over 18 months. The training is ongoing.

Memorial Hermann is now working to fully integrate private-practice physicians who contract with the eight-hospital system into the quality program. Some 2,000 independent physicians have agreed to establish care protocols in their specialty areas, implement the same health information system as Memorial Hermann and report outpatient quality data in exchange for improved rates.

"We need to finish up that work," Wolterman says. "It's the highest priority right now."

In late 2008, Memorial Hermann went through a restructuring, cutting 16 top management positions.

Wolterman says the restructuring allowed the system to maintain an even performance through the financial crisis of the past two years.

The restructuring also showed that the system spent too much on overhead. As a result, Memorial Hermann decentralized its service line structure, distributing that work among top management at individual hospitals, and put more resources into physician employment and outpatient services, especially diagnostics, Wolterman says.

## **Planning for the future**

Sister Mary Jean Ryan, chairwoman and CEO of SSM Healthcare in St. Louis, and No. 19 on the list, worries about the future of healthcare governance amid all the changes.

"We need to focus our attention on how do we prepare people to govern wisely and well in the future," Ryan says. "So many of us with tenure are retiring. I don't know if we have the luxury of not paying attention to this."

Ryan says governance is too often confused with management. "I'm looking for people who can take large amounts of information and make big decisions," she says.

For decades, Ryan has been a champion of quality improvement in healthcare. She says that while there is more awareness today than ever about quality, there is still a long way to go.

She says it's time to take the next step in quality improvement. "What we have to be able to do is assure our patients that we are doing everything we can do to make them safe," she says.

Robert Wachter, director of hospital medicine at the University of California at San Francisco, agrees. Wachter, a quality expert and a national leader in the hospitalist movement, debuts on the 100 Most Powerful list at No. 72.

Wachter says what's happening now is a groundswell of change toward quality, at a time when the CMS and private payers are demanding better results.

"Real front-line nurses and doctors are getting into this," he says. "To me, this is very exciting and just as important as what Medicare does. It can't just be coming from the mountaintops of Medicare and the Joint Commission."

The Patient Protection Act isn't what is driving these changes, he says. "The stuff in the health reform bill is not revolutionary," he says. "It is connecting the dots."

Paul Ginsburg—coming in at No. 10 on the 100 Most Powerful list this year (after falling off the list in 2009)—says there is real excitement for transformation among clinicians. Ginsburg is a healthcare economist and president of the Washington-based, not-for-profit Center for Studying Health System Change. He was tapped last year to head the National Institute for Health Care Reform, a research group backed by the United Auto Workers and the Big Three U.S. automakers.

"There's an eagerness from the physician perspective to change," Ginsburg says.

But these changes might not always be to the benefit of the public, he warns. Ginsburg has been making waves lately by writing about the dangers of too much provider consolidation under health reform.

In a paper published in April in the journal *Health Affairs*, Ginsburg and his colleagues at the Center for Studying Health System Change wrote that "providers' growing market power to negotiate higher payment rates from private insurers is the 'elephant in the room' that is rarely mentioned." Integrated care, through accountable care organizations, could lead to "higher rates for private payers," Ginsburg and his colleagues warned.

Under an existing fee-for-service environment, hospitals are being held more accountable for quality improvement, and are eager to align physicians toward the same goal, Ginsburg says. But this could lead to less competition and higher prices for consumers and payers, and not necessarily better care.

Consolidated provider power can be addressed through the free market—for instance, by structuring employee benefits to give enrollees incentives to seek out more cost-effective providers, or through government regulation such as price caps and rate-setting, Ginsburg says.

“I think in the next five years we will see how far the market way goes,” he says.

Ginsburg says more information is needed on the actual costs of care. “Cost is an area I’d like to do more on,” he says. “There is so little known about costs.”

Gail Boudreaux, president of United Healthcare and a newcomer to the Most Powerful list at No. 53, says that addressing the cost-drivers of healthcare is paramount in reform. “I think the biggest challenge is affordability of healthcare,” she says. “As I think about the challenges, we are laser-focused on how to you make healthcare affordable.”

Armstrong of Group Health says the work is just beginning. “More so than even a year ago,” he says, “we are poised to make real changes in care delivery.”