4sight Health Roundup

Podcast Transcript

American Hospitals: David W. Johnson Interviews Vince Mondillo

[intro music by C Ezra Lange]

David W. Johnson:

Welcome to a special edition of the 4sight Health Roundup, and on this special edition we have the distinct honor and pleasure of welcoming Vince Mondillo, who was the director of the movie, “American Hospital's Healing a Broken System.”

“It will be available-November 10th on Amazon, Apple TV, iTunes and Google Play. We want everybody in the country to watch it and then take its lessons to heart and think about how we can fix this broken healthcare system in America.

This is Dave Johnson, your moderator. So Vince, welcome to the Roundup. It's great to have you.

Vincent Mondillo:

Yeah, pleasure.

David Johnson:

-Why don't you just give us a little bit about your background in filmmaking and how you've come to do this particular type of documentary, which is fact-based, hard hitting, but I think very fair.

Vincent Mondillo (08:29):

I did a number of years working as a producer and editor for projects for the History Channel, A&E, Biography Channel, that kind of thing for television. And then I guess about seven years ago, I connected with Richard Master, our executive producer, and got together and made our first documentary on healthcare dealing with a single payer healthcare system. Then we followed that with a documentary on pharma prices. And then after doing those two, we realized the root of all evil was really money and politics. So that was our third. And then finally the fourth film we're doing in what we consider loosely to be a series is the piece we just did on hospitals. And basically the is to do what is a significant amount of research. Typically each project involves reading a number of books, lots and lots of articles, and then finally the interviews with a range of people, including top experts. And what we try to do is absorb as much information as possible and then come up with suggested possible solutions to some of the issues we bring up. Because we don't really want to just make films that make people angry, upset them, and say, well, what can we do about it? And that's the end of it. So we really are about solutions more than anything at the end of the day.

David Johnson (10:17):

That comes out very clearly in the American Hospitals movie. It's pretty hard hitting, but a very fair documentary at the end of the day. Vince is a very skilled documentarian and is able to weave together not only a narrative, but one that makes a compelling point and isn't afraid to challenge some conventional thinking. So I encourage everybody to watch it and learn from it.

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Vince, let's talk a little bit about this particular movie, its origins. You've given us sort of the step up to how you got here, but specifically as you started to dig into the question of hospitals in America, what you started to find and how it started to shape your editorial perspective as you assembled the parts of the film and created the narrative, hospitals are absolutely vital to society. We need them, but they don't always serve our interests and in fact often don't serve our interests. What stood out at you, what problems needed to be solved, and how did you think about bringing that to life in the film?

Vincent Mondillo:

The process typically involves trying to, as you're absorbing all of this material, try to identify a few core themes and issues that you're going to deal with. That will be kind of your umbrella theme because hospitals are so incredibly complicated and there are massive number of issues. So we had to decide what to focus on. And obviously one of the issues we are majorly concerned with is why does it cost so much?

Why are we spending twice as much as the rest of the world? And we don't necessarily do so well in quality comparisons despite all of that spending. So these are the questions that people in healthcare policy are well aware of, but the public doesn't necessarily have an awareness. So we wanted to take a deep dive into those core issues. And it's a no-brainer that the system is costing way more than it should. There's no reason why we should be spending twice as much as the rest of the world and getting results that are often inferior to the rest of the world in terms of quality and outcomes.

In looking at this, one of the shocking things, as simple as it is, is that commercial insurance pays literally two and a half times or more compared to Medicare, and then Medicaid typically differs from state to state, but typically will be significantly less than Medicare in terms of what they pay. So we're looking at that underlying economic structure and asking ourselves, we all accept that and take it for granted, particularly people in that world. But when you come into it as an outsider, just think on the simplest level, if you walked into the supermarket and based on how you were going to pay for your loaf of bread that you might pay a dollar for loaf bread or you might pay two and a half, or you might pay $3 or $4 for the same loaf of bread strictly based on how you were going to pay for it.

So this struck us from day one as absurd. And then when you begin tracking that core thing down to understand it better, you see that it has all kinds of implications in terms of cost, the disparities in our system, in terms of who gets care and what the differences in quality of care. We heard a lot about covid, for example, having some hospitals that had much higher death rates, et cetera. Well, again, I'm not saying it's the only explanation, but what you find is that a significant amount of that covid issue and the disparities came down to those certain hospitals had a lot of low payers or their particular way of paying was lower on the totem pole, which meant lower quality. That was one of the main driving forces initially, cost and implications. And I do think it surprises people that we have an entire delivery system predicated on differential pricing for largely identical services.

David Johnson:

And what I thought the movie did a very good job at was one showing the impact of high costs on individuals who, for whatever reason, either lack the insurance or the insurance they have, doesn't really protect them against a catastrophic financial burden due to an illness and how hard it is for someone to both fight a disease and manage the financial consequences of an extremely high and disproportionate cost burden. And then what you also said, or what you were also leading to is how this

differential pricing and essentially paying not only two and a half times more, but often as much as four to six to sometimes even 10 times as much as Medicare for certain services, how that thinking works its way into the decisions regarding resource allocation, services offered access and so on. So you really, I think, did a very nice job of painting the individual pain that can come from the system and then the systematic pain that afflicts entire communities and populations because they're on the outside looking in to some extent. You want to comment on any of that?

Vincent Mondillo:

Yeah, I mean the implications are incredibly deep. I literally, it results in closing of hospitals in rural areas because the hospital is unsustainable, economically unsustainable because of the fact that they have a lot of Medicare and Medicaid patients or uninsured patients. So these hospitals literally go under and then communities might not have a hospital closer than an hour away. This is life and death. And then when you go into the inner cities, it's a similar issue in that you have what are called safety net hospitals, which take care of people who are uninsured or underinsured or on Medicaid, same issue. These hospitals are desperately trying to hang on and barely survive. And then meanwhile, the hospitals that have excessive amounts of commercial insurance in wealthy areas, they are booming and gathering up so much money, they can't spend it fast enough, particularly if they're nonprofits. So they end up building buildings expanding, doing a range of things that are very excessive cost amazing amounts of money to the community. And so that becomes the core of massive disparities in our system.

David Johnson:

You mentioned nonprofit hospitals and there's a fair amount of discussion about mission and community benefit and what do nonprofits, what's their role in society and so on. And one of the interesting things about nonprofits is because they're nonprofit, they don't issue equity. They don't have owners, they don't have the typical type of corporate governance structure that operates in most enterprises in the country, but they do have a corporate enterprise structure. And to the extent they're profitable and they acquire philanthropic contributions, that money goes onto the balance sheet. So you do see these nonprofit organizations carrying as much as 300, 400, 500, 600 days cash on hand. So how great would it be to be in a company that had two years of working capital just right at its fingertips without having to do anything? And so that is also an impetus, the over building, because if you have all these resources, what do you do? And when you're in the business of providing hopefully at great prices with lots of volume that tends to think about how to allocate the resources, and really the nonprofit organization, even though and mission-oriented often is operating within a mindset of how do we operationalize our activities in such a way as to maintain our long-term existence, which gets to some of the aberrant behaviors that you're talking about. Really, really interesting.

Vincent Mondillo:

That is another crucial element, and what we're really referring to here partly is the notion of reserves. And as you said, most every hospital has reserves X number of days where they can survive financially apart from any of their other economic structure. So what happens is a safety net hospital, which has very low funding, might have seven days of reserves. That's how long the hospital can survive without other income. A commercial hospital, like you said, it could be six months to a year, even two years in reserves, a massive amount of money. IE in our region, we point out in the film, one of our hospitals,

we're talking a population of approximately half a million. One hospital has $2 billion in liquid reserves. Now that money did not come out of thin air. That money was extracted from the community. So when we're paying these exorbitant fees, not only are we paying that to the hospital infrastructure, but they're actually stashing cash and investing it, et cetera. And this again becomes then a driving force that hospitals distortion of mission because they begin focusing more on the expansion, revenue enhancement, and all of those elements rather than the core mission that we would argue should be community health.

Vincent Mondillo:

Sometimes we hear this data and it just kind of flows in one ear and out the other. But when I took my calculator out and we combined the two, that hospital with the other one, which we're going to say is about a billion and a half, that is $23,000 per family of four.

David Johnson:

Wow.

Vincent Mondillo:

When meanwhile we know most people don't have $500 in the bank and there's the hospital sitting on that massive amount of money per capita.

David Johnson:

I sometimes think the number one principle of all organizations is just to continue their existence.

Vincent Mondillo:

Absolutely.

David Johnson:

Whatever that existence is. And the hospitals though, have become very good at keeping or sustaining their existence through both, not only the way they operate, but through political influence and lobbying and so on. It's funny, Vince, when I was an investment banker starting out in the late eighties doing hospital financing, an A-rated institution had roughly 60 days cash on hand.

Vincent Mondillo:

For A rating.

David Johnson:

For a rating. That's amazing. And then fast forward 20 years and a reigning was up to almost 200 days cash on hand. And to me it was a form of grade inflation. It wasn't that the hospital needed three to four times as much cash because its risk was three to four times greater than it had been in the late eighties. It kind of organically grew, and there were other characteristics that were going to make it an a-rated borrowing entity above and beyond the amount of cash. But at some level, it's absurd. If you have twice

as much cash as you're going to borrow, you should be a Triple A borrower. But that's not the way it works.

We've got this behemoth on our hands that's behaving in ways that aren't necessarily good for the country, we want to expose that, but at the same time, we want to offer some hope to the population at large and reformers that we can collectively organize in ways that can generate better healthcare outcomes for our communities at lower costs. And why don't you tell us about how you thought about the solutions and ultimately how you ended up focusing on Maryland, not as the solution necessarily, but as indicative of another way of organizing or investing in healthcare in ways that could generate more positive results, both in terms of cost, quality and outcome, or all in terms of cost, quality and outcomes.

Vincent Mondillo:

So we were aware that most of the rest of the world deals with hospital costs with some kind of rate control. IE, the hospital does not get to just charge whatever they want, and that systematically is what happens in the rest of the world. So then we realized that Maryland was one state that had rate control going back to what the eighties if not before the eighties?

David Johnson:

Yeah, I think all the way to the seventies.

Vincent Mondillo:

So we looked at Maryland and saw that that was successful in keeping costs down. But the intriguing thing about Maryland is they developed another problem as a result of that. And that is for some mysterious reason, the hospitals in Maryland upped their volume tremendously because that was the only way they could make more money. They couldn't do it by jacking up prices. So they did it by jacking up volume. So Maryland was basically going to lose. They had a special waiver from Medicare in order to do their rate control, which means by rate control, I mean Maryland has roughly equal payments to all the payers. If you have an appendectomy in all the payers are going to pay roughly the same amount of money.

So that ended up being a good thing and solved some of these other problems we're talking about. But again, what did we see? They became number one in the country in terms of volume of services. So again, I hate to say it, but that indicates that whether consciously or unconsciously, they're figuring out how do we make the most money? And obviously if they're doing more services that are not creating better outcomes, it means it's purely an economic driving force. So anyway, Maryland was about ready to lose their waiver from Medicare, and they try to determine how can we control this volume problem. So then they put into place what's called global budgeting, which means that the hospitals essentially given a cap to how much revenue they can take in that put a stop on their expansion of volume. Maryland, even though it is not a perfect system, they are one system that has been able to bend the cost curve, meaning they're controlling the rate of growth in a better way than virtually any other state because they have a commission that decides, number one, how much a hospital can take in, and secondly, the rates they can charge.

And thirdly, they can put in quality measures. That becomes a way that a hospital can actually enhance their revenue, not by expansion or raising their rates, but let's just say by decreasing hospital infections

by a certain percentage, you want to make more money in the hospital in Maryland. That's the way you do it or reduce readmissions to the hospital. So it's, again, as Dave knows, there's a tremendous amount of potential for the kinds of quality measures you can start putting in. But they're at least at the beginning stage of shifting the incentives and shifting the way a hospital can actually make more money.

David Johnson:

And I don't know if we can attribute this directly to the movie or not, but CMMI, which you've mentioned earlier, the Centers for Medicare and Medicaid innovation in September. So just a month ago came out with a new program, the ahead program that's looking for up to eight other states to replicate Maryland's all payer system. That's what Vince meant when he was saying that in a particular hospital, whether you're Medicare, Medicaid, commercial self-pay, the hospital gets paid the same rate. So there's no incentive to favor one group over another. And then within the global budgets, CMMIs, the government is looking to replicate Maryland in other states and maybe even be more aggressive in its implementation.

One interesting note on Maryland and how it got into trouble, and this is what Vince was talking about when he was talking about volume is Maryland left out ambulatory rates or ambulatory care in its formula for how it paid hospitals. And so not surprisingly, Maryland had the number one usage rates of ambulatory care in the country. And it took the global budget coming in saying you can't leak out and do these other things to really reign in the behavior. And as a state, Maryland has gone from the second most expensive per capita in the country in 2014 when this new waiver program started now in the next tier double digits. So while the rest of the country's been going up on a relative basis, they've been coming down. And I think that's what drove CMMI to say, maybe we should be doing more of this in the country.

David Johnson:

Very, very interesting. So Vince, we're kind of getting close to the end now, but I wonder if you could just talk a little bit about the movie and why you hope people go see it. Any surprises that you've discovered in making the movie and just any thoughts you might have now being at the end of a process, it took, what did it take three years to bring this from creation to production? So why should people go see it? What surprised you and what could surprise others? And then any other color you'd like to add to encourage people to get out there, get out of their homes, or maybe not get out of their homes, but get onto their TV and stream American hospitals.

Vincent Mondillo:

So the film is dealing with some issues obviously that require national or state action in terms of rate control and global budgeting. But the other thing we wanted to do with this movie is inspire people on their own local level in terms of what they can do. So as an example, a local county controller in our area, his name is Mark Pinsley. Seeing the film caused him to look closely at what the county was paying in healthcare as a self-insured entity. And what he found was pretty shocking. IE, when we talk about the two and a half to one ratio of Medicare payment that you normally see as the national average, and PA is pretty close to that. He found out as a county payer that it was way over two and a half times. So he was able to, he's in the process of leveraging that understanding of what they're paying to demand

lower rates, and hopefully in the end that literally in one county, it's going to save, in theory millions of dollars.

The other thing that we hope to inspire with this film is a rationale for community demanding community health benefits from the hospital. And Dave and I have talked about this. It does not necessarily mean the hospital starts a program, but that the community says, wait a minute, you're sitting on that $2 billion in reserves. Some of that needs to come back into the community and in ways that benefit community health. So these are the kinds of things that the movie could inspire locally and be a tool for an understanding of this. This stuff is really complicated, and what we hope is that the movie gives some degree of clarification of what's going on. We all get the $11 Tylenol when we go into the hospital, but nobody knows how it got that way, what we can do about it. And everybody just says that's just the way it is. I'm hoping that after people see the movie, that there's a wide range of things that they can do and they can have a much better understanding of the economics of how we got here and how we might get out of this situation. And then finally, what Maryland is doing, it's very interesting, is they are creating a structure to force hospitals to keep within normal economic growth of the state. Normally and historically, hospital costs have gone up at twice the rate of normal inflation or twice the rate of the growth of the state's economy. And this is why over a 10 year period or 20 year period, this stuff gets out of control. So even though they're not slashing and burning prices overnight, what they're telling the hospitals is the days of you raising your prices at twice the rate of inflation. We're not doing it that way anymore. So what we're hoping is that that model over a 10 to 20 year period is ultimately going to reduce the growth and reduce the out of control cost situation

David Johnson:

To that. I mean, if we can reduce the overall cost of healthcare in the country while continuing to maintain high quality and even better outcomes, we'll free up money to pay workers more, to invest in more productive industries to fund vital societal needs. And we can actually prove to ourselves that America can tackle a big problem and come out on the other side in ways that benefit the everyday Americans.

David Johnson:

Thanks, Vince. It's been a fantastic session with you.

Vincent Mondillo:

I have a very important, very important words. One of the things you talk about VOD and people watching the movie, what our real objective is beyond that is getting community screenings. And what we have done is in our own area, we're intending on doing many, many, many local screenings. And at each screening we gather names and emails of people that would like to be active. And what we're trying to do is get a active committee that will take real action in terms of making local change the extent that we can. And let's just say too, that if a community decides to do that, we may have people available to come in on a call, to answer questions and help with that. And we're building our own local blueprint that communities will be able to use as a model for their own action.

David Johnson:

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Vince, can't thank you enough. And this will brings us to a close, this special episode of 4sight Health Roundup, where we've been talking about American Hospitals: Healing a Broken System, a hard hitting documentary on the current state of hospitals in America that actually has a path forward. We've been talking about the movie with its director, Vince Mondillo, who's an extraordinary filmmaker. I'll encourage everyone in our audience to see the movie wherever you can, whenever you can. And it will be broadly available on streaming services after November 10th.

David Johnson:

That is all the time we have for today. If you'd like to learn more about the topics we've discussed on today's show, please visit our website at 4sighthealth.com. And don't forget to tell a friend about the 4sight Health Roundup podcast. Subscribe now and don't miss another segment of the best 20 minutes in healthcare each week. Thanks for listening. This is Dave Johnson for 4sight Health.

[Outro music]