Navigating the Current Environment in the Healthcare Ecosystem

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Tom O'Neil leads BRG's Governance, Risk & Compliance (GRC) advisory practice. He is a managing director with broad private and public-sector experience, including leadership roles in boardrooms and C-suites of companies in the health sector. He was joined by Rich Bajner, a BRG managing director and leader of the firm's Integrated Health Solutions practice. Rich is a nationally recognized leader and executive advisor who has worked with over 150 payers and providers to tackle complex operational challenges by implementing sustainable strategies that drive greater financial stability, improve clinical quality, and enhance enterprise performance.

Tom: Thanks very much for joining me today.

Before we turn to some of the challenges facing healthcare governing bodies and C-suite leaders, I'd like to ask: What academic and early professional milestones influenced your career path?

Rich: Personal experience fuels passion. Early in my life, when I had experiences with the healthcare industry and realized that millions of people were navigating similar complex environments, I knew this could become a dynamic and exciting career. My path into consulting began during a college internship through a pivotal connection with a professor. He opened the door to a firm where I started as an intern—a journey that eventually came full circle when I departed two decades later as the practice leader.

Tom: The mandate for consulting has evolved considerably over the past two decades. How has your approach changed over the years, and what do you focus on now?

Rich: Through the past twenty years, my consulting practice has evolved from function-specific projects into a long-term, relationship-driven practice focused on transformation. There is real value in being available, bringing insight, outworking others, and demonstrating a keen understanding of the opportunities and challenges that confront clients. That stickiness and empathy helped me develop trusted relationships that have compounded over time into larger opportunities and helped to shape my career.

Early in my career I was a generalist and moved through facility planning, performance improvement, and strategy, but each on its own felt incomplete. The inflection point came when I intentionally brought together strategy, operations, and payer-provider experience into a value transformation team—focused on the space where strategy becomes real and payers and providers overlap. That integrated approach scaled rapidly, absorbing traditional strategy, payer, and state healthcare work, particularly around Medicare Advantage and Medicaid managed care.

Today I focus on building ecosystems of opportunity rather than pursuing isolated engagements. By playing the long game, I help clients create value across the healthcare industry while also creating long-term career journeys for the people who grow the practice alongside me.

Tom: I'm struck by your successful navigation of an intensely competitive landscape. What was your North Star?

Rich: A key point of differentiation involved bringing together strategists and operators. I prioritized a multidisciplinary approach combining clinical, financial, and operational insights to foster an integrated perspective and cultivate a more compelling value proposition.

I focus on leveraging the expertise of my colleagues. My clients know that when I am not the optimal lead expert for the engagement, I will find that professional. A handful of strong early relationships led to an entire ecosystem of opportunities on the east coast.

Tom: Tell us about the work you did with Henry Ford Health and the partnership that was announced with Blue Cross Blue Shield of Michigan?

Rich: The opportunity arose through my long-standing collaboration with Dennis Butts, who became the chief strategy officer at Henry Ford Health. Dennis had been leading the integration of the Ascension Michigan assets into Henry Ford Health, and as that work ramped up, he asked me to come in and help—with not only with integration strategy but also a major upcoming negotiation with Blue Cross Blue Shield of Michigan.

I was in a unique position as an employee of Henry Ford who had previous relationships with leaders at Blue Cross. That allowed me to sit squarely between the two organizations, recognize what mattered to both sides, and help shape a viable partnership

Detroit is a complex healthcare market. It has some of the highest risk scores in the country, extremely high inpatient utilization, and some of the lowest physician and ambulatory prices. For decades, Detroit had seen very little investment in ambulatory care because the economics simply didn't work. We had a rare opportunity to step back and reexamine market constructs that hadn't been challenged in twenty years. I essentially served as an internal consultant to both organizations, helping design a three-year partnership strategy that aligned incentives around improving care delivery, expanding access across southeast Michigan, and bending utilization and risk trends in a way that treated Henry Ford Health and Blue Cross as true partners.

That approach ultimately led to a longer-term engagement that created an achievable and sustainable roadmap. It allowed both organizations to move away from short-term contracting toward a market-shaping strategy focused on access and better outcomes for the communities they serve.

Tom: I'm struck by how you addressed the payer-provider dynamic—so many initiatives stall or fail during the transition from paper to practice. **What did you identify as "must-haves" to ensure this was a sustainable partnership for everyone involved, rather than just a well-designed plan?**

Rich: Early on, it would have been easy for both sides to fall into a "least-common-denominator" negotiation—fighting, for example, over unit price and short-term economics—but everyone recognized that approach would be bad for the broader healthcare ecosystem. That tension forced us to slow down and step back from transactional thinking. When we did that, we were able to have a more honest conversation about the underlying business model of healthcare and how unsustainable it had become due to layers of cross-subsidization: commercial cross-subsidizing government, inpatient subsidizing outpatient, outliers subsidizing non-outliers, and facilities subsidizing professional services.

The breakthrough came when we aligned around containing and reducing those cross-subsidies. We agreed that the gaps between commercial/Medicare and inpatient/outpatient couldn't keep widening over the first three years of the partnership. Once we framed the problem that way, we realized that we had far more mutual interest than points of disagreement. We then began to unpack the healthcare business model together instead of negotiating against each other, and that shared understanding became what we called our "bridge forward." From there, the deal construct itself came together relatively quickly. The shift from negotiation to joint problem solving was ultimately the most critical driver.

Tom: Following your role as a strategic advisor at Henry Ford Health, you joined BRG. What drew you to our firm?

Rich: I saw the consulting market changing even faster than the healthcare markets our clients operate in, and I wanted to be somewhere that could evolve at that pace. I knew I needed an environment that could continually transform how we earn the right to serve clients.

Several things mattered deeply to me. First, I was looking for a leadership team with a broad but measurable vision for the firm. Second, I needed a capital partner willing to take a real swing on healthcare because I knew my ambitions were bigger than an individual hire—I was looking for the opportunity to build something meaningful and scaled.

Equally important was the firm's operating philosophy. I wanted to be in a place where decision rights lived with the experts closest to the market and decentralization was viewed as a strength.

Tom: In many respects, the COVID-19 pandemic is now behind us. But it created significant headwinds for hospitals and health systems in particular. What are your observations?

Rich: Over the last thirty years, we have made some big bets in healthcare that have not always paid off. Medicare Advantage, Medicaid, and value-based care come to mind. When COVID-19 hit, we entered a period where the structural cost of providing the services necessary to run a health system changed. Labor costs rose, the supply chain was disrupted, and new technologies rapidly emerged.

Today, artificial intelligence (AI) is accelerating the velocity of healthcare processes and increasing the amount of information available. The structural changes and organizational challenges we face across the industry are creating a ripe environment that I believe will spur innovation over the next decade.

Tom: I couldn't agree more. A historic lesson in healthcare is that adversity can fuel remarkable innovation. AI is forcing the healthcare industry to reimagine what is possible. While AI certainly presents risks that must be identified and mitigated, it has unleashed a new spectrum of strategic and operational imperatives.

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How are you seeing success and failure with AI? What are the keys to successful deployment of new use cases?

Rich: If we view AI as a technology layer, we are less likely to be successful. Viewing AI instead as an integrated part of our operating model offers many opportunities for success. We should be able to predict which patients are more likely to have complications because of certain medical or clinical indicators that previously we have been unable to identify. Current use cases are focused on billing and labor, which we do need. However, I don't see enough focus on strategic access and care model design. That is where the care journey lives and where we can create a differentiated value proposition.

Tom: How do you see care changing as consumers seek a greater spectrum of care outside of the hospital?

Rich: Over the last twenty-five years, healthcare has become a pillar of the economy. It is the single biggest employer in about forty states across the country, and it has the largest job sector in the world.

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As healthcare shifts toward providing care at home and in ambulatory settings, health systems are under growing pressure to act as better stewards of cost. It is a passion of mine—it's a challenge to find a not-for-profit health system that profitably operates a freestanding care site. Until these systems redesign their ambulatory operating and economic models, we will see a bimodal market in areas of population growth where for-profit systems will continue to expand their footprints. This poses an important challenge for not-for-profit health systems that they can overcome and achieve, but that will require a rethinking of existing business models.

Tom: Our team works closely with health system boards to assess and enhance their governance models. What observations can you share about the ramifications of our conversation for boardrooms?

Rich: With state and federal policies shifting rapidly, governing bodies need to translate policy changes into strategic and operational impact, making policy literacy a critical skill that should be developed within the C-suite. Health systems are facing major transitions in leadership, as many C-suite executives are aging out and a new generation of leaders is stepping in. There is an opportunity to move beyond historical strategies and rethink the long-term direction of the organization over a ten- to twenty-year period.

Governing bodies and boards also must place increased pressure on cost structures, ensuring that patients have access to affordable, high-quality, and personalized care. As new and nontraditional partnerships emerge, boards must actively challenge senior leadership to reassess legacy models and embrace new strategic relationships to build a more resilient and effective healthcare system for the communities that depend on it.

Tom: Well said. Rich, thanks very much for carving out the time for our discussion. And welcome to BRG!

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