Cost, Quality, Mission: The Challenges Ahead

By KATHERINE ARBUCKLE, CPA

As a ministry, health care and financial leader, I see the challenges ahead through a lens focused on the economics of our ministry so it can sustain us into the future. Our mission thrives on long-term financial funding and detailed, practical and sometimes daily stewardship so that we may serve the poor and vulnerable now and in the future.

As a finance leader, I am especially aware that uncertainty is a critical element in the success of any organization. Our ministry requires the support and financing of our communities, our provider communities and the capital markets, asking them to pledge their trust in us with long-term and life-changing commitments. Balance sheets and income statements are negatively affected by uncertainty in many forms.

Today, those who serve in the health care ministry in the United States face unprecedented levels of uncertainty. Our future seems to depend on a disparate set of largely unpredictable variables: the U.S. economic recovery, continuing global financial problems, ongoing effects of the housing and unemployment crises and the implications of the U.S. Supreme Court's decision on health reform, as well as any potential fallout from the November elections.

Beyond these uncertainties is the reality that the health care delivery model must and will change, causing a fundamental shift in how providers will be paid. But how quickly, with whom and how these models change adds to the uncertainty of our future.

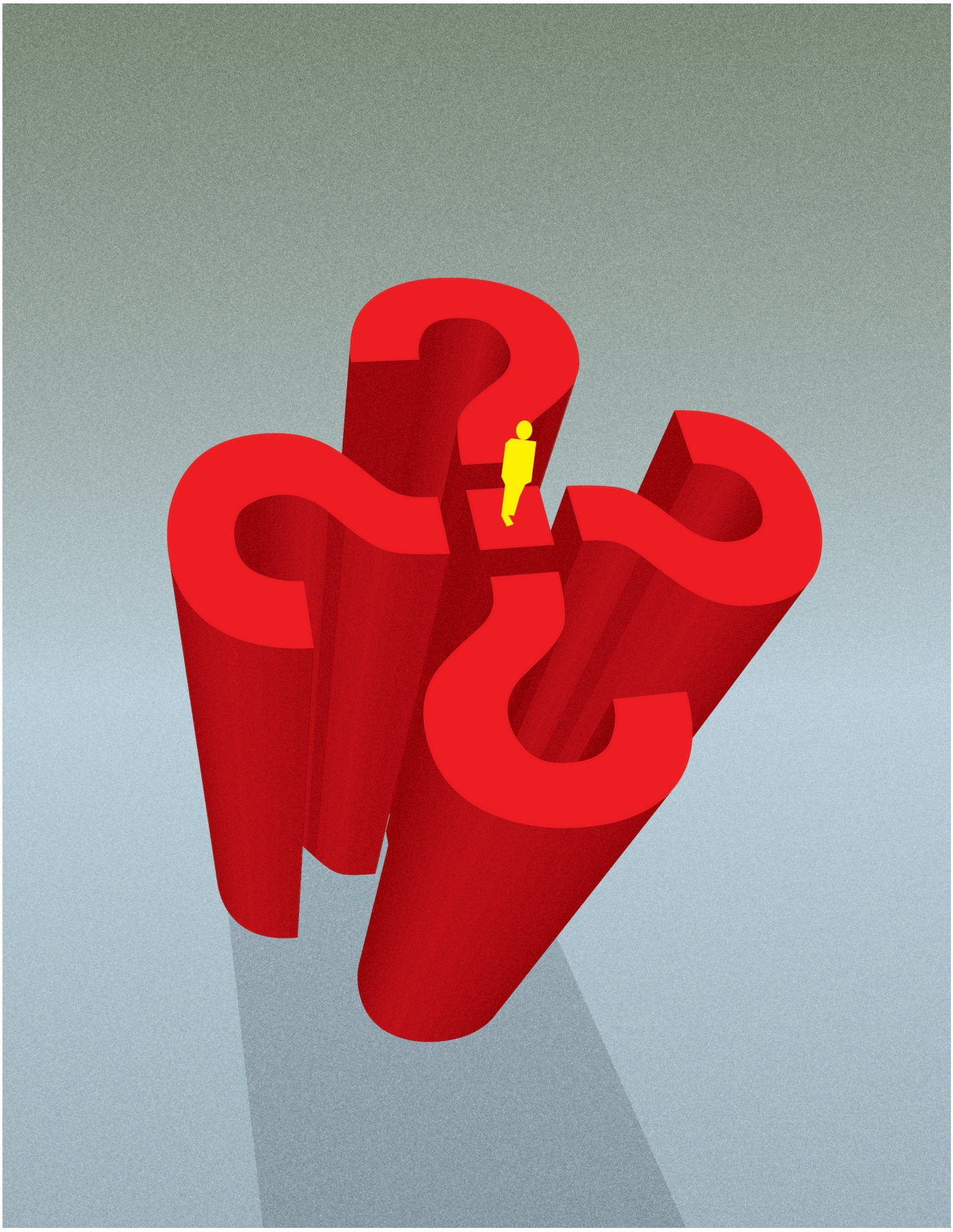
This environment creates both a burden and a call to action. We cannot stand still and wait for clarification and resolution. Those we serve — individuals, communities and our nation — deserve our best, most creative and most innovative ideas as we strive to meet their growing needs.

CHANGE IN THE DELIVERY MODEL

Many organizations, including my own, St. Louis-based Ascension Health, have determined that a paradigm shift is required, moving from a provider-centric model to one that puts the person at the center of all we do. Rather than serving patients who come to our facilities for care, we seek instead to create continuous, dynamic relationships with individuals throughout their lifetimes, helping them live healthier lives by meeting their needs on their terms, when and where they want, not simply caring for them when they are sick. This change in delivery is a radical departure from providers delivering episodic medical services to providers developing trust-based relationships that transcend an individual health care encounter.

But this shift brings with it not only a major challenge in how we engage with patients and families, but also in how we develop appropriate payment models to ensure that this new approach is economically sustainable. We all face this key question.

As providers, we have a responsibility to look for new ways to collaborate and build a new model of delivering person-centered health care in a way that ensures the financial sustainability that will allow us to continue to carry out our mission of serving all, with special attention to those who are poor and vulnerable. We must challenge ourselves to look for ways we create value and benefit across our system — from sharing best-practice models to initiating innovation. We also must ask our



payer partners to look at reimbursement from a different perspective as care is delivered in new ways.

CHANGE IS INEVITABLE

Affordable health care is a major contributor to the economic vitality of communities. And yet, the current state of health care as a part of the U.S. economic system is unsustainable. The size of the federal budget deficit is on an unsustainable trajectory, as is the rate of annual increase in the Medicare budget. Spending more than 17 percent of our country's gross domestic product on health care also is unsustainable, especially when you consider we spend a much greater percentage than many developed countries, but we have outcomes that often are worse. Further, most state Medicaid programs are on an unsustainable path. The transfer of health care costs to employers and consumers cannot continue; employee contributions toward health insurance premiums, deductibles and copays have increased from 15 percent of median family income in 2002 to 26 percent in 2011. If left unchecked, it could grow to as much as 45 percent by 2020.

Health care reform has the potential to play a role in dealing with these issues. Under the health reform law, 31 million more Americans will have health insurance coverage. But challenges and questions remain. More than 20 million people will still be without coverage, many of them the most vulnerable among us. Many newly covered individuals may struggle with access. What if coverage does not expand as expected, but reimbursement continues to decline? We do not know how pricing and coverage options will be offered through health exchanges. Will employers provide less coverage, causing employees to purchase coverage through exchanges at lower reimbursement rates? It's possible employees may retire or leave employer-sponsored health plans to pursue coverage at more competitive rates available in the exchanges. Increased transparency and competitiveness between the exchanges and employer plans may cause more downward pressure on insurance premiums and reimbursement to providers.

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Objective # 1: Reconfigure: As we consider the future, there are many questions. But regardless of the answers, we believe that in order to meet current and future health care needs and to contribute positively to communities with special attention to those who are poor and vulnerable, providers must fundamentally reconfigure delivery systems, care processes and cost structures.

Health care research firm Sg2 in Skokie, Ill., estimates that 30 percent of all health care spending is waste, including provider error, unnecessary care, preventable readmissions and lack of care coordination. Peter Orszag, former head of the Congressional Budget Office, translates this into $700 billion of annual spending in the United States that does not improve health outcomes.

Our efforts, then, must focus on reconfiguring our processes of providing care; integrating our clinical and financial data to better allocate resources toward positive outcomes; and identifying and eliminating waste. Identifying waste can be elusive. The improved efficiency of one department can have negative consequences on another. Moving a patient through care protocols too quickly can create complications. Likewise, many positive initiatives appear to reduce the need for resources but have little impact on the huge percentage of costs that are fixed.

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Our financial competencies and capabilities have never been more tested. Our financial leadership will need to be partnered and integrated with clinical staff in ways that have not occurred in the past. Reliance on medical clinical data as produced by our enhanced information technology platforms will need clinical and financial leaders to jointly and correctly interpret data. Experiments with new care processes and protocols will need communication, planning and assessment as they are implemented. Changing our care processes and understanding the impact on our cost structures is critical, and it represents a new space for us as a ministry.

SHARING RISK

Our passion for serving those in need, particularly those most vulnerable, puts our community of providers in the best position to determine new ways to reconfigure the delivery of care. We can reconfigure, redesign and achieve better outcomes. In the shift from a volume-based reimbursement system to a value-based system, we know the future will require a more continuous, dynamic relationship with those we serve. As the old models of funding the ministry through inpatient volume growth or commercial rate increases will be limited, we will need to share risk with the purchasers of health care.

Innovative payment models must be part of the solution. As we reduce

utilization and costs, providers are at risk for limiting their reimbursement. Payers are being asked to compensate providers for this value through many types of risk-sharing arrangements. Assuming risk on the provider part, however, is required in reimbursement structure based on value.

There are hundreds of examples of new risk-sharing arrangements — payers and providers exploring new ways to reward each other with value provided. These arrangements are generally unique to the provider network and each payer.

The federal government, the largest payer in the health care system, is exploring such payment models. The Centers for Medicare and Medicaid Services launched a pilot program on January 1, 2012, with the intention of aligning incentives among providers of care to increase the coordination of care for the patient, aiming to improve both cost and quality outcomes. The pilot program identified 10 conditions for which payments will be bundled for episodes of care. The concept is that bundled payments will give doctors and hospitals new incentives to coordinate care, improve the quality of care and, as a result, save money.

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The government is also experimenting with accountable care organizations (ACOs). In theory, the ACOs would hold providers jointly accountable for the health of their patients, offering incentives to cooperate and save money by eliminating unnecessary tests and procedures. When an ACO succeeds in delivering high-quality care and allocating health care resources wisely, it will share in the savings it achieves.

As we prepare for taking on responsibilities for managing the health of populations, we recognize that different populations will require different care models. Several of our health ministries have launched pilot programs across different populations. Genesys Health System in Grand Blanc, Mich., and Seton Healthcare Family in Austin, Texas, have been named Pioneer ACOs. There also are a number of health ministries exploring potential participation in the Medicare bundled payment program. Ascension Health has several Medicaid managed care capabilities such as in Mercy Care in Tucson, Ariz., and other health ministries are aggressively moving forward to develop such capabilities.

A number of our health ministries are exploring relationships with commercial payers or directly with self-insured employers. We also are developing an associate health plan to optimize our $700 million annual health spending and create a platform for broader population health management efforts.

We expect we will struggle to build new types of relationships based on common goals and agendas, finding aligned economic incentives among payers, physicians, providers and those we serve together within every market and every payer. All parties will be appropriately cautious, particularly as they generally have limited experience and familiarity with these new models.

The uncertainty before us is not just the need for risk-based relationships, but the diversity of these relationships. Scores of different models are being introduced, all with the intent of reducing waste and improving care provided to persons. But managing in a world of diverse reimbursement models, each rewarding value in a different way, will add to the challenge of our future. Neither the payer nor the provider community is uniform in its approach to transitioning contracts and reimbursement arrangements. As leaders, we will be responsible for bringing solutions to the table, persuading payers that we can provide the value they seek while fulfilling our mission of care.

LOOKING TO THE FUTURE

We know that sustaining the ministry and the mission into the future will require different relationships and new areas of focus. And we know that the needs of those who are poor and vulnerable will continue to challenge us. In FY 2011 alone, Ascension Health provided more than $1.2 billion in care for persons living in poverty and other vulnerable persons, and we project that figure to grow this year. The need to continue to improve quality while ensuring the financial sustainability of our health care system in an uncertain environment is an unprecedented challenge, and it will require significant changes in how we, a Catholic health ministry, operate. We must be open to new, innovative models while staying true to the vision of our founders and to our mission.

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