Disruptive Trends Bring Ministry Opportunities

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Disruptive forces are a constant threat to incumbent market-leading companies, products and alliances. For a variety of reasons, most notably the rise of the internet and digital technologies, there has been no shortage of U.S. industries and legacy businesses disrupted since the 1980s. To name a few: Taxi companies have seen their business decimated by ride-hailing services such as Uber and Lyft; network television stations and cable/satellite TV services have been marginalized by digital distribution outlets such as Netflix and Hulu; stockbrokers and financial advisers have lost significant business to online trading websites like E*Trade and TD Ameritrade; and the hotel industry has been radically altered by the likes of Airbnb and HomeAway.

U.S. health care has remained stubbornly resistant to this same level of disruption, at least until recently. Since the global recession in 2009 and the passage of the Affordable Care Act in 2010, disruptive trends have started to fundamentally change the way health care is structured, delivered and paid for. Disruption is challenging incumbent health systems the most, especially those with a large concentration of hospitals and a business model built around fee-for-service reimbursement. For Catholic health care, particularly, this is a pivotal moment, one in which the choices made today will define the ministry for decades to come. Although the tendency might be to oppose disruption and cling to what is known and safe, Catholic health care should instead see this as an opportunity to reimagine how it can better live out its mission and make health care better, more accessible and affordable for all.

DISRUPTIVE TRENDS IN U.S. HEALTH CARE

When people talk or think about disruption, they often link it to innovation. Indeed, the terms "disruption" and "innovation" have become almost synonymous ever since Clayton Christensen, the Kim B. Clark Professor of Business Administration at the Harvard Business School, introduced the term "disruptive innovation" in the 1990s.[1] However, not every innovation leads to disruption, and not every disruption is driven by innovative technologies or products that create new markets and value networks. For purposes of this article, we will use the term "disruption" to refer broadly to any breakthrough or development that upsets the status quo whereby the practices, products and market position of previously successful incumbents are challenged as a result of changes to the industry's competitive patterns.

Perhaps the most disruptive trend in U.S. health care currently is the aggressive growth strategies of the nation's largest commercial health insurers, putting them into direct competition with incumbent health systems. Leading the way is UnitedHealth Group through its Optum division, a venture encompassing data analytics, pharmacy benefits management and clinical services that complement UnitedHealthcare, the nation's leading health insurer.[2] Within

the last two years, Optum has made a series of transactions, including acquisition of Deerfield, Ill.-based Surgical Care Affiliates for $2.3 billion, bringing into its fold SCA's 190 owned or operated ambulatory surgery centers and surgical hospitals serving roughly 1 million patients in more than 30 states; and its proposed acquisition of Denver, Colo.-based DaVita Medical Group for $4.9 billion, through which Optum will add 17,000 physicians, 300 medical clinics, 35 urgent-care locations, and six outpatient surgery centers across six states to its existing base of more than 30,000 medical providers.

Similarly, the nation's second-largest health insurer, Anthem Inc., has completed two major vertical acquisitions. The first involves Nashville, Tennessee-based Aspire Health, the nation's leading community-based palliative care provider, which has contracts established with more than 20 health plans serving consumers in 25 states. The second involves Coconut Grove, Florida-based HealthSun, one of the fastest growing integrated Medicare Advantage health plans and health care delivery networks in Florida, serving more than 40,000 seniors in Miami-Dade and Broward counties through its network of 19 wholly owned primary care and specialty centers.[3]

The other major commercial health insurers have been just as active. Aetna, the nation's third-largest health insurer, has agreed to be acquired for $69 billion by CVS Health Corp. Humana Inc., the nation's fourth-largest insurer, has acquired a large at-risk provider group, Orlando, Florida.-based Family Physicians Group, and partnered with a private equity company in acquiring Louisville, Kentucky-based Kindred Healthcare and privately held Mooresville, North Carolina-based Curo Health Services. The combined companies are the nation's largest providers of home health and hospice services.[4] Cigna, the nation's fifth-largest health insurer, has received federal approvals to acquire St. Louis-based Express Scripts for $54 billion in cash and stock.

FEDERAL GOVERNMENT ACTIONS

A close second to the disruption being caused by health insurers is the activity by the federal government, which is looking to rein in health spending and accelerate efforts to value-based payment and delivery models. Although Congress has been largely idling, the Centers for Medicare and Medicaid Services has issued a series of proposals meant to lower the cost of Medicare that will directly impact incumbent health systems, especially those with large numbers of employed physicians that have been converted to hospital outpatient departments. In one proposal, CMS calls for Medicare to move away from a system that pays more than twice the amount for a routine clinic visit at a hospital outpatient department than it does at an independent physician's office. If finalized, this "site-neutral payments" proposal would reduce by roughly 60 percent the amount hospital outpatient departments receive for such visits and save the Medicare program $760 million in 2019.

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CMS also is proposing to extend cuts already made in payments to hospitals through the 340B Drug Pricing Program — a program that allows eligible hospitals to buy certain outpatient drugs at a lower cost. After reducing payments in 2018 for drugs administered at hospital outpatient departments by 28 percent, CMS plans to extend the payment change in 2019 to non-excepted off-campus departments of hospitals. The 2018 policy resulted in a $1.6 billion cut in payments, although CMS maintains that increases in Medicare Part B non-drug payments will offset the effects for 85 percent of hospitals.[5]

On the health care delivery side, CMS also has been aggressive, issuing a proposal meant to force accountable care organizations in the Medicare

Shared Savings Program to take on financial risk sooner. Currently, Medicare ACOs have six years to transition to a risk-bearing model, and 82 percent of the existing ACOs in the program are in the non-risk track, meaning they are eligible for performance bonuses but do not incur penalties when performance lags.

The proposed rule would give existing ACOs one year to shift to a risk-bearing track and give new ACOs two years. U. S. Health and Human Services Secretary Alex Azar also has signaled his intent to move quickly to risk-based Medicare payment models. He commented that the Center for Medicare and Medicaid Innovation would be launching "bold" new value-based models that include making physicians and hospitals into "accountable" navigators of the health system.[6] Azar and his colleagues at CMS look to build on the success of risk-bearing Medicare Advantage primary care providers such as Miami-based ChenMed and Boston-based Iora Health, which have substantially lowered the cost of care for seniors while achieving exceptional clinical outcomes through smaller patient panels, meticulous medical management, concierge-like customer care and attention to social determinants.[7]

EMPLOYERS' ROLE IN EMPLOYEE HEALTH

Another disruptive trend in U.S. health care involves steps employers are taking to slow the growth of employee health costs. For the past several decades, the share of employer expenses related to employee health benefits has increased well above the rate of inflation, and the overall amount is becoming unsustainable for many employers. To offset the growth, employers in recent years have resorted to cutting some benefits and increasing the amount employees pay in deductibles and copayments. This has helped slow expense growth to some extent, but employees are now at the edge of what they will accept, and employers cannot realistically push more costs onto them. As such, many employers are adding wellness programs to their employee benefits — with mixed results.

Some employers are experimenting with such novel ideas as adding telehealth and virtual visit options to employee health benefits as a way for employees and their beneficiaries to obtain convenient online access to low-cost care from clinicians who can treat a number of health issues and even prescribe medications. Two of the companies making a big splash in this area are Harrison, New York-based Teladoc and San Francisco-based Doctors on Demand, both of which have garnered considerable business from employers.

Another idea is onsite health clinics to provide convenient, accessible urgent and primary care services to employees. Employers see this as a win-win, given that, like telehealth and virtual visits, onsite clinics can reduce unnecessary emergency department and specialist visits, enhance employee satisfaction and reduce absenteeism. The idea has extended to some of the nation's most prominent employers, including Apple and Amazon, both of which are developing and staffing state-of-the-art primary care clinics for their employees.

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And, the buzz early in 2018 was about Amazon, Berkshire Hathaway and JPMorgan Chase coming together to form an independent health care company to improve care and reduce costs for their more than 1 million U.S. employees. The first step toward this end was selecting the well-known physician and writer Atul Gawande, MD, as CEO of the new company. Though not the first employer coalition to tackle health care, the Amazon, Berkshire Hathaway and JPMorgan Chase collaboration could be the most disruptive.

IMPLICATIONS OF DISRUPTION

The impact of most disruptive trends falls disproportionately on incumbent health care providers and their core services of inpatient care, surgery

and imaging. The common thread uniting most disruptors is that, for different reasons, they are intent on reducing health care costs by moving as much care as possible out of the hospital and away from specialists into more convenient, lower-cost outpatient settings. The impetus behind the push to curb health spending is that health care costs have become unsustainable for government and commercial payers, employers and consumers.

As is well documented, the United States spends far more than any other nation on health care, an estimated $3.5 trillion in 2017, which comprises 18 percent of the gross domestic product or nearly $1 in every $5 spent as a nation.[8] Of this astonishing amount, hospital services account for more than 30 percent and physician and clinical services 20 percent, a substantial portion of which is related to specialty care.

Some perceive traditional health systems, with their large, expensive, technology-laden institutions, to be responsible — along with drug manufacturers — for driving the high cost of U.S. health care. Meanwhile, disruptors are seizing the opportunity to make their mark on an industry that has been largely insulated and dominated by acute and specialty providers.

After having a virtual monopoly on the provision of health care services and experiencing comfortable margins for decades, health systems, especially those in the nonprofit sector, have started to feel the effects of the disruptive trends sweeping over U.S. health care. A recent analysis by Navigant Consulting, which looked at the financial performance of 104 leading health systems that operate roughly half of all community hospitals in the U.S., confirms this.

According to the analysis, over the three-year study period of fiscal years 2015 through 2017: health system operating margins dropped 38.7 percent overall; two-thirds of the health systems saw operating income decline; 27 percent lost money on operations in at least one of the three years, while 11 percent had negative operating margins all three years. Fueling the decline is the fact that expense growth outpaced revenue growth by a full 3 percentage points, resulting in a total operating earnings decline of $6.8 billion, representing a 44 percent drop from 2015 to 2017.[9]

For their part, health systems are not just sitting idly by, hoping their fortunes will change. Virtually all are trying to improve operations and financial performance by increasing productivity, reducing expenses, managing the supply chain and improving the revenue cycle. The problem is that, while necessary, these efforts to date haven't been and may not be sufficient to match the declines in revenue caused by continued reimbursement cuts and the migration of once hospital-based services to lower-cost outpatient settings.

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To supplement these efforts, many health systems have been active in mergers and acquisitions. Since the ACA's passage in 2010, there have been more than 800 hospital and health system mergers, including 115 transactions in 2017, the highest annual number in recent history. That number is likely to be eclipsed in 2018.[10] Yet for all of the hoped-for benefits of merging, recent research suggests scale doesn't necessarily correlate with profitability, and merged organizations tend to have difficulty achieving financial synergies and integrating disparate cultures.[11] This doesn't mean health systems should avoid mergers and acquisitions, but they should avoid being seduced by the scale myth and only pursue transactions that make sense from a broad strategic perspective.

AN OPPORTUNITY FOR CATHOLIC HEALTH CARE

How should the Catholic health ministry respond to these disruptive trends?

The typical human and organizational reaction to disruption is resistance, at least at first. Incumbents tend to dig in, resist the change and fight to preserve the status quo while ceding ground to companies that are leading the industry transformation.

However, this is no longer a viable option. Change is proceeding inexorably in U.S. health care. Rather than resist, Catholic health care should embrace the disruption occurring and approach this time in its history as an opportunity

to rethink and reimagine how to better live out its mission of transforming the health of communities, especially those that are physically, economically and socially marginalized, so all persons have an opportunity to flourish and experience God's healing love. By embracing the disruptive trends in U.S. health care, the Catholic health ministry can assume a leadership role in making health care better, more accessible and affordable, especially for the poor and disadvantaged.

By way of conclusion, here are several suggestions and questions in the spirit of furthering the dialogue among leaders in Catholic health care:

Keep the Catholic vision of health and health care at the forefront. Let that guide the way we structure our health ministries and deliver care to our patients and communities. Rooted in the Gospels and the Catholic social tradition, Catholic health care views health broadly as wholeness — "not only physical, but also spiritual and psychological wholeness; not only individual, but also social and institutional wholeness."[12] This understanding of health leads to a vastly different view of health care and takes on the aim of promoting "health and wholeness in all facets of the human person and human community" with the social, economic and environmental causes of illness becoming an important focus of concern and action.[13]

- Are our health systems and other ministries structured in a way that reflects this comprehensive, integrated vision of health and health care?
- Are we playing a sufficient role in promoting health equity on a communitywide scale, and do our care delivery models attend to the whole person and actively address the social determinants of health?

Reflect on the sisters who founded our great ministries and invoke their spirit. We frequently recall the sisters for spiritual inspiration, but we may not emphasize sufficiently their business acumen, strategic creativity and faith-filled courage. From Mother Joseph Pariseau (Sisters of Providence) and Mother Odelia Berger (Franciscan Sisters of Mary) to Saint Elizabeth Ann Seton (Daughters of Charity) and the Venerable Mother Catherine McAuley (Sisters of Mercy), our founding sisters provide a model of leadership that we should emulate. In some sense, the disruption occurring in U.S. health care calls us back to our roots, away from expensive, institutionalized health care centered around hospitals toward the itinerant, unencumbered health ministries of our founding sisters who went where they were needed and provided care through whatever means necessary to help people in need. The sisters were unafraid of change and evolved constantly in response to the signs of the times. In doing so, they fulfilled the vision and mission of Catholic health care.

- Do we exhibit the same pioneering and intrepid spirit of our founders?
- Are we in the right places, providing the right services in areas and to people who need us most?

Radically reinvent our health ministries, shifting from a traditional acute care business model to one focused on providing high-quality care at low costs in convenient settings where services are needed, as opposed to areas with the best payer mix. Reinvention will be painful because it will require decentralizing hospitals and allocating hospital assets in response to changing utilization trends and population health needs. Inevitably such change will lead to tough questions about what to do with struggling and/or unnecessary hospitals. Given our ethical commitments, community need, rather than profitability, should be the determining factor in deciding a hospital's fate. Creative options always need to be explored before selling or closing a hospital. If selling or

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closing is the ultimate decision, then the ethical course is to pursue alternative ways of maintaining a Catholic health ministry's commitment to the community.

The make-up of our health systems must change to meet the signs of the times, and sponsors and boards must be prophetic in directing management and be patient during the relative short term as financial performance lags and the business model evolves. A number of Catholic health systems already have started to pivot in this direction, which is an encouraging sign and can serve as inspiration for others.

- Have we evolved and redesigned our ministries and service offerings to meet the needs of our patients and communities? If not, are we willing to evolve and change, as the founders did, without clinging to what is comfortable and safe?
- Can we rise creatively above the practices of those not operating from a mission standpoint, who simply shed distressed hospital assets and exit unprofitable markets?

We need to rapidly transition our Catholic health systems to value-based care. To do so, we will need to allocate capital differently by directing the majority of available funds toward value-based care modes of delivery rather than acute/specialty care structures and technologies. Additionally, we also will need to drop the "two-canoe" metaphor of having one foot in fee-for-service and another in value-based care. Instead, we should jump headlong into the latter, reimagining strategies with an emphasis on value-based care and population health versus maximizing high-margin service lines and expensive, low/no-value procedures.

Failure to do so not only is contrary to the vision and mission of Catholic health care, but it is no longer supported from a business standpoint and borders on the unethical. As Gary Kaplan, chair and CEO of Seattle-based Virginia Mason Health System, and his colleague Craig Blackmore note: "Hiding behind the mantra of 'I can't change my delivery model until the payment system changes,' providers have, intentionally or unintentionally, continued to provide non-value-added or even inappropriate care, driving up health care costs without benefit and potentially harming patients."[14]

- Do our strategic plans support a rapid transition to value-based care?
- Are our delivery models and compensation practices, especially for clinicians, promoting value-based care or fee-for-serve medicine?

We need to think beyond horizontal mergers and develop vertical strategic alliances. Although merger and acquisition is a valid strategy in the midst of industry consolidation, there are other ways in which Catholic health systems can evolve and fulfill the vision and mission of Catholic health care. Acquiring all the pieces and expertise necessary to succeed in today's health care environment is next to impossible, especially at the speed required.

As some Catholic health systems are already doing, we should look to partner with like-minded organizations that share our values and commitment to transforming the health of communities. This can include those we know well, like Catholic Charities, in helping to address social determinants of health, and Catholic universities in developing a pipeline of talented, diverse individuals to serve in the ministry. Partnerships also can include others like Lyft on transportation, Amazon on cloud-based information technology services, Google on artificial intelligence and predictive analytics, CVS on retail clinics, UnitedHealthcare on narrow networks and value-based contracts, Teladoc on virtual visits, ChenMed on Medicare Advantage, and so on. In some ways, it would be a paradigm shift for the ministry to accept a complementary role versus the lead role and to jettison the concepts of competition for collaboration and self-interest for the common good.

- Are we thinking creatively enough about whom we might partner with to radically reinvent our health systems and better meet the needs of our patients and communities?
- Are we willing to accept a less dominant role in the interest of measurably improving the health

of communities and making health care better, more accessible and affordable for all?

DISRUPT OURSELVES

Incumbent health systems, including those within Catholic health care, do not have to be the culprits or victims in reshaping U.S. health care. We can be part of the solution, complementing the efforts of disruptive companies that are having a positive impact on the access, cost and quality problems that have plagued the U.S. for decades.

This will only be accomplished if we not only embrace disruption but also disrupt ourselves, becoming more resilient and adaptable, and not wait any longer as forward-thinking companies build insurmountable leads necessitating reactionary moves. It will be a major undertaking for Catholic health systems to disrupt themselves, and it won't be easy. But the status quo is failing. There always will be a market for hospital and specialist services, but macro- and micro-economic factors are coalescing in such a way that the good old days will never return. Catholic health systems that double down on hospital-centric strategies, hoping that current disruptive trends pass, will be marginalized by those leading the transformation of U.S. health care.

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