FALL REGIONAL MEETINGS

MEDICARE/MEDICAID RESTRUCTURING

Challenges and Opportunities of Managed Care

The restructuring of the Medicare and Medicaid programs poses significant operational, legislative, and mission challenges for the Catholic health ministry. This report highlights meetings held in Chicago and Philadelphia in November and December 1996 to prepare healthcare leaders for the changes that are coming. The meetings were two of seven held across the country last fall. Cosponsored by the National Coalition on Catholic Health Care Ministry, the Catholic Health Association (CHA), and Consolidated Catholic Health Care, these regional conferences were part of *New Covenant*, a process to strengthen the Catholic presence in healthcare through regional and national collaborative strategies.

The meetings blended operational and mission concerns. On the first day, speakers reinforced mission as the ministry's foundation and market advantage, and they defined opportunities and strategic responses to the restructuring of the Medicare and Medicaid programs.

The second day's sessions moved into collaborative strategies for dealing with Medicare and Medicaid changes. The day concluded with CHA's public policy proposals related to these programs' restructuring.

Marian Jennings, of Jennings Ryan & Kolb, Waltham, MA, led a "managed care primer" session, which provided essential information for Catholic providers. This well-received session will be presented at CHA's Annual Assembly in June.

MISSION: OUR FOUNDATION AND MARKET ADVANTAGE

"Mission is too often put in the background when we go to the negotiating table," but mission is a "duty from which there can be no relief," said Sr. Jean deBlois, CSJ, PhD, as she set the context for the meeting. To continue the Catholic health ministry in today's changing times, those in the ministry must continually reflect on what the imperative of mission requires of them, she said. "It's simple to say, 'Here's who we are,' but difficult to deliver on the commitments embodied in that statement."

View through the Mission Lens

She noted that some Catholic providers are questioning whether they should get out of institutional ministry. They fear that managed care is "morally flawed," that it focuses exclusively on controlling costs, that big business is inimical to ministry, and that partnerships with non-Catholics will dilute organizations' Catholic identity. But she insisted that "if we look at these concerns through the lens of our mission," a different perspective emerges:

"Managed care is neither good nor evil in itself—it is the way we use it that counts."

— Sr. Jean deBlois, CSJ, PhD

- "Managed care is neither good nor evil in itself—it is the way we use it that counts." If managed care is structured appropriately, "it can be conducive to mission ends."
- By controlling costs, "we can serve more vulnerable people."
- "Business is a human endeavor, and all human endeavor can be graced."
- In partnership with other-than-Catholic organizations that share their commitments, Catholic healthcare organizations can create a power base strong enough to make a difference in developing a healthcare system that serves all God's people.

As Catholic healthcare organizations shift from being only care providers to being both providers and guarantors of health services, it is appropriate for the ministry to become more embedded within the broader American healthcare culture, Sr. deBlois said. She continued with an analogy. "This shift allows us to move from the role of 'lighthouse' to 'leaven' and affords the Catholic health ministry a greater opportunity to bring about the transformation of the broader culture in accord with ministry values," she said. But the new role is not easy. "If a ship crashes, nothing happens to the lighthouse," she pointed out, "but when you are leaven, you have to accept that the leaven changes as other things change. You can't be catalytic and prophetic without changing too."

Mission as a Market Advantage

To make mission a market advantage, the Catholic health ministry must take concrete action, reaching out to the poor and vulnerable and to patients and healthcare professionals, Sr. deBlois said.

She noted that physicians, for example, want a place where they can find meaning again in practicing medicine—"a place where they can have the unique relationship with patients that their professional ethos calls for." Catholic healthcare has the opportunity to provide that place, she said. "What we have to offer is what our world is crying out for today. We must make Catholic health ministry a radical healing presence in our world, building up the household of God; unless we do this, there will be no Catholic health ministry in the future."

The full text of Sr. deBlois's presentation will appear in the March-April 1997 issue of Health Progress.

MANAGED CARE'S GROWTH DRIVES MARKET CHANGE

Less than 60 percent of the nation's employees can choose a fee-for-service plan for their healthcare coverage, a 30 percent drop since 1988. But this rapid growth of managed care in the private sector will soon be outstripped in the public sector. Enrollees in Medicare HMOs are increasing by more than 25 percent annually, and Medicaid managed care enrollment is reaching the 12 million mark.

These figures demonstrate a dramatic reorganization of healthcare delivery, driven by the federal government's need to reduce spending on healthcare, said Roseanne Pajka, senior manager at the Lewin Group, Washington, DC. Simply cutting payments to providers, she said, will not be sufficient; systemic change is required.

Medicare/Medicaid's Piece of the Federal Pie

Pajka predicted that federal spending on Medicare and Medicaid will rise by 9 percent each year until 2002, when spending on Medicare alone will far exceed today's expenditures on both programs. Medicare and Medicaid will then account for almost 25 percent of the federal budget.

Adding to this problem, she said, is the projected insolvency of the Medicare Hospital Insurance trust fund by 2001, as well as long-term demographic trends. Baby boomers will begin reaching retirement age in 2010, and they will live longer than today's retirees. Persons over 65 will make up almost 20 percent of the population, versus about 12 percent today; thus fewer people will be working and paying taxes to support the Medicare and Medicaid programs.

Pressures on Healthcare Costs

Systemic change is also needed because of other "sustained, relentless pressures on healthcare costs," Pajka said. "The number of uninsured is growing at 1 million a year," she noted, and reducing health insurance payments is "still the best way for businesses to reduce costs." Employers now provide health insurance to only 80 percent of full-time workers, and only 40 percent of companies offer health benefits to part-time workers, down from 50 percent in 1995, she said. Fewer businesses are offering health insurance to retirees, she remarked, and many are downsizing and outsourcing work to smaller firms that do not provide health insurance.

"There hasn't been a better time to differentiate yourself and leverage your interest in caring for the whole person and your ability to do it."

— Roseanne Pajka

Silver Lining for Mission-driven Providers

Mission-driven providers have strong reasons for hope in this environment. "There hasn't been a better time to differentiate yourself and leverage your interest in caring for the whole person and your ability to do it," Pajka said. "Over the long run, too, with this kind of sustained pressure on costs, for-profit speculation in this industry may not pay off.

"In the West," she continued, "commercial managed care has led the way, but in Florida and other markets, Medicare managed care will lead the way." She warned those who think managed care is unlikely to affect them for a while that Medicare managed care can cause things to change quickly.

"Medicare acts as a catalyst to commercial utilization," she said. "If you're managing Medicare lives, there are good reasons to add commercial

lives; and if you have commercial lives, then Medicare just gives you another product line."

Medicare HMO concentration is so much greater in states with high fee-for-service costs than it is in cheaper states that "a major goal of Medicare reform is to diversify geographically," Pajka said. "This is beginning to happen," she noted, and this growth presents opportunities for providers (see **Map**).

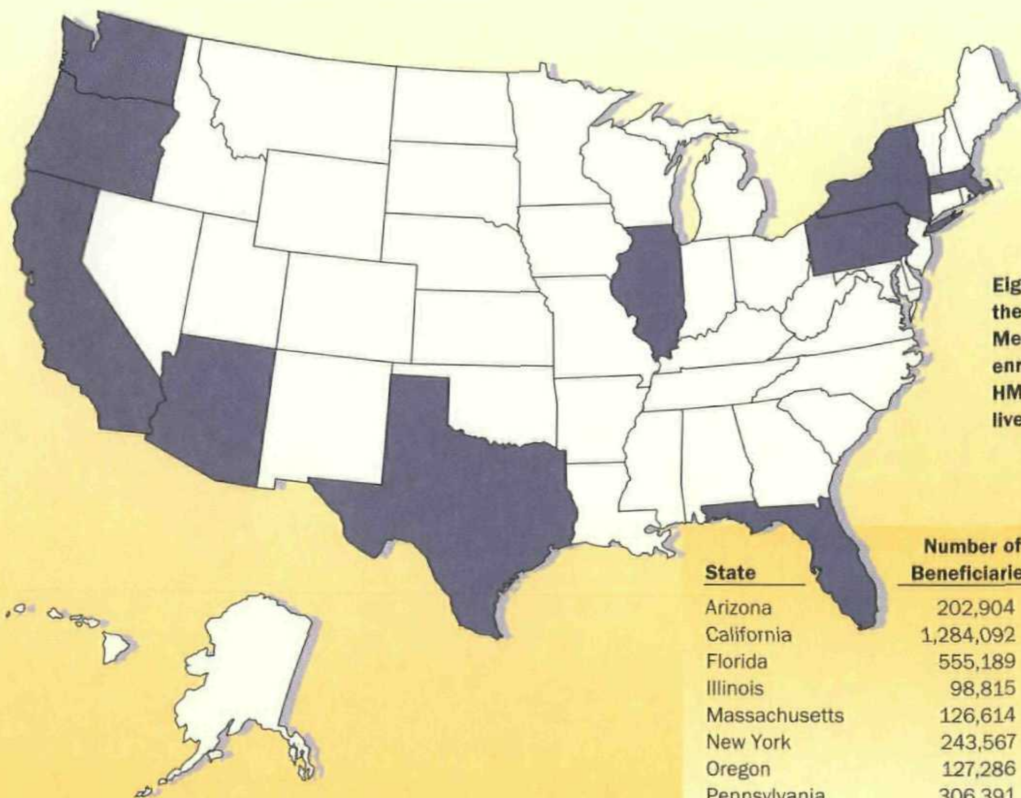
Who Will Drive Systemic Change?

"Investors who have contributed capital—with high hopes of return on that investment—will want to be in the act," Pajka said. But she insisted the real issue is, "Will the changes be driven by for-profit stock companies, or will providers get in the act to organize the continuum of care to take care of folks?" She suggested that providers take on some of that risk with insurers (or as insurers). "The way to stay mission driven is to integrate and care for populations," she said.

"Providers have the opportunity to shape the way things work out" as the federal government addresses the short- and long-term budget problems of Medicare and Medicaid, Pajka insisted. They can capture the premium dollars and use the money to care for people "instead of pulling dollars from the system to make a profit or to send to shareholders quarter after quarter and year after year," she said.

She cautioned participants that they will need more than good intentions. "It will take focus and knowledge," she said. "It will be important to choose like-minded partners, not just let the marketplace decide for you or have your partnerships end up an accident. You have a chance to do better in the future than you've done in the past. With creativity, you can succeed."

TOP 10 STATES FOR MEDICARE RISK CONTRACT ENROLLMENT



Eighty-two percent of the 3.96 million Medicare beneficiaries enrolled in risk-contract HMOs in October 1996 lived in 10 states.

State	Number of Beneficiaries	Percent
Arizona	202,904	33.1%
California	1,284,092	34.7
Florida	555,189	20.8
Illinois	98,815	6.0
Massachusetts	126,614	13.3
New York	243,567	9.1
Oregon	127,286	26.7
Pennsylvania	306,391	14.6
Texas	198,490	9.3
Washington	124,000	17.7

From Health Care Financing Administration, Office of Managed Care; % = Medicare risk penetration rate.

KEY TO SUCCESS: DIFFERENTIATION

CHA's Executive Vice President William J. Cox sees *differentiation* as a key to success in competitive markets. "The waves of change washing over healthcare in the next decade will increase the temptation to frenzied behavior," he warned. "What mission provides us in that environment is a compass and a direction," Cox said. As leaders change an organization, it is important to chart for boards, sponsoring organizations, physicians, and employees a direction that is "larger than survival itself," he said. Cox advised leaders to "always explain change in the context of why we need to change: so that we continue to provide Catholic healthcare services in this community after the transition in healthcare. Mission offers us this opportunity."

"We have the potential to develop partnerships with health and social service agencies, many within the Catholic community."

— **William J. Cox**

Catholic Healthcare's Advantages

Cox noted that many participants in the Catholic health ministry have been working toward a vision of integrated delivery networks that prepares them well for managed care (see **Figure**). Building on this vision, they can become the "integrators"—those who organize the continuum of care—and thus capture the full premium dollar for providing a wide spectrum of services to the populations they serve. "The ministry's focus on serving the whole person and the whole community is consistent with operational success in the future," Cox said.

He listed the ministry's advantages that move it toward integrated systems of care:

• Catholic healthcare organizations derive a higher percentage of revenues from the Medicare program than do other community hospitals. This is not surprising. "When older people are sick and vulnerable, they want to be in an environment where they feel safe—and that is often in a religious environment."

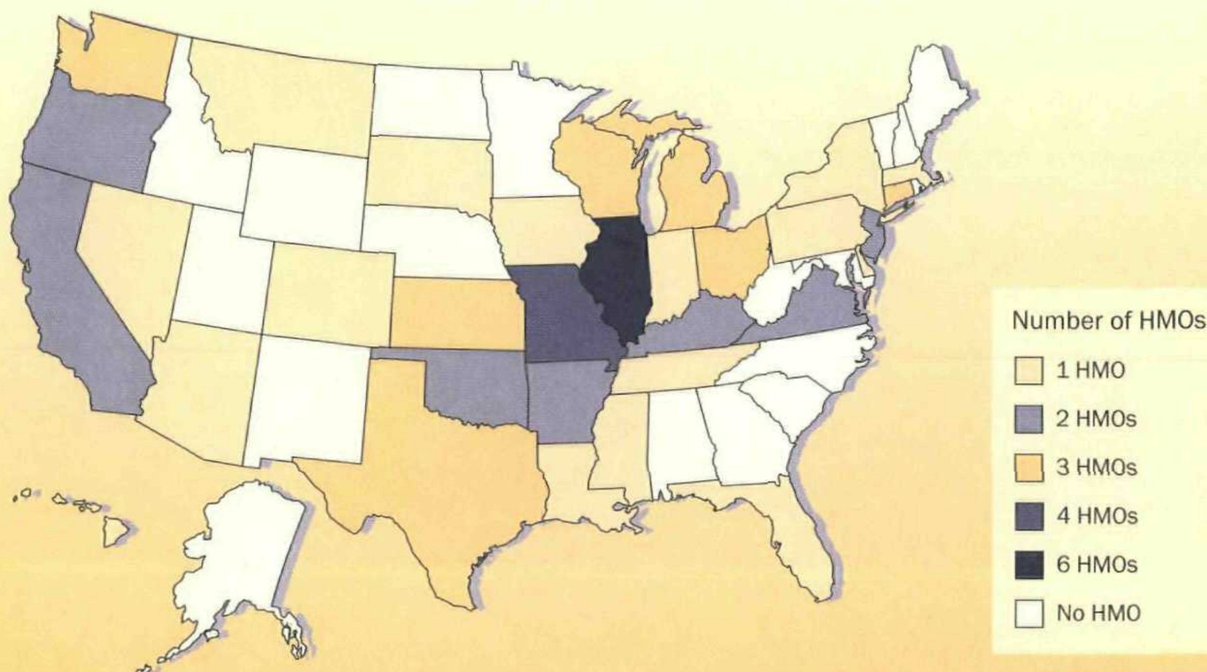
• As managed care becomes the dominant means of providing and financing care, "a lot of patients are going to be nervous about how they're being treated. Are they going to get all the care that is necessary for their condition? Are they going to be treated with compassion and dignity?" At a time when healthcare costs will be compressed dramatically, "the need for our type of healthcare will become ever more important."

• Catholic healthcare facilities have a great deal of experience over time in caring for poor and vulnerable populations. The demand for that type of experience will grow as the number of uninsured persons increases.

CATHOLIC HEALTH MINISTRY'S VISION FOR THE INTEGRATED DELIVERY NETWORK

51 HMOs LICENSED IN 32 STATES COVERING MILLIONS OF LIVES

CHA member-affiliated HMOs by state



From CHA's *1996 Profile of Catholic Healthcare*; includes HMOs in which the Catholic organization has a minority ownership.

• "We have the potential to develop partnerships with health and social service agencies, many within the Catholic community. We have the largest private social service delivery system in the United States—it's called Catholic Charities."

• Opportunities for linkages outside traditional healthcare also abound. Catholic healthcare organizations have the potential to partner with 20,000 parishes nationwide and the largest private elementary and secondary education system in the United States to create parish and school health programs. Such programs can be used as a base for providing services to the larger community.

Capitalizing on Integration's Promise

In spite of the dramatic changes that Pajka predicted, Catholic healthcare organizations will achieve economic viability, Cox said. Integration of services will lead to more prudent use of resources and healthier communities, making it possible for providers to free up resources for other community healthcare needs.

Making this scenario reality will require size. "In markets characterized by overcapacity, it will be critical to collaborate with one another and with non-Catholic healthcare organizations whose values are compatible with ours in order to develop a mass in that market that requires us to be dealt with," Cox insisted.

"Insurance" expertise and experience—the ability to manage the health of a population within a fixed budget—will be critical. Many Catholic organizations are developing this experience. As an example, Cox noted the growing participation of Catholic providers in HMO ownership and management (see **Map**). Catholic healthcare organizations do not necessarily have to become insurers, he continued, but to remain single-service care providers is no longer viable in many markets. They must get experience in coordinating care across multiple settings and in working with insurers to assume some risk, he said.

"To survive in this environment, every healthcare executive, board, and sponsoring group is going to need to give serious thought to how their organization is positioned in the community."

— **William J. Cox**

How to Meet Strategic Challenges

Cox recommended that every organization create a strategic plan that recognizes what the organization has to do to survive as a Catholic entity in the new environment. But he emphasized that Catholic healthcare organizations face "a set of strategic challenges that are common to the entire ministry" and must learn from each other.

Noting that this is the first time a ministry of the Catholic Church has had to survive in a price-competitive environment, Cox said the CHA 1996-97 Strategic Plan identifies six areas that pose strategic challenges for the ministry (see **Box**). He described a CHA research project that will address the first—markets. CHA will develop a set of best practices for developing physician relationships, linking with other health providers, linking with nonhealth entities, and managing the capitation revenue stream. Much of the information from the research will be available at CHA's assembly in Chicago in June 1997.

"We ignore market pressures at our peril," Cox said. "To survive in this environment, every healthcare executive, board, and sponsoring group is going to need to give serious thought to how their organization is positioned in the community."

Values: Advancing the Ministry

Cox believes that because Catholic healthcare organizations want to advance the ministry, not merely survive, they must look at their market goals through the prism of Catholic ministry values and develop values-based strategies to help them shape local markets and national healthcare policy. He said these strategies must help them perform at a high level with respect to price and quality while ensuring ethical integrity. "By developing values-based strategies, we have the potential to move into the next century with our mission intact as our foundation."

CHA'S 1996-97 STRATEGIC PLAN

Projects and services in the association's strategic plan are designed to address six challenges confronting the ministry.

Markets

1. Demonstrate successful market strategies for integrated delivery informed and driven by ministry values.

2. Promote regional and national collaborative strategies for optimizing collective ministry strengths.

Partnerships

3. Provide guidance and innovative models for reinforcing ministry presence and ethical integrity in other-than-Catholic partnerships.

Care Continuum

4. Demonstrate methods for building on ministry strengths and traditions to develop a coordinated care continuum.

Sponsorship

5. Foster advanced forms of sponsorship to meet future ministry needs and market challenges.

Leadership

6. Work with members to prepare executives and sponsors for their leadership role in sustaining a vibrant ministry.

Public Policy

7. Strengthen the ministry voice for public policy.

For more detail, see the complete strategic plan in the November-December 1996 issue of *Health Progress*.

RISK CONTRACTING: OPERATIONS ROOTED IN VALUES

If current proposals become law, providers may be able to form provider-sponsored networks or integrated delivery systems that contract directly with Medicare to assume full risk for a patient population. Providers involved in such networks have the responsibility to set the standards of care, said Cathy Sullivan Clark, vice president, Jennings Ryan & Kolb.

Medicare managed care offers healthcare providers the opportunity to address many problems that the system currently fails to handle.

— Cathy Sullivan Clark

Care for Medicare patients involves considering their special needs and behaviors, she said. Medicare patients typically have an "urgent-emergent care" mind-set, Clark said. Elderly people often do not call a doctor until they are seriously ill, and they usually have significant "hidden" problems because they do not receive routine care. She said this raises an ethical issue: "You may uncover more costly conditions if you look."

Addressing New Issues

Medicare managed care offers healthcare providers the opportunity to address many problems that the system currently fails to handle, Clark pointed out. These include poor drug compliance, inadequate family support systems, transportation constraints, and the clinical and social issues surrounding chronic disease. Providers, she insisted, have responsibility to set standards of care.

SUCCESSFULLY MANAGING MEDICARE RISK

Cathy Sullivan Clark advised providers to understand 10 key points as they enter into Medicare managed care arrangements:

- Good management of commercial risk does not mean success with managed Medicare.
- A health assessment of all enrollees (after enrollment) is critical to managing care effectively.
- A full complement of ancillary providers must be in place.
- The panel should include gerontologists.
- Social workers must be used in the care management process.
- Specific clinical pathways should be in place for high-impact diagnoses.
- Physician assistants and nurse clinicians should be used when appropriate.
- Pharmacy management protocols must be implemented.
- Significant investments should be made in demand management.
- Information systems must be in place.

Adapted from Towers Perrin

Comprehensive Services

A Medicare managed care contractor must be prepared to provide services that are more comprehensive than those normally offered to a commercial population, Clark said. "You absolutely need hospice and skilled nursing facilities." She advised managed care contractors to plan how they will provide the three different kinds of care required by patients:

• Demand management and prevention programs for healthy patients

• Care pathways for patients needing episodic acute care

• Case management programs to provide a continuum of care for high-risk and high-cost chronically ill patients

In a seamless continuum, people who either use or provide care recognize the care as part of a system; information systems communicate with each other across all areas; and protocols are in place for all care, not just acute, Clark said.

MANAGED CARE'S ETHICAL POTENTIAL

Neale

As Cathy Sullivan Clark presented strategic guidelines for providers involved in risk contracting, CHA ethicist Ann Neale, PhD, provided an ethical framework for leaders. She said managed care arrangements hold great promise for making our healthcare system more just, accountable, and high quality than it is now. Managed care has the potential to serve the mission of the Catholic health ministry by requiring providers to develop a community-based focus on wellness, continuity of patient service, and more just relationships between patients and clinicians and healthcare institutions, she said. She warned, however, that "we have the potential to betray our mission" if cost efficiency and productivity are seen, not as means to serve the mission, but as ends in themselves.

"We have the potential to betray our mission" if cost efficiency and productivity are seen, not as means to serve the mission, but as ends in themselves.

— **Ann Neale, PhD**

In risk contracting, she said, executives in Catholic healthcare must make ethical decisions regarding:

• Selection of the population the managed care entity covers (avoiding "cream skimming" techniques that jettison sicker patients)

• Organizations included in the network (avoiding networks that include only providers in areas with relatively well populations)

• Utilization control and quality assurance (investigating how utilization review is conducted throughout the HMO and whether physicians are involved in the negotiations)

• Shared decision making, so that the HMO's financial interests do not override the interests of network members

• Ways of meeting the special needs of the elderly, such as transportation and bereavement counseling

• Benefits the managed care entity offers (e.g., mental healthcare, prescriptions)

• Community benefit activities the HMO undertakes

To discern whether a proposed arrangement is morally acceptable, she advised decision makers to ask, Would we ourselves enroll in this managed care plan?

WILL MEDICAID RESTRUCTURING BENEFIT THE POOR?

Medicaid managed care is exploding in state after state—and that can be either good news or bad news, according to Joel Menges, vice president of the managed care practice group of the Lewin Group. Savings achieved by managing the care of the Medicaid population could be "recycled" to improve access to healthcare for the poor, Menges said. "Medicaid managed care can create a system out of a nonsystem and try to mainstream the Medicaid population," which often has difficulty gaining access to the most basic services, he added.

"Medicaid managed care can create a system out of a nonsystem and try to mainstream the Medicaid population."

— **Joel Menges**

On the other hand, Medicaid managed care could strip away funds that providers are using to subsidize care for the uninsured. "It's really not clear yet whether Medicaid managed care is going to make it easier for uninsured folks to get coverage or harder for uninsured folks to find a provider who will take them," Menges said.

Whether Medicaid managed care benefits or hurts the poor, Menges said, depends on how aggressive the state is in emphasizing quality, as opposed to cost savings, through carefully certifying the health plans involved and assuming a meaningful oversight role. Advocacy efforts by Catholic healthcare providers can influence the state's establishment and enforcement of fair and equitable Medicaid policies, he noted.

Three Program Choices

Hospitals establishing Medicaid managed care programs have three basic choices, which can be used alone or in combination, Menges said:

- Participate in multiple HMO networks on a fee-for-service basis
- Contract on an at-risk basis with one or more HMOs (through a physician-hospital organization [PHO] vehicle or by "renting" an HMO license)
- Own and operate a health plan

The decision rests on where on the "continuum of risk" you want to be, Menges advised (see **Box**). Each option has its advantages and disadvantages. For example, contracting with HMOs as a fee-for-service provider would be less threatening to the HMOs—the hospital's major clients—than the other options, but the hospital still needs to work hard to ensure it gets referrals from primary and specialty physicians, he said.

In capitated PHOs, on the other hand, providers have more direct access to patients and revenue, Menges continued, but they still take on substantial risk, since service volume can be hard to predict and control and Medicaid managed care plans have a certain amount of "leakage" to other providers.

Owning and operating its own health plan puts a provider in the "driver's seat position," with control over provider payment incentives, policies, and programs, Menges said. This can enable a Catholic provider to carry out its mission in new ways, such as opening a clinic in an inner-city area or providing transportation services to the elderly. The initial capital outlays can be reduced by forming partnerships with other providers and contracting out some administrative functions, at least initially, Menges advised.

Illinois Medicaid Program

Managed care represents a "quantum leap" in how Medicaid beneficiaries obtain access to healthcare, how providers interact with the program, how healthcare is paid for, and how healthcare is delivered, according to Linda Renée Baker. Illinois is preparing to take that leap in introducing MediPlan Plus, a Medicaid managed care program, said

Baker, who is assistant director of the state's Department of Public Aid. Baker said that 180,000 persons (41 percent of all Medicaid clients) are currently enrolled in a voluntary HMO program in Cook County. Clients in the Cook County HMO can enroll or disenroll at will, but the new statewide program will lock clients in for 12 months (although they can leave the program for cause).

MediPlan Plus will begin provider procurement in February 1997, client education and enrollment in August, and coverage in November. "Timing is everything in terms of trying to ensure that your clients have the information they need," Baker said. "You don't want to assign clients to a plan without thorough information about it." Baker said that the current program in Cook County contracts with two community-based organizations, which send a staff member to each of the 85 public aid offices in the county to explain the options available to clients. MediPlan Plus will feature a similar education and outreach program. And, beginning in spring of 1997, Illinois will ban door-to-door marketing in order to prevent unscrupulous firms from taking advantage of Medicaid clients, she said.

Those enrolled in MediPlan Plus will have two basic service delivery choices: a managed care entity or an enrolled managed care provider. The requirements and characteristics of each differ, allowing a variety of providers with differing levels of managed care experience to participate from the beginning, Baker said.

New Ethical Questions

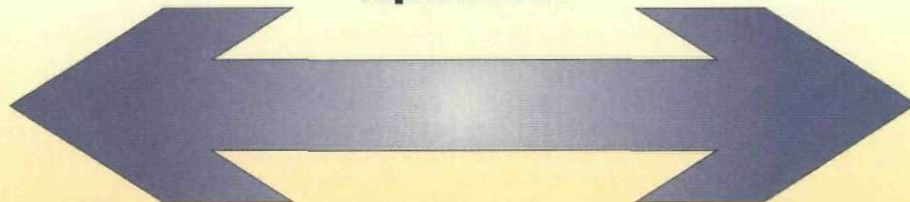
Enrollment procedures are just one of the areas requiring ethical scrutiny, according to Thomas F. Schindler, director of ethics in the office of mission services for Mercy Health Services, Farmington

> *"Timing is everything in terms of trying to ensure that your clients have the information they need."*
>
> **— Linda Renée Baker**

Hills, MI. Schindler cautioned that Catholic providers entering the managed care arena need to look beyond traditional ethical concerns. Although obstetric issues (such as abortion and sterilization) are important, Schindler said, Catholic providers also need to examine ethical questions involving enrollment procedures, marketing, the stability of the physician-patient relationship, how physician incentives affect care, and community service. The bottom line, Shindler said, is, "Is this a way to make sure basic healthcare is available to everybody?"

CONTINUUM OF RISK

Capitated PHO



Fee-for-Service Provider

- Nonthreatening to HMOs
- Little risk, little capital required
- Not saddled with burdens of "becoming a payer"
- Little internal restructuring

Full-Risk Health Plan

- Control over patient care and outreach programs, policies
- *More direct access to patients,* revenue stream
- Fosters integrated system

MANAGED CARE NETWORKS DIFFICULT BUT ESSENTIAL

As managed care continues its inexorable growth across the nation, many Catholic providers are building regional networks so they can compete. "Network development is extremely difficult, but giving up in frustration is not an option," Robert Pezzoli said.

Baltimore-Area Network

Pezzoli, who is president/CEO of St. Agnes HealthCare, Baltimore, described the development of Maryland Health Network, a regional vehicle that negotiates contracts with managed care firms and establishes networkwide systems, such as case management structures, practice guidelines, and a decentralized information system. PHOs (established by each network member) "are responsible for implementing all those activities and feeding the information back into the systems that have been built by the network in order to assist the providers in managing the care," Pezzoli said.

They have found it very "difficult to think like a system, to act like a system, to operate across the system."

— **Robert Pezzoli**

The network, which encompasses two Catholic and three non-Catholic hospitals in the Baltimore area, "had great expectations but only moderate success in the first year," Pezzoli noted. The hospitals spent a lot of time building the infrastructure but have found it hard to attract local physicians for network integration, Pezzoli said. In addition, they have found it "very difficult to think like a system, to act like a system, to operate across the system instead of having competition between the components."

New York Network

Another promising venture involves Catholic hospitals throughout New York State. Like all such efforts, it has had its difficulties in trying to tie together disparate organizations. Mary Healey-

COMMUNICATION KEY TO SUCCESSFUL JOINT SPONSORSHIP

As they plan collaborative activities with one another, sponsors must communicate with each other, not leave the discussion to managers. Sponsor-to-sponsor conversations must both parallel and accompany those of managers. If sponsors give the necessary time to meetings and discussions, and keep them focused on the intent and purpose of the collaboration, their efforts will likely succeed. These were the messages of experienced sponsors at a session on joint sponsorship of organizations and networks.

Communication is necessary, not only to iron out business details, but also to help sponsors deal with fears and concerns as their ministry, to which they have deep emotional ties, changes, said Sr. Felice Sauers, RSM, and Sr. Eileen Kenny, DC. Sr. Sauers, a member of the leadership team of the Sisters of Mercy regional community in Burlingame, CA, and Sr. Kenny described their experiences when the Daughters of Charity–West Province transferred its healthcare facilities to Catholic Healthcare West, San Francisco, during Sr. Kenny's term on the

Sr. Sauers

Sedutto, PhD, executive director/CEO of the Catholic Health Care Network of New York, said that the organization's statewide Medicaid managed care plan was designed to include all 42 Catholic hospitals in the state, offering a variety of risk options to enable everyone to participate.

"It was imperative to have a statewide initiative," she explained, "because those areas that did not have any Catholic opportunities were finding themselves literally at the mercy of the for-profit plans," which were enrolling the Catholic facilities' patients and then sending them to the hospitals at significant discounts.

In planning the network, however, developers failed to take into account the differences in sponsorship, with downstate hospitals being largely diocesan sponsored and upstate hospitals sponsored by congregations, Healey-Sedutto said. She explained: "We very myopically began this whole push with the ordinaries" and did not consult congregational leaders until later. Healey-Sedutto advised healthcare leaders to involve an objective outsider who could think in terms of the entire state, not just his or her region. (A detailed account of the network's development will appear in the March-April issue of *Health Progress*.)

Process for Collaboration

David Schopp, executive director of the Catholic Managed Care Consortium in St. Louis, described a more deliberative process he has been using in working with Catholic hospitals in two states to identify and select collaborative initiatives in managed care. The two-part process includes collecting data, establishing criteria to evaluate potential opportunities, and agreeing on which one to pursue.

"Those areas that did not have any Catholic opportunities were finding themselves literally at the mercy of the for-profit plans."

— Mary Healey-Sedutto, PhD

Schopp advised that providers look not just at market opportunities but also at relationship issues, such as the motivation and urgency behind the desire to collaborate, trust between the parties, willingness to share risk, and willingness to contribute capital. "You have to make sure it's 'saleable,' that somebody's going to buy it," he said, "but you also have to make sure that you're not going to waste time building something that's not going to come off."

He warned against focusing exclusively on creating products such as a Catholic HMO. The danger, Schopp said, is that the potential partners may conclude that the product will not sell and walk away from the table without pursuing other collaborative activities that would support their ministries.

"You have to make sure you're not going to waste time building something that's not going to come off."

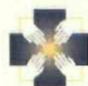
— David Schopp

Sr. Kenny

provincial council for the West Province of the Daughters of Charity National Health System. "It is a leadership task to get commitment and build buy-in by CEOs and employees," said Sr. Kenny. Sr. Sauers advised sponsors to "stay aware of the big picture" of what is happening in their region and act before they are in danger of losing their ministry.

Sr. Bea Eichten, OSF, who facilitated the session, added that it is best for sponsors to make affiliation decisions while their organizations are strong rather than waiting till they have to have a "fire sale." Sr. Eichten, who is a consultant for organizational life in Park Ridge, IL, and is assisting some Catholic hospitals in southern California with cosponsorship arrangements, advised sponsors to be willing to let go of control and focus on what is best for the people they serve.

Sr. Eichten



PREPARING FOR LIKELY CONGRESSIONAL ACTIONS

In her opening address, Sr. Jean deBlois (see p. 18) noted that mission calls Catholic providers to influence healthcare delivery through public policy as well as through operations. To help participants understand the public policy environment, Michael M. Hash, principal with the consulting firm Health Policy Alternatives, Washington, DC, reviewed issues Congress will address in 1997, as well as CHA's planned strategies related to them. He asked attendees to send feedback on CHA's proposed activities to CHA's Washington staff.

"Congress will consider ways to reduce Medicare expenditures—particularly hospital spending—in order to balance the federal budget."

— Michael M. Hash

Medicare Budget Proposals

"Congress will consider ways to reduce Medicare expenditures—particularly hospital spending—in order to balance the federal budget and extend the life of the Medicare Hospital Insurance trust fund," Hash said. Among short-term options Congress will consider are cuts in payments to hospitals for operating and capital expenses and graduate medical education. Disproportionate-share hospitals, which serve large numbers of poor and disadvantaged, will likely see payments cut also, as will some physicians, he said.

Hash said other short-term options include extending the prospective payment system to hospital outpatient services, skilled nursing facilities, home health agencies, and rehabilitation and long-term care hospitals; expanding managed care; and modestly increasing beneficiaries' participation. A "wild card" to keep an eye on is the growing interest in placing a cap on Medicare spending to make the annual budget more predictable, he said.

CHA plans to advance its *Responsible Balanced Budget* (*RRB*), an example of how to eliminate the federal deficit without imposing large cuts on Medicare and Medicaid. The *RRB* rejects tax cuts, spreads the pain of deficit reduction across the board, and supports Medicare reforms.

To provide feedback to CHA on its strategies or to obtain more information on CHA's *Responsible Balanced Budget* or other concepts mentioned here, contact CHA's Washington office at 202-296-3993.

Medicare Managed Care Concerns

Options for improving the payment methodology for Medicare HMOs are also being considered, Hash noted. Changes are needed to correct wide variations across the country in the adjusted average per capita cost (AAPCC) payments to HMOs in different counties. Hash said ideas include setting a payment floor; replacing the AAPCC with a blended rate, made up of a national average rate plus an area rate; and paying directly for graduate medical education and disproportionate-share services.

CHA supports payment equity and predictability and measures to provide transitional relief for HMOs whose payments would be cut under the new system. CHA also proposes to support paying teaching and disproportionate-share hospitals directly for each plan enrollee.

Provider-sponsored Organizations (PSOs)

Employers are contracting directly with integrated delivery networks, a trend Hash sees as an analogy

for the Medicare program. He said Catholic providers are accepted in their communities and could become full-fledged health plans if Medicare allows them to contract for its beneficiaries.

CHA supports reasonable payment standards for PSOs, an equitable regulatory structure (e.g., licensing and marketing requirements), and outcome reporting.

Coverage for the Uninsured

Hash predicted a rise in the number of uninsured in the United States from about 41 million in 1996 to almost 45.5 million in 2002. "There's some commitment in Congress to fix some of the problem," he said. Reform proposals generally lean toward making coverage available rather than free. Other ideas include mandating children's benefits in private plans, subsidizing premiums for children and the unemployed, and expanding Medicaid eligibility.

In response to this critical need, CHA will support federal legislative efforts this year to expand coverage, particularly for vulnerable groups such as low-income children.

—Judy Cassidy and Susan K. Hume

STEPS TO A STRONGER MINISTRY

Meeting participants identified the following steps organizations can take to strengthen the Catholic health ministry and influence care.

Collaboration

- Work with others to jointly develop values-based HMOs for areas currently lacking a managed care option.
- Share experiences with other providers.
- Take the initiative to create healthy community partnerships (e.g., shared support of an outreach worker serving the poor and underserved; research on health promotion, alternative treatments, and illness prevention).
- Collaborate on a statewide basis.
- Bring other systems and organizations together; work to bridge cultures as different organizations come together.
- Work with other-than-Catholic organizations.

Ethics

- Articulate and promote ethical guidelines for care.
- Hold the organization and its partners accountable for Catholic values.

Education

- Educate the community, consumers, boards, partners, and bishops.
- Be a voice to the external world; publicize your learnings and struggles.
- Explore and share information on varied forms of collaboration short of mergers.

Organizational Strategies

- Develop a strategic plan specific to managed care and share this with other Catholic healthcare organizations.
- Identify big-ticket investments (e.g., development of software for information systems) that could be shared.
- Experiment with risk sharing.
- Establish best practices for patient management.

Advocacy

- Influence statewide quality standards and service requirements for Medicaid managed care.
- Build advocacy coalitions with Catholic Charities and other organizations.
- Work with boards to obtain their commitment to advocacy positions.