

The BBA's Challenge to Mission-Driven Hospitals

BY REV. MICHAEL D. PLACE, STD

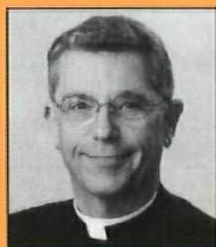
The last decade of the 20th century opened with the promise of hope that our citizens would finally gain access to a seamless continuum of healthcare delivered through community-based institutions. As the decade closed, we found that universal coverage remained just a hope and that mission-driven community healthcare providers are themselves more fundamentally challenged than at any time since the Great Depression. These challenges are testing the ability of not-for-profit, mission-driven providers to deliver to their communities a continuum of healthcare; in some cases even their ability to survive is threatened.

Today's community healthcare providers are struggling with a host of factors that, together, have the potential to debilitate mission-driven healthcare. I refer to the managed care phenomenon, the growing numbers of uninsured, the increasing tendency to treat healthcare as a commodity, and the decline of government support for social services and healthcare in particular. The most recent example of this last trend is the Balanced Budget Act of 1997 (BBA), whose impact has been so onerous that last November Congress and the administration took action to limit some of the damage. Although this was a step in the right direction, the debate over the BBA and its impact serves to remind us once again that this nation lacks a true health policy; legislative decisions are primarily budget driven.

I want to explore here the distinctive qualities of community-based, mission-driven healthcare organizations, including Catholic providers. I then want to consider how these mission-driven providers can respond to private and public policies that reduce resources. Finally, I will reflect on what these observations tell us about the delivery of community healthcare and the role of mission-driven providers in the new millennium.

THE MEANING OF MISSION

The concept of mission is central to the identity of not-for-profit healthcare and similar organiza-



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tions in the "voluntary sector" of U.S. society. In the words of David Seay and Bruce Vladeck, mission "refers to the philosophical tenets that underlie an institution's commitment to serve." To this I would add, "religious" and philosophical tenets.

Service is the source, cause, and goal of mission and mission-driven organizations. For such institutions, service is the means and the end. Ultimately, this is what sets them apart from other organizations whose origins are commercial in nature. While these commercial entities often have a stated mission, I believe that, in general, it would be more accurate to say they have a purpose. For these commercial entities, service is a means to an end—that is, a financial return to the owners or shareholders—rather than an end in itself.

Thus, it is this mission to improve the human condition which characterizes not-for-profit healthcare and sets it apart from business organizations whose primary purpose is ensuring a reasonable return to stockholders. Rather than evaluate options and strategies in terms of the impact on stockholders, a properly focused not-for-profit healthcare organization asks what is best for the patient, for the community, and for the continued availability of services in the community.

Healthcare thrives in the not-for-profit mission-driven environment because it is one of those goods that, in the late Cardinal Joseph Bernardin's words, "are not and cannot be mere commodities." Cardinal Bernardin suggested four characteristics of healthcare delivery that are best served by not-for-profit institutions (see *Celebrating the Ministry of Healing: Joseph Cardinal Bernardin's Reflections on Healthcare*, Catholic Health Association, St. Louis, 1999):

- *Access to healthcare.* Since we have not yet succeeded in our efforts to achieve universal access, meeting this requirement falls on healthcare providers—particularly not-for-profits—and their communities.

- *A patient-first ethic.* As payment systems

shift the financial risk in healthcare from payers to providers, the issue of who is the patient's advocate has become critical. Not-for-profits have an advantage in not having to cope with the additional pressure of generating returns to investors.

- *Community commitment.* Some healthcare services, such as burn units, neonatal intensive care, and immunization programs, are not necessarily profitable. Communities, however, need such services, and not-for-profits are more likely to provide them in spite of the economic impact on the institution. These institutions are also more likely to remain in communities, in good times and bad, providing needed services and reaffirming the significance of the community.

- *Volunteerism and philanthropy.* Not-for-profit healthcare promotes these values, which are essential to strong communities and to the interlocking relationships between communities and providers.

Faith-based institutions add a further dimension to their mission. For these institutions, service to fulfill the needs of their communities is also fulfillment of their own religious commitment. Through the service they provide, they actualize the faith that is at the basis of their mission.

The mission of a Catholic healthcare organization in its community, articulated in different ways for different organizations, generally reflects a ministry commitment to patient and community needs with a special emphasis on the poor and vulnerable. In this sense, mission undergirds a set of services and activities in a given community.

The fact that the mission for a Catholic healthcare organization comes ultimately from the mission of Jesus and the church's ministry provides meaning and, I believe, a special energy to Catholic healthcare. An organizational mission tied to community service that flows from this special understanding of mission becomes a potent force for strength and direction in a time of turbulent change.

MISSION UNDER SIEGE

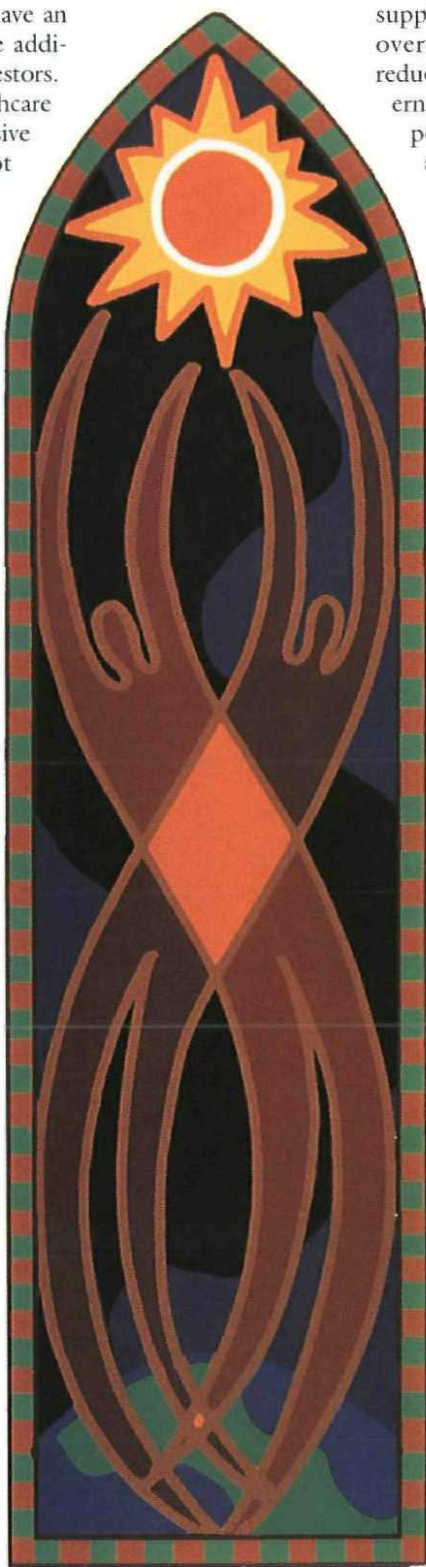
As we step into the next century, mission-driven not-for-profit healthcare

providers face daunting challenges. One critical challenge is that of the marketplace. An excess supply of hospital beds and, in many areas, an oversupply of physicians, coupled with cost-reduction efforts by employers, insurers, and government, have resulted in not-for-profits competing for paying patients with one another and with for-profits. In this environment, not-for-profit institutions put themselves at risk of sacrificing their fundamental mission, abandoning their traditional role as safety-net providers, participating in the commercialization of healthcare, and eroding the patient-first ethic.

A second challenge is the continuing erosion of existing government-sponsored health and social welfare programs. In some cases, the withdrawal of support is dramatic and controversial, as in the adoption of welfare "reform" or in the stunning reductions contained in the BBA. In other cases the erosion is more insidious, resulting from forces like the inexorable action of federal budget caps that provide for less spending on domestic programs in 2002 than was actually spent in 1999. The effect is to further unravel communities' fabric of social support and shift what should be public responsibilities to not-for-profit organizations that themselves are targets of budget reductions.

A third challenge is our continuing failure as a society to ensure universal access to healthcare. This national policy—for it is indeed a conscious public policy—is an affront to human dignity and social justice. It is not only offensive to human values, but it is adding to the burdens of not-for-profit healthcare providers that, by default, must underwrite the cost of uncompensated care or shift that cost to others. The problem of the uninsured continues to worsen, even in this era of unprecedented economic growth.

But external challenges are not the only challenges facing mission-driven providers. One internal challenge is the gradual distancing of many not-for-profit healthcare institutions from their original founding organizations and their philanthropic purposes. Many hospitals, nursing homes, and other institutions have lost their connection to religious, fraternal, and charitable organizations



and ideals. For such institutions, mission can become merely window-dressing rather than a vital, informing core of their organizational culture. As a result, they risk becoming indistinguishable from the for-profit entities with which they compete.

As the same time the bonds between not-for-profit institutions and their communities have become stretched as institutions increasingly look to networks, joint ventures, and purchasing groups as their organizational reference points. Though partly a response to marketplace pressures, it can also be a symptom of an organization's loss of connection to the community and its unique needs.

THE BBA CHALLENGE

In light of these external and internal pressures, public policy challenges facing mission-driven providers can be even more acute. One example is the BBA. It is instructive that, for the past two decades, virtually every new Medicare or Medicaid policy has been adopted as part of a budget bill. Last month, Congress and the administration took steps to postpone or reduce some of the worst effects of this legislation, but it is fair to ask, How did such a situation come to pass in the first place? How could Congress adopt a bill that inadvertently cut nearly twice as much spending from the Medicare program as was originally estimated—\$200 billion over five years instead of \$112 billion? The answer is that we live in an era of budget-driven healthcare policy. If left uncorrected, the BBA would have cut funding for America's hospitals by more than \$70 billion over five years and cut funding for home healthcare by \$5.5 billion. Even with the changes in the recently adopted BBA relief legislation, healthcare providers still face unprecedented payment reductions.

As disturbing as the *size* of the spending cuts is the *choice* of targets and their unintended consequences. One example will make this clear. A new "transfer policy" contained in the BBA financially *penalized* hospitals that discharge certain patients from inpatient to subacute care, such as skilled nursing. At the same time, the act reduced payments to skilled nursing facilities for the care of medically complex cases. The result? Through these perverse financial incentives, hospitals—arguably the worst environment for recovering frail elderly—were encouraged to keep patients longer than necessary, while nursing homes have a financial incentive to avoid accepting patients who can benefit from their services. Instead of a continuum of care, the BBA created a chasm. While the BBA

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relief package delays expansion of the new transfer policy and improves payments to nursing homes, the fundamental policy issues remain.

If there were any remaining doubt as to the impact of this legislation on healthcare providers, surely it was put to rest by the finding that in fiscal 1999, for the first time in the history of the program, Medicare spending actually dropped, despite an increase in the number of beneficiaries.

MISSION IN ACTION

How can mission-driven providers respond to such challenges? I suggest that mission-driven responses fall into two categories: adapt and advocate.

Adaptation is what comes naturally to us. We tighten our belts, figure out ways to do the same or more with less, find ways to carry on in spite of the worsening odds. Adapting flows from the nature of mission as we have described it. If an institution's *raison d'être* is service, if it is committed to its community for the long run, if it is serious about providing access to care, then it takes the steps necessary to fulfill its mission.

For example, in Carrington, ND, Catholic Health Initiatives (CHI) operates a community nursing home. To continue serving Carrington in spite of the BBA cuts, CHI is consolidating operations with nursing homes under other sponsorship in two neighboring communities. They have formed a single operating company with the goal of generating enough savings to keep all three facilities in service. In another case, however, BBA cuts have forced CHI to close down a home health program in Tacoma, WA, that was losing \$840,000 a year. Despite its commitment to providing a continuum of care in Tacoma, losses of this magnitude simply made the program untenable.

The second avenue of response is advocacy. For mission-driven institutions, adaptation and advocacy are complimentary, not alternative, modes of action. The concept of service includes advocating for changes in healthcare policy and on related issues that affect the lives of the people who are served.

It was such a sense of commitment to mission and advocacy that led to Mercy Medical's successful advocacy efforts in the BBA relief bill. Mercy Medical, which serves the greater Mobile, AL, area, specializes in providing intensive subacute services for the elderly, often returning patients to their homes or residential settings who otherwise would need extended hospital and nursing home stays.

Over the past year, Mercy Medical conducted a focused effort to educate and inspire administration officials and members of Congress about the services Mercy provides to special populations. These efforts included arranging on-site visits by top HCFA officials, a congressman, and a senator. Once they gained a personal understanding of Mercy Medical's mission and its importance, these officials were willing to help find a solution, which was ultimately incorporated in the BBA relief bill.

In terms of the overall legislation, the Catholic Health Association of the United States, working with the American Hospital Association and others, sponsored print and television ads on the adverse impact of the BBA on nursing facilities, hospitals, home care agencies, and their patients. We also encouraged our members to write and meet with members of Congress. In the end, I believe the effective communication of mission played a crucial role in the nearly unanimous vote for this legislation.

MISSION—IMPOSSIBLE?

Despite the catalog of challenges I have enumerated, I find myself hopeful, even optimistic, about the future. I do not underestimate the magnitude of the task that confronts mission-driven providers. It is clear that navigating the present perils requires a clear vision of mission and the vigorous application of that vision to programmatic and resource decisions.

The possibility of effective advocacy depends primarily on our fidelity to mission and the demonstrable public benefit of our policy goals. We cannot ignore "bottom line" concerns, but if we are limited by them, our potential to contribute to a true national healthcare policy will be diminished.

Mission-driven healthcare providers face a full and urgent advocacy agenda. Among the most pressing issues are:

- *Continuing the effort to reform the BBA.* The roughly \$20 billion in additional payments included in the BBA relief bill passed last November and related administrative actions represents less than 10 percent of the Medicare payment reductions that providers must cope with. With our entire healthcare system in deep financial trouble, threatening fundamental patient care, CHA strongly urges Congress to revisit this issue early in 2000.

- *Reforming Medicare.* The Medicare benefit package must be updated to reflect the current practice of medicine, which includes a greater

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reliance on prevention, prescription medications, and chronic care than was the case in the 1960s. Any changes in benefits must be balanced with the financial ability of Medicare to sustain these benefits over time. Financing of Medicare must be a shared societal responsibility and be adequate to ensure a strong program well into the future.

- *Expanding coverage for the uninsured.* CHA has promised to be the fingernail on the blackboard on this issue. We need to take a substantial, unequivocal step toward coverage of the 44 million uninsured. As we complete a decade of unparalleled sustained economic expansion, we must ask, If not now, when?

Despite these challenges, several recent events offer reasons for hope for the future of our healthcare system and of mission-driven healthcare:

- The passage of the BBA relief legislation. While more needs to be done, this is a significant first step.

- The attention given by Congress to patients' bill-of-rights legislation, perhaps indicating a shift toward a patients-first outlook.

- The announcement by the United Health Group, a major managed care organization, that it intends to return decision-making power over patient care to physicians.

- The growing attention to the problem of the uninsured by candidates for the 2000 presidential nomination.

- A resurgence of congressional interest in broadening healthcare coverage. A number of bills to increase access to health insurance have been introduced in the current Congress, many of which focus on using the tax system to support coverage.

- The Health Sector Assembly sponsored by the American Medical Association, which brought together more than 50 organizations representing physicians and other healthcare professionals, consumer groups, government, business, academia, and the insurance industry. The organizations agreed that the lack of adequate healthcare coverage must be addressed.

These and other signs offer hope that mission-driven healthcare will survive and even flourish in the new millennium. If this hope is fulfilled, it will be the result of the continued commitment of not-for-profit healthcare providers—hospitals, nursing homes, home health agencies, and other providers that honor their missions through adaptation and advocacy. □