Reimagining Catholic Health Care Beyond Hospital Walls

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For more than a century, one of the most prominent symbols of Catholic health care in the United States has been the Catholic community hospital, most often sponsored by a congregation of Catholic women religious. Health care is now a more than $3 trillion enterprise with many organizations vying to meet the needs of every imaginable patient condition. As health care has evolved, so too should its care and payment models.

As a result of the dual challenges of the ever-increasing complexity of health care delivery and the declining numbers of women religious, the congregations have evolved their organization models to fit the times. Early efforts in the 1970s and '80s saw a move toward creating systems of hospitals where expertise in the business of running hospitals could be concentrated among those with special knowledge in areas such as compliance, law, accounting, human resources, supply chain and revenue cycle. By 1990, the majority (nearly 75%) of Catholic hospitals belonged to just such a system.[1] In some cases, religious congregations sought to divest their ministries and turn them over to groups including lay leaders in the form of a public juridic person. The aim is to preserve a thriving Catholic health care ministry serving patients and their communities in the face of mounting challenges.

Until recent years, spending on hospital care was the largest segment of medical expenditures in the U.S. That is changing, however. Among many efforts to reduce the cost of medical care has been a move away from expensive inpatient care to outpatient and ambulatory sites of care. Today, most hospitals and systems derive well over 50% of their reimbursement from outpatient and ambulatory care.

One of the consequences of this evolution is that hospitals continue to close in the U.S., with Catholic hospitals among them. To avoid closure and create strong networks, some Catholic hospitals are choosing to merge their operations with non-Catholic systems, making it even more challenging to maintain their mission and identities. The future path for Catholic health care in the U.S. is far from certain given these factors. We believe that rooted in the rich history of vision, innovation and persistence demonstrated by congregations of women religious, there is another path forward to preserve and grow their ministries of caring for the most vulnerable.

A SHIFT TOWARD COST CONTROL

For years, hospitals have dealt with the shift from inpatient care to outpatient care, and from independent physician practices to integrated ambulatory clinics. These changes are primarily the result of advances in technology and the evolution of how sick care is paid for; as mentioned, most hospitals now generate the majority of their revenue from outpatient and ambulatory care. Nevertheless, this shift is only foreshadowing what is yet to come. For those working at the hospital operational level, the perception about these changes is linear, but for the industry the reality is exponential.

Government payers are unable to manage the

cost of care, and commercial payers will no longer tolerate cost shifting, whereby employers pay higher rates to make up the shortfall from government payers. The response from government payers is risk-based payment models, while the response from commercial payers is steering preauthorizations away from hospitals; tiering hospitals out of benefit plans; and vertical integration with ambulatory sites of service and employed physicians of their own. And yet hospitals still cling desperately to their declining market power and reliance on cost shifting to prop up their margins. This is about to change. In fact, the following examples demonstrate that this change may be at our doors.

It is well established that admissions per 1,000 population have, and will continue, to decline.

UnitedHealth Group, through its subsidiary Optum, has created the largest physician group in the country with more than 50,000 employed physicians.[2] Through its subsidiary, Surgical Care Affiliates, UnitedHealth Group is the third largest owner of ambulatory surgery centers in the United States.[3] All the major insurance carriers, as well as Medicare, first allowed and now sometimes insist that certain surgical procedures that once required an acute care admission be done at an ambulatory surgery center.

Furthermore, UnitedHealthcare, the insurance network of UnitedHealth Group, is rolling out a plan across the country to narrow coverage for imaging and laboratory services to providers it selects as Designated Diagnostic Providers. Not surprisingly, the primary criterion for inclusion by UnitedHealthcare appears to be cost.[4-6] Hospitals have traditionally used these high-margin ancillary services as part of their cost shifting strategy, but commercial payers are no longer willing to subsidize payment shortfalls from government payers, nor inefficient operations at some traditional sites of service.

Another insurance network, Anthem, started to cover a wide range of virtual provider visits to enable members to obtain basic care while minimizing the risk of COVID-19 transmission when the pandemic started in 2020. As the risk appeared to stabilize, Anthem discussed a continuation of virtual visits for its members, but only with specific physicians who are part of an Anthem-sponsored care team.

These strategies to control costs by controlling sites of service and limiting the number of enrolled providers have proven effective in generating profits for commercial payers. The tactics are relatively easy to implement and don't require substantial capital or long lead times. Mostly through the use of technology, data and unilateral policy changes, commercial carriers can buy high-margin ancillary and specialty services at a much lower cost.

It is worth noting that the impact of the COVID-19 pandemic has done little to alter these macro trends. Although COVID hospitalizations have gone up in most hospitals, non-COVID hospitalizations have been reduced, in some regions of the country quite dramatically.[7] In addition, in the early days of the pandemic there was a dramatic uptake in the use of telehealth technology. While that utilization has fallen as well, it is still above levels dating before the pandemic.

Hospital systems increasingly will be left with hospitals that provide high-acuity, high-cost, low-margin care services and clinic practices that require ongoing subsidies because of the shortfall between high physician salaries and low reimbursement for physician fees. This dynamic is well understood and deals mostly with the disintegration of the hospital's traditionally bundled service model, and the collapse of cost shifting as a funding mechanism for health care.

Another less well-recognized aspect of the pending collapse of the traditional hospital system is the ongoing but increasingly rapid decline in the demand for acute care services. It is well established that admissions per 1,000 population have, and will continue, to decline.[8] What we may not currently see is the growing effect that technology and data will have on the management and even prevention of chronic illness, as well as a network of early intervention that will avoid the need for hospitalization in many patients.

The cumulative effect will mean patients with less acute needs may be cared for with resources outside of hospital systems, and patients with higher acuity needs will be fewer in number. And because the forces driving this change rely on technology and data, while we perceive the pace of this change to be linear, it is in fact exponential.[9,10] Within a decade, the inpatient tower of the typical community hospital may be mostly empty and largely irrelevant to the delivery of health

care in many communities.

Many hospital systems, especially those in isolated, rural areas that have relied on the hospital to be not only the hub of health care but the economic engine of the community, are at risk of closing. In communities where that care is provided by a Catholic hospital, there is a danger that the ministry will not be able to offer services to those who need them. Is there another path forward?

In service to their mission, congregations of women religious have a track record of being creative about ways in which they delivered and paid for care to meet community needs. It seems regrettable to us that the closure of Catholic hospitals has often resulted from a failed effort to reimagine the mission and to continue serving community needs.

Fortunately, we live in a time of unparalleled innovation in both the development of digital technology and the application of data science in health care. We believe the judicious adoption of these technologies can allow Catholic health care to not only survive, but thrive, in changing, uncertain times.

BACK TO THE FUTURE

The irony is not lost on us that many Catholic ministries began serving patients and their families one at a time in their homes. Sisters would go house to house ministering to patients' health needs using the tools and techniques of the time.

As the ministries grew under the sisters' leadership, additional hospitals were built as a more efficient way to care for patients. Fast forward to the 1990s and early 2000s, and as reimbursement changed to make home care less profitable, many systems dropped their home care programs or sold these services to competitors.

Today, with the advancement of home therapies and the use of digital communication and monitoring technology, home care has evolved into a viable and growing way to serve patients more effectively and efficiently — and to do so profitably.

Catholic hospital systems that have maintained their home care services should use them to adopt the safest, most reliable disease management programs. To differentiate themselves as Catholic, however, they need to reimagine how faith-based care can be delivered using this technology. This can serve as a gift to homebound patients to have their spirits nurtured at the same time that their bodies are being cared for. The treatment options for in-home care have expanded so much that there are even demonstration projects to determine the viability of at-home hospital care.[11, 12]

Could Catholic hospital systems in small or struggling markets look to pivot their declining resources and care for patients more aggressively in their homes or nursing homes and look to reduce the overhead and expense of their hospitals? We think the answer is yes.

It also helps that during the pandemic, the Centers for Medicare & Medicaid Services expanded payments for conditions that can be treated through telehealth, which is quickly evolving to be so much more than one practitioner speaking to one patient remotely. New technology allows us to monitor patients with chronic conditions in their homes, transmitting real-time data to their providers who can monitor and respond immediately.

Technology-assisted home and nursing home care is a rapidly growing segment of the health care market that we believe offers a viable alternative, especially for small rural health care ministries, to realign their resources. This would shift from supporting expensive and inefficient hospital care to a contemporary care model based on patients remaining in their own homes and leveraging currently available technology to maintain Catholic ministries.

In addition to reimagining how and where healing is provided to remain relevant, hospital systems must embrace change in how health care is paid for. Any payment method that charges payers (government, commercial or patients) based on how much work was done and the complexity/cost of that work will inevitably either fail altogether or, at best, relegate hospital systems to the role of commodity supplier of a narrow subset of services in the overall health care industry.

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The alternative is for Catholic health care to step out of the hospital and go to those in need of a ministry of wellness — in body, mind and spirit.

Done well, this notion of health care outreach is exactly what is required to succeed in population health. A ministry of healing that reaches out into the community, rather than wait for the patient to come to us, could improve the individual experience of care, improve the health of populations and reduce the per capita costs of care.[13,14]

This change, however, also requires a shift in how Catholic hospital systems get paid. If we are going to put resources into keeping people healthy, we need to generate revenue from lower hospital utilization. Who profits from lower hospital utilization? Commercial insurance, that's who.

The hope has been that through the formation of Accountable Care Organizations (ACOs), hospital systems might get paid for value in the Medicare Shared Savings Program (MSSP). Nevertheless, various program design flaws and selective participation have created relatively few innovations in the MSSP.[15] We seem now to be evolving beyond the ACO to Value Based Enterprises (VBEs) that will further eliminate barriers to innovation. But there remains no clear path for hospital systems to monetize quality and get paid for preventing illness — at least not at levels that offset the loss of revenue from simply focusing on efficiently caring for those who are sick.

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EXPLORING A MEDICARE ADVANTAGE STRATEGY

One strategy for hospital systems to be financially viable while shifting the focus of Catholic ministries is to adopt the strategies of national commercial insurance networks. The fastest growing and often most profitable line of commercial health insurance is Medicare Advantage.[16-18] This privatization of Medicare offers unique opportunities for hospital systems, especially integrated ones in rural markets with at least a few hundred million dollars in net revenue annually.

We do not, however, think hospital systems should rush to their state regulators to become licensed insurance companies. The industry tried that before, and many systems failed. Instead, integrated hospital systems serving rural markets should focus on their strengths and partner with regional Medicare Advantage plans to "private label" under the hospital system's brand. Patients trust their providers, and a provider-sponsored Medicare Advantage plan can have significant competitive advantages in the direct-to-patient marketplace of Medicare Advantage.

This strategy also works in the Direct to Employer (DTE) market. Most DTE strategies involve a narrow network designed to trade price concessions to employers for a captive patient list of employees. The biggest problem with narrow networks as a DTE strategy is that neither the patients nor employers like them, and they don't offer hospital systems a path to financial stability as their census continues to drop, their surgeries move to ambulatory surgery centers and their ancillaries shift to low-cost commodity suppliers — not to mention the coming technology and data disruption that has only just begun.

These narrow networks, however, typically have a "wraparound network" to provide coverage outside the hospital system's service area. This out-of-area coverage is often offered through a recognized national insurance network. Instead of making a national network the wraparound coverage, a national insurance network can be used both outside and within the hospital's service area. Instead of a narrow network, regional providers should offer a wide area network. Don't tier out the competition — instead, layer our strengths on top of both the national insurance carrier product and the other hospitals and providers we've typically viewed as competition.

A NEW WAY OF CARE

We need to shift our focus so that our strengths are built upon the following: meaningful care management and home health programs with a Catholic charism; rural health clinics that make a full range of primary care services (especially behavioral health services) financially viable in even the most remote areas of the country; and value-based arrangements for physician compensation that not only put the physician at the center of the care delivery model, but also insist physicians be truly committed to ministry.

Ultimately, our journey forward can no longer be to wait for the patient to come to us but instead to leave our campuses and go to the patient; to minister not only to the body, but also more to

mind and spirit; to set aside our pride in our big glass buildings; and to be willing, when the time comes, to let go of any part of our hospitals that no longer support our mission. This can be an opportunity for change.

In Catholic health care, we must not see this decade as a time of fear and regret. We must see this as a time of hope and joy. We have much work yet to do.

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