Systems Gear Up For New Demands

By MARK CRAWFORD

Part of the Affordable Care Act (ACA) calls for the expansion of Medicaid in 2014, which is expected to cover about 17 million previously uninsured Americans. The Supreme Court's recent ruling that the federal government cannot force states to expand their Medicaid programs complicates the issue, making it more difficult for health care systems operating in several states to develop efficient strategies for delivering care to a population that is central to Catholic health care's mission. Further, although more people will be covered under Medicaid, reimbursements are unlikely to cover the cost of services.

"There's little doubt that many states will continue experiencing immense fiscal pressure," said Jon Fishpaw, vice president of advocacy and government relations for Catholic Health Partners (CHP) in Cincinnati. "This is especially true here in Ohio as approximately a million more people will become Medicaid beneficiaries. Offsetting this round of government spending within the next two years will not be achieved by raising taxes. Rather, health systems like CHP may have to brace for patient care reimbursements being adjusted lower to help pay for the Medicaid expansion."

With the numbers of patients sure to rise and funding uncertain at best, Catholic health systems must be proactive in making improvements to ensure they have the capacity to handle the large numbers of customers. This includes expanding the necessary infrastructure for enrolling eligible populations, providing all current and new Medicaid patients with appropriate primary care and effectively coordinating this care across the health care continuum.

"While Catholic health care already serves many of the people who will be newly covered by Medicaid under the ACA, today they enter our systems as self-pay or uninsured patients," said Tina Grant, vice president of state public policy and advocacy for Trinity Health in Novi, Mich. "The expansion means we will now get paid for serving these populations, and it also means we will see their numbers grow substantially."

This, however, may not be a trade-off. Medicaid reimbursement rates vary by state; in some states the Medicaid program does a better job of covering costs than in other states, so these variations in reimbursement will continue with expanded Medicaid. Some states may opt out entirely, refusing federal money and creating even more funding challenges. Governors in Texas, Florida, Louisiana, North Carolina, Iowa and Wisconsin, for example, have all said they plan to fight Medicaid expansion in their states.

"We don't know yet how many states will ultimately choose not to move forward with the Medicaid expansion," said Mary Ella Payne, senior vice president for policy at Ascension Health in St. Louis. "Some may wait a year or two for political reasons, but the federal matching is very generous [100 percent] in 2014-2016, and phases down to 90 percent by 2019. So there are strong financial reasons to come in. A key issue in every state will be to encourage take-up — making sure that those eligible, under whatever choice the states make, actually enroll."

Hospitals could face significant payment cuts without the benefit of a greater number of insured if state policymakers reject the Medicaid expansion.

"The Affordable Care Act included market basket cuts, productivity adjustments and reductions in disproportionate share hospital (DSH) payments to absorb the cost of expanding coverage," said Gabriela Saenz, director for advocacy and public policy for

CHRISTUS Health System in Austin, Texas. "These cuts will remain in place, even if a state does not expand coverage. As a result, hospitals will face substantial payment cuts while continuing to provide care for a greater number of uninsured individuals if a state does not opt to expand its Medicaid program."

Regardless of what happens in these states, Catholic health care systems must implement more efficient, lower-cost ways to deliver high-quality care, especially greater primary care capacity and better care coordination across the continuum. This is the only way to ensure adequate funding and sustainability, pursue high-value care programs and increase provider participation.

GETTING READY FOR 2014

Catholic health systems are implementing innovative programs to better coordinate patient care, reduce hospital readmissions and prevent or manage chronic disease, all while reducing health care costs. Innovative models include accountable care organizations, patient-centered medical homes, public-private partnerships and multipayer approaches. Although health care is already moving in this direction, the expansion of Medicaid has created a greater sense of urgency.

One innovation that CHRISTUS Health System has launched is an Integrated Nurse Training and Mobile Device Harm Reduction Program (INTM) within the St. Michael Health System in Texarkana, Texas. The hospital received a $1.6 million grant to carry out the program, which is designed to strengthen collaboration between critical access hospitals and long-term care facilities in order to reduce the number of preventable admissions and readmissions. "The INTM program will elevate the skill level of the workforce to recognize early warning signs of conditions that can escalate to become patient harm events," said Saenz. "It will combine advanced nursing training, simulation and decision-support technology to engage nursing care staff across multiple organizations to reduce the number and severity of preventable hospital admissions and to reduce serious preventable harms to inpatient beneficiaries."

Trinity Health is focusing on prevention and wellness in managing the care of patients with chronic conditions.

"We must leverage community resources to encourage healthy behaviors for these patients, and we must empower them with information they can clearly understand and the skills and tools they need to take charge of their health by working to ensure their transitions — from hospital to home, short-term or long-term care facilities or to a family member's home — go smoothly," said Grant. "We have initiated targeted programs to manage the care of diabetes and heart failure patients in our free and subsidized clinics. We also continue to analyze ER and hospitalization utilization data, including the ambulatory care sensitive conditions of our frequent users. This data is analyzed to determine the leading causes of preventable ER usage and/or preventable hospitalizations. Our hospitals are also developing plans, including population interventions, to reduce preventable ER usage and/or preventable hospitalizations."

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Providers anticipate that many of the newly insured (as well as the uninsured in the states that refuse Medicaid expansion) will continue to seek care in the emergency room, thereby increasing the uncompensated care burden for health care providers while at the same time shifting costs to the privately insured. Hospitals and clinics need to have systems in place to efficiently manage these greater numbers of patients coming to the emergency department, most of whom seek primary care.

One of the challenges, noted Juan Serrano, vice president of managed care strategy and operations at Catholic Health Initiatives (CHI) in Englewood, Colo., is identifying and overcoming the barriers that direct this flow of patients to the ER. "Barriers may include lack of transportation or not being able to afford a prescription," said Serrano. "Solutions might include providing transportation to a primary care clinic, collaborating with health plans to review prescription patterns or helping patients find pharmaceutical subsidies, or even discounts on utilities where the savings make it more affordable to buy their medicines."

CHI's goal is to lower its costs to the point where it can break even on Medicaid. "We have lost money on every Medicaid patient, so it will definitely be a challenge with the expected influx of millions of additional Medicaid beneficiaries," commented Michael Rowan, CHI's executive vice president and chief operating officer.

An in-depth analysis by CHI indicates it needs to lower costs by $2 billion over the next four years — "this means, primarily, we will need to reduce expenses," said Rowan. "We have a plan to try to improve by about $500 million a year, most of which is expenses, but we also believe there is a $200 million opportunity on an annual basis by improving billing and collection."

As a national system, CHI is focus-

ing on a number of key areas, including clinician information technology, data analytics and care management for managing this new population of patients in 2014. "We have a number of pilot projects focused on virtual health and remote care to try to handle the increase in patients," Rowan said

Mental health and substance issues are expected to be significant in the new Medicaid population. "Kaiser Family Foundation research in 2010 estimated that about 7 percent of this group is likely to have a chronic mental condition only, and about 4 to 5 percent more are expected to have a mental and physical chronic condition," said Payne. "One of the most significant challenges facing providers will be caring for those individuals."

Medicaid will be the primary source of coverage for individuals with mental illness who gain insurance under the ACA. "If a state elects not to expand its Medicaid program, individuals with mental health disorders who would have been able to obtain coverage under the expansion may increase the burden on inpatient care units and public mental health systems," said Saenz.

Integrating behavioral and mental health is an issue connected to much more than Medicaid expansion, observed Grant. Examples of current behavioral and mental health care integration efforts are those included in efforts aimed at coordinating care for dual eligible populations.

"As part of Trinity Health's policy recommendations around dual eligibles, we have encouraged states to focus on the behavioral health needs of this dual eligible population and ensure availability of patient-centered services to meet those needs," she said. "This includes viewing the management of behavioral health problems as similar to the management of other medical conditions. Behavioral health treatments should require an initial diagnostic assessment, development of a treatment plan, monitoring and follow-up."

ADVOCATE, ADVOCATE, ADVOCATE

Catholic health systems must make state policymakers aware of the significant negative impact on hospitals if they choose to vote against Medicaid expansion. CHRISTUS Health System and other organizations are heavily engaged in statewide coalitions to advocate for expansion of Medicaid in each state.

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"Our advocacy efforts include meeting regularly with state and federal policymakers, providing comments on regulations, motivating our associates, friends and patients to take action by writing legislators and contributing leadership to state and national associations like the Catholic Health Association (CHA)," said Grant. "CHA has been a tremendous leader in coordinating advocacy in this space. It's critical that we are all engaged — this is a pressing issue for all hospitals, and as leaders in this space, all eyes and ears will be on Catholic health care to be the voice for the vulnerable."

Most states are still deliberating over their expansion options and have spent little time engaging providers in discussions around preparedness. However, state efforts to address workforce shortages will be critical, especially for primary care physicians. Equally important are efforts to develop high-value Medicaid programs that lower per capita costs.

"By continuing to pursue new payment and delivery models, states can offset future costs of an expanded Medicaid program," Grant said. "States can help by continuing to advance payment models that reward innovation and high-value care delivery. Finally, states would be wise to engage the systems that have demonstrated over time a commitment to coverage and access expansion in dialogue around how we collectively best meet the health care needs of those we serve."

Health systems should also work with their states with respect to outreach and enrollment for the newly eligible Medicaid population, said Payne. "Many people may not be aware that they are now eligible for Medicaid, and systems will want to assist them in enrolling at the time of care. But systems may also want to work to enroll people sooner, before they are seeking care in the emergency department."

The message from Catholic health care to state leaders is simple — expanding access and coverage is an essential element of health care transformation. To support this goal, it is critical for all Catholic health organizations to collectively and consistently reach out to state leaders to deliver this message.

"All state leaders need to be reminded that Medicaid functions as a safety net for the most vulnerable in our communities and that by expanding Medicaid, states will offer basic, cost-effective health care services to those who would otherwise go without," Grant said. "Also, state efforts to develop high-value Medicaid programs have resulted in lower per capita costs, so by continuing to pursue new payment and delivery models, states can use these cost reductions to offset future costs of an expanded Medicaid program."

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