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**NATIONAL
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Hospital-Based Health Care Systems in Transition: The Post-BBA Era

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Annapolis, Maryland

A Conference Concerning Site Visits to
Bon Secours Health System (*Richmond and
Hampton Roads*),
Henry Ford Health System (*Detroit*),
University of Washington Academic Medical
Center (*Seattle*)

The
George
Washington
University
WASHINGTON DC



CONFERENCE REPORT

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Director's Note

Hospital-Based Health Care Systems in Transition: The Post-BBA Era summarizes impressions of a two-day workshop in Annapolis, Maryland, and three small-group site visits that preceded it. Designed to look at the far-reaching changes enacted under the Balanced Budget Act of 1997 (BBA) and how they would play out across the health delivery system, the exercise grew out of discussions with the National Health Policy Forum's Private Market Technical Advisory Group (TAG). It brought together a range of federal policymakers and hospital-based system executives to share their perspectives on the outlook for operating in the post-BBA era. While initially intended to look at impacts on many kinds of institutions, the workshop focused on hospital-based systems but attempted to incorporate attention to post-acute needs and services across the continuum of care.

As this project took shape, the policy environment was shifting considerably. Rapidly rising Medicare costs and major budget deficits that had given rise to the BBA already belonged to the past, replaced by unprecedented reductions in Medicare outlays and rapidly increasing budget surpluses. And there was disagreement about the reasons for such a turnaround in expenditures, with questions being raised about the extent to which increased fraud and abuse surveillance and overall belt-tightening in light of managed care pressures might be at work. Against this backdrop, examining the effects of the BBA turned out to be a difficult task, because the data are incomplete and conflicting on what actually has occurred. Also, because implementation of the BBA extends through 2001, some of its effects have yet to be experienced.

By the time of the workshop, congressional staff members were still quite mindful of the budget pressures their bosses had been under and the specific objectives they wanted the BBA to achieve, while interest groups were intent on "givebacks" that would alleviate the legislation's impact. Comments received after the workshop indicated equally mixed emotions because many of the disruptions and inequities felt by various players—and explored at the workshop—had been swept under the rug as election-year politics made across-the-board restoration of funds likely. It was noted, however, that at some point a variety of issues such as the stability of safety net functions and the support for graduate medical education will need to be addressed, with further analysis required before meaningful action can be taken.

This report takes these factors into account. It was authored by the three NHPF staff members who developed the project. Nora Super Jones, senior research associate and coordinator of the project, contributed the "Origin and Description" and

Bon Secours section. Lisa Sprague, senior research associate, prepared the Henry Ford Health System (HFHS) portion. Karen Matherlee, co-director, supplied the University of Washington Academic Medical Center (UW AMC) section and wrote the "Overall Perspectives" of the Annapolis conference.

In doing so, the three drew upon the contributions of numerous people. Thanking them all would be a document in itself. Joeann Karibo, director of community commitment, and Everard Rutledge, Ph.D., vice president of community health, Bon Secours, were instrumental to the organization and conduct of the Bon Secours site visit. Gail Warden, president and chief executive officer of HFHS and a member of the Private Market TAG, was the force behind the Detroit site visit and, indeed, of this BBA project itself. He was ably assisted by Darlene Burgess, vice president, government affairs, for HFHS. Aaron Katz, director of UW's Health Policy Analysis Program; Bruce Ferguson, assistant vice president for planning in the UW AMC School of Medicine; and Elise Chayet, director of planning and regulatory affairs at Harborview Medical Center, as well as John Coombs, M.D., associate vice president and associate dean of the UW School of Medicine, were key advisors and contributors to the Seattle site visit.

Sheila Burke, at the time associate dean of the Kennedy School of Government, Harvard University, and Linda Bilheimer, senior program officer, Robert Wood Johnson Foundation, served as moderators at the Annapolis conference and gave generously of their expertise. Julie James, a principal at Health Policy Alternatives; William Scanlon, Ph.D., director of health financing and public health issues at the General Accounting Office; and William Vaughan, minority professional staff member of the House Ways and Means health subcommittee, were extremely helpful in organizing the Annapolis meeting. Julie James, Linda Bilheimer, and Bill Scanlon, along with Katharine Levit of the Health Care Financing Administration and Sibyl Tilson of the Congressional Research Service, reviewed and made invaluable suggestions for this report. The responsibility for the report's contents, however, belongs to NHPF.

With deep thanks to all who participated in this project, NHPF looks forward to tackling the research agenda that resulted, with the help of the dedicated corps of people who appear on this page and those that follow.

Judith Miller Jones, Director
July 2000

Origin and Description of the Project

In the last decade, the health care marketplace has undergone dramatic change, fundamentally altering how and where care is delivered, how providers are organized and operate, as well as how care is financed by both private and public sources. Hospitals—traditionally the bedrock of the health care system—have developed new ways of doing business to respond to this changing environment. Many hospital-based systems have moved to integrate care across delivery sites, forging new relationships with physicians, skilled nursing facilities (SNFs), home health agencies, and other parts of the health care delivery system. Others have consolidated and merged operations to respond to competitive pressures. Changing payment structures and incentives have made it more challenging for hospitals to continue to fulfill historical social missions such as providing care to the poor, training new medical professionals, and conducting clinical research.

In the midst of these challenges, Congress enacted the Balanced Budget Act of 1997 (BBA), which contained numerous changes to the Medicare program as well as other health provisions. These include some changes in Medicaid plus new State Children's Health Insurance Program and Medicare+Choice initiatives. Designed primarily to balance the federal budget, the act significantly reduced projected federal spending on the Medicare program. A majority of these savings result from slowing the rate of growth in payments to hospitals, physicians, and other providers. A second major source of savings comes from new payment methodologies for SNFs, home health agencies, rehabilitation hospitals, and outpatient services—sectors that many hospital-based systems had expanded prior to the BBA.

Most of the provisions of the BBA began to take effect in fiscal year 1998; the remainder will gradually be phased in, with full implementation by 2002. As its many provisions have come into effect, and with providers feeling increased financial pressure, Congress has been heavily lobbied by industry groups to restore Medicare funding. In 1999, Congress responded with the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA), which provides \$16 billion of additional funding over five years and \$27 billion over 10 years (\$7 billion directly to hospitals).

It is difficult to sort out the effects of the BBA on the financial status of hospitals and related providers from those

brought about by other factors. Because Medicare accounts for about 40 percent of the income of the average U.S. hospital, BBA payment reductions were bound to have an impact on hospitals' bottom lines. The extent of the impact seems to be the result of a variety of factors, including level of integration and range of services provided, service area location, breakdown of funding sources (Medicare, Medicaid, private, and uncompensated), managed care penetration, demographics of the population served, level of competition from other delivery systems in the same markets, and the effects of other federal and state policies, such as fraud and abuse detection and Medicaid payment rates. Hospitals that have historically subsidized other lines of business with Medicare funds seem especially vulnerable to the effects of the BBA.

Data needed to evaluate the impact of the BBA changes are not available in many cases. In addition, the gradual or delayed phase-in of many BBA provisions, the concomitant effects of marketplace changes, and other legislative and regulatory activities make it difficult to precisely determine the impact of the BBA. Nevertheless, the enactment of the BBA marked the end of an era in health care financing. The philosophies that undergird many of its provisions raise fundamental questions about the role of Medicare in the broader U.S. health care system. How hospital-based systems respond to this new financial environment has important ramifications for the future of health care delivery.

To better understand the changes that hospitals and related providers face in the post-BBA environment and ways in which those changes might affect access to and delivery of care, the National Health Policy Forum sponsored three separate site visits in March and April 2000, with the support of the Robert Wood Johnson and John A. Hartford Foundations. Supplementary funds were also provided by the W. K. Kellogg Foundation. These site visits were designed as case studies to examine three hospital-based systems that represent alternative combinations and configurations of services operating in different types of markets.

SITE VISITS

Site visitors learned about the structures of each of the participating hospital-based systems, the services they

provide, the populations they serve, and the circumstances they face. The key objective was to assess how each hospital-based system plans to meet the challenges of the post-BBA era and what its strategies may mean for the system's ability to fulfill its missions as well as for broader national policy objectives. Because of their limited scope, these case studies were not meant to provide definitive conclusions about the status of all hospital-based systems today; however, they were intended to provide new insights and perspectives regarding the future of health care delivery.

Three different hospital-based health systems opened their doors to NHPF site visitors, allowing participants to have an inside look at each system's challenges, priorities, and strategies for the future. The three selected health care systems offered an opportunity to look at BBA impacts from different vantage points. First, the Bon Secours Health System, Inc. (BSHSI), with its heavy emphasis on post-acute services, allowed participants to better understand the impact of payment changes across delivery sites. Next, the Henry Ford Health System (HFHS) presented an excellent example of the challenges facing an integrated delivery system, known for delivery innovation and quality improvement, as it struggles to stay financially viable in the wake of reduced Medicare and Medicaid payment rates. Finally, site visitors to the University of Washington Academic Medical Center (UW AMC) gained new insight into how one of the most significant AMCs in the country is dealing with private and public challenges.

ANNAPOLIS WORKSHOP

On April 27 and 28, NHPF sponsored an invitation-only workshop in Annapolis, Maryland, at which the findings from the site visits were featured. Participants included nearly 70 health policy officials, including members of the Forum's Steering Committee and Private Markets Technical Advisory Group (TAG), as well as other invited representatives from Capitol Hill, congressional support agencies, and executive branch agencies.

On the first afternoon, workshop participants examined the trend data leading up to the BBA, the rationale for many of its provisions, and the legislative and fiscal environment in which both the original law and subsequent refinements were enacted. In addition, the most recent post-BBA data regarding Medicare spending and utilization were presented. This session was moderated by Sheila Burke, chair of NHPF's Private Markets TAG and executive dean of the John F. Kennedy School of Government. Speakers included current and former legislative aides who were instrumental in writing and designing the BBA as well as analysts who have been monitoring the impact of the BBA on Medicare spending and utilization trends.

Day two highlighted findings from the three site visits described above. Representatives from each of the participating health systems made presentations that were followed by commentary from site visit participants regarding their key impressions.

Gail Warden, president and chief executive officer (CEO), spoke on behalf of HFHS at the workshop. His focus was an assessment of how Medicare payment policies help or hinder integration of care. He observed that the BBA had removed some Medicare dollars from the system altogether and redistributed others among different components of an integrated system such as HFHS. At the same time that HFHS was trying to re-orient itself to absorb BBA cuts, the state of Michigan sharply reduced Medicaid payment rates. The combined impact has caused HFHS to eliminate 1,300 staff positions, downsize community-based programs, and reduce its commitments to graduate medical education, health promotion, clinical quality improvement training, and other innovative programs. Warden acknowledged that BBA-related belt-tightening had brought about improvements in HFHS's business practices; however, he expressed concern over the growing numbers of uninsured and the federal government's increasing distance from the needs of low-income populations.

Everard O. Rutledge, Ph.D., vice president of community health, BSHSI, described Bon Secours' vision of a new delivery model that seeks to provide an integrated continuum of care. To pursue this vision, Bon Secours has engaged in a proactive strategy to diversify operating risk, achieve adequate organizational size, and enhance system behaviors (for example, adopting best practices). Eileen Malo, vice president of continuing care for Bon Secours Hampton Roads, focused her remarks on the health system's operations in Hampton Roads, Virginia. Bon Secours Hampton Roads has estimated the net impact of the BBA and the BBRA to be nearly \$36 million over three years. While she acknowledged that the BBA provided needed reforms such as improved patient care delivery design and processes as well as data development to benchmark quality, she warned that the act has also resulted in several negative, unintended results. She said that continuity of care has been impaired by delinked financial incentives and that access to needed services has been limited or denied, especially skilled nursing for medically complex residents and certain home health services. Finally, she emphasized that the BBA has resulted in an increasing workload and stress for health care workers and that the inadequate payment rates have left the system with no opportunity to adjust wages to reflect value, leading to shortages of certified nurse assistants, registered nurses, and nursing home administrators.

In the briefing that John B. Coombs, M.D., associate vice president for medical affairs and associate dean of the

University of Washington's School of Medicine, provided Annapolis participants, he reviewed UW AMC's component parts and described the environment in which each component operates and the public and private policies to which each responds. Focusing on the academic program, he emphasized its five-state reach (Washington, Wyoming, Alaska, Montana, and Idaho), as he looked at state and regional pressures on a system that is broadly dispersed. In breaking down revenues and costs, he stressed the public benefits—in regional and safety-net services, basic scientific advances, and technology—that the system provides. In looking at Medicare, Medicaid, charity care, and other aspects of the BBA, he predicted a \$58 million to \$65 million impact in the next five years, compounded by cutbacks in state-funded programs.

The workshop concluded with a wrap-up session at which participants were asked to tie together the legislative, regulatory, and delivery system priorities that had been discussed throughout the conference. The key question driving the discussion was what role Medicare should play in an interdependent, public-private financing and delivery system.

The Three Site Visits: Background and Impressions

BON SECOURS HEALTH SYSTEM, INC.

BACKGROUND

NHPF organized a two-day site visit to Richmond and Hampton Roads on March 16 and 17, 2000, to study post-BBA issues in the context of the Bon Secours Health System's Virginia operations. The site visit was designed to help policymakers better understand how changing payment incentives—particularly the move to prospective payment systems for post-acute services—has affected the ability to implement a continuum of care across delivery sites. Eleven individuals participated in the site visit, including representatives from the U.S. General Accounting Office, U.S. Department of Health and Human Services, Congressional Budget Office, Congressional Research Service, and U.S. House and Senate staff.

Components

The not-for-profit Bon Secours Health System, Inc., includes 24 owned or joint-ventured acute care hospitals, nine long-term nursing care facilities, seven assisted and independent living facilities, 11 home care and hospice services, and numerous primary care and outpatient facilities in 14 communities across nine states. Bon Secours has pursued strategic growth in existing and new communities. The growth objectives are to develop a concentrated presence on the East Coast and, within each community served, to develop a continuum of health care services that meet the community's needs and is attractive to managed care plans. This site visit examined the system's operations in Virginia, which include four hospitals in Richmond and three hospitals in the Hampton Roads area, in addition to nursing care, home health, assisted living, and ambulatory care facilities.

Health Marketplace

In the Richmond metropolitan area, two major networks have developed, Bon Secours and Columbia. Columbia has four hospitals in Richmond and holds 40 percent of the market share. The leading hospital is operated by the Medical College of Virginia, with a 24 percent market share. CenVaNet is a physician-hospital joint venture formed in 1996. This regional organization comprises 11 participating hospitals, 1,500 physicians, and

a complete continuum of ancillary services. In addition, it is the leading delivery system in Medicare and Medicaid managed care in central Virginia, accounting for 21,000 combined lives. Managed care penetration in Richmond is low. Payers have either abandoned products designed around capitation/risk or are discontinuing capitation/risk deals as corporate strategies.

Bon Secours Richmond Health System owns four geographically dispersed hospitals. It participates in the CenVaNet as a founding member and holds approximately a 30 percent market share. Besides acute care, the continuum of services includes hospice, home care, occupational medicine, senior services, assisted living facilities and physician support services.

In Hampton Roads, Sentara and Tidewater Health Care recently merged their two systems into a joint operating company, making Sentara the leading acute care provider in Hampton Roads and the only acute care provider in Virginia Beach. Bon Secours Hampton Roads has two major competitors—Sentara, which operates five acute care hospitals, and Riverside Health System, which operates four hospitals. Sentara commands 46 percent of the market share; Bon Secours is the second leading provider network, with a 20 percent market share. Managed care penetration in Hampton Roads is stabilizing at around 28 percent. Capitated products have not been successful in this market, except for specialty services such as behavioral medicine.

Bon Secours Hampton Roads consists of three acute care hospitals, a behavioral medicine facility, two nursing care centers, and one existing assisted living facility and an assisted living facility in construction. Additionally, the service continuum includes home health, off-site diagnostics, primary care, urgent care, outpatient rehabilitation and occupational health services, physician practices, and an outpatient facility.

PROGRAM

Site visitors spent the first day in Richmond discussing the changing health care financing environment, the responses of the hospitals and other parts of the Bon Secours system, and the impact on the system's patient care and social missions. Discussions centered on shifts in the sources of revenue, federal and state policy changes,

and market consolidation and competition. On day two, participants visited the Hampton Roads Virginia area, which includes Portsmouth, Norfolk, and Virginia Beach. Discussion focused on the challenges of developing an infrastructure across the continuum of care and the impact of new prospective payment policies on acute, skilled nursing, and home health care delivery. Site visitors also toured a nursing home and an assisted living facility.

IMPRESSIONS

Competition has caused the Bon Secours Health System to think more strategically.

Through a series of acquisitions, BSHSI has pursued strategic growth in existing and new communities. These acquisitions have enabled Bon Secours to consolidate services and thereby reduce excess capacity. For now, the acquisitions seem to allow them to stay competitive in the managed care market. Yet it remains to be seen whether these multiple lines of business will remain profitable. Bon Secours has found that effective consolidation of services requires significant investments in information systems. Future success will depend on its ability to successfully coordinate care through the various levels of integration.

Bon Secours has developed comprehensive assessments of the unique needs and capacities of each of the fourteen communities it serves. Observations of the differences between the Richmond and Hampton Roads marketplaces show that while the corporate parent can offer direction, all health care is essentially local.

Bon Secours' business strategies seemed designed to make money or avoid losses and mirrored strategies usually associated with for-profit entities. This troubled some site visitors who thought the Catholic non-profit had lost sight of its mission. They raised concerns about the implications for charity care and care of the uninsured. Other site visitors thought the hospital-based system had responded appropriately to payment incentives and had done what it needed to do to survive in today's marketplace, such as reducing marginal services and consolidating to improve efficiency.

In each of the markets in which it operates, Bon Secours tries to find its niche and focus on core strengths, striving to be the number one or number two delivery system (direct or aligned) in markets served.

BSHSI is willing to exit unprofitable operations when needs can be met by other means or providers. Selective movement of certain profitable services outside of institutional settings (for example, oncology, neurology, radiology) have made it difficult to subsidize unprofitable lines of business.

In Richmond, Bon Secours has recently acquired Stuart Circle Hospital and Richmond Community Hospital and plans to close Stuart Circle in the near future. This closure will shift more of the burden of indigent care onto the Medical College of Virginia. Initially, the community—through the certificate-of-need process—had objected to the closing of Stuart Circle but these objections seemed to have been overcome.

In Hampton Roads, Bon Secours has acquired DePaul Medical Center and Portsmouth General, which was closed shortly after purchase. Services previously provided at Portsmouth General have been consolidated at Maryview Medical Center, a Bon Secours hospital, and at Bon Secours Health Center at Harbor View, an outpatient facility.

In light of competition and population shifts, Bon Secours has elected to move facilities to the suburbs.

Payer mix seems more critical for financial stability than patient mix in the new health financing environment. Bon Secours Richmond has entered into joint ventures to relocate urban hospitals to suburban locations strategically placed near interstates. Moving to the suburbs seems to be a direct effort to follow insured patients.

Relocation of hospitals is also important for successful managed care contracting. Bon Secours is number two in the marketplace in both Richmond and Hampton Roads. This position gives it much less negotiating clout with managed care plans. For example, Columbia/HCA, which has a 40 percent market share in Richmond, routinely achieves a 30 percent greater reimbursement from private payers than Bon Secours does.

In Hampton Roads, the leading system, Sentara, had been able to shut Bon Secours' facilities out of managed care contracts. Bon Secours has had to work aggressively to be included in the Sentara network of products, which includes Optima—the area's largest health maintenance organization (HMO).

Creating a system to deliver an integrated continuum of care is a key operating principle of Bon Secours.

The Bon Secours service continuum includes acute care hospitals, SNFs, assisted or independent living facilities, primary clinics, physician service organizations, home health services, hospices, and community-based prevention and wellness programs.

The basic strategy of Bon Secours is to operate as a system, with each entity doing its best to carry its own weight. Site visitors speculated that, through Medicare policies, managed care, and private payer policies, the future may see the demise of the stand-alone facility. Views on whether this was positive or negative varied.

In care management, Bon Secours has been trying to move from episodic care to population management. While it is not quite there yet, it has made improvements in chronic care patient management. Its model favors heavy R.N. involvement across the continuum.

Care management has also focused on reducing variations by comparing all facilities in the system to one another. Bon Secours has focused on developing an infrastructure to successfully work within the “averages” dictated by prospective payment systems.

While integrated delivery is the goal, the Bon Secours systems have a way to go in terms of full system integration. Payment incentives often create instances in which one part of the system competes against another. It is difficult to integrate care delivery in such a way as to ensure that loss to the overall system is at a minimum (for example, trouble placing hospital patients into skilled nursing can result in higher total system cost). Impact on the bottom line could be lessened if services were better coordinated.

Labor pressures have hampered Bon Secours’ ability to provide needed services and keep costs down. Nursing shortages and home health and nursing aide shortages are prevalent. The booming economy, coupled with increased paperwork requirements and the demands of caring for complex patients, have made recruitment extremely difficult.

■

The BBA has challenged Bon Secours’ ability to fulfill its mission.

Changed financial incentives and payment reductions have caused the system to better coordinate and manage post-acute care. For example, home health care providers reported that they have had to move their care philosophy more in the direction of teaching family caregivers to provide care and away from providing care directly. Hospital discharges to SNFs have had to be better coordinated and marginal home health visits have been reduced.

SNF, home health, and transfer payment changes have affected acute facilities’ ability to discharge patients, according to BSHSI representatives. Several staff members said it had been increasingly difficult to place patients who meet care criteria because the SNFs will not or cannot accept them.

Reduced revenue has forced Bon Secours to eliminate select missions programs and to search for grant funding to support missions such a mobile “care-a-van.” Yet, site visitors noted that, despite payment reductions, Bon Secours has been able to make significant capital acquisitions.

The Bon Secours Richmond home health agency has a low interim payment system cap rate based on earlier experiences. As a result, Bon Secours officials contend, efficient providers have been penalized. The interim payment system has been a major challenge; Bon Secours representatives believe their organization will do better under the prospective payment system.

As an integrated health care system, Bon Secours officials believe the most needed additional BBA refinements are an increase in the Medicare hospital inpatient payment rate and the repeal of the 15 percent reduction in payments for home care services. The anticipation of an outpatient prospective payment system causes them to be concerned about the system’s future ability to provide care in the most appropriate setting.

One Bon Secours hospital in the Richmond area receives disproportionate share payments from Medicare. The BBA changes have created concerns about the ability to provide a safety net to uninsured patients.

While Medicare’s tightened payments have clearly affected BSHSI’s bottom line, the evidence presented at the site visit indicated that private-payer efforts were at least as important in contributing to the system’s financial condition. In addition, Virginia’s Medicaid program has also had a negative impact, with a recent move to mandatory managed care and a practice of retroactive payment reductions.

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Gearing up for new regulations places significant burden on staff and resources.

For example, the SNF’s entire profit margin for 1998 was used to get systems in place for prospective payment. OASIS has been a big expense and time drain, according to the home health agency representative. However, site visitors expressed concern that the agency did not recognize the value in measuring quality and health status—key objectives of the OASIS system.

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The promise of more choice in the Medicare program has not materialized in the Richmond and Hampton Roads markets.

Medicare HMOs have not done well in either marketplace. Before the BBA, Richmond had five HMOs participating in the Medicare-risk program; today, only one HMO (CIGNA) participates in Medicare+Choice. In Hampton Roads, there are currently no Medicare HMOs available for beneficiaries.

HENRY FORD HEALTH SYSTEM

BACKGROUND

NHPF organized a one-day site visit to the Henry Ford Health System in Detroit on March 20. Participants included representatives of the Office of Management and Budget, the Health Care Financing Administration, the Veterans Health Administration, Medicare Payment Advisory Commission, and the Urban Institute. HFHS president and CEO Warden and HFHS government affairs vice president Burgess assembled a rota of key executives to discuss the impact of the BBA on an integrated health system.

Components

HFHS provides acute, primary, specialty, and preventive care to a diverse population. It includes the Henry Ford Hospital, a 903-bed tertiary facility in Detroit, and the 359-bed Henry Ford Wyandotte Hospital to the west of the city; HFHS also participates in joint ventures with Bon Secours and Mercy Health Services to provide services in outlying areas. (A Mercy hospital in Detroit, formerly part of the joint venture, was recently closed.)

HFHS operates the Health Alliance Plan (HAP), a mixed-model managed care plan with 540,000 members, and the Child Health Network, a joint venture with the Children's Hospital of Michigan to coordinate pediatric care. The Henry Ford Medical Group is one of the nation's largest group practices, with 850 salaried physicians in 40 specialties. Horizon Health System is one of the major osteopathic providers in Michigan. Henry Ford Behavioral Health offers inpatient care for those experiencing severe episodes of mental illness and both residential and outpatient treatment for chemical dependency. Henry Ford Senior Services coordinates care for the elderly and operates two nursing homes. The William Clay Ford Center for Athletic Medicine treats many members of Detroit's professional sports teams. Henry Ford Hospice serves more than 1,100 patients annually. Community Care Services offers a variety of supplies and services, including

pharmacy, home infusion, dialysis, and home health and private-duty nursing care.

The Henry Ford Sciences Center, which comprises the Henry Ford Research Institute and the School for Health Sciences, combines teaching, research, and advanced patient care. The School for Health Sciences offers more than 70 physician, nurse, allied health, and continuing medical education programs. It has educational affiliations with a variety of midwestern institutions, including Case Western Reserve University School of Medicine, University of Michigan School of Medicine, Chicago Medical School, and the Medical College of Ohio.

Health Marketplace

HFHS operates primarily in an area comprising Wayne, Oakland, Monroe, Washtenaw, and Macomb counties, which encompasses a range of socioeconomic conditions from inner-city Detroit to upscale suburbia (Oakland is said to be the second-richest county in the United States). Henry Ford Hospital, HFHS's anchor facility, is located in Detroit, where it shares safety-net responsibility with the Detroit Medical Center (DMC). Since two other safety-net hospitals have closed, and DMC's financial situation is precarious, the responsibility for uncompensated care is of grave concern to HFHS. The Beaumont system dominates in well-to-do Oakland. Other players include the St. John, Mercy, Oakwood, and Bon Secours systems, as well as the University of Michigan.

HFHS owns two of the area's 12 hospitals, and accounts for approximately 11 percent of admissions in southeast Michigan. HFHS officials point out that no one in southeast Michigan lives more than 10 or 15 minutes from an HFHS facility. HFHS is recognized as a market leader in general medicine, neurosciences, and orthopedics.

One in four residents of southeast Michigan is enrolled in a managed care plan. Of this group, approximately one-third are members of HFHS's Health Alliance Plan.

HFHS's payer mix in 1999 was 43 percent managed care (primarily from HAP), 26 percent Medicare, 10 percent Blue Cross Blue Shield, 5 percent Medicaid, and 16 percent other. Medicaid patients are also reflected in the managed care figure.

PROGRAM

Warden and various staff members kicked off the day with a breakfast briefing on HFHS's overall structure, case mix, competition, and strategies for adapting to changes in health care delivery and financing. Successive panels focused in turn on financing and information systems, the integration of diversified services, academic mission and outreach, safety net services, and hospital operations.

IMPRESSIONS

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Henry Ford Health System (HFHS) is not contemplating abandoning either its mission in Detroit or its commitment to delivering a full range of integrated health care.

However, “the need to earn revenues where we can” is forcing greater concentration on certain “centers of excellence” within the system.

■
Responding to the BBA was like the process of grief (anger, denial, etc.), but ultimately the scrutiny of expenditures and assumptions and the redesign of processes that it forced were beneficial.

In this light, the BBA may be regarded as a necessary call to greater efficiency. Cost containment has been achieved, and still patient satisfaction reportedly is higher than it has ever been.

■
HFHS president and CEO Warden credits his optimism—a belief that the system will return to profitability—to HFHS characteristics not shared by all hospital systems: (a) an in-house medical group that can to some extent be told what to do and that in any case has a stake in the whole organization’s performance; (b) an ability—still—to attract the best and brightest practitioners; and (c) an in-house health plan that has been challenged but not obliterated.

The Health Alliance Plan (HAP) steers business to the hospitals, and disputes between the plan and provider sides are “family feuds” that can be resolved at the executive level rather than fought to the death. (It should be noted that other HFHS executives, taking a perhaps narrower view, are concerned about their ability to continue to fulfill all aspects of HFHS’s education, research, and community missions.)

■
There have been casualties of the post-BBA turnaround plan.

Five hundred employees were laid off and other positions shed through attrition and a voluntary severance package. No component of the system has gone unscathed in this process. Programs not directly linked to patient care,

such as training, prevention, and outreach, have been de-emphasized or suspended. Nevertheless, there was surprisingly little discussion of Medicare payment inadequacy.

■
HFHS’s biggest problem may well be the state of Michigan.

An ongoing certificate of need requirement has stymied plans to expand into geographic areas with a stronger payer mix. Medicaid rates have been slashed, even though the state has a substantial rainy-day fund at its disposal. Medicaid reimbursement is adjusted for age and sex but not health status. The only profitable category is males under the age of one. Michigan is one of only a few states that includes the disabled in the capitated population.

■
Safety-net funding is problematic across the board.

The county has not increased its reimbursement rates in at least ten years. Very little federal money is available for Detroit’s uninsured. “The market is not going to decide in favor of the poor.”

■
Emergency services are a major concern for HFHS, particularly in that Detroit Medical Center, the other safety-net provider, has severe financial problems.

The emergency room is a significant source of admissions to Henry Ford Hospital, not surprising given the poor population in the surrounding community, where some health indicators were described as “third-world-like.”

■
Local employers, notably the automobile companies, place heavy emphasis on quality measurement and improvement.

HFHS is GM’s benchmark plan. HFHS physicians are involved in and committed to in-house quality improvement efforts.

■
The most significant variable in generating revenue is payer mix, not case mix or volume.

Overall, though, each payer increasingly wants to cover only its own population and wants any gains from

efficiency to be returned in the form of lower rates. Cross-subsidization is a thing of the past.

■

CarePlus, the electronic patient record system, continues to develop.

A current project is an enhanced security protocol, designed in anticipation of allowing patients access to their own records. Getting doctors to use CarePlus has not been an issue; making the system available whenever they want it is still a challenge.

UNIVERSITY OF WASHINGTON ACADEMIC MEDICAL CENTER

BACKGROUND

NHPF organized an April 10 and 11 site visit at the University of Washington for seven federal congressional and agency health staff and a health policy analyst from a think tank to explore post-BBA academic health center (AHC) issues. The visit focused on the challenges UW faces in carrying out its three missions of delivery of health services (with emphasis on the safety net), health professions education, and health science and clinical research. The visit developed the themes through briefings, panel discussions, a van tour of the UW complex and affiliated organizations, and stops at individual facilities.

Components

UW has Schools of Dentistry, Medicine, Nursing, Pharmacy, Public Health and Community Medicine, and Social Work that collectively are referred to as “the health sciences.” The vice president for medical affairs/dean of the School of Medicine oversees UW’s Academic Medical Center, which owns and/or manages UW Medical Center, Harborview Medical Center, UW Physicians, UW Physicians Network, Children’s University Medical Group, and Seattle Cancer Care Alliance. The AMC is closely affiliated with Children’s Hospital and Regional Medical Center, Fred Hutchinson Cancer Research Center, and VA Puget Sound Health Care System. It administers a well-known education program in five states: Washington, Wyoming, Alaska, Montana, and Idaho (WWAMI). The program’s service area occupies about 27 percent of the land mass of the United States and contains 9 million people.

Rankings

UW ranks high in various national AHC statistics. The School of Medicine ranks sixth in the percentage of gradu-

ates practicing in the primary-care fields of family medicine, general internal medicine, and general pediatrics. The school has nearly 1,500 residents and fellows in accredited clinical training, including 343 residents in its affiliated family medicine network. Residency training in primary care and some specialties takes place at more than 26 community sites in the five states that UW serves. The school is consistently among the top five medical schools in receipt of federal research funding. In FY 1999, it received approximately \$282 million in grant and contract awards. It also is among the top ten institutions in the nation in technology transfer.

The School of Nursing also is top-ranked nationally. It has 450 clinical agreements for delivery of acute, long-term-care, and public health and community services. With 151 undergraduate and 300 graduate students, it provides baccalaureate, master’s, and doctoral degree programs and has one of the oldest F.N.P. programs in the United States. It ranks second in National Institutes of Health grants and third in health science funding in the country. Moreover, it has numerous interdisciplinary health service and education projects.

Health Marketplace

Although UW serves five states, most of its services, education, and research are concentrated in Washington. According to Aaron Katz, director of UW’s Health Policy Analysis Program, who provided an overview of the marketplace at the beginning of the visit, the insurance status of Washingtonians in 1998 was, as follows:

- 25 percent in large groups and 6 percent in small groups;
- 19 percent in self-funded plans;
- 6 percent with individual policies;
- 2 percent in Medicare;
- 3 percent in the state’s Basic Health Plan;
- 4 percent in Medicaid fee-for-service;
- 8 percent in Healthy Options, Medicaid’s managed care plan;
- 6 percent in Department of Defense programs; and
- 11 percent (540,000 persons) uninsured.

The state’s 1993 enactment and 1995 repeal of state health insurance reforms resulted in extensive fluctuations in the marketplace. For example, in response to the law, Providence Health System, a Catholic provider in Seattle and the rest of the state, had invested heavily in the acquisition of primary-care practices and steadily lost money after the repeal. It recently joined with Swedish Medical Center to consolidate its Seattle-based Providence Medical Center with

Swedish, putting the new operation in control of 52 percent of the licensed nonfederal staffed beds in the city.

According to Katz, Seattle has a long-standing tradition of local, not-for-profit health plans and providers. Major plans include Premera Blue Cross, Group Health Cooperative/Kaiser Permanente, Regence Blue Shield, and First Choice (a provider-owned preferred provider organization [PPO] and health plan).

HMO penetration rose to 35 percent in 1998 from 26 percent in 1997, although the popularity of PPOs and point-of-service plans is said to be growing as consumers opt for greater choice. Seattle's HMO penetration rate was slightly lower than the average for all metropolitan areas and particularly low for the West Coast; however, the state's capitation rate (the percentage of providers accepting some capitation) of 70 percent was higher than that for all metropolitan areas (about 63 percent). Its 1998 percentage of Medicare enrollees in risk contract health plans was 26 percent, while the national rate was 15 percent. The health plan underwriting margin that year—approximately minus 4 percent—was in the red for the fourth straight year.

According to Katz, recent developments include the following:

- Health plan withdrawals from public programs, such as Medicaid and the Basic Health Plan, as well as Medicare+Choice.
- The collapse of the individual insurance market.
- Limits on state spending and revenue reductions through two initiatives, affecting payments for health care.
- A decline in overall hospital margins, with UW Medical Center at 2.4 percent and Harborview Medical Center at 2.2 percent.
- A tight labor market, affecting the supply of health workers.

PROGRAM

Before the site visit program began, five attendees made an optional visit to Children's Hospital and Regional Medical Center. The program, which began in mid-afternoon on April 10, featured a briefing—followed by discussion—of UW's health components and a dinner for federal and Seattle participants. On April 11, federal participants engaged in a series of tours and discussions at UW Physicians Belltown Clinic, Pioneer Square Clinic (a facility for persons who are homeless), Harborview Medical Center, and UW AMC. Topics included the market implications of the BBA; UW's health service, health professions education, and research missions;

ambulatory care, education, and research; safety-net issues; and impacts of the BBA and other issues.

The case study showed that UW AMC runs a gamut of services—from preventive and primary to tertiary and quaternary—with links to various kinds of post-acute care. It underlined UW AMC's heterogeneity, as the institution draws upon public and private payers and multiple other sources, with different payer mixes for its individual facilities. Relative to missions, the case study demonstrated that UW AMC more than meets the definition of an AMC. Its missions include delivery of services to a wide range of patients (including those categorized as safety net), health professions education across the health-care spectrum, and broad-based health services and biomedical research.

IMPRESSIONS

■
UW fully fits the definition of an “academic health center” in its service delivery, health professions education, and health sciences and clinical research components, which has policy implications relative to federal and state recognition of those missions.

Prior to and during the visit, there was some discussion of differences among AHCs and between an AHC and a teaching hospital. From the start, participants saw UW as a full-fledged AHC. In addition to meeting the Association of Academic Health Centers' base requirements of a medical school plus one other health professions school (for example, a nursing school), UW has five other health professions schools; in addition to at least one teaching hospital, it manages another and is affiliated with others. Moreover, its complex includes numerous other entities: physician clinics, research centers, and other organizations. For those who arrived with preconceptions, UW confirmed the adage, “If you've seen one AHC, you've seen one AHC.” In terms of policy, it called into question whether service and education adjustments intended to preserve the two AHC missions cover the circumstances of contrasting AHCs. For instance, can one payment policy address the circumstances of an AHC like UW as well as those of much smaller complexes that rank low in the acuity of patients and in the number and breadth of residents trained?

■
While UW provides concentrated services to Seattle, the surrounding counties, and Washington, its status as an AHC serving five states seems to have both positive and negative ramifications.

Most participants had a favorable view of the uniqueness and geographic reach of UW as the one AHC in the region—for example, in its specialty referral services, provision of the only Level I trauma services in the state of Washington, and WWAMI education program. For example, one participant had this impression: “UW serves as a unique educational resource for five thinly populated states. It would have been economically and organizationally unthinkable for states like Idaho and Montana, which only recently approached one million population, to develop their own medical schools. It’s an example of taking regional responsibility.” Some other participants took a different view. They tended to see UW as monolithic. Seeing health care as local, they were suspicious of UW’s concentrated resources, especially as an educational and referral center for people from other states. For instance, even within Washington, some worried about barriers to trauma care due to traffic, weather, distance, and time. UW officials indicated, however, that their data regarding trauma care in the region did not support this worry.



A state institution that manages or is affiliated with a group of facilities and organizations (for example, a county hospital, a federal health network, and not-for-profit physician clinics), UW acts as an “academic entrepreneur.” However, its entrepreneurialism is tempered, so that it seemingly has avoided the mistakes of some other providers in the Seattle area or of some other AMCs in the country.

Participants discerned dynamism at UW—at Belltown Clinic, Pioneer Square Clinic, Harborview Medical Center, and at UW Medical Center—that led one federal site visitor to say, “UW is academically entrepreneurial.” Officials at UW seem to have a knack for putting pieces together while avoiding the pitfalls that some other providers in the area, such as Providence Health System, have encountered. For example, instead of acquiring physician practices in order to build a primary-care base, the UW AMC had organized the not-for-profit Physician Network of nine primary-care clinics from the ground up. On the other hand, in the words of one federal participant, there were no indications that UW is making overt moves to “game” the reimbursement system, for example, by developing post-discharge “subacute” beds or by setting up satellite clinics as hospital outpatient departments.



While UW has all the service delivery pieces, either by ownership or affiliation, necessary

for a full continuum of care, continuity of care seems to be a facility-by-facility, rather than a systemwide, concern.

While it could have been a function of separate discussions—particularly at Harborview Medical Center and UW Medical Center—the idea of a system of care seemed to be institution-specific rather than systemwide. UW officials contended that development and oversight of the continuum are at the system level, while execution of the strategy for continuity—which is dependent on collaboration among physicians, nurses, social workers, and others—is at the institutional level. However, some individual physicians seemed to be integrators. Examples include F. Bruder Stapleton, M.D., pediatrician-in-chief at Children’s Hospital and Regional Medical Center and chair of UW’s Department of Pediatrics, and Wayne C. McCormick, M.D., associate professor of medicine in the Division of Gerontology and Geriatric Medicine, Harborview Medical Center, and medical director of VNS. In addition, some departments seemed more interested than others in integrating care; the School of Nursing, for instance, seems to be behind numerous interdisciplinary continuum-of-service efforts.



UW facilities and providers share the safety-net mission.

Participants were struck by the sense of mission that pervaded UW, a sense of shared commitment to safety-net services. This was particularly striking at Harborview Medical Center. The county hospital managed by UW, Harborview gives priority for care to persons who are incarcerated, mentally ill, substance-abusing, indigent, or belong to certain other vulnerable populations. The commitment to mission was demonstrated first-hand at Harborview’s Pioneer Square Clinic, an ambulatory facility for persons who are homeless or otherwise without access to care, and at Harborview’s Crisis Triage Unit, a crisis stabilization center in the Emergency Department for screening mental health, chemical dependency, and developmental disability needs.



Harborview Medical Center is an unusual public hospital, in that it combines public patient caseloads with a high percentage of privately insured, seems to seek to deliver services (generally subsidized) that some other facilities shun, has access to capital, and is breaking even.

Harborview Medical Center’s financial profile for 1999 includes 34 percent Medicaid, 21 percent Medicare, 7

percent no pay, and 38 percent private pay/insured. With its 11 categories of priority patients, it combines last-resort (public inebriates) with first-resort (burn treatment and specialized emergency care) patients. To break even, it supplements its routine patient-care revenues with public subsidies: Medicaid disproportionate-share hospital (DSH), special state, trauma, and interagency funds; Medicare DSH, direct medical education, and indirect medical education (IME) dollars; and other funds. It has access to capital through UW, the state, Medicare, and periodic bond issues.

■

UW health facilities are efficiently managed, which works to their detriment when national payment policies are imposed upon them. Some think this calls for better recognition of geographic variation in Medicare payment policy, while others are doubtful that it would reward the more efficient.

As discussed during the site visit and summarized by one federal participant, health care in the Northwest is traditionally viewed as efficient. The average length of stay (ALOS) in the region is consistently lower than the national average. In 1998, for example, the ALOS in Washington was 4.6 days, while the national average was 5.8 days. Home health utilization averaged 24 visits per patient in the state, compared to the national average of 51. Skilled-nursing facility utilization averages were also lower in Washington, at 24.5 days, while the national average was 28.5. The AAPCC (Medicare capitation amount) in Washington is also consistently lower than the national average, and there are debates about the reasons. One participant who attributed it to greater efficiency concluded that it means the system experiences a greater impact from global changes to federal programs, particularly those aimed at getting greater efficiency from inefficient providers. This participant thought it advisable to consider geographic diversity in Medicare payment policy. Another participant opposed this idea, indicating that the Northwest generally benefitted when Medicare moved to one national standardized amount (as opposed to payments based on regional costs).

■

Complaints about the effects of the BBA on operating revenues are obviated somewhat by UW's ambitious construction projects, a contrast that has come to be called "the crane problem."

As some participants saw and heard about new projects—the construction of an expanded Fred Hutchinson Cancer Research Center, a new Research and Technology Building at Harborview Medical Center, and a bond

issue for a new building at Harborview to replace one that is not seismically sound—they reacted. To use a term coined during an NHPF site visit to AHCs in Boston, they had a “crane problem.” A crane problem arises when AHC administrators complain about federal cuts in hospital operating revenues when their complexes are filled with the cranes of construction projects. In Seattle, the crane problem came up even though the Fred Hutchinson hotel facility was funded by private donations and the Research and Technology Building by a mix of university and state funds; the bond issue, the first in 15 years, is scheduled to go before county taxpayers this year for approval. Moreover, UW officials indicated that these projects had been in the planning stages for ten or more years and that UW ranks low among its peer AMCs in the ratio of square footage per dollar of research funding.

■

UW is experiencing a shortage of workers in post-acute settings (largely due to a robust economy) and difficulty (attributed to BBA cuts) in referral of patients from acute to post-acute care, but its post-acute provider arrangements seem to be stable at present.

In Seattle and in Washington as a whole, as in other parts of the country, competition for employees has led to a shortage of low-wage workers in nursing homes and home health agencies. Aware that this affects the ability of acute facilities to discharge patients needing a lower level of care, participants sought to learn how severe the problem is and to what extent it is influenced by market forces as opposed to provisions in the BBA (for example, provision for SNF prospective payment, ceilings on rehabilitation services, and imposition of a home health interim payment system). Anecdotally, while SNFs and home health agencies in Seattle were described as having undergone strain, they also were said to have survived. Practice patterns seem to be a factor, such as having the second- or third-lowest days per 1,000. (UW does not have SNF or home health facilities; it does have six teams of geriatric-trained providers who go to 12 affiliated nursing homes and other facilities to see patients.) There seems to be continuity in providers' following patients from acute to post-acute beds, a practice said to ease problems in the discharge of patients from one setting to another.

■

There are shortages of certain health professionals (for example, pediatric specialists and nurses).

Some participants took part in a pre-site visit to Children's Hospital and Regional Medical Center, which is

affiliated with UW; it handles most pediatric cases, trains 72 pediatric residents, and conducts pediatric-based research. Participants learned that there is a shortage of pediatric specialists, at a time when policymakers in Washington have become attuned to thinking of pediatricians mainly as primary-care providers. (However, the graduate medical education program for children's hospitals enacted in late 1999 does not differentiate between types of pediatric residents.) A severe shortage of nurses of all types was also pointed out, with one participant noting that a positive benefit of a BBA provision on independent practice for nurse practitioners was enhancement of the value of their work.

■

CHIP is viewed as unsuccessful in Washington, because providers do not want to accept patients and because enrollment has been slow.

Washington had already moved to 200 percent of the federal poverty level for Medicaid eligibility before CHIP was enacted as part of the BBA. So Washington's CHIP target is to enroll eligible children at 250 percent of poverty in its Medicaid program. Because this applies only to 9,200 children (out of 72,671 children who are uninsured), the chances for success seem slim, according to information provided by Children's Hospital and Regional Medical Center. While CHIP did not figure prominently in site visit discussions, the comments about it invariably centered on its small enrollment and its general lack of acceptance by providers.

■

Overall, UW health facilities' level of acuity is higher than the levels of other providers in the area, which has led UW officials to seek a severity adjustment, but the adjustment's definition and ultimate benefit are in doubt.

UW participants presented a Milliman & Robertson, Inc., analysis of patient severity and efficiency that compared UW Medical Center 1995 and 1996 data on commercial patients with those of three other hospitals. The firm used specific ALOS and charge bias to examine discharges for all patient refined diagnosis-related groups (APR-DRGs). It found an estimated severity factor of 1.41 percent, which it said was "the highest we have found for any health care system we have evaluated, academic or otherwise." The firm also looked at inpatient records for commercial patients treated at UW Medical Center in 1997. Its analysis "indicated 125 potentially avoidable days out of a total of 1,057 days reviewed, or 12 percent of total days." The firm concluded that the "finding of 12

percent potentially avoidable days is one of the lowest we have observed and indicates well managed delivery of care." It concluded that current case rates "do not accurately compensate for the care of these severity level patients." Responding to UW's assertion that it handles 70 percent of the high-risk obstetrics patients in the Seattle area, federal participants questioned the availability of an adequate measure of severity, the determination of winners and losers relative to the type of measure, and, because the IME is used as an indicator of greater acuity in teaching hospitals, the need to separate out what supports teaching and what supports patient care.

■

While confusing in policy terms, the lack of explicit definitions for Medicare payment adjustments—for example, IME and DSH—is viable in political terms.

Picking up on the discussion of the level of acuity and the fuzziness of the concept of IME and, to some extent, DSH, some participants indicated that strict definitions would fail to gain the adjustments political acceptance. Other participants pointed to the need for targeting and adjusting for specific needs: in the case of IME, the costs of training residents, and, in the case of DSH, care for low-income people in the Medicare program.

■

Across the country, the VA's relationships with AHCs in providing safety-net services to veterans, offering health professions education, and conducting research (especially in focused areas, such as spinal-cord injury) tend to be overlooked. This is not the case in Seattle.

VA Puget Sound Health System is a vital partner of UW. VA Puget Sound Health System has 250 staff with faculty/teaching appointments at UW. Whether in providing care to service-connected veterans (and being part of the safety-net that reaches out to the homeless); educating 500 medical residents (a \$7 million program) as well as nursing, dentistry, social work, and pharmacy students; or conducting research, it has a large presence. Of VA units, it is the fourth largest service network and has the second largest research program in the country.

■

UW faces significant cross-cultural pressures, such as Harborview's need to provide interpreters for 70 languages, and is responding positively.

UW's cross-cultural initiatives—responding to the patients from diverse immigrant populations in the area—has become a model for other parts of the country. For example, UW has a web link called “EthnoMed” that provides cultural profiles, medical topics, cross-cultural issues, and patient education. Some participants were intrigued by the challenges UW—especially Harborview Medical Center—has relative to cross-cultural competency, the growing emphasis on effective responses from the health care system, and the costs involved.

somewhat of a power struggle, similar to that played out in Washington, D.C., in the aftermath of the BBA and passage of the BBRA.

■

One of the top academic research institutions in the country, UW has research initiatives ranging from collaborative programs with the Fred Hutchinson Research Center, where the physician who developed bone-marrow transplants is on staff, to a Harborview Medical Center facility that conducts research centered on the health problems of vulnerable people.

In exploring UW's research initiatives, participants saw the same degree of scope and breadth that they had with its service delivery and education missions. Although they spent less time discussing and seeing research components—because of lesser relevance to BBA provisions—they nonetheless appreciated the commingling and interdependence of UW's three missions and the participation in all three by some UW faculty and staff with whom they talked. Prominent examples are John Harlan, M.D., of Harborview Medical Center's Research and Technology Building, who provided a tour of the new facility, and Christopher Marsh, M.D., associate director of the Division of Transplantation, UW Medical Center, who described the service, education, and research aspects of UW's transplant program. Similarly, they benefitted from the health services research of the Health Policy Analysis Program, which publishes studies of health care in Washington on an ongoing basis.

■

In responding to the BBA, UW seemingly is not changing its modus operandi but is staying on course and is seeking revisions in policy.

Some federal participants came to Seattle expecting behavioral changes at UW in response to BBA provisions. They came away from UW believing that the AMC itself does not want to change the ways it is addressing its service, teaching, and research missions to adapt to the changes, but instead wants policymakers to revise the policies to fit their practices. In this sense, there was

The Annapolis Conference: Overall Perspectives

The April 27–28 Annapolis conference had three primary aims: (a) to put the BBA into context, particularly relative to Medicare’s role; (b) to explore the post-BBA implications for hospital-based systems, and (c) to examine ways of aligning public and private incentives in delivery and payment of health services. The two days of briefings and discussions, focusing on the three case studies (Bon Secours, Henry Ford, and UW AMC), resulted in some concluding views as well as some new questions, contributing to an agenda for future NHPF meetings and site visits.

Putting the BBA into Context, Particularly Relative to Medicare’s Role



The three driving forces for the BBA Medicare provisions were to reduce growth in federal spending for health services, expand private options for beneficiaries, and eliminate cost-based reimbursement by extending the Medicare prospective payment system (PPS) to additional services.

When the bipartisan BBA was passed in 1997, achieving a balanced budget was a major concern. Medicare budget outlays were increasing rapidly, with home health the fastest growing Medicare program of all. Another motivator was the desire to inject private market incentives into the Medicare program: to offer beneficiaries a choice of managed care services and to encourage health plans to compete to enroll them (ideally, with added benefits). This led to inclusion of Medicare+Choice in the BBA. A third impetus was to continue the move toward prospective payment of Medicare services by placing home health, skilled-nursing, and rehabilitation services, as well as hospital outpatient care, under separately developed PPS arrangements.



The BBA was a broad-brush effort to reduce the growth of health costs relative to those of other budget categories, recognize the importance of Medicare as a portion of the overall budget, and adjust the payments for Medicare Part A services (paid from the payroll-tax-based Hospital

Insurance Trust Fund) relative to those for Medicare Part B services (paid from beneficiary premiums and general revenues).

In 1997, with discretionary federal funding already squeezed and Social Security off limits, Medicare became the major target of federal budget cutters. Short of significant tax increases, the budget could not otherwise have been balanced, some federal participants pointed out. Moreover, the looming retirement of baby boomers put pressure on budgeteers. While lawmakers were reluctant to engage in Medicare reform, they could—and did—consider achieving budget savings by reducing provider payment rates. At the same time, they deemed the program too important to impose cuts that might compromise services. Additionally, with the Medicare trust fund projected (at the start of 1997) to start running out of money in 2001, the drafters of the legislation were able to address the drain in part by moving most of home health services to Part B.



On the acute-care side, teaching and safety-net hospitals seem to be the providers most affected by BBA provisions, while on the post-acute side, home health and SNFs appear to be receiving the most impact.

The BBA targeted certain hospitals and providers. For instance, in making reductions in the Medicare indirect medical education (IME) adjustment and in Medicare disproportionate-share hospital (DSH) payments, it more heavily affected teaching hospitals and safety-net institutions, which are sometimes one and the same. But some participants indicated that the goal was to restrain Medicare spending relative to hospitals that they thought were overpaid (as reflected, in part, by operating margins), and the additional payments resulting from the IME and DSH adjustments therefore became targets. In subjecting Medicare post-acute and outpatient hospital care to PPS arrangements, the BBA also focused on the providers of those services, although full implementation had yet to be achieved at the time of the site visits and the Annapolis meeting. Mainly because of the pre-PPS interim payment system established by the BBA, participants tended to think that home health and SNFs received the hardest BBA post-acute “hit.” However, they disagreed about whether that entailed the weeding out of unnecessary, uncovered, or fraudulently

obtained care or the rationing of necessary, covered, and appropriate services.

■
In singling out individual components, the BBA swept into the “intricate webs of internal and external cross-subsidies the federal government provides for care of the poor, teaching medical students, and conducting clinical research.”

Not only in its provisions (such as IME and DSH) but also in its squeezing out of opportunities for cross-subsidies, the BBA affected the delicate balance upon which federal payments to AMCs have depended over the years. Different participants reached different conclusions about the value of doing this, based on whether they think the cross-subsidies support excessive payments or result in valued outcomes.

Exploring the Post-BBA Implications for Hospital-Based Systems

The definition of the Medicare home health benefit is unclear, while that of the Medicare SNF benefit is clear and has standards. Participants agreed that the home health benefit differs significantly from the SNF benefit, which is well-defined in law, carefully monitored, and subject to conditions of participation that have been revised over the years. The home health benefit, on the other hand, is “fuzzily defined,” difficult to supervise because it takes place in patients’ homes, and not subject to a comparable level of standards.

■
There is disagreement over the effects of the BBA on discharges from acute-care settings and on referrals for services.

While 38 percent of the BBA reductions in Medicare came from hospitals, participants were unsure of the effects on those institutions. One theory is that the BBA is increasing discharges. Another is that it is resulting in patients’ staying in acute beds longer because of greater difficulty—particularly for more complex patients—in referring them to BBA-affected post-acute settings. While there is anecdotal evidence from providers and some studies—for example, conflicting results from the General Accounting Office and Center for Health Policy and Research on access to home health care—the debate continues.

■
Policymakers and providers alike are sorting out BBA effects (as well as the

ameliorating effects of the BBRA) and the continued rollout of additional BBA policy changes over time.

It is difficult to assess the impact of the BBA because of the transitional implementation of some BBA changes, provision for shifts in payment systems (in the case of home health, for instance, from an interim payment system to a PPS), and amendment of some of the BBA provisions by the BBRA.

■
Policymakers and providers also are sorting out BBA-BBRA effects relative to Medicaid, particularly in terms of the impact of changes in Medicare on the Medicaid market.

It was brought out that a reduction in Medicaid payment rates in some states (such as Michigan)—occurring at the same time as Medicare BBA changes—complicated provider efforts to adjust. While policymakers have been more concerned about the impact of changes in welfare law upon the Medicaid program, they would do well to look at Medicare-Medicaid interactions, as well as the effects on dual Medicare-Medicaid eligibles and on persons “on the edge” (relative to their becoming eligible for Medicaid or of needing indigent care).

■
Policymakers and providers additionally are sorting out BBA-BBRA effects relative to those that resulted from changes in the private health marketplace.

Rapid changes in the health marketplace—for example, mergers and acquisitions, managed care fiscal arrangements, and adoption of care management programs—make it difficult to separate the impacts of legislative and regulatory changes from those of plan and payer actions.

■
For organizations that lobbied for changes to the BBA, the BBRA is just a down payment.

Providers who participated in the Annapolis conference saw the estimated \$16 billion in BBRA Medicare savings over five years to be retained by the industry as a first step in reversing BBA provisions. Some of the federal participants, on the other hand, indicated that, in the words of one participant, “the feds were rolled.” All of the hospital systems provided data on the potential impact of various provisions in the BBA (and the ameliorating

effects of the BBRA). Some federal participants, questioning the methodologies suggested by provider lobbying groups and the validity of studies conducted by contract research organizations for such groups, seemed doubtful. All seemed to agree on the importance of and the need for getting good predictive and impact data.

■

While the industry charge that the BBA has given the wrong message to efficient and innovative providers draws some federal adherents, it distresses others.

Provider participants and some of the federal attendees contended that provisions in the BBA give the wrong message to providers, particularly efficient ones that are harder hit than inefficient or new providers because of baselines and certain other factors. For example, they said the “caps” on medical rehabilitation services in the BBA (revised by the BBRA) and the expansion of PPS to post-acute services emphasize cost over quality of care. Other participants, mainly federal, indicated that the BBA changes bring cost to bear as a positive factor in whether and how care should be delivered and actually provide incentives for efficient providers. On a related point, some providers charged that the BBA is having an adverse impact on providers’ willingness and capacity to innovate—that providers and plans that play it safe do better than those that try or adopt new approaches. They cited the blow to newly thriving rehabilitation firms because of the physical therapy, occupational therapy, and speech-hearing-language pathology provisions in the BBA. They mentioned health plans’ difficulty with the Medicare+Choice program, as it was mandated by the BBA. They brought up prominent progressive AMCs that have suffered well-publicized setbacks. Other participants challenged the bases for such claims. They indicated that the providers’ strategies may have been rash or not thought out or that the organizations may have been victimized by market forces unrelated to legislative actions.

■

In assessing BBA-BBRA as well as market changes, it is important to look at the significance of the growth of pharmaceuticals.

While pharmaceuticals’ increasing share of the health care dollar was not related directly to BBA or BBRA provisions, numerous participants found it worth noting. In examining various BBA provisions—relative to their compound effects on hospitals and health plans—various participants noted the importance of taking pharmaceutical costs into account. That is, such costs have exacerbated the

impact on facilities and therefore should be given attention in any future determinations policymakers make relative to the delivery and payment of health services.

■

The BBA forged some new federal-state linkages that bear examination and evaluation.

This point received little discussion and may, in fact, belong to the conference’s research agenda. Nonetheless, it highlighted the growing influence of Medicaid on the managed care marketplace, the Child Health Insurance Program that was enacted by the BBA, the impact of welfare changes, the state and regional differences in health plan acceptance of Medicare+Choice, the failure of provider-sponsored organizations as authorized by the BBA, and other initiatives.

Aligning Public and Private Incentives in Delivery and Payment of Health Services

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There are various views of the process of change, as initiated by the BBA: (a) change does not happen until it has to, (b) change is occurring in every direction (for example, inpatient, outpatient, and post-acute), (c) change is very difficult to cope with, and (d) change can force a reevaluation of operational and managerial practice, leading to a stronger organization.

Participants expressed these concepts of change during the two-day Annapolis conference. Overall, they implied that policymakers seem to be pushing change and providers and plans are resisting it. Moreover, in the view of some, the current unrest over the sweeping BBA legislation is due to the field’s experiencing too many changes (for example, the fallout of merger and consolidation activity, hospital purchase of physician practices, and heightened government anti-fraud and -abuse initiatives).

■

Policymakers are concerned about the impact of multiple changes (for example, in Medicare, Medicaid, welfare, and anti-fraud and -abuse initiatives) as well as about their combined effects upon providers and patients.

A lot of policy changes occurred around the same time, as Congress and the president strove to reduce health care outlays in Medicare and Medicaid and provide a

transition for Aid to Families with Dependent Children (AFDC) recipients to enter workfare programs and cut the AFDC-Medicaid link. Moreover, with stepped up funds, the DHHS inspector general, in coordination with the Department of Justice, intensified efforts to attack fraud and abuse in federal health programs. The multiple program changes, combined with the anti-fraud and -abuse efforts (and their chilling effect), have had a strong impact upon providers and the patients they serve.

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A complex data problem is apparent: the BBA projections demonstrate difficulty in making estimates and projections, in sorting out costs and revenues, and in taking into account the interaction of federal and state programs.

While some participants pointed to inadequate data and others to wrong data, all agreed that lack of accurate data is a major shortfall in understanding the BBA and is a major pitfall in health policy. “There’s no point at which data are stable,” one participant said, noting the absence of realistic baselines upon which determinations can be made. Another participant stressed the importance of independent data, contending that studies contracted for by interest groups tend to be biased. Still another indicated that “pulling numbers out of the air is scary”—that more needs to be done to get good data and to facilitate judgments about connections and interactions.

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Regional differences get too little attention in the formulation and implementation of Medicare policy.

Various participants—from both the provider and the federal sectors—underlined the importance of regional differences in the delivery of health services and the need for recognition of these differences in payment policy. They stressed that BBA-BBRA provisions are affecting different parts of the country unevenly, due to practice patterns, demographics, and other factors. While health plan acceptance (or the lack thereof) of Medicare+Choice may be the most obvious example, the inclusion of outpatient services in PPS and the challenges of providing home health services drew attention as well. A key question was how to differentiate the unique needs of each market. Another was whether or not the federal government should adopt such a strategy at all. For instance, when do Medicare reimbursement policies seriously jeopardize access to care for beneficiaries and under what circumstances should the Medicare program consider modifying its reimbursement policies in certain markets? Another was how to

analyze the impact on payment rates of federal and state interactions.

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A major policy question is whether or not there should be a common denominator for the public contributions to AMC service, teaching, and research missions—if the policy goal should be to seek an average in the level of facilities, provision of care, training of students, and conduct of research.

This question arose during discussion of the UW AMC case study and focused on the use of federal government resources to help support AMCs. Given a limited pot of health service, health professions education, and research dollars, should the funding be divided among various institutions or targeted to those that have demonstrated the best quality or highest success? In other words, with certain geographic and other considerations, should the center-of-excellence concept apply to AMCs? Should an AMC be rewarded for drawing resources from other public as well as private sources, offering top-notch clinical and educational services as well as pursuing various lines of research, and otherwise acting like “the best”? Or does that put it in a “no-win” position as far as federal policymakers are concerned? Should National Institutes of Health funds, for instance, be concentrated among a small percentage of AMCs, as they are now, or spread out more equally among those that have research programs? All of this centers on the question of “averaging” in the distribution of federal funds, inviting future debate.

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HCFA needs to undertake aggressive and proactive development and monitoring activity, using diverse indicators, to determine the area impacts of its policies.

Because the traditional data sources are unreliable or lag behind developments in the field, one participant said that HCFA is trying new outlets and is seeking others. For example, by looking at employment trends in the industry, carrier and fiscal intermediary daily reports on providers, regional office information, and other data, HCFA might be able to get a better idea of the effects of its policies on providers and plans. As private data resources dwindle (for example, the American Hospital Association has dropped its monthly panel survey of community hospitals and the American Medical Association is cutting back on its data initiatives), participants indicated that HCFA needs to do more in developing existing data sources and creating new monitoring mechanisms.

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The BBA and BBRA renewed the debate about medical education issues, such as which providers should be recognized, whether there should be a proxy for case mix and severity of illness, and how explicit definitions should be relative to social goods.

Renewing an old debate about the federal role in medical education, participants looked at whether patient services should be subsidized by medical education payments. They also explored whether the IME is an appropriate proxy for teaching hospitals' greater case mix of complex patients requiring more intensity of care, and what the tradeoffs (relative to safety-net patients) are between the IME and DSH adjustments. For example, the same institutions commonly have received both adjustments, with the residents upon which the IME formula is based tending to be the providers of services to the low-income patients upon which the Medicare DSH adjustment is defined.

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The BBA and BBRA also highlighted the need for appropriate measures of risk adjustment, severity of illness, and intensity of services and the usefulness of morbidity, co-morbidity, and mortality data in developing policy, devising payment strategies, and assessing quality of care.

Participants acknowledged that the health industry is still grappling with the need for adequate measures to differentiate among providers and patients and that it is still arguing about the effectiveness of the measures that it has.

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Growth of the uninsured needs to be taken into account in aligning and assessing incentives for delivery and payment of services for publicly (and privately) insured patients.

With the uninsured having reached 44 million persons in a robust economy, a few participants raised the subject of the role of social goods in health policy. HFHS President Warden addressed the cumulative effects of reductions in DSH payments, slim hospital margins, and other factors on community-based programs, health promotion and preventive care, AIDS and other specialty clinics, innovations in long-term care, and other programs. Calling the growth in uninsured "a ticking time bomb," he and others raised the question of what happens if the economy declines.

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The BBA has forced providers to pay closer attention to their management and business practices.

Impelled by provisions in the BBA to take a prospective position relative to the continuum of services they provide, providers have had to focus on the business aspects of delivery and payment. In other words, as home health, SNF, rehabilitation, and hospital outpatient PPS strategies are added, providers have to think PPS rather than cost-based reimbursement. As providers compete based on pricing systems—indeed, different pricing systems—their degree of acumen becomes even more important. According to one provider, as a result, "patient satisfaction ratings are higher than they have ever been. We'll come out stronger as an organization. But it has been painful."

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The BBA-BBRA changes raise workforce issues, such as the use and shortage of nursing and service personnel in health care settings and the roles of formal versus informal caregivers.

Participants noted that health industry studies document a shortage of both licensed registered and practical nurses and other personnel and a decline in those being trained. For example, the average age of nurses is over 40, and the vast majority of nurses are women with growing employment opportunities in this strong economy that offer more income and less strain. Some participants blamed the BBA for increasing the stress on workers in already over-stressed health care organizations, especially hospitals. Providers on the site visits and at the Annapolis conference complained most about the problem of getting lower-income workers, those who do service jobs in both acute and post-acute settings. This gave rise to discussions of caregiving, particularly in terms of training family members (informal caregivers) to do some of the housekeeping and patient care tasks previously done by aides and support personnel.

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While continuity of care is given a lot of lip service, it is not a reality.

Although continuity of care seems to have become a "buzz term," it means little, participants concluded. In the fragmented U.S. system, it remains a goal yet to be defined and reached. For instance, some participants assumed that it means the range of services, from preventive and primary through quaternary, offered by paid providers. Others implied that it means the scope of services, from preventive through palliative, provided by both formal

health care workers and informal caregivers. However, in the review of the UW case study, it was pointed out that UW is one of six schools in the nation with a required chronic-care clerkship. UW officials contended that its diverse offerings provide medical students ample exposure to the full continuum of services.



Ultimately, revisiting the BBA and BBRA comes down to what kind of system public policy people can negotiate with providers and plans in order to provide quality care.

Quality of care was a byword of the Annapolis conference rather than a major theme. While it came up often relative to the three systems' efforts to serve their patients, adverse effects due to BBA cutbacks, and the difficulty of assessing the delivery of services in various settings, no conclusions were reached. Federal and provider participants seemed to look to public-private negotiations to ascertain what services consumers want and how they can be delivered and financed.

A Research Agenda

- To explore federal agencies' needs for data and to estimate the funding they would need in order to obtain them.
- To gain a better understanding of the interface between AMCs and the private health marketplace.
- To examine regional differences in home health care delivery in order to better understand "appropriate" home health services for various conditions.
- To make acute-care length-of-stay comparisons pre-BBA and post-BBA.
- To study trends (positive or negative) in horizontal and vertical integration of health systems.
- To examine tax-based funding of health services.
- To look at the interactions between Medicaid and Medicare relative to payment.
- To explore the future of Medicare funding.
- To examine ways of funding GME.
- To revisit the policy of devolution of Medicaid to the states.
- To look at ways of supporting health systems where innovation is taking place and the safety net is assured.
- To consider the growing problem of the uninsured.
- In Medicare payments, to develop ways of accounting for acuity of illness and intensity of services.
- In both entitlement and appropriated spending (with particular reference to AMCs' service, education, and research missions), to look at the concept of "averaging" versus promotion of centers of excellence.
- To conduct research on formal versus informal caregiving along a care continuum relative to both services and payment (or the lack thereof).

Selected Comments from Annapolis Participants

- “It is clear from the three cases and the views of the Beltway folks that there is a huge disconnect between reality and D.C. We need to bridge this gap. Additionally, there is an amazing lack of trust between the two parties. The people providing health care question the D.C. ethics and motives, while the D.C. folks don’t believe (to the point of pushing fraud and abuse actions) the people providing health care.”
- “[We need to look at] the outcome consequences for the BBA and other federal policy changes.”
- “[There needs to be follow-up on] measures, data on interactions, and more.”
- “Try to continue the case study approach. It forces federal staff to justify thinking with real applications. Similarly, political interventions would not be needed if federal policy were more directed by actual examples.”
- “Is there a way to have the same type of discussion with a full standing of providers? (For example, home health agencies, physician groups, hospitals—providers from the same market, working together or not working together.)”
- “After the actual issues are distilled out from the discussions, further programming [should] attempt to drill down to obtain a better understanding of the contributing factors. For example, what makes certain systems efficient? What is the character of the actual impact on ‘safety net’ providers from the BBA? Can incentives be tailored to geographic areas?”
- “What are the effects of market segmentation? Rural, handle with care.”
- “East Coast is always a problem for West Coast people.”
- “Felt we made progress in breaking through prejudices and policy biases derived from 30,000-foot analysis.”
- “Should have invited a ‘failed’ system leader, for example, purchased hospital in Hampton [Roads]/Richmond, Detroit Medical Center [to balance] Henry Ford, and Providence in Seattle.”
- “The disparate pieces of information are difficult to pull together to inform my work, but that is probably the nature of the beast, why this work is so interesting and hard.”



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