

Obamacare changes the way faith-based hospitals deliver care

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Whether most Americans like it or not, the Affordable Care Act—also known as Obamacare—is now the law, and faith-based health-care providers say it’s changing the way hospitals view patient care.

A new poll by the [Kaiser Family Foundation](#) says public support for the Affordable Care Act is at an all-time low, with 53 percent of Americans voicing an unfavorable impression of the law. Numerous lawsuits challenge it, and House Republicans have voted more than 50 times seeking its repeal.

Brian Keeley While almost everyone agrees the 3,000-page law passed by Congress and signed by President Obama in 2010 is far from perfect, healthcare providers don’t have the luxury of watching all the wrangling from the sidelines.

“Whether you agree with Obamacare or not, it’s the law of the land,” Brian Keeley, president and CEO of [Baptist Health South Florida](#), said in blog announcing roll-out of the Health Insurance Marketplace last October. “Baptist Health is well-positioned to meet the challenges and changes of healthcare reform.”

Hugh Greene, CEO of Baptist Health in Jacksonville, Fla., said in a presentation last year the law didn’t come out of a vacuum. Greene said two primary factors—spiraling costs and increasing numbers of the uninsured—have been driving the need for healthcare reform for several years.

✘ Hugh Greene “It is a travesty in the most sophisticated democracy on the face of the earth that nearly 50 million Americans do not have access to the health insurance system as you and I know it,” Greene said. “We see them in the form of the uninsured who come to our emergency rooms on a daily basis.”

Greene was part of the [Health Systems Learning Group](#), a self-organized group of 43 organizations—including 36 nonprofit health systems—participating in meetings across the country over the course of 18 months inspired by passage of the Affordable Care Act and eager to transform their organizations and communities.

Another member, Gary Gunderson, vice president for faith and health of [Wake Forest Baptist Medical Center](#) in Winston-Salem, N.C., describes the law as “a huge landmark” in the history of mission-based health care and “a tremendous opportunity for the faith community to help make it work.”

A different perspective

“The gift of the faith communities at the intersection of faith and health is that we don’t just see it as a journey of death and disease and disability and gradual entropic decline of everything we love and care for in our life, and then we die,” Gunderson said at a [“Navigating the Affordable Care Act Conference”](#) hosted by Garrett-Evangelical Theological Seminary last fall. “Actually, we think life is going on.”

Gunderson, a one-time anti-hunger activist who co-launched [SEEDS](#) at Oakhurst Baptist Church in Decatur, Ga., before joining the [Carter Center](#) as director of the Interfaith Health Program in 1992, said he doesn’t share the view that faith communities once were at the lead of healthcare ministries but that no longer is true.

✘ Gary Gunderson speaks during the opening plenary of the Navigating

the Affordable Care Act Conference at Garrett-Evangelical Theological Seminary last fall. “I think faith-based health care is still in the lead,” Gunderson said. “In a curious way, we just don’t talk about who we actually are very much.”

Gunderson serves on the advisory council of [Stakeholder Health](#), an ongoing learning collaborative of 40-plus health systems and other organizations that see the current public-policy environment as an opportunity for positive change in America’s health-care delivery system.

“The mission, in almost every case, has a deep religious resonance that’s something to the effect that we want to be an agent of advancing the health of our whole community,” Gunderson said of the participating institutions.

Greene insists the old healthcare system—which costs more and has worse outcomes than those in other industrialized nations—is not sustainable. Under Obamacare, Greene explains, the model shifts “from volume to value” in determining how much hospitals get paid.

“We are rewarded based on volume,” Greene said of the old system. “Every time we do something, we get paid. When we do something else, we get paid again.

“And if we don’t do anything, we don’t get paid. So it is a fee-for-service, volume-driven system.”

The new model re-orientes payment incentive toward services and activities that improve patient care by linking reimbursements to patient satisfaction and positive outcome.

For example, Greene said, congestive heart failure is the most common  cause of hospital readmission. Until Obamacare, if a patient were treated and released and later readmitted with a relapse, each visit was billed as a separate hospital stay. Under the Affordable Care Act’s Hospital

Readmissions Reduction Program, hospitals that readmit certain patients within 30 days of discharge are penalized. The idea is to shift the focus from acute care to prevention, and to get more patients under the care of a primary physician instead of more expensive visits to the emergency room.

Early reports indicate in some cases, ER volumes actually have increased under Obamacare, but more of the patients showing up now have insurance. That means instead of eating the cost of uninsured patients, hospitals now are more likely to get paid for emergency room care.

Baptist Memorial Health Care, with 14 affiliate hospitals serving 110 counties in Tennessee, Mississippi and Arkansas, undertook a comprehensive community health needs assessment beginning in late 2011, both to comply with current requirements set forth in the Affordable Care Act and to further the health system's own commitment to community health improvement.

Greene says the Affordable Care Act "is the most significant and complex piece of healthcare legislation in this country since the passage of Medicare and Medicaid in 1965."

"Nothing comes close," he said.

The bill in its current form has many flaws, he asserted. Malpractice reform, a huge factor driving up costs of healthcare, did not make it into the law for political reasons. Unlike Medicare, which was tweaked after passage to address unintended consequences, Greene said, the current deadlock in Congress makes it highly unlikely fixes are coming anytime soon.

Hospitals voluntarily took a cut in the amount they are reimbursed by Medicare, thinking the increase in newly insured patients from Medicaid expansion would more than make up the difference, Greene said. They didn't anticipate the Supreme Court ruling that states could refuse to

accept federal funds to expand Medicaid coverage, and that a number of them would do so.

Under Obamacare, Greene explains, the model shifts “from volume to value.”

In his home state, Greene said, “We are turning away \$50 billion of federal money and leaving 1.1 million Floridians uninsured.”

Some already struggling hospitals may close. Other big-city hospitals, meanwhile, are exploring partnerships to reduce duplication of services that can cost vastly different amounts even within the same community.

Baptist Health South Florida, headquartered in Coral Gables, signed a preliminary agreement in February to explore possible affiliation with [Bethesda Health](#), another not-for-profit hospital based in Boynton Beach.

“We see a very positive cultural fit between our two organizations, which is the foundation for any partnership,” Baptist Health CEO Keeley said. “This possible affiliation would give us the opportunity to jointly develop and share best practices in order to continue improving quality and access to care for our patients. It will also allow us to better prepare for healthcare reform and the Affordable Care Act.”

Kentucky’s Baptist Health—formerly Baptist Healthcare System—formed a joint purchasing agreement for the acquisition and distribution of supplies with Norton Healthcare, expected to save \$15 million over five years for medical and surgical supplies, implants and devices.

Partnerships provide economy of scale

“It’s a new day in healthcare,” said Michael Reeves, system executive of supply chain services for Baptist Health. “Providers are under intense pressure to hold down costs because of the Affordable Care Act and other

reforms, and doing business the way we've always done it simply won't do. Partnerships like these provide economies of scale and allow us to be more efficient in our delivery of quality care."

Early reports indicate hospitals are getting a stronger-than-expected benefit from a new influx of low-income patients whose bills are paid by the government's Medicaid program. The administration says 6.7 million people have signed up for Medicaid and other healthcare programs for the poor since Obamacare enrollment began last October.

HCA Holdings Inc., the largest for-profit hospital chain, reported a 6.6 percent drop in uninsured patients at its 165 hospitals. In four states that expanded Medicaid, the reduction grows to 48 percent.

A big challenge for churches is "to convince people of faith that their faith compels them to the intersection of faith and health," Gunderson said.

A 'profound opportunity'

Most uninsured Americans are not the indigent or elderly, because they are covered by Medicaid or Medicare, he explained. Rather, it's those who work but don't get insurance from their job and cannot afford to pay for it on their own. Those people often are concentrated in communities where churches already minister, he noted.

The Affordable Care Act presents "a profound opportunity" for congregations already committed to a particular community to both "invent some new stuff, and reinvent some stuff we've already got," Gunderson said.

He used a church soup kitchen to illustrate. "Some of the people who are eating soup actually need insurance," Gunderson said. "You're in relationship to them, so what you think is part of the soup kitchen answer of the world turns out to be part of the Affordable Care Act part of the

world.”

The same is true of other groups with structure and a role to play, including less-obvious examples like a prayer group for older women, he added.

“It turns out that’s relevant,” Gunderson said. “They are probably all on Medicare. They don’t need to sign up for the exchange, but they have daughters and sons and their neighbors. They’re relevant.”