MHA Michigan Health & Hospital Association | 100 YEARS OF LEADING HEALTHCARE

To: Members of the Senate Committee on Health Policy and Human Services

From: James “Chip” Falahee, Senior Vice President for Legal and Legislative Affairs
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Subject: Testimony on behalf of the Michigan Health & Hospital Association about the characteristics of urban hospitals

Good afternoon, Mr. Chairman and members of the committee. Thank you for the opportunity to talk about the characteristics of an urban hospital system, and the challenges all hospitals face in the current healthcare environment.

I am James “Chip” Falahee, senior vice president for legal and legislative affairs at Bronson Healthcare system. I joined Bronson in 1987 and have seen many changes in healthcare over that time. I am also the current chairman of the Michigan Certificate of Need Commission (CON). While the time today is not intended to cover CON, as you are aware, Michigan is a state that requires review or prior authorization of certain healthcare investments, such as new hospitals, new ORS, MRIs and CTs. The eleven members of the CON Commission are appointed by the governor with the advice and consent of the Senate. The commission has the responsibility to develop, approve, disapprove, or revise the CON Review Standards. The review standards are used by the CON Program Section to issue decisions on CON applications.

I am happy to provide you with some of my experience and insights today. I hope you will consider me a resource in the future as well, both for CON and hospital issues.

The Bronson Healthcare system is made up of four hospitals located in Kalamazoo, Battle Creek, Paw Paw and South Haven. We are a not-for-profit, community-governed health system serving nine counties in southwest and south central Michigan. With 9,500 employees, more than 1,400 medical staff members, and 836 licensed beds, Bronson is the largest employer and leading healthcare system in southwest Michigan. We are also southwest Michigan’s only children’s hospital and offer a full range of services from primary care to critical care across more than 90 locations. Our annual outreach and charitable care amounted to over $111 million in 2017.

I am proud that I am part of an organization that is committed to delivering exceptional care to those we serve. In 2005, our vision to be a national leader in healthcare quality led Bronson Methodist Hospital to become only the fifth healthcare organization in the U.S. to receive the Malcolm Baldridge National Quality Award. The Baldrige Award is the nation’s highest presidential honor for quality and organizational performance excellence. Each year, it is awarded after vigorous review to a handful of U.S. organizations in the business, healthcare, education and nonprofit sectors.

Bronson Methodist Hospital is also an American College of Surgeons verified Level 1 Trauma Center. The standard for being Level 1 means the hospital can provide complete care for every level of injury from emergency to rehabilitation:

- We have 24-hour, in-house coverage by general surgeons, and immediate availability of care in specialties such as orthopedic surgery, neurosurgery, anesthesiology, emergency medicine, radiology, internal medicine, plastic surgery, oral and maxillofacial, pediatric and critical care.
- We are a referral resource for communities in nearby regions.
- We provide leadership in prevention and public education to surrounding communities.
- We provide continuing education of the trauma team members.
- We have a comprehensive quality assessment program.
- We operate an organized teaching and research effort to help direct new innovations in trauma care.
- We have a program for substance abuse screening and patient intervention.

Bronson Battle Creek Hospital, our Level III Trauma Center, can provide prompt assessment, resuscitation, surgery, intensive care and stabilization of injured patients and emergency operations. This includes:

- 24-hour, immediate coverage by emergency medicine physicians and the prompt availability of general surgeons and anesthesiologists.
- A comprehensive quality assessment program.
- Transfer agreements for patients requiring more comprehensive care at Level I or Level II trauma centers.
- Providing back-up care for nearby rural and community hospitals.
- Continued education of the nursing and allied health personnel or the trauma team.
- Prevention efforts and an active outreach program for our referring communities.

Many things are going well for the Bronson health system and organizations like the one I represent. However, healthcare is changing rapidly around us. Healthcare is no longer tied to a single location downtown, or a large tertiary care campus spread across a multi-acre plot with a large parking lot. For people who are generally well, and who have few healthcare needs, which is most of us, a large tertiary care hospital is a landmark, not a destination. People without serious illnesses or complicated chronic diseases may not use the healthcare system at all. Instead, they may visit an urgent care center, a walk-in clinic, or use their smart phone to conduct an online visit for minor healthcare needs. Just this week, there was an article in the Wall Street Journal titled: *It's Time to Fire Your Doctor*. The author noted that medical technology allows us to monitor health, get advice and seek care remotely and cheaply. Surgeries, too, are moving away from the inpatient setting to outpatient care.

Disruptors to the healthcare marketplace, whether they be CVS-Aetna, Amazon, Berkshire Hathaway, J.P. Morgan, or Silicon Valley entrepreneurs, are hoping to find ways to make healthcare more readily accessible, cheaper, less time-consuming and frictionless. Suffice it to say, they are not concentrating their efforts on the Medicare and Medicaid population. However, at the same time, hospitals must maintain staff and infrastructure, which involve high fixed costs. Nonprofit hospitals must also remain committed to serve Medicare and Medicaid and charity care patients. This leaves the burden of fixed costs and the underfunded government programs to the healthcare system to try to absorb.

I gave you an extensive description of our Level I and Level III trauma resources, because I want to make the point about fixed costs. To be a Level I Trauma Center, all surgeons and other personnel, as well as the programs and facilities I previously listed must be in place at all times. Whether we have five trauma patients this week or 105 trauma patients, everything must be available and on stand-by 100 percent of the day and night. Teaching our physician residents, which involves a program director who is a skilled physician as well as numerous attending physicians, is a year-round activity and is not dependent on volume (other than to the degree that we meet the minimum requirements for being Level 1 certified).

Many times, you will hear the claim that healthcare will be less expensive if we can just reduce the number of patients who are seen in hospital emergency departments. This is only true for the marginal

costs of emergency care. To provide access to emergency trauma services in our state, we must incur sizable fixed costs which continue regardless of how many people are directed away from a hospital.

I also mentioned that hospitals are always available to Medicare and Medicaid patients. In Michigan, almost 25 percent of our citizens use Medicaid as their healthcare coverage; 20 percent are enrolled in Medicare. Neither the Medicare nor Medicaid program rates cover the entire cost of caring for the patients they insure. This means that 45 percent of the people in our state who visit a hospital for emergency services, inpatient care, cancer treatment, or to deliver a baby, have an insurance card that promises to pay a fee that is less than what it costs to care for that patient. Anyone who is an entrepreneur will tell you it is unwise to design a business model aimed at attracting any sizable amount of its reimbursement from government programs.

Almost all hospitals in Michigan have a mission of caring for everyone in their communities, regardless of their ability to pay. As I like to say, hospitals do not do a “wallet biopsy” on a person before he or she is admitted as a patient. As a not-for-profit organization, Bronson regularly faces an intense challenge of finding the way to provide all of the services, technology and facilities our communities need, while accepting the limited payments from our government programs, negotiating with our largest commercial payer, Blue Cross Blue Shield of Michigan, which imposes both traditional and creative cost containment strategies of its own, and doing the same with other third-party payers, which have similar strategies to reduce what they pay for healthcare services. This is all in the context of the disruptive marketplace I mentioned earlier, and those disruptors to “remake” the healthcare system into something less complex and more profitable.

These pressures mean hospital operating margins are getting thinner and thinner, and sometimes are in the red, even for the larger healthcare systems. Not everyone will make it as this new marketplace continues to develop. I foresee continual consolidation in the healthcare market as these pressures increase.

You may believe that covering nearly 700,000 new lives in Michigan through the Healthy Michigan Plan is a windfall for hospitals. Yes, the Healthy Michigan Plan is a financial positive for health plans, who receive premiums every month for every covered life, and for hospitals, who receive reimbursement for the patients when they receive services.

But those reimbursements come with a price tag. Beginning in April 2010 (even though Healthy Michigan did not begin until April 2014), Michigan hospitals began taking mandated reductions in Medicare reimbursement to help pay for coverage expansion under the Affordable Care Act (ACA). For 10 years, from 2010 to 2019, Michigan hospitals will forego $7 billion in Medicare reimbursement to pay for coverage expansion. This reduction comes out of the base and will permanently reduce the cost of Medicare reimbursement.

In addition to the $7 billion contribution Michigan hospitals make for the ACA, Michigan hospital Medicare reimbursement was reduced by almost the same amount ($6.9 billion), over almost the same time period and beyond, for the federal budget sequestration. Sequestration reduces every Medicare bill paid to every hospital by two percent. This type of government payment policy helps explain the financial pressure on legacy hospital systems.

Under reimbursement in one area of the operation can threaten the financial well-being of an entire hospital. As of now, Bronson has not been one of those systems that has had to make difficult decisions about cutting services, like labor and delivery or psychiatric services, to make ends meet. But I hope you can understand why any hospital organization, large or small, urban or rural, may be forced to make such difficult decisions in the disruptive climate we are in. This is never a happy circumstance for the hospital board, leadership and community. However, it is a financial reality in many areas of the country, including Michigan.

In summary, there are many positive and exceptional things happening at Michigan hospitals. We are leaders in being aware of the need to continually improve our service and the quality of care we deliver to our patients. We have achieved remarkable progress in providing new coverage through the Healthy Michigan Plan. We remain challenged in the disruptive healthcare marketplace as new entrants seek the profitable areas of healthcare and leave the costly, complex patients to the legacy healthcare systems.