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Vizient Research Institute 2022 Study Findings

Reducing Health Disparities: A Common Goal

America is becoming increasingly uncomfortable with—approaching an outright intolerance for—health disparities. Inequalities in health status can arise biologically or socioeconomically. Everything from genetics to food insecurity, education, homelessness, employment, or social isolation contributes to a person's wellbeing. On the other hand, healthcare disparities can arise from the same socioeconomic factors as well as insurance status. Patients with private insurance tend to have superior access to healthcare services than the uninsured or those funded by public programs, particularly Medicaid.

Payer mix has the largest single impact on the financial position of any healthcare provider. Government payers often pay providers unit prices below the cost of providing services. Losses accruing from publicly funded patients are offset by profitable revenue arising from higher private sector prices for the same services. We aspire to eliminate healthcare disparities, but the current financing system makes it economically impossible for providers to avoid favoring one subset of the population over others when investing in infrastructure and implementing regional strategies. To afford any care for the underserved, providers must pursue privately insured patient volume, with its higher unit prices and profitable revenue streams.

The 2022 Vizient Research Institute investigation centered around a fictional case study set in the future and assumed the emergence of regional healthcare cooperatives (RHCC), which controlled all spending for the populations within their geographic borders. The project involved a year-long roleplaying exercise for member senior executives organized into four task forces. Each task force served as the governing board of a hypothetical regional healthcare cooperative. Participants were asked to step outside of their normal professional roles and to serve as the stewards of regional resources and the wellbeing of those fictional populations. They were tasked with articulating a set of guiding principles and adopting directional policies around a new financing system intended to reduce or eliminate healthcare disparities.

The case study described a series of social crises, which in turn created governance imperatives for the task forces. The three social crises were: 1) Healthcare disparities result in civil unrest and political upheaval over access barriers and unacceptable gaps in infrastructure. 2) School violence, opioid addiction, suicide rates and pandemic stress combined to create a mental health calamity and 3) The sheer scale of health systems has resulted in their tax-exempt status now being on the table for public debate.

The crises created five governance imperatives for the regional healthcare cooperative task forces:

1. Establish the scope of the common good classification; how much of healthcare is to be a regulated entitlement and what should be left to the market to price and distribute?
2. Regulate prices of common goods to remove economic bias toward the privately insured population.
3. Expand access in traditionally underserved geographies and narrow infrastructure gaps to alleviate "experiential disparities."

4. Expand regional capacity in mental health.
5. Address dwindling tolerance for public's perception of corporate medicine.

The task forces convened multiple times throughout the year to address each government imperative, review data analyses, and discuss implications associated with the solutions proposed by the RHCC governing boards. In undertaking these challenges, the RHCC governing boards envisioned three foundational and four infrastructure changes to the way that we pay for healthcare.

The first foundational change came in the form of an answer to an often-asked question: Is healthcare a right or a privilege? In contrast to the current financing system, which leaves both pricing and care distribution to the market, task forces determined that all medically appropriate services—everything traditionally covered by Medicare or private insurance—would now be considered common goods…universally available with prices regulated. The second foundational change would discontinue the cross-subsidization of unprofitable public sector patients by highly profitable private sector margins, which has contributed to an economic bias toward privately insured patients. In its place, the task forces voted to institute all-payer price parity. Citing public/private price inequality as a root cause of healthcare disparities, members made all-payer price parity the cornerstone of their systemic changes. The third foundational shift moved away from pure fee-for-service payments to global spending budgets. Not to be confused with capitation, global budgets were neither linked to specific individuals nor did they involve the assumption of actuarial risk. Based on recent regional utilization patterns and periodically recalibrated to reflect durable volume changes, global spending budgets would give providers flexibility to innovate while reducing short-term economic pressure to compete for incremental market share.

Once the foundational changes were enacted, the task force members turned their attention to infrastructure initiatives. The first two initiatives employed similar financing mechanisms. Regions would retain funds (withheld from global spending budgets of all provider systems) to (i) facilitate targeted investments in mental health and rural access and (ii) infuse capital into historically underfunded facilities. The third infrastructure change would be transformational. Members mandated clinical program consolidation—first within health systems but between health systems if necessary—to eliminate the performance of high-risk procedures in settings below widely accepted minimum proficiency thresholds. Over time, global spending budgets would be expected to motivate additional program consolidation whenever economic efficiencies could be achieved. Finally, concerned by the erosion of public perception over healthcare as big business, and faced with vulnerability over tax-exempt status, the task forces took two additional steps: (i) unless granted a specific exception, proposed mergers or acquisitions involving potential partners with no contiguous service areas would be prohibited; and (ii) the administrative component of any health system's global spending budget would be capped at a regional benchmark. Capping administrative overhead at regional benchmarks would generate savings sufficient to fund 20% of the incremental demand expected to result from the inclusive consideration of all medically appropriate services as common goods.

Role-playing exercises such as that employed in this study afford participants the opportunity to assess their environment from outside the confines of their day-to-day responsibilities and to contemplate solutions to refractory problems from new vantage points. This approach blended the hypothetical set of facts with a highly quantitative and iterative assessment of the potential economic impact of a range of policy options under consideration by the participants. The most important discovery arising from the

study came as a result of reverting task force members back to their traditional roles and asking them to respond as stakeholders to the changes that they had enacted as RHCC board members. Particularly noteworthy was their reaction as providers to their earlier adoption of all-payer rate parity as a necessary condition for the reduction of healthcare disparities. Rather than being viewed as a disruption to business as usual, all-payer price parity emerged as an enabler of long held, but largely unmet organizational priorities. Migrating more inpatient care to outpatient settings or to the home, investing in the medical manifestations of social determinants of health, and consolidating clinical programs would be measurably more achievable with all-payer price parity than they have been without it.