BREAKING THE MOLD TO ADAPT TO PAYMENT AND DELIVERY CHANGES

Presentation to the Rural Hospital Conference

May 13, 2015

Avon, Colorado

Keith J. Mueller, Ph.D.
Director
RUPRI Center for Rural Health Policy Analysis
Head, Department of Health Management and Policy
College of Public Health
University of Iowa

Overview

- Change is here
- Creates opportunities as well as threats
- Why respond other than an incremental adjustment?
- How should organizations (hospitals) respond?
- What are the results to which we should aspire?

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“The Times They are A-Changin’”

Come gather 'round people
Wherever you roam
And admit that the waters
Around you have grown
And accept it that soon
You'll be drenched to the bone
If your time to you
Is worth savin'
Then you better start swimmin'
Or you'll sink like a stone
For the times they are a-changin'.

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Times When Rural Delivery Can Change or Sink

- Hospital care as the cornerstone of health care: rural challenge answered with Hill-Burton
- Hospital financial structure challenged by Prospective Payment System (PPS): rural challenged answered with Flex Program
- Health care delivery challenged by changes in site of care and payment shift to “value”: rural challenge answered with …

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Current rural landscape

- Population aging in place
- Increasing prevalence of chronic disease
- Sources of patient revenue change, including doubt about ability to collect in era of increased use of high deductible plans
- Is small scale independence sustainable?

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The Answer Is …

- “My sense is that most small, rural hospitals have a feeling they will need to pick a partner eventually. Rural communities in the West are fiercely independent. It’s how they define who they are. John has a good hospital and he’s an excellent administrator so they don’t feel desperate. But it’s hard for rural hospitals to look ahead and think that they won’t have to have a partner.” [Sr VP for network development at Centura Health]

The Answer Is …

- "There has to be a way for small, independent hospitals to show that they have high-quality, affordable care and to get reimbursed for what they do locally." [CEO of Black River Falls Hospital in Wisconsin]
- "Everyone is having trouble crossing the shaky bridge into value-based systems. If we do it correctly, rural health care will emerge stronger. I'm bullish on it in the long. In the short-run? We will have a lot of trouble." [Brock Slabach, NRHA]

Source: Rite Pyrillis, "Rural Hospitals Innovate to Meet New Health Care Challenges." *Hospitals and Health Networks* January 13, 2015 http://www.hhnmag.com/display/HHN-news-article.dhtml?dcrPath=/templatedata/HF_Common/NewsArticle/data/HHN/Magazine/2015/Jan/cov-rural-hospitals-challenges

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Tectonic shifts occurring

- Insurance coverage shifts: through health insurance marketplaces; private exchanges; use of narrow networks
- Public programs shifting to private plans
- Volume to value in payment designs

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Policy Change: Insurance Coverage

- Approximately 15 million newly insured as of Q1 2015: health insurance marketplace enrollment, Medicaid enrollment, employer-based insurance, purchase from traditional sources
- National data for all adults show 7.2% increase in insurance coverage in rural, 6.3% in urban (Urban Institute data)
- In Colorado 141,639 through “Connect for Health Colorado,” 433,172 through Medicaid & CHIP (state data)
- New payment contracts to negotiate for rural providers

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Tectonic shifts occurring

- Public programs shifting to private plans

Medicare Advantage and Changes to Medicaid Programs

- Rural Enrollment in MA, including prepaid plans, as of March 2015 more than 2.0 million, 21.2 percent of all beneficiaries
- Medicaid conversion to managed care organizations contracting to provide care; the MCOs determine provider payment
- Variations of accountable care organizations, with provider risk sharing

Colorado and Other States

- Managed care to ACOs to …
- Managed Care Organizations since 1983
- Accountable Care Collaborative started in 2011; now enrolling 58% of Medicaid clients
- Net savings of $29 to $33 million: reductions in ER use, imaging services, readmissions
- Oregon with Coordinated Care Organizations (2012
- Minnesota with Integrated Health Partnerships (2013)

Sources: Colorado Department of Health Care Policy & Financing, “Accountable Care Collaborative: 2014 Annual Report

Tricia McGinnis, The Commonwealth Fund, “A Unicorn Realized? Promising Medicaid ACO Programs Really Exist” March 11, 2015

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Tectonic shifts occurring

- Volume to value in payment designs

Speed and Magnitude: Goals for Medicare Payment

- 30 percent of Medicare provider payments in alternative payment models by 2016
- 50 percent of Medicare provider payments in alternative payment models by 2018
- 85 percent of Medicare fee-for-service payments to be tied to quality and value by 2016
- 90 percent of Medicare fee-for-service payments to be tied to quality and value by 2018

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Parallel in Commercial Insurance

- Coalition of 17 major health systems, including Advocate Health, Ascension, Providence Health & Services, Trinity Health, Premier, Dartmouth-Hitchcock
- Includes Aetna, Blue Cross of California, Blue Cross/Blue Shield of Massachusetts, Health Care Service Corporation
- Includes Caesars Entertainment, Pacific Business Group on Health
- Goal: 75 percent of business into value-based arrangements by 2020

Source: http://www.hcttf.org/

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Evolution of Medicare Payment Through Four Categories

- Fee-for-service with no link to quality
- Fee-for-service with link to quality
- Alternative payment models built on fee-for-service architecture
- Population-based payment

Source of this and following slides: CMS Fact Sheets available from cms.gov/newsroom

Illustration of Move to Population-Based Payment

	Payment Taxonomy Framework			
	Category 1: *Fee for Service—No Link to Quality*	**Category 2:** *Fee for Service—Link to Quality*	**Category 3:** *Alternative Payment Models Built on Fee-for-Service Architecture*	**Category 4:** *Population-Based Payment*
Description	*Payments are based on volume of services and not linked to quality or efficiency*	*At least a portion of payments vary based on the quality or efficiency of health care delivery*	*Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk*	*Payment is not directly triggered by service delivery so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. ≥1 yr)*
Medicare FFS	• Limited in Medicare fee-for-service • Majority of Medicare payments now are linked to quality	• Hospital value-based purchasing • Physician Value-Based Modifier • Readmissions/Hospital Acquired Condition Reduction Program	• Accountable care organizations • Medical homes • Bundled payments • Comprehensive primary care initiative • Comprehensive ESRD • Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model	• Eligible Pioneer accountable care organizations in years 3-5

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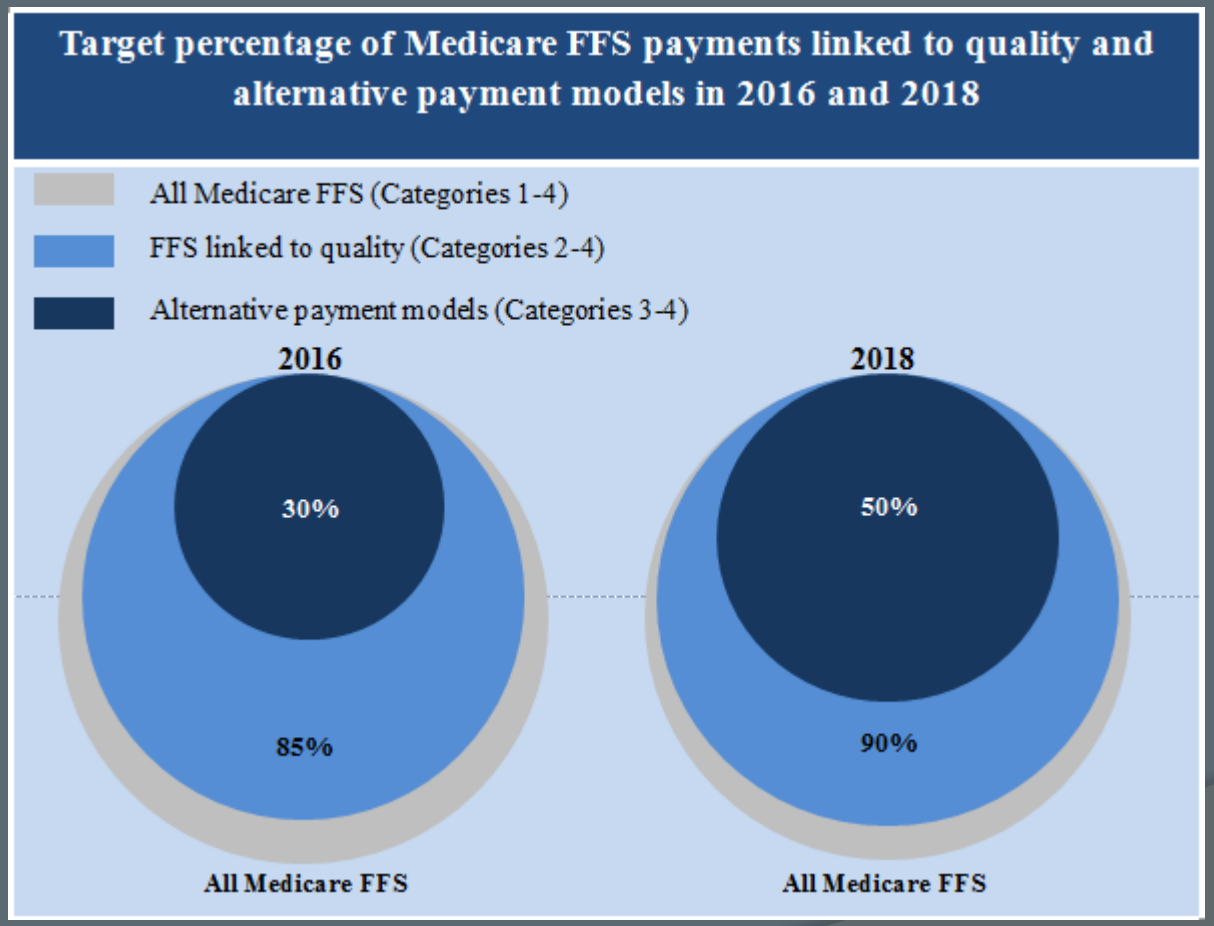
Shrinking Band of Traditional Payment



CMS Slogan: Better Care, Smarter Spending, Healthier People

- Comprehensive Primary Care Initiative: multi-payer (Medicare, Medicaid, private health care payers) partnership in four states (AR, CO, NJ, OR)
- Multi-payer Advanced Primary Care Initiative: eight advanced primary care initiatives in ME, MI, MN, NY, NC, PA, RI, and VT
- Transforming Clinical Practice Initiative: designed to support 150,000 clinician practices over next 4 years in comprehensive quality improvement strategies

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CMS Slogan: Better Care, Smarter Spending, Healthier People

- Pay for Value with Incentives: Hospital-based VBP, readmissions reduction, hospital-acquired condition reduction program
- New payment models: Pioneer Accountable Care Organizations, incentive program for ACOs, Bundled Payments for Care Improvement (105 awardees in Phase 2, risk bearing), Health Care Innovation Awards

CMS Slogan: Better Care, Smarter Spending, Healthier People

- Better coordination of care for beneficiaries with multiple chronic conditions
- Partnership for patients focused on averting hospital acquired conditions

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Summary: Market Forces Shaping Rural Health

- Hospital closure: 50 since 2010; up to 283 “vulnerable” now
- Enrollment into insurance plans and function of choice and cost (“Geographic Variation in Plan Uptake in the Federally Facilitated Marketplace” http://www.shepscenter.unc.edu/wp-content/uploads/2014/09/EnrollmentFFMSeptember_rvOct2014.pdf)
- Choices among plans (“Geographic Variation in Premiums in Health Insurance Marketplaces” http://cph.uiowa.edu/rupri/publications/policybriefs/2014/Geographic%20Variation%20in%20Premiums%20in%20Health%20Insurance%20Marketplaces.pdf)
- Development of health systems
- Growth in Accountable Care Organizations: United Health just announced developing 750 more; Next Generation in Medicare

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What is the next move to rural vitality?

- Goals of a high performance system
- Strategies to achieve those goals
- Sustainable rural-centric systems
- Aligning reforms: focus on health (personal and community), payment based on value, regulatory policy facilitating change, new system characteristics

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The high performance system

- ✓ Affordable: to patients, payers, community
- ✓ Accessible: local access to essential services, connected to all services across the continuum
- ✓ High quality: do what we do at top of ability to perform, and measure
- ✓ Community based: focus on needs of the community, which vary based on community characteristics
- ✓ Patient-centered: meeting needs, and engaging consumers in their care

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Strategies

- Begin with what is vital to the community (needs assessment, formal or informal, contributes to gauging)
- Build off the appropriate base: what is in the community connected to what is not
- Integration: merge payment streams, role of non-patient revenue, integrate services, governance structures that bring relevant delivery organizations together

Approaches to use

- Community-appropriate health system development and workforce design
- Governance and integration approaches
- Flexibility in facility or program designation to care for patients in new ways
- Financing models that promote investment in delivery system reform

Community-appropriate health system development and workforce design

- Local determination based on local need, priorities
- Create use of workforce to meet local needs within the parameters of local resources
- Use grant programs

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Governance and integration approaches

- Bring programs together that address community needs through patient-centered health care and other services
- Create mechanism for collective decision making using resources from multiple sources

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Flexibility in facility or program designation to care for patients in new ways

- How to sustain emergency care services
- Primary care through medical home, team-based care models
- Evolution to global budgeting

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Financing models that promote investment in delivery system reform

- Shared savings arrangements
- Bundled payment
- Evolution to global budgeting
- New uses of investment capital

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Getting to the new system: demonstrations

- "Local Primary Care Redesign" projects that combine primary care and other health care providers (including the local hospital) in organizational configurations that expand and sustain access to comprehensive primary care focused on individual and community health improvement
- "Integrated Governance" projects align various organizations in a community or region in a new model of governance, using affiliation agreements and memoranda of understanding, requiring new governing entities such as community foundations, or establishing new designs that merge financing and funding streams and direct new programs

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Getting to the new system: demonstrations

- "Frontier Health Systems" – innovative models to secure sustainable essential health care services integrated with services across the horizontal and vertical care continua
- "Finance tools to repurpose existing local health care delivery assets;" support projects that leverage existing assets to develop sustainable rural systems meeting needs of local populations

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Rapid Cycle Learning and Change

- Momentum is toward something very different, more than changing how to pay for specific services
- Need to be strategic, in lock step with or ahead of change in the market
- Change in dependencies from fee-for-service to sharing in total dollars spent on health

Some Specifics

- Chief Medical Financial Officer in a CAH in Montana
- Chief Patient Officer at Johns Hopkins
- Use of health coaches in Winona MN
- Collaborations forming ACOs
- Joint ventures – with health plans, health systems

Fundamental Strategies

- Integrating care: driven by where the "spend" is and therefore where the "savings" are
- From inside the walls to serving throughout the community
- Collaborations are critical
- Culture of Health Framework

Retaining rural values

- ✓ Accessible
- ✓ Affordable
- ✓ High quality
- ✓ Community-based
- ✓ Patient-centered

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Act Because ...

The line it is drawn
The curse it is cast
The slow one now
Will later be fast
As the present now
Will later be past
The order is
Rapidly fadin'
And the first one now
Will later be last
For the times they are a-changin'.

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For further information

The RUPRI Center for Rural Health Policy Analysis

http://cph.uiowa.edu/rupri

The RUPRI Health Panel

http://www.rupri.org

The Rural Health Value Program

http://www.ruralhealthvalue.org

Dr. Keith J. Mueller

Department of Health Management and Policy
College of Public Health
145 Riverside Drive, N232A, CPHB
Iowa City, IA 52242
319-384-3832
keith-mueller@uiowa.edu

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