

MISSOURI RURAL HEALTH CONFERENCE

Presented at the 8th Annual Missouri Rural Health Conference
November 18, 2015
Columbia, MO



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Overview

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

Current rural landscape

- Population aging in place
- Increasing prevalence of chronic disease
- Sources of patient revenue change
- Is small scale independence sustainable?

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]

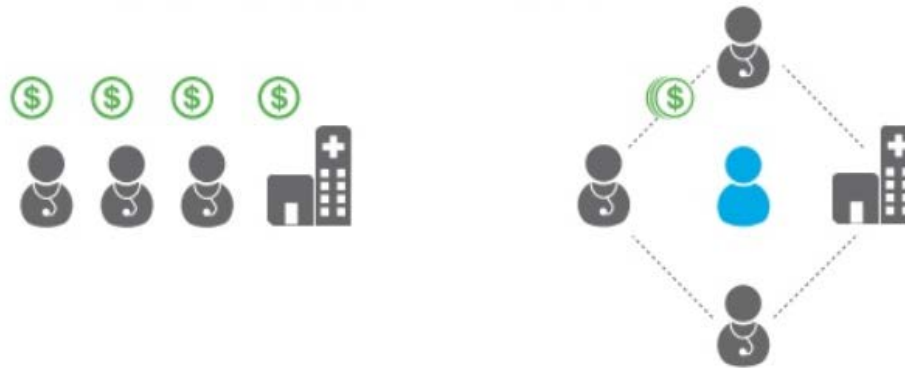
The Answer Is ...

- “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 Pyrellis, “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

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)
- New payment contracts to negotiate for rural providers

Tectonic shifts occurring

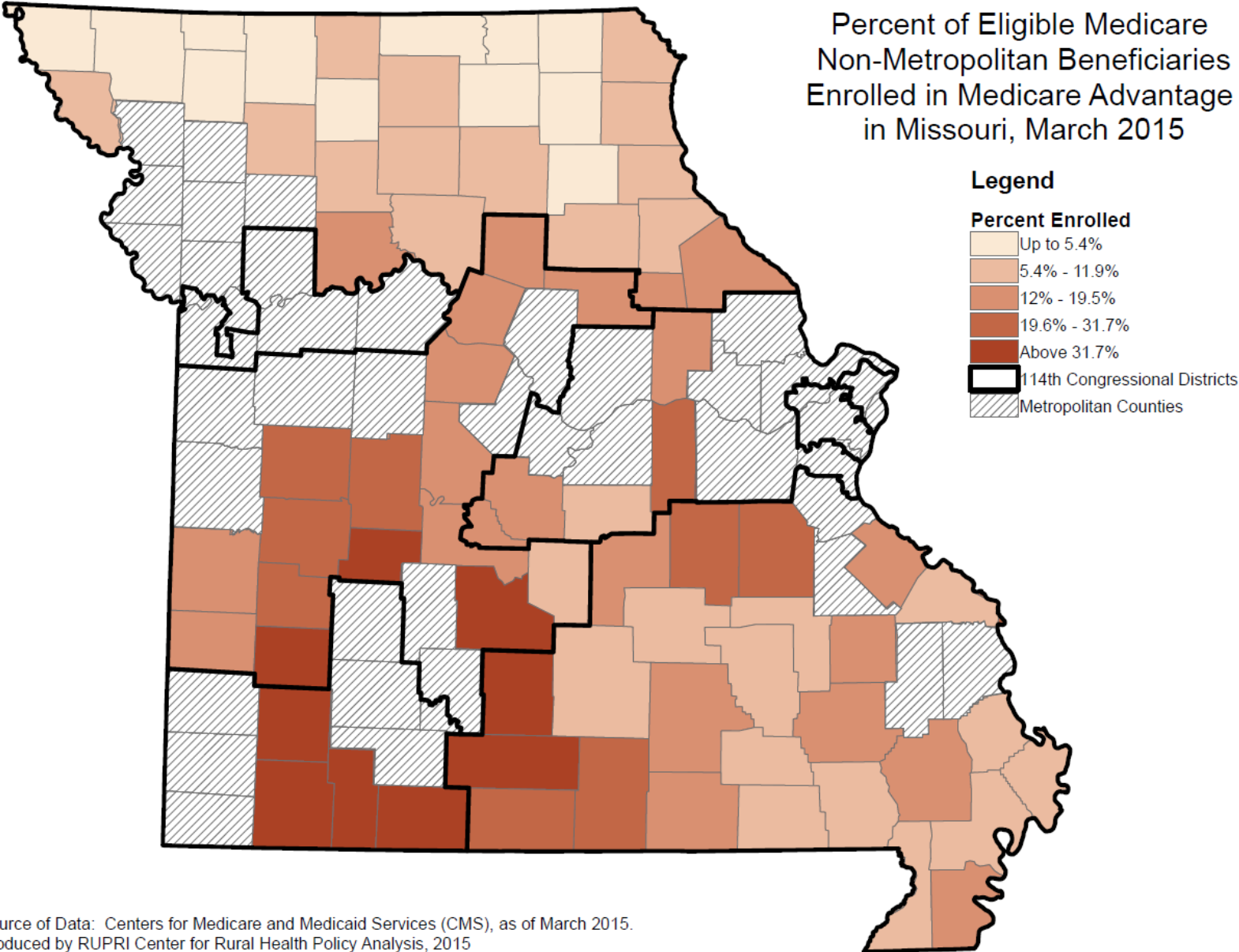
- Public programs shifting to private plans



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

Percent of Eligible Medicare Non-Metropolitan Beneficiaries Enrolled in Medicare Advantage in Missouri, March 2015



Source of Data: Centers for Medicare and Medicaid Services (CMS), as of March 2015.
 Produced by RUPRI Center for Rural Health Policy Analysis, 2015

Medicaid ACOs: 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

Medicaid ACO Activities

- MN: IHPs must demonstrate partnerships with other agencies: social service public health
- MN: total cost of care calculations
- OR: CCOs must have community health needs assessment, encouraged to build partnerships with social service and community entities

Source: R. Mahadevan and R Houston, Center for Health Care Strategies, Inc. "Supporting Social Service Delivery Through Medicaid Accountable Care Organizations: Early State Efforts." *Brie* February, 2015.

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

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/>

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

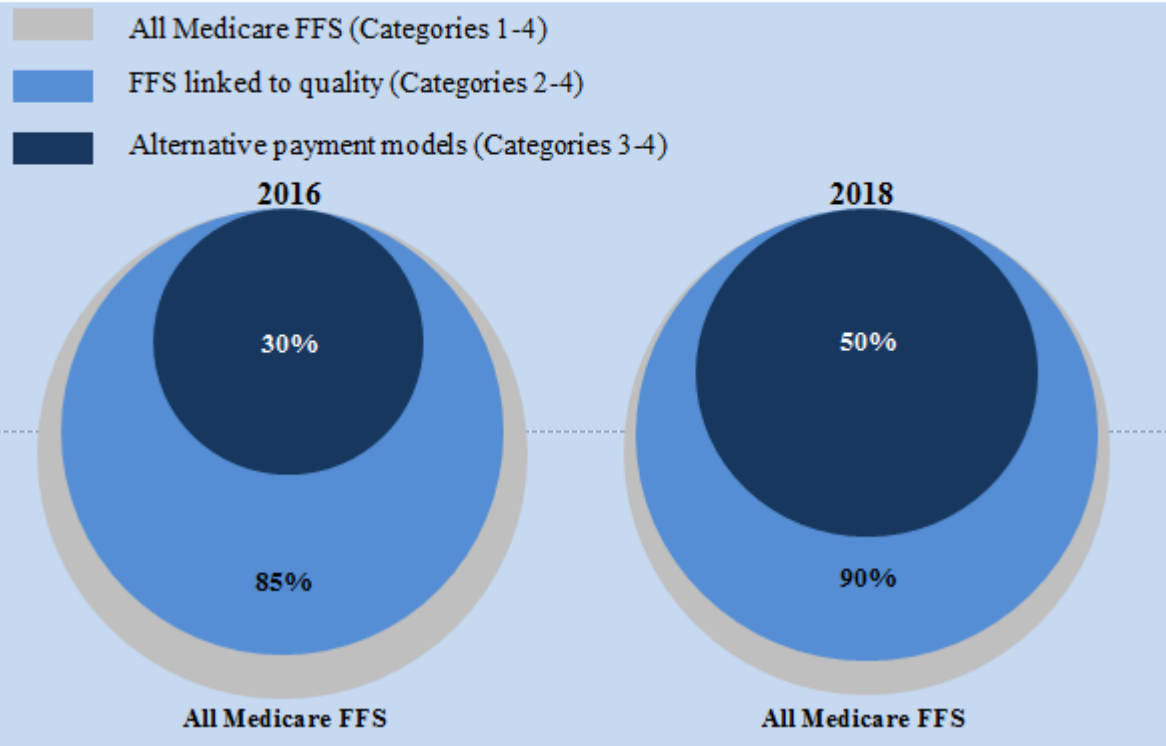
Source of this and following slides: CMS Fact Sheets available from [cms.gov/newsroom](https://www.cms.gov/newsroom)

Illustration of Move to Population-Based Payment

Payment Taxonomy Framework					
		Category 1:	Category 2:	Category 3:	Category 4:
		<i>Fee for Service—No Link to Quality</i>	<i>Fee for Service—Link to Quality</i>	<i>Alternative Payment Models Built on Fee-for-Service Architecture</i>	<i>Population-Based Payment</i>
Description		<i>Payments are based on volume of services and not linked to quality or efficiency</i>	<i>At least a portion of payments vary based on the quality or efficiency of health care delivery</i>	<i>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</i>	<i>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)</i>
	Medicare FFS	<ul style="list-style-type: none"> Limited in Medicare fee-for-service Majority of Medicare payments now are linked to quality 	<ul style="list-style-type: none"> Hospital value-based purchasing Physician Value-Based Modifier Readmissions/Hospital Acquired Condition Reduction Program 	<ul style="list-style-type: none"> Accountable care organizations Medical homes Bundled payments Comprehensive primary care initiative Comprehensive ESRD Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model 	<ul style="list-style-type: none"> Eligible Pioneer accountable care organizations in years 3-5

Shrinking Band of Traditional Payment

Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018



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

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



Facilitating a Drive to High Performance

- Financing care coordination
- Use incentives to move behavior and system configuration (category 2)
- Alternative payment as the walk across the bridge
- Population based payment on the other side



Recommendations from the RUPRI Health Panel

1. Organize rural health systems to create integrated care.
2. Build rural system capacity to support integrated care.
3. Facilitate rural participation in value-based payments.
4. Align payment and performance assessment systems.
5. Develop rural appropriate payment systems.

Summary: Market Forces Shaping Rural Health

- Hospital closure: 57+ 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

Hospital Closures: Effects?

- Study of 195 hospital closures between 2003 and 2011 “found no significant difference between the change in annual mortality rates for patients living in the hospital service areas (HSAs) that experience closures with rates in matched HSAs without a closure”
- Also no difference in all-cause mortality rates
- So not worse for residents

Source: K E Joynt, P Chatterjee, EJ Orav, and AK Jha (2015) “Hospital Closures Had No Measurable Impact on Local Hospitalization Rates Or Mortality Rates, 2003-11.” *Health Affairs* 34, No. 5. 765-772

Hospital Closures: Effects?

- They are “One of the Cornerstones of Small Town Life” – Kaiser Health News March 17, 2015 (Guy Guliottta); example of Mt Vernon, TX (2 hours east of Dallas)
- Communities depend on the hospitals for health care (Casey, Moscovice, Holmes, Pink Hung *Health Affairs* April, 2015)

Hospital Closures: Effects?

- “rural hospitals and the rural economy rise and fall together”; examples from Georgia (A Ragusea, www.marketplace.org. April 17, 2014)
- But many rural hospitals “rise to the challenges” (R Pyrellis, *Hospitals & Health Networks* cover story January 13, 2015)

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



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

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



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



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



Financing models that promote investment in delivery system reform

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



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>



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