Rural Perspectives on Reform – From Volume to Value

Giving Back
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Agenda

- Why the changes
- Health care “risk”
- Health care “value”
- Risk transfer from payers to providers (eg, ACOs)
- Optimizing opportunities for reward
Health Care Risk

- Insurance risk, eg.
  - Demographics
  - Technology change
  - Prior health status

- Clinical risk, eg.
  - Care plans
  - Drug choices
  - Procedures

Variation = Risk = Opportunity

Variation suggests a risk for underperformance, but also an opportunity to excel
Health care should be:
- Safe
- Effective
- Patient-Centered
- Timely
- Efficient
- Equitable

The Triple Aim

Value Equation

Value = Quality + Experience

Cost

- Safe
- Effective
- Patient-Centered
- Timely
- Efficient
- Equitable

“Triple Aim”
- Better care
- Better health
- Lower cost
### Alaska CAH Quality Reporting

<table>
<thead>
<tr>
<th>Year</th>
<th>Alaska</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of CAHs</td>
<td>Inpatient data</td>
</tr>
<tr>
<td>2006</td>
<td>11</td>
<td>2 (18.2%)</td>
</tr>
<tr>
<td>2007</td>
<td>12</td>
<td>2 (16.7%)</td>
</tr>
<tr>
<td>2008</td>
<td>13</td>
<td>3 (23.1%)</td>
</tr>
<tr>
<td>2009</td>
<td>13</td>
<td>6 (46.2%)</td>
</tr>
<tr>
<td>2010</td>
<td>13</td>
<td>7 (53.8%)</td>
</tr>
</tbody>
</table>


### Alaska CAH Clinical Quality

#### Figure 7. Pneumonia: Most Appropriate Initial Antibiotic(s)

<table>
<thead>
<tr>
<th>Year</th>
<th>Alaska</th>
<th>CAHs Nationally</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>95.5%</td>
<td>89.9%</td>
</tr>
<tr>
<td>2009</td>
<td>91.1%</td>
<td>87.4%</td>
</tr>
<tr>
<td>2010</td>
<td>93.3%</td>
<td>88.7%</td>
</tr>
</tbody>
</table>

### Rural Quality

**CAH v. Urban PPS Quality Performance**

<table>
<thead>
<tr>
<th>Service</th>
<th>CAH (%)</th>
<th>Urban PPS (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpt Med - C/D b/c w/in 15 min.</td>
<td>90.0%</td>
<td>70.0%</td>
</tr>
<tr>
<td>Outpt Surg - D/B w/in 1 hour</td>
<td>80.0%</td>
<td>60.0%</td>
</tr>
<tr>
<td>HF - Access of Lab.</td>
<td>95.0%</td>
<td>85.0%</td>
</tr>
<tr>
<td>HF - DC Instruct.</td>
<td>100.0%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Pres - Prescribe</td>
<td>95.0%</td>
<td>85.0%</td>
</tr>
<tr>
<td>Prn - A/P w/in 6 hours</td>
<td>100.0%</td>
<td>90.0%</td>
</tr>
<tr>
<td>HRH/PPS - Overall rating 8 of 10</td>
<td>95.0%</td>
<td>85.0%</td>
</tr>
</tbody>
</table>

Source: Flex Monitoring Team. Critical Access Hospital Year 6 Hospital Compare Participation and Quality Measure Results. April 2011

### Patient Experience

**Patients who reported YES, they would definitely recommend the hospital.**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Recommendation</th>
<th>Average Reporting Hospitals in Minnesota</th>
<th>Average Reporting Hospitals in The United...</th>
</tr>
</thead>
<tbody>
<tr>
<td>ST Gabriel's Hospital</td>
<td>74.0%</td>
<td>72.0%</td>
<td></td>
</tr>
<tr>
<td>ST Cloud</td>
<td>81.0%</td>
<td>72.0%</td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>76.0%</td>
<td>72.0%</td>
<td></td>
</tr>
</tbody>
</table>

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Medicare Spending Per Enrollee

Source: Kaiser Family Foundation. 2009 Data

Quality/Cost

Overall quality ranking

Annual Medicare spending per beneficiary (dollars)

Sources: K. Baicker and A. Chandra, "Medicare Spending, The Physician Workforce, and Beneficiaries' Quality of Care," Health Affairs Web Exclusive (April 7, 2004).
Unacceptable Healthcare Value

- **Quality** suboptimal
  - Deficient when compared internationally
  - Wide geographic variation
- **Cost** unsustainable
  - Growth in excess of GDP growth
  - Highest cost in the world
- **Waste** intolerable (20%)*
  - Care delivery, care coordination, overtreatment, administration, pricing failures, fraud and abuse.

**Nobody agrees about what to do!**


The Value Conundrum

*You can always count on Americans to do the right thing – after they’ve tried everything else.*

- Fee-for-service
- Capitation
- Market
- Single payer
- Self-police
- **Value-based purchasing?**
- **Accountable Care Organizations?**
Form Follows Finance

- How we deliver care is predicated on how we get paid for care
- Health care reform is changing both
- Fundamentally, a transfer of risk from payers to providers
- Supreme Court ruling has accelerated change

Accountable Care Organizations

- A coordinated network of providers with shared responsibility for providing high quality and low cost care to their patients.*
- Couples risk-based provider payment with health care delivery system reform
- Accepts performance risk for quality and cost

Shared Savings Program

- Medicare pays fee-for-service, then shares any gains at end of 3 years
- Percent of gains shared will be less if suboptimal quality
- Success requires excellent care and low cost – value!

ACOs’ Rapid Expansion

- 164 private insurer ACOs nationwide (Nov 2011)
  - 60% hospital, 23% physician, 37% health plan
- 174 Medicare ACO Programs (August 2012)
  - Medicare Shared Savings Program (116 ACOs)
  - Physician Group Practice Transition (6 ACOs)
  - Pioneer ACO demonstration (32 ACOs)
  - Advanced Payment ACO demonstration (20 ACOs)
  - ~2.5 million (>5%) of Medicare beneficiaries
To support rural and physician-owned organizations

- CMMI has budgeted $170 million

- Only two types of organizations are eligible
  - No inpatient facilities and less than $50 million annual revenue
  - CAH(s) and less than $80 million annual revenue

- Co-ownership with health plan not allowed
**Advanced Payments**

- Upfront fixed payment
  - $250,000 for ACO start-up
- Upfront variable payment
  - $36 per beneficiary
- Variable monthly payment
  - $8/month per beneficiary
- $1.87 million in new money
  - Payment in addition to FFS for 5,000 beneficiaries over 3 years
- Payments recouped
  - From savings in three years, but “loan” forgiven if not enough savings

**Managed Care Redux?**

- Better data regarding cost and quality
- New care management strategies
- Physician-hospital alignments
- Gain-sharing, thus less risk
- More physician (less insurance) control
- Yet Medicare a leader
- Insurer investment in “value” programs
- Private equity/capital market investment
- Public financial pressures
Payment Risk Continuum

High Payer Risk

High Provider Risk

Cost-Based

Capitation

Charge-Based

Shared Risk

Per Diem

Bundled

Case Rate

The Risk of Doing Nothing

"We've considered every potential risk, except the risks of avoiding all risks!"

Clint MacKinney, MD, MS
New Thinking

- As risk shifts, old business models are turned upside down
  - Where are our costs?
  - Where is our revenue?

- New world demands
  - Transferring risk to providers
  - Higher quality at lower cost
  - Doing what's needed, not more
  - Dealing with "stranded capital"

- The devil is in the transition
  - One foot on the dock and one in the boat
  - It'll be competitive – winners and losers

Tool Box for Delivering Value

- System thinking
- Balanced approach
- Medical homes
- Health coaches
- Performance improvement
- Medical staff relationships
- Collaboration
- **What we can do now**
System Thinking

- Currently a non-system
  - Fragmented, poorly coordinated, and excessively costly

- Integrated Delivery Systems
  - An organized and collaborative provider network designed to provide coordinated and comprehensive health care services.
  - Moves from hospital-centric to physician- and patient-focused

- Care continuum
  - Personal health to palliative care
  - Health and human services

Balanced Approach

Safety/Quality  Financial Stability  Employee Growth  Patient Experience

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New Perspective

Source: Roland A. Grieb, MD, MHSA - Health Care Excel and Premier, Inc.

Non-Linearity

- **“No margin, No mission”**
- **Balance** will be the success strategy
  - Health care safety/quality
  - Financial stability
  - Patient experience
  - Employee growth
- It’s never about either/or; it’s always about **and/both**
Medical Home Definition

The people, processes, and resources that deliver 24/7 accessible, patient-centered, and community-oriented primary care.

- Not a nursing home
- Not home health
- Not a “facility”
- A care team is essential
- Synonyms?
  - Patient-centered medical home
  - Health care home
  - Medical neighborhood

Health Coaches

- Identifies high-risk patients
- Proactively manages care
- Prepares for visits
- Develops disease registries
- Monitors reminder systems
- Provides patient education
- Coordinates care and transitions
- Works proximate to the team
The Value Equation

- Quality
  - ACO, VBP, HEDIS, etc.
  - Common diagnoses
  - Many – so “harmonize”
- Experience
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Cost
  - To the payer

Medical Staff Relationships

The hospital CEO’s most important job is developing and nurturing good medical staff relationships.

Source: Personal conversation with John Sheehan, CPA, MBA
Medical Staff Development

- Physicians see themselves as independent, autonomous, and in control!
- Yet, hospital-physician alignment is essential to deliver value

Some ideas
- Develop and engage physician leaders
- Provide data transparency, but do not overstate discrete measure importance
- Offer rewarding, yet reasonable salary, rather than paying piecework


Some Ideas (continued)
- Offer physicians direct ability to influence outcomes
- Provide a continual sense of accomplishment and recognition

Action Plans
- Recruitment and retention
- Governance and engagement
- Leadership development
- Relationship development
Collaboration Questions

- How do we develop a common vision and “culture?”
- How do we respect physician identity and independence, yet promote collaboration?
- How do we define success by *mission*, not hospital growth?
- How do we accept that *increased collaboration will require some loss of control*?

What We Can Do Now

- Measure and report performance
  - We attend to what we measure
  - *Attention* is the currency of leadership
- Educate Board, providers, and staff regarding performance
  - We are all “above average,” right?
- Consider self-pay and hospital employees first for care mgmt
  - Direct care to low cost areas that provide equal (or better) quality
  - Reduces Medicare cost dilution
What We Can Do Now

- Negotiate with third party insurers to pay for quality (funds ACO infrastructure)
- Aggressively apply for value-based demonstrations and grants
- Begin implementing processes designed to improve value
- Move organizational structure from hospital-centric to patient/community-centric
- Assess potential affiliations

Collaboration and Value

- ACOs and other “programs” less important
- Collaboration that fosters health care value is key
- Future paradigm for success
- **Good medicine and good business**
Leadership

- Great leaders look into the future and see the organization not as it is... but as it can become.
- Reform will require:
  - Paradox
  - Vision
  - Savvy
  - Perseverance
  - Courage

The Risk of Something New
Healthy People and Places

Reactor Panel

"I think you should be more explicit here in step two."