ACOs and Much More: Health Reform Comes to Rural America

Presentation to the CAH Administrator Meeting
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Importance of Transitions to Optimize Opportunities

- Changes are coming, under auspices of reform or otherwise
- Implement the changes in the context of what is desirable for rural communities
- How do we pull that off?
The Changing Landscape

- $$ must be squeezed out of current health care expenditures: 20+% of GDP by 2020 is not acceptable
- Both price and quantity of services must be reduced
- Changes will happen in the delivery system, fundamental not cosmetic
- For health systems, PRESSURE TO GROW AND SUSTAIN PATIENT VOLUME
Coincidental Presence of Models for Change (old and new)

- Prevention and population health
- Community well-being
- Bundled payment
- Value based purchasing
- Managed care organizations
- Accountable care organizations
Demands for service will shift

- Expansion of Medicaid enrollment with some federal help in paying providers, but limited
- Expansion of enrollment in the individual and small group markets
- CAN’T EXPECT CURRENT / HISTORIC APPROACHES TO DELIVERING AND FINANCING CARE TO RESPOND TO THIS SHIFT
Changes in Finance / Payment: Value based purchasing

- Inpatient payment to PPS hospitals effective October 1, 2012
- Will be developed for outpatient payment
- Demonstration project for CAH payment
- Value based modifiers for physician payment
Finance Change: Payer mix

- Decrease in uncompensated care
- Increase in covered lives (commercial health plans) and therefore “negotiated” prices
- Increase in Medicaid coverage and shift of that client base toward different payment schemes
- Non patient revenues subject to turns in the economy
The RUPRI Health Panel envisions rural health care that is affordable and accessible for rural residents through a sustainable health system that delivers high quality, high value services. A high performance rural health care system informed by the needs of each unique rural community will lead to greater community health and well-being.
Should be:
Foundations for Rural Health

- **Better Care**: Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe.

- **Healthy People/Healthy Communities**: Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care.

- **Affordable Care**: Reduce the cost of quality health care for individuals, families, employers, and government.

Source: “Pursuing High Performance in Rural Health Care.” RUPRI Rural Futures Lab Foundation Paper No. 4. 
http://ruralfutureslab.org/docs/Pursuing_High_Performance_in_Rural_Health_Care_010212.pdf
A High Performance Rural Health Care System Is

- **Affordable**: costs equitably shared
- **Accessible**: primary care readily accessible
- **Community-focused**: priority on wellness, personal responsibility, and public health
- **High-quality**: quality improvement a central focus
- **Patient-centered**: partnership between patient and health team
Central points from RUPRI Health Panel regarding change

- Preserve rural health system design flexibility: local access to public health, emergency medical, and primary care services
- Expand and transform primary care: PCMH as organizing framework, use of all primary care professionals in most efficient manner possible
Use health information to manage and coordinate care: records, registries

Deliver value in measurable way that can be basis for payment

Collaborate to integrate services

Strive for healthy communities
In innovate to accelerate pace of change

- In health care work force: community paramedics, community health workers, optimal use of all professionals, which requires rethinking delivery and payment models – implications for regulatory policy including conditions of participation
- In use of technology: providing clinical services through local providers linked by telehealth to providers in other places – E-emergency care, E-pharmacy, E-consult
- In use of technology: providing services directly to patients where they live
The future can be healthy people in healthy communities

- Through local providers linked to integrated systems of care
- Who, together with their patients, manage health conditions
- Not the same design everywhere, but the high quality, patient-centered everywhere
Health Care Organizations of the Future

- Accepting insurance risk
- Focus on population health
- Trimming organization costs
- Using the data being captured (e.g., electronic health records)
- Health care as retail business
Considerations

- Using population data
- Evolving service system (e.g., telehealth)
- Workforce: challenges to fill vacancies, and shifts to new uses of new categories
- Best use of local assets; including physical plant (the hospital)
Local Assets to Consider

- Raw material
- Data and information
- Connectivity
- Core capabilities, e.g., primary care
- Leadership
Recommendations

- Align with primary care doctors
- Ratchet all costs out
- Measure and improve quality
- Know your value proposition
Value Equation

Value = Quality + Experience

Cost

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

“Triple Aim”
- Better care
- Better health
- Lower cost
Unacceptable Healthcare

- **Quality** suboptimal
  - Deficient when compared internationally
  - Wide geographic variation

- **Cost** unsustainable
  - Growth in excess of GDP growth
  - Impact on budgets: public, business, family

- **Waste** intolerable (20%)*
  - Care delivery, care coordination, overtreatment, administration, pricing failures, fraud and abuse.

- **Nobody agrees about what to do!**

Elements of a Successful System Redesign

- Clear Vision
- Principles for redesign (reliability, customization, access, coordination)
- Teamwork
- Leadership
- Customer focus
- Data analysis and action plans
- Inclusive beyond health care system

Changes in delivery system: Patient-Centered Medical Homes (PCMH)

- Not your father’s “medical home”
- Potential future of primary care
- Emphasis on integrated services, management of chronic conditions, team-based, patient-centered care
Billings Clinic PCMH Development

- A building block toward accountable care: health home, population health data management
- Began in 2009 in 2 clinics (Western Montana Clinic and Billings Clinic)
- Now 12 physician groups (9 active as of 11/12), 242 MDs, 66 Midlevel
- 2012 BCBSMT program focuses on chronic diseases and preventative care
Billings Clinic PCMH Development

- Provider perspective
- Team model: improve access, re-energize profession
- “rules of the road” help: standards, framework for payment, quality metrics and reporting
- Investment and change: IT, FTEs, financial risk
Billings Clinic PCMH Development

- Payer perspectives
- Financial risk/commitment with need for ROI
- Assurances that practice is transforming: standards, quality reporting
- Patient perspectives: improved access, better outcomes, increased satisfaction

Changes in the delivery system: Accountable Care Organizations (ACO)

- Including Medicare Shared Savings Program (MSSP)
- Including Pioneer Demonstration from Centers for Medicare and Medicaid Innovation (CMMI)
- CMMI anticipates doubling in 2013
- And much more.....
Tally Sheet

- 32 Pioneer ACOs
- 116 MSSP ACOs
- 20 116 are Advanced Payment
- 318 total ACOs; in 48 states
21-31 million Americans receive care through ACOs
2.4 million in Medicare ACOs
15 million non-Medicare patients of Medicare ACOs
8 to 14 million patients of non-Medicare ACOs

In 19 states more than 50% of residents have access to ACOs

In 12 states between 25% and 50% have access to ACOs (includes Montana)

Source:
http://www.oliverwyman.com/media/OW_ENG_HLS_PUBL_The_ACO_Surprise.pdf
ACO DISTRIBUTION BY STATE

Source: David Muhlestein, Andrew Croshaw, Tom Merrill, Cristian Pena.
“Growth and Dispersion of Accountable Care Organizations: June 2012 Update.”
Core Components of An ACO

- People-centered foundation
- Health home
- High-value provider network
- Population health and data management
- ACO leadership
- Payer partnership

Revenue reduced for readmissions
Must prove quality and cost to be part of network
More patient shopping, even across rural hospitals
By 2020 6% of Medicare payment tied to risk incentives: VBP, readmissions, hospital-acquired conditions
Transition Thinking

- Volume to value
- Group contract to patient service
- Care coordination across the continuum
- Patient centered care
- Lower costs
From clinical care to health and health promotion
From discharges to people enrolled in system and interactions with people
Managing patients according to patient need across illness spectrum and continuum of care
Where do we want to be?

- Who do we serve?
- How do we provide best possible service?
- How do we get strategy and money to match mission?
Patient-centered care
Use of technology to provide optimal services
Link to other care providers in continuum, being first source, transition source
Core services as center of excellence
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 management
  - 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
Concluding with reminders of reality

- Payment per event will moderate
- Tolerance for services of questionable use will diminish
- Systems will form and spread
- Multiple payers moving in similar directions, opportunities to influence should be captured and exploited
Pursuing Alternative Futures

- Organizations should pursue “first do no harm” but also alternative visions for the future
- Health care systems active in reshaping delivery, with Triple Aim in mind
- Dialogue has to lead to action
Pursuing the possible

- When community objectives and payment and other policy align
- Community action is where policy and program streams can merge
- Community leadership a critical linchpin
- Pursuing a vision
For Further Information

The RUPRI Center for Rural Health Policy Analysis
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