The March to Accountable Care Organizations: How Will Rural Fare?

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Agenda

- National Context
- ACOs
- Rural Perspective
- ACO Obstacles
- Rural ACO Preparation
- Gain-sharing Challenges

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Affordable Care Act Themes

- Major titles
  - Insurance coverage and reform
  - Public programs and public health
  - Quality and efficiency
  - Workforce
  - Transparency
  - CLASS
- A provider's perspective
  - **Value-based purchasing**
  - **Health care provider integration**

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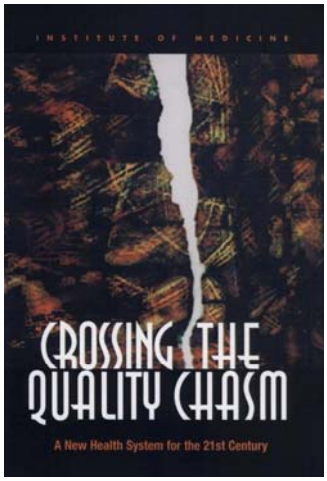
Value – Institute of Medicine's Six Aims

Health care should be:

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



Source: Corrigan, et al (eds.). *Crossing the Quality Chasm.* Committee on the Quality of Health Care in America. National Academies Press. Washington, DC. 2001.

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Value Equation

$$\text{Value} = \frac{\text{Quality + Service}}{\text{Cost}}$$

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

"Better care"

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Solutions to the Value Conundrum

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

- Fee-for-service
- Capitation
- Free-market
- Single payer
- Self-police
- Accountable Care Organizations?

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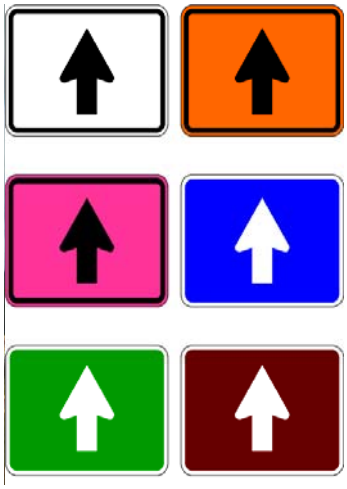
Integration

- Current non-system: fragmented, uncoordinated, and costly
- Integrated Delivery Systems
  - An organized and collaborative provider network designed to provide coordinated and comprehensive health care services.
  - Is the urban integrated delivery system the genesis of, and template for, ACOs?
- The rural question:
  - How do we do get these ACO things to work with autonomous and independent hospitals and physicians?



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Accountable Care Organizations

- A health care delivery system organized to improve health care quality and control costs through care coordination and provider collaboration, and then is held accountable for its performance
- Couples provider payment and delivery system reforms
- Accepts *performance risk*
  - Quality and cost
- A new Medicare program

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Medicare ACO Program

- Usually includes hospitals/physicians
- Must provide all health care for a Medicare beneficiary (Parts A + B)
- 5,000 beneficiary minimum
- Medicare pays fee-for-service, plus shares any gains at end of 3 years
- ACO must provide high levels of quality and service
- Success will require excellent care and low cost – **value!**

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Managed care redux? Probably not!

- Provider led, not insurance
- Medicare as a leader
- New care management strategies
- Physician-hospital alignments
- Information technology (EHR)
- Gain-sharing, thus less risk
- Public finance pressures

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The Rural Imperative

- Rural landscape
  - 13 million rural Medicare beneficiaries
  - 20% of the population (90% of the land)
  - 1,300 Critical Access Hospitals (25%)
  - 25% of the primary care physicians
- Medicare often dominates a rural provider's payer mix
- **Value** will increasingly drive health care purchasing (and market share)
- Skeptical of ACO longevity?
  - Changes coming anyway!
  - Good medicine and good business

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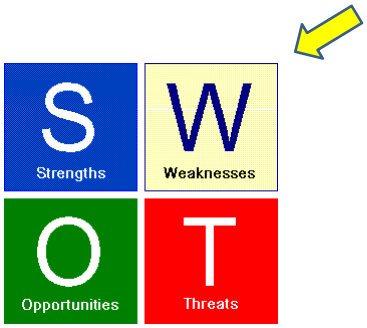
Rural Motivations (SWOT)

- Internal Factors
  - Band-Aid station image
  - Management inexperience
  - Operational inefficiency
  - Professional recruitment
  - Minimal health management
  - Underdeveloped care processes
  - Inadequate information technology
  - Financial instability



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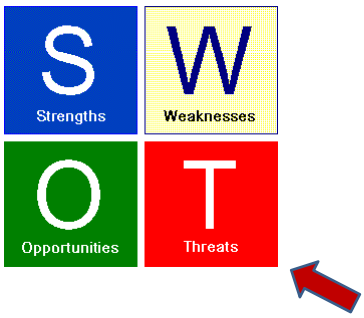
Rural Motivations (SWOT)

- External Factors
  - Market-based payments
  - Eroding market share
  - Inability to access capital
  - Clinical excellence demand
  - Technology demand
  - Performance reporting
  - New payment strategies
  - Demographic changes



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Urban Motivations

- Primary care base expansion
- Preparation for capitation
- Efficient use of health management resources
- Referrals to specialists and for procedures
- Use of significant fixed costs (volume = profit)
- Post-acute care management to reduce readmissions
- Scope of influence

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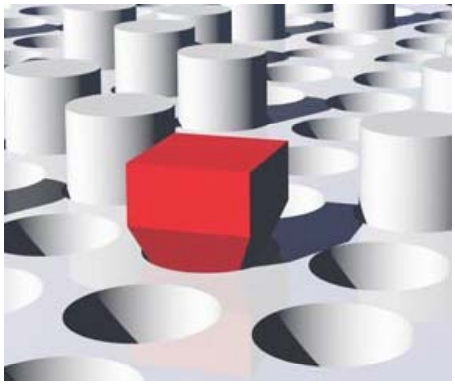
What Will Rural Look For?

- An appreciation of the rural experience
- Respectful negotiation
- Knowledge of rural reimbursement systems
- Clinical excellence
- Commitment to community with defined services
- Outmigration reduction



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What Will Rural Look For?

- Staying power/market power
- Infrastructure development
- Commitment to future capital investment
- Professional recruitment
- Protection from low volume inefficiencies
- Cost-based reimbursement?
- Local control?

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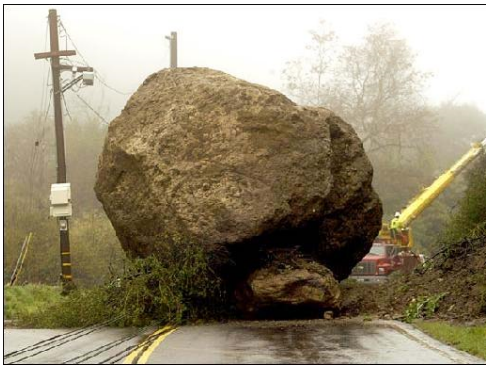
Rural Obstacles

- Provider autonomy
- Practice design
- Unbalanced focus
- Low volumes
- Historic efficiency
- Local control mandate
- Leadership inexperience



Obstacles must become opportunities for improvement

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Urban Obstacles

- Insensitivity to rural
- Inexperience with rural
- Inertia
- Central control mandate
- Lack of creativity
- Anti-trust and related issues
- Significant fixed costs

Obstacles must become opportunities for improvement

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Medicare Gain-Sharing Challenges*

- Larger hospitals
  - Prospective payment (DRGs)
- Critical Access Hospital
  - Cost-based
- Rural Health Clinic
  - Cost-based, with limits
- Community Health Center
  - Grant support
- Private physicians
  - Fee-for-service

* It will be difficult to design gain-sharing plans without the financial performance benchmark and other regulations!

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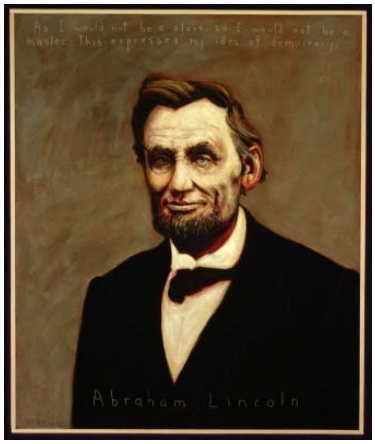
ACO Competencies

- Leadership (culture change)
- Teamwork in action
- Care coordination (pop health)
- Quality management and reporting
- Financial risk management
- Savings (gains) distribution
- Patient education and support
- Physician engagement/leadership
- High-cost patient management
- Local nonprofit ownership



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Preparing for ACOs

1. Fundamentals
2. System thinking
   - Care coordination
3. Health management
4. Quality and cost linkage
   - Clinical v. financial
   - Quality/profit correlation
5. Medical staff development
6. Leadership
   - Negotiation

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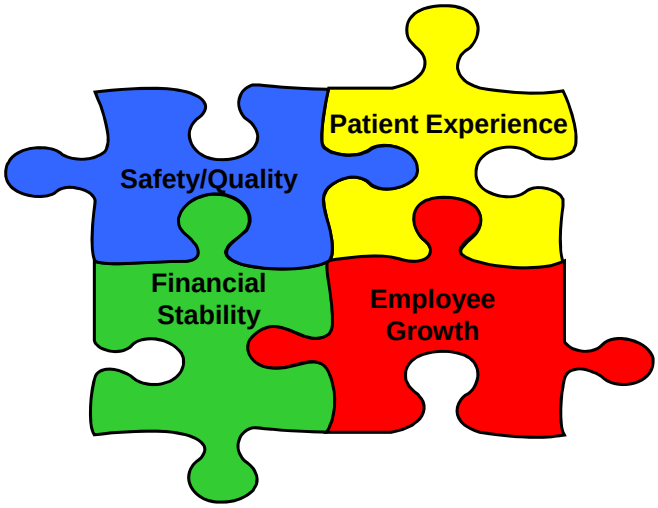
Integrative Thinking Fundamental



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New Perspective Fundamental

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

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Non-Linearity Fundamental

- ~~"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**

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System Thinking

- Health care continuum
- Process management
- Primary care emphasis
- Care coordination
- Communication strategies
- Consistent care policies
- Information technology

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Health Management

- Health coaches
- Proactive care management
- Visit preparation
- Disease registries
- Tickler systems
- Patient education
- Care coordination

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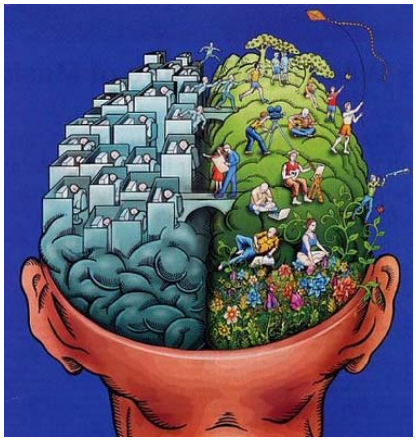
Clinical v. Financial

- Financial officers
  - Protect the organization
  - Maintain economic well-being
  - Defend the bottom line
  - Experience high costs
- Clinicians
  - Protect patients
  - Save lives, stamp out disease
  - Defend professionalism
  - Experience hassles/errors
- Conflict understandable, but success demands both



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Quality/Profit Correlation in PPS

- Quality, safety, and clinical vigilance improvements significantly correlated with profitability and financial success.
- Core Measure performance correlations
  - ↑ net operating margins, ↑ collections, ↑ cash, ↓ denials, ↓ supply costs, and ↓ LOS (strongest correlation)
- A "system" focus designs/implements both exceptional patient care processes and strong business processes.

Source: Gillean, Shaha, Sampans, Mullins. A search for the "Holy Grail" of health care. *HFM*. December 2006.

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Quality/Cost Linkage Becoming More Clear

- Medicare program fee-for-service plus gain-sharing, not capitation, but…
- *Reduce* unnecessary care
  - E.g., readmissions and adverse events
- *Direct* patient to optimal care at site of lowest cost
  - Care need prevented **0**
  - In-home, remotely **$**
  - School, workplace, etc. **$$**
  - Outpatient clinic **$$**
  - Emergency department **$$$**
  - Local inpatient **$$$$**
  - Tertiary care **$$$$$**

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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

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Medical Staff Development

- Demands hospital-physician alignment, especially primary care
- Provider autonomy and cottage industry practices are barriers

<u>Strategies</u>

- Recruitment and retention
- Governance and engagement
- Leadership development
- Relationship development

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Leadership

- Balance, with a system perspective
- New foci for attention
  - E.g., health management, HIT to coordinate care, primary care
- Negotiation skill
  - Interest versus position
  - Urban motivations
- *Attention*
  - The currency of leadership
  - Success will be intentional, not accidental
- New paradigms

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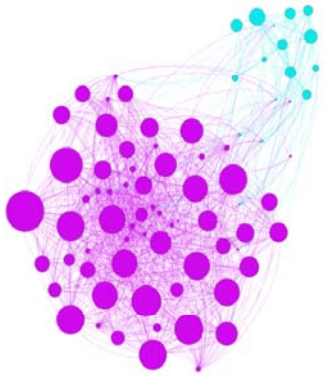
New Paradigms

- Beyond the hub and spoke paradigm
- Immediate geography is less important; technology is critical
- Community (population) focus
- Learning and adaptations up and down the continuum of care
- Competitive advantage to those that consistently deliver positive experience and high quality at any 'node'



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Gain-sharing Considerations

- How might we reconcile historic payment differences?
- How are costs allocated among disparate organizations?
- Who pays for health management investment (e.g., health coaches and HIT), and how is that investment recouped?
- How do we consider decreased hospital utilization?
- How can we reduce significant fixed hospital costs?
- How will we know that additional primary care costs are outweighed by decreased hospital costs?
- If available, how would we divide shared gains?

***Fundamentals* are good medicine and good business – regardless of the reimbursement system!**