Accountable Care Organizations, Health Insurance Exchanges and Rural Primary Care Providers

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The Changing Landscape

- $$ must be squeezed out!!!
- Both price and quantity of services must be reduced
- Changes in the delivery system, fundamental not cosmetic
- PRESSURE TO GROW AND SUSTAIN PATIENT VOLUME

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Coincidental Presence of Models for Change (new and old)

- Prevention
- Community Health
- Bundled payment
- Value based purchasing
- Accountable Care Organizations

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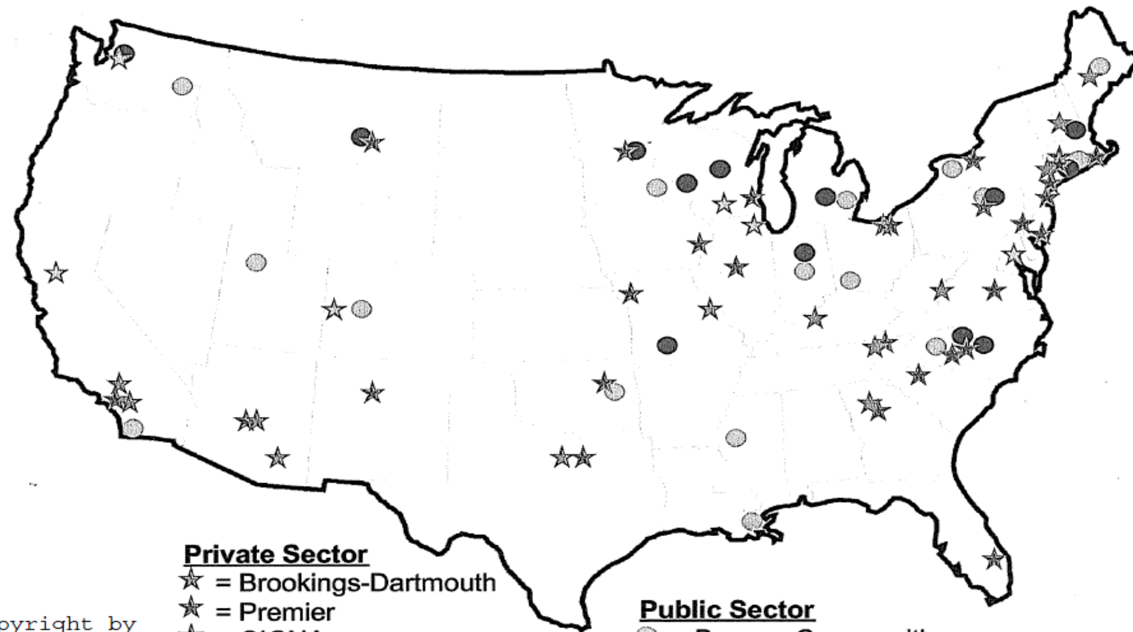
The future is NOW in many places

- Private action: Brookings-Dartmouth learning sites, Premier, CIGNA, Others
- Public Sector: Beacon communities, Practice Group Demonstrations, Medicaid, Medicare
- Urban based, FOR NOW
- But reaching beyond: Carilion System in Virginia

The National Map: Constructed by the ACO Learning Network



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So, we **need** these conversations

- "Spread" is critical to those who are driving change
- Including rural specific language in the Affordable Care Act
- Systems that buy rural presence
- Lives, volume, lives

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Pursuing a Greater Good

- Affordable care
- Access to high quality care
- And being held accountable

While maintaining the enterprise

- Mission matters
- Payment formulae matter
- Community orientation matters

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Moving forward

- What are the preparatory activities?
- What can we learn from the policy activities?
- What should be done to prepare to succeed?

Lessons From Large Organizations: Scott & White attributes of Ideal Systems

- Information continuity
- Care coordination and transitions
- System accountability
- Peer review and teamwork for high-value care
- Continuous innovation
- Easy access to appropriate care

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Eight Rural Constraints

- From *Journal of Rural Health*. Winter, 2011 article by MacKinney, Mueller and McBride
- Rural provider autonomy
- Rural practice design
- Low rural volumes
- Historic rural efficiency

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Continued

- Urban motivations
- Urban provider cost structure
- Legal and regulatory barriers
- Rural leadership inexperience

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Strengthening Rural Provider Roles

- Developing rural provider networks in better negotiation postures
- Understand large health system motivations
- Adopting best practices in clinical management
- Help develop rural-relevant ACO performance measures

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Rural Providers in the Proposed Final Rule

- CAH: Method 1 Payment may participate, not form
- CAH: Method 2 Payment may form
- FQHC and RHC may not form, can participate in multiple ACOs
- Physician Group Practices can form, or participate in, only 1 ACO

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Quality Measures in Proposed Rule

- 65 measures in 5 domains: must report all
- Meet benchmarks, either improvement or threshold
- 50% of physicians must meet meaningful use

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Savings ??

- CMS keeps 2% of savings off the top
- Must achieve minimum savings, 3.9% in ACO with 5,000 beneficiaries
- Share 50% in one-sided model, 60% in two-sided

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Savings ??

- Additional savings shared if RHC and/or FQHC participate; 2.5% in one-sided; 5% in two-sided
- Small ACOs share on first dollar basis

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Anti-Trust in the Proposed Rule

- A 30% threshold for any review
- For each service line
- Can include rural hospital on non-exclusive basis

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RUPRI Comments on CMS Proposed Rule

- Attribution of patients, using "physician directed care"
- Allow RHCs to begin reporting systems to enable them to receive assigned patients
- Change minimum savings ration (MSR) to a ceiling of 3.0%
- Extend "under performing" ACOs for an additional 3 year contract, with 40% sharing

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RUPRI Panel Comments to FTC

- Use RUCAs to define rural, the adjustment to OMB metropolitan definition
- Define rural hospital using RUCA places
- Extend rural Exception and Dominant Provider Limitation to primary care providers are exclusive to one ACO-MSSP
- Rural exception should include "practice" as well as "physician"

Some take away messages

- Change in delivery systems with payment differences to follow from that
- Findings from Brookings-Dartmouth demonstrations instructive (presented by Elliott S. Fisher, MD, MPH, ACO Learning Network): Independence is a key element of MD identity, shared identity fosters cooperation within collaborative model, transparent measurement, payment for improvement, shared risk using sound actuarial principles.

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Take away messages

- CHANGING THE FUNDAMENTALS OF THE SYSTEM IS NOT EASY WORK!
- All about the triple aim
- THE REWARD IN PATIENT CARE IS WORTH THE EFFORT!

Health Insurance Exchanges

- 13 states have enacted legislation establishing exchanges
- Detail varies considerably
- Proposed rule has been published, comments close September 28

Major considerations for HIEs

- Governance
- Enrollment
  - Navigator program
  - Access through broadband services to web site
  - Potential provider burden

More Considerations

- Certification of Qualified Health Plans
- Boundaries of exchanges, rating areas
- Extent of managing the market
- Small business health options program (SHOP)

For Further Information

The RUPRI Center for Rural Health Policy Analysis

http://cph.uiowa.edu/rupri

The RUPRI Health Panel

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