The Future of Rural Health Care

Presentation to the Joint Fall Meeting of the Iowa Rural Health Association & Iowa Association of Rural Health Clinics

September 20, 2012

Johnston, Iowa

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Themes of this presentation

- Changes in delivery and finance of care
- Policy implications of those changes
- Developing a high performance rural system
- Closing thoughts for rural advocates and associations

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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

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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

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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

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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

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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

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

- Not your father's "medical home"
- Potential future of primary c are
- Emphasis on integrated services, management of chronic conditions, team-based, patient-centered care

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

- Including Medicare Shared Savings Program (MSSP)
- But don't wait for that to sink or swim
- Including Pioneer Demonstration from Centers for Medicare and Medicaid Innovation (CMMI)
- And much more…..

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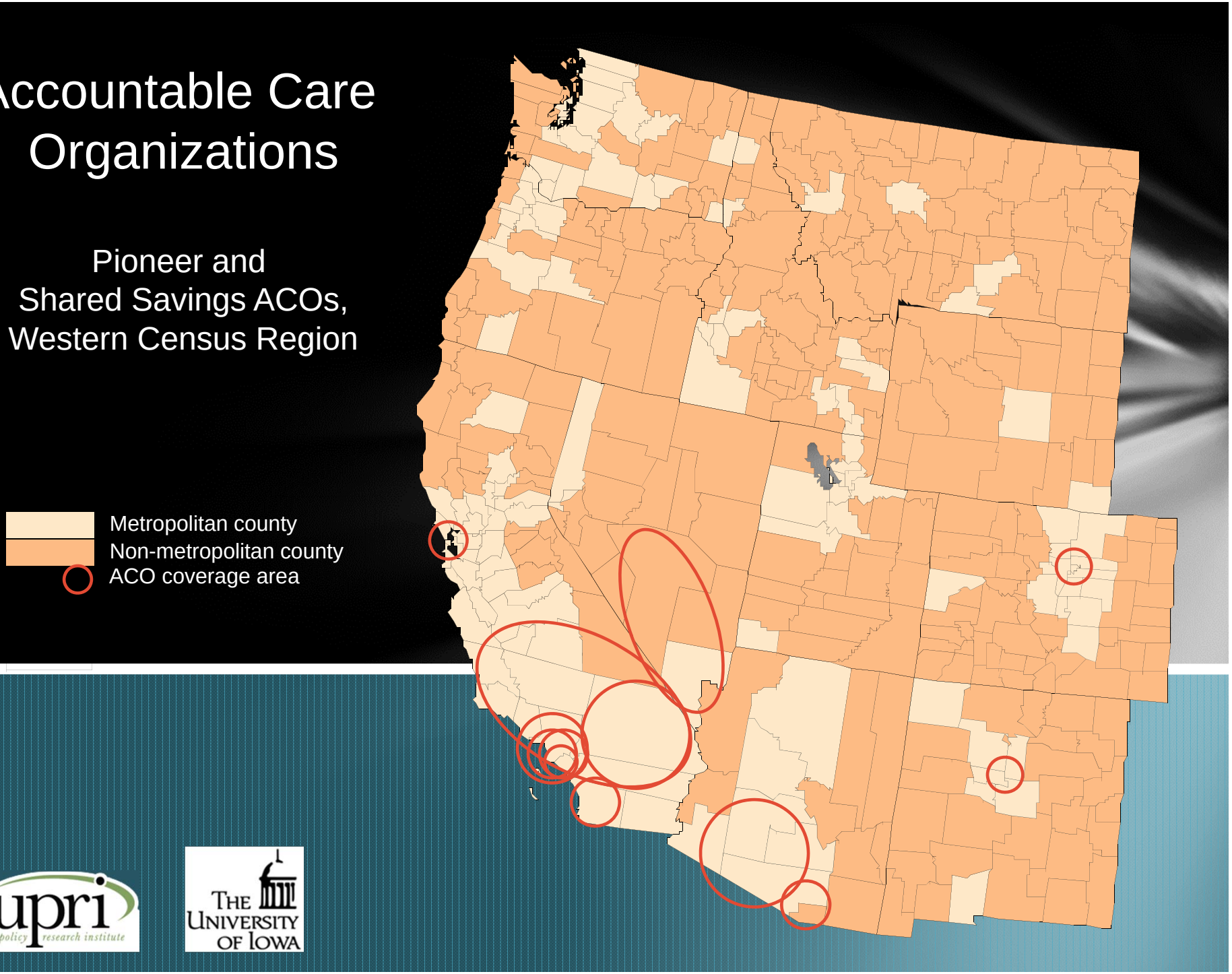
Accountable Care Organizations

Pioneer and
Shared Savings ACOs,
Western Census Region



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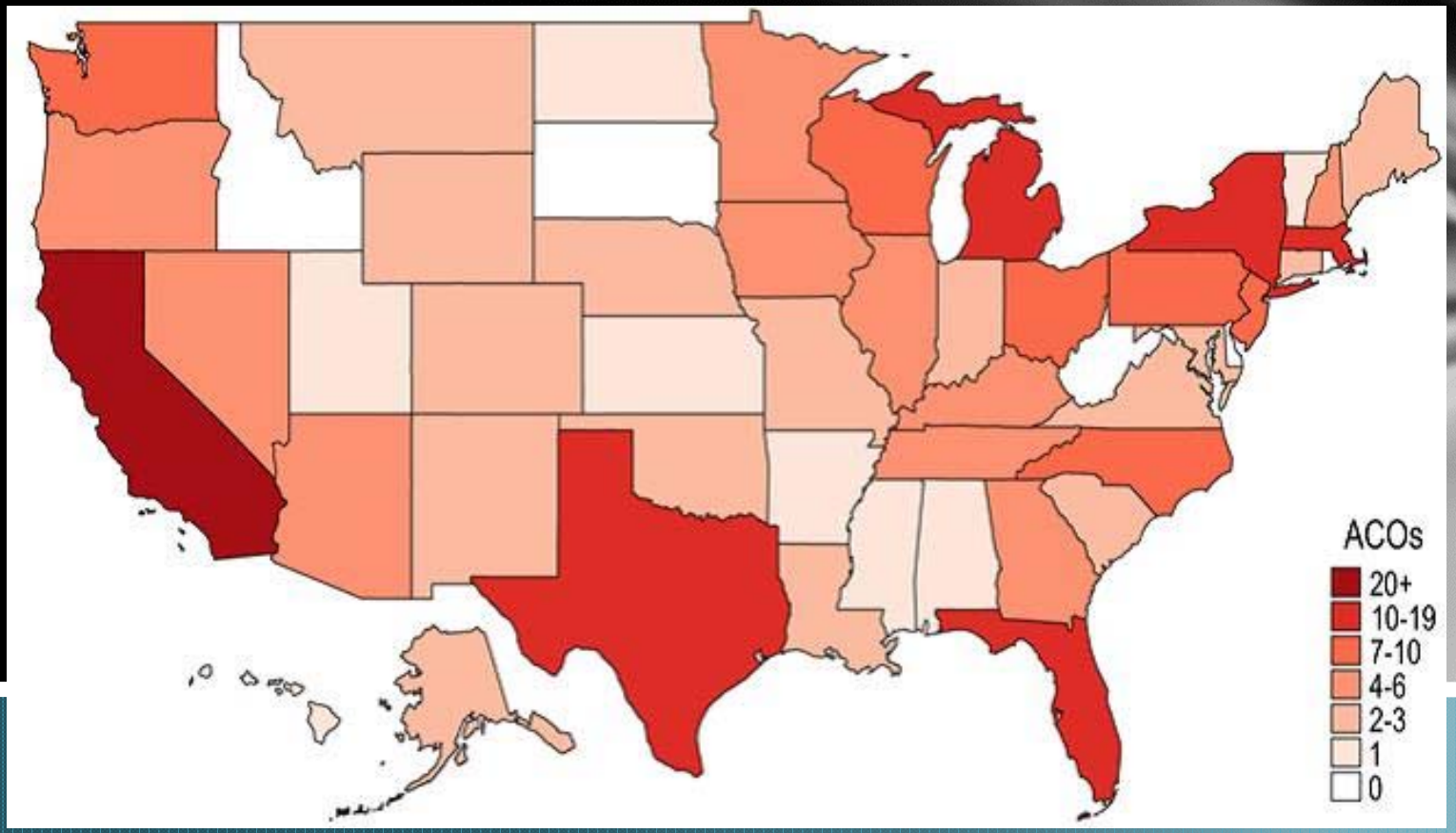
ACO DISTRIBUTION BY STATE



Source: David Muhlestein, Andrew Croshaw, Tom Merrill, Cristian Pena. "Growth and Dispersion of Accountable Care Organizations: June 2012 Update." Leavitt Partners. Accessed August 20, 2012 from LeavittPartners.com

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Overview of Change

- Time of change: health care systems, new private insurance products, new payment methods
- Creates threats and opportunities
- Public programs are part of the trends
- Aligning policy specifics with the broad goals for a better system in the future

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Summary of Direction of Changes

- FFS to VBP
- PC Physicians to Other Primary Care and PCMH personnel
- Face-to-face encounters to telehealth
- Independent entities to systems
- Encounter-based medicine to person-based health
- Revenue centers to cost centers and vice versa

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Policy: address immediate disruptions

- Verify they are real
- Place in perspective and priority
- Intervene as necessary
- Example of Medicare Dependent Hospitals

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Facilitate Local and Regional Improvements

- Merging funding and policy streams: community transitions meet CMS innovations
- Support innovations that meet minimum access standards

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Important Policy Lever in Rural: Medicaid

- Medicaid is currently a crucial safety net program for **rural persons**:
- In 2010, 17.9% of rural persons were enrolled in Medicaid compared to only 15.5% of urban persons.
- 13.2% of rural persons over age 65, but only 12.1% of urban persons in this age group are on Medicaid.
- 9.8% of rural elderly received Medicaid benefits compared to 9.0% of urban elderly

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Importance of Medicaid to Rural Providers

- In part because of the higher rates of coverage of rural persons, Medicaid is a particularly important source of payment for **rural providers**:
- Almost one-third of rural physicians derive 25% or more of their patient revenues from Medicaid, as compared to 19.9% in urban areas.
- Physicians in rural areas are more likely to serve Medicaid beneficiaries than are their urban counterparts.

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Continued

- Medicaid financed 40% of the $177.6 billion spent nationally on long-term care in 2010.
- Medicaid is the primary source of funding for publicly provided mental health services, accounting for 46% of spending in 2007.

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Medicaid, ACA, and Moving Forward

- Access standards for any contracts
- FMAP and state participation: expectations and balance
- Weighing rural consequences

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Considerations about Medicaid Expansion

- Short term and long term costs to Medicaid program and state budget
- Estimated (by Urban Institute) 130,000 persons newly eligible in Iowa
- Balance of state cost through 2020 and federal government matching payment
- Burden of uncompensated care without balancing Disproportionate Share payment
- Cost to public treasuries and public insurance from uncompensated
- Economic impact of Medicaid expansion

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Medicare Policy Levers

- Preservation in the face of threats (20+ years of rural policy activities)
- Pay-for-performance and rural considerations
- Health systems and payment changes: ACOs

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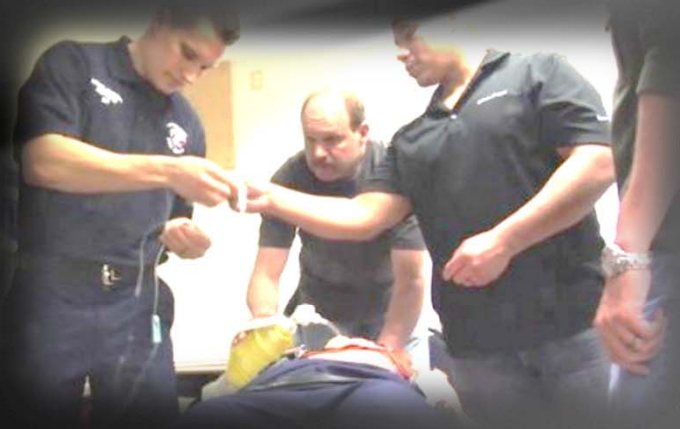
Other Public Policy Levers

- Health professions training programs
- Loan repayment and other incentive programs
- Public health programs
- Infrastructure support



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A Vision for the Future from the RUPRI Panel

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.

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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

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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

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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

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Continued

- 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

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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

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The future can be healthy people in healthy communities

- Where people choose to live
- 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

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Pursuing Alternative Futures

- Organizations should pursue "first do now 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

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For Further Information

The RUPRI Center for Rural Health Policy Analysis

http://cph.uiowa.edu/rupri

The RUPRI Health Panel

http://www.rupri.org

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