ACOs and Much More: Health Reform Comes to Rural America

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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?

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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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Future Should be: RUPRI Health Panel Vision

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

- 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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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

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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)

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Local Assets to Consider

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

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Recommendations

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

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Value Equation

Value = Quality + Experience / Cost

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

"Triple Aim"

- Better care
- Better health
- Lower cost

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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!**

*Source: Berwick and Hackbarth. Eliminating Waste in US Health Care. *JAMA* , April 11, 2012. Vol. 307, No. 14

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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

Source: *Pursuing the Triple Aim*, Bisognano and Kenney. Jossey-Bass. 2012.

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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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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

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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

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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

Source: F. Douglas Carr, "Accountable Care Organizations: Perspectives from the Billings Clinic Experience." Presentation to the Montana Health Care Forum, November 28, 2012

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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…..

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Tally Sheet

- 32 Pioneer ACOs
- 116 MSSP ACOs
- 20 116 are Advanced Payment
- 318 total ACOs; in 48 states

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Serving Millions

- 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

Source: "The ACO Surprise" by Niyum Gandhi and Richard Weil. Oliver Wyman, Marsh & McLennan Companies. 2012. http://www.oliverwyman.com/media/OW_ENG_HLS_PUBL_The_ACO_Surprise.pdf

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People Live in Areas with ACOs Available

- 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

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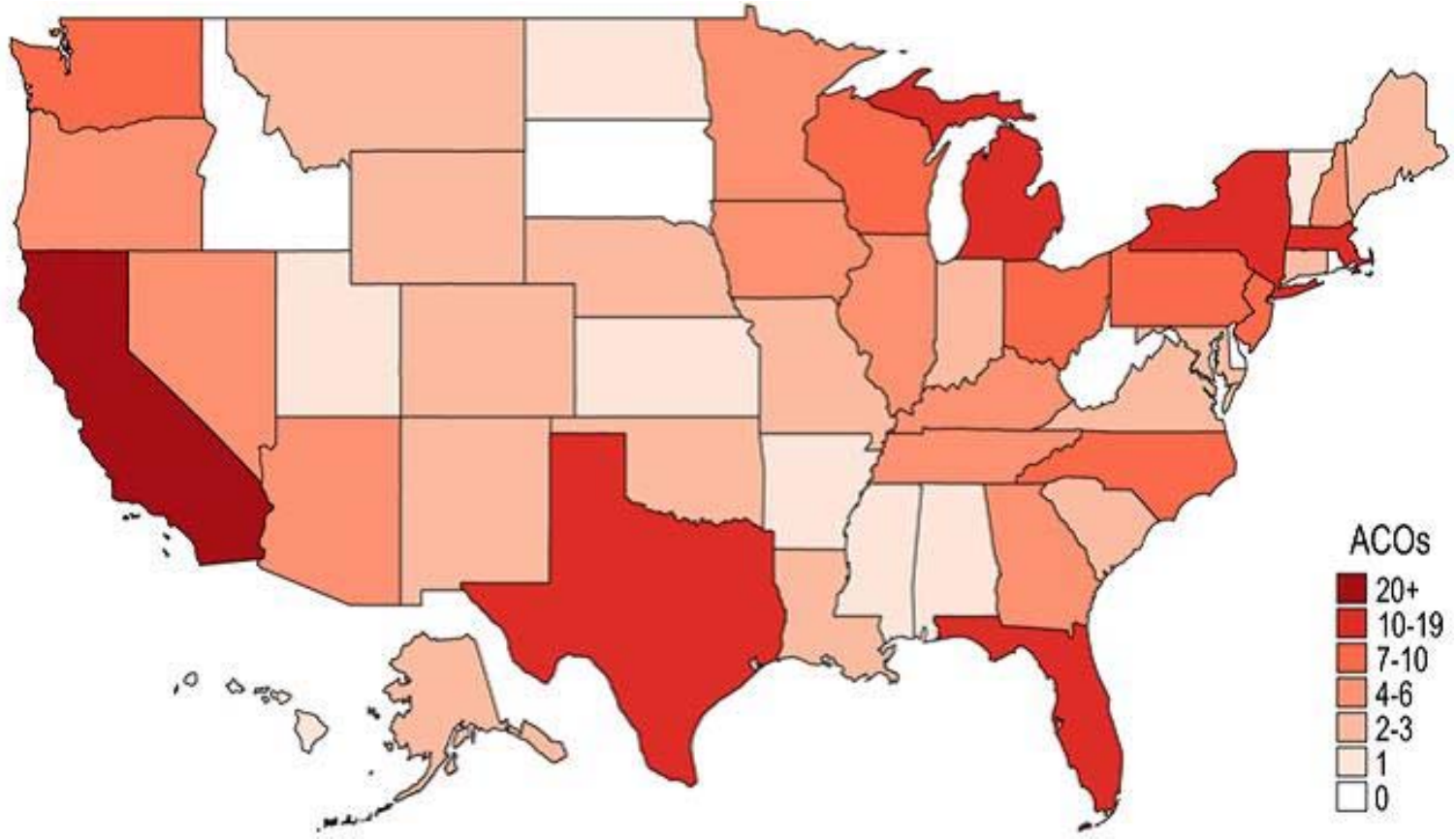
ACO DISTRIBUTION BY STATE



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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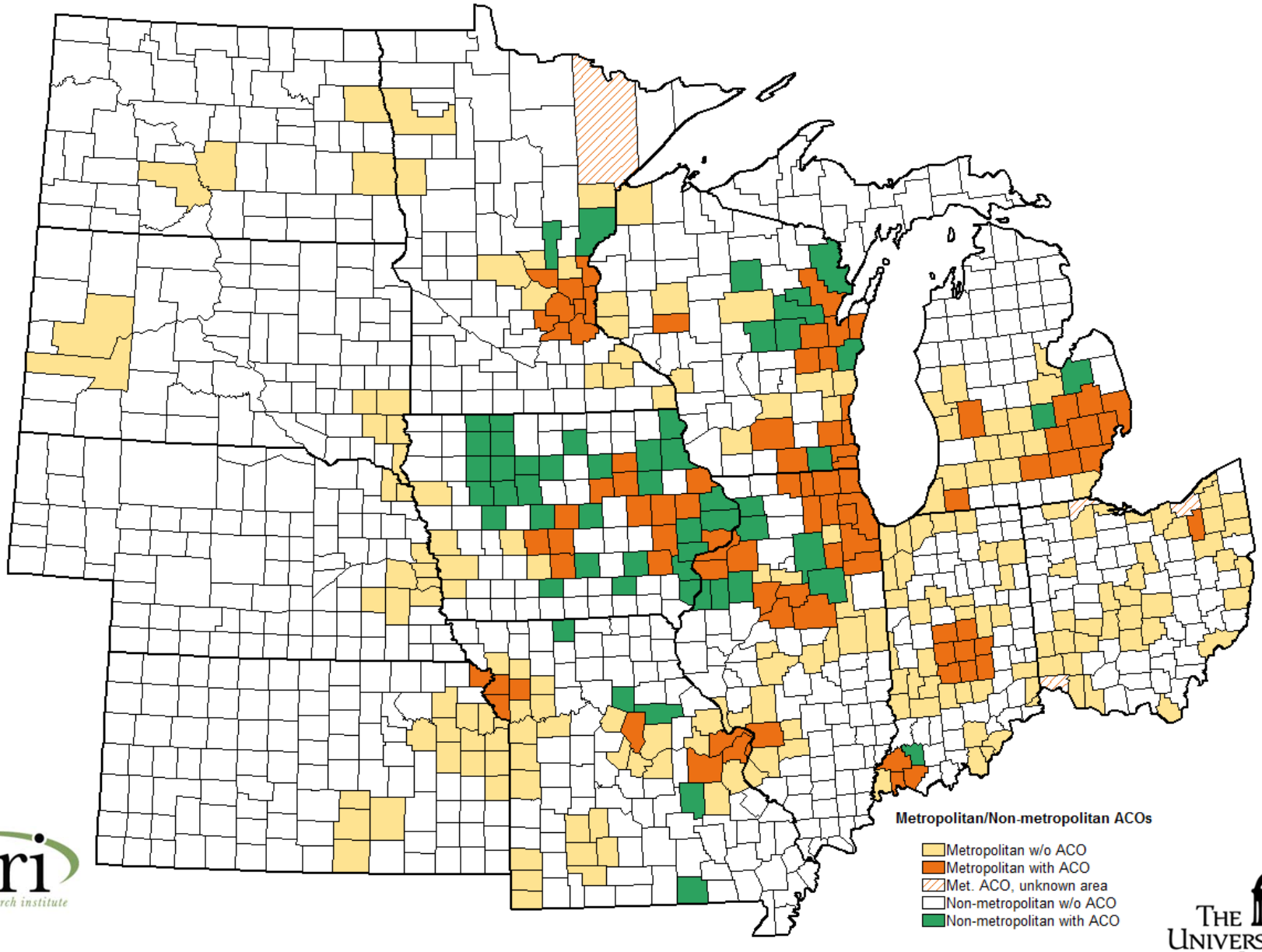
County Medicare ACO Presence

Midwest Census Region



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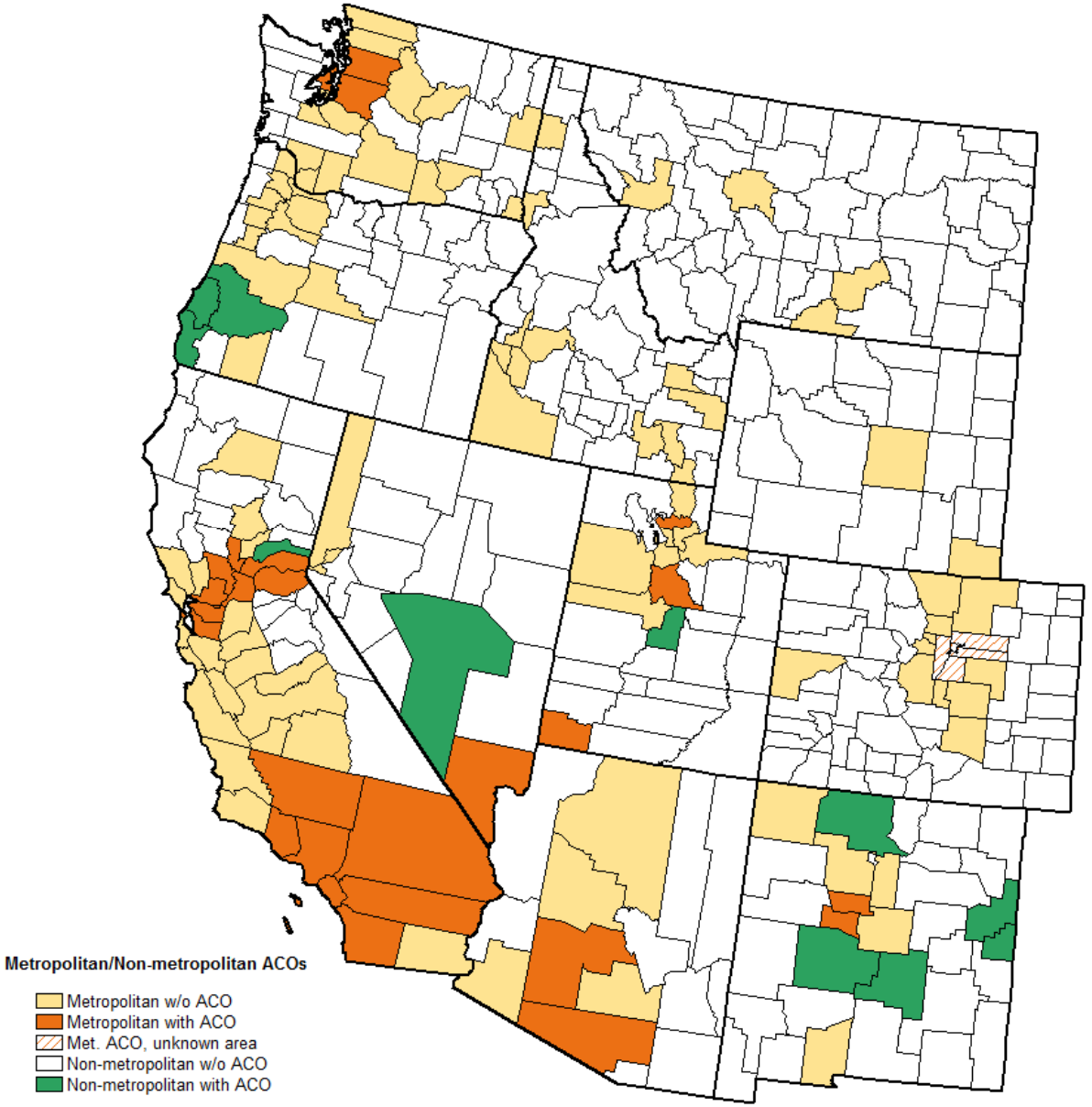
CMS-designated sites as of August, 2012.
Produced by: RUPRI Center for Rural Health Policy Analysis, 2013.

County Medicare ACO Presence

West Census Region



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CMS-designated sites as of August, 2012.
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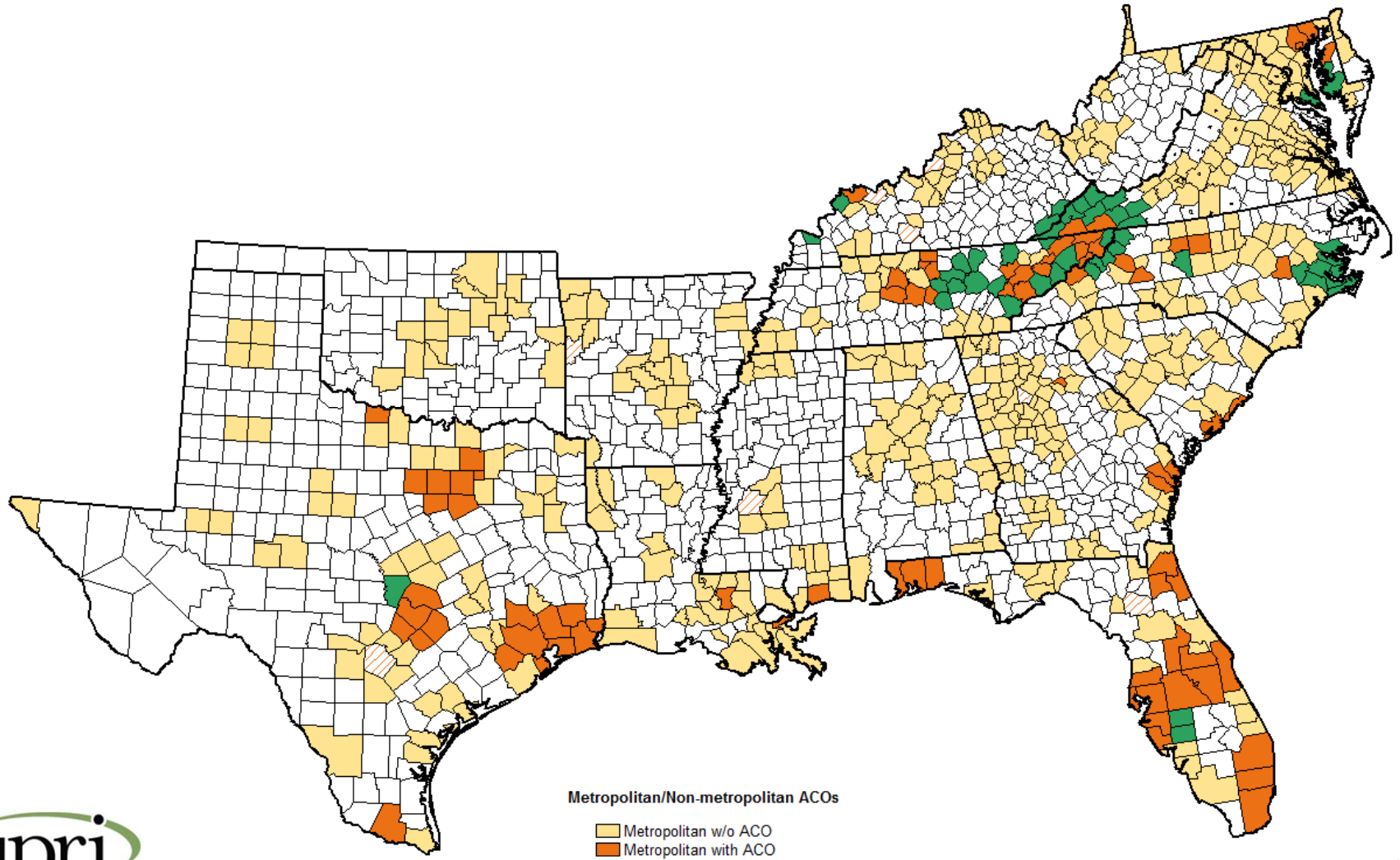
County Medicare ACO Presence

South Census Region



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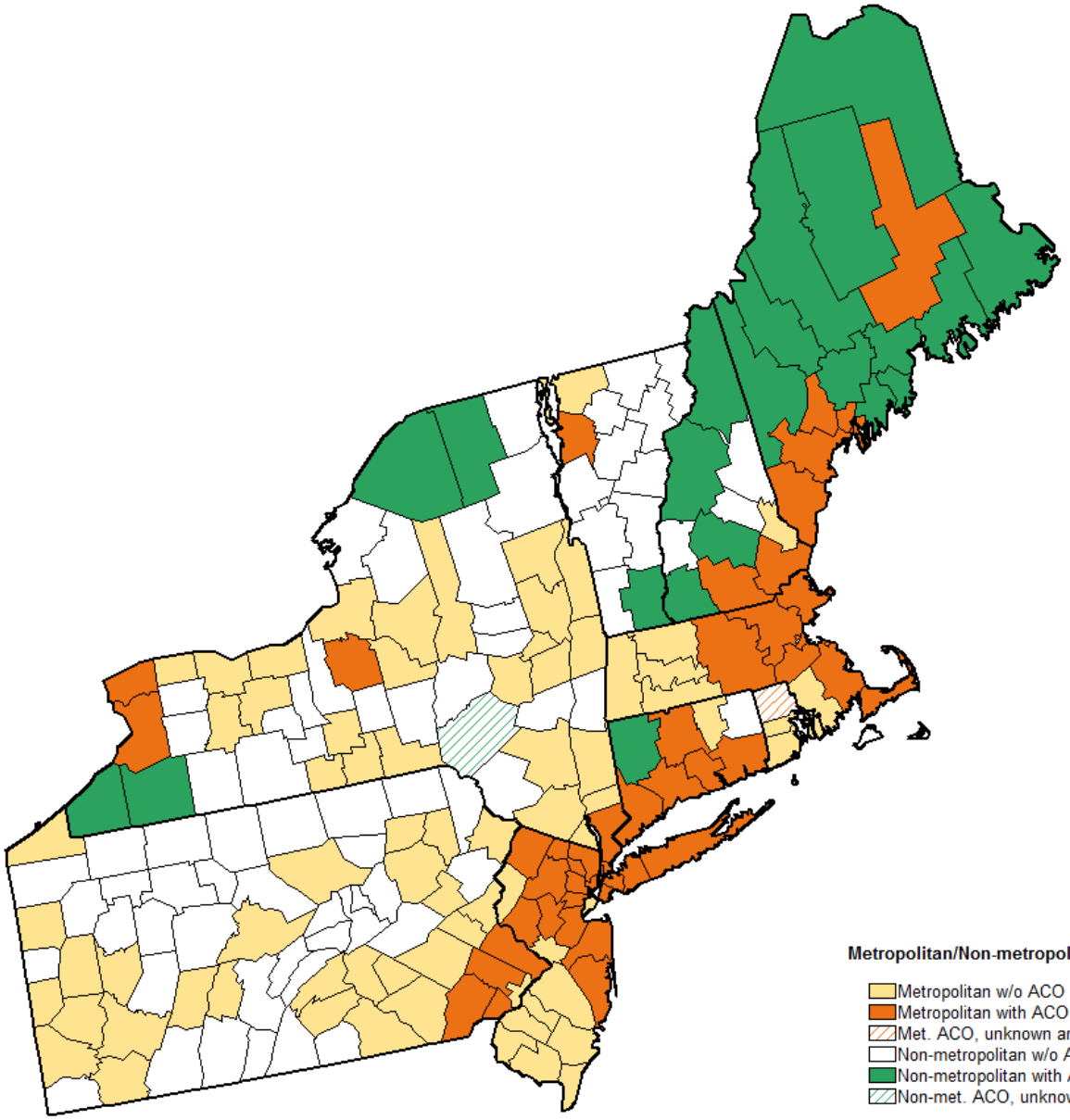
CMS-designated sites as of August, 2012.
Produced by: RUPRI Center for Rural Health Policy Analysis, 2013.

County Medicare ACO Presence

Northeast Census Region



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CMS-designated sites as of August, 2012.
Produced by: RUPRI Center for Rural Health Policy Analysis, 2013.

Core Components of An ACO

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

Source: AJ Forster, BG Childs, JF Damore, SD DeVore, EA Kroch, and DA Lloyd "Accountable Care Strategies." Commonwealth Fund. August, 2012. http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2012/Aug/1618_Forster_accountable_care_strategies_premier.pdf

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The World According to Payers, 2016 and Beyond

- 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

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Transition Thinking

- Volume to value
- Group contract to patient service
- Care coordination across the continuum
- Patient centered care
- Lower costs

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Continued

- 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?

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Elements of excellence

- 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

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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

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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

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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**

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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

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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

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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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