Rural Strategies for a Value-Based Future

Presentation to the Kansas Hospital Association

by

Keith J. Mueller, PhD

RUPRI Center for Rural Health Policy Analysis

University of Iowa

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Getting There From Here

- Setting the stage: current state of affairs for Critical Access Hospitals
- Toward a new world of value-driven principles in health care delivery and finance
- Ultimately to performance measured as population health

Present Challenges for Critical Access Hospitals and Rural Systems

- Cost-based reimbursement under duress
- Political future of Medicare Rural Hospital Flexibility Program (CAHs and grant program) less certain
- Diffusion of new models of care may question place of CAHs and inpatient services
- New models of care may connect rural services to systems providing care across the continuum

Cost-based Reimbursement Under Duress

- Discomfort a constant in the Centers for Medicare and Medicaid Services (CMS) and the Medicare Payment Advisory Commission (MedPAC)
- Understanding of special rural circumstances minimal in CMS and MedPAC: analytical approach is one payment formula at a time
- Driver is cost containment, getting the price "right"

Cost-based Reimbursement Under Duress

- “Explosion” of CAHs to 1,332
- Many designated as necessary providers by states
- Exceeded expectations created by legislative requirements of distance (35 miles or 15 given terrain)

Cost-based Reimbursement Under Duress

- Result: proposals to enforce federal mileage requirement, or at least some distance (10 or 15 miles)
- Fire stoked by Office of Inspector General report recommending decertifying 849 CAHs
- Debate likely to rage on until alternatives are created and implemented for many CAHs

Escape to the Future

- Retain cost-based long enough to complete a transition
- But be about the transition to value
- Policy environment includes medical homes, bundled payment, accountable care
- Ultimately need integrated care/service models for communities

All About Value

- Value will determine payment, initially partial eventually all
- Responding to those changes
- Value will take on a new meaning beyond the hospital/clinic walls
- Will require focus on population health

Value Equation

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

Payers Are Getting Smarter

Total Cost = Price x Quantity

Current Way

- Negotiate *unit price*
  - Discount on charges
  - CPT codes
  - Per diems
  - Case rates (DRGs)
- Hospital success strategy
  - Negotiate for high unit prices, then optimize volumes

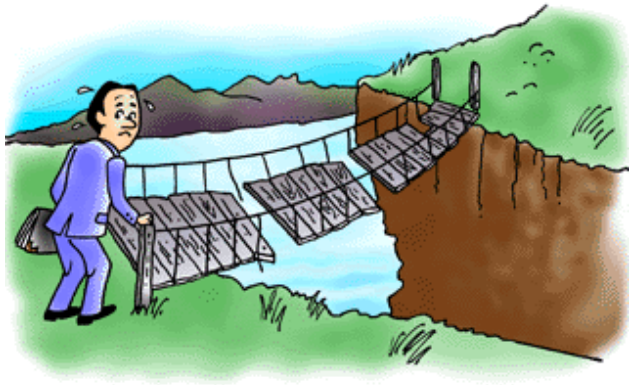
Future Way

- Negotiate *total cost of care*
  - Bundled payment
  - Shared risk (ACOs)
  - Capitation (beyond medical care)
- Hospital success strategy
  - Negotiate high per capita rate, favorable base period, and accurate risk adjustment, then optimize community health

The Volume to Value Gap

Volume-based success strategies

- Pay-for-service
- Cost-based reimbursement
- Inpatient focus
- Hospital and physician independence
- Stand alone care systems
- Illness care

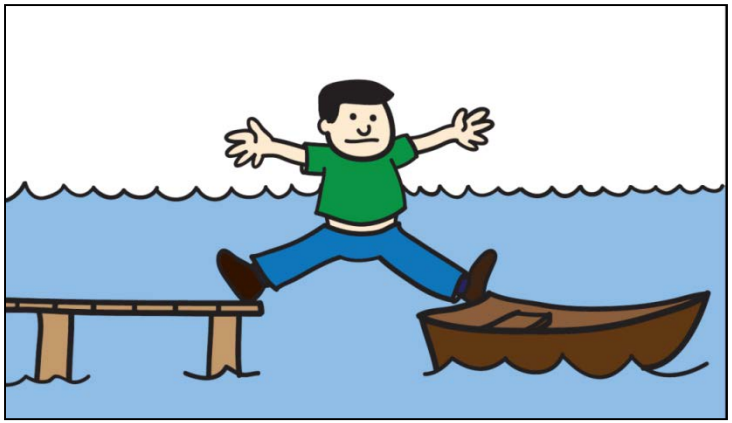


Value-based success strategies

- Pay-for-results (quality/efficiency)
- Shared risk
- Partnerships and collaborations
- Continuum of care consideration
- Community health improvement

Hospital Transformation

- How do we move toward delivering value when our revenue is primarily volume-driven?
- How do we not get “soaked” during the transition?
- We can “test the waters” with a new set of tools.



Tool Box for Delivering Value

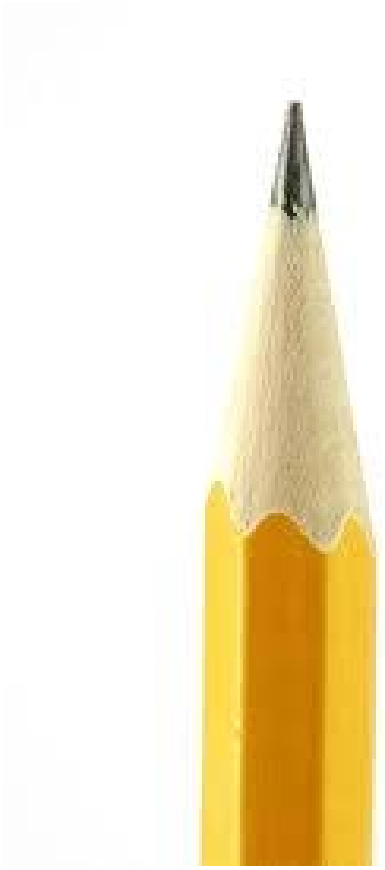
Strategies

- Optimize fee-for-service (transition)
- Attend to performance and innovation
- Drive in efficiency
- Drive out variation
- Develop medical homes
- Engage the medical staff
- **Potpourri – what we can do now**

Get Your FFS House in Order

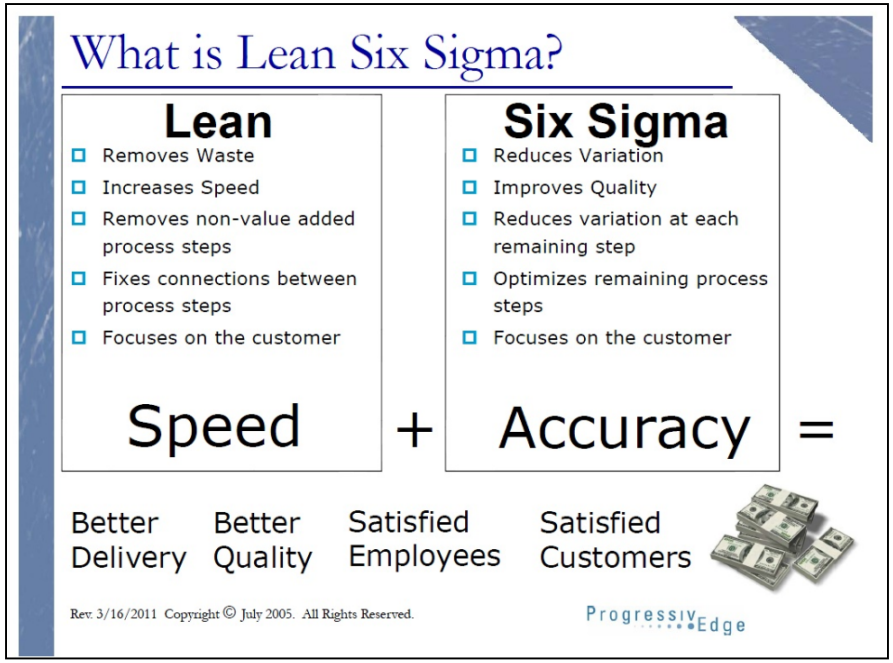
Attention to

- Market share
- Revenue cycle
- Payer contracts
- Purchasing contracts
- Inventory management
- A*ppropriate* volumes



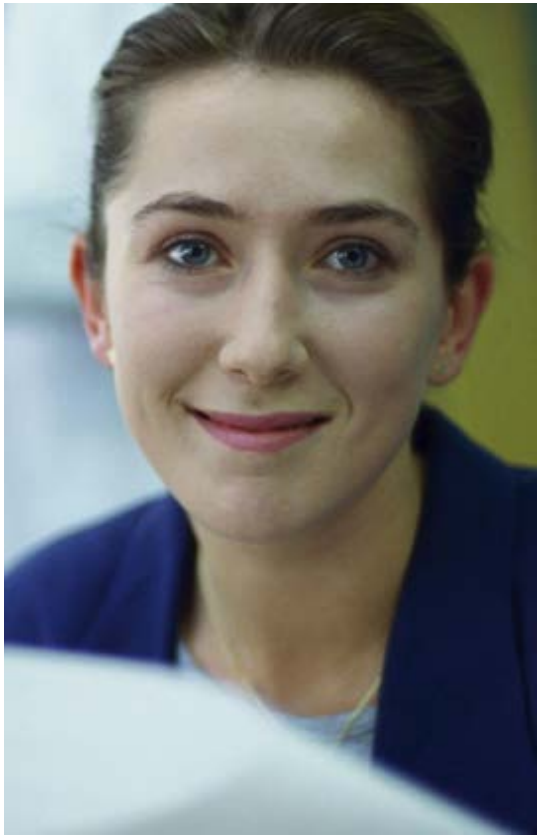
Efficiency

- Eradicate waste (Lean)
- Reduce variation (6 Sigma)
- Aggressively review "bricks and mortar" budgets
  - Do planned expenditures support the new reality?
  - Avoid trapped equity!



Innovation Requires New Foci

- Inpatient Beds → Clinics (and more)
  - Expanded and robust primary care
  - Workplace nursing
  - Mobile clinics
  - Telehealth
- Illness → Wellness
  - Health Risk Assessments
  - Community Health Assessments
  - Health coaching
  - Care coordination



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

Elements of a Successful System Redesign: Lessons from Systems

- 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.

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

What CAHs and Small Rural Hospitals Must Consider

- Future for any hospital-based care in their communities: *if the apparent becomes necessity, transition with foresight, not hindsight*
- Best financial models for sustaining *essential hospital-based services* (could include other services)
- How to get to those models
- Role of the hospital in community-based care; *the business model indicates this is financially wise in addition to being mission driven*
- *From "hospital" to "health hub"*

Conversation About Getting There

- Ideas generated by learning and participating
- Learning and doing among hospitals in similar circumstances
- Broadened to the communities
- Spread across geography (state, region, nationally)

Illustration: Chief Medical Financial Officer

- Bonner General Hospital in Sandpoint, Idaho: CAH conversion in 2011
- Meld financial and clinical goals – example of opening wound center after physician recognized market potential
- “Engaging physicians to cut costs while maintaining quality” (from article cited below)

Illustration: Chief Medical Financial Officer

- Dr. Kenneth Cohn, CEO of Healthcare Collaboration: "It's about giving doctors a more proactive role in strategy and identifying physician finance champions"
- CFO conducts rounds with physicians

Source: Bob Herman, "In the Future, Will Hospitals Have a Chief Medical Financial Officer?" *Beckers Hospital Review,* April 8, 2014.

Lessons from “progressive hospitals”

- Address social issues related to healthcare: Montefiore focuses on social determinants of health
- Take holistic approach to population health: affiliate with organizations who are not healthcare providers; Truman Medical Center in Kansas City partnered to open grocery store
- Promote price transparency: promotes patient trust
- Include physicians in administrative decision-making: in the C-suite, in all decisions of the hospital
- Serious about hospitality: patient experience as area of expertise in upper management

Lessons from “progressive hospitals”

- Partner with employers: big time example is contract between Cleveland Clinic and Lowes for heart procedures, with Wal-Mart and Boing for cardiac care; rural reality is working with local employers on wellness initiatives, primary and preventive care
- Let patients access personal health information: leader has been Geisinger allowing access to physician notes

Taken from “10 Things the Most Progress Hospitals Do,” Molly Gamble, *Beckers Hospital Review*. July 8, 2013

What if Medicare Were the Only Payer?

- Can be a target for management
- Question used by Benefis Health System in Great Falls, Montana – two hospital system with only tertiary hospital for 37,800 square miles, 70% of payment from government
- Made Medicare break-even a goal in 2009, annual operating margin since has been at least 3.6%, 2.6% on Medicare in 2012

Imperatives Learned by Benefis

- Entrench cost reduction mindset throughout management supervisory ranks
- Emphasize why cost reduction is important to all employees
- Measure results and report often, celebrate success
- Include physicians, employed and independent, as cost reduction partners
- Be prepared to look beyond low-hanging fruit
- Evaluate external partners, their contribution to reducing costs

Taken from “What if Medicare Were the Only Payer,” Bob Herman. *Beckers Hospital Review* May 6, 2014.

Getting to the End Point of Population Health

- Completing the transition to value measured as health
- Moving out the boundaries of health systems
- New data and analysis
- Collaborations and community leadership

Transition Thinking

- 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
- From exclusively local to inclusive within region

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)

Source: The U.S. Census Bureau

Financial Risk and Total Cost of Care

- Recognize role of social determinants of health: socio-economic factors contribute 40% of different to population health, health behaviors 30% (calculations for MN)
- Importance of community collaborations

Summary Considerations

- Forming relevant, aggressive leadership teams: Internal, Community, Beyond
- Functioning within parameters of community dynamics as a health hub
- New assessments of revenues and expenses; new analytics

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
- Future is in *health improvement* for population served (community)

Collaborations to Share and Spread Innovation

The National Rural Health Resource Center

The Rural Assistance Center

The National Rural Health Association

The National Organization of State Offices of Rural Health

The American Hospital Association

For Further Information

http://ruralhealthvalue.org

http://cph.uiowa.edu/rupri

http://www.rupri.org

Dr. Keith J. Mueller

Department of Health Management and Policy
College of Public Health, N232A
145 Riverside Drive
Iowa City, IA 52242-2007
319-384-3832
keith-mueller@uiowa.edu