The Race To Value-Based Payment

Presentation to Pennsylvania Rural Health Model Summit
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The University of Iowa
College of Public Health

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The Change in Payment

- Starting line is fee-for-service (ffs), determined by allowable cost
- The slow lane is to modify incrementally with incentives
- Moderate lane supports elements of restructuring health finance but leaves in place current core (ffs)
- Fast lane blows past current design to a total redesign of payment, aligned with quality measures

The Vehicles: Knowledge and Tactics

- Understanding financial risk
- Knowing what influences health outcomes
- Managing care (patient)
- Managing health (population)

The Driver: Health Care Organization (Hospital) Leadership

- Generating resources and investing strategically
- Local leadership
- Facilitating coalitions

Policy Motivator: Cost

- Total expenditure growing faster than Gross Domestic Product: crowds out other uses of GDP
- Strain on national, state, local budgets
- Cost of private insurance predicted to exceed $14,000 annually
- What is the return on investment of this use of GDP?

Track 1: The Slow Lane for Providers

- Incentives affecting small percentage of payment
- Payment change for only a small portion of patients
- Adjustments to limited number of services
- Retaining the FFS payment design

Track 2: A Moderate Pace with Potential for More Rapid Pace: ACO Model

- Fee-for-service chassis remains in place
- But payment tied to total expenditures
- With an element of quality measurement and accountability
- Accountable Care Organization: each term has meaning

Why Travel Down the ACO Lane?

- Opportunity to test (training wheels)
- Strategic investments using advance payment or other commitments
- Building delivery systems that can negotiate contracts

Medicare Results Are Mixed

- There have been savings to the Medicare program, significance in the eyes of the beholder
- Some ACOs receiving shared savings: some rural ACOs exceeding $2 million in shared savings
- Quality scores have improved
- Is the lane most traveled: following slides show Medicare Shared Savings Plan growth, based on beneficiaries attributed to ACOs

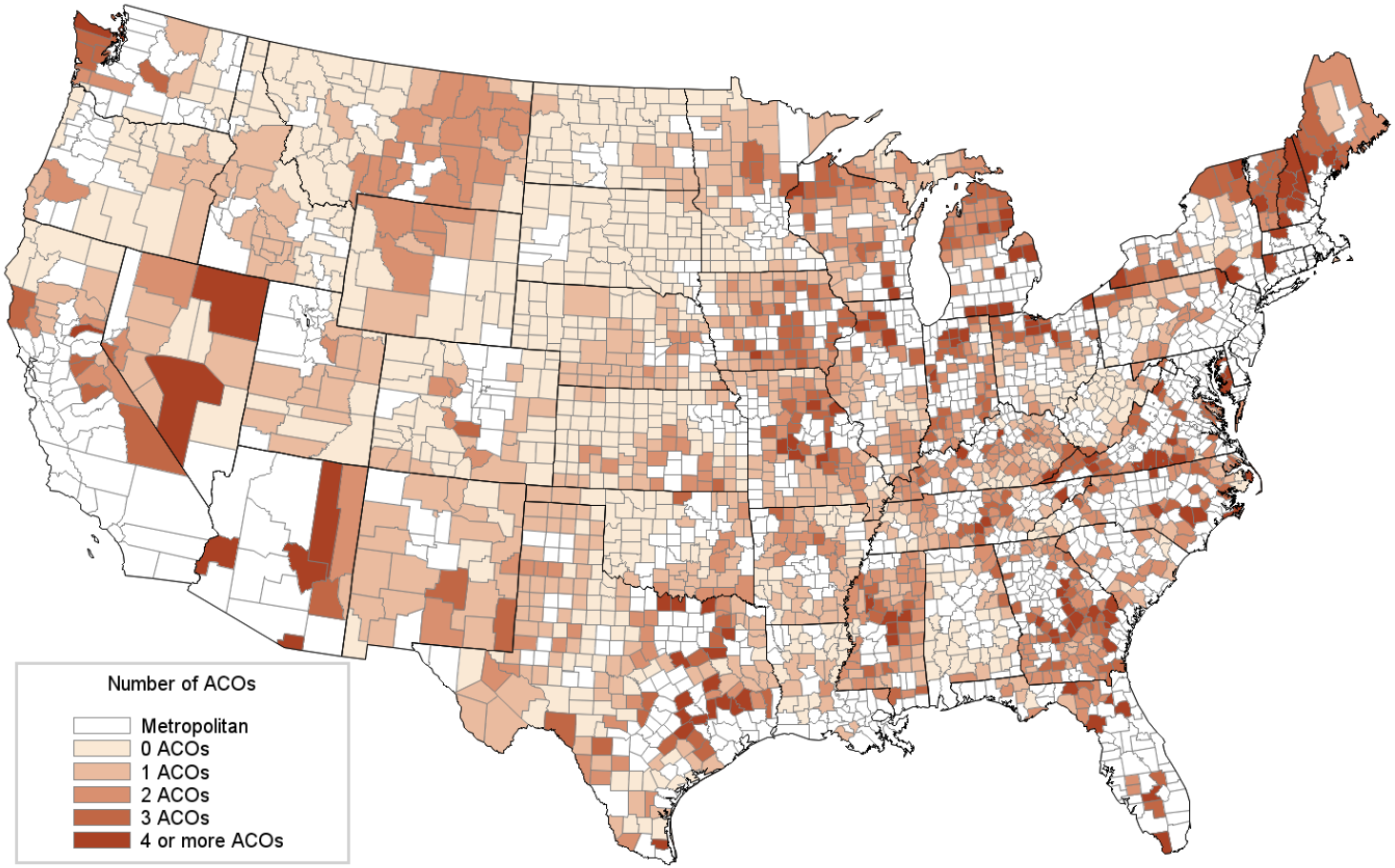
State-Level County ACO Presence and Enrollment - METROPOLITAN

		2014		2015		2016		2014-2016 Chg.	
State	Counties	1+ACO	5%+Att.	1+ACO	5%+Att.	1+ACO	5%+Att.	1+ACO	5%+Att.
Connecticut	7	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%
Delaware	3	100.0%	66.7%	100.0%	100.0%	100.0%	100.0%	0.0%	50.0%
Maine	5	100.0%	80.0%	100.0%	80.0%	100.0%	100.0%	0.0%	25.0%
Maryland	19	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%
Massachusetts	11	100.0%	81.8%	100.0%	90.9%	100.0%	81.8%	0.0%	0.0%
New Hampshire	3	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%
New Jersey	21	100.0%	90.5%	100.0%	100.0%	100.0%	100.0%	0.0%	10.5%
New York	38	92.1%	63.2%	97.4%	86.8%	94.7%	73.7%	2.9%	16.7%
Ohio	38	94.7%	57.9%	100.0%	78.9%	100.0%	81.6%	5.6%	40.9%
Pennsylvania	37	73.0%	40.5%	100.0%	81.1%	100.0%	91.9%	37.0%	126.7%
Rhode Island	5	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%
Vermont	3	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%
Virginia	81	98.8%	81.5%	98.8%	85.2%	98.8%	88.9%	0.0%	9.1%
West Virginia	21	42.9%	23.8%	81.0%	28.6%	100.0%	57.1%	133.3%	140.0%

State-Level County ACO Presence and Enrollment - NON-METROPOLITAN

		2014		2015		2016		2014-2016 Chg.	
State	Counties	1+ACO	5%+Att.	1+ACO	5%+Att.	1+ACO	5%+Att.	1+ACO	5%+Att.
Connecticut	1	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%
Delaware	0								
Maine	11	100.0%	81.8%	100.0%	81.8%	100.0%	100.0%	0.0%	22.2%
Maryland	5	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%
Massachusetts	3	100.0%	33.3%	66.7%	33.3%	66.7%	0.0%	-33.3%	-100.0%
New Hampshire	7	100.0%	85.7%	100.0%	100.0%	100.0%	100.0%	0.0%	16.7%
New Jersey	0								
New York	24	75.0%	50.0%	100.0%	87.5%	100.0%	87.5%	33.3%	75.0%
Ohio	50	74.0%	40.0%	94.0%	56.0%	100.0%	80.0%	35.1%	100.0%
Pennsylvania	30	73.3%	36.7%	96.7%	60.0%	93.3%	63.3%	27.3%	72.7%
Rhode Island	0								
Vermont	11	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%
Virginia	53	96.2%	77.4%	100.0%	84.9%	96.2%	84.9%	0.0%	9.8%
West Virginia	34	23.5%	11.8%	73.5%	35.3%	97.1%	64.7%	312.5%	450.0%

Medicare ACO Presence, non-Metropolitan Counties: 2014



Produced by: RUPRI Center for Rural Health Policy Analysis, 2017.

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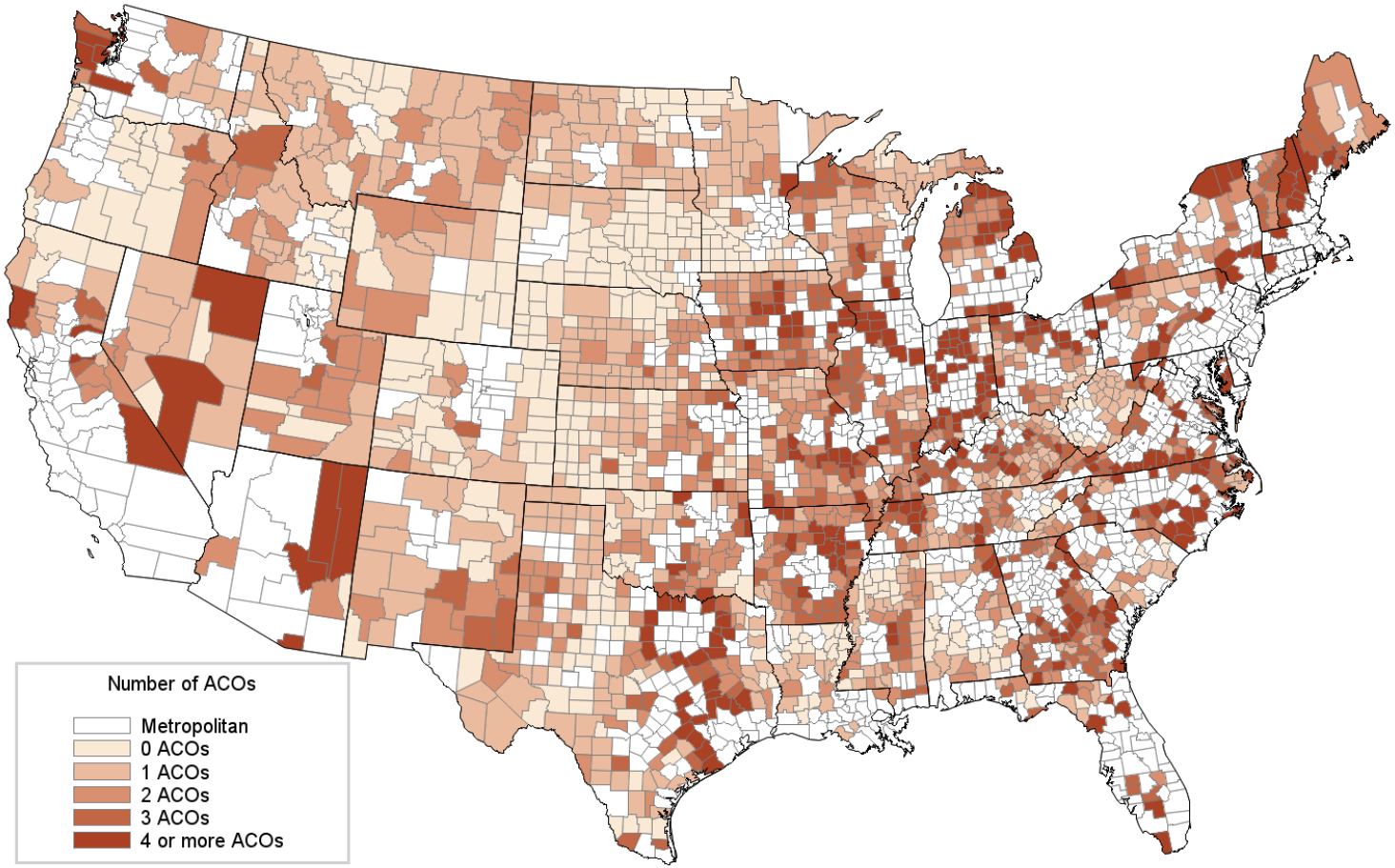

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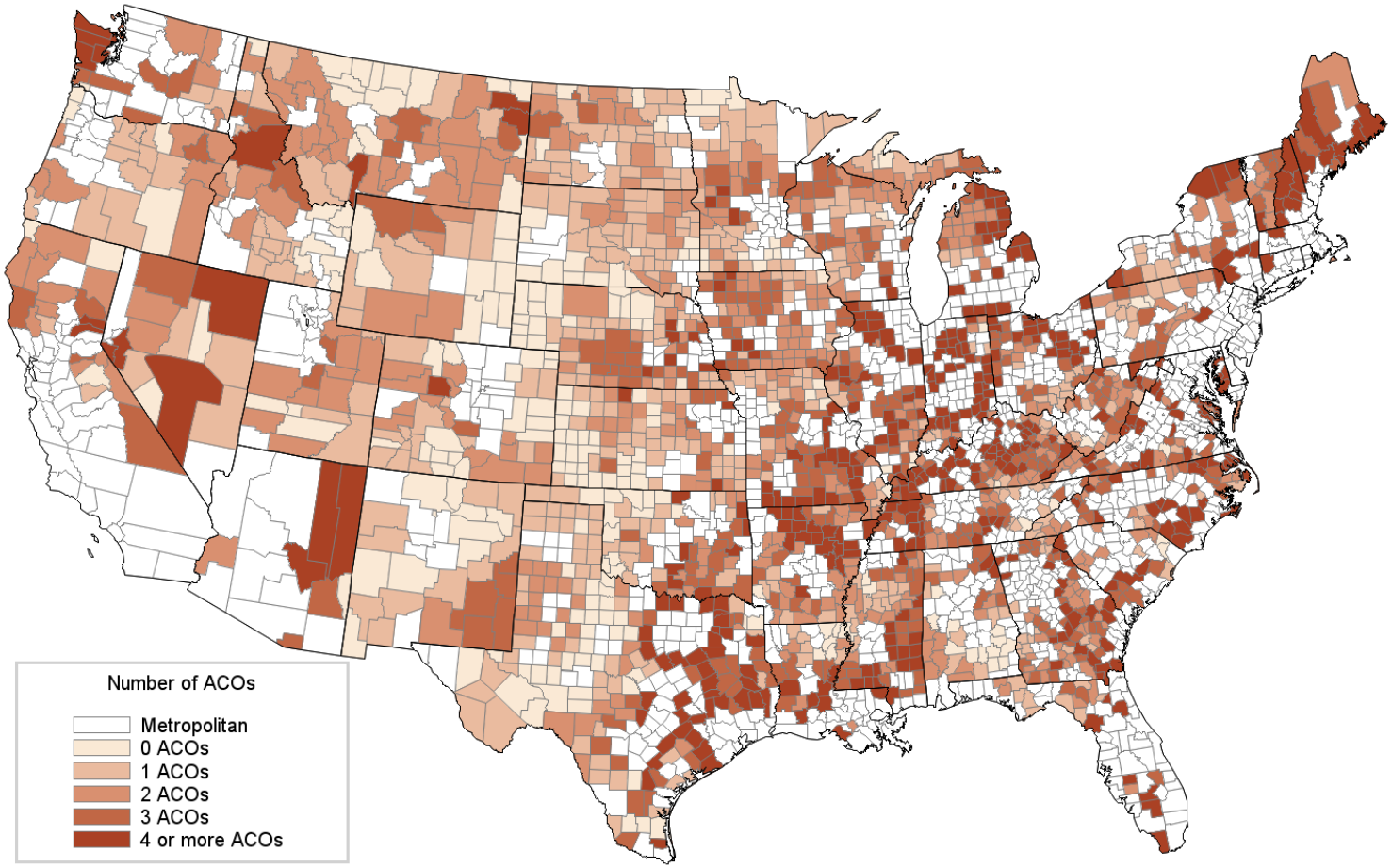
Medicare ACO Presence, non-Metropolitan Counties: 2016



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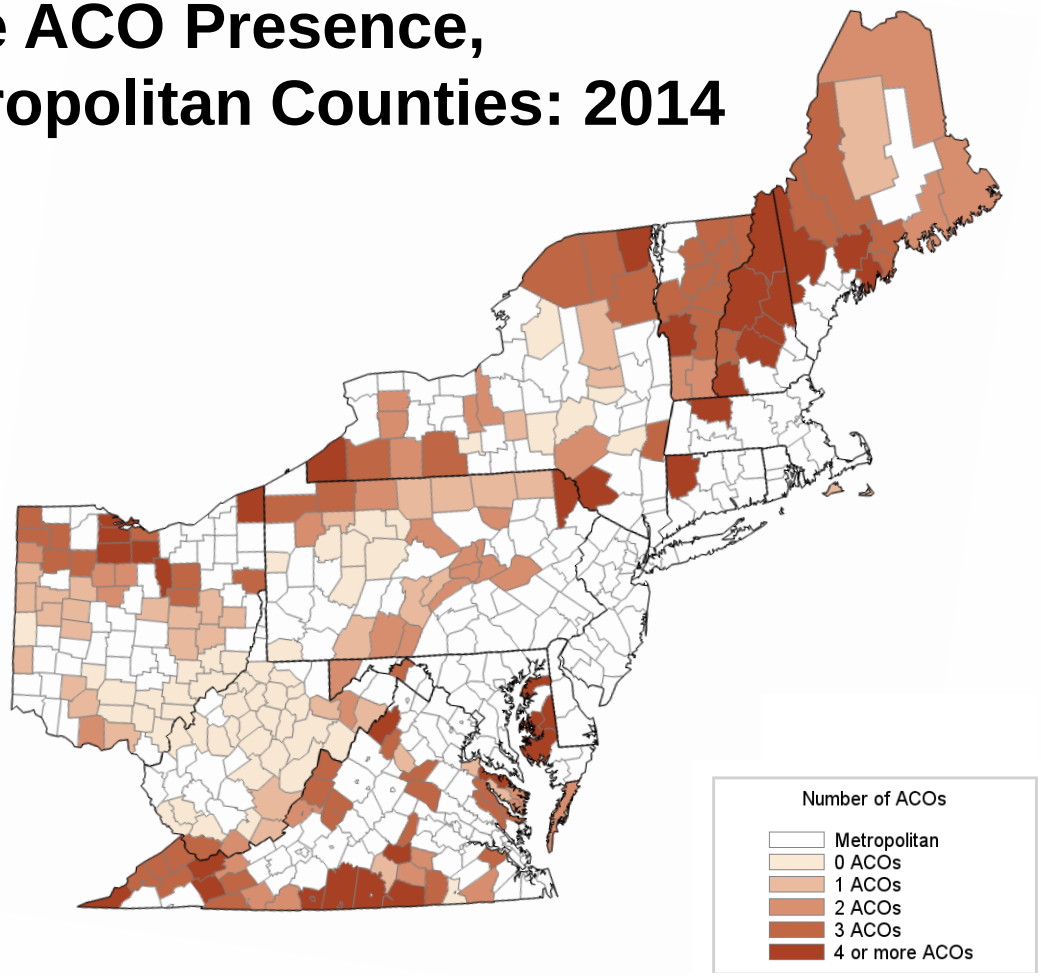

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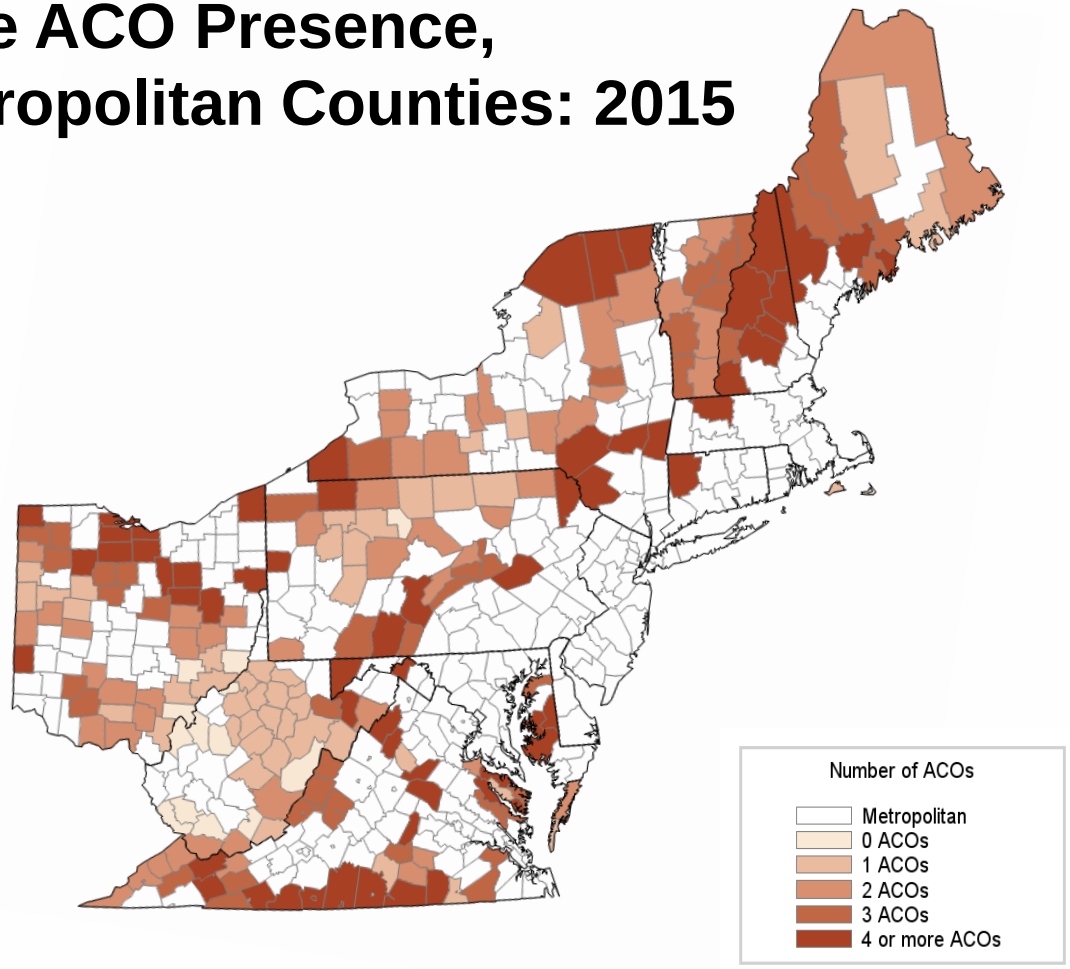

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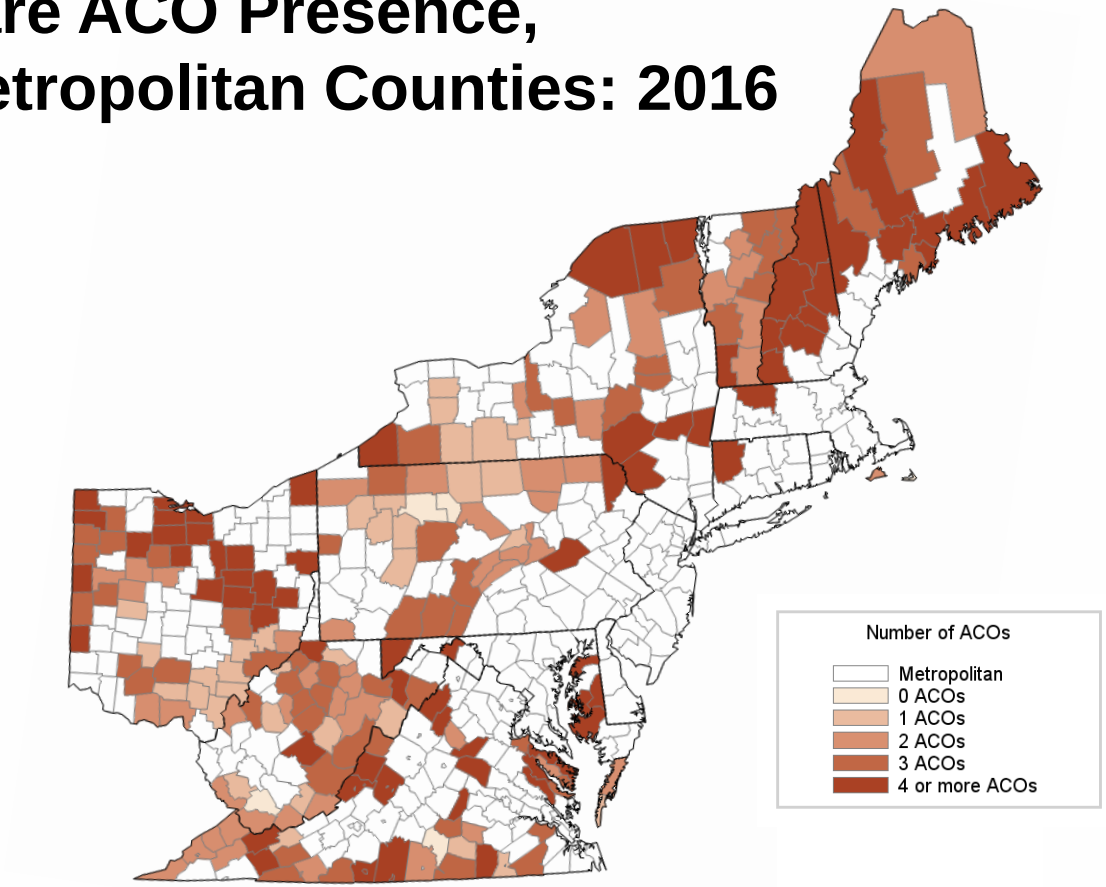

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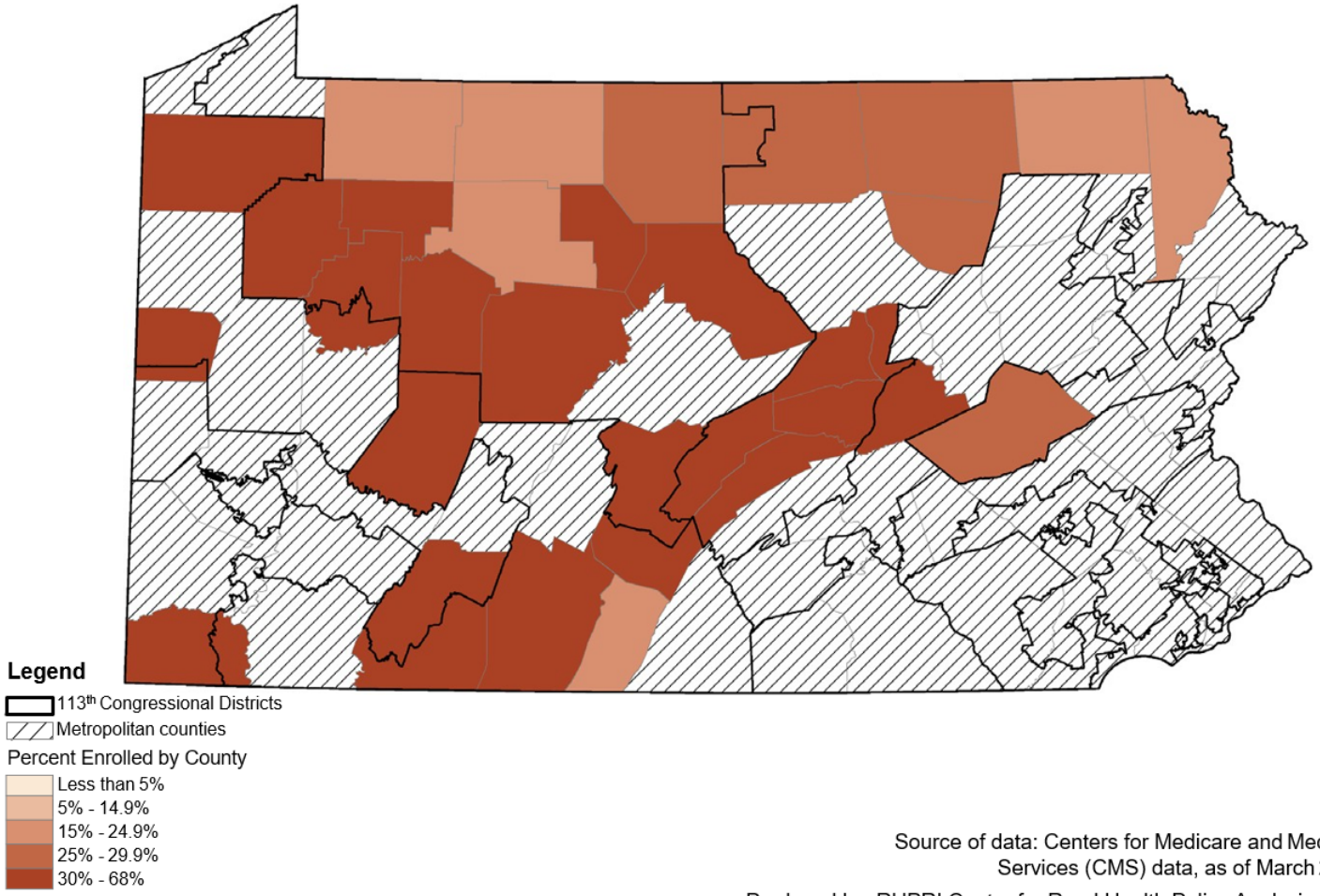
Fast Lane to Controlling Cost: Fixed Cost Contracting

- Managed Care Organization (MCO) contracts in Medicaid programs
- Fixed budget between states and MCOs, “negotiated” prices between MCOs and providers
- MCO managing care: utilization generally and use of specific services
- Medicare approach with Medicare Advantage plans (MA): combine quality scoring with payment, resulting in higher outlay
- Provider payment determined by the MA plan

Percent of Eligible Medicare Non-Metropolitan Beneficiaries Enrolled in Medicare Advantage and other Prepaid Plans: Pennsylvania, March 2017



Source of data: Centers for Medicare and Medicaid Services (CMS) data, as of March 2017.

Produced by: RUPRI Center for Rural Health Policy Analysis, 2017

Track 3, Fast Lane: Global Budgeting in Maryland

- Meeting the spending targets of the demonstration (rate of growth below that of the state's economy)
- Total Medicare savings of $429 million 2013 – 2016; net savings of $319 million
- Quality measures also improving

Source: Nelson Sabatini, Joseph Antos, Howard Haft, and Donna Kinzer. "Maryland's All-Payer Model—Achievements, Challenges, and Next Steps." *Health Affairs Blog*. January 31, 2017.

Track 3, Fast Lane: Global Budgeting in Maryland

- The story of McCready Health in Crisfield, population 2,726 (service area approximately 7,.000)
- Increased capital investments
- Build new services

"The switch from volume payment to value payment is driving McCready to understand and improve the health status of its populations"

Sources: Joy A. Strand. "Global Budget in a Rural Hospital." Presentation to the NRHA CAH Conference. September 22, 2016

"Global Budget Process as an Alternative Payment Model." *Rural Innovation Profile*. Rural Health Value. www.ruralhealthvalue.org.

Track 3: Fast Lane: Direct Contracting

- System-owned insurance plans
- Contract directly with large groups
- Develop products for exchanges
- Other: could be association plans

Building the Race Car: Engine is Finance

- Current finance: pro forma
- Operating in a shared savings environment
- Understanding cross-payer issues (helps tremendously to be an all-payer demonstration)
- Operating at full risk
- Crucial to keep it lubricated: in McCready biweekly meetings of CEO and CFO to make rate adjustments

The Wheels for the Car

- Community partnerships
- Maintains continuous progress toward community health objectives
- Maintaining tire pressure: spreading resources to meet health needs through the appropriate agency

The Body of the Car: Strategies and Tactics

- Care management for high risk patients
- Identifying pressure points driving expenditures and work to control (readmissions down in MD; “high flyers” in emergency rooms)
- Population health measures to achieve community health goals

Tactics: Community-Wide Efforts

- The Heart of New Ulm Project lead by the New Ulm Medical Center (CAH): 36-member steering committee from multiple sectors focused on healthy lifestyle behaviors; diet, daily aspirin, exercise – will impact utilization

- Mt Ascutney Hospital and Health Center in Windsor, VT (CAH) formed community health infrastructure to close fragmented and decentralized care services, establishing new infrastructure and programs; result is 34,248 individuals receiving assistance in social services and numerous antidrug programs being introduced; needed to build trust with community partners, sharing credit

Source: "The Role of Small and Rural Hospitals and Care Systems in Effective Population Partnerships" Health Research and Educational Trust, AHA. June, 2013.

- Dansville, NY Noyes Health: in healthiest county in NY; work with community partners across the continuum of care; from CEO: "We no longer see ourselves as a standalone organization, but rather as part of the region's broader healthcare ecosystem."

Source: Ellie Rizzo, "Population Health Lessons from Hospitals in the U.S.' Healthiest Counties: 3 CEOs Share Successes." *Becker's Hospital Review* June 2, 2014)

Tactics: Addressing Patient Social Needs

- Winona MN hospital: network formed to support chronically ill individuals with services that included purchasing meals post discharge: ED visits fell 91% in first three months, readmission rates 94%

Source: Rite Pyrillis, “Rural Hospitals Innovate to Meet New Health Care Challenges.” *Hospitals and Health Networks.* January 13, 2015)

- St Joseph’s Hospital in Highland, IL: rigorous discharge review, including daily huddles during inpatient stay

Source: John Commins, “This Tiny CAH Says ‘No Excuses’” *HealthLeaders Media* September 16, 2015)

- Anson County hospital in North Carolina: designed hospital to improve communication, patient flow and create a “healing environment”; use medical home approach to care; use community health advocates and patient navigators

Source: “Re-envisioning the Rural Hospital. *North Carolina Health News*. July 31, 2015)

Tactics: Population Health

- Garden City, KS St. Catherine Hospital formed Finney County Community Health Coalition, was awarded a grant in 2007, results: drop in teen binge drinking, grew into new 501(c)(3) organization that had success with no-smoking ordinance, bus service, child health initiatives

Source: "Garden City harvests a thriving crop of community health improvement projects." *AHA News* September 12, 2014)

- Employee wellness program in Mason District Hospital, Havanna, IL saved money for the hospital and improved community health; Kish*Health* System in DeKalb IL using CHNA to influence programming

Source: Melissa Henriksen and Norman Walzer. "Illinois Critical Access Hospitals: Managing Healthy Communities in Rural Illinois." *Rural Health Care White Paper Series: Issue 3* Northern Illinois Center for Governmental Studies. October, 2013.

Conclusion

- The tracks are still being defined, especially track 3
- The shift to track 3 is underway, but at different paces in different places and from different payers
- Lots of pieces already in place or available to build and drive the car

For further information

The RUPRI Center for Rural Health Policy Analysis

http://cph.uiowa.edu/rupri

The RUPRI Health Panel

http://www.rupri.org

Rural Telehealth Research Center

http://ruraltelehealth.org/

The Rural Health Value Program

http://www.ruralhealthvalue.org

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Collaborations to Share and Spread Innovation

- ✓ The National Rural Health Resource Center https://www.ruralcenter.org/
- ✓ The Rural Health Information Hub https://www.ruralhealthinfo.org/
- ✓ The National Rural Health Association https://www.ruralhealthweb.org/
- ✓ The National Organization of State Offices of Rural Health https://nosorh.org/
- ✓ The American Hospital Association http://www.aha.org/

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