

# The Brave New World of Health Systems Organization and Payment: Will Rural Providers be Left Behind?

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# The Patient Protection and Affordable Care Act Changes the Landscape

- Value Based Purchasing is here to stay
- Quality reporting continues to evolve
- Now part of a national plan
- Activities of the new Center of Medicare and Medicaid Innovation

# Section 3022: Medicare Shared Savings Program

- Emphasis of the title is intentional
- Coordinate care in the FFS program through Accountable Care Organizations (ACOs)
- Must meet quality standards
- Accountable for patients for at least three years

## Section 3023: National Pilot Program on Payment Bundling

- Integrated care during and episode around a hospitalization
- Consult with representatives of small rural hospitals, including CAHs, regarding participation in the program
- Episode encompasses 3 days prior to admission, length of stay, 30 days following discharge

## Other provisions

- Independence at home demonstration program
- Hospital readmissions reduction program
- Community-based care transitions program
- Patient-centered medical homes

# Importance of considering total change

- Building delivery systems
- Focused on quality
- Generating savings
- Improving places

## ACOs: Eligibility

- Could start with physicians
- Could start with hospitals
- Need formal legal structure to receive and distribute funds
- Need 5,000 beneficiaries

## Continued

- Leadership and management structure
- Process to promote evidence-based medicine, report data on quality measures, coordinate care
- Meet patient-centeredness criteria



# Savings

- As compared to benchmark amount (benchmark to be determined by CMS)
- Meeting clinical standards in process, outcomes, patient experience, utilization (latitude for CMS)
- Sustaining the savings a challenge

# Some Troublesome Assumptions Being Modified

- Requires large multi-disciplinary practices: one study published in May 2010 Health Affairs found 3.6% lower annual costs from group practices
- Minimum population requirements – meet for one carrier at a time or for multiple carriers?

# Flexibility: The three tiers approach (Shortell, Casalino and Fisher in July 2010 Health Affairs)

- Tier 1: minimal financial risk but eligible to receive shared savings and bonuses for meeting quality benchmarks and reduces per beneficiary spending
- Tier 2: eligible to receive greater proportion of savings if achieve spending rates below target, but also at risk for spending above target; partial capitation; report more comprehensive data
- Tier 3: full capitation or extensive partial capitation and bundled payments; highest potential reward but with greatest risk

# Measuring Performance of ACOs (from Health Affairs May 2010 article by McClellan et al)

- Care Coordination: hospital readmissions, depression follow-up and management to reconciled medication list and discharge plan
- Care effectiveness/population health: cancer care screenings to quality of life and functional outcomes

## Continued

- Safety: testing for patients using high-risk medications to outpatient medication errors
- Patient engagement: physician instructions understood
- Overuse/efficiency: imaging for low back pain during first 30 days to episode-based resource-use metrics linked to quality of life, functional, and patient engagement measures

# 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

# Competencies Found by AHA Review of Brookings/Dartmouth, Baylor Med School, Premier

- Leadership
- Organizational culture of teamwork
- Relationships with other providers
- IT infrastructure of population management and care coordination

# Continued

- Infrastructure for monitoring, managing, and reporting quality
- Ability to manage financial risk
- Ability to receive and distribute payments or savings
- Resource for patient education and support



## Other points made by AHA

- Spread of best practices
- Reach – linkages between ACOs and public health/community resources
- Regional health information exchange

# Key findings from Vermont ACO Pilot

- ACO cannot exist in a vacuum
- Working design for pilot built on three major principles
  - Local accountability for defined population
  - Payment reform based on shared savings
  - Performance measurement, including patient experience data, clinical process and outcome measures

# Continued

- Pilots need capabilities in five areas to get started
  - Manage full continuum of care settings and services, beginning with PCMH
  - Be financially integrated with both commercial and public payers
  - HIT platform that connects providers in the ACO and allows for proactive patient management
  - Physician leadership, as well as commitment of hospital CEO
  - Have process improvement capabilities to change clinical and administrative processes

# Policy Advice

- Set realistic expectations
- Consider pairing new starts with existing ACOs
- Provide technical assistance to develop legal and other structures to support new relationships
- Provide practice redesign technical assistance

# Continued

- Structure shared savings to consider historic cost-efficiency
- Offer various levels to financial risk
- Encourage other payers to develop healthcare delivery and payment models to parallel Medicare ACO program

# Bundled Payment

- Start with focus on specific conditions based on mix of chronic and acute, mix of surgical and medical, opportunity to improve quality while reducing expenditures, variation in number of readmissions and expenditures for post-acute care, high volume, amenability to bundling across spectrum of care
- Measure functional status improvement, hospital readmissions, discharge to community, admission to emergency room, health care-acquired infections, patient-centeredness

# Bundled Payment

- Implications for rural-urban collaboration
- Implications for rural networks

# 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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