

Impact on Health System Market Changes on Rural Health: ACO, PCMH, VBP Consolidation

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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
- Patient-Centered Medical Home
- 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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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_020212.pdf









Why is Rural Different?

- Same Triple Aim goals same as everywhere:
 - Better care
 - Better health
 - Lower cost
- But there are persistent rural priorities
 - Access to services (includes how to finance)
 - Community focus (IOM report of 2005)
 - Innovative use of personnel and facilities

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

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

- 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



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.



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

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



Core Features of PCMH

- Personal physician (some believe APNs)
- Physician-directed medical practice (ditto)
- Whole person orientation
- Care coordination and/or integration
- Quality and safety
- Enhanced access (timely and convenient)
- Payment for the value added

Source: James M Gill, "Reducing Hospital Costs by Means of Enhanced Primary Care." *Prescriptions for Excellence in Health Care*. Summer, 2011. Jefferson School of Population Health and Lilly USA, LLC.



PCMH Readiness

- From 2008 data: 41% of all primary care practices offer minimal or no PCMH services
- Large practices do better; in non-metro areas 18.8% meet 7 "must pass" elements vs. 4.5% of small practices – metro is 17.4% v. 9.6%

Source: Fred A Ullrich, A Clinton MacKinney and Keith J Mueller, "Are Primary Care Practices Ready to Become Patient-Centered Medical Homes?" *The Journal of Rural Health* 29 (2013) 180-187.



Bundled Payment in Rural Places?

- May improve quality of care but impact likely to be unevenly distributed (geography and care systems)
- May lead to provider consolidation
- Incorporating CAHs challenging and may not work
- May need safeguards to protect rural consumer choice and patient/provider relationships





Source: Robert Town, Walter Gregg, Ira Moscovice, Shalendra Prasad, and Jill Klinger. "Will Bundling Work in Rural America? Analysis of the Feasibility and Consequences of Bundled Payments for Rural Health Providers and Patients." *Policy Brief* (September, 2011). Upper Midwest Rural Health Research Center.





Bundled Payment Models

- Model 1: Discount on Part A payment for inpatient hospitalization
- Model 2: Inpatient and all related services plus 30, 60, or 90 days after discharge
- Model 3: Retrospective Post-Acute Care Only; begin within 30 days and end up to 90 days; 48 clinical condition episodes
- Model 4: Prospective bundle for inpatient only to include Part B





Model 2 Participants Include

- Catholic Health Initiatives in CO, KY, NE, TN, AR
- Health Choice Utah Accountable Care LLC
- Maine Heart Center in Portland, ME
- WY Medical Center in Casper
- Geisinger Clinic in Danville, PA



Model 3 Participants Include

- Remedy Partners, Inc with facilities in 11 states
- Amedisys Holdings with facilities in 7 states
- Evangelical Lutheran Good Samaritan Society in Sioux Falls, SD with facilities in SD and MN



Model 4 Sites Include

- St Rose Dominican Hospitals in Henderson, NV
- Health Quest Systems, Inc. in LeGrangeville, NY
- Sisters of Charity of Leavenworth Health System/Exempla, Inc in Denver with facilities in CO, KS, MT



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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 (now 23)
- 220 MSSP ACOs (will grow by 6)
- 32 are Advanced Payment
- more than 400 total ACOs; in 48 states



Source: MedPAC presentation by David Glass and Jeff Stensland.
April 4, 2013



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Medicare ACOs in Rural Places

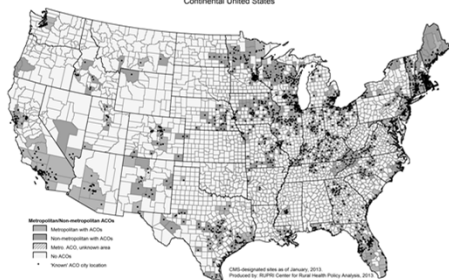
- Medicare ACO presence in 17% of nonmetropolitan counties
- 88 Medicare ACOs with beneficiaries assigned to them from 343 nonmetropolitan counties in 38 states

Source: RUPRI Center for Rural Health Policy Analysis estimates based on data collected from Medicare ACOs



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County Medicare ACO Presence
Continental United States



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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/2618_Forster_accountable_care_strategies_premier.pdf



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Parallel Developments in Medicaid

- States implementing care coordination models include: CO, OR, NC, ME
- 25 states implemented new payment systems so providers function as PCMHs

(Health Affairs, November 2012 article by Takach)



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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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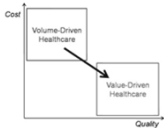
- From clinical care to health and health promotion
- From discharges to people enrolled in system and interactions with people
- Managing patients according to patient need across illness spectrum and continuum of care



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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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Actions to Consider

- Measure organizational performance
- Inform key stakeholders regarding performance
- Consider employees for care management
- Negotiate payment for measurable quality and patient satisfaction
- Collaborate with health care and human services providers
- Strategic focus on patients/community


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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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Financial Risk and Total Cost of Care (TOCC)

- Roll out Minnesota Institute for Clinical Systems Improvement
- 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



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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



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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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Role for State Offices of Rural Health

- Community focus will require convening stakeholders that may not have done so
- Providing and brokering technical assistance
- Full utilization of available demonstration and pilot project support
- Helping understand influence of payment and regulatory policies
- Other?



What is RHSATA?

- Rural Health System Analysis and Technical Assistance
 - Funded by HRSA Office of Rural Health Policy (ORHP)
 - Led by University of Iowa RUPRI Center for Rural Health Policy Analysis, in partnership with Stratis Health and Washington University
- The RHSATA team will analyze rural implications of changes in the organization, finance, and delivery of health care services and will assist rural communities and providers transition to a high performance rural health system.





RHSATA Aims

- Assess rural implications of policies and demonstrations
- Develop tools and resources
- Inform and disseminate





Process for Change

- > **Inform:** Create awareness of the need for change
- > **Assess:** Understand strengths, needs, and capacity to build value
- > **Prepare:** Identify action based on organizational and community needs
- > **Action:** Change to create value

What Next?



- There is help!
 - www.RuralHealthValue.org (RHSATA) –
 - www.raonline.org (Rural Assistance Center)
 - www.ruralcenter.org/tasc (National Rural Health Resource Center)
 - www.flexmonitoring.org (Flex Monitoring Team)
 - www.hrsa.gov/ruralhealth (Office of Rural Health)

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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