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
- 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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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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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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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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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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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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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.

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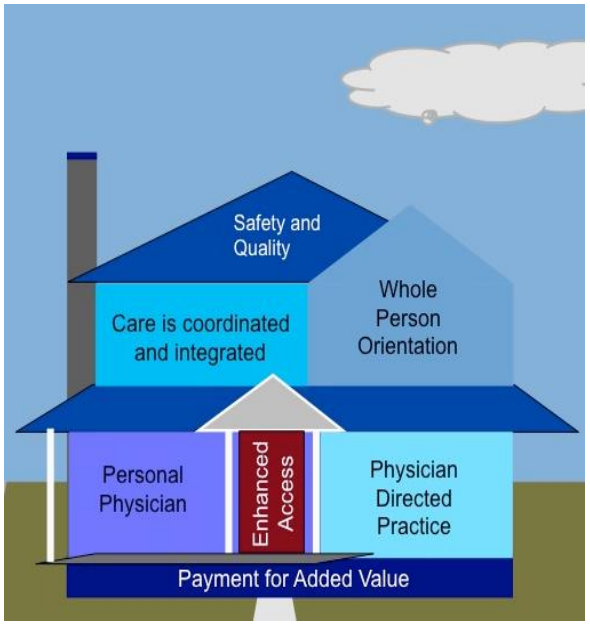
PCMH Readiness

- 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.

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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, Shailendra 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.

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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
- 220 MSSP ACOs
- 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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Serving Millions

- 21-31 million Americans receive care through ACOs
- 2.4 million in Medicare ACOs (more than 3 million after January 2013)
- 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

Source: http://www.oliverwyman.com/media/OW_ENG_HLS_PUBL_The_ACO_Surprise.pdf

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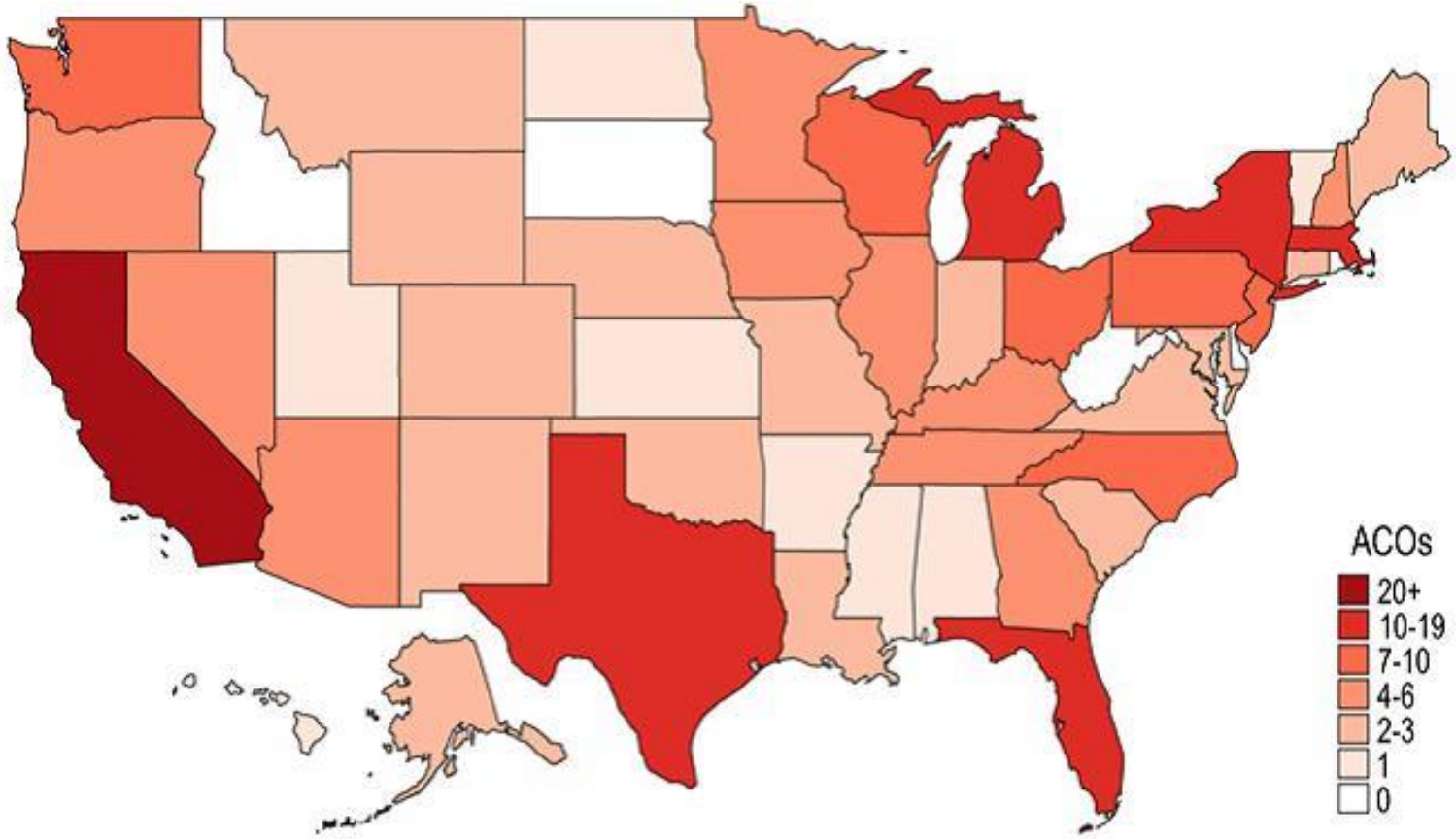
ACO DISTRIBUTION BY STATE



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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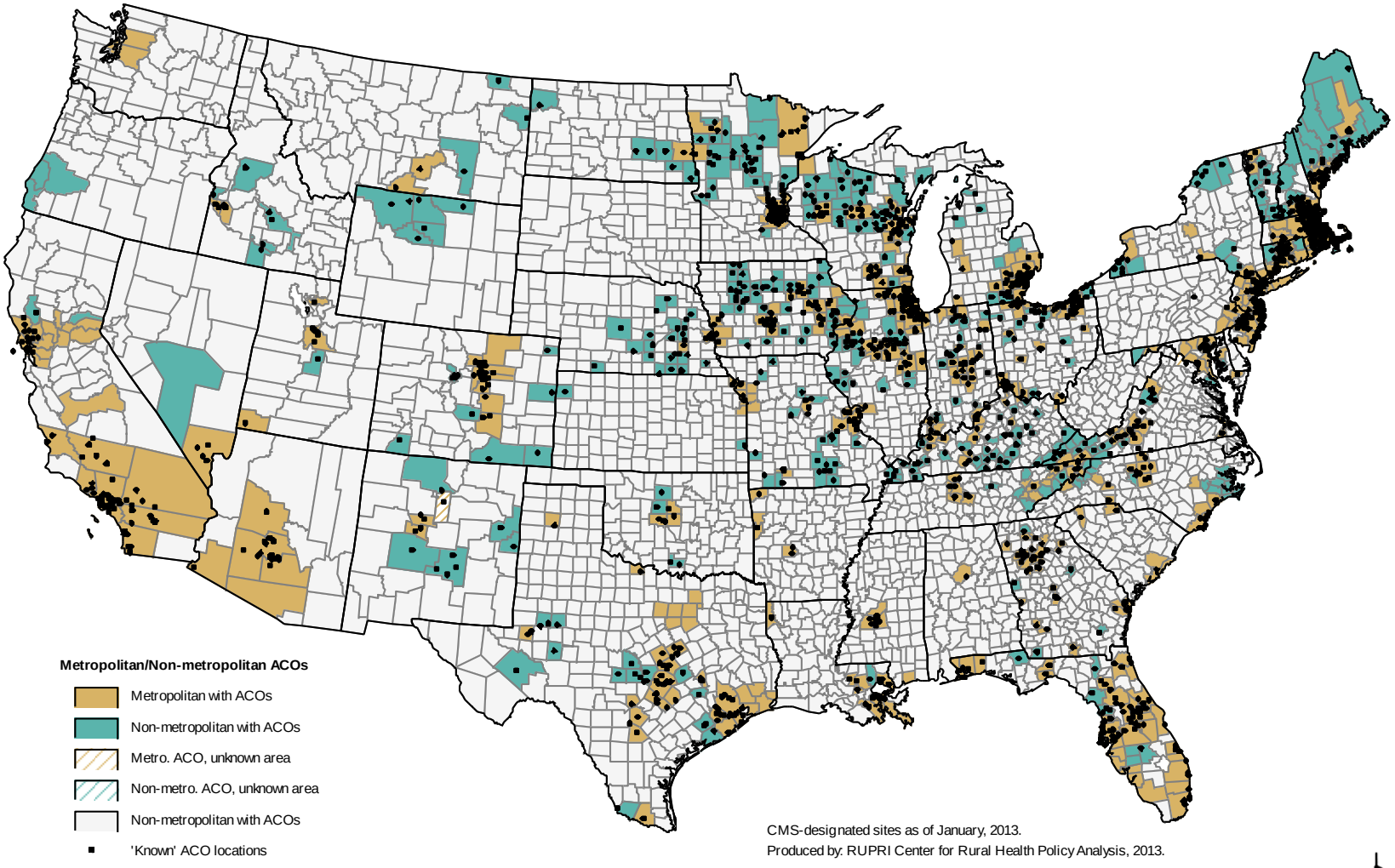
County Medicare ACO Presence

Continental United States



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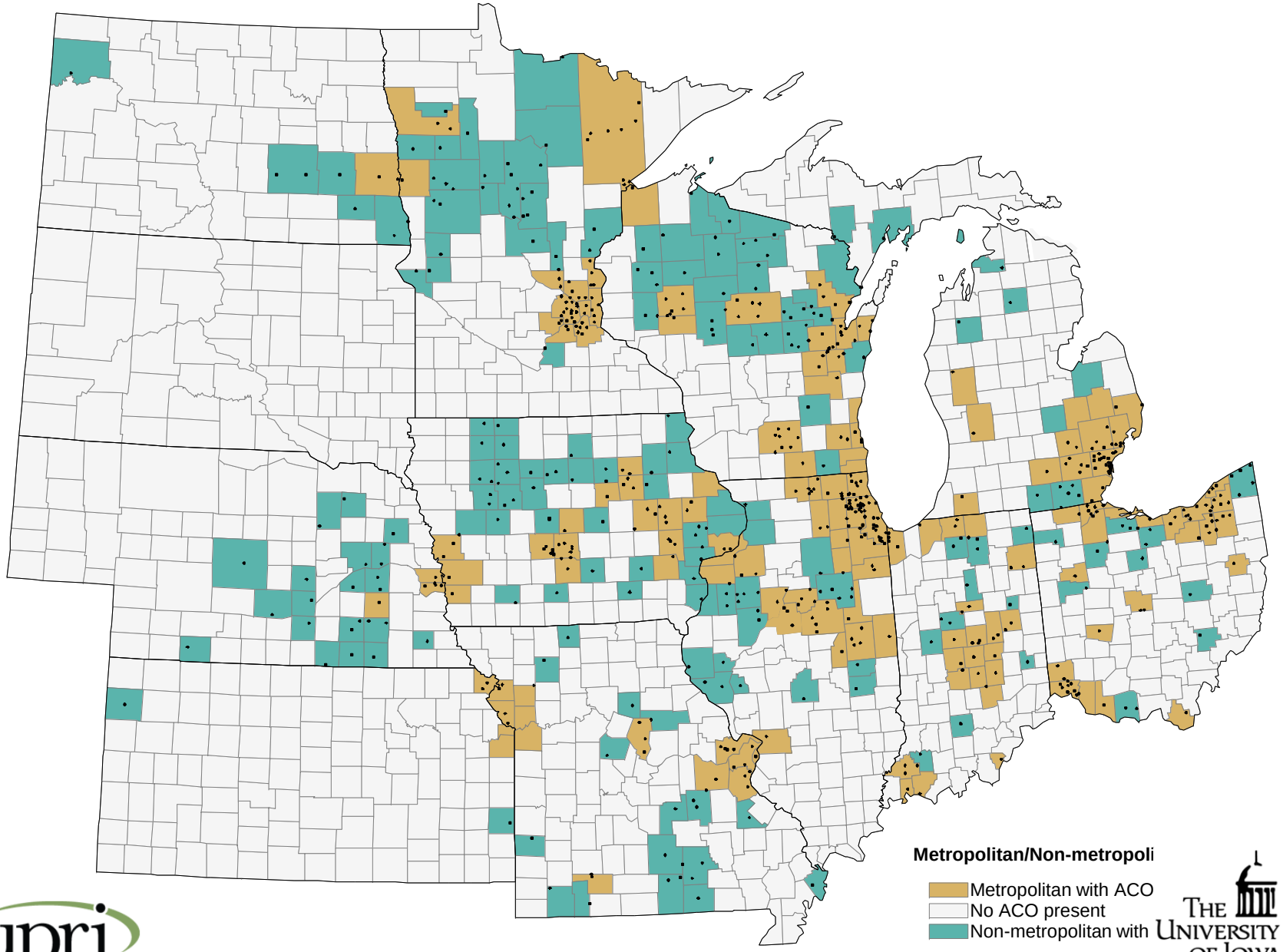
County Medicare ACO Presence

Midwest Census Region



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January, 2013

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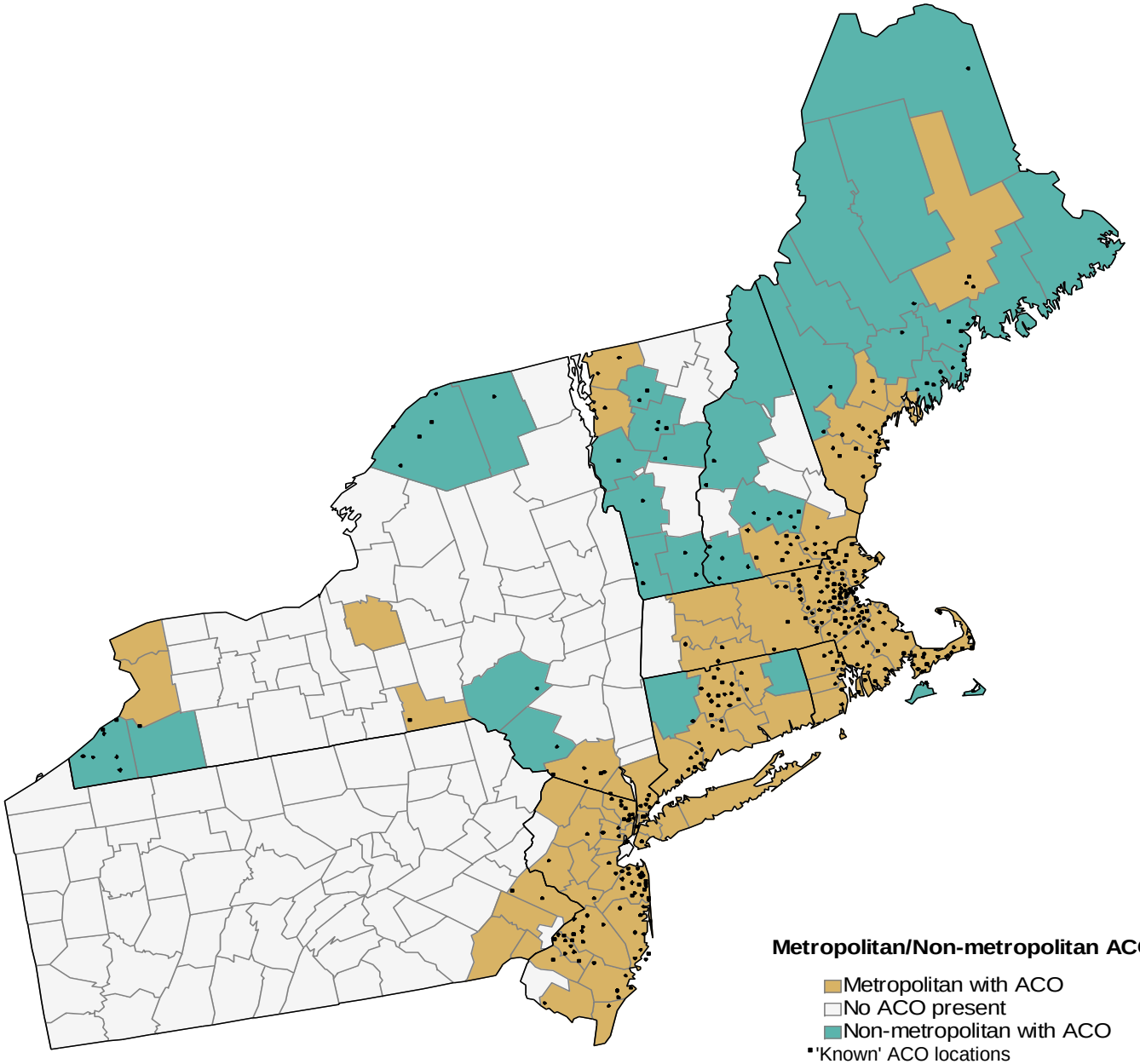
County Medicare ACO Presence

Northeast Census Region



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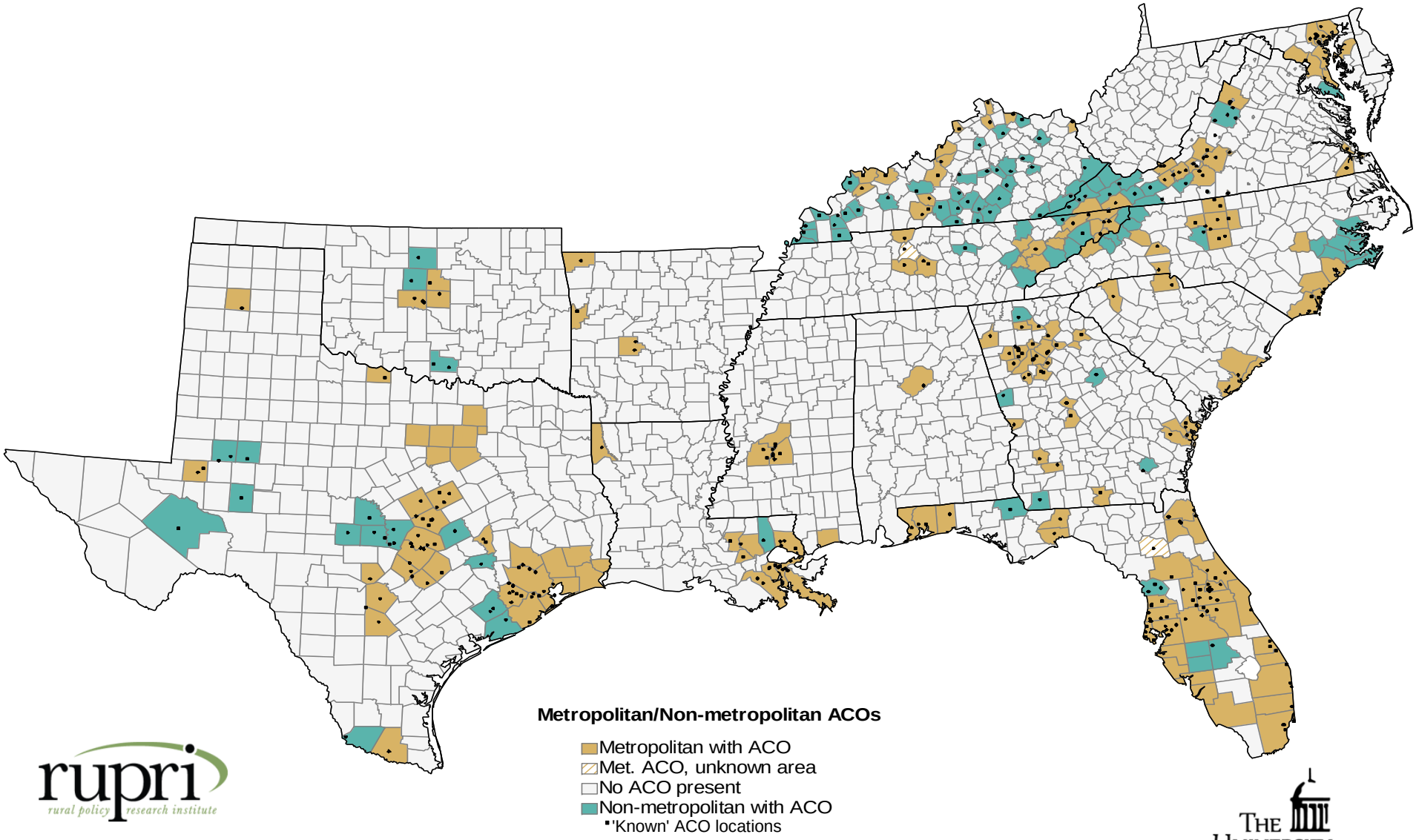
CMS-designated sites as of January, 2013
Produced by: RUPRI Center for Rural Health Policy Analysis, 2013.

County Medicare ACO Presence

South Census Region



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CMS-designated sites as of January, 2013
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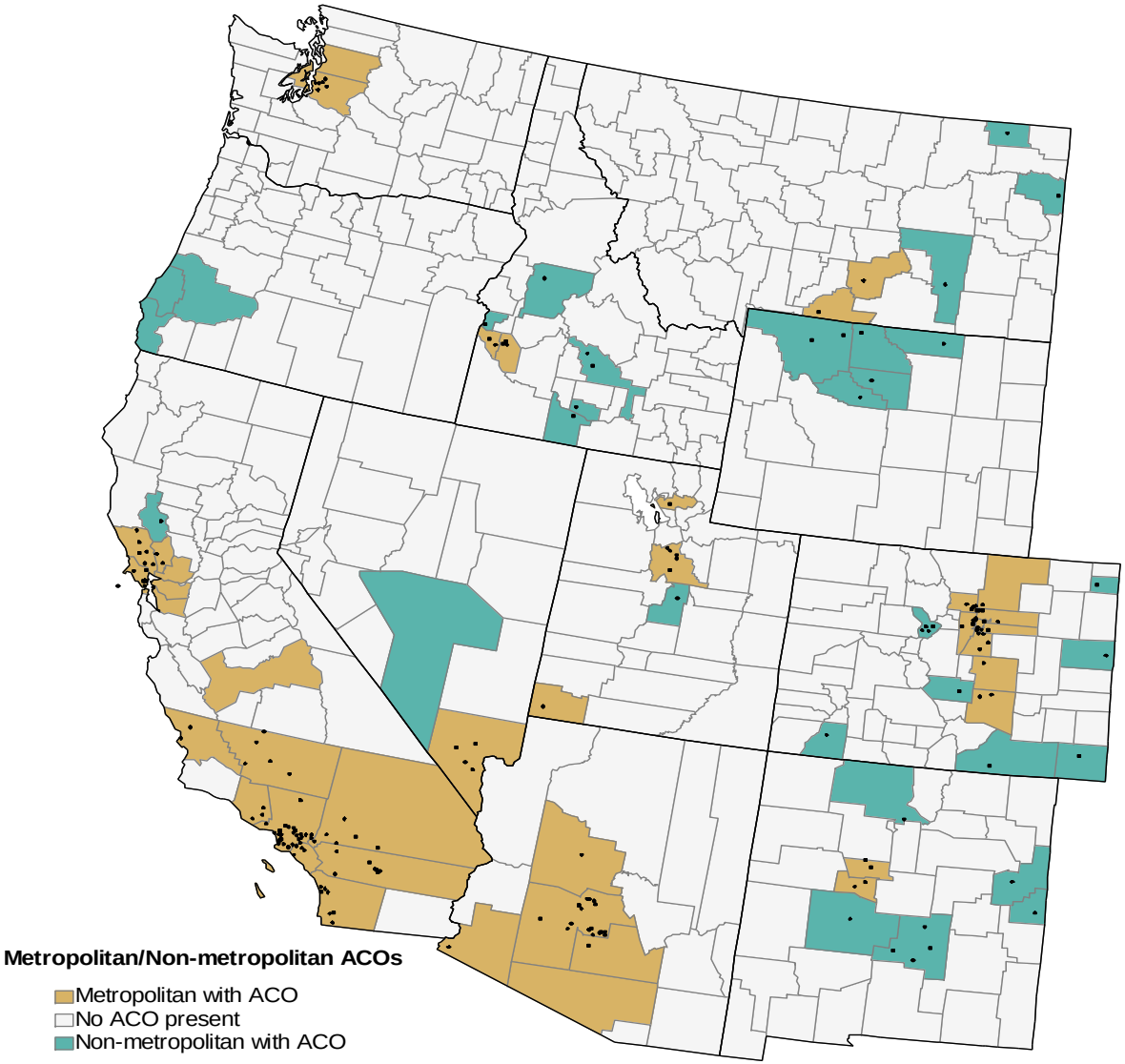
County Medicare ACO Presence

West Census Region



CMS-designated sites as of January, 2013.
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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/1618_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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CMS Health Home Core Quality Measures (sample)

- Adult Body Mass Index Assessment, documenting
- Ambulatory Care Sensitive Condition Admission, measuring rate
- Care Transition – Transition Record Transmitted to Healthcare Professional
- All Cause Readmission (for members 18 years of age and older)

Medicaid Change in Colorado

- As of June 2012, 132,227 enrolled in Accountable Care Collaborative (ACC) Program

- Administrative fees and costs include payment to Regional Care Collaborative Organizations and Primary Care Medical Providers; and Statewide Data and Analytics Contractor (from the Nov 2012 report)

Sources of Savings in CO ACC Program

- Reduced utilization of emergency room visits
- Reduced hospital readmissions
- Reduced high-cost imaging services
- Lower rates of aggravated chronic health conditions
- Reduced total cost of care

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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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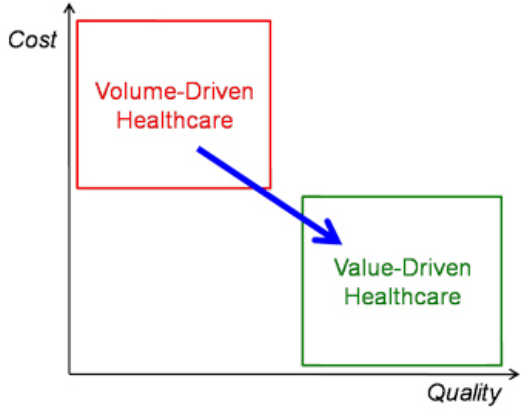
Transition Thinking

- 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

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

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 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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