Continuing the Journey to Oz: Finance and Organization Change as a Means to an End

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Where the Journey Ends: Oz

- A rural place that is vibrant, with high quality of life
- A rural-focused health care system that serves that place
- Local services that are sustainable
- Including the pillars of a high performing rural healthcare system

The Pillars

- Affordable: to patients, payers, community
- Accessible: local access to essential services, connected to all services across the continuum
- High quality: do what we do at top of ability to perform, and measure
- Community based: focus on needs of the community, which vary based on community characteristics
- Patient-centered: meeting needs, and engaging consumers in their care

The Journey So Far

- 1997: The Balanced Budget Act creates the Medicare Rural Hospital Flexibility Program
- 1997 – 2003: The “build out” of Critical Access Hospitals as a financially viable approach
- 2003: The Medicare Modernization Act enhances affordability for Medicare beneficiaries
The Journey So Far

- 2003 – 2010: Improvements in the Flex Program, including resources devoted to quality and community health
- 2010: The Patient Protection and Affordable Care Act (ACA) and a new emphasis on community health, quality outcomes
- 2015: Announcement of goals in the Medicare program to create a value-driven payment system

And Now the Storm Hits

- Years of sequestration hit cost-based reimbursement
- Sources of payment change from government administrative price setting (and political decisions) to negotiations with private plans
- Consumers change purchasing decisions in private insurance, accepting high deductibles in exchange for lower premiums

Waves of Change

- Medicare and Medicaid provided through private managed care organizations
- Medicare and Medicaid sharing financial risk with providers in shared savings models

Medicare Advantage Grows

- Rural enrollment in 2009: 1.17 million (13.5%)
- Rural enrollment in 2012: 1.5 million (16.5%)
- Rural enrollment in 2016: 2.2 million (21.8%)

Data from CMS reports, calculations by the RUPRI Center for Rural Health Policy Analysis
Data extracted from Centers for Medicare & Medicaid Services public information for years 2012–2015, plus “first look” at 2016

Non-metropolitan presence (defined as participating provider) in each cycle

Non-metropolitan presence in three models: Pioneer demonstration, Advanced Payment demonstration/Medicare Shared Savings Program, ACO Investment Model, Next Generation demonstration

Increased rural presence across time

Accountable Care Organizations Have Come to Rural America
By the Numbers...

- ACOs operate in 72.9% of metropolitan counties, 39.7% of non-metropolitan counties
- 7.6 million beneficiaries now receiving care through ACOs
- Rural sites in all four census regions

By the numbers...

- Approximately half of Medicare ACOs have rural presence, although for 18% (76) that is between 1 and 24 percent of counties included
- 7 (1.7%) are 100% non-metropolitan
- 23 (5.4%) are 75-99% non-metropolitan
- 104 (24.6%) are 25-74% non-metropolitan
- At least 37 of the 101 new ACOs in 2016 have a rural presence, many of those exclusively rural

Data are as of the end of 2015

And Now the Visuals

- 2013 national map
- 2015 national map
- Regional map
**Medicaid Enrollment In Managed Care Organizations**

- Nationally 59.7%
- Arizona: 85.1%
- New Mexico: 79.8%
- Nevada: 67.5%
- Colorado: 6.3%

Reports as enrollment in Comprehensive Managed Care.

Source: Centers for Medicare & Medicaid Services, Medicaid Managed Care Enrollment and Program Characteristics 2014.

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**Medicaid ACOs: Colorado and Other States**

- Managed care to ACOs to...
- Managed Care Organizations since 1983
- Accountable Care Collaborative started in 2011; now enrolling 58% of Medicaid clients
- Net savings of $29 to $33 million: reductions in ER use, imaging services, readmissions
- Oregon with Coordinated Care Organizations (2012)
- Minnesota with Integrated Health Partnerships (2013)

Sources:
Medicaid ACO Activities

- MN: IHPs must demonstrate partnerships with other agencies: social service public health
- MN: total cost of care calculations
- OR: CCOs must have community health needs assessment, encouraged to build partnerships with social service and community entities


Insurance Coverage Changes

- Approximately 20 million newly insured as of Q4 2015 (compared to 2010): health insurance marketplace enrollment, Medicaid enrollment, employer-based insurance, purchase from traditional sources, effects of new rules
- National data for all adults show 7.2% increase in insurance coverage in rural, 6.3% in urban (Urban Institute data)
- Consequence: new payment contracts to negotiate for rural providers; role of deductibles and copays

Changing World of Private Insurance

- A nagging constant: premium increases
- Result: shift to deductibles and copayments to cover financial risk (by insurers)
- Result: different patterns of use and payment

Changing World of Private Insurance

- Market dynamics: competing plans come and go; markets carved out within rating areas; varying strategies for covering actuarial risk
- Contracting with narrow networks
- Sharing financial risk with providers
Evolution of Medicare Payment Through Four Categories

- Fee-for-service with no link to quality
- Fee-for-service with link to quality
- Alternative payment models built on fee-for-service architecture
- Population-based payment

Source of this and following slides: CMS Fact Sheets available from cms.gov/newsroom

CMS Slogan: Better Care, Smarter Spending, Healthier People

- Comprehensive Primary Care Initiative: multi-payer (Medicare, Medicaid, private health care payers) partnership in four states (AR, CO, NJ, OR)
- Multi-payer Advanced Primary Care Initiative: eight advanced primary care initiatives in ME, MI, MN, NY, NC, PA, RI, and VT
- Transforming Clinical Practice Initiative: designed to support 150,000 clinician practices over next 4 years in comprehensive quality improvement strategies

CMS Slogan: Better Care, Smarter Spending, Healthier People

- Pay for Value with Incentives: Hospital-based VBP, readmissions reduction, hospital-acquired condition reduction program
- New payment models: Pioneer Accountable Care Organizations, incentive program for ACOs, Bundled Payments for Care Improvement (105 awardees in Phase 2, risk bearing), Health Care Innovation Awards
CMS Slogan: Better Care, Smarter Spending, Healthier People

- Better coordination of care for beneficiaries with multiple chronic conditions
- Partnership for patients focused on averting hospital acquired conditions

Waves Keep Rolling In

- Medicare and CHIP Reauthorization Act (MACRA) – tidal wave coming at physician payment
- Increased activity to measure quality of physician care and pay accordingly
- Increased financial risk sharing, either through Advance Payment Models or through Merit Based Incentive Payment
- Comprehensive Primary Care Plus initiative – up to 20 regions including up to 5,000 practices, more than 20,000 doctors and clinicians

Summary: Market Forces Shaping Rural Health

- Hospital closure: 73 since 2010; up to 283 “vulnerable” now
- Enrollment increasing through Health Insurance Marketplaces and in plans outside of those marketplaces
- Development of health systems: 1,299 health care sector mergers and acquisitions in 2014, up 26% from the year before, with value of deals up 137%
- Growth in Managed Care Organizations and Accountable Care Organizations
- Continued evolution of payment systems

Choices Begin

- Adopt a strategy of preserve and protect – political battles to continue status quo
- Choose to build a road to a different future
- And there is the reality of a combination of approaches, but emphasizing the new road
The Road to Oz?

- Turn adversity into motivation to change
- Turn onslaught of program changes and demonstration programs into opportunities to invest in change
- Requires that key stakeholders take the road together: Board of Trustees, C-suite, clinicians, community
- Shared commitment to local services and well being of population and community

Adversity to Positive Change: Hospital Transition

- To urgent care clinic (5 hospitals that had closed)
- To emergency center (5 hospitals)
- To skilled nursing facility (3 hospitals)
- To acute rehabilitation center (1 hospital)
- To outpatient facility (3 hospitals)
- To primary care clinic (4 hospitals)

Case Examples of Hospital Reconfiguration

- Epic Medical Center in Eufaula, McIntosh County OK closed as a hospital and reopened next day as urgent care clinic; May 23, 2016
- Memorial Hospital and Physician Group in Frederick OK will transition from inpatient to outpatient (no emergency) during 2016

Taking Action: Serving the Community

- Hill Country Memorial Hospital in Fredericksburg, TX
- Used Toyota principles to better management to cut costs
- Used knowledge of community to focus on elderly
- Turned hospital near closure to a thriving community provider
Beyond Crisis Management: Building the Road Starts with Strategic Framing
- What does the community need?
- How is the hospital configured to meet that need?
- What changes would improve the ability to meet the need?
- What resources are available?
- What is the roadmap to sustainable local services?

Finding the Answers
- Importance of community data, role of community health needs assessment, epidemiological grounding
- Understanding the market forces in your region, such as activities of large system (Intermountain Health) and alliances (Western Healthcare Alliance)

Finding the Answers
- Requires creating teams with equitable share in decision making
- Develop a framework for working through issues, e.g., AHA Committee on Research material
- Use all available and applicable demonstration and innovation support resources: Flex program, State Innovation Models, Centers for Medicare and Medicaid Innovation programs, FORHP programs, foundation programs

Results of Reconfiguration
- Post-acute care at Mayo system hospitals in Minnesota
- Replication in Oregon, with state funding support for development
- Anson County, NC hospital rebuilt with new design for patient flow that reduced use of the emergency room; 52 beds to 15, added van service because needs assessment identified transportation needs, and a patient navigator – facilitated because part of Carolinas HealthCare System
Paving the Road with Sound Fiscal and Process Management

- Managing as a “pay-for-performance hospital”: St. Joseph’s Hospital in Highland, IL
- Implementing Lean management: Mercy Network in IA
- Takeaways from sources of technical assistance

Turning the Corner: Population Health

- Motivation is that the wave of the future is global payment, not payment per encounter, changing currency from encounters/patients to enrolled lives/population
- Requires some reframing of traditional strategic questions to apply to managing care and engaging populations in healthy behaviors

Ways to Get There: Lean Principles

- Bringing a focus to patient populations
- Freeing people to ask why
- Connecting hospitals and systems to communities
- Empowering voice of customers

Ways to Get There: Lean Principles

- Connecting data and metrics to identify better-targeted solutions
- Allowing states and regions to adapt and learn from successes of local health systems
- Moving community clinics and public health toward regular reporting of quality measures

Hospitals and System Act

- Trinity Health (Catholic health system with 88 hospitals) investing $80 million in 6 communities over five years to improve public health, particular focus on obesity and tobacco use
- Senior VP for safety net and community health: "We need to be part of the business of creating health in our communities"
- Additional $40 million in low-interest loans to communities

Source: Maria Castelluccu. "Trinity Health to invest $80 million to improve health in six communities." Becker's Hospital Review. November 19, 2015

North Carolina Hospitals Take Action

- Statewide effort (Rural Health Action Plan) has four strategies addressing healthy activities including investments in local industry
- Southeastern Health in Robeson County: case manages, transportation, assist with Medicaid applications
- Halifax Regional Medical Center: fitness campaign


North Carolina Hospitals Take Action

- Granville Medical Center in Oxford: transitional care team
- Transylvania Regional Hospital: evolve into something different, including what services to offer, (orthopedics and emergency) and not (labor and delivery)


Choices to Make Along The Road

- Commit to change
- Interplay with the move to pay for value
- Major shift to population health calls for two major directions
- Different foci, but need to focus: data to identify patients by chronic condition profiles; population health for community
Summary from Survey of Hospital CEOs

- Engaging physicians in cost and quality improvements
- Redesigning service portfolios for population health
- Establishing sustainable acute care cost structures
- Patient engagement strategies
- Controlling avoidable utilization

Source: Ben Umansky. The five issues every health care CEO cares about. The Advisory Board. March 25, 2015.

For Further Information

Rural Health Value
http://ruralhealthvalue.org
The RUPRI Center for Rural Health Policy Analysis
http://cph.uiowa.edu/rupri
The RUPRI Health Panel
http://www.rupri.org

Closing Thoughts

- We are on the road
- Pave with transitions, not rural causalities
- Directed to the healthcare system we want
- "Heavy lift" for all involved
- Use all resources that are available

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