The New World of Value – Strategies for Rural Hospitals

Preserving Community Hospitals
National Rural Health Association
Milwaukee, WI
August 27, 2013

Timothy D. McBride, PhD
Professor, Brown School
Washington University in St. Louis
RUPRI Center for Rural Health Policy Analysis
tmcbride@wustl.edu

RUPRI Health Panel

- **RUPRI Rural Health Panel**
  RUPRI Rural Health Panel has developed a unique role in providing policy relevant analysis of rural health services delivery to nonprofessional audiences.
  Since 1993 the Panel has built a particular expertise linking policy suggestions to broader conceptual frameworks.
- **RUPRI Center for Rural Health Policy Analysis**
  The RUPRI Center for Rural Health Policy Analysis conducts original research in the topical areas of access to health care services, Medicare policies, development of rural delivery systems (including effects of national policy), and public health.
  The mission of the Center is to provide timely analysis to federal and state health policy makers, based on the best available research.

Agenda

- **Health Care Reform**
  - The Affordable Care Act and more
- **The Transformation**
  - From volume to value
- **Transfer of Risk**
  - Fundamental to health care reform
- **RHSATA and more**
  - Resources to help

My hypotheses

1. Health reform a big deal – the most important piece of social legislation in 40 years (since Medicare)
2. The politics was hard; but also proponents did not explain the legislation well, and public still does not understand it
3. Legislation is more popular than people think
4. The whole debate has been hampered by misconceptions and "myths"
5. The law (called the ACA) will have huge impact on the medical care sector, especially in rural areas

Health Reform is a Big Deal:
Cycles of Reform Debates

- 1915-1920 Progressive Era
- 1932 New Deal
- 1938 FDR – Second Term
- 1945-50 Truman
- ***1964-65*** ***Medicare and Medicaid (***
- 1974 Nixon
- 1993-94 Clinton
- ***2010*** ***ACA (Obama)***

- Pattern: Major proposal every 15-20 years
  - Only twice has reform been passed in 8 tries
  - Passage of health reform took 100 years, and was enormously difficult

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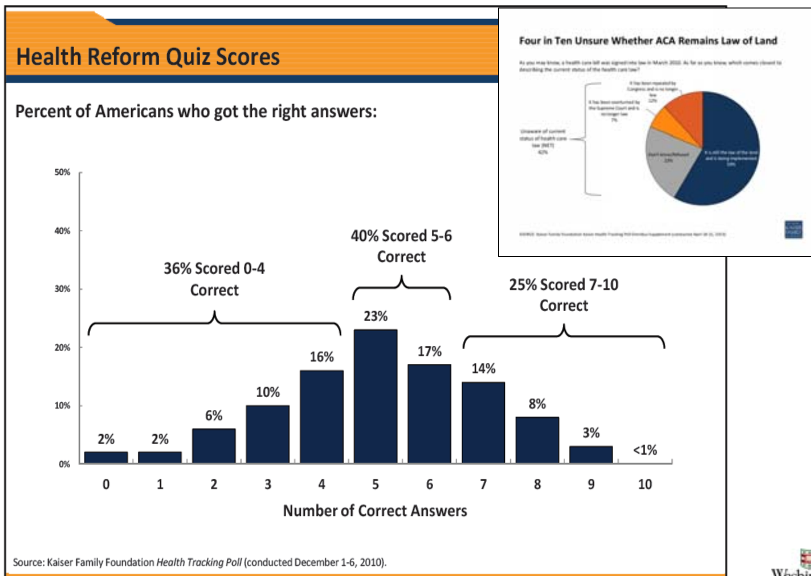
Health Reform Not Well Understood by Public



Maybe this is why health reform has been a struggle… "Putting policy above Storytelling"

- President Obama told CBS News that his biggest has been putting policy over storytelling.

  - *"When I think about what we've done well and what we haven't done well. The mistake of my first term - couple of years - was thinking that this job was just about getting the policy right. And that's important.*
  - *"But the nature of this office is also to tell a story to the American people that gives them a sense of unity and purpose and optimism, especially during tough times.*
  - *It's funny - when I ran, everybody said, well he can give a good speech but can he actually manage the job? And in my first two years, I think the notion was, 'Well, he's been juggling and managing a lot of stuff, but where's the story that tells us where he's going?' And I think that was a legitimate criticism."*

-- President Obama to CBS News, July 12, 2012.

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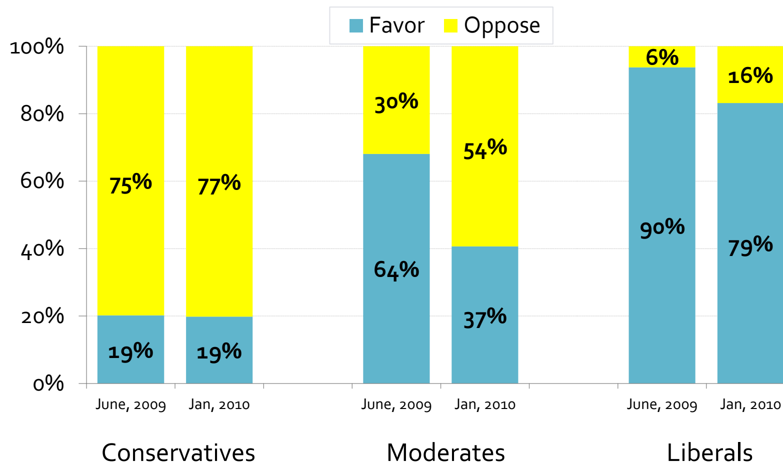
Health Reform is Controversial:
Health Care Reform Plan Opinion



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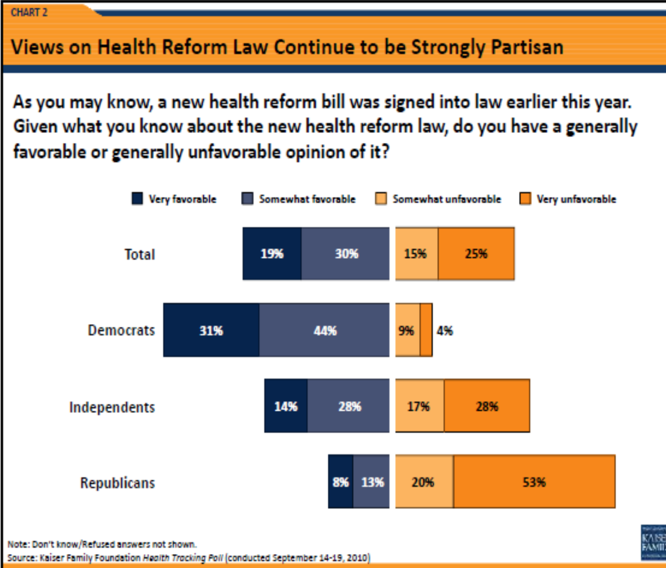
Health Reform views remain VERY partisan…

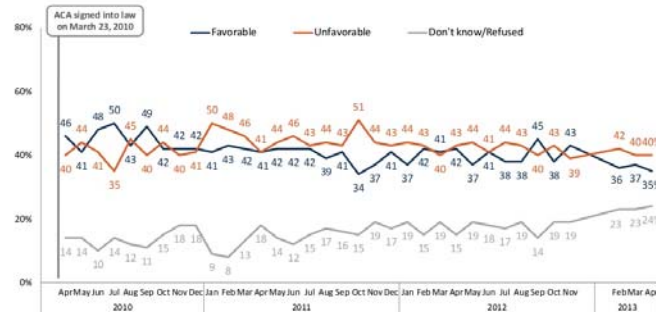


D: +62%

I: -3%

R: -52%

Misunderstanding public's views on reform



While it is true that public is sharply divided on the law (40% unfavorable and 35% favorable)…

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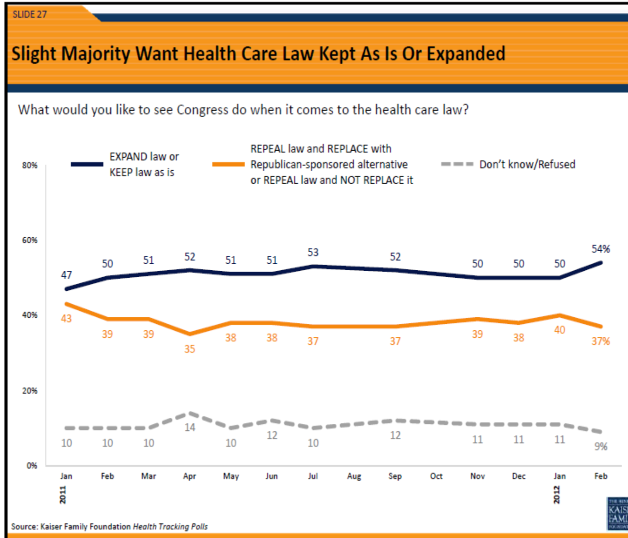
Misunderstanding public's views on reform



A MAJORITY (54% want to expand the law or keep it as)

While only 37% say repeal law and replace it.

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Affordable Care Act (and More!)

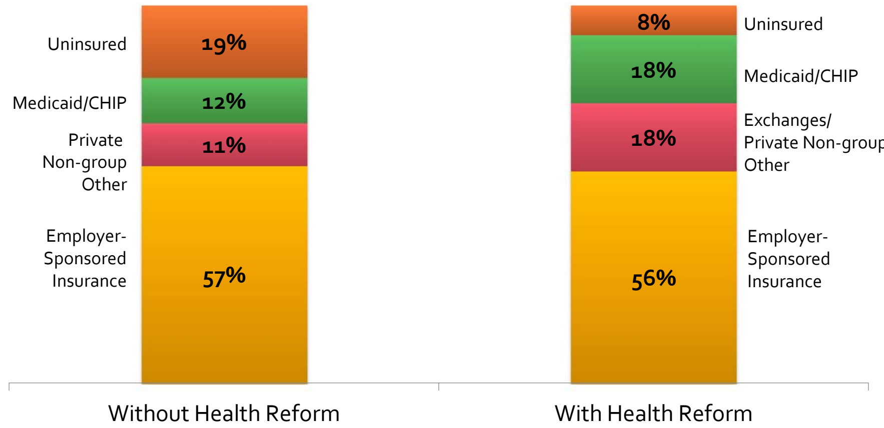
- Major ACA titles
  - Insurance coverage and reform (Titles I-II)
  - Quality and efficiency (Title III)
  - Public programs / public health (Title IV)
  - Workforce (Title V)
  - Transparency, efficiency (Titles VI-VII)
    - CLASS Act repealed (Title VIII)
- Different perspective – major *themes*
  - **Value**
  - **Collaboration**
- New emphases
  - Insurance coverage
  - Primary care
  - Financing innovation (incremental)

Building Blocks: Expanding Insurance Coverage

- **Health Insurance Exchange:**
  - Access to affordable coverage for uninsured and small businesses
  - Exchange offers access to Private insurance plans
  - Modeled on Federal Employee Health Benefits Plan (FEHBP)
- **Insurance Reforms:**
  - Eliminate pre-existing conditions, exclusions, rescissions, denials of coverage
- **Public Program Expansions**:
  - Strengthen and Expand Medicaid (up to 133% of poverty line)
- **Subsidies**:
  - Provide assistance to make insurance affordable (up to 400% of poverty line)
- **Mandates:**
  - Individual and Employer Responsibility

Key points: no public option, expansions of coverage through PRIVATE plans

Estimated Coverage in 2019



Source: Congressional Budget Office, March 20, 2010

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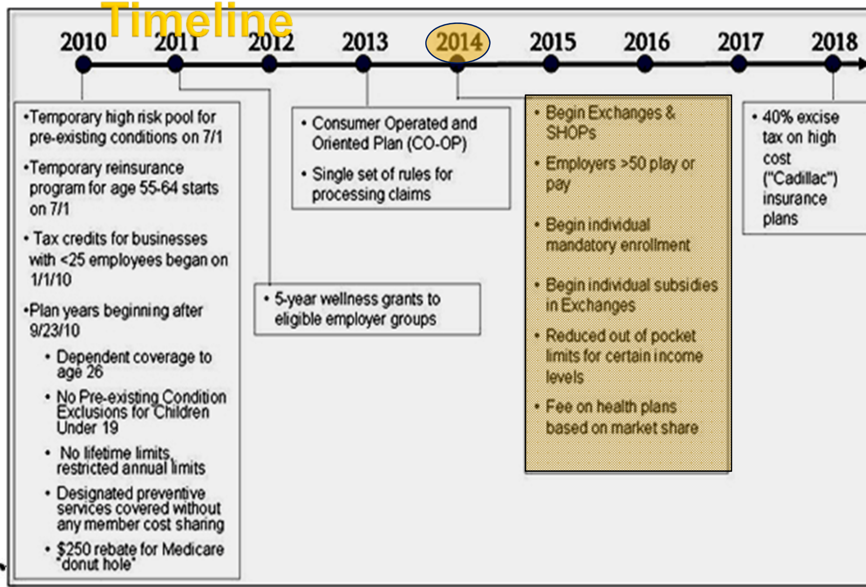
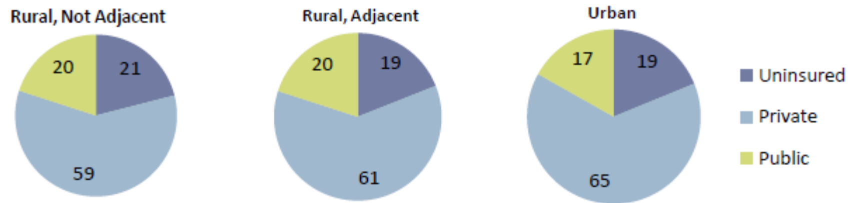
Health Reform Implementation Timeline



Rural people start out more uninsured



Data: Medical Expenditure Panel Survey, 2004-05
Uninsured differences by residence significant at $p < .05$.
Due to rounding, some characteristics may not total 100 percent.

Rural residents rely more on public sources of health insurance than urban residents.

Source: Ziller, Coburn, and McBride. 2009. "Profile of Rural Health Insurance Coverage: A Chartbook," Muskie School of Public Service

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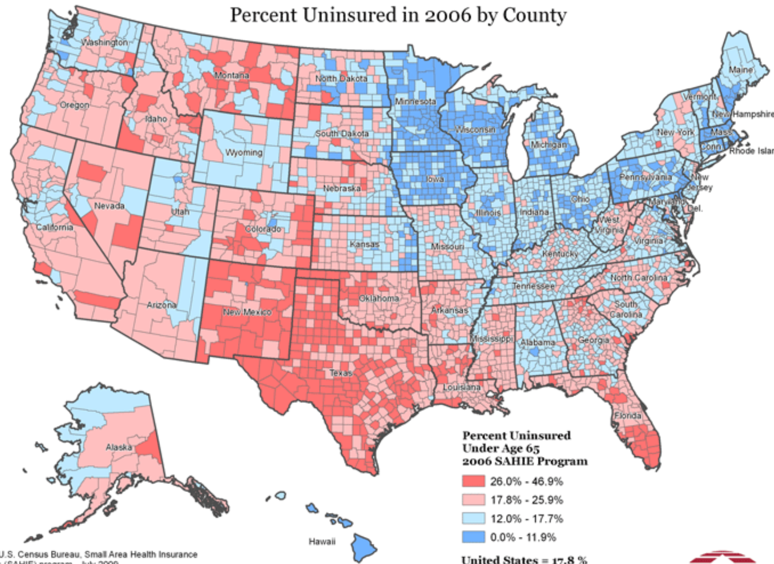
Health Insurance Coverage Status

Percent Uninsured in 2006 by County



Rural Coverage and Reform

- Obtaining insurance differs in rural compared to urban
  - Rural people have less access to generous insurance provided through employer or individual insurance policies
- Why is rural different?
  - More small employers
  - Lower incomes and higher poverty
- Health reform will matter more in rural areas:
  - Subsidies and Medicaid more important due to low incomes
  - Insurance exchanges could help, especially small employers
  - Will exchanges work in rural areas, and will rural people have the same access to private plans?

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Washington University in St. Louis

Impact of ACA on Coverage, Rural and Urban

	Rural	Urban	Total
Number of uninsured persons (in millions)			
Before reform	8.1	41.9	50.0
After reform	2.9	16.5	19.4
Insurance Coverage rate after reform			
Before reform	17.0%	16.9%	16.9%
After reform	6.6%	7.3%	7.2%
Proportion of persons obtaining coverage through:			
Health Insurance Exchange (adults)	44%	46%	45%
With subsidies or tax credits	37%	36%	36%
Employer or individual responsibility	7%	10%	9%
Medicaid expansion (adults)	33%	30%	30%
Children	23%	25%	24%

SOURCE: RUPRI Health Reform Simulation Model, December 2010.

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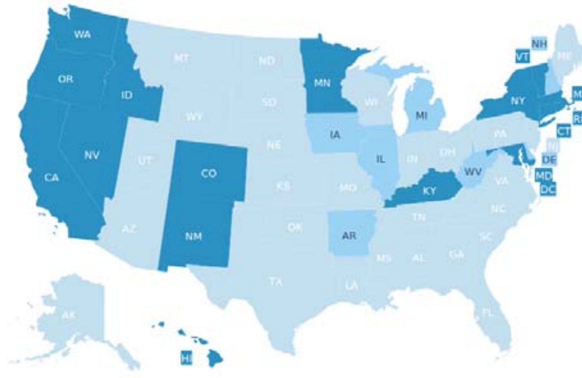
Whither Health Reform?

Establishment of State Health Exchanges, as of May 2013



State activity on Health Insurance Exchanges:

17 State-Based Exchange

7 Partnership Exchange

27 Federal Exchange

SOURCE: Kaiser Family Foundation, http://www.statehealthfacts.org/comparetable.jsp?ind=962&cat=17&sub=205&yr=1&typ=5

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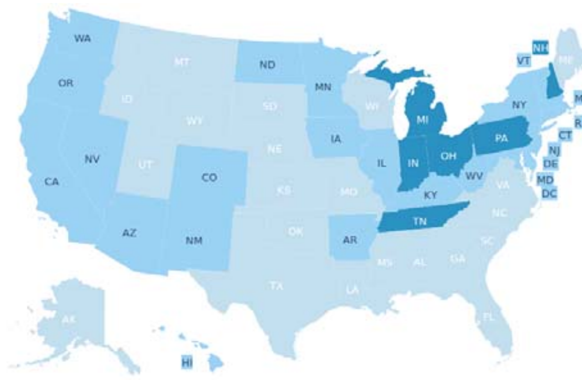
Whither Health Reform?

Status of Medicaid Expansion Decisions, as of August 2013



State activity on Medicaid Expansion:

24 Moving Forward

6 Debate Ongoing

21 Not Moving Forward

SOURCE: Kaiser Family Foundation, http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/#table5

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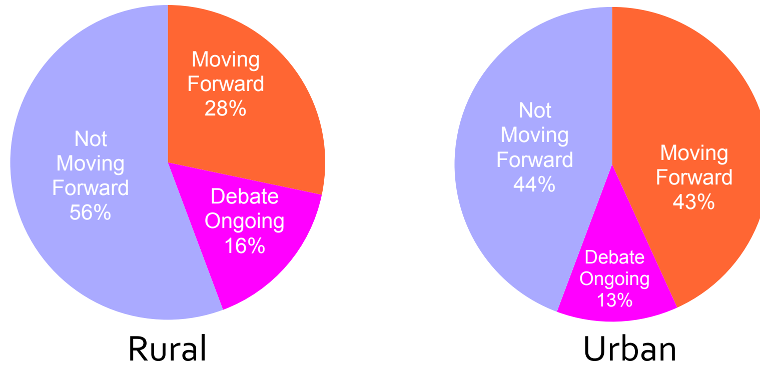
Whither Health Reform?

Status of Medicaid Expansion Decisions, as of August 2013

Distribution of Total Potential Medicaid Enrollees (Uninsured Persons <138% Poverty Line) By Medicaid Expansion Decision (2010 data)



SOURCE: RUPRI Center for Rural Health Policy Analysis, August 2013.

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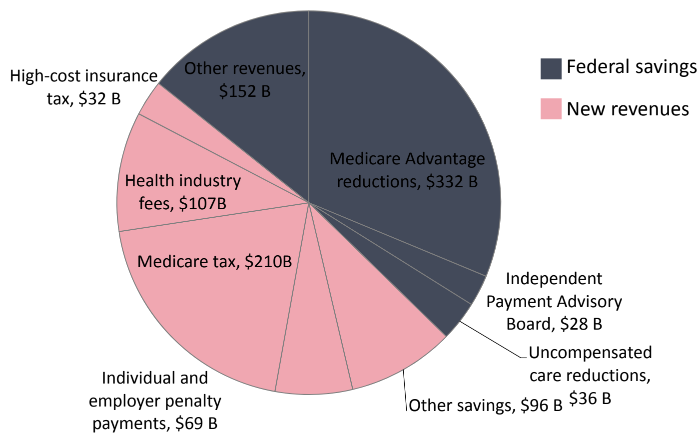
How Health Reform is Financed, 2010-2019 (the federal government's expenditures)



Total Cost = $938 Billion

Savings to Federal Deficit = $124 Billion

Source: Congressional Budget Office, 2010

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Payment and Cost

- Widespread recognition of need for health care delivery reform
  - FFS rewards volume- over value-based care; and procedural over cognitive care
  - Payment silos impede care coordination
  - Supply-induced demand increases costs
  - Lower pay for primary care providers results in less access to primary care
  - HIT is inadequately applied to improve patient and community health
- Widespread recognition by health economists that there are significant "market failures" in health markets

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Washington University in St.Louis

Reform Bending the Cost Curve?

November 17, 2009

President Barack Obama
The White House
Washington, DC 20500

Dear Mr. President,

As the full Senate prepares to debate comprehensive health reform legislation, we write as economists to stress the potential benefits of health reform for our nation's fiscal health, and the importance of those features of the bill that can help keep health care costs under control. Four elements of the legislation are critical: (1) deficit neutrality, (2) an excise tax on high-cost insurance plans, (3) an independent Medicare commission, and (4) delivery system reforms.

Including these four elements in the reform legislation – as the Senate Finance Committee bill does and as we hope the bill brought to the Senate floor will do – will reduce long-term deficits, improve the quality of care, and put the nation on a firm fiscal footing. It will help transform the health care system from delivering too much care, to a system that consistently delivers higher-quality, high-value care.

Signed by 21 health economists (two Nobel Laureates), including:
Arrow, McFadden, Newhouse, Cutler, Gruber, Reinhardt, Rivlin, McClellan…

*"…we write as economists to stress the potential benefits of health reform for our nation's fiscal health, and the importance of those features of the bill that can help **keep health care costs under control**."*

Four elements of the legislation are critical:

(1) deficit neutrality,

(2) excise tax on high-cost insurance plans,

(3) independent Medicare commission, and

*(4) delivery system reforms (that) … will help transform the health care system from delivering too much care, to a system that consistently delivers **higher-quality, high-value care**…"*

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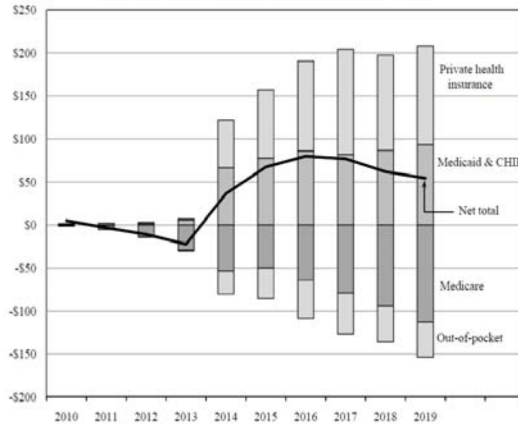
Washington University in St.Louis

ACA may add to health spending



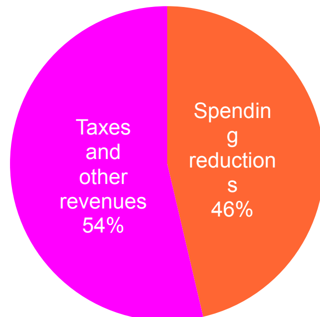
Estimated effect of ACA on overall national health expenditures for 2010-19 would be $311, or 0.9%.

"…[there are] substantial challenges in modeling national reform … estimates are uncertain … future impacts could differ significantly from these estimates." *[Richard Foster, 2011]*

SOURCE: Richard S. Foster, Chief Actuary Cent[er] … [Est]imated Effect of the Affordable Care Act on Medicare and Medicaid Outlays and Total National Health Care Expenditures, testimony before the House Committee on the Budget, January 26, 2011.

Fiscal Realities: Contrasting recent additions to health safety net: Part D and ACA, 2010-19

Obama's ACA



Total Cost = $938 Billion

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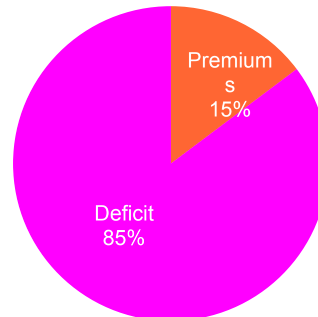
G.W. Bush's Part D



Total Cost = $1,078 Billion

Total Addition to the Federal Deficit = $920 Billion

Source: Congressional Budget … Social Security Administration, 2011.

Improving Public Health (Title IV)

- *"...to truly reform health care ...the Act will promote prevention, wellness, and the public health and provides an unprecedented funding commitment to these areas."*
  - Preventive health coverage, Insurance Reforms (Title I)
  - Disease Prevention and Public Health Systems (Title IV)
  - Increasing Access to Clinical Preventive Services (Title IV)
  - Creating Healthier Communities (Title IV)
  - Support for Prevention, Public Health Innovation (Title IV)

Workforce (Title V)

- Increased Medicare and Medicaid payments for primary care providers
- Loan repayments and scholarships for new physicians and others to practice primary care
- No cost-sharing in Medicare, Medicaid (some), and new private plans for certain preventive services
- Funding for population-based prevention activities
- National Workforce Strategy

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- RHSATA and more
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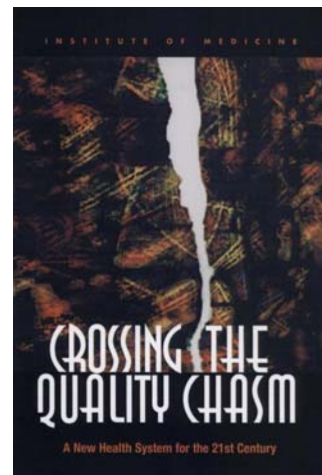
Value – IOM Six Aims

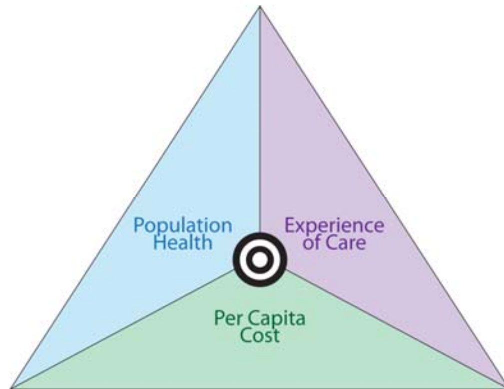
Health care should be:

- **Safe**
- **Effective**
- **Patient-Centered**
- **Timely**
- **Efficient**
- **Equitable**



Source: Corrigan, et al (eds.). *Crossing the Quality Chasm.* Committee on the Quality of Health Care in America. National Academies Press. Washington, DC. 2001.

The Triple Aim



Payment: Tipping Point for Reform?

- Widespread recognition of need for payment reform
  - Fee-for-service payment
    - rewards volume, not value; procedures over primary care
  - Payment silos impede coordination
  - Supply-induced demand increases costs
  - Lower pay for primary care: decline in access to primary care physicians
  - Health information technology concerns and data issues

Will health reform 'bend the cost curve'?

- Approaches to cost containment
- Payment reform
  - Bundle payments for acute care episodes
  - Value-based payment
  - Accountable care organizations
  - Patient-centered medical home
- Reduce growth in Medicare
  - Medicare Advantage reductions
  - Reduce growth in prospective payments
  - Fix the Sustainable Growth Rate (SGR) formula
- More efficient use of medical care
  - Uninsured obtain care appropriately
  - Prevention?

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Form Follows Finance

37

- How we deliver care is predicated on how we get paid for care
- Health care reform is changing both
- Fundamentally, reform involves a **transfer of financial risk** from payers to providers

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Risk Assessment is Ubiquitous

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- Risk is present when an outcome is uncertain or unpredictable
- Types of health care risk
  - Random
  - Insurance
  - Political
  - Medical Care
- Where/how can hospitals:
  - **Influence or control risk**
  - **Reduce risk of harm**
  - **Optimize risk of benefit**

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Rural Risk?

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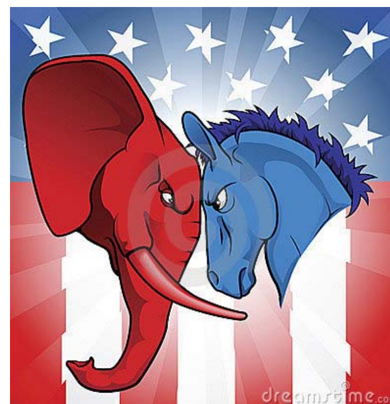
Political Risk

- Rules, regulations, and legislation
- Profound impact on health care delivery and finance
- Modest control, often via advocacy avenues



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Medical Care Risk

- Medical care *variation*
  - Diagnostic accuracy
  - Care plan implementation
  - Guideline use compliance
  - Pharmaceutical choice
  - Procedural skill
  - Efficient resource use
- How our choices influence health care **value**
- Greatest control, how we deliver care

The Risk of Inertia

Because
we've ALWAYS
done it that way!

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RUPRI Health Panel

High Performance Rural Health System

- Design flexibility to meet local needs
- Local access to public health, emergency care, and primary care
- Robust primary care using the PCMH framework
- HIT to manage and coordinate care
- Demonstrable value as basis for payment
- Collaboration and integration to improve value
- Healthy community focus

New World Realities

- ACA as a powerful initiator of health care delivery and financing change
  - But not the only initiator
  - State and private sector moving too!
- Risk transfer to providers
  - Higher quality at lower cost
  - Doing what's needed, not more
- New business models
  - More primary care, less inpatient
  - Rewarding value, not just volume
- The devil is in the transition
  - One foot on the dock and one in the boat
  - It'll be competitive – winners and losers

Hospital Transformation

- How do we move toward delivering value when our revenue is primarily volume-driven?
- How do we not get "soaked" during the transition?
- We can "test the waters" with a new set of tools.

Tool Box for Delivering Value

Strategies

- Optimize fee-for-service
- Be ACO aware
- Drive out variation
- Develop medical homes
- Engage the medical staff
- **Potpourri – what else we can do now**

Accountable Care Organizations

- A coordinated network of providers with shared responsibility for providing high quality and low cost care to their patients.*
- Couples risk-based provider payment with health care delivery system reform
- Accepts *performance risk* for quality and cost

*Source: Robert Wood Johnson Foundation. Accountable Care Organizations: Testing Their Impact. 2012 Call for Proposals.

Core Components of an ACO

- People-centered foundation
- Health homes
- High-value provider network
- Population health
- 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., 2012.

Medicare ACO Program

- Medicare Shared Savings Program
  - Pioneer Demonstration
  - Advanced Payment Demonstration
  - CMMI anticipates doubling in 2013
- Medicare *shares savings* (if any) with ACO if certain quality and satisfaction thresholds achieved
- And much more…
  - Commercial payer ACO programs
  - Value-based purchasing
  - Bundled and care coordination payments

ACO Stats

- 220 MSSP ACOs (32 are Advanced Payment) with
  - **> 3 million** Medicare beneficiaries
  - **6.5%** of the Medicare population
  - Plus 32 Pioneer ACOs
- 21-31 million Americans receive care through ACOs
  - In 19 states, more than 50% of residents have access to ACOs
  - In 12 states, between 25% and 50% have access to ACOs

Sources:
Centers for Medicare and Medicaid Services. Fast Facts – All Medicare Shared Savings Program ACOs. March 2013.
Niyum Gandhi and Richard Weil. The ACO Surprise. Oliver Wyman, Marsh & McLennan Companies. 2012.

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Rural ACO Stats

- 79 Medicare ACOs operate in both metro and rural (non-metro) counties
- Medicare ACOs operate in **16.7 %** of all rural counties
- 9 Medicare ACOs operate exclusively in rural counties
- At least 1 exclusively rural Medicare ACO operates in each US Census Region

Source: RUPRI Center research. 2013.

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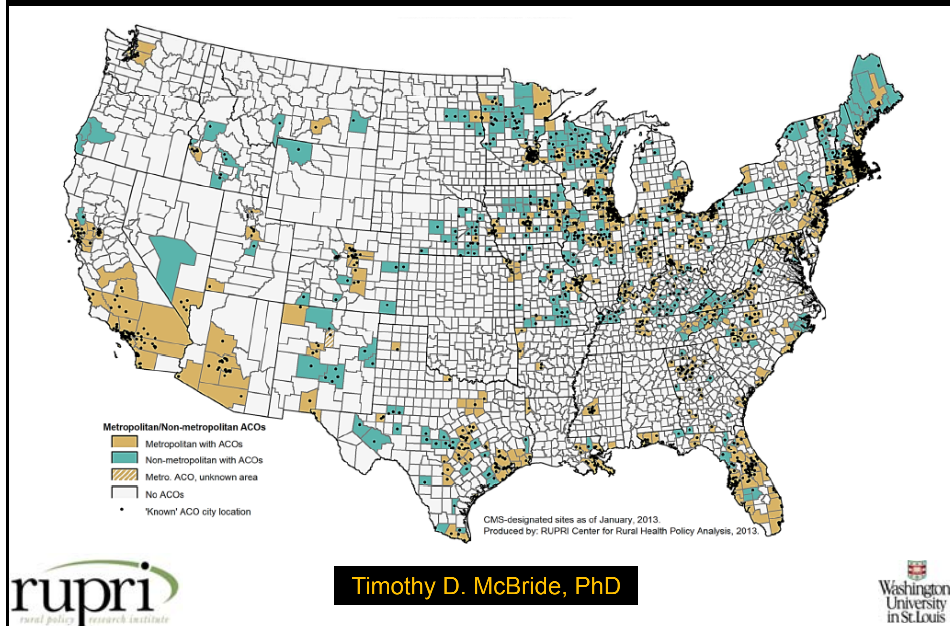
Rural (teal) Counties with ACOs



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Medical Home Definition

Patient-centered medical homes are primary care practices that offer around-the-clock access to coordinated care and a team of providers that values patients' needs.

- **Access and communication**
- **Coordination of care**
- **Patient and family involvement**
- **Clinical information systems**
- **Revised payment systems**

Sources: Commonwealth Fund. http://www.commonwealthfund.org/
Joint Principles of Patient-Centered Medical Homes – 2007. http://www.aap.org/en-us/professional-resources/practice-support/quality-improvement/Documents/Joint-Principles-Patient-Centered-Medical-Home.pdf

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Medical Home Quotes

- All team members practice at the top (optimum) of their license and experience
- Best evidence is the best and only way we deliver care
- Care is the same, regardless of the provider
- Continuous performance improvement of our care is rigorously driven by data
- There are no non-compliant patients, only those we have not reached
- An EHR is critical to proactively managing patient/population health
- Let care protocols do (at least some of) the work (eg, lab orders, med refills, vaccines)

Crete Physicians Clinic
Crete, Nebraska

What To Do Now

- Measure and report performance
  - We attend to what we measure
  - *Attention* is the currency of leadership
- Educate Board, providers, and staff regarding performance
  - We are all "above average," right?
- Control the data
  - EHR and sophisticated data analytics
- Aggressively apply for value-based demonstrations and grants
- Negotiate with third party insurers to pay for quality

More What To Do Now

- Consider self-pay and hospital employees first for care mgmt
  - Direct care to low cost areas with equal (or better) quality
  - Reduces Medicare cost dilution
- Consider how to manage care beyond the hospital
- Move organizational structure from hospital-centric to patient/community-centric
- Explore potential collaborations with physicians and others

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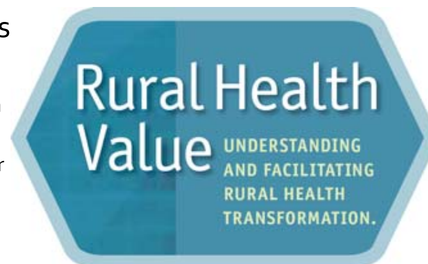
What is RHSATA?

- 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.

Timothy D. McBride, PhD

RHSATA Aims

- Assess the rural implications of policies and demonstrations
- Develop tools and resources to assist rural providers and communities
- Inform and disseminate rural health care innovations

Timothy D. McBride, PhD

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

Concluding Thoughts

Conclusion: Whither Health Reform?

- SCOTUS decision was a "game changer"
  - Opponents of health reform figured ACA would be derailed by SCOTUS
  - Also that it would be repealed by next President
  - So implementation was put on skids
- Now it is becoming more clear it will be very difficult, if not impossible to repeal it
  - Implementation is going forward
  - Implications for health sector are enormous

Timothy D. McBride, PhD

Figure 17

Future of Health Reform: *Legislation Is Just the Beginning*

- Implementation will be challenging
  - Federal rulemaking has just begun
  - Guidance and federal oversight needed
  - Resources for infrastructure and capacity building
  - State budgetary challenges ($700M budget shortfall)
- Policy and political challenges
  - More legal challenges?
  - More political challenges?

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The Unfinished Agenda

- Cost Containment
- Entitlement Reform
- Long-Term Care
- Quality

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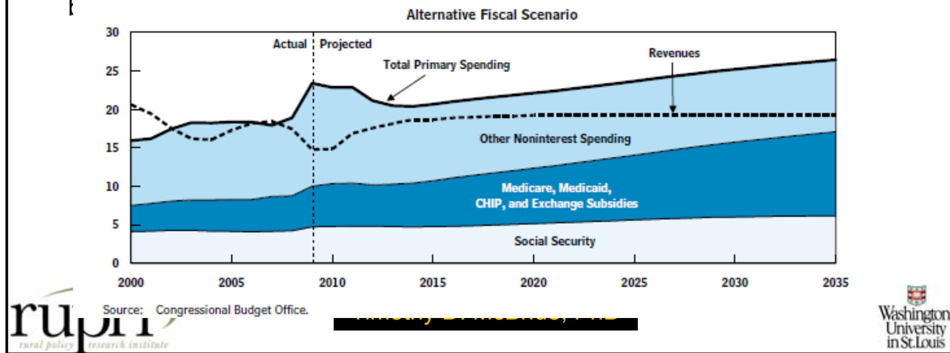
Entitlement Reform, or:

Where will we find the Money for Social Security, Medicare and Medicaid?

Is the Sky Falling?

Finding the money: facing reality

- President G.W. Bush, on funding Social Security, asserted:
  - *"I will not prejudge any solution,"* but added *"we will not raise payroll taxes to solve this problem"* (12/09/04)
- Rep. Paul Ryan's plan: By 2019, government's contribution to Medicare is cut in half.
- Obama and Deficit Commission: Combination of tax increases and



Source: Congressional Budget Office.

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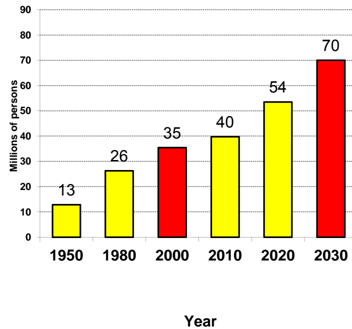
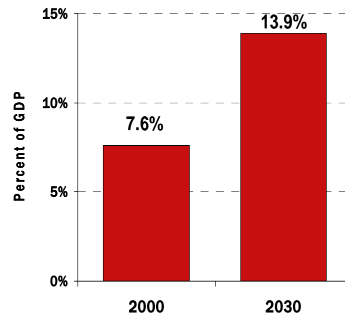
We must face reality …

The number of elderly will nearly double by 2030



Year

Costs of Medicare, Medicaid and Social Security



Are we surprised? If the elderly doubles, should we be surprised if the costs of these programs double too? Can we sustain this under current tax rates?

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Disconnect

- How will we finance the needs of the Baby Boom?
  - There is a huge disconnect between
    - what the needs will be
    - and what the public thinks we can afford
- This is because …
  - politicians are not engaging us in a serious debate of these issues
  - And there is a serious misunderstanding about some of the key facts

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Churchill is always right…

- ***"You can always count on Americans to do the right thing - after they've tried everything else."***
  - **Winston Churchill**

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What Next?

- There is help!
  - www.RuralHealthValue.org (RHSATA)
  - www.raconline.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)
  - www.ruralhealthweb.org (National Rural Health Association)
  - www.ihi.org (Institute for Healthcare Improvement)
- Share an innovation with RHSATA that has moved your organization (or another) toward delivering value.
- Continue to be a leadership voice for rural health care value.
- Our glass is at least half full. A positive attitude is infectious!

Healthy People and Places