The Times They Are A Changing

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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
Coincidental Presence of Models for Change (old and new)

- Prevention and population health
- Community well-being
- Bundled payment
- Value based purchasing
- Managed care organizations
- Accountable care organizations
Expansion of Medicaid enrollment with some federal help in paying providers, but limited
Expansion of enrollment in the individual and small group markets
Balancing changes in disproportionate share payments
CAN’T EXPECT CURRENT/HISTORIC APPROACHES TO DELIVERING AND FINANCING CARE TO RESPOND TO THIS SHIFT
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
Other payment changes

- Bundled payment
- Payment for different modalities: telemedicine involving providers, telemedicine to the home, payment for lay health workers
Finance Change: Payer mix

- Decrease in uncompensated care
- Increase in covered lives (commercial health plans) and therefore “negotiated” prices
- Increase in Medicaid coverage and shift of that client base toward different payment schemes
- Non patient revenues subject to turns in the economy
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
Changes in the delivery system: Accountable Care Organizations (ACO)

- Including Medicare Shared Savings Program (MSSP)
- But don’t wait for that to sink or swim
- Including Pioneer Demonstration from Centers for Medicare and Medicaid Innovation (CMMI)
- And much more.....
The future is NOW in many places

- Private action: Brookings-Dartmouth learning sites, Premier, CIGNA, Others
- Public Sector: Beacon communities, Practice Group Demonstrations, Medicaid, Medicare
- Urban based, FOR NOW
- But reaching beyond: Carilion System in Virginia
The National Map: Constructed by the ACO Learning Network

Looking back: the obvious progress
Many moving forward with ACOs

Private Sector
★ = Brookings-Dartmouth
★ = Premier
★ = CIGNA
★ = AQC (9 organizations in MA)
★ = Other private-sector ACOs

Public Sector
◯ = Beacon Communities
◯ = PGP, MHCQ

www.acolearningnetwork.org
“Spread” is critical to those who are driving change
Including rural specific language in the Affordable Care Act
Systems that buy rural presence
Lives, volume, lives
Pursuing a Greater Good

- Affordable care
- Access to high quality care
- And being held accountable
While maintaining the enterprise

- Mission matters
- Payment formulae matter
- Community orientation matters
Moving forward

- What are the preparatory activities?
- What can we learn from the policy activities?
- What should be done to prepare to succeed?
Information continuity
Care coordination and transitions
System accountability
Peer review and teamwork for high-value care
Continuous innovation
Easy access to appropriate care
Eight Rural Constraints

- Rural provider autonomy
- Rural practice design
- Low rural volumes
- Historic rural efficiency
Continued

- Urban motivations
- Urban provider cost structure
- Legal and regulatory barriers
- Rural leadership inexperience
Changes in Approaches to Population Health and Community Well-Being

- Coverage of preventative services without copayment
- Programs for wellness in workplace, schools, for young elderly (55 - 64)
- How hospitals view community contribution (new rules)
- Community transformation grants from CDC
- Public health fund in Title IV of the ACA
Pressures on the system: Increased demand for services

- The new market in health insurance exchanges: implications for enrollment strategies and patient services
- Medicaid expansion: eligibility, enrollment, payment
A New Bottom Line?

- Payment structure is changing
- So what about the cost structure?
- Strategic positioning
- Different management strategies
Times Are Changing

- The demise of cost-based fee-for-service reimbursement – slow ... but sure
- The rise of patient-centered care, with new sense of what that means, including patient responsibility
- The buzzword is VALUE, not cost or volume
- The pathway to value is being constructed
Wild Cards

- Co-op plans
- Medicaid in vice – expansion at a time of pressure on the budget
- Medicare in the same vice
- US Supreme Court decision on the individual mandate in 2012
- What happens with workforce supply and utilization
For Further Information

The RUPRI Center for Rural Health Policy Analysis
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The RUPRI Health Panel
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