Rural Perspectives on Reform – From Volume to Value

Giving Back
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Agenda

- Why the changes
- Health care “risk”
- Health care “value”
- Risk transfer from payers to providers (eg, ACOs)
- Optimizing opportunities for reward
Health Care Risk

- Insurance risk, eg.
  - Demographics
  - Technology change
  - Prior health status

- Clinical risk, eg.
  - Care plans
  - Drug choices
  - Procedures

Anthem, Aetna, Unicare, Humana, Pacificare, Cigna, United Healthcare, Health Net

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Variation = Risk = Opportunity

Variation suggests a risk for underperformance, but also an opportunity to excel

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Calculated Risk

There's a fine line between taking a calculated risk and doing something dumb.

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Health care should be:

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

The Triple Aim

Population Health
Experience of Care
Per Capita Cost

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Value Equation

Value = Quality + Experience

Cost

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

“Triple Aim”
• Better care
• Better health
• Lower cost

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# Alaska CAH Quality Reporting

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of CAHs</th>
<th>Inpatient data</th>
<th>Outpatient data</th>
<th>HCAHPS data</th>
<th>Number of CAHs</th>
<th>Inpatient data</th>
<th>Outpatient data</th>
<th>HCAHPS data</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>11</td>
<td>2 (18.2%)</td>
<td>N/A</td>
<td>N/A</td>
<td>1287</td>
<td>811 (63.0%)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2007</td>
<td>12</td>
<td>2 (16.7%)</td>
<td>N/A</td>
<td>N/A</td>
<td>1293</td>
<td>891 (68.9%)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2008</td>
<td>13</td>
<td>3 (23.1%)</td>
<td>N/A</td>
<td>1 (7.7%)</td>
<td>1301</td>
<td>914 (70.3%)</td>
<td>N/A</td>
<td>442 (34.0%)</td>
</tr>
<tr>
<td>2009</td>
<td>13</td>
<td>6 (46.2%)</td>
<td>1 (7.7%)</td>
<td>2 (15.4%)</td>
<td>1312</td>
<td>943 (71.9%)</td>
<td>209 (15.9%)</td>
<td>465 (35.4%)</td>
</tr>
<tr>
<td>2010</td>
<td>13</td>
<td>7 (53.8%)</td>
<td>1 (7.7%)</td>
<td>2 (15.4%)</td>
<td>1329</td>
<td>977 (73.5%)</td>
<td>282 (21.2%)</td>
<td>505 (38.0%)</td>
</tr>
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</table>

Alaska CAH Clinical Quality

Figure 7. Pneumonia: Most Appropriate Initial Antibiotic(s)

<table>
<thead>
<tr>
<th>Year</th>
<th>Alaska</th>
<th>CAHs Nationally</th>
</tr>
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<tbody>
<tr>
<td>2008</td>
<td>86.8%</td>
<td>86.9%</td>
</tr>
<tr>
<td>2009</td>
<td>81.1%</td>
<td>87.4%</td>
</tr>
<tr>
<td>2010</td>
<td>93.3%</td>
<td>88.7%</td>
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Rural Quality

Source: Flex Monitoring Team. Critical Access Hospital Year 6 Hospital Compare Participation and Quality Measure Results. April 2011

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Patients who reported YES, they would definitely recommend the hospital.

**Why is this important?**

100%

80%

60%

40%

20%

0%

**ST GABRIELS HOSPITAL**

74.0%

**ST CLOUD**

81.0%

**Average for all Reporting Hospitals in Minnesota**

72.0%

**Average for all Reporting Hospitals in The United...**

70.0%

Medicare Spending Per Enrollee

Source: Kaiser Family Foundation. 2009 Data

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Quality/Cost

Sources: K. Baicker and A. Chandra, "Medicare Spending, The Physician Workforce, and Beneficiaries' Quality of Care," Health Affairs Web Exclusive (April 7, 2004).
Unacceptable Healthcare Value

- **Quality** suboptimal
  - Deficient when compared internationally
  - Wide geographic variation

- **Cost** unsustainable
  - Growth in excess of GDP growth
  - Highest cost in the world

- **Waste** intolerable (20%)*
  - Care delivery, care coordination, overtreatment, administration, pricing failures, fraud and abuse.

- **Nobody agrees about what to do!**

The Value Conundrum

You can always count on Americans to do the right thing – after they’ve tried everything else.

- Fee-for-service
- Capitation
- Market
- Single payer
- Self-police
- Value-based purchasing?
- Accountable Care Organizations?
How we deliver care is predicated on how we get paid for care

Health care reform is changing both

Fundamentally, a transfer of risk from payers to providers

Supreme Court ruling has accelerated change
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

Medicare pays fee-for-service, then shares any gains at end of 3 years

- Percent of gains shared will be less if suboptimal quality
- Success requires excellent care and low cost – **value!**
ACOs’ Rapid Expansion

- 164 private insurer ACOs nationwide (Nov 2011)
  - 60% hospital, 23% physician, 17% health plan
- 174 Medicare ACO Programs (August 2012)
  - Medicare Shared Savings Program (116 ACOs)
  - Physician Group Practice Transition (6 ACOs)
  - Pioneer ACO demonstration (32 ACOs)
  - Advanced Payment ACO demonstration (20 ACOs)
  - ~ 2.5 million (>5%) of Medicare beneficiaries
ACOs Nationwide

The Engelberg Center for Health Care Reform at Brookings | The Dartmouth Institute

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To support rural and physician-owned organizations

CMMI has budgeted $170 million

Only two types of organizations are eligible
- No inpatient facilities and less than $50 million annual revenue
- CAH(s) and less than $80 million annual revenue

Co-ownership with health plan not allowed
Advanced Payments

- Upfront fixed payment
  - $250,000 for ACO start-up
- Upfront variable payment
  - $36 per beneficiary
- Variable monthly payment
  - $8/month per beneficiary
- $1.87 million in **new** money
  - Payment in addition to FFS for 5,000 beneficiaries over 3 years
- Payments recouped
  - From savings in three years, but “loan” forgiven if not enough savings
Managed Care Redux?

- Better data regarding cost and quality
- New care management strategies
- Physician-hospital alignments
- Gain-sharing, thus less risk
- More physician (less insurance) control
- Yet Medicare a leader
- Insurer investment in “value” programs
- Private equity/capital market investment
- Public financial pressures
Payment Risk Continuum

High Payer Risk
- Cost-Based
  - Charge-Based
    - Per Diem
  - Case Rate

High Provider Risk
- Capitation
  - Shared Risk
  - Bundled
The Risk of Doing Nothing

"We've considered every potential risk except the risks of avoiding all risks."

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As risk shifts, old business models are turned upside down
- Where are our costs?
- Where is our revenue?

New world demands
- Transferring risk to providers
- Higher quality at lower cost
- Doing what’s needed, not more
- Dealing with “stranded capital”

The devil is in the transition
- One foot on the dock and one in the boat
- It’ll be competitive – winners and losers
Tool Box for Delivering Value

- System thinking
- Balanced approach
- Medical homes
- Health coaches
- Performance improvement
- Medical staff relationships
- Collaboration
- What we can do now
System Thinking

- Currently a *non*-system
  - Fragmented, poorly coordinated, and excessively costly

- Integrated Delivery Systems
  - An organized and collaborative provider network designed to provide coordinated and comprehensive health care services.
  - Moves from hospital-centric to physician- and patient-focused

- Care continuum
  - Personal health to palliative care
  - Health *and* human services
Balanced Approach

Safety/Quality

Patient Experience

Financial Stability

Employee Growth

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New Perspective

Source: Roland A. Grieb, MD, MHSA - Health Care Excel and Premier, Inc.

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Non-Linearity

- “No margin, No mission”
- **Balance** will be the success strategy
  - Health care safety/quality
  - Financial stability
  - Patient experience
  - Employee growth
- It’s never about either/or; it’s always about **and/both**

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Medical Home Definition

The people, processes, and resources that deliver 24/7 accessible, patient-centered, and community-oriented primary care.

- Not a nursing home
- Not home health
- Not a “facility”
- A care team is essential
- Synonyms?
  - Patient-centered medical home
  - Health care home
  - Medical neighborhood
Health Coaches

- Identifies high-risk patients
- Proactively manages care
- Prepares for visits
- Develops disease registries
- Monitors reminder systems
- Provides patient education
- Coordinates care and transitions
- Works proximate to the team
The Value Equation

- Quality
  - ACO, VBP, HEDIS, etc.
  - Common diagnoses
  - Many – so “harmonize”

- Experience
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS)

- Cost
  - To the payer
The hospital CEO’s most important job is developing and nurturing good medical staff relationships.

Source: Personal conversation with John Sheehan, CPA, MBA
Physicians see themselves as independent, autonomous, and in control!
Yet, hospital-physician alignment is essential to deliver value

Some ideas
- Develop and engage physician leaders
- Provide data transparency, but do not overstate discrete measure importance
- Offer rewarding, yet reasonable salary, rather than paying piecework

Some Ideas (continued)

- Offer physicians direct ability to influence outcomes
- Provide a continual sense of accomplishment and recognition

Action Plans

- Recruitment and retention
- Governance and engagement
- Leadership development
- Relationship development
Collaboration Questions

- How do we develop a common vision and “culture?”
- How do we respect physician identity and independence, yet promote collaboration?
- How do we define success by mission, not hospital growth?
- How do we accept that increased collaboration will require some loss of control?
What We Can 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?

- Consider self-pay and hospital employees first for care mgmt
  - Direct care to low cost areas that provide equal (or better) quality
  - Reduces Medicare cost dilution
What We Can Do Now

- Negotiate with third party insurers to pay for quality (funds ACO infrastructure)
- Aggressively apply for value-based demonstrations and grants
- Begin implementing processes designed to improve value
- Move organizational structure from hospital-centric to patient/community-centric
- Assess potential affiliations
Collaboration and Value

- ACOs and other “programs” less important
- Collaboration that fosters health care value is key
- Future paradigm for success
- Good medicine and good business
Leadership

- Great leaders look into the future and see the organization not as it is... but as it can become.
- Reform will require:
  - Paradox
  - Vision
  - Savvy
  - Perseverance
  - Courage
The Risk of Something New