The Future of Rural Health Care

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Themes of this presentation

- Changes in delivery and finance of care
- Policy implications of those changes
- Developing a high performance rural system
- Closing thoughts for rural advocates and associations
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
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
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
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.....
Accountable Care Organizations

Pioneer and Shared Savings ACOs, Western Census Region

Metropolitan county
Non-metropolitan county
ACO coverage area
ACO DISTRIBUTION BY STATE

Overview of Change

- Time of change: health care systems, new private insurance products, new payment methods
- Creates threats and opportunities
- Public programs are part of the trends
- Aligning policy specifics with the broad goals for a better system in the future
Summary of Direction of Changes

- FFS to VBP
- PC Physicians to Other Primary Care and PCMH personnel
- Face-to-face encounters to telehealth
- Independent entities to systems
- Encounter-based medicine to person-based health
- Revenue centers to cost centers and vice versa
Policy: address immediate disruptions

- Verify they are real
- Place in perspective and priority
- Intervene as necessary
- Example of Medicare Dependent Hospitals
Facilitate Local and Regional Improvements

- Merging funding and policy streams: community transitions meet CMS innovations
- Support innovations that meet minimum access standards
Medicaid is currently a crucial safety net program for rural persons:

- In 2010, 17.9% of rural persons were enrolled in Medicaid compared to only 15.5% of urban persons.
- 13.2% of rural persons over age 65, but only 12.1% of urban persons in this age group are on Medicaid.
- 9.8% of rural elderly received Medicaid benefits compared to 9.0% of urban elderly.
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In part because of the higher rates of coverage of rural persons, Medicaid is a particularly important source of payment for **rural providers**:

- Almost one-third of rural physicians derive 25% or more of their patient revenues from Medicaid, as compared to 19.9% in urban areas.
- Physicians in rural areas are more likely to serve Medicaid beneficiaries than are their urban counterparts.
Medicaid financed 40% of the $177.6 billion spent nationally on long-term care in 2010.

Medicaid is the primary source of funding for publicly provided mental health services, accounting for 46% of spending in 2007.
Medicaid, ACA, and Moving Forward

- Access standards for any contracts
- FMAP and state participation: expectations and balance
- Weighing rural consequences
Considerations about Medicaid Expansion

- Short term and long term costs to Medicaid program and state budget
- Estimated (by Urban Institute) 130,000 persons newly eligible in Iowa
- Balance of state cost through 2020 and federal government matching payment
- Burden of uncompensated care without balancing Disproportionate Share payment
- Cost to public treasuries and public insurance from uncompensated
- Economic impact of Medicaid expansion
Medicare Policy Levers

- Preservation in the face of threats (20+ years of rural policy activities)
- Pay-for-performance and rural considerations
- Health systems and payment changes: ACOs
Other Public Policy Levers

- Health professions training programs
- Loan repayment and other incentive programs
- Public health programs
- Infrastructure support
A Vision for the Future from the RUPRI Panel

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.
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_050212.pdf
A High Performance Rural Health Care System Is

- **Affordable**: costs equitably shared
- **Accessible**: primary care readily accessible
- **Community-focused**: priority on wellness, personal responsibility, and public health
- **High-quality**: quality improvement a central focus
- **Patient-centered**: partnership between patient and health team
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
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
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
The future can be healthy people in healthy communities

- Where people choose to live
- Through local providers linked to integrated systems of care
- Who, together with their patients, manage health conditions
- Not the same design everywhere, but the high quality, patient-centered everywhere
Organizations should pursue “first do no harm” but also alternative visions for the future.

Health care systems active in reshaping delivery, with Triple Aim in mind.

Dialogue has to lead to action.
For Further Information

The RUPRI Center for Rural Health Policy Analysis

http://cph.uiowa.edu/rupri

The RUPRI Health Panel

http://www.rupri.org