The Future of Healthcare: Affordable Care Act and Market Reforms

Keith J. Mueller, PhD
Director, RUPRI Center for Rural Health Policy Analysis
Head, Department of Health Management & Policy
University of Iowa College of Public Health
Keith-mueller@uiowa.edu

Presented to the Western Flex Conference
June 12, 2014
Santa Fe, New Mexico
Adapting to Changing Environment

- Integrating systems of care in the marketplace, driven by financial pressure and changes in care delivery
- Aligning public and private policies with what is now state of the art in care to improve sustainability of high quality services in rural places
Adapting to Changing Environment

- Emphasizing value instead of service volume: translation is population health, which means need to think of the total community being served in the places they live, work, and play
- Blending health and human services
- Maintaining the appropriate, sustainable service mix locally
Importance of Transitions to Optimize Opportunities

- Changes are coming, under auspices of reform or otherwise
- Implement the changes in the context of what is desirable for rural communities
- How do we pull that off?
The Changes in Health Insurance Coverage

- Will influence “patient flow”
- Will also direct “consumers” to use system differently
- Will affect revenue
- Creates backdrop for different investment strategies
Changes In Insurance Status

Percentage Uninsured in the U.S., by Quarter
Do you have health insurance coverage?
Among adults aged 18 and older

% Uninsured

Quarter 1 2008-Quarter 1 2014
Gallup-Healthways Well-Being Index

GALLUP
Data from April 14 Gallup Poll

- 4% of US population newly insured as of April; 2.1% through exchanges, 1.9% not
- Among newly insured, 30% aged 18-29 (constitute 21% of population)
- Among newly insured, 75% with household incomes below $60,000

Gallup Daily tracking poll of more than 20,000 adults, aged 18 and older
Data from RAND Study

- Representative sampling design; 2,641 individuals aged 18 to 64, weighted to provide national estimates, changes September 2013 – March 2014
- Net gain of 9.3 million insured; gain in employer-sponsored insurance of 8.2 million and net loss in individual market of 1.6 million
- Marketplace enrollment of 3.9 million
Changes to Medicaid

- Eligibility changed to 138% of federal poverty guideline
- No categorical eligibility
- Moves closer to insurance model
- Increased population covered, brings increased focus on cost and value
New Medicaid Enrollment

- Some in all states, woodwork effect and marketplace redirecting some
- Total new enrollment: 6 million
- Variation by state (affected by expansion decision)
  - New Mexico: 63,210 (11% increase)
  - Arizona: 143,633 (12% increase)
  - California: 1,443,000 (15.8% increase)
  - Nevada: 136,551 (141.1% increase)

New sources of payment

New rules associated with the sources of payment

Initial federal involvement in raising payment for primary care (2013 and 2014)

Rating areas, service areas, and network contracts with commercial insurers
What the Changes May Mean

- Types of insurance plans may “devolve” when premiums increase
- Could be more shifting into “consumer driven” health insurance design
- Increase in deductibles and copayments drives consumer behavior
- Premium dollar becomes a source of revenue in new risk-sharing arrangements
Variation Within the State

Rating Areas for New Mexico

Classification by County
Urban
Rural

13
Variation Within the State

Rating Areas for Nevada

Classification by County
- Urban
- Rural

Source: WEFT, U.S. Census, ESRI
RUPRI Rural Health Indicators & COVID-19 Map Creation by Sarah Geier & Tim Walker (2021-14)
Prepared by Maproom, Mapgym, info@openstreetmap.com, and the GIS Lab, University of Iowa
Variation Within the State

Rating Areas for Arizona

Classification by County

Urban
Rural

[Map showing different areas of Arizona, with counties numbered 1 to 7, and the map is color-coded to indicate urban and rural areas.]
Basic Forces Motivating Change

- “Form follows finance”
- Commercial insurance changing, and employer plans changing
- Medicare changes are dramatic and could be more so
- Medicaid changes spreading
Commercial Insurance and Employers

- Value-based insurance design to steer utilization: wellness, disease management, medication management
- Payment methodologies shifting to value-driven, at least in part
- Engagement in care management, population health
- Use of narrow networks
Uncertain future (at best) for cost-based reimbursement, unless through exceptions (FCHIP)
- Demonstrations of new methods, including bundled payment, value-based for Critical Access Hospitals
- Value-based purchasing across provider types
- ACOs as a harbinger
66 public and private ACOs
366 Medicare ACOs
23 Pioneer ACOs
35 are Advance Payment
Medicare ACOs located in 48 states (and DC and Puerto Rico)
ACO development being seen as an answer to cost of current and expanded program

- Reduced payments in systems based on pay for service
- Other innovations to reduce cost such as primary care case management, divert from emergency rooms
Early Results in Medicaid

- Colorado: $44 million in gross savings or cost avoidance in FY 2013; reduced hospital readmissions 15-20%
- Oregon: in place 16 months, 90% of Medicaid beneficiaries

Aligning Market Based Changes with Clinical and Delivery Changes

- Shifts in modality of care
- Shift in vision/mission to be more encompassing
- Innovation consistent with vision/mission and changing financial and policy context
Changes in Delivery Modalities Create Opportunities

- Telehealth
- Using professionals to full capacity of licensing
- Care in different settings
- Inter-disciplinary care
Innovate to accelerate pace of change

- In health care workforce: 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.
Health Care Organizations of the Future

- Accepting insurance risk
- Focus on population health
- Trimming organization costs
- Using the data being captured (e.g., electronic health records)
- Health care as retail business
Elements of a Successful System Redesign

- Clear Vision
- Principles for redesign (reliability, customization, access, coordination)
- Teamwork
- Leadership
- Customer focus
- Data analysis and action plans
- Inclusive beyond health care system

Actions to Consider

- Measure organizational performance
- Inform key stakeholders regarding performance
- Consider employees for care management
- Negotiate payment for measurable quality and patient satisfaction
- Collaborate with health care and human services providers
- Strategic focus on patients/community
Considerations

- Using population data
- Evolving service system (e.g., telehealth)
- Workforce: challenges to fill vacancies, and shifts to new uses of new categories
- Best use of local assets; including physical plant (the hospital)

Source: The U.S. Census Bureau

January 1, 2014
317,297,938
How to Succeed with Collaboratives

- Use population data (County Health Rankings)
- Shared governance of resource use
- Methodology for sharing savings and re-investing
- Understand linkages between health outcomes and determinants – “patient responsibility”
Being an Effective Leader or Partner

- Focus on center of excellence or pillar of excellence
- Proving cost effectiveness, including ability to reduce costs
- Engaging board of trustees and stakeholders
Pursuing the possible

- When community objectives and payment and other policy align
- Community action is where policy and program streams can merge
- Community leadership a critical linchpin
- Pursuing a vision
Value will determine payment, initially partial eventually all
Responding to those changes
Value will take on a new meaning beyond the hospital/clinic walls
Responding to those changes -- population health
Bonner General Hospital in Sandpoint, Idaho: CAH conversion in 2011
Meld financial and clinical goals – example of opening wound center after physician recognized market potential
“Engaging physicians to cut costs while maintaining quality” (from article cited below)
Dr. Kenneth Cohn, CEO of Healthcare Collaboration: “It’s about giving doctors a more proactive role in strategy and identifying physician finance champions”

CFO conducts rounds with physicians

Source: Bob Herman, “In the Future, Will Hospitals Have a Chief Medical Financial Officer?” Beckers Hospital Review April 8, 2014.
Rural Health System Analysis and Technical Assistance
- 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

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!

www.RuralHealthValue.org
Collaborations to Share and Spread Innovation

- The National Rural Health Resource Center
- The Rural Assistance Center
- The National Rural Health Association
- The National Organization of State Offices of Rural Health
- The American Hospital Association
For Further Information

The RUPRI Center for Rural Health Policy Analysis
http://cph.uiowa.edu/rupri

The RUPRI Health Panel
http://www.rupri.org
Dr. Keith J. Mueller

Department of Health Management and Policy
College of Public Health, N232A
145 Riverside Drive
Iowa City, IA  52242-2007
319-384-3832
keith-mueller@uiowa.edu