Volume to Value: Will the Promised Transition Come to Alaska?

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Rural Health Value
UNDERSTANDING AND FACILITATING RURAL HEALTH TRANSFORMATION.

THE UNIVERSITY OF IOWA

IHI Triple Aim – CMS Three-Part Aim

Improved community health

Better patient care

Smarter spending

The Health Care *Value* Equation

$$\text{Value} = \frac{\text{Quality + Service}}{\text{Cost}}$$

But…

- Who measures these things?
- What does each of these words mean?
- Why is each important compared to the others?
- How does a person's *perspective* change value?

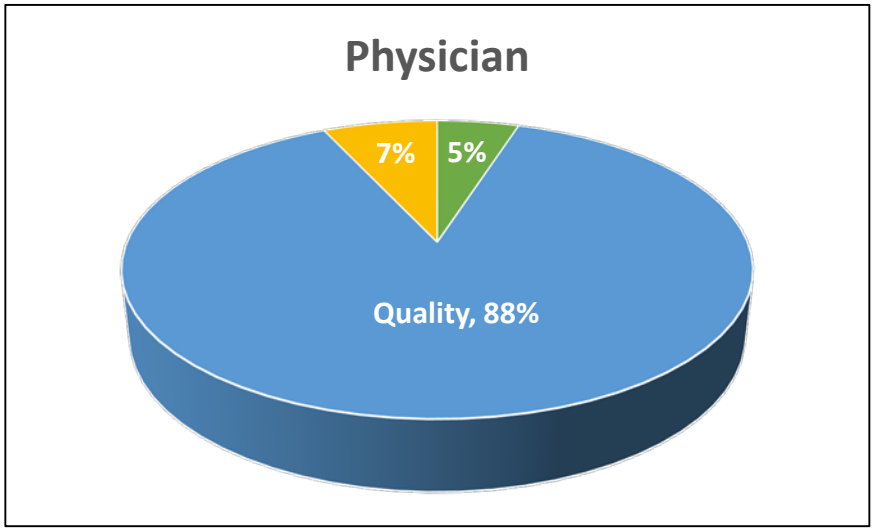
Value in Health Care Survey Responses

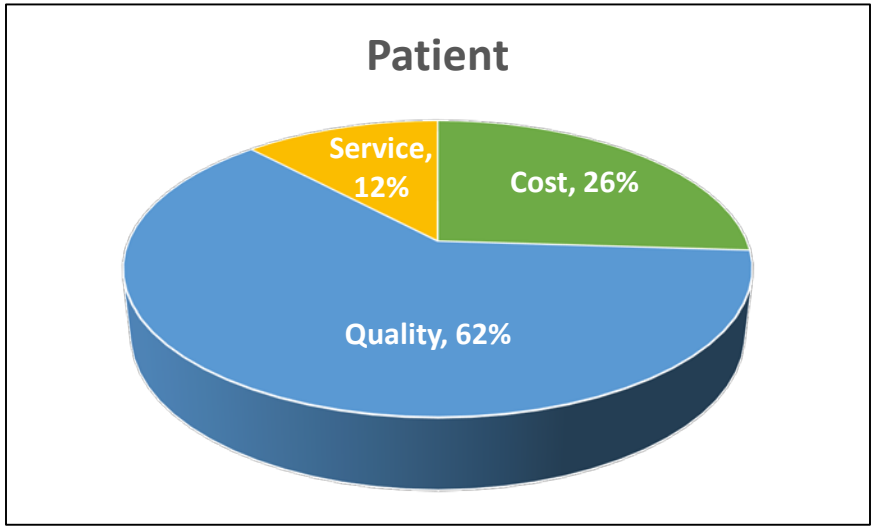
- 5,031 patients
- 687 physicians
- 538 employers

Most Important Component of Value

Legend

- Quality/Productivity
- Cost
- Service/Satisfaction





Rural Health Value — Understanding and Facilitating Rural Health Transformation.

Clint MacKinney, MD, MS

The University of Iowa

What is Value-Based Payment?

- **Payment** for one or more parts of the Three-Part Aim
  - Better care
  - Improved health
  - Lower cost
- NOT fee-for-service, prospective payment, or cost-based reimbursement
- Why is value-based payment important to rural hospitals and physicians?

Form Follows Finance

- *How we are paid for health care determines how we deliver health care*
- CMS and other payers are reforming health care payment to reward **value**
- Fundamentally, payment reform involves **shifting financial risk** from payers to providers

Financial Risk Transfer

- Feds → States
- States → Insurers
- Insurers → Providers
- Insurers → Patients

- Who is best at managing *insurance* risk?
- Who is best at managing *clinical* risk?
- Who is best at managing *population health* risk?

Leadership Matters

Recent HHS Secretaries

- Sylvia Burwell
  - New stretch goals for value
  - Flurry of ACA demonstrations
- Tom Price
  - Retreat!
  - Anti-bundled payment
- Alex Azar
  - Mandatory bundles
  - *Bold* changes to alternative payment programs
  - But no new programs yet!

CMS Value-Based *Programs*

- Medicare Shared Savings Program (ACOs)
- Value-Based Purchasing Program (VBP)
- Hospital Readmission and HAC Reduction Programs
- Quality Payment Program (part of MACRA)

- **All are active in Alaska (only one Medicare ACO in Alaska)**

CMMI Value-Based *Demonstrations*

- **Accountable** Care demos
- **Medicaid** and CHIP initiatives
- **Dual** Medicare-Medicaid enrollees
- **New payment** and service delivery models
- **Bundled** payment initiatives (two initiatives in Alaska)
- **Best practices** adoption (one initiative in Alaska)
- **Primary care** transformation (one initiative in Alaska)

Source: CMMI website. https://innovation.cms.gov/initiatives/. Accessed September 15, 2018.

The New HHS Priorities

1. **Cost reduction**
   - Cost reduction for whom?
2. **Demonstrable outcomes**
   - What about reliability in low-volume situations?
3. **Patient choice**
   - Are patients sufficiently informed?

- No new HHS programs yet, but three ongoing examples
  - MSSP, QPP, global budget

Medicare Shared Savings Program (ACOs)

- >$541m savings 2013-15
- Correlated with savings
  - High initial benchmark
  - Physician-owned
  - Experience in program
- Managing financial risk and population health via CINs
- Proposed rules
  - 2-sided risk after 2 years
  - Decrease shared savings to 25%
  - Shift to regional benchmarks

Source: “Medicare Shared Savings Program Produces Substantial Savings: New Policies Should Promote ACO Growth, " Health Affairs Blog, September 11, 2018.

QPP (MACRA) – New Physician Payment Reality

- Minimal FFS payment increase
  - 0.5% x 5 years, then 0% x 5 years
  - Actually payment decrease (inflation)
- Merit-Based Incentive Payment System
  - Eventually **-9%** to **+27%** adjustment in pay
  - Plus, up to **10%** Exceptional Performance Incentive Payment (budget neutral exclusion)
  - Up to **46%** payment differential between high and low performers in 2024!
- Or, 5% AAPM bonus
  - Excluded from MIPS performance reporting requirements

CMMI Global Budget Models

- Maryland All-Payer system sets uniform hospital rates
  - Medicare waiver since 1977
  - All payers pay the same rate for hospital care
- 2015-2018 Maryland All-Payer Model (extended to 2023)
  - All hospitals (including 4-bed rural)
  - Based on historical revenue base
  - Transfers manageable risk to hospitals
  - Provides predictable revenue flow
  - Allows focus on Tripe Aim (mission)
- Results
  - $586 million saving over 3 years
  - 44% reduction HACs
  - Readmissions approximately US rate

Is Medicare/Medicaid still the 800# Gorilla?

- Medicare impacts Alaska less than other states. Why?
- Alaska Medicaid pays comparatively well
  - No burning platform… yet?
  - Legislature is feeling the heat of increased demand and decreased state revenues
  - Response? Off-load risk.
- Enter managed Medicaid; e.g., UnitedHealth
  - 7% lower admissions in AZ
  - 8% lower ED visits in TN

Value-Based Care Survey of Payers

- 5.6% decrease in overall medical costs
- 5.0% - 5.4% decrease in medical costs due to bundles
- 80% of payers report improved clinical quality
- Pure fee-for-service represents only 37.2% of reimbursement
- If these VBC savings realized, why is transformation so slow?

Source: Finding the Value in Value-Based Care: The State of Value-Based Care in 2018. Change Healthcare. (The results of a 2018 online survey of 120 payers in different regions and of different sizes.)

Healthcare Incongruities (= Paralysis?)

Health care is a right.	→	Health care is a privilege.
We love drugs.	→	We hate drug costs.
Anywhere or anytime.	→	Someone else should pay.
Physicians are well paid.	→	Physicians are burnt out.
We preach primary care.	→	We pay the most elsewhere.
We talk affordability.	→	We avoid transparency.
Our work is noble.	→	We pursue profit.
One person's cost.	→	Is another person's profit.
53% favor single-payer.	→	43% oppose single-payer.

Sources: Adapted from Keckley Report. Radical Incrementalism or System Re-Design: Which Way Forward. April 23, 2018. And Kaiser Family Foundation Polling. July 5, 2017.

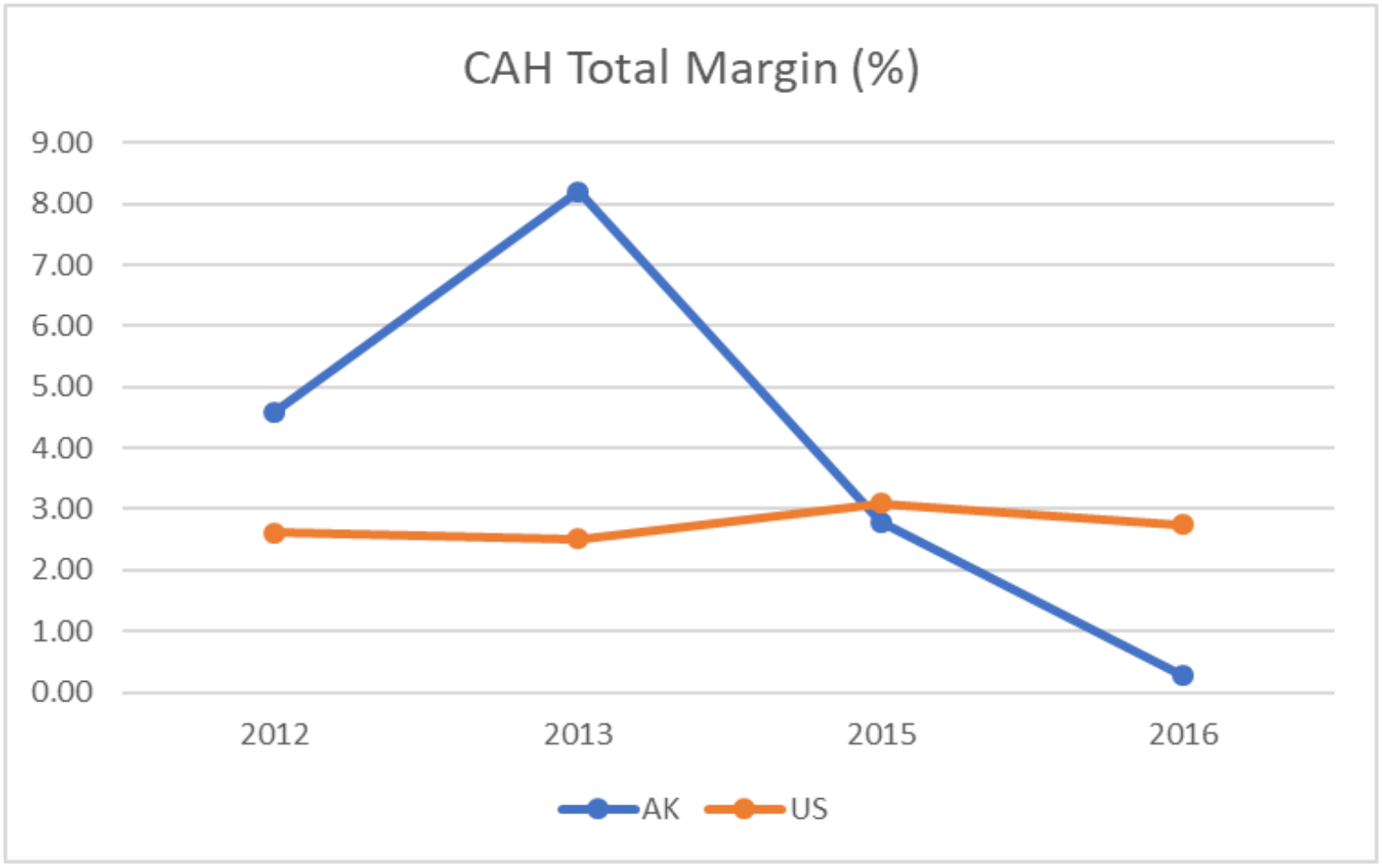
The Alaska Pace

- Why slower yet here?
  - Few Medicare beneficiaries
  - Isolated rural and few people
  - Few employer buyer groups
  - Less provider alignment
  - Insufficient political will
  - Risk of worsening access
  - Few policy glide scopes
- Is avoidance of value-based payment wise?
- Is “separate but equal” true?
- What’s the risk of being left behind?
- What’s the Alaska hospital financial landscape?

Alaska Hospital Finance Realities

- Revenue constriction
  - Alaska state revenue decline and consequent Medicaid impacts
  - More aggressive CMS value-based purchasing and “reduction” programs
  - Commercial payers less tolerant of covering low government payments
  - High deductible insurance plans and increasing bad debt
  - Baseline physician payment *decreases* under MACRA
- Excel tool: CAH Financial Pro Forma for Cost Reimbursement (www.ruralhealthvalue.org)

Alaska CAH Financial Performance 2012 - 2016



Source: Flex Monitoring Team. Critical Access Hospital Financial Indicators Reports. www.flexmonitoring.org/publications/annual-financial-indicator-reports/. Accessed September 18, 2018.

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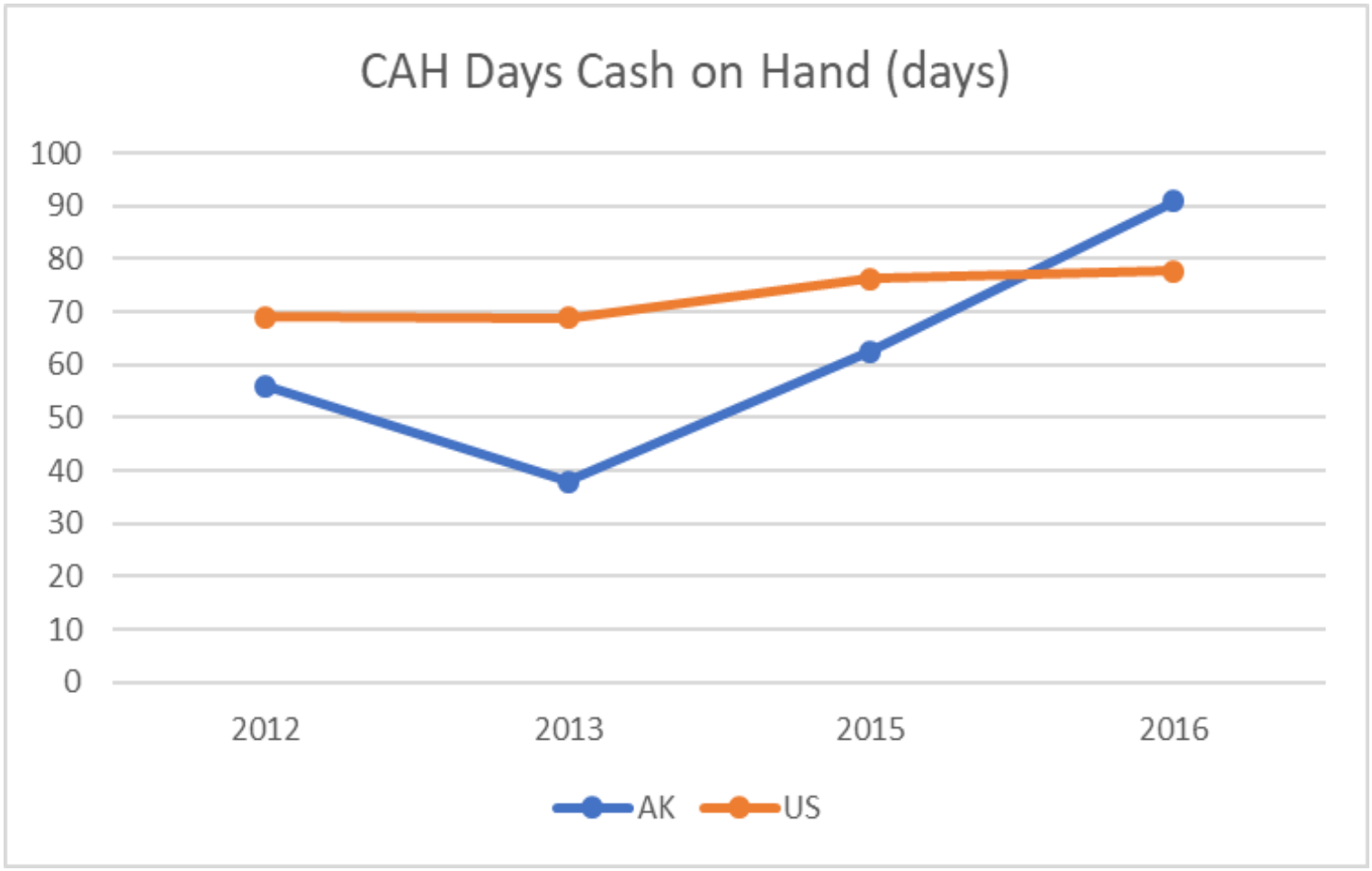

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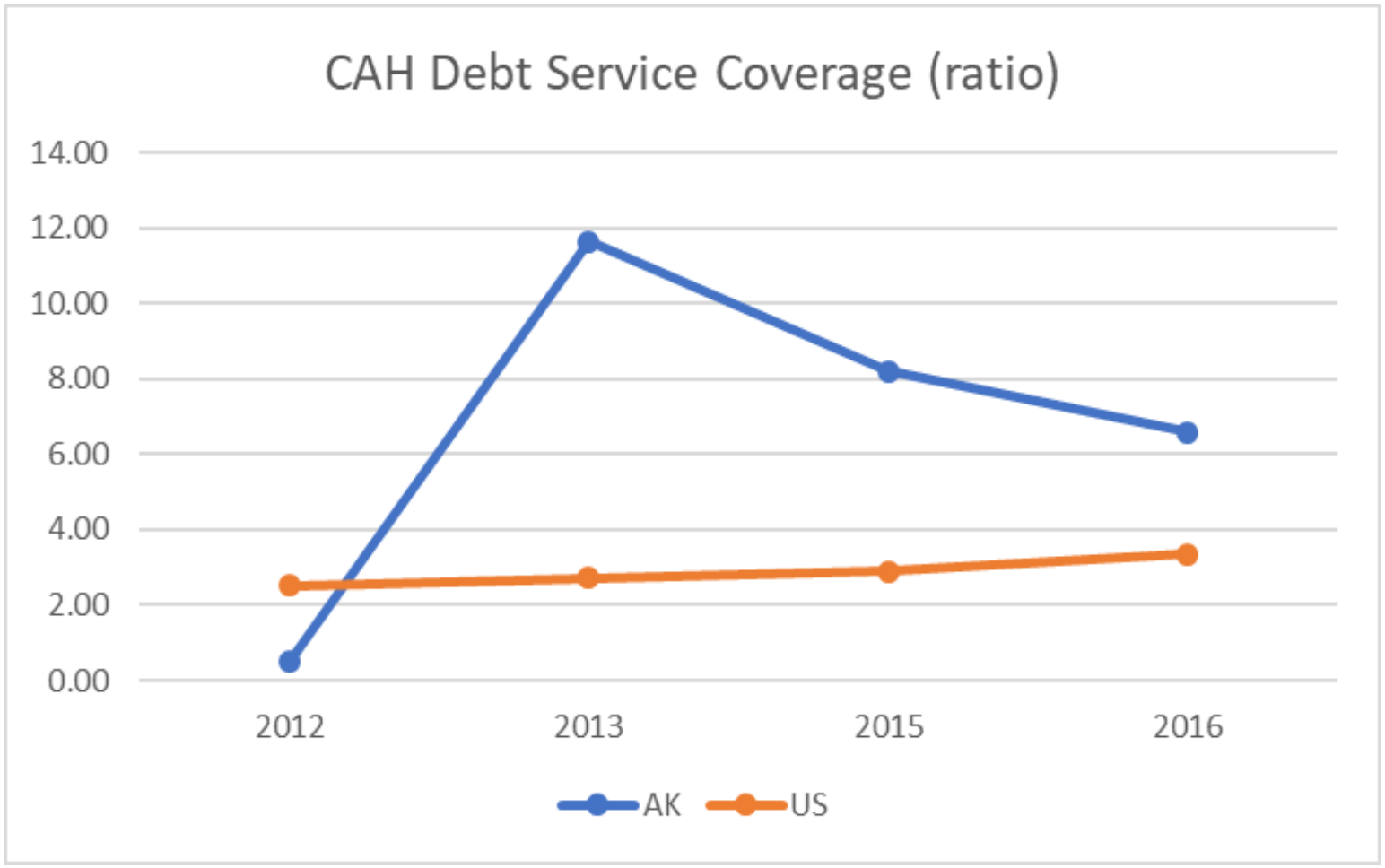

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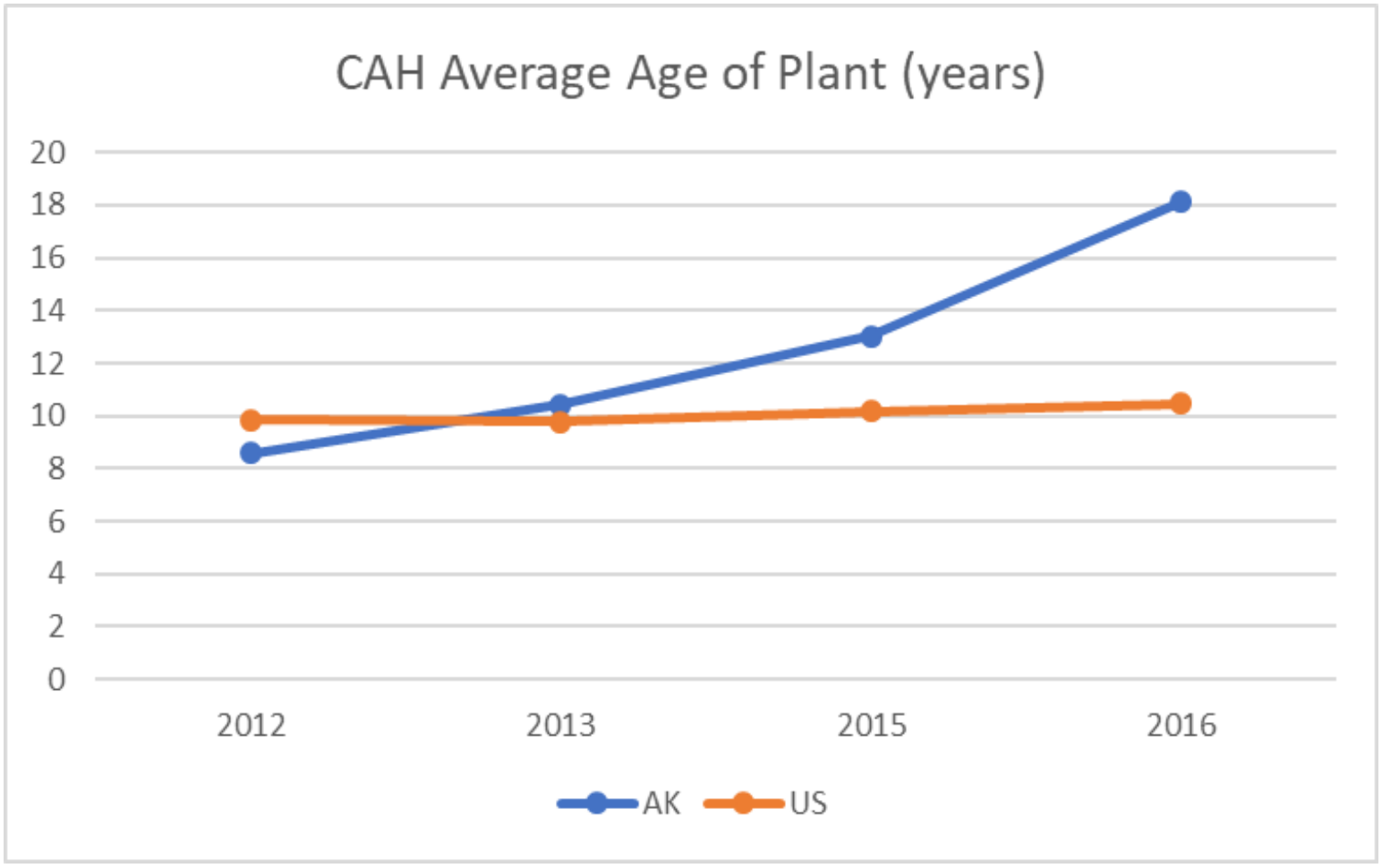

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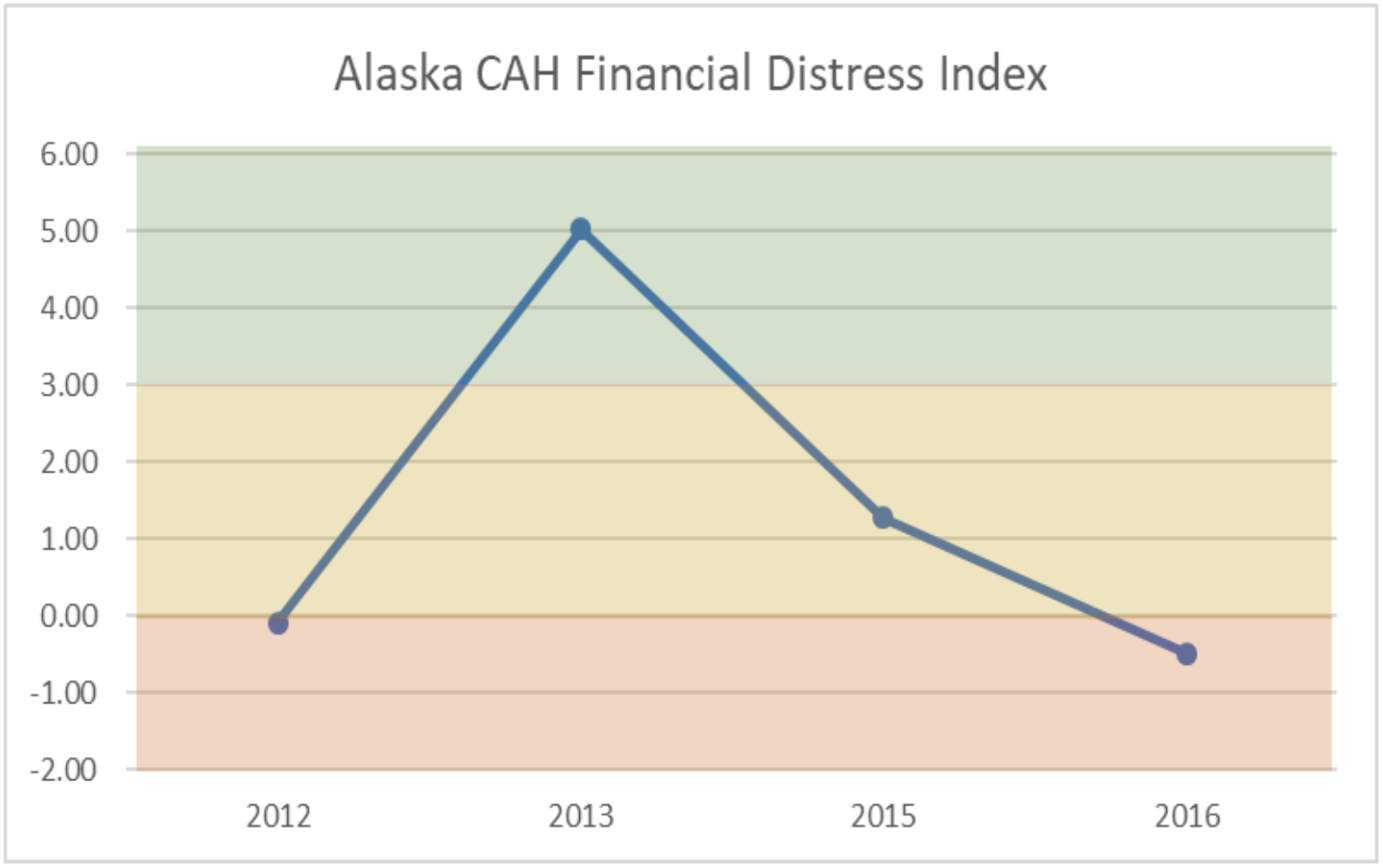
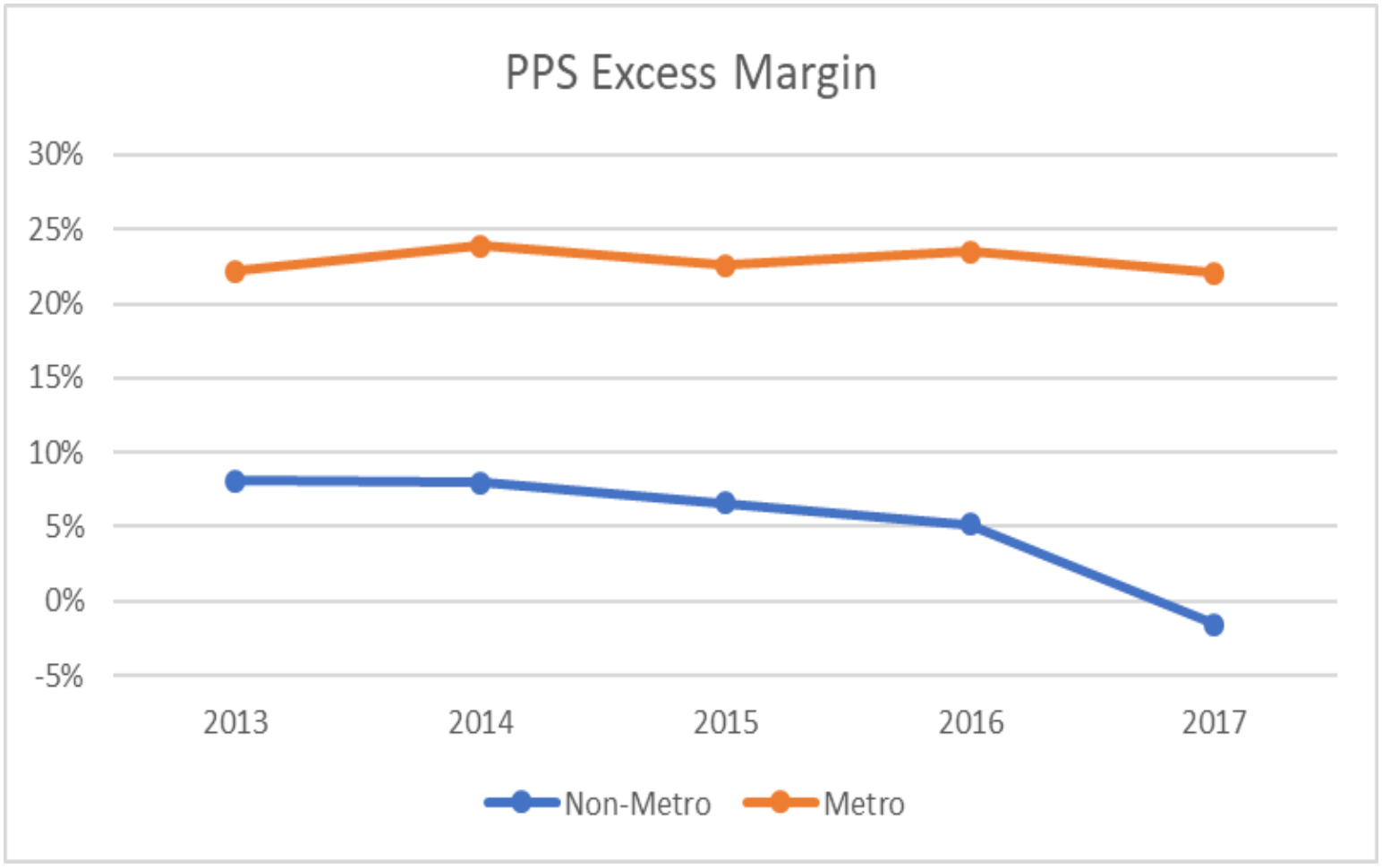


Source: Holmes, GM. Kauffman, BG. Pink, GH. Predicting financial distress and closure in rural hospitals. *Journal of Rural Health*. Volume 33, Issue 3. Summer 2017.

Alaska PPS Financial Performance 2013 - 2017



Source: American Hospital Directory. www.ahd.com. Accessed September 21, 2018.

The Hospital Reality

- Decreasing piece of the pie
  - 45%→32% (past 20 years)
- Shrinking inpatient care
- Competing outpt providers
- Increasing technology costs
- Unrelenting regulations
- Fading safety net programs
- Response? Redefine the **H**
  - Look outside the four walls
  - Adapt to new payments systems
  - Move from “hospital” to “health”

Redefining the H – from Hospital to Health

- **Adapting** to new payment and delivery system models.
- Confronting the challenge of disruptive **innovators**.
- Managing new and sometimes difficult **partnerships**.
- Assembling and developing the right **talent** in the hospital and in the community.
- Ensuring **diversity** that reflects the community.
- Developing a deep understanding of **community** health and wellness.

Source: AHA. Leadership Toolkit for Redefining the H: Engaging Trustees and Communities. 2015.

But… Is the Sky Really Falling?

- *"We face a massive crisis in this area." Without prompt administrative and legislative action, we will have a break-down in our medical care system."*

  Richard Nixon (1969)

- Incremental reform: it's been the pattern for decades
- Incrementalism is still change!

Services May Diminish; Hospitals May Close

- We must avoid death by 1,000 cuts.
- There may be times for doin' nothin' – but this ain't the time.
- Our hospitals, patients, and communities deserve our action.
- What's our role to play? (think *mission)*

Responding to Revenue Constriction

- Reduce expenses
  - *Lean Thinking* is good
  - But fixed/variable cost ratio lessens impact on margin
- Increase revenue (volume)
  - The fuel of the FFS chassis
  - Only if clinically indicated
  - Is volume most important?
- Or… change the fee-for-service payment game
  - Go upstream to the dollar
  - Shift from volume to value

Some Next Step Ideas

- Protect hospital's financial integrity
  - Manage to the income statement
  - Establish an R+D (value) account
- Follow the money – up
  - Hospital employees
  - Self-funded employers
  - Uninsured/high-deductible patients
- Seek low-risk learning opportunities
  - E.g., ACO, bundled payment, P4P
  - Propose a value-based payment system to a payer
- Align with primary care providers
  - Old thinking: PCPs don't pay for themselves
  - New thinking: **value** (= dollars) will be delivered by PCPs

Will the Promised Transition Come to Alaska?

- It's already here!
- But not particularly financially impactful… yet
- Take cues from CMS and the lower 48
- File your own flight plan to health care value
- Go low and slow, but still fly to value

Exciting Time and Anxious Time

Some of you may opt to retire and just go fishing.

For those that fish part-time:

- Be courageous. Grab *value* by the horns and bend it to your will.
- That <u>will</u> is your mission – the health and happiness of your patients and your community.
- VBC and payment may allow you to shift focus from “heads in beds” to a new purpose – **health**.

Bill Gates, Jr.

"We always overestimate the change that will occur in the next two years and underestimate the change that will occur in the next ten."

Collaborations to Spread Innovation

- ✓ Rural Health Value Project
  https://ruralhealthvalue.org
- ✓ Rural Policy Research Institute
  https://www.rupri.org
- ✓ The National Rural Health Resource Center
  https://www.ruralcenter.org/
- ✓ The Rural Health Information Hub
  https://www.ruralhealthinfo.org/
- ✓ The National Rural Health Association
  https://www.ruralhealthweb.org/
- ✓ The American Hospital Association
  https://www.aha.org/front