Rural Hospitals on the Brink: An Rx for Population Health

National Rural Health Resource Center

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A minor brush with the fee-for-service system following a skiing accident…

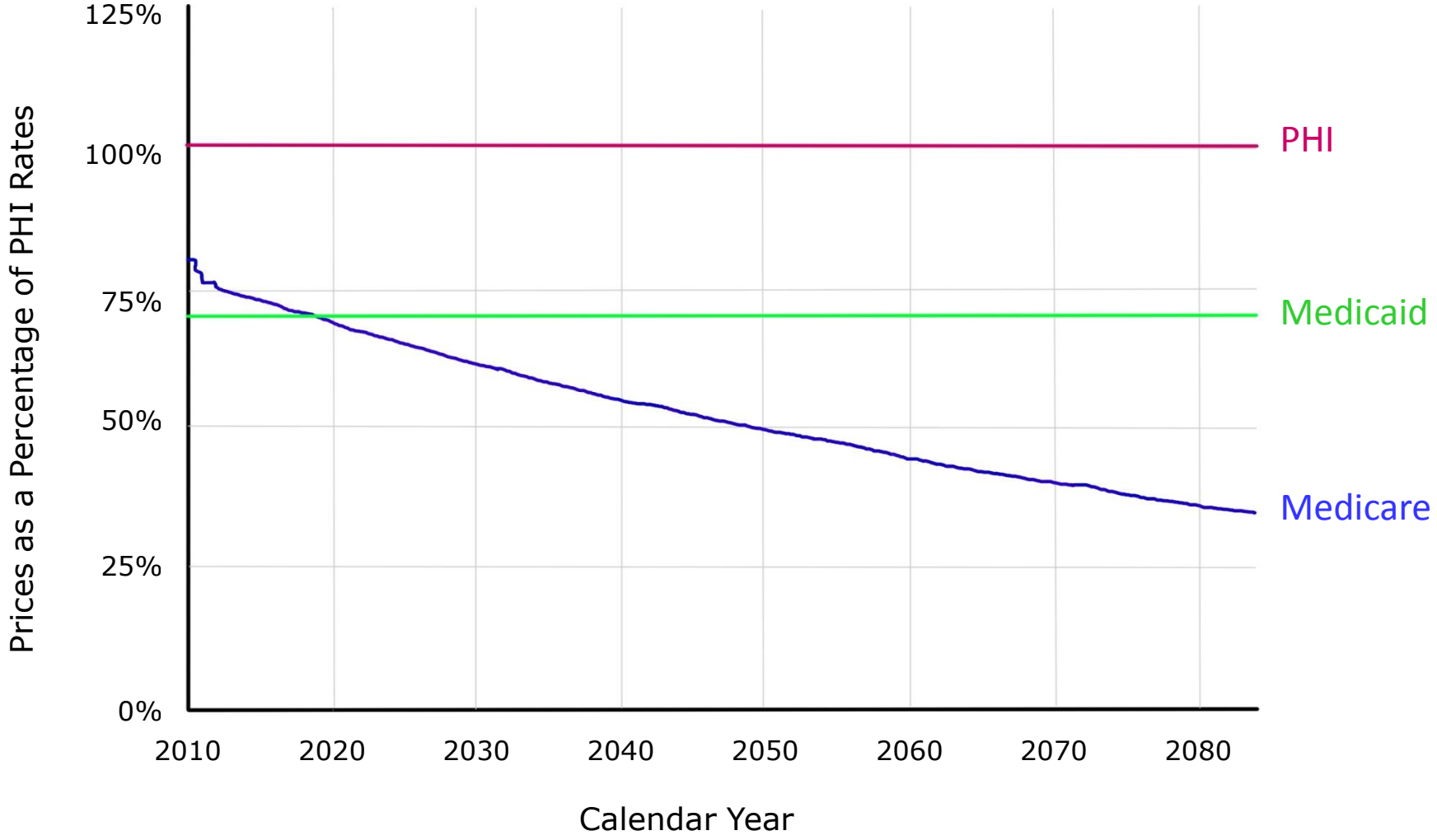
What Hath 3rd Party Fee-For-Service Wrought?

1. 30-40% of all medical expense is wasted[1]
2. Half of all medical care is substandard[2]
3. 75% of medical costs treat preventable disease[3]
4. Transaction costs consume up to 31% of every health care dollar[4]
5. Hospitals facing reimbursement pressure from *all* payers[5] (including patients)

1 2005 report by the National Academy of Engineering and the Institute of Medicine
2 NEJM http://www.nejm.org/doi/full/10.1056/NEJMsa022615#t=articleResults
3 CDC http://www.medicaid.state.al.us/documents/News/Transformation/Workgroup3-8-07/Chronic_Disease_Overview.pdf
4 Richard L. Clarke, "Healthcare Complexities Work Against All of Us," WSJ 11/28/03
5 Hospital Revenues In Critical Condition; Downgrades May Follow Moody's Investors Services 8/10/11

Medicare FFS rates vs Medicaid and Private Health Insurance (PHI)

Insurance Reimbursements Under Current Law (assumes constant Medicaid, PHI rates)

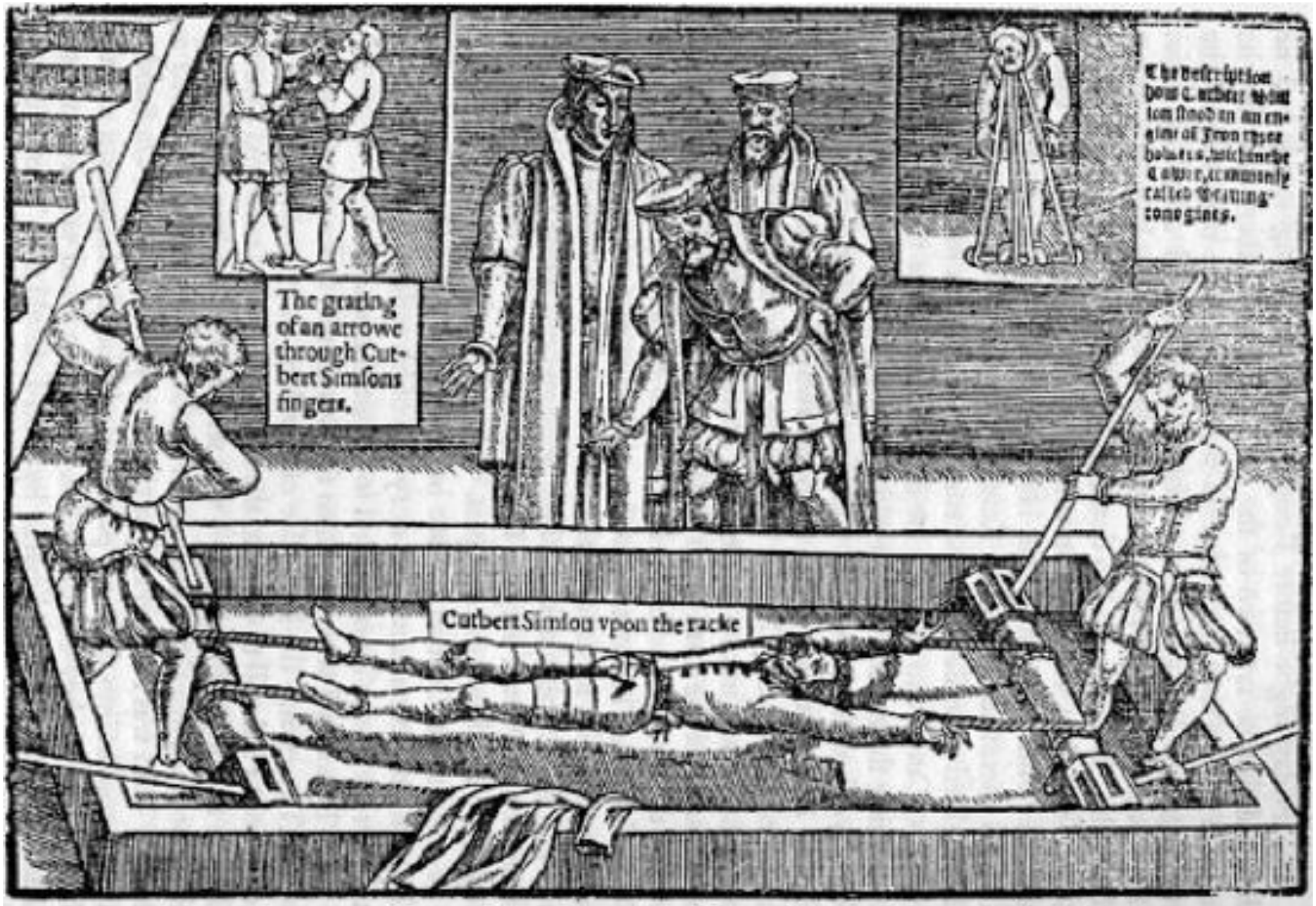


Source: CMS Office of the Actuary - 2010

Medicare's provider death by a thousand cuts

- Value-based purchasing program
- Readmission penalties
- Hospital acquired condition penalties
- RBRVS adjustments
- SGR cuts
- Annual update & geographic adjustment reductions
- DSH payment reductions
- IPAB actions to reduce covered services
- RAC audits

RAC audit in progress



'A true description of the racking and cruell handeling of Cutbert Simson in the Tower.'

Medicare's provider death by a thousand cuts

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8. IPAB actions to reduce covered services
9. RAC audits
10. Bundled payment initiative
11. Sequester reimbursement cuts
12. Sequester EHR Incentive Program cuts
13. Combined Part A & B deductible?
14. DRG reform?
15. Premium support?
16. President promising more cuts

Will Critical Access Hospitals be immune to Medicare cuts?

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Medicaid Cuts

- "Illinois Medicaid Cuts: Gov. Quinn $1.6 Billion"
- "Thousands of Illinoisans to be affected by Medicaid cuts"
- "Colorado's Medicaid expansion plan must cut costs"
- New York State to eliminate most Medicaid FFS by 2016
- "White House Backs States' Power To Cut Medicaid Payment Rates"
- "California to reduce certain Medi-Cal payments by 10%"
- "13 States Cut Medicaid to Balance Budgets"

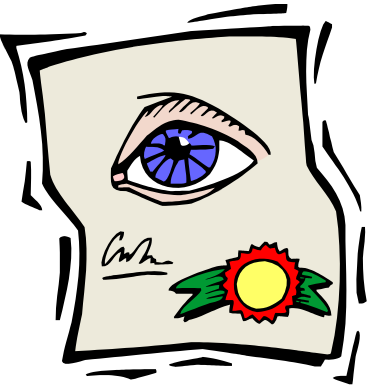
As a result…

There are two kinds of Medicaid states…

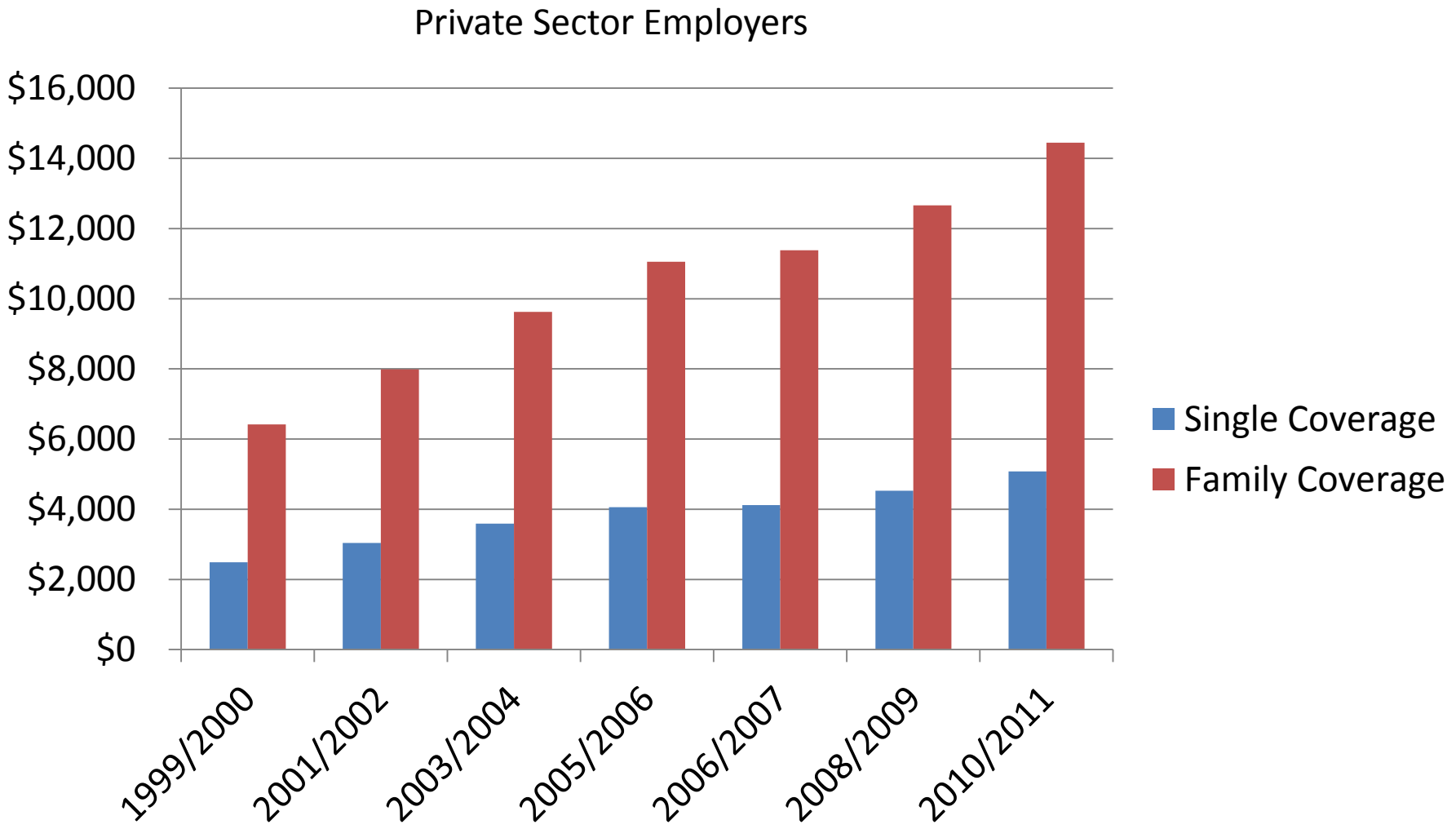
Commercial Insurance Pressure

- Increased regulatory scrutiny of premiums
- Fewer hospital rate increases, more decreases
- Reduced ability to accept cost-shift
- Shrinking market share
- Payers are as desperate for solutions as you are

Hospital Revenues In Critical Condition; Downgrades May Follow Moody's Investors Services 8/10/11



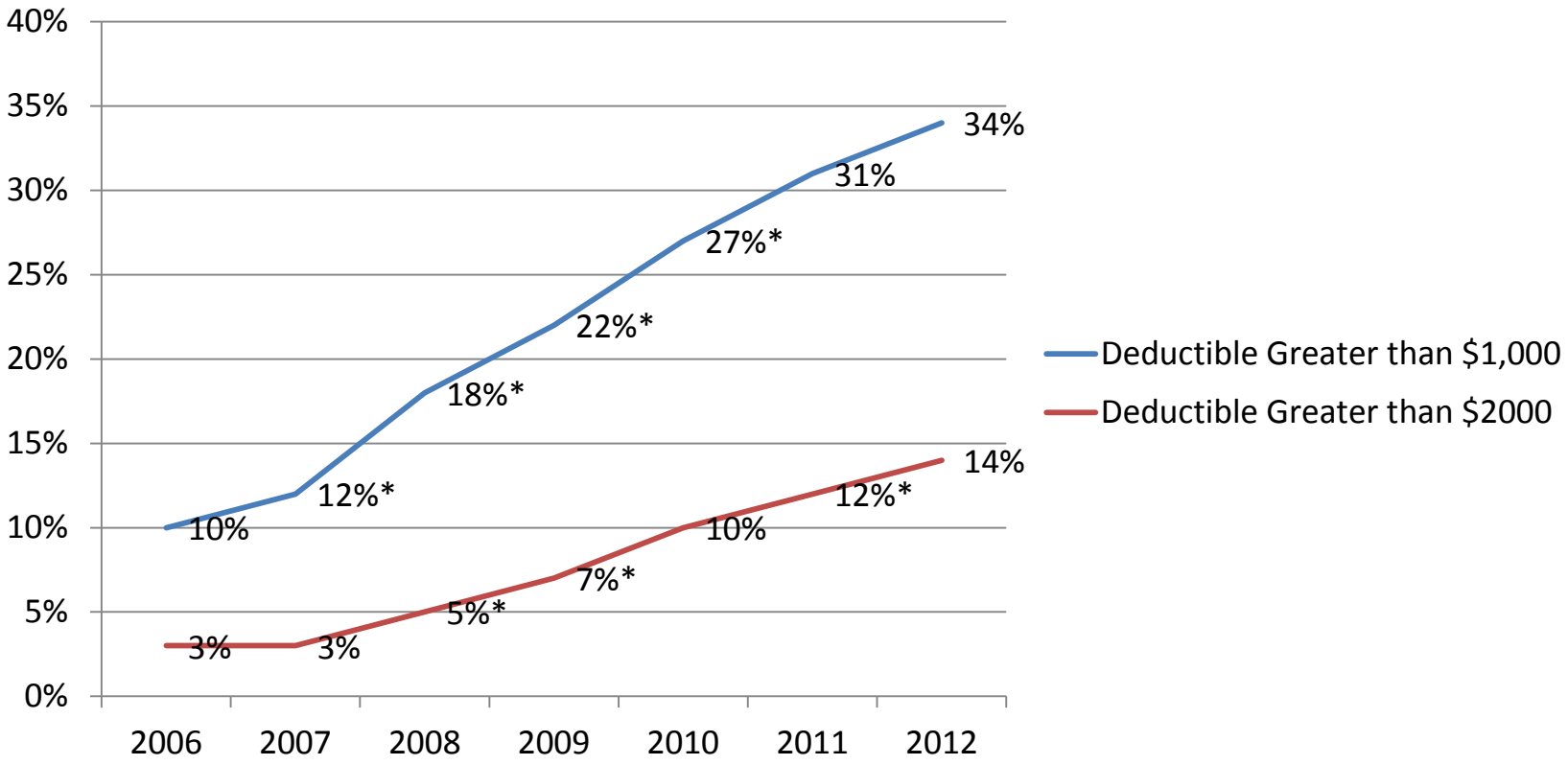
Employer Insurance Premiums



State Health Access Data Assistance Center. 2013. "State-Level Trends in Employer-Sponsored Health Insurance." SHADAC Report.

Growing deductibles, patient price sensitivity & collection problems

Percentage of Covered Workers with Higher Annual Deductibles (Single Coverage)



*Estimate is statistically different from estimate for the previous year shown. (p.<.05).
Note: These estimates include workers enrolled in HDHP/SO and other plan types. Because we do not collect information on the attributes of conventional plans, to be conservative, we assumed that workers in conventional plans do not have a deductible of $1000 or more. Because of the low enrollment in conventional plans, the impact of this assumption is minimal. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2012.

The BIG question…

Is there a solution for beleaguered providers *and* payers?

A population-health business model that produces…

$$\text{Patient Value} = \frac{\text{Quality}}{\text{Cost}}$$

What is Population Health?

Any provider arrangement with a payer in which you agree to provide care to a defined group of people (the population) in which you must do 3 things:

1. Improve the group's medical outcomes
2. Reduce the group's per-capita costs
3. Contractually capture the savings from the value you've created in 1 & 2

The good news & bad news about improved value

Higher quality generates lower per-capita patient costs...

… which, under FFS, can kill your hospital.

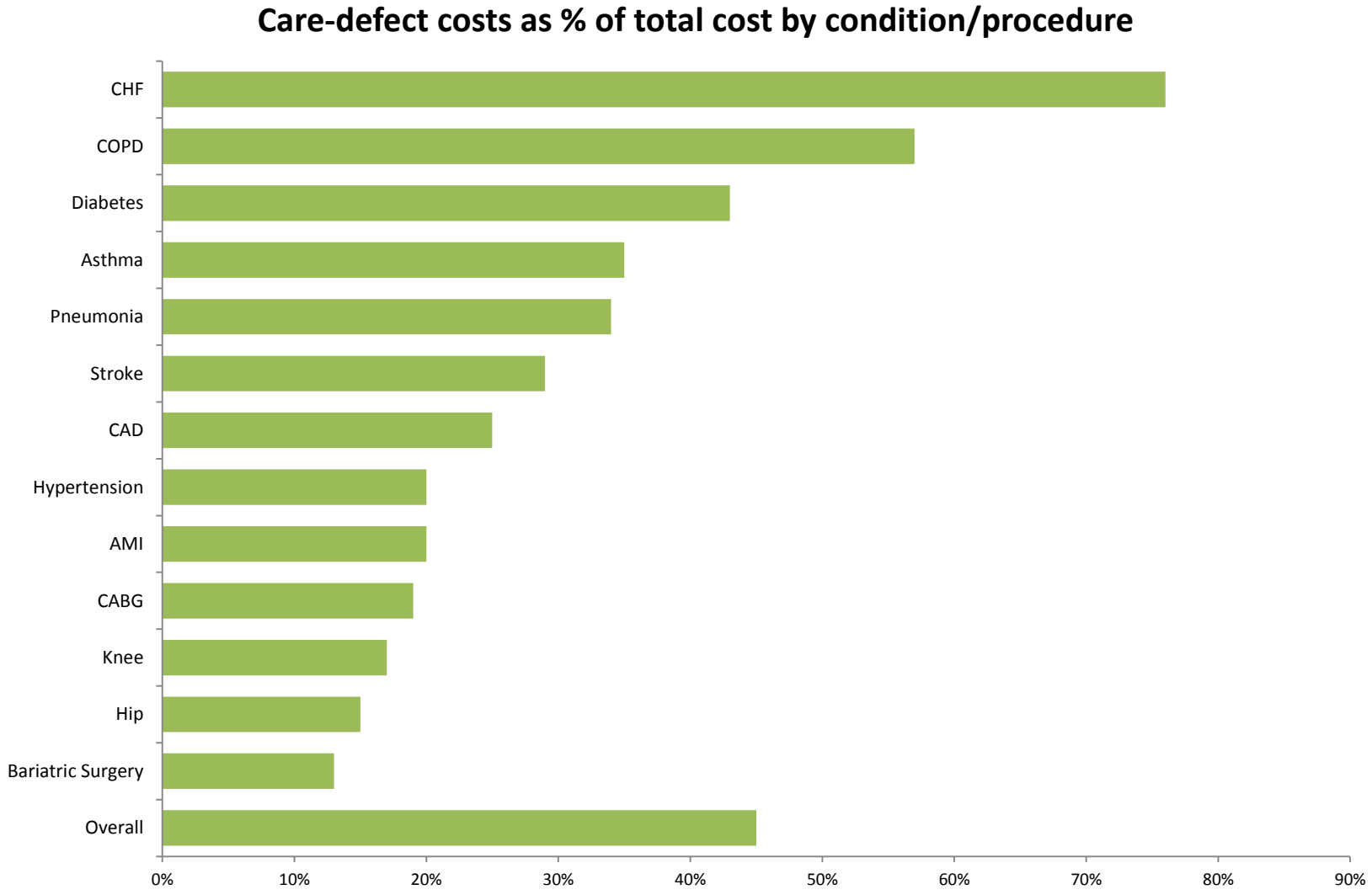
For example

A Duke University Hospital CHF disease management program cut total costs by 40 %, or $8,600 per patient…

…but because there were fewer complications and hospitalizations, the hospital actually lost money from reduced FFS revenues, and the project was discontinued.

"Specialty Hospitals, Ambulatory Surgery Centers, And General Hospitals: Charting A Wise Public Policy Course," by David Shactman; Health Affairs, 04/05

Massive Opportunities for Quality-Driven Cost-Reduction



Source: Health Care Incentives Improvement Institute, Inc.
Prometheus Payment 2009

Any focused attempt to provide better patient value requires a new revenue model…

1. …that—unlike with FFS—incentivizes & rewards providers for improving quality and reducing per-capita costs.

2. And if you want per-capita results , you need per-capita revenue models that allow you to capture the savings you generate. In other words, you need…

The C-Word

CAPITATION

The Key: Capitation without decapitation

Successful capitation revenue models require 4 things

1. Focused commitment on PCP care coordination, improved quality, and reduced per-capita cost—i.e., producing patient value

2. Capitation rate actuarial adequacy

3. PMPM cost measurement and management

4. Actuarially credible population size: THE central problem for individual rural & CAH population health revenue models

For example: Illinois

2010	
# CAHs	52
Avg. CAH PSA pop.	15,600*
Rural % total State	13%
Total rural pop.	1,679,801

Sources:
Melissa Henriksen & Norman Walzer at
http://www.cgsniu.org/portfolio/pdf/icahn-04.10.2012-interactive.pdf

* Based on SA sample of 25 CAH's

Crossing the shaky bridge to population health

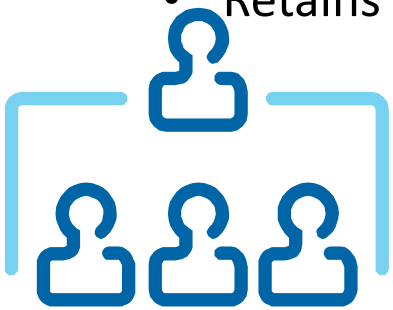
Volume-Driven Fee for Service

Value-Driven Population Payment System

2013 2014+ 20XX

Creating a Community Care Organization (CCO)

- CCO: A narrow rural/urban provider network focused on patient value
- Aggregates multiple rural/CAH populations for critical mass
- Restricted to payers willing to commit to population health *and payment*
  - On CCO's terms
  - NOT for existing fee-for-service or cost contracts
- CCO actively secures and manages risk/reward-based payer contracts
- CCO supports PCP-focused quality & care coordination across the network
- Legal entity with corporate powers
- Governance structure for setting strategy, policy, accountability
- Retains local hospital independence, but with contractual accountability



Getting there in 7 parallel phases:
2. Creating the CCO's population-health provider network

- Include only those providers willing to commit to medical quality improvement
  - Provider selection
  - Quality credentialing
  - Quality measurement
  - Quality reporting
  - Quality management
  - Provider pruning
- Make available only for population-based payer contracts, *NOT* FFS.
- Develop value-based participant compensation system to reward
  - Achieving quality standards
  - Cost effectiveness
- Develop capitation-management system
- Focus on PCP/PCMH as your new, highest level profit center.

Getting there in 7 parallel phases:
3. CCO's 4 rules for participating payers

1. Voluntary, positive patient attribution to your PCPs
2. Comprehensive, timely claims and demographic data sharing
3. Capitation-based payment
4. Collaborative relationship

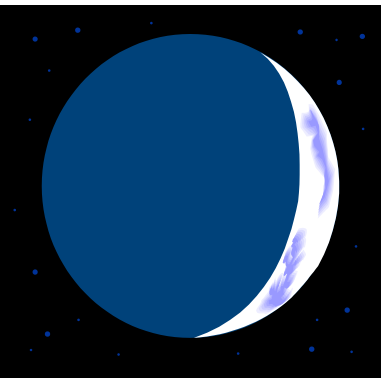
If you've got the numbers and a credible model, the payers will talk.

Getting there in 7 parallel phases
4. Prioritize markets & take the initiative

- Optimize (if necessary, create) jointly-funded employee health plan (ERISA, MEWA, etc.)
- Private health insurers
- Medicare Advantage and ACOs
- Medicaid managed care
- Self-funded employers
- Insurance exchanges

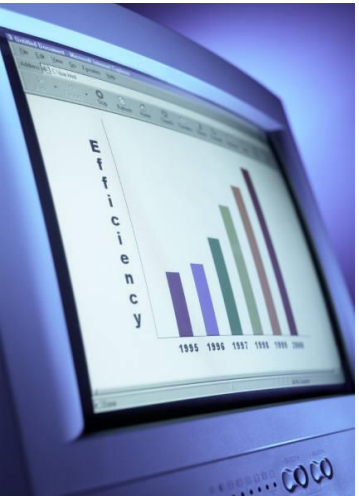
Getting there in 7 parallel phases:
5. Capitation implementation

- Phase in global capitation as actuarial confidence grows
  - FFS against capitation benchmark w/ shared savings
  - Partial capitation & sub-capitation options w/ shared savings
  - Global capitation as size, experience allows, targeting 85-90% of total premium
  - Reinsurance as risk-management tool
- Capitation management dashboard capability from Day 1



Getting there in 7 parallel phases:
6. Operational efficiency improvement

- Baseline requirement
- Fine-grained cost accounting
- Waste reduction
- LEAN
- Six Sigma
- CQI, etc.



Getting there in 7 parallel phases:
7. Adopt rapid learning curve

- Start where beating your personal best is sufficient (e.g., employee health plan and/or private insurers)
- Rapidly move up your learning curve
- "Borrow" good ideas (e.g., Adenoma Detection Rate vs Polypectomy Rate)
- Ask for help
- Use the 80/20 management rule

80/20 management

"What we have before us are some breathtaking opportunities disguised as insoluble problems."

- JOHN W. GARDNER

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