Population-based health care: can you get there from here?

by David Howe
SORH Contracted Rural Writer

Hospitals and insurance companies are acquiring other hospitals and insurance companies. Other hospitals are closing. Against that backdrop laid out for his Nebraska Rural Health Association Annual Conference audience, Eric Shell had cautionary advice in the form of a sports analogy: It’s not the time to be “looking at the scoreboard. Instead, play the game.”

Shell, Director of Stroudwater Associates, a health care consulting firm with extensive experience working with rural hospitals, said the shift from fee-for-service to value-based payments is already well underway, driven by health care reform’s value-based payment emphasis. Providers will have to compete on the basis of value, not volume, for health care consumers, he told the Kearney gathering. The old “‘Do more, make more’ isn’t there anymore,” Shell said.

In his presentation, Shell characterized the changing health care environment by noting that the health care field has experienced considerable changes in the past 24 months with “an increased number of rural-urban affiliations, physicians transitioning to hospital employment models, flattening volumes, and CEO turnovers.”

He sees the transition for rural providers beginning with aggressively pursuing operating efficiencies and patient safety and quality improvement. The next phase is aligning with a primary care network and, finally, a service network based on “population-based health care” (payment standards based on preventive care to reduce hospitalizations and avoid duplication of services and unneeded procedures for the population being served).

Many of the more sweeping changes under health care reform will be implemented in the next three years, Shell said. State Medicaid programs are moving toward managed care models or reduced fee-for-service payments to deal with budget deficits. And, “commercial insurers are steering patients to lower-cost options.”

The formation of accountable care organizations as an approach to delivering higher quality of care at less cost is growing, Shell said, citing these figures: As of August 2012, there were 154 ACOs. Effective January 2013, there were 259, a 68 percent increase.
He noted in his Power Point presentation that “more than half of the U.S. population now lives in localities served by ACOs and almost 30 percent live in areas served by two or more (APOs).” As of September, four million Medicare beneficiaries, or about 11 percent of total Medicare fee-for-service beneficiaries, will now receive their health care from ACOs. That’s up from 2.4 million, or 6 percent, compared with the previous September, he said, with 29 million Medicare and non-Medicare patients served by Medicare-approved ACOs.

Commercial insurance companies are getting into the act with ACOs, Shell continued. A number of insurance companies have announced accountable care agreements with health care organizations. Among companies entering into those agreements are Aetna, Cigna, and Blue Cross Blue Shield.

Small and rural providers are not without clout in how the transition to delivery systems that address their sustainability challenges will be designed, Shell noted. The revenue stream of the future, he explained, is tied to primary care physicians, with the primary care providers belonging to one ACO and hospitals and specialists belonging to several ACOs. “Smaller community hospitals and rural hospitals have value through alignment with revenue drivers (primary care physicians) rather than cost drivers, but must position themselves for the new market,” Shell related in his presentation.

The trick for rural providers is identifying at what point to cross over from fee for service to value-based payment, Shell acknowledged. He compared it to stepping onto a “shaky bridge” where a provider’s delivery system has to stay aligned with the current fee for service payment system up to that critical point when it begins to implement a health care delivery system ready to capitalize on a value-based payment system, once the latter payment system is adequately in place.

“We’re in a new world,” Shell told his Kearney audience. Market competition and innovation in health care delivery systems are changing rapidly right now. “We can’t ride this thing out.” It means planning for and taking actions now to respond to these rapidly changing conditions, he said.
No time to waste for rural providers

by David Howe
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Brace yourself for major changes!

The kick-off speaker at the Nebraska Rural Health Association’s Annual Conference in Kearney held in September had sobering points to make about fast-approaching changes in provider payment systems and what it will take to survive—maybe even thrive—under those changes.

Those points by healthcare consultant Guy Masters, author of more than 90 healthcare articles, underscore what he sees as rapidly approaching trends from a fee-for-service (FFS) payment system to “value-based reimbursement.”

His advice for rural healthcare providers: If you aren’t already doing so, begin now to prepare for that transition.

Masters, Senior Vice President of the Camden Group, a California-based healthcare consulting firm, sees the “tipping point” for that transition occurring when a hospital’s value-based reimbursement reaches 30 percent to 35 percent of its reimbursements.

He highlighted several trends for 2013 and beyond, including:
1. Physicians engaging/aligning with provider organizations such as hospitals, as opposed to setting up practices on their own.
2. Integration of clinics and redesign of care delivery.
3. “Smart growth” based on factors other than volume.
4. Consolidation, closures, alliances, and mergers of providers.

Masters told the audience that the following major changes are expected:

- One in 10 hospitals is at risk of closing. Pressure on accessing capital and reducing costs will lead to hospital closures, mergers, and consolidations.
- Ninety-five percent of primary care physicians will be aligned in some way with other providers, rather than operating their practices independently.
- Medicare reimbursement rates will become the payment standard.
- Inpatient admissions will decline by 25 percent.

Healthcare reform is in some degree encouraging these actions, Masters said.
The points he laid out for his Kearney audience suggest that the day of fee for service is rapidly nearing its end, with economic survival of hospitals and physicians lying in what he refers to as “population-based healthcare”—in other words, provider models structured to deliver care efficiently and profitably under a value-based payment system tied to characteristics of the population that comprise the provider’s market.

And how do you get there?

The path, as outlined by Masters, begins with preventive care and patient safety, followed by a progression of steps that include hospital-based physicians, reduced readmissions, bundled payment, patient-centered medical home, system-wide case management/restructuring, clinical integration, and ultimately an accountable care organization (ACO).

“Population health will be part of the future,” Masters said.

The impact of implementing patient-centered medical home intervention in a prospective valuation study that Masters cited in his presentation indicated the following outcomes:

- 36.3 percent drop in hospital days.
- 32.2 percent drop in emergency department use.
- 9.6 percent decline in total cost.
- 10.5 percent reduction of inpatient specialty care costs.
- 18.9 percent reduction in ancillary costs.
- 15 percent reduction of outpatient specialty costs.

Masters doesn’t see a standardized strategy for all rural healthcare providers to follow. Strategies will need to follow models based on populations and trends in the provider’s market, according to Masters. That includes such factors as age distribution; ratios of Medicare/Medicaid patients to the rest of the patient population; proportion of the population in a providers market that needs frequent, acute care; and total population size. In other words, your market in a rural area may not look like the market in another rural area. Hence, there is no universal prescription for rural healthcare providers, Masters explained.

And what about addressing patient non-compliance under population healthcare models? Responding to that question in a follow-up telephone interview to Masters’ Kearney presentation, Cleo Burtley, planning manager at the Camden Group, said public health agencies, social workers or some other support network coordinating with primary care providers would have a role to play in encouraging compliance. Incentives in the form of lower insurance premiums in exchange for a patient maintaining a healthy lifestyle (not using tobacco, for example) might also be part of the strategy, she said.
Addressing the Affordable Care Act’s provisions for health insurance exchanges, Masters told his Kearney audience that the exchanges will exert pressure on commercial insurance companies to lower their premiums, which will lead to lower commercial insurance payments to doctors and hospitals. Those payments by commercial insurance companies in many markets could come down to average Medicare levels in five to seven years, Masters noted.

Commercial insurance payments to doctors and hospitals that once made up Medicaid and Medicare shortfalls in covering expenses won’t fill the void, Masters noted.

Making up that shortfall will put pressure on reducing the cost per patient through such strategies as patient-centered medical homes, accountable care organizations, clinical integration, clinical care process design, and improvement in operations.

Primary care physicians will have to align themselves with ACOs, according to Masters. And ACOs will need to be able to control where their patients go for care. “Many of you will be part of an ACO,” he said. He foresees primary care physicians’ role devolving from “gatekeepers” to functioning as “navigators” to appropriate care for their patients, according to Masters. It’s part of what he sees as providing “the right care at the right place at the right time.”

He encouraged “. . . healthcare leaders to work with their boards, physician leadership, and community members to examine how changes in the industry, the economy, and local service areas will impact the healthcare delivery model financially and clinically.”

Sustainable healthcare will require more partnerships and cooperation at all levels, Masters emphasized.