The Race To Value-Based Payment

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The Change in Payment

- Starting line is fee-for-service (ffs), determined by allowable cost
- The slow lane is to modify incrementally with incentives
- Moderate lane supports elements of restructuring health finance but leaves in place current core (ffs)
- Fast lane blows past current design to a total redesign of payment, aligned with quality measures
The Vehicles: Knowledge and Tactics

• Understanding financial risk
• Knowing what influences health outcomes
• Managing care (patient)
• Managing health (population)
The Driver: Health Care Organization (Hospital) Leadership

- Generating resources and investing strategically
- Local leadership
- Facilitating coalitions
Track 1: The Slow Lane for Providers

- Incentives affecting small percentage of payment
- Payment change for only a small portion of patients
- Adjustments to limited number of services
- Retaining the FFS payment design
Track 2: A Moderate Pace with Potential for More Rapid Pace: ACO Model

- Fee-for-service chassis remains in place
- But payment tied to total expenditures
- With an element of quality measurement and accountability
- Accountable Care Organization: each term has meaning
Track 3 Fast Lane: Global Budgeting

• McCready Health in Crisfield MD, population 2,726 (service area approximately 7,000)*
  – Increased capital investments
  – Build new services
  – “The switch from volume payment to value payment is driving McCready to understand and improve the health status of its populations.”

• Pennsylvania Rural Health Model
  – All-payer, focused on rural hospitals
  – 5 hospitals launched January 2019
  – Inquiries from more than 20 states about process/program

*Sources: Joy A. Strand. “Global Budget in a Rural Hospital.” Presentation to the NRHA CAH Conference. September 22, 2016
Track 3: Fast Lane: Direct Contracting

- System-owned insurance plans
- Contract directly with large groups
- Develop products for exchanges
- Other: could be association plans
The Driver: Health Care Leadership

- Identifying resources and investing strategically
- Culture of organizational learning and improvement
- Engaging clinicians, patients, and caregivers
- Facilitating and/or supporting coalitions to address community needs
Building the Race Car: Engine is Finance

• Current finance: pro forma
• Operating in a shared savings environment
• Understanding cross-payer issues (helps tremendously to be an all-payer demonstration)
• Operating at full risk
• Crucial to keep it lubricated: in McCready biweekly meetings of CEO and CFO to make rate adjustments
The Wheels for the Car

- Community partnerships
- Maintains continuous progress toward community health objectives
- Maintaining tire pressure: spreading resources to meet health needs through the appropriate agency
The Body of the Car: Strategies and Tactics

• Care management for high risk patients
• Identifying pressure points driving expenditures and work to control (readmissions down in MD; “high flyers” in emergency rooms)
• Population health measures to achieve community health goals
Conclusion

• The tracks are still being defined, especially track 3
• The shift to track 3 is underway, but at different paces in different places and from different payers
• Lots of pieces already in place or available to build and drive the car
For further information

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

The RUPRI Health Panel
http://www.rupri.org

Rural Telehealth Research Center
http://ruraltelehealth.org/

The Rural Health Value Program
http://www.ruralhealthvalue.org
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Collaborations to Share and Spread Innovation

✓ 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 National Organization of State Offices of Rural Health
  https://nosorh.org/

✓ The American Hospital Association
  http://www.aha.org/