Reinventing Rural Healthcare

Ian Morrison PhD

www.ianmorrison.com
Outline

• Key Environmental Drivers
• The Quest for Value
• The Purchaser Perspective
  – Employers
  – Government
  – Consumers
• Delivery System Transformation
• What this all means for Rural Healthcare
Key Environmental Drivers

- **Health Reform**
  - Health reform (particularly ACOs and exchanges) creates increased demands on care delivery and changes in economics of all actors
  - Mandated coverage expansion under PPACA and the primary care surge in demand

- **Reimbursement Pressures and Reimbursement Reform**
  - Federal and state budgets (particularly Medicaid) under huge pressure politically and economically
  - Private payers resisting cost shifting through skinny networks and costs sharing
  - From payment for volume to payment for value, quality needs to be measured along the way
  - Rise of new payment models to promote coordinated, integrated care
  - All payers seeing payment tied to quality

- **Provider Consolidation**
  - Doctors and Hospitals are coming together in anticipation of coordinated accountable care across the country
  - Larger regionalized systems of care

- **High change environment involving multiple stakeholders**
Defining Value of Health Services

Value = \frac{(Access+Quality+Security)}{Cost}
Health Care Spending per Capita by Source of Funding, 2012
Adjusted for Differences in Cost of Living

Dollars ($US)

<table>
<thead>
<tr>
<th>Country</th>
<th>Out-of-pocket spending</th>
<th>Private spending</th>
<th>Public spending</th>
</tr>
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<tbody>
<tr>
<td>US</td>
<td>1,045</td>
<td>8,745</td>
<td>4,160</td>
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<tr>
<td>SWIZ</td>
<td>1,582</td>
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<td>4,001</td>
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<tr>
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<tr>
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<td>NZ*</td>
<td>347</td>
<td>3,172</td>
<td>2,623</td>
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* 2011.
Source: OECD Health Data 2014.
US Last in Overall Ranking of 11 Countries

EXHIBIT ES-1. OVERALL RANKING

<table>
<thead>
<tr>
<th>COUNTRY RANKINGS</th>
<th>AUS</th>
<th>CAN</th>
<th>FRA</th>
<th>GER</th>
<th>NETH</th>
<th>NZ</th>
<th>NOR</th>
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<th>SWIZ</th>
<th>UK</th>
<th>US</th>
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<tbody>
<tr>
<td>Top 2*</td>
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<table>
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<th>OVERALL RANKING (2013)</th>
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<th>SWIZ</th>
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<td>Quality Care</td>
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<td>5</td>
<td>7</td>
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<td>Effective Care</td>
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<td>Safe Care</td>
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<td>6</td>
<td>5</td>
<td>2</td>
<td>11</td>
<td>10</td>
<td>8</td>
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<td>3</td>
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<td>Coordinated Care</td>
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<td>10</td>
<td>2</td>
<td>6</td>
<td>7</td>
<td>9</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>7</td>
<td></td>
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<tr>
<td>Patient-Centered Care</td>
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<td>8</td>
<td>9</td>
<td>10</td>
<td>5</td>
<td>2</td>
<td>7</td>
<td>11</td>
<td>3</td>
<td>1</td>
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<tr>
<td>Access</td>
<td>8</td>
<td>9</td>
<td>11</td>
<td>2</td>
<td>4</td>
<td>7</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>1</td>
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<tr>
<td>Cost-Related Problem</td>
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<td>5</td>
<td>10</td>
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<td>3</td>
<td>1</td>
<td>7</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Timeliness of Care</td>
<td>6</td>
<td>11</td>
<td>10</td>
<td>4</td>
<td>2</td>
<td>7</td>
<td>8</td>
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<td>Efficiency</td>
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<td>9</td>
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<td>Equity</td>
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<td>4</td>
<td>8</td>
<td>10</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Healthy Lives</td>
<td>4</td>
<td>8</td>
<td>1</td>
<td>7</td>
<td>5</td>
<td>9</td>
<td>2</td>
<td>3</td>
<td>10</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Health Expenditures/Capita, 2011</td>
<td><strong>$3,800</strong></td>
<td><strong>$4,522</strong></td>
<td><strong>$4,118</strong></td>
<td><strong>$4,495</strong></td>
<td><strong>$5,099</strong></td>
<td><strong>$3,182</strong></td>
<td><strong>$5,669</strong></td>
<td><strong>$3,925</strong></td>
<td><strong>$5,643</strong></td>
<td><strong>$3,405</strong></td>
<td><strong>$8,508</strong></td>
</tr>
</tbody>
</table>

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.
U.S. Lags Other Countries: Mortality Amenable to Health Care

Deaths per 100,000 population*

* Countries’ age-standardized death rates before age 75; including ischemic heart disease, diabetes, stroke, and bacterial infections. Analysis of World Health Organization mortality files and CDC mortality data for U.S.

Exhibit 10. Mortality Amenable to Health Care

Deaths per 100,000 population

- 57–67 (12 states)
- 71–81 (13 states)
- 82–95 (14 states)
- 97–136 (11 states + D.C.)

THE POLICY CONTEXT
Obama Care: The Original Simple Version

- Coverage Expansion to 30 million people by 2015 on
  - 15 million through Medicaid Expansion
  - 15 million through subsidized health insurance exchanges
- Regulation of health insurance practices
  - Guaranteed issuance
  - Individual Mandate
- Paid for by supplementary Medicare Tax on $250K+ earners and “voluntary” taxes on healthcare stakeholders
- Promising pilots and processes for reimbursement reform
  - Patient Centered Medical Homes
  - Accountable Care Organizations
  - Innovation Center at CMS
- The Cadillac Tax
The Not-So-United States Of Obamacare

Polls show the Affordable Care Act is covering previously uninsured people across the country. But the effect varies widely from state to state. According to a new Gallup survey, states that embraced Obamacare have seen bigger decreases in their uninsured rates than those that resisted the law.

Change in uninsured, 2013 to midyear 2014 (percentage points)

-8.1 to -10.1%  -6.1 to -8%  -4.1 to -6%  -2.1 to -4%  -0.1 to -2%  0%  +0.1 to +2%  +2.1% & more

Source: Gallup

THE HUFFINGTON POST
NOTES: *AR and IA have approved waivers for Medicaid expansion; MI has an approved waiver for expansion and plans to implement in Apr. 2014. NH passed legislation approving the Medicaid expansion in March 2014; the expansion will start July 1, 2014. WI amended its Medicaid state plan and existing waiver to cover adults up to 100% FPL, but did not adopt the expansion. IN and PA have pending waivers for alternative Medicaid expansions. These states along with MO, VA, UT have been classified as Open Debate on the Medicaid expansion decision.

Fewer Uninsured

Fewer report difficulties paying for care

Fewer delayed care
What Might a Congress Controlled by GOP do via Reconciliation?

- Repeal the Medical Device Tax
- Repeal the Health Insurance Tax
- Repeal the Individual Mandate*
- Repeal the Employer Mandate*
- Alter definition of Full-Time Worker: 40 Hours
- Eliminate IPAB (automatic reductions to Medicare provider payments)
- Eliminate PCORI
- Repeal the 3 R’s (Risk Corridors, Reinsurance, Risk Adjustment)*
- Introduce Copper Level Plans

BIGGER ISSUES:
- Will subsidies be rolled back for exchange and Medicaid expansion?

* Strongly opposed by Managed Care Plans
Rumors

How Many Americans Could Lose Subsidies in 2016?

If the Supreme Court sides with the plaintiffs in King v. Burwell, millions could lose federal aid for insurance premiums.

- Pennsylvania: 736,178
- Georgia: 284,381
- North Carolina: 926,023
- Texas: 1,750,688
- Florida: 2,545,469
- 32 other states: 6,660,150
- Total = 13.4 million

Source: Kaiser Family Foundation estimates based on projected national totals from the Congressional Budget Office.
Private Purchasers will Act by 2020

• **Short Term (1-3 years)**
  – Transparency on Cost and Quality
  – CDHP/HDHP
  – Benefit Buy Downs (including retirees and spouses)
  – Reference Pricing
  – Private Exchanges
  – Narrow Networks
  – Out of Network Prices

• **Longer Term (3-10 Years)**
  – Stay or Go
  – Defined Benefit to Defined Contribution
  – Activist Engagement
  – Cadillac Tax 2018
Two Competing Visions

Berwickian Nirvana of large Accountable Care Organizations encourages rationalization of the delivery system

Atomistic view of consumers armed only with High Deductible health plans will impose market discipline on providers

Private Purchasers reassessing their role

- **Redefinition of benefits:** Buy-downs (CDHP) and elimination or scaling back of commitment to spouses, dependents, retirees and early retirees, part timers etc
- Consideration of the role of *Exchanges and possible ‘exit’* from employer-sponsored benefits
- Growing interest in **direct contracting** with providers and ‘accountable’ systems
- Pushing greater responsibility onto employees to encourage them to **shop based on cost, quality** (movement toward defined contribution strategy, more limited plan offering, consumer shopping tools).
- **More activist wellness** including biometric screening

Source: Personal Communication, PBGH, 2013
Signs of an exit?

More Employers are actively exploring ways to avoid providing health insurance to their employees

Employer Agreement with Key Benefit Sentiments

- My company is actively exploring ways to get out of providing health insurance to our employees
  - 2014: 26%
  - 2013: 45%
  - 2012: 45%
  - 2011: 21%
  - 2010: 18%

- My company feels it is worth it to pay the penalty associated with not providing employee health benefits rather than providing health benefits to our employees.*
  - 2014: 58%
  - 2013: 59%
  - 2012: 44%
  - 2011: 21%
  - 2010: 18%

Base: All Employer Health Benefit Decision Makers (n=313) * Asked only of Employers with 50 or more employees
Q800: Please indicate your level of agreement with the following statements. Do you strongly agree, somewhat agree, somewhat disagree or strongly disagree?
Employers likely to move away from defined benefits
Retirees more likely candidates, but Active employees not far behind

**Employer Likelihood to Move from Defined Benefit to Defined Contribution**
*(Extremely/Very Likely)*

<table>
<thead>
<tr>
<th>Year</th>
<th>For Active Employees</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>7%</td>
<td>32%</td>
<td>41%</td>
<td>45%</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>For Retired Employees</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>10%</td>
<td>42%</td>
<td>47%</td>
<td>52%</td>
</tr>
</tbody>
</table>

Base: All Employers who currently offer a defined benefit plan to active or retired employees (n=244 active; n=168 retired)

Q1055: How likely are you to move from defined benefit plans to defined contribution plans for each of the following?
Confidence in health insurance exchanges grows among employers

Over a third currently express a high level of confidence in public and private exchanges as viable alternatives to employer-sponsored coverage.

Employer Confidence in Public/Private HIXs as a Viable Alternative

<table>
<thead>
<tr>
<th></th>
<th>Public Exchange</th>
<th>Private Exchange</th>
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</thead>
<tbody>
<tr>
<td>2012 (B)</td>
<td>7%</td>
<td>10%</td>
</tr>
<tr>
<td>2013 (A)</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>Not sure</td>
<td>16% A</td>
<td>25%</td>
</tr>
<tr>
<td>Not at all</td>
<td>37%</td>
<td>22%</td>
</tr>
<tr>
<td>Not very</td>
<td>26%</td>
<td>37%</td>
</tr>
<tr>
<td>Somewhat</td>
<td>21%</td>
<td>18%</td>
</tr>
<tr>
<td>Very confident</td>
<td>11%</td>
<td>8%</td>
</tr>
<tr>
<td>Extremely</td>
<td>9%</td>
<td>9%</td>
</tr>
</tbody>
</table>

Base: All Employer Health Benefit Decision Makers (n=303)

Q1400: How confident are you that public Health Insurance Exchanges will ultimately be a viable alternative to employer-sponsored healthcare coverage?
Q1405: And how confident are you that private Health Insurance Exchanges will ultimately be a viable alternative to employer-sponsored healthcare coverage?
Seven Large Employer Archetypes

How do these archetypes view their benefit responsibilities?

**GE:**
- Large Diversified company with unions and high wage base.
- Very sophisticated Purchaser using consumerism and DB to DC for retirees to reduce benefit burden.
- Spread across a dozen or more regional markets

**Disney:**
- Bifurcated workforce: Theme Park workers and Johnny Depp
- Geographic Concentration in Orange County California and Orange County Florida
- Consumerism strategy and engagement with local delivery systems

**Wal-Mart:**
- National retailer with 2 million plus associates
- Centers of Excellence Model for high cost cases
- Eliminating coverage for part-timers and encouraging them to use exchanges

**Walgreen’s:**
- Large pharmacy/retail chain
- Private Exchange model outsourced to AON/Hewitt
- 142,000 signed up
- Insured product model
- Choice causes buy-down
- 80% picked silver or bronze

**Intel:**
- Geographic concentration of fabrication plants and facilities: OR, NM, and CA
- Healthcare treated just like any supplier: tough performance requirements
- Going direct e.g. Presbyterian in New Mexico, onsite clinics

**Silicon Valley Employer Network:**
- War for talent
- Average age 12
- Want the primary care on campus and telehealth for everything else

**CALPERS:**
- Large public purchaser system
- Unionized workers
- Pioneered reference pricing as shot across the bow of providers
- In the retiree health benefits business big time
- Wants high performing HMO product
Public Purchasers

- **Medicare Advantage** is surprisingly resilient
- **Medicaid** expansion is massive in half the country
- **Public exchanges** will grow after a rocky start
- **Public employers** have huge retiree health benefit problems
- **Public payers** more dominant by 2020
Medicare Advantage Enrollment is Highly Variable Across the Country (0% to 49%); Mostly in HMOs

Share of Medicare Beneficiaries Enrolled in Medicare Advantage Plans, by State, 2013

National Average, 2013 = 28%

Distribution of Enrollment in Medicare Advantage Plans, by Plan Type, 2013

Total Medicare Advantage Enrollment, 2013 = 14.4 Million

NOTE: FFS is Private Fee-for-Service plans, PPOs are preferred provider organizations, and HMOs are Health Maintenance Organizations. Other includes MSAs, cost plans, and demonstration plans. Includes enrollees in Special Needs Plans as well as other Medicare Advantage plans.

(When you retire,) If you had a choice, would you prefer to get your Medicare health insurance benefits from...

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>18-29</th>
<th>30-49</th>
<th>50-64</th>
<th>65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>The current government Medicare program</td>
<td>34%</td>
<td>26%</td>
<td>28%</td>
<td>33%</td>
<td>57%</td>
</tr>
<tr>
<td>A private health plan, such as a PPO or HMO offered through Medicare</td>
<td>56%</td>
<td>65%</td>
<td>63%</td>
<td>57%</td>
<td>29%</td>
</tr>
<tr>
<td>Don’t know/refused</td>
<td>10%</td>
<td>7%</td>
<td>8%</td>
<td>9%</td>
<td>13%</td>
</tr>
</tbody>
</table>
Obamacare: 2014 Results

• Total exchange enrollment: **8.0 million**
• 90% are eligible for financial assistance
• 85% picked Silver (65%) or Bronze (20%)
• 80-90% have paid their premium
• Some number were **previously insured** (McKinsey survey found only 27% were previously uninsured, KFF survey found 57% were previously uninsured, CF Survey 63%)
• 28% of enrollees are 18-34
• **At least 10 million newly covered** by all sources

Source: DHHS, Covered California 2014, NEJM 7/12/14
How to Pick a Health Plan on an Exchange

• Step 1. Decide on the diseases you and your family are going to have in the coming year
• Step 2. Find the best doctors and hospitals for those diseases
• Step 3. Identify which plans offer those doctors and hospitals
• Step 4. Select the cheapest plan
• Step 5. If there are no affordable plans with all the doctors and hospitals you want, go back to Step 1 and pick some new diseases
Medicaid

- Medicaid expansion is a big deal in the states that are doing it...e.g. California Medi-Cal will have 10.5 million enrollees and a budget of $89 Billion for 2014-15 FY most from Federal sources
- Oregon Medicaid enrollment now over 900,000 a 43.7 % increase YOY according to DHHS
- The last mile of enrollment
- Churning in Medicaid eligibles
- Who will take these enrollees and what will be the financial impact on providers that do take them?
THE AMERICAN HEALTHCARE CONSUMER
Average Annual Premiums for Single and Family Coverage, 1999-2014

* Estimate is statistically different from estimate for the previous year shown (p<.05).

CONSUMERS CONSISTENTLY VALUE LOWER PREMIUMS, WANT TO KEEP CURRENT DOCTOR

Virtually no difference over prior year in benefit tradeoffs

**Relative Importance of Benefit, Under Age 65**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>2014 Rank</th>
<th>3 yr Trend</th>
<th>2013 Rank</th>
<th>2012 Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low monthly premiums</td>
<td>1</td>
<td>--</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Keeping my current doctor(s)</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Unrestricted access to all medical technologies</td>
<td>3</td>
<td>--</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Low copay costs for generic drugs</td>
<td>4</td>
<td>--</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Coverage for dependents</td>
<td>5</td>
<td>▲</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Direct access to all specialist(s)</td>
<td>6</td>
<td>--</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Direct access to leading specialist(s) in my area</td>
<td>7</td>
<td>▼</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Reasonable copays for brand name drugs</td>
<td>8</td>
<td>--</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Unrestricted access to cutting edge medical devices</td>
<td>9</td>
<td>--</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Choice of hospitals</td>
<td>10</td>
<td>▲</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>Unrestricted access to cutting edge drugs</td>
<td>11</td>
<td>▼</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>Access to all brand name drugs at low cost-sharing</td>
<td>12</td>
<td>▼</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>Coverage for a wide selection of brand name drugs</td>
<td>13</td>
<td>--</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>Access to prestigious institutions</td>
<td>14</td>
<td>--</td>
<td>14</td>
<td>14</td>
</tr>
</tbody>
</table>

Base: All US Adults Less Than 65 (2010 n=2501, 2012 n=2052, 2013 n=1546), 2014 n=1233 in half sample

Respondents were given a maximum difference trade off exercise in which they were forced to choose the most preferred and least preferred plan feature.
The American Healthcare Consumer

• Reluctantly Empowered
• Cranky and Confused
• Subject to Gotchas after the event...from health plans, provider billing departments....and even the Supreme Court
• Finding their own way: picking silver plans and utilizing retail clinics
• Bring all the expectations from their life as consumers of Amazon, Apple, OpenTable, Netflix etc
• Reference Pricing, Value Based Benefit Design, narrow networks may offer some promise
• But....still need better information tools and consumers lack literacy
• Basically the problem is affordability
• When you become a patient....that’s when things change
• “It’s tough to be cost conscious, when your unconscious”
Ahead of the Curve on Value-Based Payment

• “The future is already here…it is just not evenly distributed” – William Gibson

• California has 55.4% in value-based payment (in all in-network commercial based payment) up from for 41.8% in 2013

• US has leapt up to 40% in 2014 up from 10.9% in 2013 according to CPR exceeding CPR’s 2020 goal of 20%

Source: Catalyst for Payment Reform, 2014
Health Systems Taking Risk

Lots of big systems showing interest patient flow through these models is not large except for legacy players

Referral management (preventing leakage from the IDN) can provide FFS fuel for transformation to risk

“Eat your own cooking” is a common starting point

Link to ACO strategy

Link to going direct to employers or exchanges e.g. North Shore Long Island Jewish

Link to Population Health Interest and Clinical Integration Organization strategy
Health Systems Taking Risk

• Health Systems with Legacy Health Plans
  – Inter-Mountain, Sharp, Presbyterian, Spectrum Health, Providence

• Health Systems that recently built, acquired or merged with a Health Plan function
  – Partners (Boston), Sutter, Dignity Health (Western Healthcare Advantage), Memorial (Long Beach), Baylor Scott and White, North Shore Long Island Jewish, Ascension (in discussions), CHI

• Health Systems that are going deep on Commercial ACO plans and/or CMS ACOs with plan partners
  – Montefiore, Steward, Aetna Whole Health (Inova, Banner, Aurora),
  – Vivity (UCLA, Cedars, Memorial, Cedars et al)

• Health Systems “Go Your Own Way”
  – Evolent Health (UPMC and Advisory Board Offering) includes Piedmont/Wellstar, Medstar
Larger hospitals anticipate faster move to capitation

Anticipated Growth in Capitation/Value

<table>
<thead>
<tr>
<th>Completely Fee for Service</th>
<th>Evenly Split</th>
<th>Completely Capitated Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>(0)</td>
<td>(50)</td>
<td>(100)</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>IN 5 YRS</strong></td>
<td><strong>TODAY:</strong></td>
</tr>
<tr>
<td>&lt;100 Beds</td>
<td>TODAY: 16</td>
<td>IN 5 YRS 44</td>
</tr>
<tr>
<td>100-299 Beds</td>
<td>TODAY: 34</td>
<td>IN 5 YRS 55</td>
</tr>
<tr>
<td>300-499 Beds</td>
<td>TODAY: 37</td>
<td>IN 5 YRS 52</td>
</tr>
<tr>
<td>&gt;500 Beds</td>
<td>TODAY: 41</td>
<td>IN 5 YRS 59</td>
</tr>
</tbody>
</table>

Base: All Hospital-Based Execs (2014: n=202; 2013 n=210)

Q705/Q706/Q707: Many hospitals are starting to be paid differently for their services, moving from a fee for service environment to more capitation or value based payments. Where is your hospital/hospital system on the spectrum today, and where will you be five years from now?
Physicians anticipate FFS will DECREASE

Anticipated Growth in Capitation/Value

CURRENT:
- Completely Fee for Service (0)
- Evenly Split (50)
- Completely Capitated Payments (100)

2014: 28

FIVE YEARS FROM NOW:
- Completely Fee for Service (0)
- Evenly Split (50)
- Completely Capitated Payments (100)

2014: 72

In 5 Years
- Solo 72
- Group, Affiliated 65
- Group Unaffiliated 74

*New in 2014
Base: All 2014 Physicians (n=600)
Q1280: Many physician practices are starting to be paid differently for their services, moving from a fee for service to more capitation or value based payments. Where is your practice on the spectrum today, and where will you be in five years from now?
At the end of the day, people trust hospitals

% Trust in Industries

- Hospitals: 40% in 2013
- Supermarkets: 30% in 2013
- Online Search Engines: 28% in 2013
- Banks: 27% in 2013
- Computer Hardware Companies: 27% in 2013
- Online Retailers: 23% in 2013
- Electric and Gas Utilities: 22% in 2013
- Computer Software Companies: 22% in 2013
- Packaged Food Companies: 23% in 2013
- Airlines: 20% in 2013
- Car Manufacturers: 14% in 2013
- Life Insurance Companies: 14% in 2013
- Pharmaceutical and Drug Companies: 13% in 2013
- Health Insurance Companies: 13% in 2013
- Telecommunications Companies: 12% in 2013
- Managed Care Companies, such as HMOs: 7% in 2013
- Social Media Companies: 6% in 2013
- Oil Companies: 6% in 2013
- Tobacco Companies: 3% in 2013

Source: Harris Poll, December 2013
NEW THINKING: SOME EXAMPLES

Montefiore
- An AMC on the way to being an at-risk integrated system of care

Centura/Colorado Health Neighborhoods
- 2,200 Physicians at various places on the journey
- System steps to Integration and “Leakage management”

Vivity
- Health systems in LA including UCLA Health, Cedars and Memorial Care come together with Anthem to develop an HMO product to compete with Kaiser

Stanford Health Care Alliance
- Going head to head with KP for Stanford employees, what’s next?
  - Medicare Advantage, Employer Specific Narrow Network
MANAGING REFERRALS: A KEY BATTLEGROUN
Preventing Leakage can provide FFS fuel to move to Risk

Current Approach to Referral Management from Physicians Affiliated with Hospital

<table>
<thead>
<tr>
<th>Approach</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>We have already made significant investments in an organized referral</td>
<td>18%</td>
</tr>
<tr>
<td>management system and are actively keeping more referrals within our</td>
<td></td>
</tr>
<tr>
<td>employed physician network</td>
<td></td>
</tr>
<tr>
<td>We have identified that modifying referral patterns of our medical staff</td>
<td>45%</td>
</tr>
<tr>
<td>is a critical success factor in our clinical integration strategy and we</td>
<td></td>
</tr>
<tr>
<td>are planning to actively manage referrals in the future using an organized</td>
<td></td>
</tr>
<tr>
<td>approach to keep more referrals within our facilities/medical groups</td>
<td></td>
</tr>
<tr>
<td>We recognize that there is considerable inpatient and outpatient volume</td>
<td>24%</td>
</tr>
<tr>
<td>that &quot;leaks&quot; to our competitors because our medical staff does not refer</td>
<td></td>
</tr>
<tr>
<td>exclusively to our facilities, but we have no immediate plans to influence</td>
<td></td>
</tr>
<tr>
<td>those referrals beyond offering privileges</td>
<td></td>
</tr>
<tr>
<td>We do not actively manage referral patterns of the physicians who admit</td>
<td>10%</td>
</tr>
<tr>
<td>to our facilities and have no plans to do so beyond offering hospital</td>
<td></td>
</tr>
<tr>
<td>privileges</td>
<td></td>
</tr>
<tr>
<td>Not sure/not applicable</td>
<td>7%</td>
</tr>
</tbody>
</table>

*New in 2014*

*Base: All 2014 Hospital-Based Execs (n=202)*

Q417: Which of the following best describes your approach to the management of the referrals from physicians affiliated with your hospital?
The Work

• Centrality of Clinical Integration
• Health IT as platform not panacea
• Learning to live on Medicare
• Managing Business Model Migration
• Building a culture of Quality and Accountability
  – “We have the anatomy of an Accountable Care Organization but none of the physiology”
Change is clearly a top-down initiative

<table>
<thead>
<tr>
<th>Role</th>
<th>Not in agreement</th>
<th>Somewhat in agreement</th>
<th>Very much in agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your CFO</td>
<td>4%</td>
<td>19%</td>
<td>77%</td>
</tr>
<tr>
<td>Your CEO</td>
<td>4%</td>
<td>22%</td>
<td>74%</td>
</tr>
<tr>
<td>Your board</td>
<td>3%</td>
<td>33%</td>
<td>64%</td>
</tr>
<tr>
<td>Other senior management</td>
<td>4%</td>
<td>36%</td>
<td>60%</td>
</tr>
<tr>
<td>*Physicians on your staff</td>
<td>17%</td>
<td>62%</td>
<td>21%</td>
</tr>
<tr>
<td>Specialists who do a lot of procedures in hospital</td>
<td>26%</td>
<td>57%</td>
<td>17%</td>
</tr>
<tr>
<td>Nurses</td>
<td>27%</td>
<td>57%</td>
<td>15%</td>
</tr>
<tr>
<td>Other medical staff</td>
<td>18%</td>
<td>68%</td>
<td>14%</td>
</tr>
</tbody>
</table>

*Large Hospitals are more likely to report that staff physicians are Very Much in agreement about changes

Greatest financial challenge for hospital*

- Neither, 2%
- Revenue, 17%
- Margin, 27%
- Both, 53%

SOURCE: Strategic Health Perspectives 2012 Hospital Exec Surveys

© Harris Interactive
Massively Coordinated Care

• The 5/50 Problem
  – 5% account for 50% of spending
  – 1% account for 20%
  – Bottom 50% account for about 2%

• Big Data meets Mobile Apps

• New Thinking
  – Care More
  – Hot Spots
  – The Assistant City Manager

• Meet patients and populations in their lives
  – More like social work than medicine
The Truck and the Refrigerator
Triple Aim

Better Health

Better Health Care

Lower Per Capita Costs
Triple Aim

Better Health

Information
Incentives
Integration
Integrity

Better Health Care

Lower Per Capita Costs
Rural Health Challenges

- Rural economy has few large employers
- Dominated by public coverage
- Higher health needs: sicker, older and more chronic conditions
- Difficulty attracting providers especially specialists, mental health providers and emergency responders
- Sub-optimal in scale both clinically and financially
- Quality of care differentials
- Aging plant and equipment
- Access to Capital
- Implementing Health Information Technology
- Measuring Quality with small numbers
- A cost based system in a value based world
- Can’t be: “Send Checks and leave us alone”
US Rural Populations have Lower Income

Figure 1
Rural and metropolitan families have differences in family income

**Family Income as % of FPL for Nonelderly Individuals**

**Rural**
- <100% FPL: 25%
- 100-400% FPL: 50%
- 400%+ FPL: 25%

**Metropolitan**
- <100% FPL: 21%
- 100-400% FPL: 43%
- 400%+ FPL: 36%

**NOTE:** Undocumented Immigrants are excluded from income analysis. In 2012 the federal poverty level was $19,790 for a family of three.
US Rural Non-Elderly more Dependent on Public Coverage

Figure 2
Rural residents were more likely to have public coverage and less likely to have ESI than metropolitan residents

Rural
- Uninsured: 18%
- Medicaid: 21%
- Employer: 51%*
- Other Public: 4%
- Other Private: 6%

Metropolitan
- Uninsured: 18%
- Medicaid: 16%
- Employer: 57%
- Other Public: 3%
- Other Private: 6%

40.4 million nonelderly Non-MSA residents
226.3 million nonelderly MSA residents

*the difference between rural and metropolitan groups is significant at the 0.05 level for this coverage category
US Rural Population are Disproportionately in Non-Expansion States

Figure 3
Uninsured individuals in rural areas are disproportionately likely to live in states that are not expanding Medicaid

- Total: 47.3 Million Uninsured
  - 52% living in Non-Expansion States
  - 48% living in States that are Expanding Medicaid

- Rural: 7.3 Million Uninsured
  - 65% living in Non-Expansion States
  - 35% living in States that are Expanding Medicaid

- Metro: 40.0 Million Uninsured
  - 50% living in Non-Expansion States
  - 50% living in States that are Expanding Medicaid


NOTE: “States expanding Medicaid” includes the 25 states and the District of Columbia expanding Medicaid as of March 1. “States not Expanding” includes 25 states that are not expanding as of March 1, some of which may be considering expansion in the future.
US Rural Population more Likely to be in the Coverage Gap

Figure 4
Uninsured rural residents are more likely than metropolitan residents to fall into the “coverage gap”
Coverage eligibility levels among nonelderly uninsured residents

Rural
- Ineligible Immigrant: 6%
- In The Coverage Gap: 15%
- Medicaid Eligible Adult: 18%
- Medicaid Eligible Child: 11%
- Above Subsidy-level Income: 13%
- Eligible for Tax Credits: 37%

Metropolitan
- Ineligible Immigrant: 9%
- In The Coverage Gap: 19%
- Medicaid Eligible Adult: 14%
- Medicaid Eligible Child: 11%
- Above Subsidy-level Income: 15%
- Eligible for Tax Credits: 32%

7.4 million uninsured Non-MSA residents
40.2 million uninsured MSA residents

SOURCE: Kaiser Family Foundation analysis based on 2014 Medicaid eligibility levels and 2012-2013 Current Population Survey. See Methods for more details. Tax credit eligibility does not account for offers of ESI.
Low Income Residents in Non-Expansion States strongly favor Medicaid Expansion

<table>
<thead>
<tr>
<th>Survey Respondents’ Awareness Of And Attitudes Toward Affordable Care Act (ACA) Coverage Expansion, November And December 2013</th>
<th>Arkansas</th>
<th>Kentucky</th>
<th>Texas</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Favor Medicaid expansion</td>
<td>83%</td>
<td>83%</td>
<td>79%</td>
<td>0.21</td>
</tr>
<tr>
<td>Heard or read that state will offer new Medicaid expansion in 2014</td>
<td>35</td>
<td>33</td>
<td>31</td>
<td>0.49</td>
</tr>
<tr>
<td>Heard or read that state will offer new financial assistance to purchase private health insurance in 2014</td>
<td>25</td>
<td>33</td>
<td>31</td>
<td>0.03</td>
</tr>
<tr>
<td>Believe that you’d be subject to a fine if you do not have health insurance in 2014</td>
<td>62</td>
<td>61</td>
<td>49</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

**Source** Authors’ analysis of survey data of 2,864 low-income adults (ages 19–64) in Texas, Arkansas, and Kentucky. **Note** p values are for significance in differences across states.
## US Critical Access Hospitals
### Financial Indicators Report, 2011

#### Selected Financial Indicators

<table>
<thead>
<tr>
<th>Metric</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating Margin</td>
<td>0.68%</td>
</tr>
<tr>
<td>Days Cash on Hand</td>
<td>69.15</td>
</tr>
<tr>
<td>Outpatient Revenues/ Total Revenues</td>
<td>73.09%</td>
</tr>
<tr>
<td>Medicare Inpatient Payer Mix</td>
<td>73.25%</td>
</tr>
<tr>
<td>Medicare Outpatient Payer Mix</td>
<td>37.40%</td>
</tr>
<tr>
<td>Average Age of Plant (Years)</td>
<td>10.00</td>
</tr>
<tr>
<td>FTEs per Adjusted Occupied Bed</td>
<td>5.78</td>
</tr>
<tr>
<td>Average Daily Census Swing-SNF Beds</td>
<td>1.60</td>
</tr>
<tr>
<td>Average Daily Census Acute Care Beds</td>
<td>3.74</td>
</tr>
</tbody>
</table>
Rural Health Landscape

- Rural population is 20% (but 12% is adjacent to urban areas and only 2% of population in remote rural areas)
- Rural hospitals are one third of total but only 12% of national hospital spending
- Critical Access Hospitals key policy
  - Less than 96 hour stay
  - 25 Beds or less
  - 35 miles from another hospital (15 miles in some cases)
Reinventing Rural Health

• Regional Integrated Systems
  – Avera, Mayo, Trinity
• High-Tech Rural Ambulatory Centers
  – Kaiser Hub as example
• Rural community-based continuum of care centers for the chronically ill
• Referral Platforms
Rural Reinvention: Some US Examples

• Regional Quality Improvement Initiatives: e.g. Michigan, Iowa, Mississippi
• Coordinated Care Organizations (CCOs): e.g. Oregon
• Rural IT Initiatives: e.g. Othello Community Hospital in Washington State
• Workforce Training: e.g. WWAMI in Pacific Northwest based out of University of Washington, or University of Kansas establishing rural branch
• Community Health Integration: e.g. Frontier Health in Montana or Rural Health Integration Project in Wisconsin

Source: AHA Trendwatch 2011
Reinvention Principles

- Imaginative use of contemporary information and communications technology
- Regionalized quality improvement initiatives
- Payment Reform (toward fixed global budgets/capitation with performance indicators and away from cost plus or FFS)
- Rationalized deployment of clinical technology and human resources
- New Partners
- New Thinking
Figure 1 - Core Health Hub Services with Contracted Health Services and Community Partnerships

Primary Care
- Multi-disciplinary Care Team
- Chronic Disease Management
- Health Promotion and Preservation

Emergency, Inpatient and Ambulatory Care including
- Complex Continuing Care beds
- Rehabilitation services
- Outpatient Clinics
- 24/7 Emergency Room or Urgent Care

Mental Health and Addictions
- Access Specialty Beds
- Community Support Services

Home and Community Long-Term Care (LTC)
- LTC Facility Beds
- Assisted Living
- Community Support Services
- Professional Homecare Services

Contracted Health Services
- Public Health
- Ambulance Service

Community Partnerships
- Social Services
- Recreation
- Education
Ontario Examples on the Right Path

• Governance
  – Steering Committees e.g. Dryden Regional Health Center
  – Collaboratives e.g. Winchester Health

• Partnerships
  – Community e.g. Deep River
  – Care Partners e.g. Arnprior Regional Health, St Francis

• Integration
  – Continuum of Care e.g. Hopital de Mattawa
  – Focus on Palliative Care and Chronic disease management e.g. Campbellford
  – Integration under one administration e.g. Espanola

• Leverage Technology and Telehealth
  – e.g. Weeneebayko Area Health, Wilson Memorial and Marathon
Triple Aim

Better Health

Better Health Care Lower Per Capita Costs
Triple Aim

Better Health

Information
Incentives
Integration
Integrity

Big Data
Data Analytics and Predictive Modeling
Social/Community Support
Transportation/Housing
Priority Setting
“The Mediterranean Diet”

Transparency
CQI/Lean
Shared Decision-Making
Standardization
Clinical Guidelines and CarePaths
Patient Experience

Delivery Redesign
Scope of Practice
Lowest Cost Site of Care
Telehealth
Digital Substitution
Self-Care
Palliative Care

Better Health Care

Lower Per Capita Costs
Massively Coordinated Care

• The 5/50 Problem
  – 5% account for 50% of spending
  – 1% account for 20%
  – Bottom 50% account for about 2%
• Big Data meets Mobile Apps
• New Thinking
  – Care More
  – Hot Spots
  – The Assistant City Manager
• Meet patients and populations in their lives
  – More like social work than medicine
The Truck and the Refrigerator
Key Issues to Resolve in Rural Reinvention

• Experimentation is fine but standardization on best practice would be even better
• Identify the value of relationships with the bigger institutions: Independence is overrated
• Decide on how much financial risk you can take
  – Supplementary P4P or PCMH additional funding
  – Regional Capitation
• Don’t forget quality measurement and transparency
• Pursue the Triple Aim
Summary

- Health Reform will expand coverage but payment rates and coverage levels won’t be rich on a per case or per capita basis.
- No matter what there will be huge pressure on the rural health delivery system to improve value performance.
- Health system leaders can make a difference and meet any future by improving performance and developing a new math for the delivery system.
- The Delivery System must be transformed or it will be done for you by larger outside forces.
- Rural healthcare has a unique opportunity to reinvent itself for the benefit of the community.