

Intro to Relevant Health Care Reform Concepts

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NOSORH Webinar
December 10, 2010

Health Care Reform and Quality

- Medicare payment reform proposed to address problems in current system (e.g., lack of care coordination, payment for poor quality care)
- Demonstration projects have primarily involved large urban integrated delivery systems
- Many challenges for implementation in rural areas (e.g., organizing providers; achieving minimum patient base necessary to assume risk)
- Payment reform increases need to measure and report data on quality of care

What Happened to Delivery Side Reform?

- What is in the health reform law?
 - Encourages development of new patient care models such as ACOs
 - Creates CMS Innovation Center to test and evaluate patient-centered delivery and payment models
 - Establishes a national pilot program on payment bundling
- Does it make sense to implement insurance reform without substantial delivery side reform?
- Are we simply providing increased access to an inefficient system?
- Can we achieve cost containment without substantial delivery side reform?

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Accountable Care Organizations (ACOs)

- A set of providers (hospital, primary care physicians and specialists) responsible for the quality and cost of health care for a defined population of Medicare beneficiaries
- Goal: constrain costs and improve quality
- Would need a formal organization and structure
 - Could be formed from an integrated delivery system, physician-hospital organization or academic medical center
 - Minimum of at least 5,000 patients

Source: MedPAC Report to Congress June 2009

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Accountable Care Organizations (ACOs)

- Setting cost targets
 - Base incentives on changes in spending, not levels
 - Need to address geographic variation in spending
 - To be fair to low use areas, adjust for area wages and patient severity, but not regional utilization differences
- Setting quality targets
 - Initially process measures with a limited set of outcomes
 - Future measures could include mortality, hospital readmissions, ambulatory care sensitive admissions, patient satisfaction, improvements in functionality

Source: MedPAC Report to Congress June 2009

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Accountable Care Organizations (ACOs)

- Rural Challenges
 - Achieving minimum patient base of 5,000 in thinly populated areas
 - Rural providers less likely to have formal organizational structure, integrated providers (How do CAHs, RH clinics, networks etc. fit in?)
 - Many rural areas have historically low costs
 - Financial vulnerability of many rural providers
 - Aligning bonuses (and penalties, if any) with cost-based reimbursement
 - Small volume issues in measuring quality

Source: MedPAC Report to Congress June 2009

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Bundled Payments and Care Coordination

- Silo structure of Medicare payments reduces care coordination across treatment modalities
- Bundling provides a fixed payment for a set of services (e.g. acute and post-acute care services for pneumonia, stroke, hip fractures, CHF, and AMI)
- In theory, bundled payments should encourage smoother patient handoffs and better coordination of care

Bundled Payments and Care Coordination (cont.)

- It may save money through negotiations across provider types and by choosing less expensive venues
- Challenges to bundling payments include
 - How hospitals form necessary agreements with other providers on allocation of single payment
 - Developing relevant quality measurement and QI initiatives
 - Constructing risk-adjustment systems

Bundled Payments and Care Coordination (cont.)

- Challenges to bundling payments in rural settings
 - Cost-based reimbursement incentives (e.g. for CAHs) are very different than incentives bundling attempts to provide
 - Rural patients may receive hospital care and post-acute care in geographically dispersed facilities making it difficult to “virtually” integrate
 - Some rural hospitals have few options for post-acute care and would be disadvantaged at the negotiating table
 - Changes in reimbursement structures may lead financially unstable rural providers to exit the market

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Bundled Payments: Potential CAH Reimbursement Strategies

- Congress and CMS should consider
 - Exempting CAHs from the bundled payment methodology
 - Carving out post-acute services provided by CAHs for bundled payments under the same methodology used for Prospective Payment System (PPS) providers; and/or
 - Creating a “fixed-bonus” payment to support continued operation of CAHs and avoid loss of access to needed services in rural areas without alternative sources of care

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Comparative Effectiveness

- The American Recovery and Reinvestment Act provides \$1.1 billion to AHRQ and NIH in federal support of comparative effectiveness research
- Institute of Medicine Comparative Effectiveness Committee identified a list of 100 priorities for CER
- Federal Coordinating Council for CER has recommended uses of ARRA funds for:
 - Investment in data infrastructure
 - Dissemination and translation of CER findings
 - Priority populations: racial and ethnic minorities, persons with disabilities, persons with multiple chronic conditions, elderly, and children.

Comparative Effectiveness: Rural Issues

- Lack of clinical research in rural environments and limited participation of rural patients in clinical trials
- Implementation of practice guidelines in rural settings often lags behind urban settings
- Rural health professionals may have limited access to current evidence-based information; rural patients have difficulty obtaining appropriate information to make health care decisions

Additional Information

- Upper Midwest Rural Health Research Center (University of Minnesota Rural Health Research Center and University of North Dakota Center for Rural Health) www.uppermidwestrhrc.org
- Flex Monitoring Team (Rural Health Research Centers at the Universities of Minnesota, North Carolina and Southern Maine) www.flexmonitoring.org
- University of Minnesota Rural Health Research Center www.hpm.umn.edu/rhrc



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