Rural Health Policy for the Next Decade: Changes are Upon Us

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RURAL POLICY RESEARCH INSTITUTE

IOWA
College of Public Health
Headed for the Future

- Give Us Some Room
- We’re Gonna Build a New World
- Give Us Some Time
- We’re Gonna Make it Work Right
RUPRI Visions of Future

• Rural places attract and retain residents: The Comprehensive Rural Wealth Framework
• Sustainable, high quality rural health system: The High Performing Rural Health System
Comprehensive Community Wealth Approach

<table>
<thead>
<tr>
<th>Capital</th>
<th>Brief Description</th>
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<tbody>
<tr>
<td>Financial</td>
<td>Money, Other Liquid Assets, Public Finance, etc.</td>
</tr>
<tr>
<td>Intellectual</td>
<td>Human Knowledge, Skills, Educational Attainment</td>
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<tr>
<td>Human</td>
<td>Productive Capabilities of a Population Based on Health (Physical, Mental, Emotional)</td>
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<tr>
<td>Social</td>
<td>Trust, Relationships, Networks</td>
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<tr>
<td>Cultural</td>
<td>Practices, Values, and Identities Based in Society (art, beliefs)</td>
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<tr>
<td>Political</td>
<td>Influence, Power, and Goodwill that is Held, Spent, or Shared</td>
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<tr>
<td>Physical</td>
<td>Built Environment, Infrastructure</td>
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<tr>
<td>Natural</td>
<td>Resources Provided by Nature</td>
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Comprehensive Community Wealth Approach

Foundations:
1) Quality of life IS economic development
2) Development for your current community
3) Capitals are interconnected
4) Decisions have short- and long-term impacts
Achieving a High Performing System

High-Performing Rural Health System
Foundational to the Health and Well-Being of Rural Residents

ACCESS
AFFORDABILITY
COMMUNITY HEALTH
QUALITY

Equity
The Consistent, Systematic, and Just Treatment of All Individuals
Changing Modalities and Sites of Care

• Telehealth – Disruptor?
  • Use increased dramatically in 2020-2021
  • Declined since 2021, but leveled off at higher percent of all visits than pre-PHE, including primary care
  • Not yet a major disruptor, but use in primary care and remote patient monitoring indicate potential impact
• Increased use of ambulatory sites for formerly inpatient services
• Shift in sites of care for rehabilitation, monitoring and treating chronic conditions
Changes in Service Delivery Organizations

Person-centered health teams
Engaging human services organizations
Engaging community-based organizations
Facilitating or Inhibiting The Move to the Future: Policy design

- POLICY GOALS TO MOVE TO VALUE-BASED PAYMENT
- MEDICARE ADVANTAGE
- ACCOUNTABLE CARE ORGANIZATIONS
Health Care Payment Learning and Action Network (HCP LAN) Alternative Payment Model Framework

<table>
<thead>
<tr>
<th>CATEGORY 1</th>
<th>CATEGORY 2</th>
<th>CATEGORY 3</th>
<th>CATEGORY 4</th>
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<tbody>
<tr>
<td>FEE FOR SERVICE - NO LINK TO QUALITY &amp; VALUE</td>
<td>FEE FOR SERVICE - LINK TO QUALITY &amp; VALUE</td>
<td>APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE</td>
<td>POPULATION - BASED PAYMENT</td>
</tr>
</tbody>
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<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>A</th>
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<tbody>
<tr>
<td>Foundational Payments for Infrastructure &amp; Operations (e.g., care coordination fees and payments for HIT investments)</td>
<td>Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data)</td>
<td>Pay-for-Performance (e.g., bonuses for quality performance)</td>
<td>Condition-Specific Population-Based Payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)</td>
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<tr>
<td>APMs with Shared Savings (e.g., shared savings with upside risk only)</td>
<td>APMs with Shared Savings and Downside Risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)</td>
<td>Comprehensive Population-Based Payment (e.g., global budgets or full percent of premium payments)</td>
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<tr>
<td>Risk Based Payments NOT Linked to Quality</td>
<td>Capitated Payments NOT Linked to Quality</td>
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Getting to Categories 3 and 4

- CMS Goal that 100% of beneficiaries in Traditional Medicare are in accountable care arrangements by 2030; and “the vast majority” of Medicaid beneficiaries
- Reaching toward global budgeting or per capita payment
- The journey includes emphasizing two critical components
  - Primary care delivered through person-centered health teams
  - Focus on health, including health-related social needs
- Requires a financial model to move resources to where needed in each community
Medicare Advantage

REALITY IS THAT MA IS PRIVATE INSURANCE WITHIN MEDICARE PARAMETERS

ENROLLMENT INCREASING, MORE THAN 50%, WITH NEARLY 40% OF RURAL BENEFICIARIES

FEDERAL PAYMENT IS CAPITATED, BUT TO THE HEALTH PLANS

HEALTH PLAN PAYMENTS TO PROVIDERS VARIES
Medicare Advantage

Attraction to enrollees: benefits, low premiums

Potential problems for enrollees: narrow networks, limited benefits

What does it mean for a “new world” in health care delivery and finance?
Iowa State Rural County MA Penetration Percentage of Medicare beneficiaries enrolled in MA, March 2023
Rural counties defined using Urban Influence Codes
Shared Savings Program

Plateau of 561 in 2018, fell to 456 in 2023

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<th>Composition in 2023</th>
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<td>252 low revenue (55%)</td>
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ACO Spread - 2023
Medicare Shared Savings Program ACO Assigned Beneficiary Population by Rural County

Note: This lists the Beneficiaries Assigned to an MSSP ACO by Rural County
In 2023, 467 CAHs are part of an MSSP ACO

Source: CMS - Medicare Shared Savings Program Fast Facts
Iowa State Rural County MSSP Penetration

Percentage of Medicare beneficiaries assigned to an ACO, January 2021
Rural counties defined using Urban Influence Codes
SSP Changes 2023 for 2024

- Longer time in Basic track A, for inexperienced ACOs: (upside risk only): up to 7 years
- Advanced Interest Payment: one-time $250,000 and quarterly per-beneficiary payments for first 2 years
- Changes to minimum savings rate (MSR) to allow shared savings at half regular rate until MSR is met
- Introduce Accountable Care Prospective Trend to adjust benchmarks calculated based on national and regional rates
- Reduce Negative Regional Adjustment Cap from 5% to 1.5%
SSP Changes 2023 for 2024

- Adjustment for Prior Savings: Adding back into benchmark a portion of savings generated by ACOs
- Risk Score Growth Cap Adjustment: allow flexibility within a 3 percent cap on growth in the risk score
- Sliding Scale for Shared Savings and Losses: allow percentage of shared savings when ACO quality performance is below 30\textsuperscript{th} percentile but at least in 10\textsuperscript{th} percentile in of four outcome measures

2023 Announcements

• ACO REACH
• Making Care Primary
• AHEAD
Aligning Incentives

Challenge of the legacy of encounter-based payment and volume-based incentives

Shift to enrollee-based payment and incentives to shift to lower-cost care

Value is achieving community-focused mission
Designing Delivery System and Payment to Meet the Challenges

- Hitting a reset button
- Redesign use of workforce, including use of telehealth
- Redesign roles of community-based organizations in meeting health needs of individuals, populations, communities
- Redesign payment to emphasize creating flexibility in use of resources – revenue for meeting strategic objectives
Some Specifics

• Flexible financing models: shared savings, global budgeting, broadening eligible services, accounting systems that allow for broader definition of allowable costs

• Investments in capacity to integrate services, manage chronic conditions: information systems including EHRs and interoperability
Where is the Money?

• We spend $4 trillion now – not much appetite to spend additional money to achieve value-based incentives
• Re purposing some of the $4 trillion
• But does require some new investments
Further Resources

✓ The RUPRI Center for Rural Health Policy Analysis  http://cph.uiowa.edu/rupri
✓ The RUPRI Health Panel  http://www.rupri.org
✓ 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 American Hospital Association  https://www.aha.org/front
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For more than 30 years, the Rural Health Research Centers have been conducting policy-relevant research on healthcare in rural areas and providing a voice for rural communities in the policy process.

The Rural Health Research Gateway ensures this research lands in the hands of our rural leaders.

Funded by the Federal Office of Rural Health Policy, Health Resources & Services Administration

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