Rural Health Policy: The Long and Winding Road

Presentation to the Veterans Rural Health Resource Center

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Universal Themes, General and VA

Geographic access to essential services

Affordability for patients

Quality improvement

Policy Milestones

Hill-Burton funding to build rural hospitals – in (nearly) every county – creates approach of hospital as focal point

1946

Medicare and Medicaid to use publicly-funded programs to assure affordability (and perhaps access) -- creates expectation of public commitment to defined populations, but not universal coverage

1965

Balanced Budget Act: creates Medicare Rural Hospital Flexibility program; also elevates role of managed care with Medicare+Choice

1997

Policy Milestones

Medicare Prescription Drug Improvement, and Modernization Act: first major expansion of Medicare benefits to include part D; further structural changes to what is now Medicare Advantage – both push new approach of Medicare benefits through private insurance companies

2003

Patient Protection and Affordable Care Act: Insurance Marketplaces; Medicaid Expansion, Accountable Care Organizations; Boost to a drive toward transformation

2010

Changes with the VHA Program

- Growing use of Community-Based Outpatient Clinics (more than 1,400 now)
- Deliberate efforts to access non-VA care as needed given geographic access: Choice Act, Mission Act – community care networks
- Quality Enhancement Research Initiative
- Support through Office of Rural Health for development and dissemination of new initiatives

Are the Themes Being Addressed?

Access

Affordability

Quality Improvement

Post ACA Focus on Transformation

Delivery modalities: Person-Centered Health Home, outside of hospital walls, use of community health workers, telehealth

Health Care Organizations: what hospitals are becoming, health systems

Payment (incentives)

The Journey to Value-Based Care and Payment

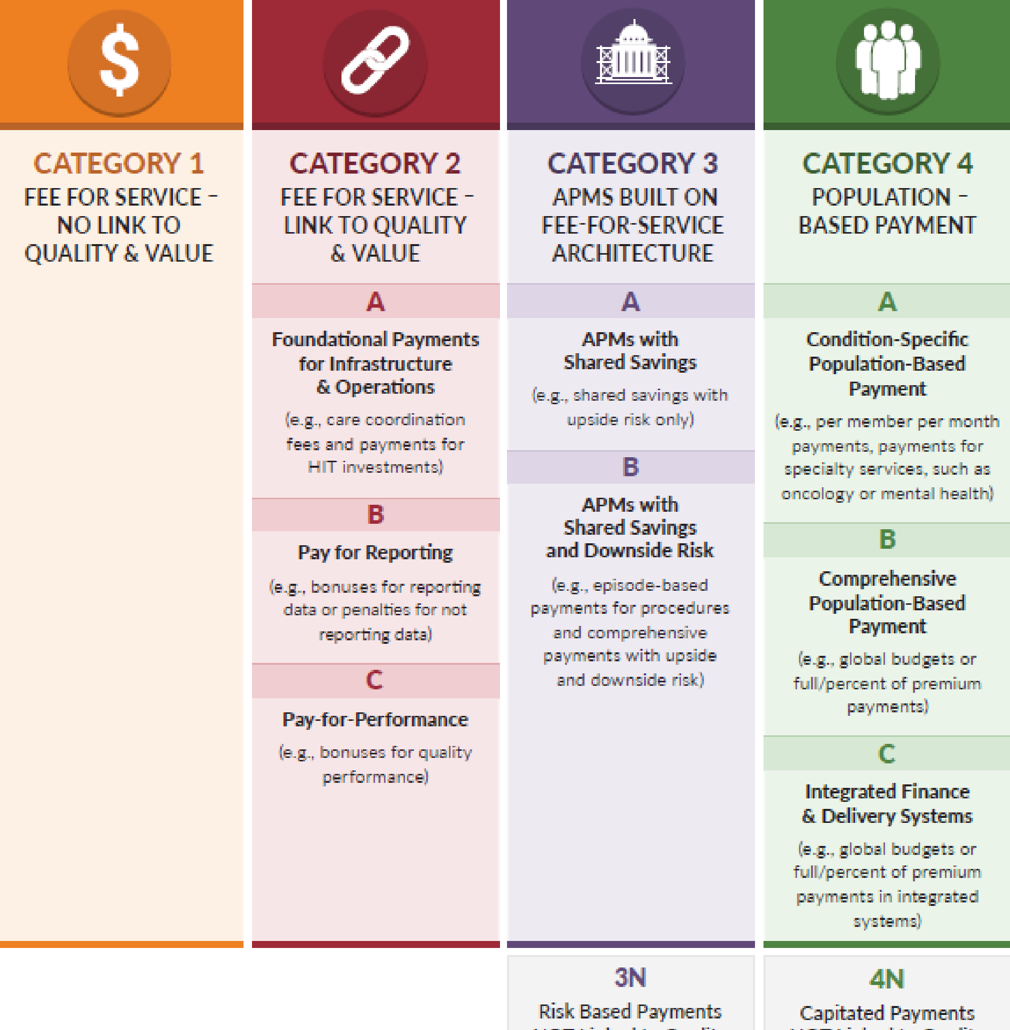
Predates the Patient Protection and Affordable Act, 2011 (ACA)

Accelerated by the ACO shared savings program in Medicare

Point of attention of three presidential administrations and associated Congressional sessions – *not going away*

Visual from the Health Care Payment Learning & Action Network

Health Care Payment Learning and Action Network (HCP LAN) Alternative Payment Model Framework



Source: http://hcp-lan.org/workproducts/apm-framework-onepager.pdf

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*

Specifics of Medicare and Medicaid Approaches

- The CMS goal is for "Traditional Medicare," not inclusive of Medicare Advantage (MA)
- MA plans will have their own strategies
- Medicaid is moving from state administered to states contracting with Managed Care Organizations (MCOs): STAR Health and STAR+ in Texas
- State leverage is in terms of contracts with MCOs
- Federal role is leveraging the federal match payment – such as waivers to allow Medicaid expenditures to address health-related social needs

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What Does Transformation Require

01

Much more than simply flipping a switch

02

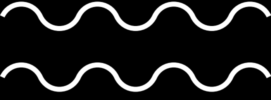
Trying to ride a crest of change

03

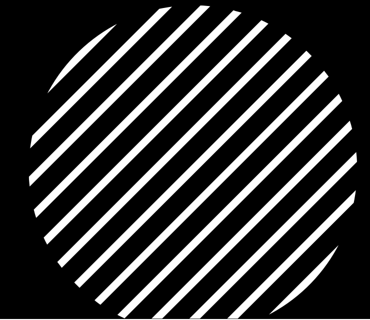
But in a delivery system set up to deliver what has been expected and rewarded for doing so – episodic care paid and assessed for each encounter

04

Change will happen over time and as policies and management practices adapt

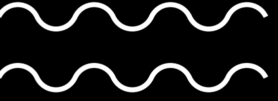


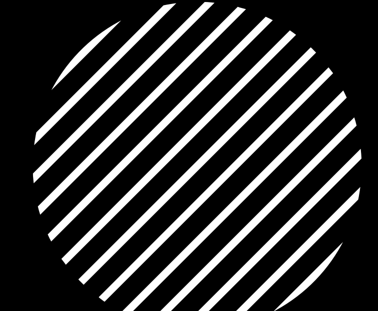
Essential Elements for Transformation



Leadership: person or team establishes new direction and strategy

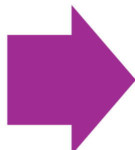
Culture, governance, and physician engagement: WESTMED has physicians develop own practice guidelines and algorithms for managing common conditions





Essential Elements for Transformation

Data: claims, lab, imaging, pharmacy, and clinical data on hospital admission



Physician-management alignment: Dean Clinic creates explicit physician-management dyads

Financial risk: creating financial incentives, usually risk contracts

Source: Ezekiel J. Emanuel (2017) *Prescription for The Future: The Twelve Transformational Practices of Highly Effective Medical Organizations* New York: PublicAffairs, imprint of Perseus Books, LLC

Twelve Practices of Transformation

1. Scheduling
2. Registration and rooming
3. Performance measurement and reporting
4. Standardization of care
5. Chronic care coordination
6. Shared decision making
7. Site of service
8. De-Institutionalization
9. Behavioral health intervention
10. Palliative care
11. Community intervention
12. Lifestyle intervention

Source: Ezekiel J. Emanuel (2017) *Prescription for The Future: The Twelve Transformational Practices of Highly Effective Medical Organizations* New York: PublicAffairs, imprint of Perseus Books, LLC

Can We Transform in Rural Health?

- Challenges
  - Geography – isolated locations of primary care hospitals and providers
  - Scale – small population size to spread risk and attract affordable secondary insurance
  - Managing care – analytics difficult to set up and support
  - Threat of change
- Are the changes sufficient to address?
  - Up front investment
  - Monthly payment
  - Savings ratio
  - Benchmark

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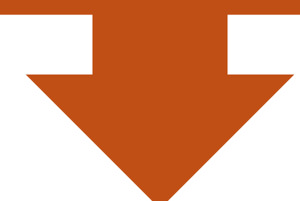
Public Policy Driving Change: ACO Example

- In Medicare policy originates with PPACA – had been experiences in commercial insurance prior to 2013
- Medicare Shared Savings Program continues to evolve
- Is the principal vehicle at the moment for creating incentives to change delivery and redirect resources

Shared Savings Program

Plateau of 561 in 2018, fell to 456 in 2023, up to 480 in 2024

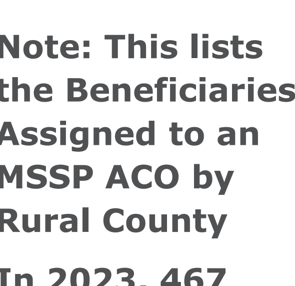


Composition in 2024

276 low revenue (57%)	2,571 Rural Health Clinics	513 Critical Access Hospitals	One-sided: 33% (159)	Two-sided include 114 in basic tracks, 207 in enhanced track	Source: CMS: Savings Program Fact Facts – As of January 1, 2024

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

Metropolitan county
0% assigned
0.01% to 7.5%
7.51% to 15.0%
15.01% to 25.0%
25.01% to 720%

Source: CMS - Medicare Shared Savings Program Fast Facts

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 30th percentile but at least in 10th percentile in of four outcome measures

Source: Medicare Shared Savings Program: Rule Changes and Implications for Rural Health Care Organizations. *Rural Health Value Policy Brief*. 2022. https://ruralhealthvalue.public-health.uiowa.edu/files/RHV%20MSSP%20Rule%20Changes%20and%20Implications.pdf

Where We Have Rural ACOs: Adirondacks ACO in New York

21 primary care practices in 60 sites, including an FQHC with 21 sites; 5 hospitals

Includes 12 behavioral health and substance use disorder organizations

MSSP (22,000), Managed Medicaid (48,000) and Commercial (67,000)

Health Information Exchange clinical data

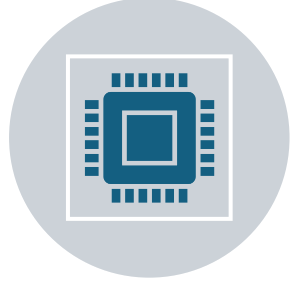
Integrated data from six of eight payors

www.Adirondacksaco.com

Community Care Partnership of Maine

15 FQHCs and 4 Community Hospitals

Generated 55.8 million in MSSP to date with $24 million returned to CCPM



Integrate claims data, real-time clinical data, and EMR data

https://www.ccpmaine.org/wp-content/uploads/2019/11/CCPM-Highlights_2019-10.pdf

2023 Announcements

- ACO REACH
- Making Care Primary
- AHEAD

Landscape: State Policies

- Medicaid payment policy, including requirements built into contracts with Managed Care Organizations (MCOs) – 29 require MCOs to implement VBP models; 26 define the types of VBP models
- State regulatory policies facilitate or inhibit change
- CMS role of transmittal letters to state Medicaid directors:
  - January 7, 2021, letter re opportunities to address SDOH
  - January 4, 2023, CMS guidance re SDOH waivers

Sources: Most States Require Managed Care Organizations to Implement VBP Models with Providers. *Insights* Guidehouse. July 19, 2022. https://guidehouse.com/insights/healthcare/2022/blogs/managed-care-implement-vbp-models?lang=en

Landscape: Commercial Plans

- Helped create the bandwagon of VBP – earliest efforts predated SSP
- Inherent interest in VBP based on
  - Marketing advantage
  - Reduces medical loss ratio
  - Impacts return on investment
  - Lower premiums in a competitive market
- Examples:
  - Cigna Collaborative Accountable Care – Core Physicians in Exeter, NH: https://www.pcpcc.org/initiative/cigna-collaborative-accountable-care-core-physicians
  - Blue Cross NC, Caravan Health expanding Blue Premier to Community and Rural Hospitals: https://www.bluecrossnc.com/provider-news/blue-cross-nc-caravan-health-collaborate-expand-blue-premier-community-and-rural

Summary of New Payment Policies

- ACOs/SSP the most widespread, new rule likely to create more momentum
- Bundled Payment still in play, may spread more through commercial plans
- Global Budgeting
- New CMMI demonstrations announced in 2023
- Next up?

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Changing 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

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Effects on Legacy Sites

- Hospital information from previous presentation: closure, financial stress, onset of a new classification (Rural Emergency Hospitals)
- Closures of Skilled Nursing Facilities in Rural places: 472 in 400 nonmetropolitan counties between 2008 and 2018; as 2018 10.1% of nonmetropolitan counties without a nursing home
- In 2021, 138 counties with no retail pharmacy, 101 in noncore counties and 15 in micropolitan counties

Sources: Sharma H et al. 2021. Trends in Nursing Home Closures in Nonmetropoitan and Metropolitan Counties in the United States, 2008-2018. *Rural Policy Brief 2021-1*. RUPRI Center for Rural Health Policy Analysis. https://rupri.public-health.uiowa.edu/publications/policybriefs/2021/Rural%20NH%20Closure.pdf

RUPRI Center for Rural Health Policy Analysis. 2022. Nursing Homes in Rural America: A Chartbook. https://rupri.public-health.uiowa.edu/publications/other/Nursing%20Home%20Chartbook.pdf

Constantin J, Ullrich F, and Mueller KJ. 2022. Rural and Urban Pharmacy Presence – Pharmacy Deserts. *Rural Policy Brief 2022-2*. RUPRI Center for Rural Health Policy Analysis. https://rupri.public-health.uiowa.edu/publications/policybriefs/2022/Pharmacy%20Deserts.pdf.

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The Health Teams of 2024

- Primary care foundation and focus – comprehensive, continuous, coordinated
- Include clinical care focused on behavioral health (including substance use disorders)
- Include community-based service providers
- Link to others in community, including public health
- Think about what is meant by *engagement* – an **action** orientation focused on quadruple aim (improve population health, enhance patient experience, increase provider satisfaction, reduce cost of care

Will VBP Spread Everywhere?

- Challenges
  - Geography – isolated locations of primary care hospitals and providers
  - Scale – small population size to spread risk and attract affordable secondary insurance
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Together We Can: VHA in Transformation

- Patient Care Teams
- Incentive structures for providers to change – nonmonetary counts as much as payment
- How to integrate care when veterans are receiving community-based clinical care
- Participation in community-based initiatives to improve community health
- Adopting new technologies, starting with telehealth

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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