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The Future of Rural Health Care:

Advanced Payment Model Updates and Strategies

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Rural Health Innovation's Purpose

Rural Health Innovations (RHI), LLC, is a subsidiary of the National Rural Health Resource Center (The Center), a non-profit organization. Together, RHI and The Center are the nation's leading technical assistance and knowledge centers in rural health. In partnership with The Center, RHI connects rural health organizations with innovations that enhance the health of rural communities.

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2

Historic Health System Results

- High cost
- Low quality
- High chronic illness
- Low access

3

It's Changing!

- Better Care
- Smarter Spending
- Healthier People

Source: Centers for Medicare and Medicaid Services (CMS)

4

The Changing Health Care Environment

- Federal health care reform
  - Value-based payment models
  - Provider-based insurance
  - MACRA/MIPPS
- State Medicaid programs adopting managed care models
- Commercial insurers developing ACOs and steering patients to lower cost options
- Large health systems forming ACOs and other APMs
- Physicians now in pay-for-performance

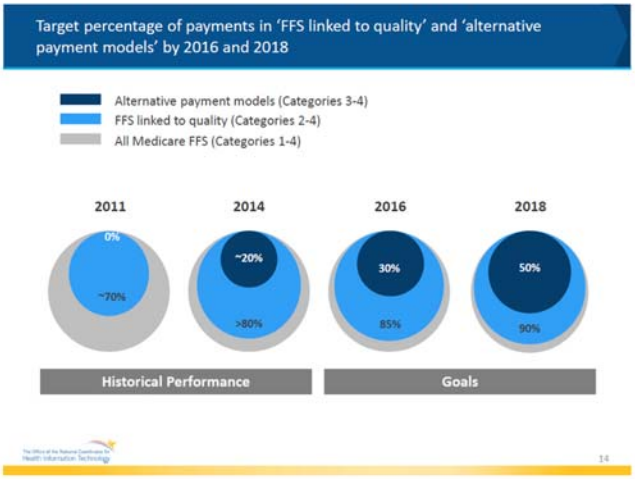
Rural providers face financial uncertainty and challenges as they seek to adapt to the changing market.

Health Care Market Overview

- High deductible health plans
- Rural-urban affiliations
- Physicians transitioning to hospital employment
- Flattening volume
- State budget deficits
- Recovery Audit Contractors (RAC)
- Reduced re-admissions
- Accelerating shift to outpatient care
- MACRA (SGR Fix)
- Comprehensive pay models
- 340B attacks
- Bipartisan Budget Act of 2015
  - Comprehensive Primary Care Plus payment model
- CEO turnover
- Population health focus
- Physician shortages

6

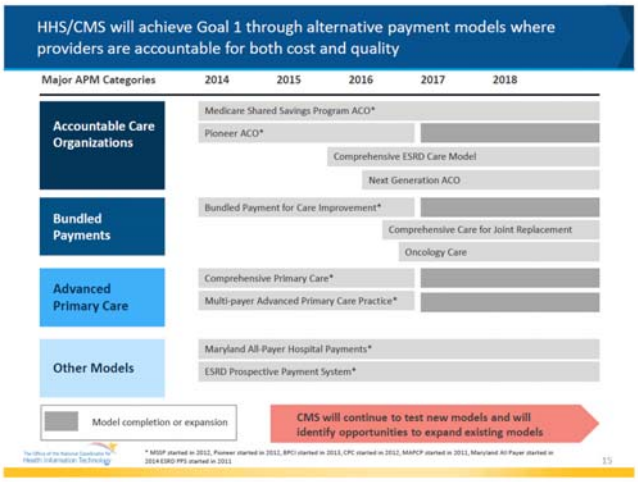
Alternative Payment Models are Taking Shape



Alternative Payment Models and Sustainability, Advance Interoperable HIE Program Senior Leader Call, February 24, 2016, John Rancourt, Deputy Director, Office of Care Transformation,

7

Timeline of Progress



Alternative Payment Models and Sustainability, Advance Interoperable HIE Program Senior Leader Call, February 24, 2016, John Rancourt, Deputy Director, Office of Care Transformation,

8

Advanced Payment Models

- Accountable Care Organizations
  - ACO Investment Model (AIM)
  - Medicare Shared Savings (MSSP)
  - Pioneer ACO
  - Next Generation ACO
- Bundled Payments
  - Care for Joint Replacement (CJR)
  - Others
- Comprehensive Primary Care
  - CPC / CPC+
  - Multi-payer Advanced Primary Care (APC)

9

Advanced Payment Models

- Transforming Clinical Practice Initiative
- MACRA
  - MIPS
  - APM
- Accountable Health Community (AHC/ACH)
- State Innovation Model (SIM)
- Global Budget

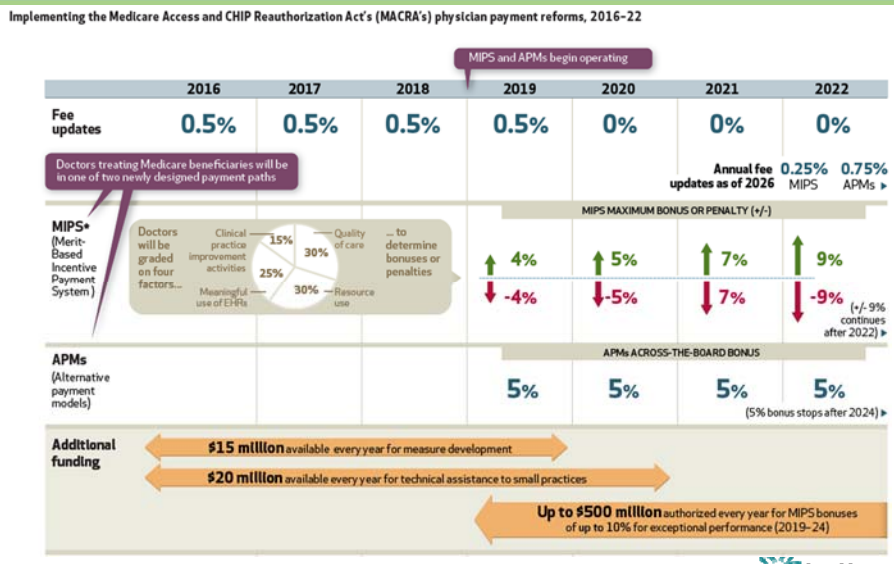
10

MACRA: Modernizing Payment for Quality

- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
- First step of implementation is a proposed rule:
  - On April 27, 2016, the DHHS issued a proposal to align and modernize how Medicare payments
  - Quality Payment Program ties payments to the cost and quality of patient care
  - Impacts virtually all doctors and other clinicians except those with very limited caseloads

Source: CMS Press Office press release 4/27/16
http://www.hhs.gov/about/news/2016/04/27/administration-takes-first-step-implement-legislation-modernizing-how-medicare-pays-physicians.html

Proposed Rule: Quality Payment Program



Source: "Health Policy Brief: Medicare's New Physician Payment System," Health Affairs, April 21, 2016.
http://www.healthaffairs.org/healthpolicybriefs/

The Merit-based Incentive Payment System (MIPS)

Most Medicare clinicians will participate in the Quality Payment Program through MIPS

Performance Category	% of Score in Years 1 - 5	Details
Quality	50% → 30%	Clinicians choose to report six measures from a range of options that accommodate differences among specialties and practices
Advancing Care Information	25% → 25%	Clinicians choose to report customizable measures that reflect how they use technology in their day-to-day practice
Clinical Practice Improvement Activities	15% → 15%	Rewards clinical practice improvements, such as activities focused on care coordination, beneficiary engagement, and patient safety
Cost	10% → 30%	Score based on Medicare claims using 40 episode-specific measures, meaning no reporting requirements for clinicians

Accountable Care Organizations (ACO's)

Accountable Care Organizations:

- A mechanism to monetize value by increasing quality and reducing cost
- A group of health care providers that takes responsibility for the cost and quality of care for a group of patients or individuals

14

Update on ACO's Presence

- Rapid growth
  - August 2012: 154
  - January 2015: 747
  - January 2016: 1,000+ (41 new in rural)
  - January 2017: 99 new
- Both hospital and physician led
- Medicare and private insurance models

15

Medicare ACO 2014 Results

- **Pioneer ACOs generated total model savings of $120 million** during Performance Year 3, an increase of 24% from Performance Year 2 ($96 million).
- **Total model savings per ACO increased** from $2.7 million per ACO in Performance Year 1 to $6.0 million per ACO in Performance Year 3.
- The mean **quality score among Pioneer ACOs increased** to 87.2 percent in Performance Year 3, compared to 85.2 percent in Performance Year 2 and 71.8 percent in Performance Year 1.
- The organizations showed **improvements in 28 of 33 quality measures** and experienced average improvements of 3.6% across all quality measures compared to Performance Year 2.
- Ninety-two Shared Savings Program ACOs **held spending $806 million below their targets** and earned performance payments of more than $341 million as their share of program savings.
- Shared Savings Program ACOs that reported in both 2013 and 2014 **improved on 27 of 33 quality measures**.

16 Adapted from Stroudwater
Source: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-08-25.html

2015 MSSP Results

- 400 ACOs = **$466 million** savings
- ACOs improved on 84% of Quality Improvement measures
- 125 ACOs qualified for shared savings
- Rural ACOs outperforming urban

17

Rural ACO Recommendations

1. Set up a Care Coordination Program
2. Perform Annual Wellness Visits
3. Provide Integrated Behavioral Health
4. Improve Hierarchical Conditioning Coding
5. Improve Process & Pre-Visit Planning

Source: National Rural Accountable Care Consortium

18

Social Determinants of Health

The conditions and circumstances in which people are born, grow, live, work, and age. These circumstances are **shaped by** a set of forces beyond the control of the individual: economics and the **distribution of money, power, social policies, and politics** at the global, national, state, and local levels.

WHO and CDC (adapted)

19

Population Health has Many Determinants

Rural Health Value, "Understanding the Social Determinants of Health: A Self-Guided Learning Module for Rural Health Care Teams.", RUPRI, Stratus Health

20

Tip of the Societal Disparities Iceberg

21

From Assistant Commissioner, MN Dept of Health, Jeanne Ayers speech to the MN Community Health Workers Alliance Meeting, May 23, 2016

Population Health has Many Partners

Rural Reasons for Concern

- Limited resources for investment in new models
  - Education
  - Expertise
  - Skill building
  - Information management
- Existing rural models – CAHs, RHCs, FQHCs – may be more costly
- Growing rural-urban value gap
  - 2.4 years lifespan difference
  - Quality outcomes
  - Cost
  - Patient satisfaction

23

Rural Reasons for Optimism

- Revenue stream of the future tied to primary care providers
- Lower beneficiary costs in rural
- Rural can change more quickly
- Rural is more community-based and collaborative

24

What Rural Providers Can Do Now

- Understand the basics of the new APMs
- Determine where their organizations are now in preparation for value – readiness
- Develop strategies to bridge the gap between current and future payment systems
- Work together to maximize efficiency, share volume and gain access to needed resources and expertise

25

The Challenge: Crossing the Shaky Bridge

Source: http://www.flickr.com/photos/67759198@N00/2974261334/sizes/o/in/photostream/

26

Leadership

- Educate & Align Key Leaders:
  - Boards
  - Providers
  - CEO/CFO/CNO/Managers
- Develop a compelling strategic plan to achieve value

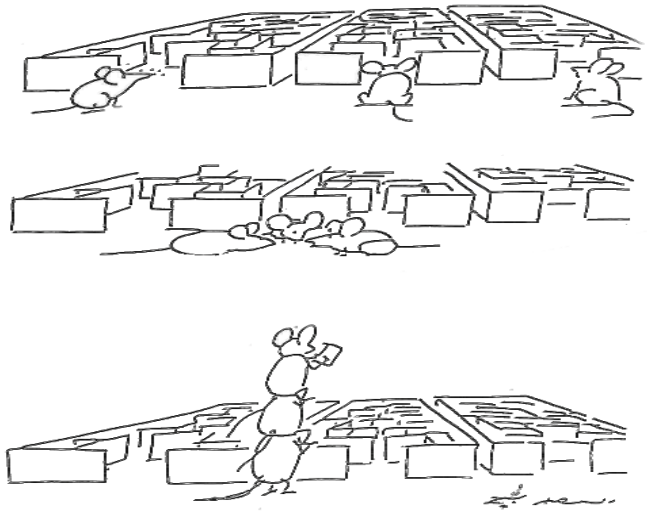
27

Collaboration/ Partnerships

- Partner with:
  - Primary care providers
  - Other/community services
  - Businesses
  - Payers?
- Join Networks/Systems
- Engage Community and Patients

28

A Collaborative Effort



29

Maximize Finances/Quality

- Maximize Financial and Quality Performance
  - Optimize revenue cycle management and cost accounting
  - Improve customer satisfaction and quality
  - Develop LEAN processes

30

Care Management

- Develop care coordination capabilities
- Redesign care processes
- Focus on high cost patients
- Focus on chronic illness management

31

Information Management

- Develop access to shared patient databases
- Gain access to in-depth data analysis
- Use information to improve value of services
- Use information to improve patient outcomes

32


Technology
• Develop effective:
o Telehealth applications
o Websites and social media
o Handheld technology applications
o Educational technology
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Workforce Preparation
• Help staff understand the "why" of change
• Develop a culture of continuous improvement
• Teach staff new value-based and population health skills and knowledge
• Maximize teamwork and customer focused services
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Population Health Management

- Develop new wellness and disease prevention services
- Engage and enlist partnerships with patients and their families
- Lead/join initiatives to address community health needs and issues

35

The Destination…

A health system that links health care with community stakeholders to create a network of organizations working together to improve population health

36

2016 Financial Leadership Summit Meeting: Results and Recommendations

Financial Leadership Summit 2016

Supported by: Federal Office of Rural Health Policy (FORHP), April 18–19, 2016, Minneapolis, MN

Purpose: To identify strategies and actions that rural hospital leaders and providers should consider as they transition to Value-Based Purchasing (VBP) and population health management

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number UB1RH24206, Information Services to Rural Hospital Flexibility Program Grantees, $957,510 (0% financed with nongovernmental sources). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

38

Summit Panelists

Minneapolis, MN
April 19, 2016

39

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Summit Panelists

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Jeffrey M. Johnson, Partner
Wipfli LLP

Lance W. Keilers, President
Connected Healthcare Solutions, LLC

Ralph J. Llewellyn, Partner
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Rebecca McCain, CEO
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Fort HealthCare, Inc.

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Kentucky Office of Rural Health

Greg Rosenvall, Rural Hospital Improvement Director
Utah Hospital Association

Eric K. Shell, Director
Stroudwater Associates

Brock Slabach, Sn.VP,
National Rural Health Association

Larry Spour, CFO
Lawrence County Memorial Hospital

Susie Starling, CEO
Marcum and Wallace Memorial Hospital

Brian Stephens, CFO
Chief Financial Officer
Door County Medical Center

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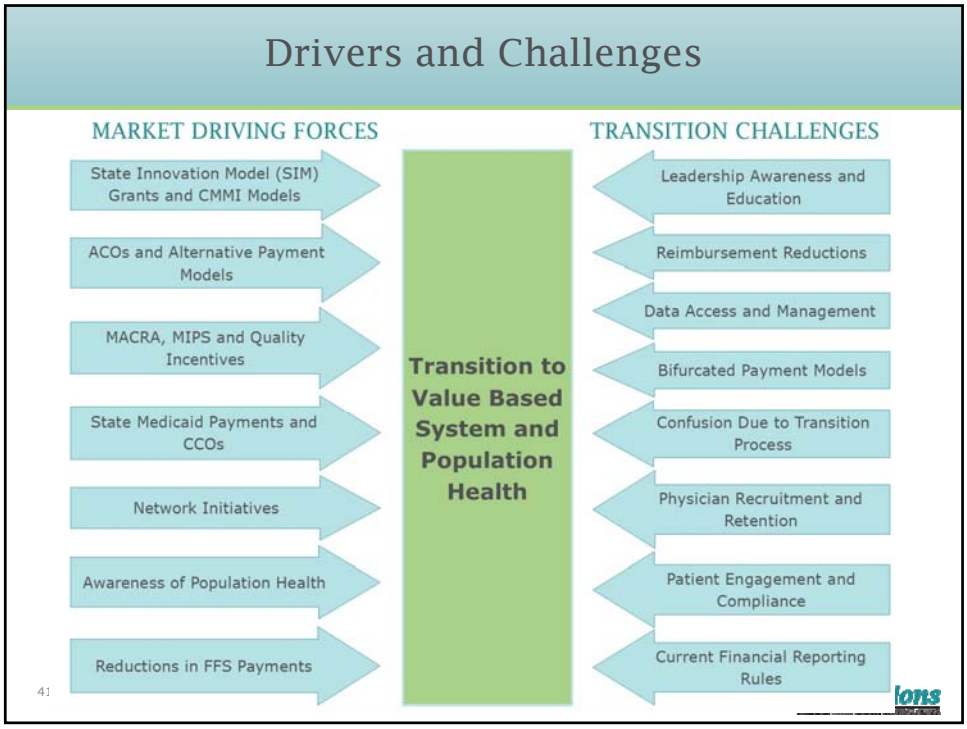
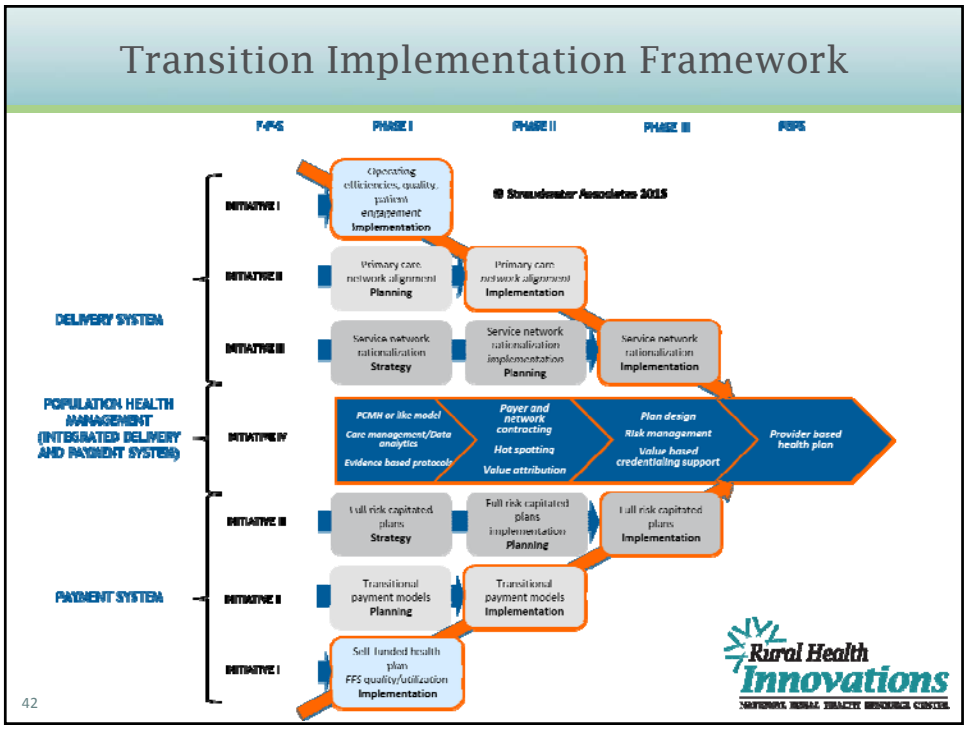
40


Drivers and Challenges
MARKET DRIVING FORCES
State Innovation Model (SIM) Grants and CMMI Models
ACOs and Alternative Payment Models
MACRA, MIPS and Quality Incentives
State Medicaid Payments and CCOs
Network Initiatives
Awareness of Population Health
Reductions in FFS Payments
Transition to Value Based System and Population Health
TRANSITION CHALLENGES
Leadership Awareness and Education
Reimbursement Reductions
Data Access and Management
Bifurcated Payment Models
Confusion Due to Transition Process
Physician Recruitment and Retention
Patient Engagement and Compliance
Current Financial Reporting Rules
41


Transition Implementation Framework
F-F/S
PHASE I
PHASE II
PHASE III
PBPS
DELIVERY SYSTEM
POPULATION HEALTH MANAGEMENT (INTEGRATED DELIVERY AND PAYMENT SYSTEM)
PAYMENT SYSTEM
Operating efficiencies, quality, patient engagement Implementation
Primary care network alignment Planning
Primary care network alignment Implementation
Service network rationalization Strategy
Service network rationalization implementation Planning
Service network rationalization Implementation
PCMH or like model
Care management/Data analytics
Evidence based protocols
Payer and network contracting
Hot spotting
Value attribution
Plan design
Risk management
Value based credentialing support
Provider based health plan
Full risk capitated plans Strategy
Full risk capitated plans implementation Planning
Full risk capitated plans Implementation
Transitional payment models Planning
Transitional payment models Implementation
Self funded health plan
FFS quality/utilization
Implementation
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42

Strategy Timeframes

- Panelists divided strategies into 3 timeframes
  - Immediate (Within the next 18 months)
  - Short-term (18 months to 36 months)
  - Long-term (36 months to 60 months)

43

Immediate Strategies

- Improve Financial, Clinical and Operational Efficiency
- Engage and Educate Leaders and Staff
- Educate and Partner with Physicians and other Primary Care Providers

44

Short-term Strategies

- Align with Community Health Needs
- Identify Available Population Health Resources
- Develop Care Transition Teams
- Collect, Manage and Act on Patient Data

45

Long-term Strategies

- Collaborate with other rural hospitals and larger, regional health systems
- Document hospital outcomes and demonstrate value

46

Resources Needed to Transition to Population Health

- Hospital grant resources such as such as Small Rural Hospital Improvement Program and Health Center Control Network Grants
- Regional, state and national financial benchmarks
- Case studies to share impact of strategies
- Materials and best practices on change processes
- Effective communication methods
- Targeted 10 to 15 minute videos for boards and medical staff
- Methods to partner with physician leadership and champions

47

Resources Needed to Transition to Population Health

- Examples of physician contracts with incentives with relative value units (RVUs) plus quality indicators
- Technical assistance through CMMI initiatives
- Follow-up support after workshops – example, Small Rural Hospital Transitions (SRHT) Project
- Access to data and ability to mine health care data
- Network development
- SRHT outcomes
- Key performance indicators
- Flex needs assessments for population health

48

Download The Report

The PDF Financial Leadership Summit Report is available on the Financial Leadership Summit webpage

49

Conclusions

- The rapidly changing health care environment presents a core set of new challenges for rural hospitals
- The movement to value and population health will require a carefully planned set of basic strategies that rural hospital leaders can use to achieve success
- Locally delivered health care (including rural hospitals) has high value in the emerging delivery systems

50

Conclusions

- Rural hospitals need to improve financial, clinical and operational efficiency in the current volume-based environment
- Rural hospitals must educate and align key leaders, including board members and providers
- It will be important to align service delivery systems with the changes in payment systems

51

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"Even if you're on the right track, you'll get run over if you just sit there."
(Will Rogers)

52

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53
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