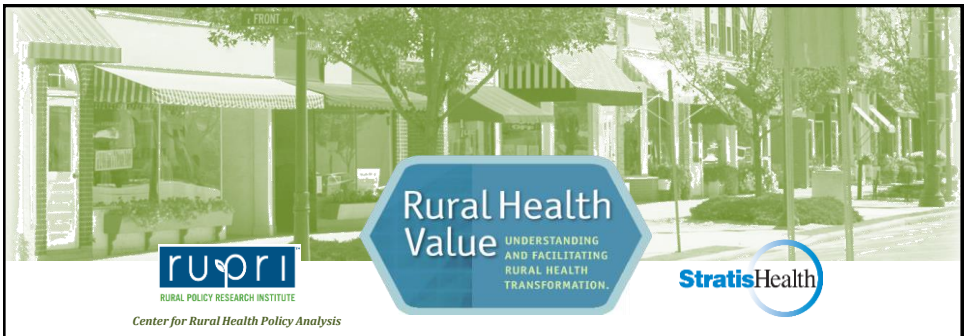


Building Capacity for Value

Nebraska Rural Health Conference
September 2, 2020

1

Rural Health Value

- **Vision:** To build a knowledge base through research, practice, and collaboration that helps create high performance rural health systems.
- Health Resources and Services Administration (HRSA) Federal Office of Rural Health Policy (FORHP) Cooperative agreement started in 2012.
- Partners:
  - University of Iowa RUPRI Center for Rural Health Policy Analysis
  - Stratis Health
- Activities:
  - Resource development and compilation, technical assistance, research

2

2

The Race to Value-Based Payment

An Analogy…

- What does the road to value-based payment look like?
- Components to building a 'car' that supports the drive to value
- Mapping a route to value through population health

3

3

Evolving view of value…

(Also depends on your point of view)

Description	Source/Timeline
Value= (Quality + Experience)/Cost	Seminal article: The Triple Aim: Care, health, and cost, Institute for Healthcare Improvement, 2008
Improved Community Health, Better Patient Care, Smarter Spending	Improving our Health Care Delivery System, Fact Sheet, Center for Medicare and Medicare Services, January 2015
Improve Care, lower costs, and better align payment systems to support patient-centered practices	About the CMS Innovation Center (CMMI), August 2020

4

Focus on value is not diminishing…

"There is no turning back to an unsustainable system that pays for procedures rather than value. In fact, the only option is to charge forward — for HHS to take bolder action, and for providers and payers to join with us."

Alex M. Azar II, Secretary of HHS,
March 5, 2018
(Remarks to the Federation of American Hospitals)

Source: https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/remarks-on-value-based-transformation-to-the-federation-of-american-hospitals.html

5

Health Care Payment Learning & Action Network

Our Goal Statement

Accelerate the percentage of US health care payments tied to quality and value in each market segment through the adoption of two-sided risk alternative payment models.

	Medicaid	Commercial	Medicare Advantage	Traditional Medicare
2020	15%	15%	30%	30%
2022	25%	25%	50%	50%
2025	50%	50%	100%	100%

https://hcp-lan.org/

6

6

Form Follows Finance

- How we deliver care depends on how we are paid for care
- Health care reform is changing both payment and delivery
- Fundamentally, reform involves transfer of financial risk from payers to providers

7

7

The Road: Payment Models

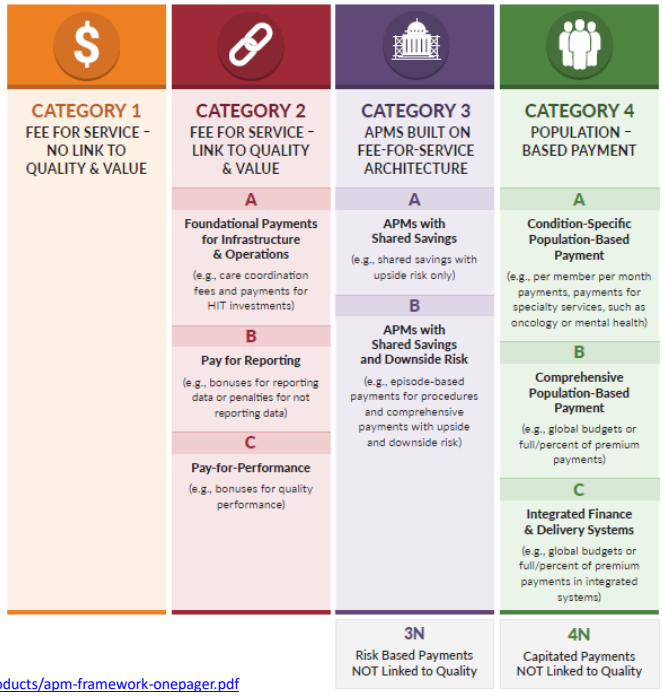
- **Starting line:** Fee-for-service (FFS)
- **Slow lane:** Incremental modifications with incentives (ex. quality scores)
- **Moderate lane:** Elements of restructuring health finance but leaves in place current FFS infrastructure (ex. ACO)
- **Fast lane:** Blows past current structure to a total redesign of payment, still aligned with quality measures (ex. global budget)

8

8

Health Care Payment Learning and Action Network (HCP LAN)

Alternative Payment Model Framework



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

9

Track 1: The Starting Line (FFS)

- In 2018, only 10% of Medicare FFS payments and 39% of all types of payments have no link to quality or value.*
- Still at the Medicare FFS starting line:
  - Critical Access Hospitals
  - Rural Health Clinics
  - Federally Qualified Health Centers

10

*Source: https://hcp-lan.org/workproducts/apm-infographic-2019.pdf

Rural Health Value

10

Track 2: The Slow Lane

- Incentives affecting small percentage of payment
- Payment change for only a small portion of patients
- Additional payments for implementing infrastructure supports
- Adjustments to limited number of services
- Retaining the FFS payment design

11

11

Track 3: A Moderate Pace with Potential for More Rapid Pace

- Examples include ACOs or bundled payments
- Fee-for-service chassis remains in place:
  - Incentive (or risk) is tied to total expenditures
  - Linked to quality measurement
- Push towards increasing levels of flexibility for increasing levels of risk

12

12

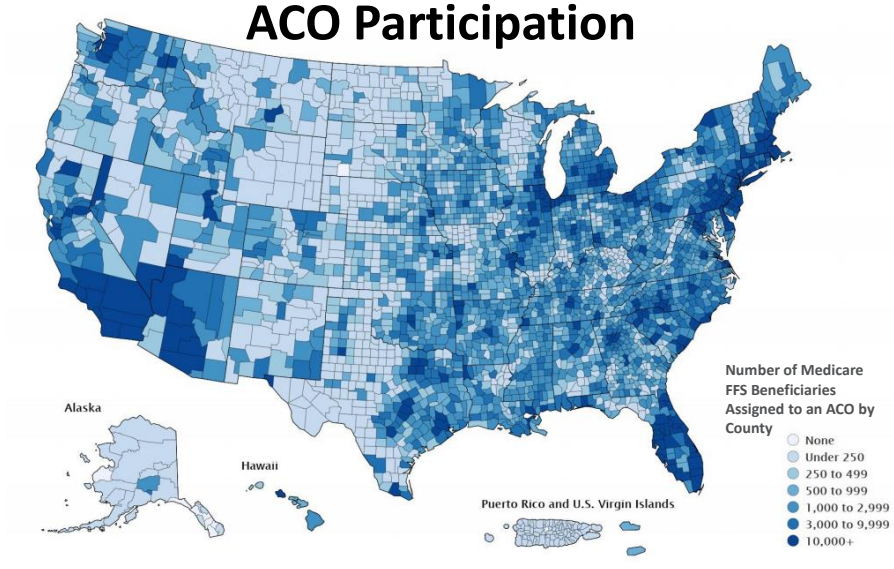
Rural Traffic on ACO Lane

- Medicare Shared Savings Program (SSP) ACOs have been a relatively low-risk opportunity for rural organizations to try out value-based strategies (training wheels)
  - Network/Aggregate across communities for scale and support
  - Road-block? 2019 changes to CMS regulations limiting timeframe for no downside risk
- Opportunity for Strategic investments (using advance payment if available)
  - Infrastructure for prevention, chronic care management, and care coordination
  - Opportunity to understand and utilize claims data to help manage care
- Building delivery systems that can negotiate contracts

13

13

2020 Medicare Shared Savings ACO Participation



14

Source: CMS - Medicare Shared Savings Program Fast Facts

14

Medicare SSP ACOs by the numbers

- Rapid growth of Medicare ACO/Shared Savings:
  - 2012/2013: 220 ACOs with 3.2 million assigned beneficiaries
  - 2020: 517 ACOs with 11.2 million assigned beneficiaries
- In 2020, 63% of SSP ACOs in one-sided risk contracts
- Rural participation in 2020:
  - Critical Access Hospitals: 435
  - Rural Health Centers: 1393
- State Medicaid Programs and other payers also using ACO models that can drive rural engagement

Source: CMS - Medicare Shared Savings Program Fast Facts

15

15

Track 4 Fast Lane: Global Budgeting

- Maryland All-Payer Model:
  - All Hospitals (including rural)
  - All Payer (Rate Setting Commission)
  - Early results indicated model was meeting spending targets and quality measures are improving*

- Maryland shifted to a Total Cost of Care (TCOC) model in 2019:
  - Builds on the all-payer model with an expanded focus on care management and primary care
  - Ten-year term, with interim model performance requirements

16

*Source: Nelson Sabatini, Joseph Antos, Howard Haft, and Donna Kinzer. "Maryland's All-Payer Model—Achievements, Challenges, and Next Steps." *Health Affairs Blog*. January 31, 2017.

16

Track 4 Fast Lane: Global Budgeting

- Pennsylvania Rural Health Model
  - All-payer, focused on rural hospitals
  - Five hospitals launched January 2019, eight additional hospitals enrolled January 2020.
    - Goal of at least 30 hospitals to enroll by 2021
  - Inquiries from more than 20 states about process/program
- To participate, PA Rural Hospitals develop "transformation plans" focused in three areas:
  - Reduce Potentially Avoidable Utilization (PAU)
  - Increase operational efficiency
  - Align services with community needs

17

17

New Options – Same Road?

CMMI Announced a new rural focused model in August 2020, Community Health Access and Rural Transformation (CHART) Model, that outlines two tracks:

Community Transformation Track (Applications due late 2020)

- Builds on lessons from the Maryland Total Cost of Care and Pennsylvania Rural Health Models
- Up to 15 Lead Organization Recipients that will support implementation for a 'Community' including:
  - Secure multi-payer alignment
  - Form an advisory council and recruit participant hospitals
  - Develop and implement a Community Transformation Plan

ACO Transformation Track (Applications due Summer 2021)

- Builds on lessons from the ACO Investment Model (AIM ACO)
- Up to 20 ACOs to participate in the Medicare Share Savings Program and quickly advance to two-sided risk
- Advance Shared Savings Payment to support infrastructure investment, repayment over time deducted from shared savings.

18

Source: https://innovation.cms.gov/innovation-models/chart-model

18

Road Conditions: Market Factors

- Growth in Medicare Advantage
  - Rural enrollment in Medicare Advantage plans increased 9.5% from 2017 to 2018, to about 2.6 million nationally (24.6%)*
- State Medicaid Program Redesign
  - Managed Care
  - ACO and other value type payment structures
- Commercial/Private Insurance
  - Increasing costs/patient risk-sharing
  - Narrow networks
- The shift to the fast lane is underway, but **road conditions matter:** different paces in different places and from different payers

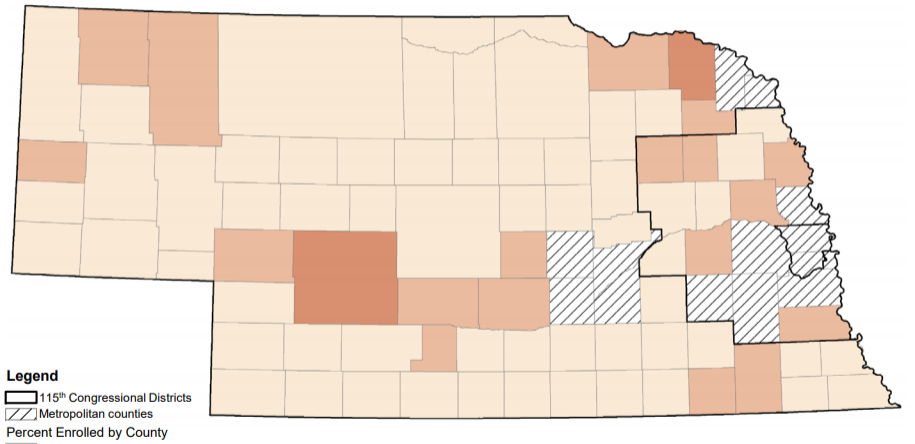
*Source: Medicare Advantage Enrollment Update 2018 RUPRI Center for Health Policy Analysis

19

19

Percent of Eligible Medicare Non-Metropolitan Beneficiaries Enrolled in Medicare Advantage and other Prepaid Plans: Nebraska, March 2018

Data table available at: https://rupri.public-health.uiowa.edu/maupdates/march2018.html



Source of data: Centers for Medicare and Medicaid Services (CMS) data, as of March 2018.

Produced by: RUPRI Center for Rural Health Policy Analysis, 2018

20

2020 – Detour?

- COVID-19 has challenged preconceived value-based priorities such as inpatient-care reduction and just-in-time inventories
- Health care organizations struggling to balance revenue reduction with need for potential surge capacity

- Increased pressure on a variety of fronts has highlighted needs and opportunities
- Overall impact unclear – but a variety of questions and for consideration:
  - COVID-19: Beyond Tomorrow; Choices for the "New Normal"
  - The Future of Rural Value-Based Health Care and Surge Capacity

21

21

Building the 'Car' for Value

22

22

The Driver: Health Care Leadership

- Identifying resources and investing strategically
- Culture of organizational learning and improvement
- Engaging clinicians, patients, and caregivers
- Facilitating and/or supporting coalitions and partners to address community needs

23

23

The Engine: Finance

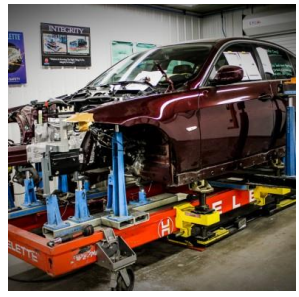
- Maximize current financial opportunities while preparing for the future
- Recognize that it may take multiple types of 'fuel' to get you going
- It can take time to build up speed, look for opportunities to pilot and test
- Watch your gauges, a balanced set of indicators is important

24

24

The Body of the Car: Strategies

- Identifying pressure points driving expenditures
  - Focusing on Potentially Avoidable Utilization (PAU)
  - Increase operational efficiency
- Reinforcements and safety features:
  - Data analytics and Health Information Exchange (HIE)
  - Appropriate coding and billing
    - Hierarchal Condition Category (HCC) Coding
    - Billing for Care Management Services



25

25

The Wheels: Community Partnerships

- Good tires take regular investment and maintenance
- Utilize opportunities, such as the Community Health Needs Assessment, to have meaningful discussions and align priorities
- Partnerships are critical for ability to capitalize on grant funding and external technical assistance to build capacity and programs
- Maintaining tire pressure: spreading resources to meet needs through the appropriate agency or partner

26

26

Mapping a Route to Value Through Population Health

- Understand local community health needs
  - Ideally in collaboration and partnership with other stakeholders
  - Prioritize and develop community-based action plans
- Consider strategy alignment with value-based care incentives
  - Potentially avoidable utilization
  - Quality metrics

- Common starting points for your journey:
  - Address patient/client social needs
  - Tackle local health issues
  - Align services to meet community need

27

27

Addressing Patient Social Needs

- Health Care Collaborative of Rural Missouri is **addressing social factors** and community needs in a patient-centered, community-based, collaborative approach with committees addressing key areas, such as homelessness, food access, transportation, and newly released incarcerated individuals.
  Source: Rural Innovation Profile: Rural Health Network Thrives on Innovation in Whole-Person Care
- Tri County Rural Health Network in Helena, Arkansas has created non-traditional partnerships using lay community members as "**Community Connectors**" to connect Medicaid-eligible seniors and adults with disabilities with home and community based services so they can continue to live safely in their homes.
  Source: Rural Innovation Profile: Using Community Connectors to Improve Access
- FirstHealth of the Carolinas in Pinehurst, NC, and Legal Aid of North Carolina **integrated legal services** into a broad array of clinical and community support services offered to low-income chronically-ill patients discharged from the hospital.
  Source: Rural Innovation Profile: Medical-Legal partnership Addresses Social Determinants of Health

28

28

Tackle local health issues

- In Staples, MN, Lakewood Health System has developed and implemented the "Engage" program partnering with schools, community and public health organizations to improve health and well-being through a **focus on access to healthy foods** including access to Community Supported Agriculture (CSA) shares, a "Food Farmacy", and home-based food delivery in senior housing.
  Source: Lakewood Health System *Engage*
- In 2012, Union General Hospital in Farmerville, LA began a community outreach program called "It's a Girl Thing! Making Proud Choices" to help **address high rates of teen pregnancy and STDs**. By educating and engaging high school girls on topics such as self-esteem, dating and violence, finances and the consequences of teen pregnancy. The program has since expanded through middle-school outreach, and added an additional focus on working with teen boys.
  Source: Hospital Spotlight: Union General Hospital "It's a Girl Thing: Making Proud Choices"
- Run by an FQHC in rural Cross County AR, the ARcare **Aging Well Outreach Network**, provides services like falls prevention assessments, transportation to appointments, medication management, and senior-specific exercise opportunities.
  Source: RHI Hub Case Study: ARCare Aging Well Outreach Network

29

29

Align Services with Community Need

- Implementation of **outpatient pulmonary rehabilitation** programs in 2 Federally Qualified Health Centers and a Critical Access Hospital in West Virginia to support evidenced-based chronic lower respiratory disease management options for rural Appalachia patients, where lung disease rates are among the highest in the country.
  Source: Rural Health Information Hub Case Study: Community-Based Pulmonary Rehabilitation Program
- Western Wisconsin Health in Baldwin WI worked **to integrate behavioral health providers and services with primary care**, including a focus on financial sustainability and cultural change to focus on whole-person care.
  Source: Rural Innovation Profile: Behavioral Health Integration into Primary care
- Care Partners of Cook County in Grand Marais MN created a **palliative care program** that utilizes local healthcare professionals and volunteers to provide supportive care and services to patients and caregivers.
  Source: Rural Health Information Hub Case Study: Care Partners of Cook County

30

30

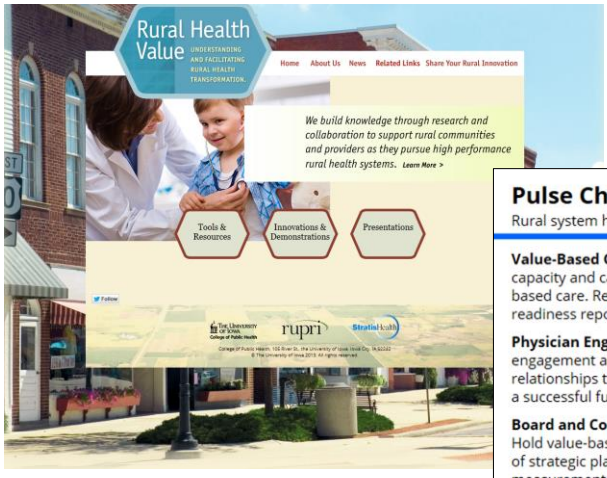
Conclusion

- Value-based reimbursement is here to stay:
  - Impact of 2020 Detour is still unclear, but the overall destination is unlikely to change
  - Models and programs will continue to develop and be refined
- The shift to the fast lane is underway, but road conditions matter:
  - Different paces in different places and from different payers
- Many of the components needed to keep moving forward on the road to value are already in place, or can be developed to design and drive a car that can help meet the needs in your community.
- Community-wide partnerships and engagement are critical, hard to move past the start line with out having good tires!

31

31

www.ruralhealthvalue.org



Pulse Check

Rural system high performance

Value-Based Care Assessment - Assess capacity and capabilities to deliver value-based care. Receive an eight category readiness report.

Physician Engagement - Score current engagement and build effective relationships to create a shared vision for a successful future.

Board and Community Engagement - Hold value-based care discussions as part of strategic planning and performance measurement.

Social Determinants of Health - Learn and encourage rural leaders/care teams to address issues to improve their community's health.

32

32

RURAL POLICY RESEARCH INSTITUTE

Center for Rural Health Policy Analysis

Rural Health Value — UNDERSTANDING AND FACILITATING RURAL HEALTH TRANSFORMATION.

StratisHealth

Karla Weng, MPH, CPHQ

kweng@stratishealth.org

www.ruralhealthvalue.org

This presentation was developed with funding from the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $250,000 with 0% financed with non-governmental sources. The contents are those of the authors(s) do not necessarily represent the official views of, nor an endorsement by HRSA, HHS or the U.S. Government.

Rural Health Value

33