

# Rural Health Policy Landscape: Implications for Addressing Behavioral Health

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# RUPRI MISSION

The mission of the Rural Policy Research Institute is to:

- Undertake unbiased research and analysis on the challenges, needs, and opportunities facing rural America.
- Improve the understanding of the impacts of public policies and programs on rural people and places, using original research and policy analysis.
- Facilitate dialogue and collaboration among the diverse community, policy, practice, and research interests focused on a sustainable rural America.

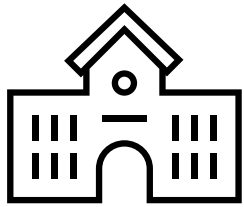


# RUPRI VISION

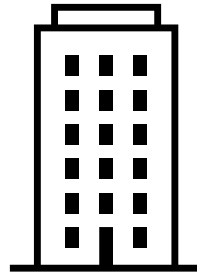
Rural people and places have the resources and capacities to create strong, viable, meaningful, and sustainable futures that can both withstand and turn to advantage the forces of globalization and economic, demographic, and social change.



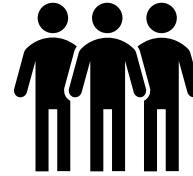
# RUPRI ORGANIZATION AND APPROACH



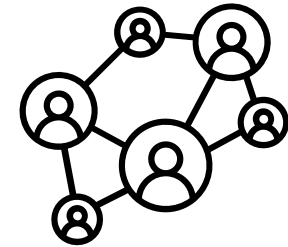
IN THE COLLEGE  
OF PUBLIC  
HEALTH,  
UNIVERSITY OF  
IOWA



OFFICES IN IOWA  
(MISSOURI) AND  
WASHINGTON  
D.C.



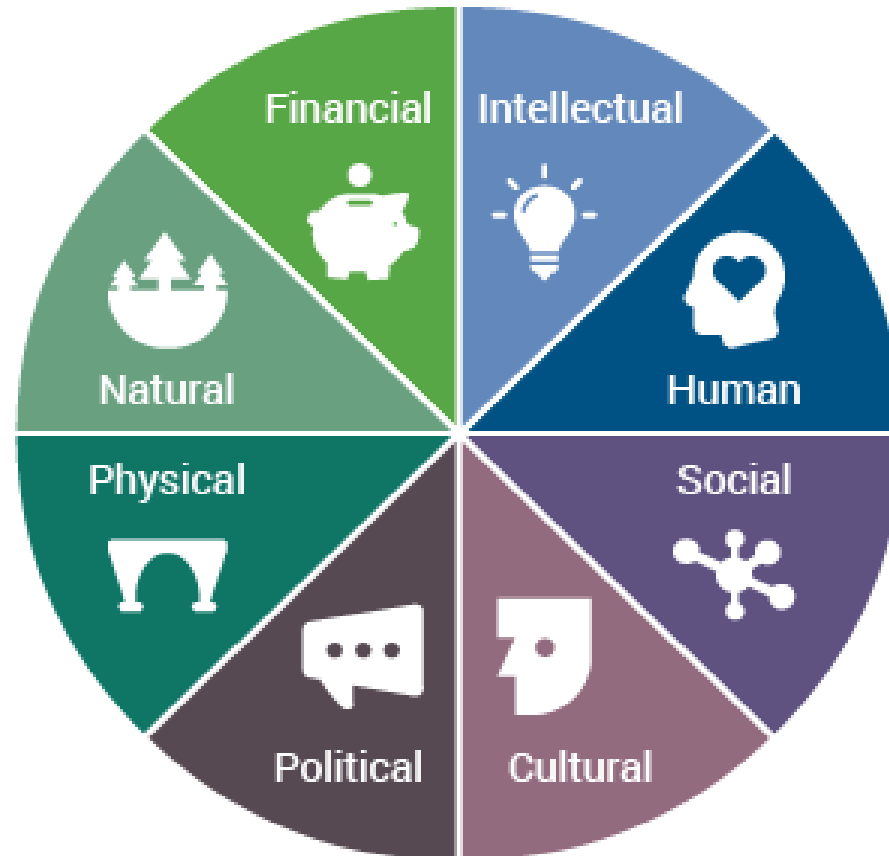
VERY SMALL CORE,  
WITH ENGAGED  
SCHOLARS IN  
MULTIPLE  
UNIVERSITY-BASED  
LOCATIONS



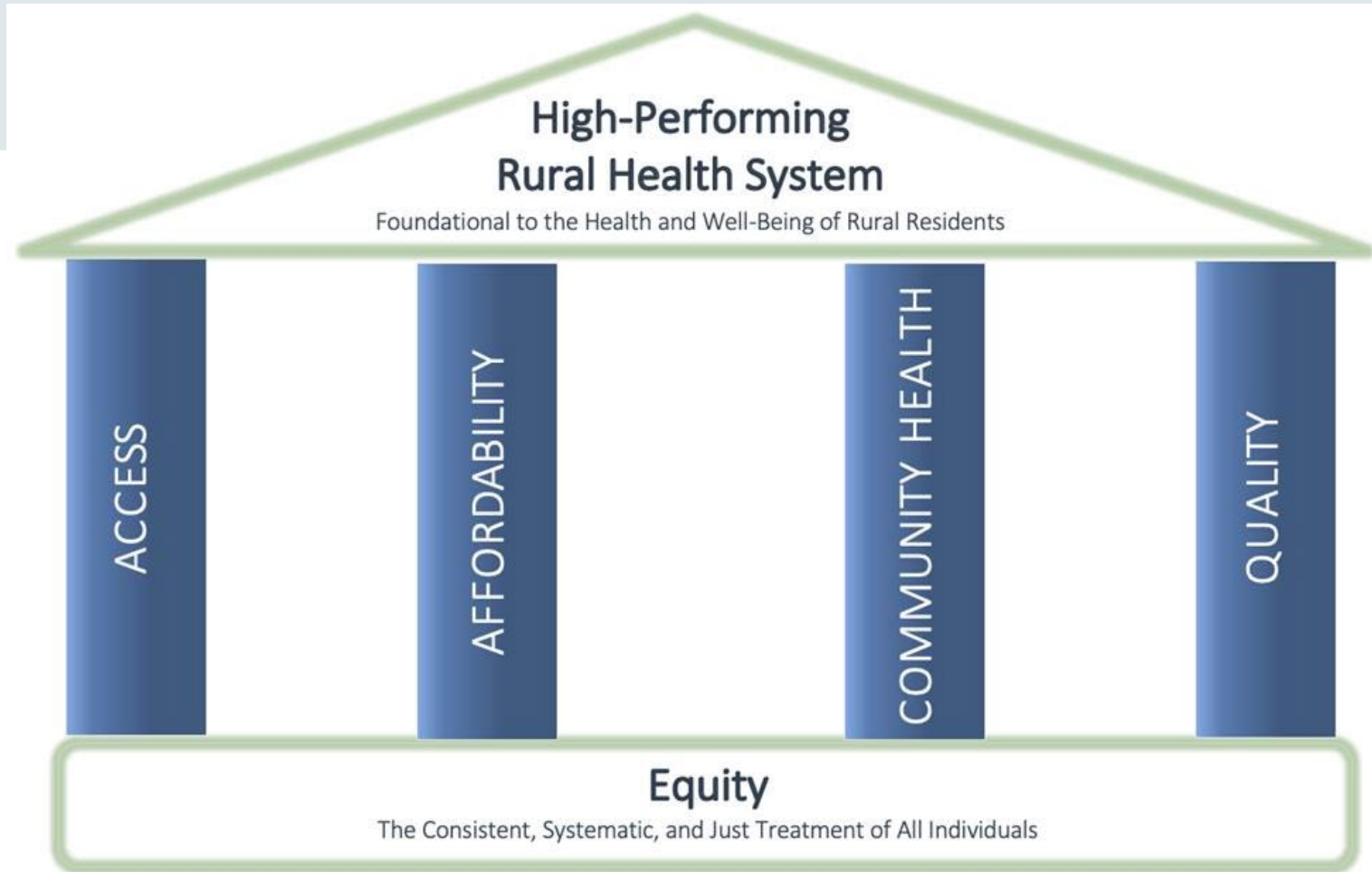
WORK THROUGH  
CENTERS, PANELS,  
POLICY  
ENGAGEMENT, AND  
COLLABORATIONS  
WITH OTHER  
ORGANIZATIONS

# RUPRI FRAMEWORKS

Comprehensive Rural Wealth Framework and the 8 capitals:



# RUPRI FRAMEWORKS



# RUPRI PORTFOLIO

- Cultural Wealth Lab
- Population and place analytics: Expert Panel
- State and local government: Center for Local and State Policy
- Health and Human Services (detail to follow)
  - History includes Poverty Center and Human Services Panel

# Summary of RUPRI Health and Human Services Current Portfolio

- Rural Health Panel: subject matter experts, started in 1993
- Center for Rural Health Policy Analysis: university-based research (primary base is U of Iowa, partner with Washington University in St Louis), started in 2000
- Rapid Response Policy Analysis (subaward with U of North Carolina), part of RUPRI Center started in 2004
- Rural Health Value: Joint with Stratis Health to provide technical assistance and policy translation for rural healthcare organizations, started in 2013



# DISCUSSION BREAK

- Questions about RUPRI generally
- Questions about RUPRI health and human services portfolio

# Changing World of Healthcare Finance and Organization

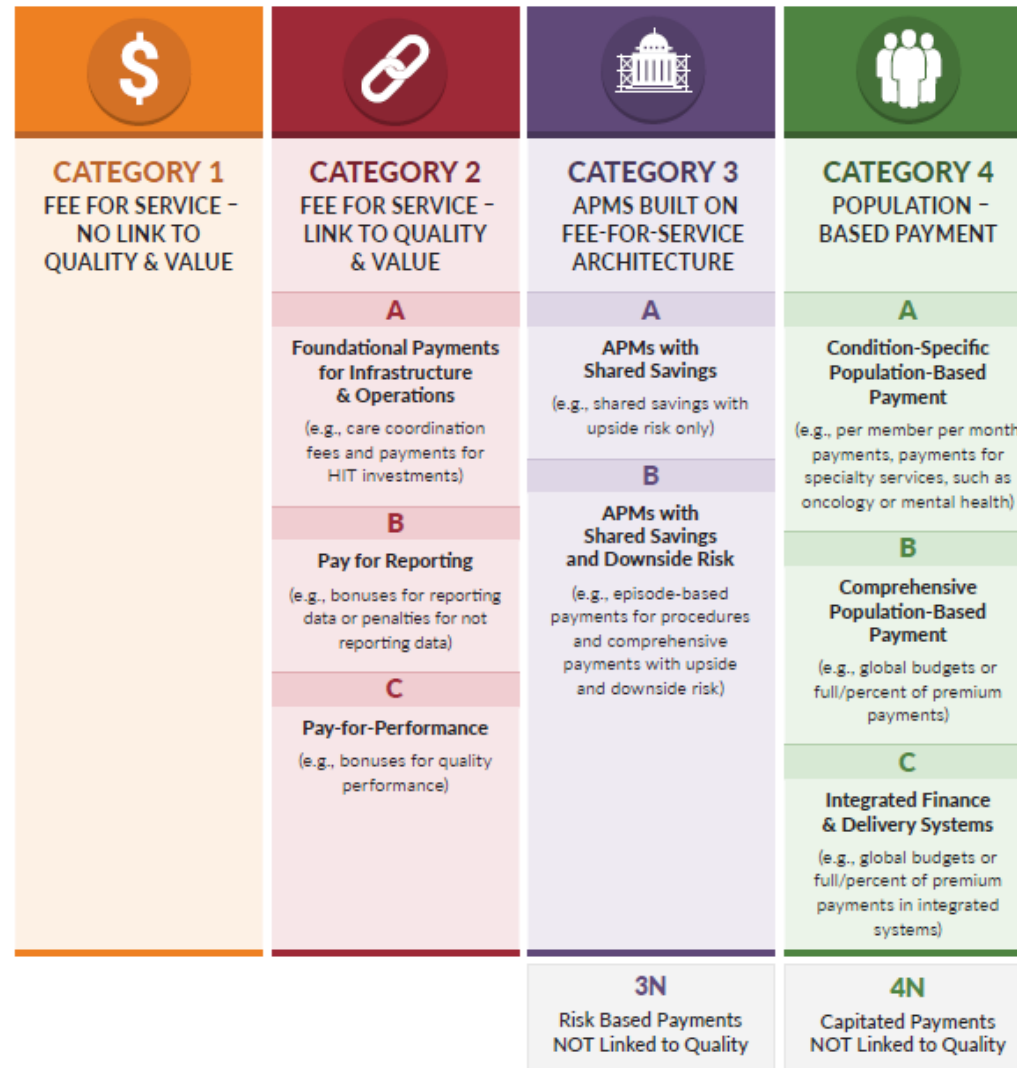
- The big dark cloud: health care expenditures back to pre-pandemic upward trend, heading to \$4 trillion and 20 percent of GDP – impacts on public budgets, employer costs, insurance company margins
- Short term pressures in price points – squeezing the turnip
- Time to aggressively move to long-term approaches
- Taking advantage of changes in how care is delivered

# Landscape: Federal Policy Goals

- Getting to categories 3 and 4 of HCPLAN model: alternative payment models with both upside shared savings and downside risk; population-based payment
- Federal policy goals to reach 100% of beneficiaries in an advanced payment model by 2030 – applied to both Medicare (directly) and Medicaid (through letters to state Medicaid directors)
- Specific actions
  - Medicare Shared Savings Program – the program, not demonstrations
  - Other designs to shift downside risk to providers (global budgets, direct contracting, i.e. ACO REACH)
  - Eye on the prize: quadruple aim

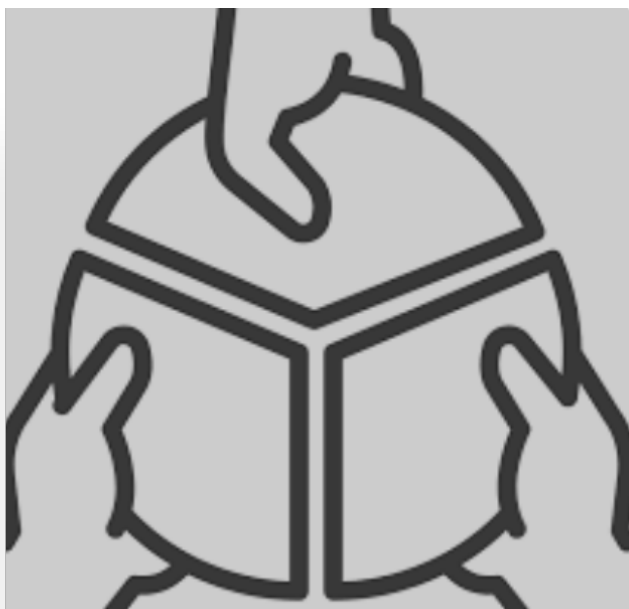


# Health Care Payment Learning and Action Network (HCP LAN) Alternative Payment Model Framework



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

# SHARED SAVINGS PROGRAM



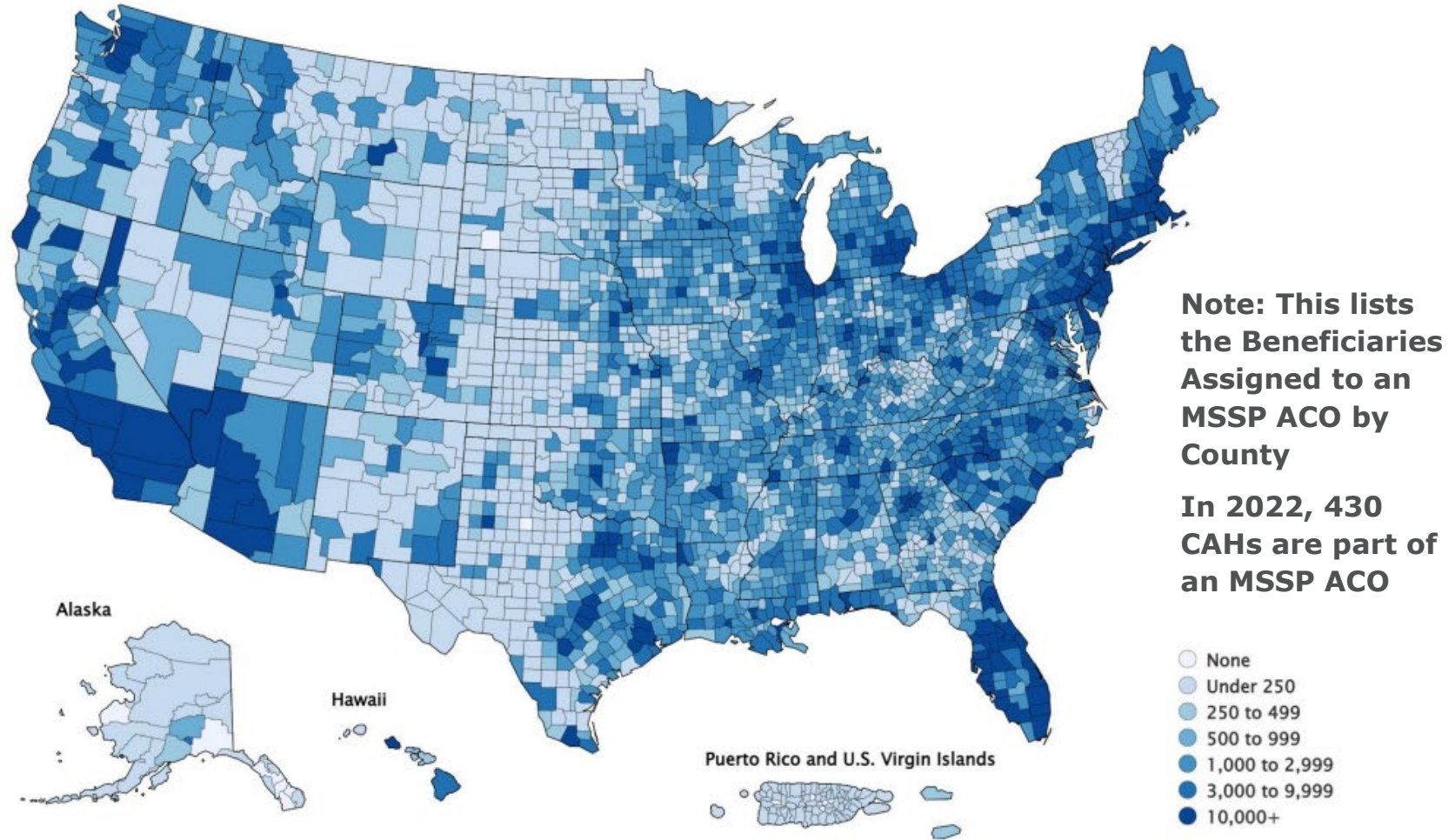
- Plateau of 561 in 2018, fell to 477 in 2021, 483 in 2022
- Composition in 2022
  - 269 low revenue (56%)
  - 1,645 Rural Health Clinics
  - 430 Critical Access Hospitals
  - One-sided: 41% (199)
  - Two-sided include 138 in basic tracks, 146 in enhanced track

Source: CMS: Savings Program Fact Facts – As of January 1, 2022



# ACO Spread - 2022

## Medicare Shared Savings Program ACO Assigned Beneficiary Population by County



# 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<sup>th</sup> percentile but at least in 10<sup>th</sup> 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>

# 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
- Other CMMI demonstrations, TBD
- Next up?



# 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

# EFFECTS OF 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 Nonmetropolitan 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>.

# THE HEALTH TEAMS OF 2024



- Primary care foundation and focus – comprehensive, continuous, coordinated
- Include clinical care focused on behavioral health (including substance use)
- 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)

# PERSON-CENTERED HEALTH HOME

- What that means
- How it fits the pressures to change
- The roles of all members of the team, including social workers



# RUPRI POLICY RECOMMENDATIONS

- Two papers in past 24 months
- Promote rural community engagement to support the design and implementation of local and regional strategies;
- Support the development of comprehensive system of local and regional behavioral health (including both mental health and substance use) services;
- Reform regulatory and payment policies to expand coverage for BHDs and encourage the development of comprehensive systems of care; and
- Expand the behavioral health workforce and create incentives for rural practice.

# RUPRI RECOMMENDATIONS FOCUSED ON FARM FAMILIES

- Leverage the resources of the Medicare and Medicaid payment systems and demonstrations to support coordinated care for families in distress
- Focus and align grant programs from multiple federal agencies to address mental health and substance use disorders among rural farm families
- Continue to integrate primary and behavioral care as the cornerstone of a high-performing rural health care system to provide initial treatment of mental health and substance abuse conditions

# CONTINUED

- Expand the workforce to improve behavioral health services capacity to meet the needs of farm families
- Increase telehealth services and repurpose available space to expand access to behavioral health services
- Expand private and public insurance coverage to improve access to essential behavioral health services

# CONCLUSION

- Could be worst of times if we think about the depths, we have reached in the confluence of health conditions and fragility of the rural health delivery system
- Could be best of times if we capture opportunities for more radical change in finance and organization of services

# FOR FURTHER INFORMATION:

[THE RUPRI  
HEALTH PANEL](#)



[THE RUPRI CENTER  
FOR RURAL HEALTH  
POLICY ANALYSIS](#)



[RURAL  
HEALTH  
VALUE](#)



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THANK YOU

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