Sustaining Essential Rural Health Services Through Changes in Payment and, Related Public Policies

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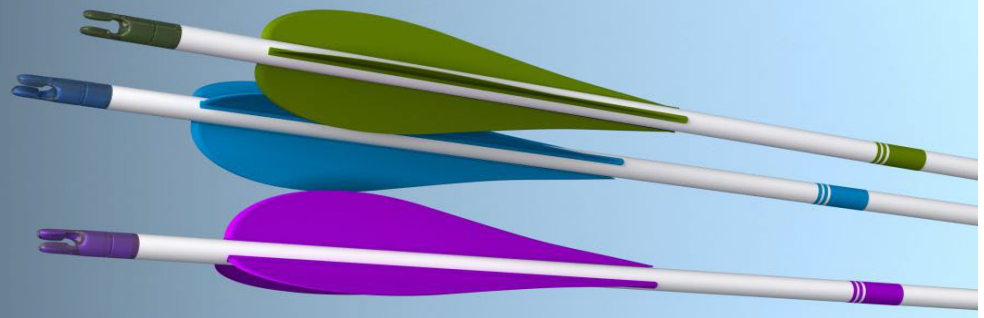
Outline of Comments

Setting the Landscape: Federal and State Policies, commercial carrier activity

Changes in Sites of Care and Workforce

Optimizing Success in New Environment

Changing Goals in Payment Policy



- Reality check: Is continued increase in expenditures exceeding general inflation palatable?
- Assume no: Can we achieve savings aim by simply squeezing the turnip?
- Reality check: Are we close to achieving optimum health for all members of our communities?
- Assume no: How do we improve but not bust the cost curve?
- Aspirational Goal: Focus on total expenditures and wise investment; the quadruple aim of best patient experience, reducing costs, improving healthcare outcomes, improving clinician experience

The Journey to Value-Based Payment Has Begun

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

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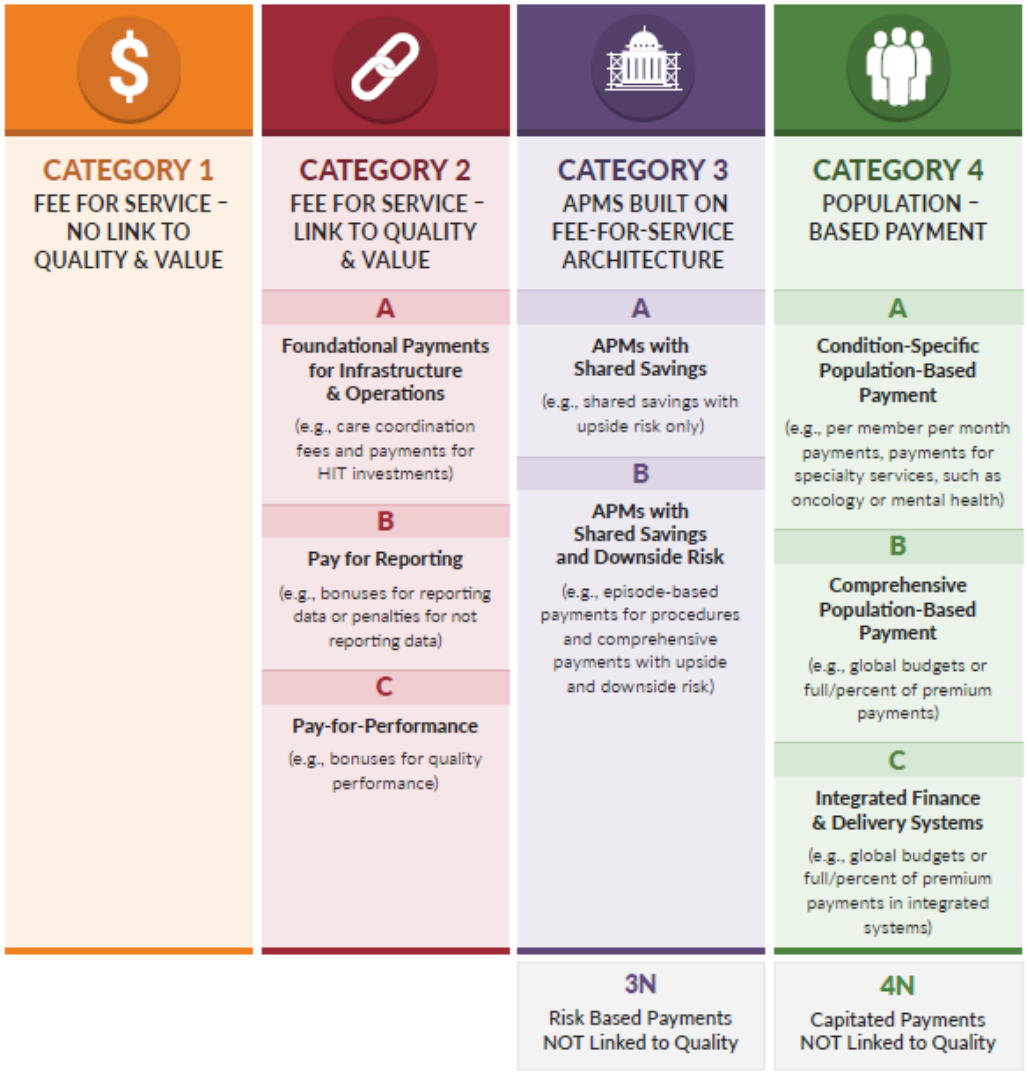
Health Care Payment Learning and Action Network (HCP LAN) Alternative Payment Model Framework



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

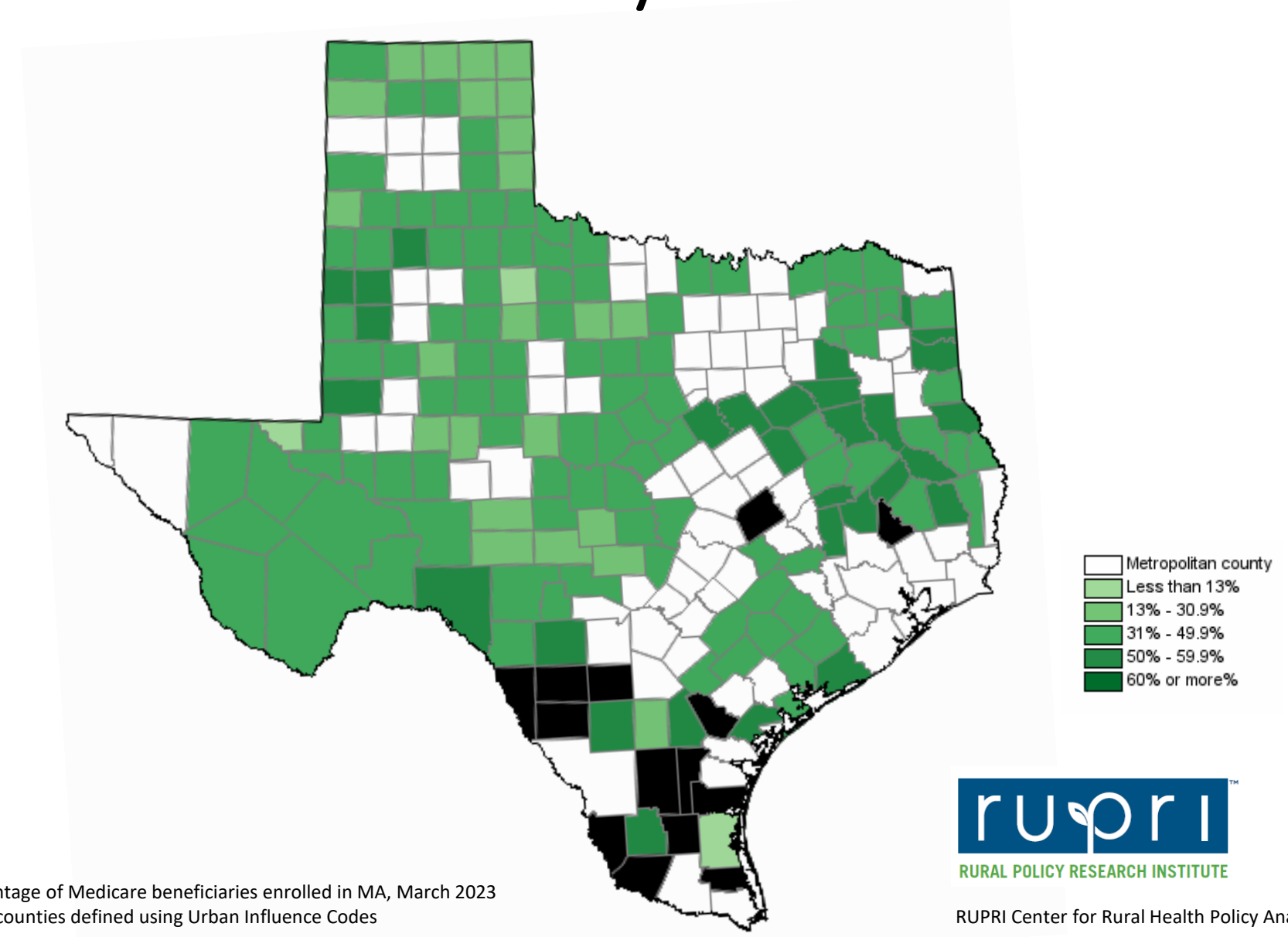
Getting to Categories 3 and 4

- 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

Texas State Rural County MA Penetration



Percentage of Medicare beneficiaries enrolled in MA, March 2023
Rural counties defined using Urban Influence Codes

RUPRI Center for Rural Health Policy Analysis

Shared Savings Program

Plateau of 561 in 2018, fell to 456 in 2023

Composition in 2023

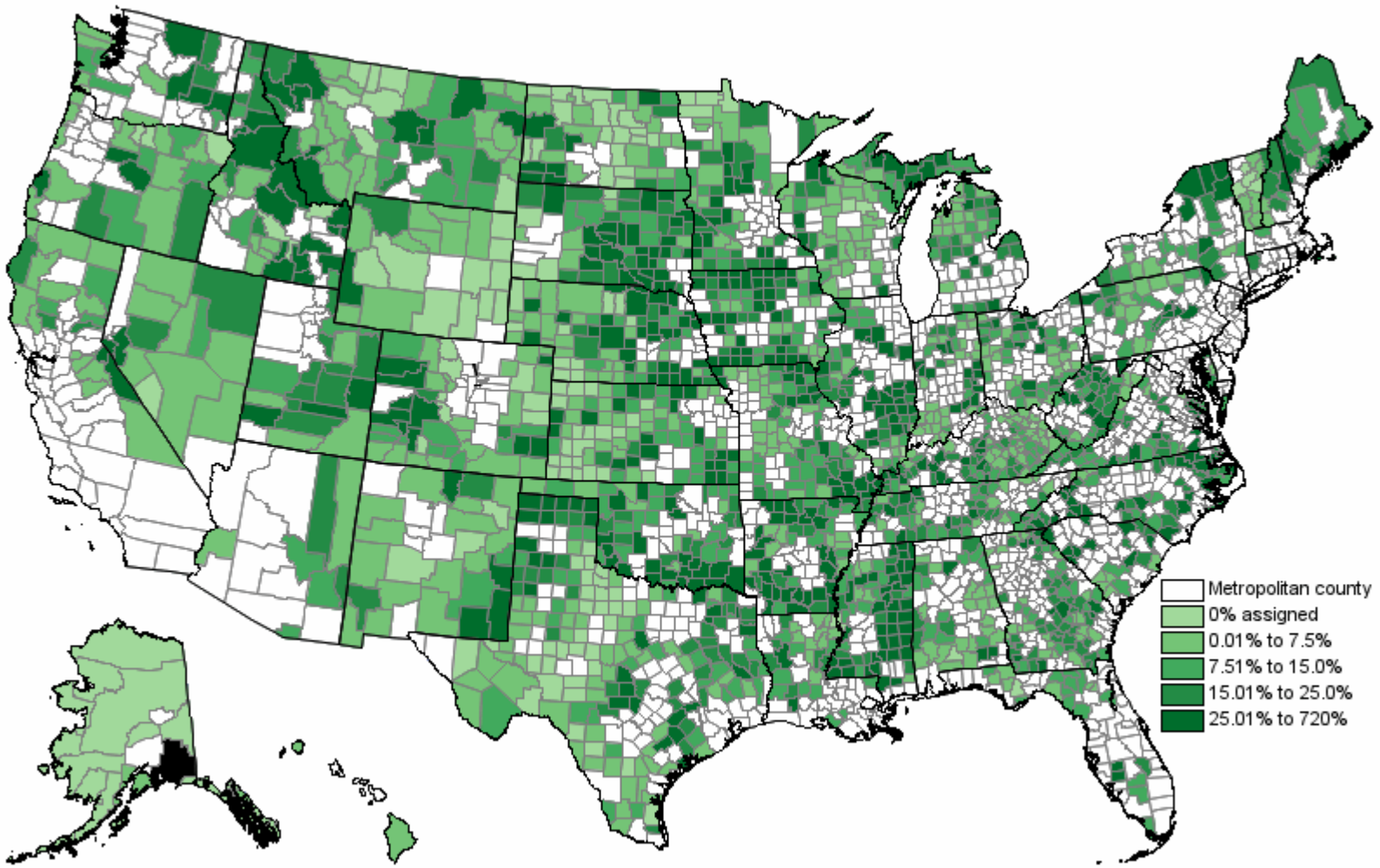
252 low revenue (55%)	2,240 Rural Health Clinics	467 Critical Access Hospitals	One-sided: 33% (151)	Two-sided include 144 in basic tracks, 161 in enhanced track	Source: CMS: Savings Program Fact Facts – As of January 1, 2023

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



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Source: [CMS - Medicare Shared Savings Program Fast Facts]

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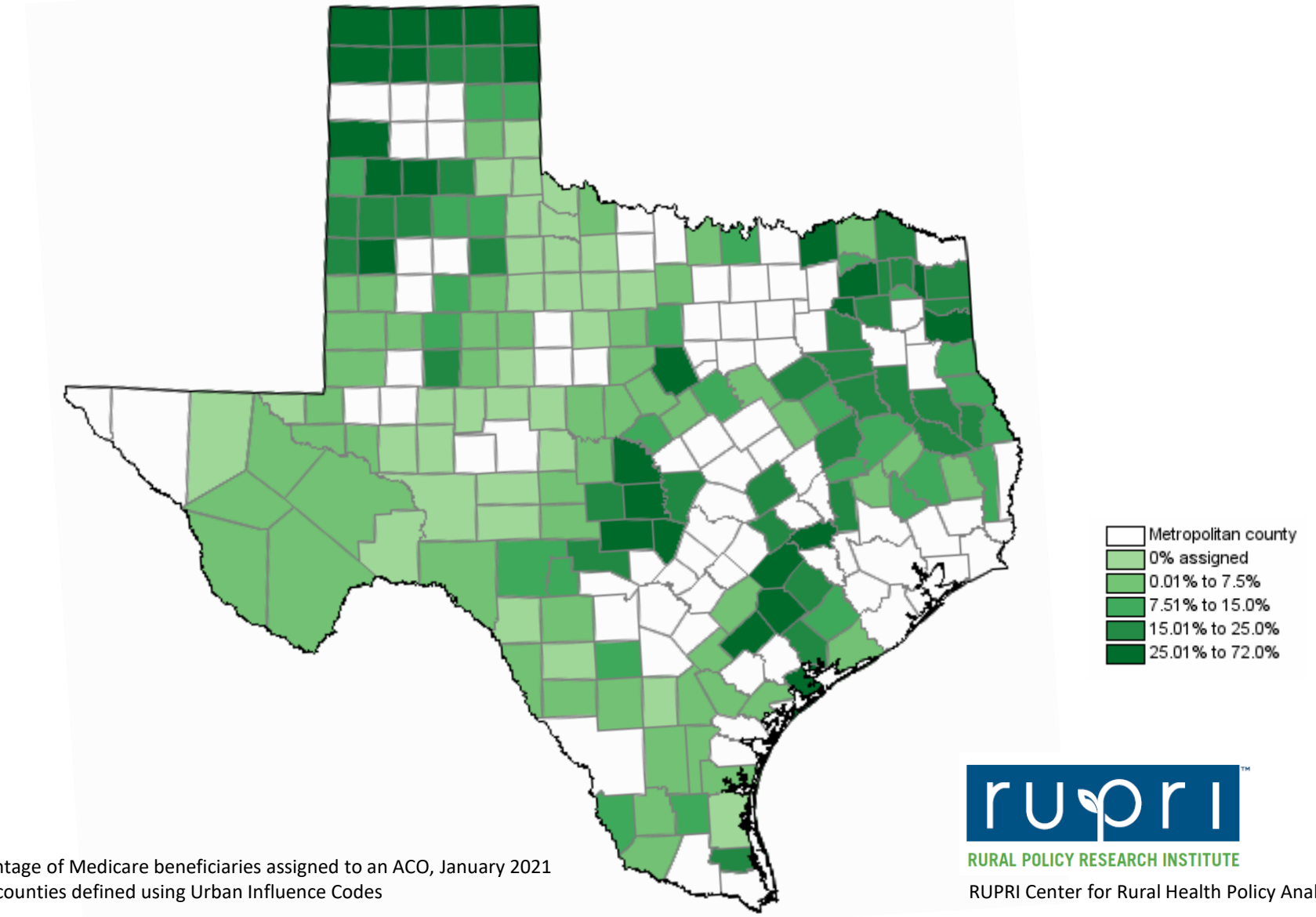
Texas State Rural County MSSP Penetration



Percentage of Medicare beneficiaries assigned to an ACO, January 2021
Rural counties defined using Urban Influence Codes

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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%

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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

2023 Announcements

- ACO REACH
- Making Care Primary
- AHEAD

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ACO REACH

- Accountable Care Organization Realizing Equity, Access, and Community Health Model
- Evolution of the Global and Professional Direct Contracting Model
- Eligible providers: group practices, networks of individual practices, hospital employing providers, FQHCs, RHCs, and CAHs
- Applications closed April 22, 2022
- 132 participants (including in Austin, Houston, Dallas areas)

ACO REACH

Two voluntary risk-sharing options:

1. Professional offers a lower risk-sharing arrangement of 50% savings/losses with one payment option: Primary Care Capitation, a risk-adjusted monthly payment for primary care services provided by the ACO's participating providers.

2. Global offers a higher risk sharing arrangement of 100% savings/losses with two payment options: Primary Care Capitation (described above) or Total Care Capitation, a risk-adjusted monthly payment for all covered services, including specialty care, provided by the ACO's participating providers.

The Model also includes a beneficiary-level Health Equity Benchmark Adjustment applied to ACOs serving higher proportions of underserved beneficiaries in order to mitigate the disincentive for ACOs to serve underserved patients by accounting for historically suppressed spending levels for these populations.

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Making Care Primary

- Announced in June 2023
- Accepting applications, due by November 30
- To be tested in 8 states: WA, CO, MN, NM, NY, MA, NJ
- Emphasis on care management, care integration, and community connection
- Excludes RHCs
- Payment differs by tracks, in 1 it remains fee-for-service; in 2 becomes 50/50 blend with capitation; in 3 becomes fully prospective, population-based

AHEAD

- States Advancing All-Payer Health Equity Approaches and Development
- Announced September 5, 2023
- Notice of Funding Opportunity in late Fall 2023, applications in Spring 2024
- Eligible entities: States, for entire state or a specified sub-state region

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AHEAD

- Hospitals paid on a prospective, bi-weekly basis using a global budget methodology for Traditional Medicare and Medicaid, encouraging commercial alignment; with modifications for CAHs
- Increase Medicare FFS investment in primary care with care management fee – must participate in state-led Medicaid transformation and the aligned Medicare Primary Care AHEAD program
- 11-year program with three cohorts with variable pre-implementation periods

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?

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 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.

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
  - 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

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

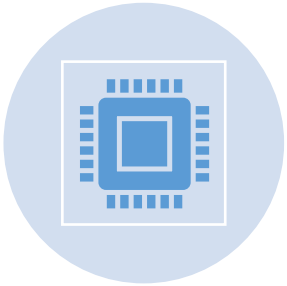
Integrated data from six of eight payors

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

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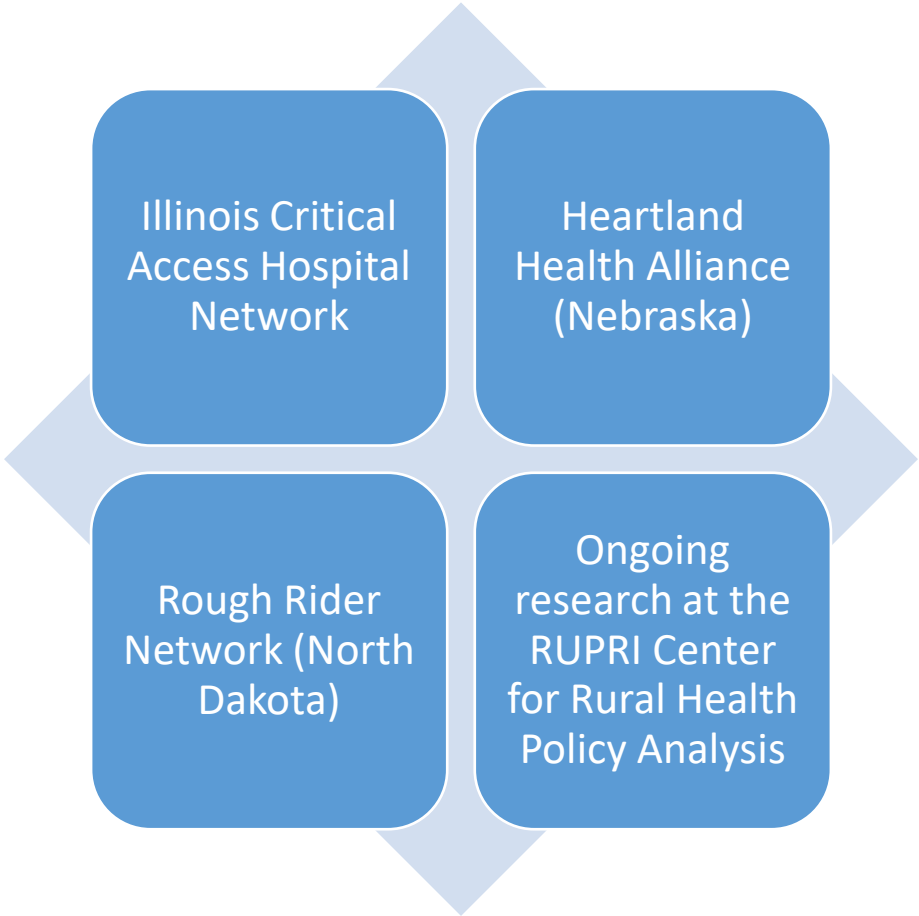
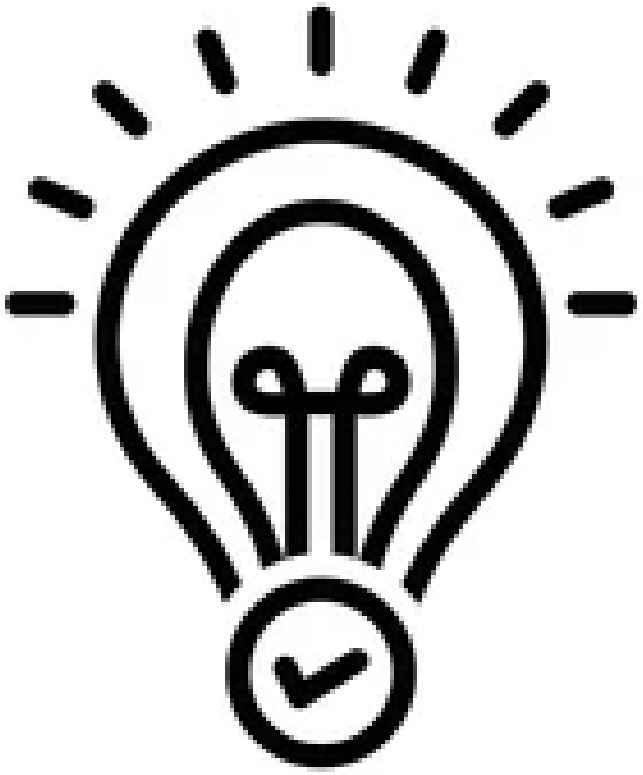
Other Rural Organizations Considering SSP and other ACO contracts



Considerations for Collaborative

- Commitment to being entirely independent
- Joining a national ACO (Signify, Alledade are examples)
- Affiliating with larger system
- The basics needed for success:
  - Information, information, information
  - Analytics using the information
  - Enrollee volume
  - Agreements for patient care across the continuum

Conclusion: What Needs to be Done



- Take full advantage of advances in health care to shift locus of care to most cost-effective site
- Take full advantage of any investment capital available to build and maintain information systems
- Take full advantage of support for building networks and taking action through networks

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Rural Health Value Resources

- Community Engagement Resource Guide
- Catalog of Value-Based Initiatives for Rural Providers
- Profiles of rural innovators
- Other tools and resources
- Web portal to all resources: www.ruralhealthvalue.org.

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