# Forces Shaping the Future of Critical Access Hospitals: A Journey to OZ

Medicare Rural Hospital Flexibility Program
Missouri Statewide Meeting
July 26, 2016
Columbia, MO

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# Where the Journey Ends: Oz

- A rural place that is vibrant, with high quality of life
- A rural-focused health care system that serves that place
- Local services that are sustainable
- Including the pillars of a high performing rural healthcare system

# The Pillars

- ✓ **Affordable**: to patients, payers, community
- ✓ **Accessible**: local access to essential services, connected to all services across the continuum
- ✓ **High quality**: do what  we do at top of ability to perform, and measure
- ✓ **Community based**: focus on needs of the community, which vary based on community characteristics
- ✓ **Patient-centered**: meeting needs, and engaging consumers in their care

# The Journey So Far

- 1997: The Balanced Budget Act creates the Medicare Rural Hospital Flexibility Program
- 1997 – 2003: The "build out" of Critical Access Hospitals as a financially viable approach
- 2003: The Medicare Modernization Act enhances affordability for Medicare beneficiaries

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# The Journey So Far

- 2003 – 2010: Improvements in the Flex Program, including resources devoted to quality and community health
- 2010: The Patient Protection and Affordable Care Act (ACA) and a new emphasis on community health, quality outcomes
- 2015: Announcement of goals in the Medicare program to create a value-driven payment system

# And Now the Storm Hits

- Years of sequestration hit cost-based reimbursement
- Sources of payment change from government administrative price setting (and political decisions) to negotiations with private plans
- Consumers change purchasing decisions in private insurance, accepting high deductibles in exchange for lower premiums

# Waves of Change

- Medicare and Medicaid provided through private managed care organizations
- Medicare and Medicaid sharing financial risk with providers in shared savings models

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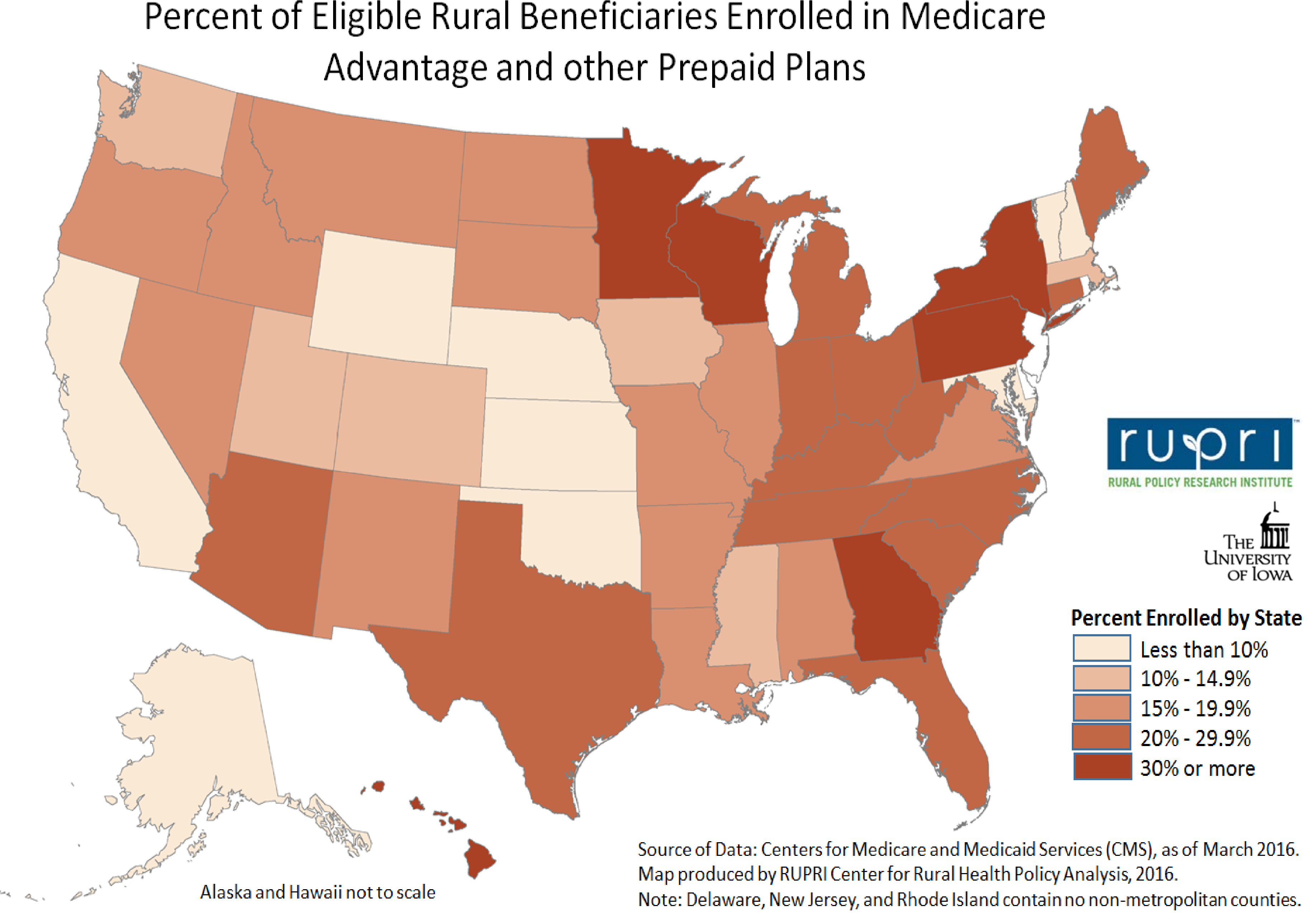
# Medicare Advantage Grows

- Rural enrollment in 2009: 1.17 million (13.5%)
- Rural enrollment in 2012: 1.5 million (16.5%)
- Rural enrollment in 2016: 2.2 million (21.8%)

Data from CMS reports,
calculations by the RUPRI Center for Rural Health Policy Analysis

# Percent of Eligible Rural Beneficiaries Enrolled in Medicare Advantage and other Prepaid Plans




Source of Data: Centers for Medicare and Medicaid Services (CMS), as of March 2016.
Map produced by RUPRI Center for Rural Health Policy Analysis, 2016.
Note: Delaware, New Jersey, and Rhode Island contain no non-metropolitan counties.

# Percent of Eligible Rural Beneficiaries Enrolled in Medicare Advantage and other Prepaid Plans

## Missouri

**Percent Enrolled by County**

- Metropolitan County
- Less than 10%
- 10% - 14.9%
- 15% - 19.9%
- 20% - 29.9%
- 30% or more

Source of Data: Centers for Medicare and Medicaid Services (CMS), as of March 2016.
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## Illinois

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## Iowa

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Source of Data: Centers for Medicare and Medicaid Services (CMS), as of March 2016.
Map produced by RUPRI Center for Rural Health Policy Analysis, 2016.

# Percent of Eligible Rural Beneficiaries Enrolled in Medicare Advantage and other Prepaid Plans – Kansas

**Percent Enrolled by County**

- Metropolitan County
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Source of Data: Centers for Medicare and Medicaid Services (CMS), as of March 2016.
Map produced by RUPRI Center for Rural Health Policy Analysis, 2016.

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# Percent of Eligible Rural Beneficiaries Enrolled in Medicare Advantage and other Prepaid Plans – Kansas

**Percent Enrolled by County**

- Less than 10%
- 10% - 14.9%
- 15% - 19.9%
- 20% - 29.9%
- 30% or more

Source of Data: Centers for Medicare and Medicaid Services (CMS), as of March 2016.
Map produced by RUPRI Center for Rural Health Policy Analysis, 2016.

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# Accountable Care Organizations Have Come to Rural America

- Data extracted from Centers for Medicare & Medicaid Services public information for years 2012 – 2015, plus “first look” at 2016
- Non-metropolitan presence (defined as participating provider) in each cycle
- Non-metropolitan presence in three models: Pioneer demonstration, Advanced Payment demonstration/Medicare Shared Savings Program, ACO Investment Model, Next Generation demonstration
- Increased rural presence across time

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# By the Numbers …

- ACOs operate in 72.% of metropolitan counties, 39.7% of non-metropolitan counties
- 7.6 million beneficiaries now receiving care through ACOs
- Rural sites in all four census regions

# By the numbers …

- Approximately half of Medicare ACOs have rural presence, although for 18% (76) that is between 1 and 24 percent of counties included
- 7 (1.7%) are 100% non-metropolitan
- 23 (5.4%) are 75-99% non-metropolitan
- 104 (24.6%) are 25-74% non-metropolitan
- *At least 37 of the 101 new ACOs in 2016 have a rural presence, many of those exclusively rural*

Data are as of the end of 2015

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# And Now the Visuals

- 2013 national map
- 2015 national map
- Regional map

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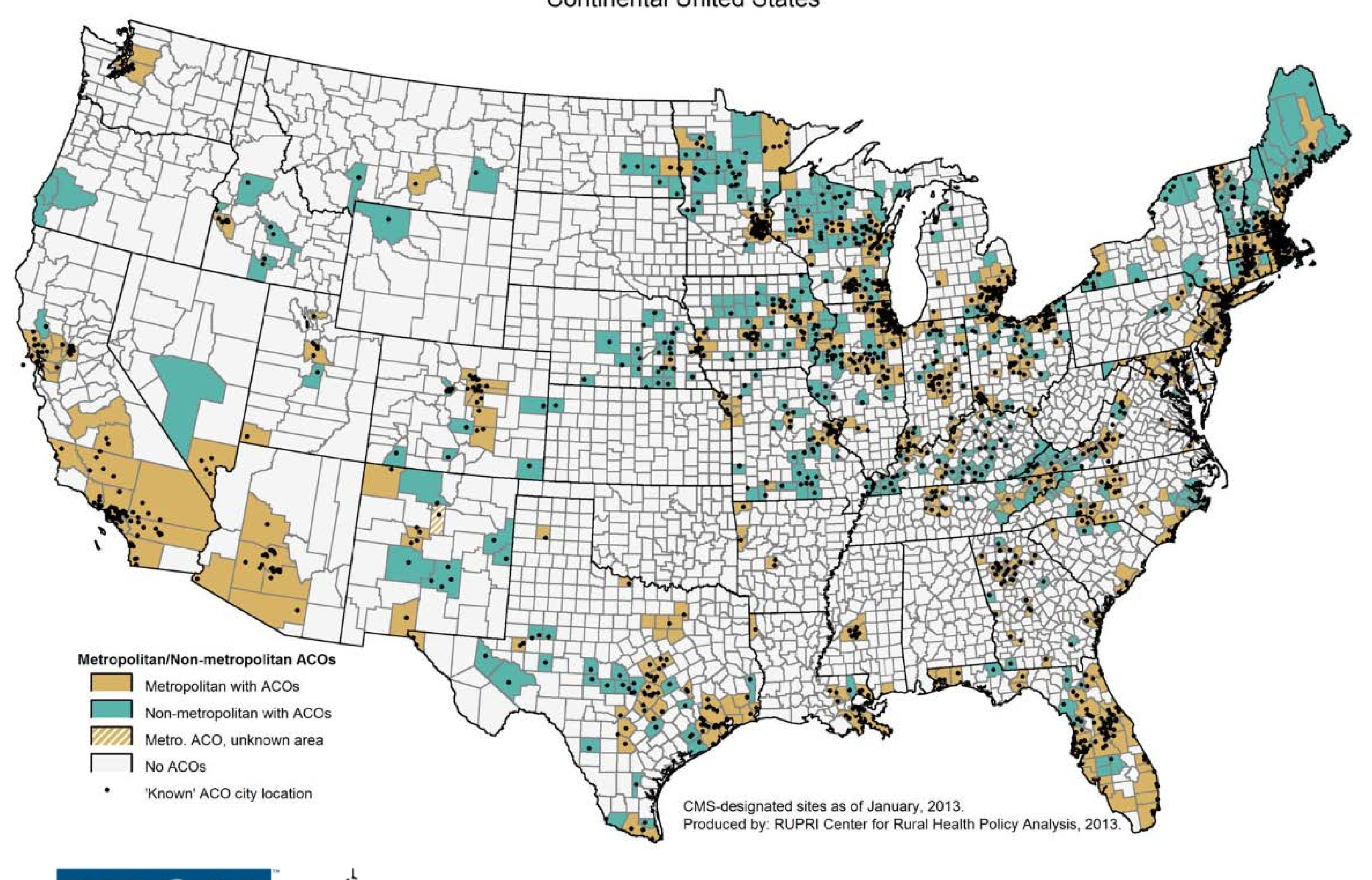
County Medicare ACO Presence
Continental United States
Metropolitan/Non-metropolitan ACOs
Metropolitan with ACOs
Non-metropolitan with ACOs
Metro. ACO, unknown area
No ACOs
'Known' ACO city location
CMS-designated sites as of January, 2013.
Produced by: RUPRI Center for Rural Health Policy Analysis, 2013.
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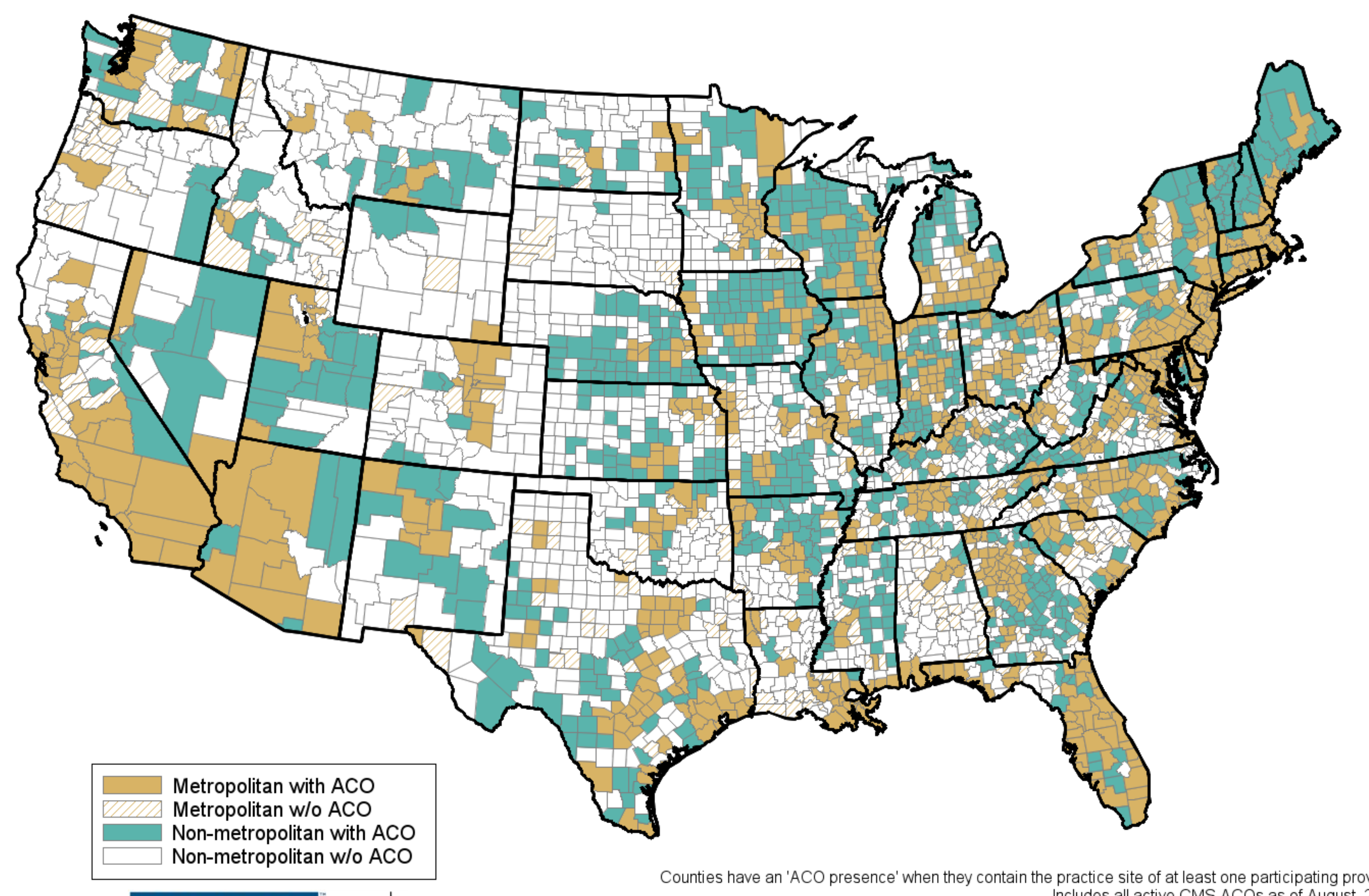
# County Medicare ACO Presence

## Continental United States




Counties have an 'ACO presence' when they contain the practice site of at least one participating provider.
Includes all active CMS ACOs as of August, 2015.
Produced by: RUPRI Center for Rural Health Policy Analysis, 2016.

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# Medicaid Enrollment In Managed Care Organizations

- Nationally 59.7%
- Missouri: 47.1%
- Iowa: 9.9% (nearly 100% in 2016)
- Kansas 89.3%
- Illinois 13.5%

Reported as enrollment in Comprehensive Managed Care

Source: Centers for Medicare & Medicaid Services. *Medicaid Managed Care Enrollment and Program Characteristics* 2014.

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# Medicaid ACOs: Colorado and Other States

- Managed care to ACOs to …
- Managed Care Organizations since 1983
- Accountable Care Collaborative started in 2011; now enrolling 58% of Medicaid clients
- Net savings of $29 to $33 million: reductions in ER use, imaging services, readmissions
- Oregon with Coordinated Care Organizations (2012
- Minnesota with Integrated Health Partnerships (2013)

Sources: Colorado Department of Health Care Policy & Financing, "Accountable Care Collaborative: 2014 Annual Report
Tricia McGinnis, The Commonwealth Fund, "A Unicorn Realized? Promising Medicaid ACO Programs Really Exist" March 11, 2015

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# Medicaid ACO Activities

- MN: IHPs must demonstrate partnerships with other agencies: social service public health
- MN: total cost of care calculations
- OR: CCOs must have community health needs assessment, encouraged to build partnerships with social service and community entities

Source: R. Mahadevan and R Houston, Center for Health Care Strategies, Inc. "Supporting Social Service Delivery Through Medicaid Accountable Care Organizations: Early State Efforts." *Brie* February, 2015.

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# Changing World of Private Insurance

- A nagging constant:  premium increases
- Result: shift to deductibles and copayments to cover financial risk (by insurers)
- Result: different patterns of use and payment

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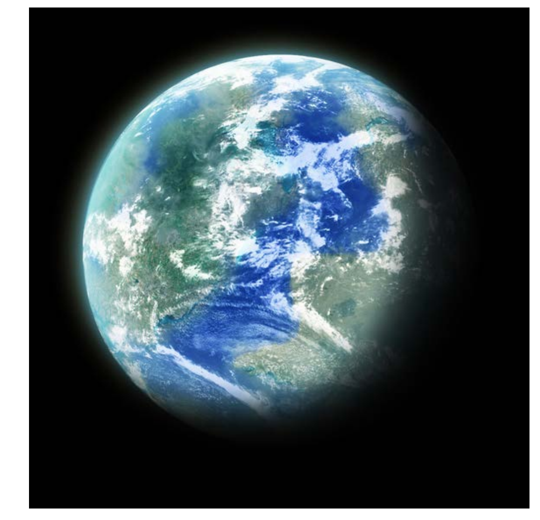
# Changing World of Private Insurance

- Market dynamics: competing plans come and go; markets carved out within rating areas; varying strategies for covering actuarial risk
- Contracting with narrow networks
- Sharing financial risk with providers



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# Evolution of Medicare Payment Through Four Categories

- Fee-for-service with no link to quality
- Fee-for-service with link to quality
- Alternative payment models built on fee-for-service architecture
- Population-based payment

Source of this and following slides: CMS Fact Sheets available from cms.gov/newsroom

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# Illustration of Move to Population-Based Payment

| | Payment Taxonomy Framework | | | |
|---|---|---|---|---|
| | **Category 1:** *Fee for Service—No Link to Quality* | **Category 2:** *Fee for Service—Link to Quality* | **Category 3:** *Alternative Payment Models Built on Fee-for-Service Architecture* | **Category 4:** *Population-Based Payment* |
| **Description** | *Payments are based on volume of services and not linked to quality or efficiency* | *At least a portion of payments vary based on the quality or efficiency of health care delivery* | *Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk* | *Payment is not directly triggered by service delivery so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. ≥1 yr)* |
| **Medicare FFS** | • Limited in Medicare fee-for-service<br>• Majority of Medicare payments now are linked to quality | • Hospital value-based purchasing<br>• Physician Value-Based Modifier<br>• Readmissions/Hospital Acquired Condition Reduction Program | • Accountable care organizations<br>• Medical homes<br>• Bundled payments<br>• Comprehensive primary care initiative<br>• Comprehensive ESRD<br>• Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model | • Eligible Pioneer accountable care organizations in years 3-5 |

# CMS Slogan: Better Care, Smarter Spending, Healthier People

- Comprehensive Primary Care Initiative: multi-payer (Medicare, Medicaid, private health care payers) partnership in four states (AR, CO, NJ, OR)
- Multi-payer Advanced Primary Care Initiative: eight advanced primary care initiatives in ME, MI, MN, NY, NC, PA, RI, and VT
- Transforming Clinical Practice Initiative: designed to support 150,000 clinician practices over next 4 years in comprehensive quality improvement strategies

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# CMS Slogan: Better Care, Smarter Spending, Healthier People

- Pay for Value with Incentives: Hospital-based VBP, readmissions reduction, hospital-acquired condition reduction program
- New payment models: Pioneer Accountable Care Organizations, incentive program for ACOs, Bundled Payments for Care Improvement (105 awardees in Phase 2, risk bearing), Health Care Innovation Awards

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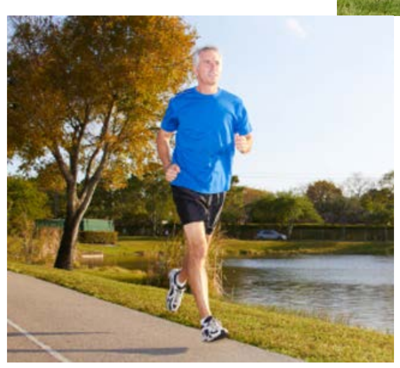
# CMS Slogan: Better Care, Smarter Spending, Healthier People

- Better coordination of care for beneficiaries with multiple chronic conditions
- Partnership for patients focused on averting hospital acquired conditions



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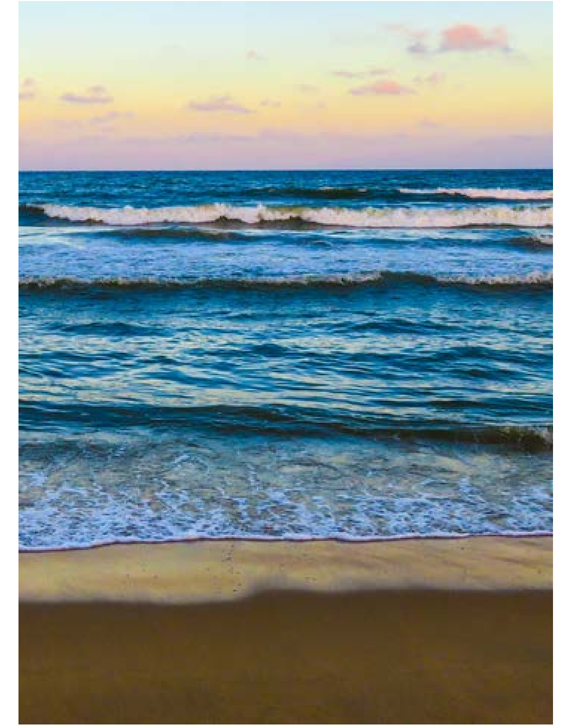
# Waves Keep Rolling In

- Medicare Access and CHIP Reauthorization Act (MACRA) – tidal wave coming at physician payment
- Increased activity to measure quality of physician care and pay accordingly
- Increased financial risk sharing, either through Advance Payment Models or through Merit Based Incentive Payment
- Comprehensive Primary Care Plus initiative – up to 20 regions including up to 5,000 practices, more than 20,000 doctors and clinicians



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# Summary: Market Forces Shaping Rural Health

- Hospital closure: 75 since 2010; up to 283 “vulnerable” now
- Enrollment increasing through Health Insurance Marketplaces and in plans outside of those marketplaces
- Development of health systems: 1,299 health care sector mergers and acquisitions in 2014, up 26% from the year before, with value of deals up 137%
- Growth in Managed Care Organizations and Accountable Care Organizations
- Continued evolution of payment systems

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# Choices Begin

- Adopt a strategy of preserve and protect – political battles to continue status quo
- Choose to build a road to a different future
- And there is the reality of a combination of approaches, but emphasizing the new road

# The Road to Oz?

- Turn adversity into motivation to change
- Turn onslaught of program changes and demonstration programs into opportunities to invest in change
- Requires that key stakeholders take the road together: Board of Trustees, C-suite, clinicians, community
- Shared commitment to local services and well being of population and community

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# Adversity to Positive Change: Hospital Transition

- To urgent care clinic (5 hospitals that had closed)
- To emergency center (5 hospitals)
- To skilled nursing facility (3 hospitals)
- To acute rehabilitation center (1 hospital)
- To Outpatient facility (3 hospitals)
- To primary care clinic (4 hospitals)

Source: Sharita R Thomas et al. "A Comparison of Closed rural Hospitals and Perceived Impact" *Findings Brief* North Carolina Rural Health Research Program. April, 2015. http://www.shepscenter.unc.edu/wp-content/uploads/2015/04/AfterClosureApril2015.pdf

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# Case Examples of Hospital Reconfiguration

- Epic Medical Center in Eufaula, McIntosh County OK closed as a hospital and reopened next day as urgent care clinic; May 23,2016
- Memorial Hospital and Physician Group in Frederick OK will transition from inpatient to outpatient (no emergency) during 2016

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# Taking Action: Serving the Community

- Hill Country Memorial Hospital in Fredericksburg, TX
- Used Toyota principles to better management to cut costs
- Used knowledge of community to focus on elderly
- Turned hospital near closure to a thriving community provider

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# Beyond Crisis Management: Building the Road Starts with Strategic Framing

- What does the community need?
- How is the hospital configured to meet that need?
- What changes would improve the ability to meet the need?
- What resources are available?
- What is the roadmap to sustainable local services?

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# Finding the Answers

- Importance of community data, role of community health needs assessment, epidemiological grounding
- Understanding the market forces in your region, such as activities of large system (Intermountain Health) and alliances (Western Healthcare Alliance)

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# Finding the Answers

- Requires  creating teams with equitable share in decision making
- Develop a framework for working through issues, e.g., AHA Committee on Research material
- Use all available and applicable demonstration and innovation support resources: Flex program, State Innovation Models, Centers for Medicare and Medicaid Innovation programs, FORHP programs, foundation programs

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# Results of Reconfiguration

- Post-acute care at Mayo system hospitals in Minnesota
- Replication in Oregon, with state funding support for development
- Anson County, NC hospital rebuilt with new design for patient flow that reduced use of the emergency room; 52 beds to 15, added van service because needs assessment identified transportation needs, and a patient navigator – facilitated because part of Carolinas HealthCare System

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# Paving the Road with Sound Fiscal and Process Management

- Managing as a “pay-for-performance hospital”: St. Joseph’s Hospital in Highland, IL
- Implementing Lean management: Mercy Network in IA
- Takeaways from sources of technical assistance

# Turning the Corner: Population Health

- Motivation is that the wave of the future is global payment, not payment per encounter, changing currency from encounters/patients to enrolled lives/population
- Requires *some* reframing of traditional strategic questions to apply to managing care and engaging populations in healthy behaviors

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# Ways to Get There: Lean Principles

- Bringing a focus to patient populations
- Freeing people to ask why
- Connecting hospitals and systems to communities
- Empowering voice of customers

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# Ways to Get There: Lean Principles

- Connecting data and metrics to identify better-targeted solutions
- Allowing states and regions to adapt and learn from successes of local health systems
- Moving community clinics and public health toward regular reporting of quality measures

Source: John Toussaint, M.D. "7 Ways Lean Principles Can Help Manage Population Health." *Hospitals and Health Networks.* March 9, 2016

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# Hospitals and System Act

- Trinity Health (Catholic health system with 88 hospitals) investing $80 million in 6 communities over five years to improve public health, particular focus on obesity and tobacco use
- Senior VP for safety net and community health: "We need to be part of the business of creating health in our communities"
- Additional $40 million in low-interest loans to communities

Source: Maria Castelluccu. "Trinity Health to invest $80 million to improve health in six communities." *Becker's Hospital Review* November 19, 2015

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# North Carolina Hospitals Take Action

- Statewide effort (Rural Health Action Plan) has four strategies addressing healthy activities including investments in local industry
- Southeastern Health in Robeson County: case manages, transportation, assist with Medicaid applications
- Halifax Regional Medical Center: fitness campaign

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# North Carolina Hospitals Take Action

- Granville Medical Center in Oxford: transitional care team
- Transylvania Regional Hospital: evolve into something different, including what services to offer, (orthopedics and emergency) and not (labor and delivery)

Source: Rose Hoban "Rural Hospitals Embrace Population Health in Quest for Relevance." *North Carolina Health News* March 4, 2016

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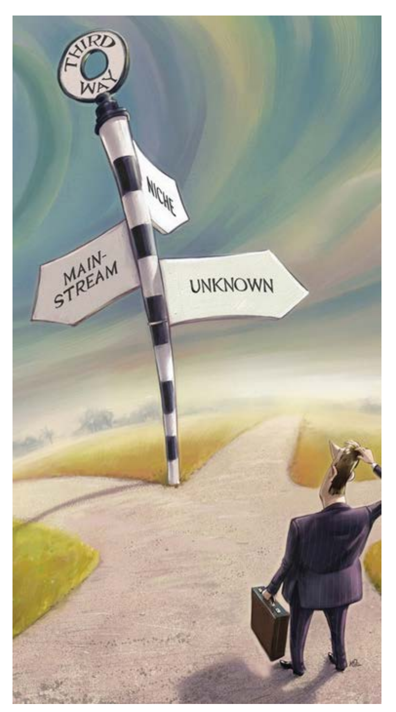
# Choices to Make Along The Road

- Commit to change
- Interplay with the move to pay for value
- Major shift to population health calls for two major directions
- Different foci, but need to focus: data to identify patients by chronic condition profiles; population health for community



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# Summary from Survey of Hospital CEOs

- Engaging physicians in cost and quality improvements
- Redesigning service portfolios for population health
- Establishing sustainable acute care cost structures
- Patient engagement strategies
- Controlling avoidable utilization

Source: Ben Umansky. The five issues every health care CEO cares about. The Advisory Board. March 25, 2015.

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# Closing Thoughts

- We are on the road
- Pave with transitions, not rural causalities
- Directed to the healthcare system we want
- "Heavy lift" for all involved
- Use all resources that are available

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# For further information

**The RUPRI Center for Rural Health Policy Analysis**
http://cph.uiowa.edu/rupri

**The RUPRI Health Panel**
http://www.rupri.org

**Rural Telehealth Research Center**
http://ruraltelehealth.org/

**The Rural Health Value Program**
http://www.ruralhealthvalue.org

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