How the Changing Marketplace Creates Challenges and Opportunities in Rural Health

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Meaning of "Marketplace"

- Implications of relying on competition
- Entry and exit into markets
- Negotiations between and among organizations
- Wither the small, solo provider?
- Wither the consumer and informed, "rational" decisions?

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Translation to Public Policy

- The backdrop of the Patient Protection and Affordability Act of 2010 (ACA)
- The belief in efficiency and continuous quality improvement drives policies (dates back to 1980s and advent of Prospective Payment Systems)
- Now present in the Secretary's goals for delivery system (payment) reform, as implemented by Centers for Medicare & Medicaid

Speed and Magnitude: Goals for Medicare Payment

- 30 percent of Medicare provider payments in alternative payment models by 2016
- 50 percent of Medicare provider payments in alternative payment models by 2018
- 85 percent of Medicare fee-for-service payments to be tied to quality and value by 2016
- 90 percent of Medicare fee-for-service payments to be tied to quality and value by 2018

Evolution of Medicare Payment Through Four Categories

1. Fee-for-service with no link to quality
2. Fee-for-service with link to quality
3. Alternative payment models built on fee-for-service architecture
4. Population-based payment

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

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 • Majority of Medicare payments now are linked to quality	• Hospital value-based purchasing • Physician Value-Based Modifier • Readmissions/Hospital Acquired Condition Reduction Program	• Accountable care organizations • Medical homes • Bundled payments • Comprehensive primary care initiative • Comprehensive ESRD • Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model	• Eligible Pioneer accountable care organizations in years 3-5

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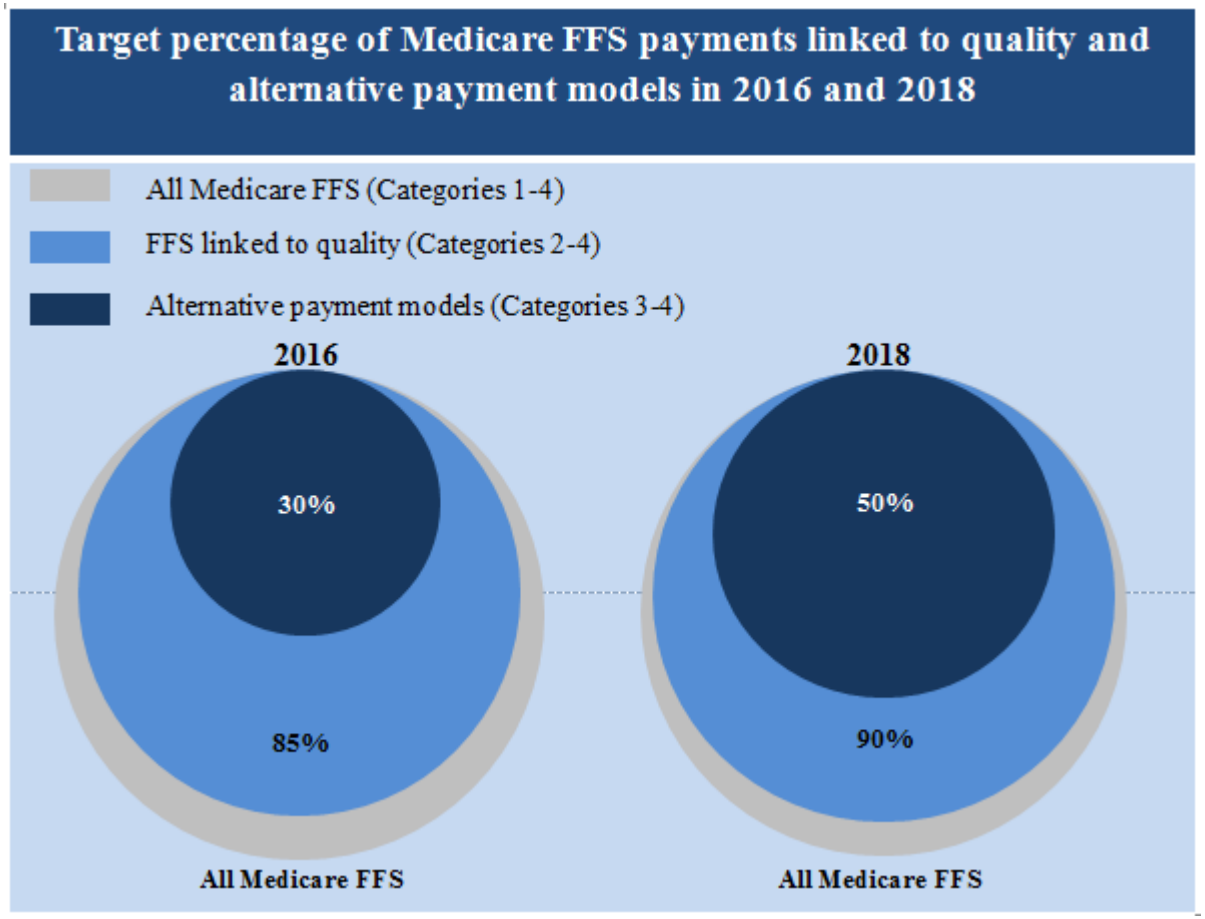
Shrinking Band of Traditional Payment



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CMS Slogan: Better Care, Smarter Spending, Healthier People

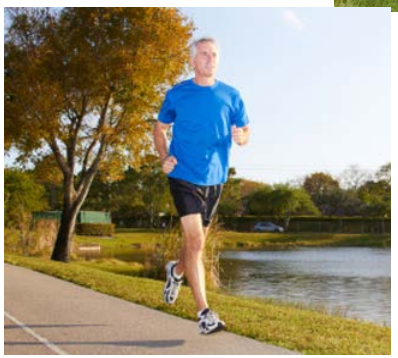
- Comprehensive Primary Care Initiative: multi-payer (Medicare, Medicaid, private health care payers) partnership in four states (AR, CO, NJ, OR)
- Multi-payer Advanced Primary Care Initiative: eight advanced primary care initiatives in ME, MI, MN, NY, NC, PA, RI, and VT
- Transforming Clinical Practice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

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

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



So What Does All That Mean?

- Continued use of value measures in hospital payment
- Ultimately the Maryland experience playing out through the multi-payer prospective budget initiative
- Hospitals shifting attention from patient encounters to patient panel management to promoting health (social determinants

So What Does All That Mean?

- Medicare 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

Specifically in Medicare

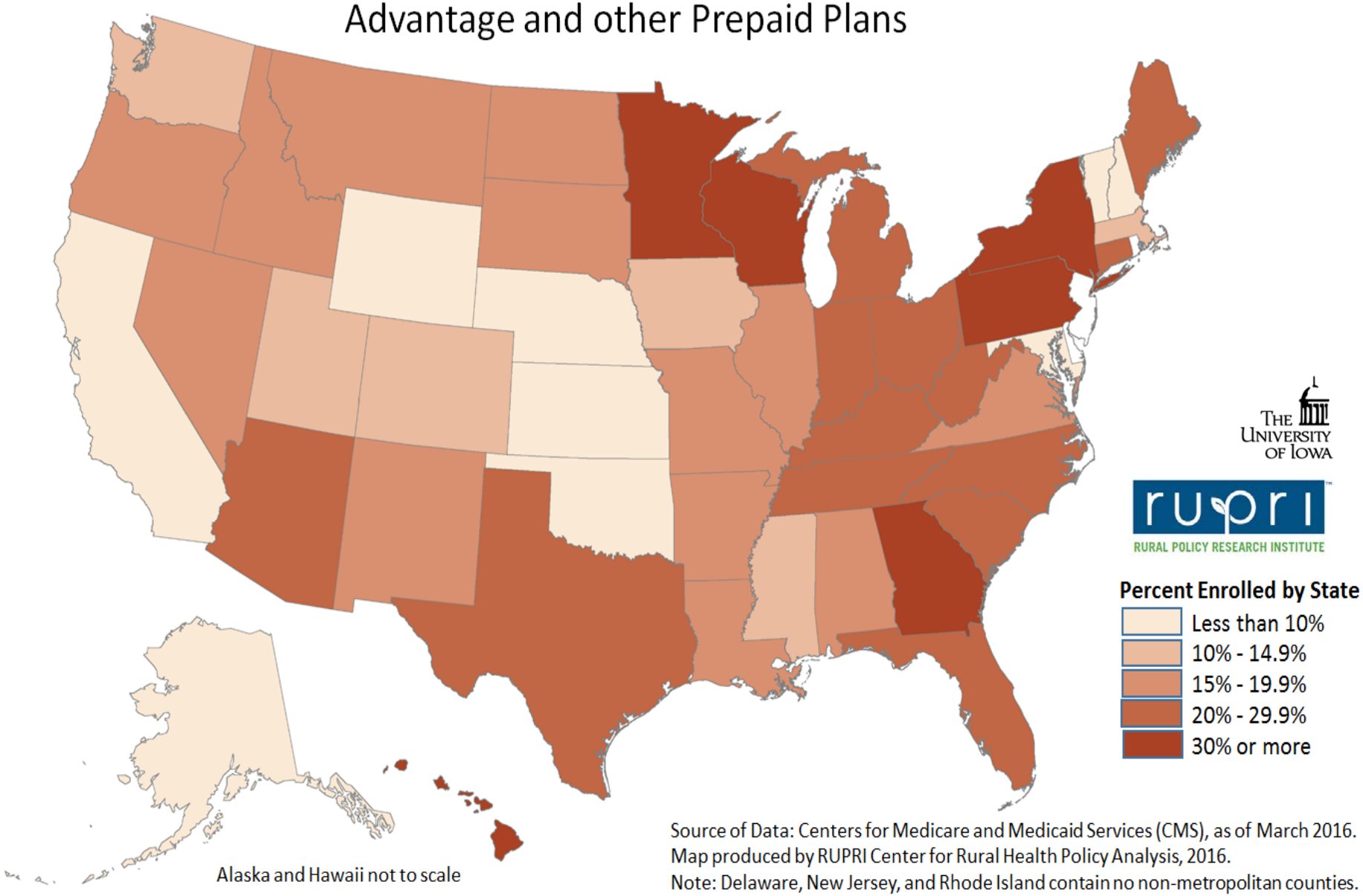
- Medicare Advantage
- Medicare Accountable Care Organizations

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



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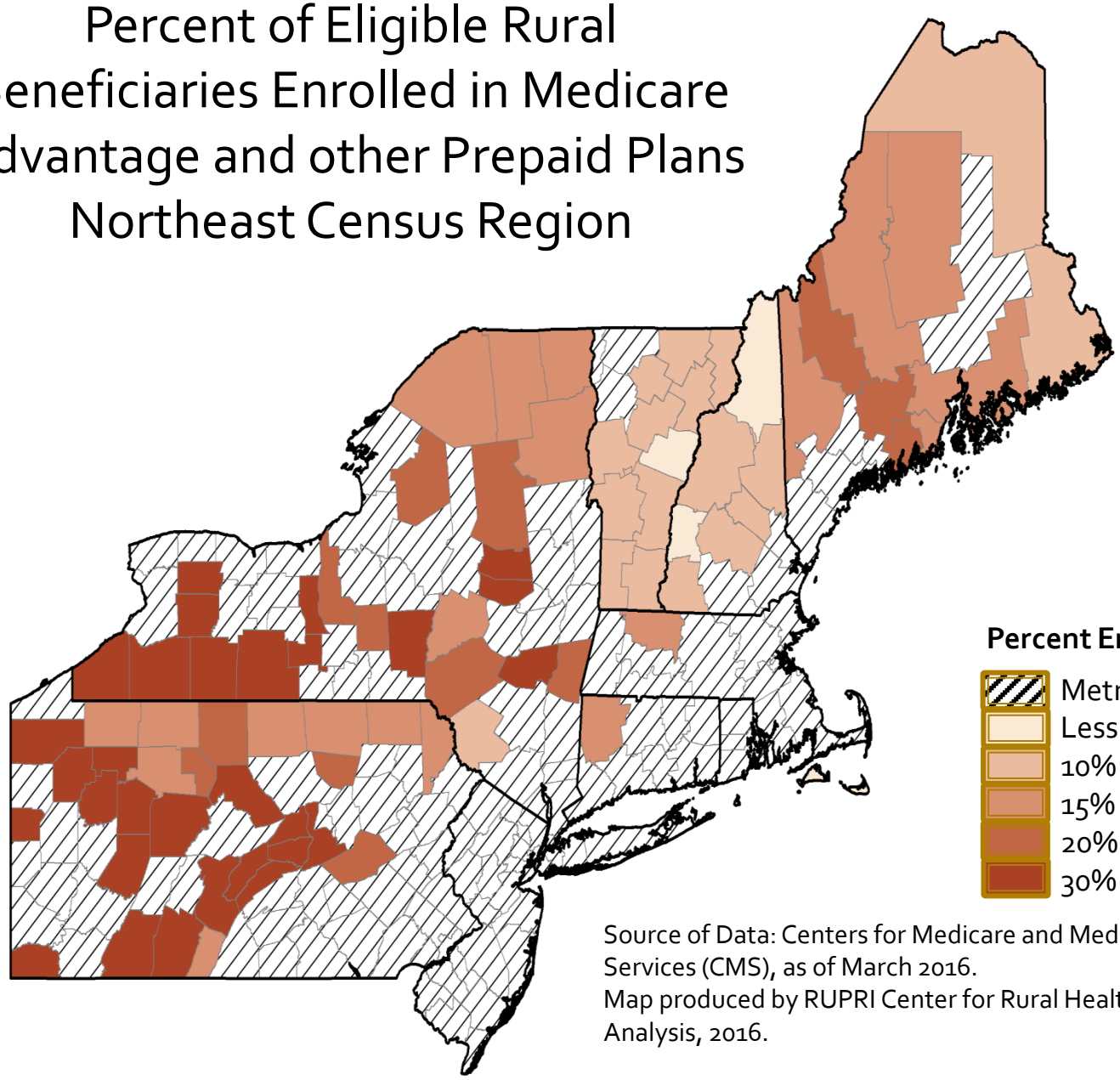
Source of Data: Centers for Medicare and Medicaid Services (CMS), as of March 2016.
Map produced by RUPRI Center for Rural Health Policy Analysis, 2016.
Note: Delaware, New Jersey, and Rhode Island contain no non-metropolitan counties.

Percent of Eligible Rural Beneficiaries Enrolled in Medicare Advantage and other Prepaid Plans Northeast Census Region



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The Continuing Spread of ACO Presence in Rural Places

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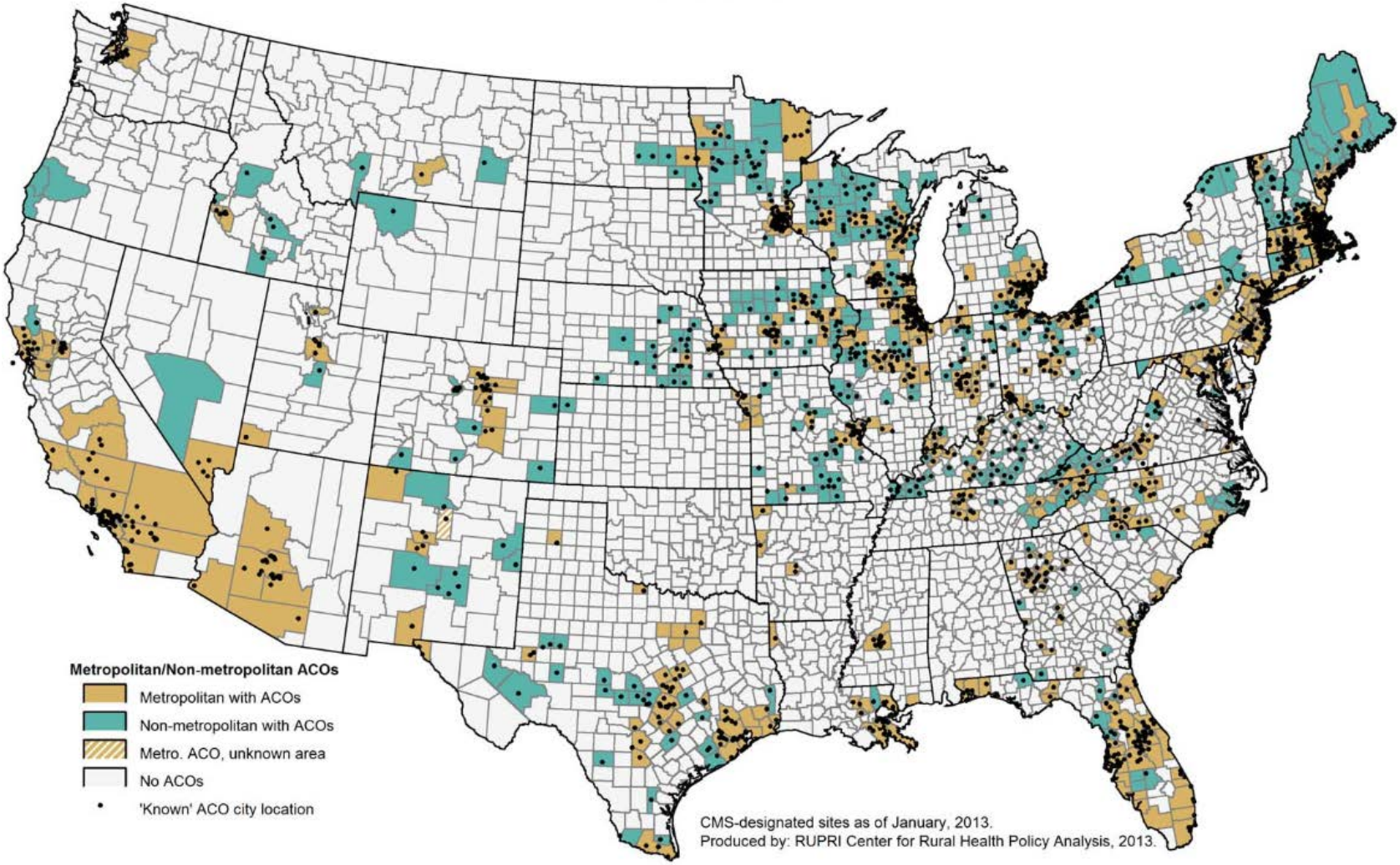
By the Numbers …

- 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

County Medicare ACO Presence
Continental United States



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County Medicare ACO Presence

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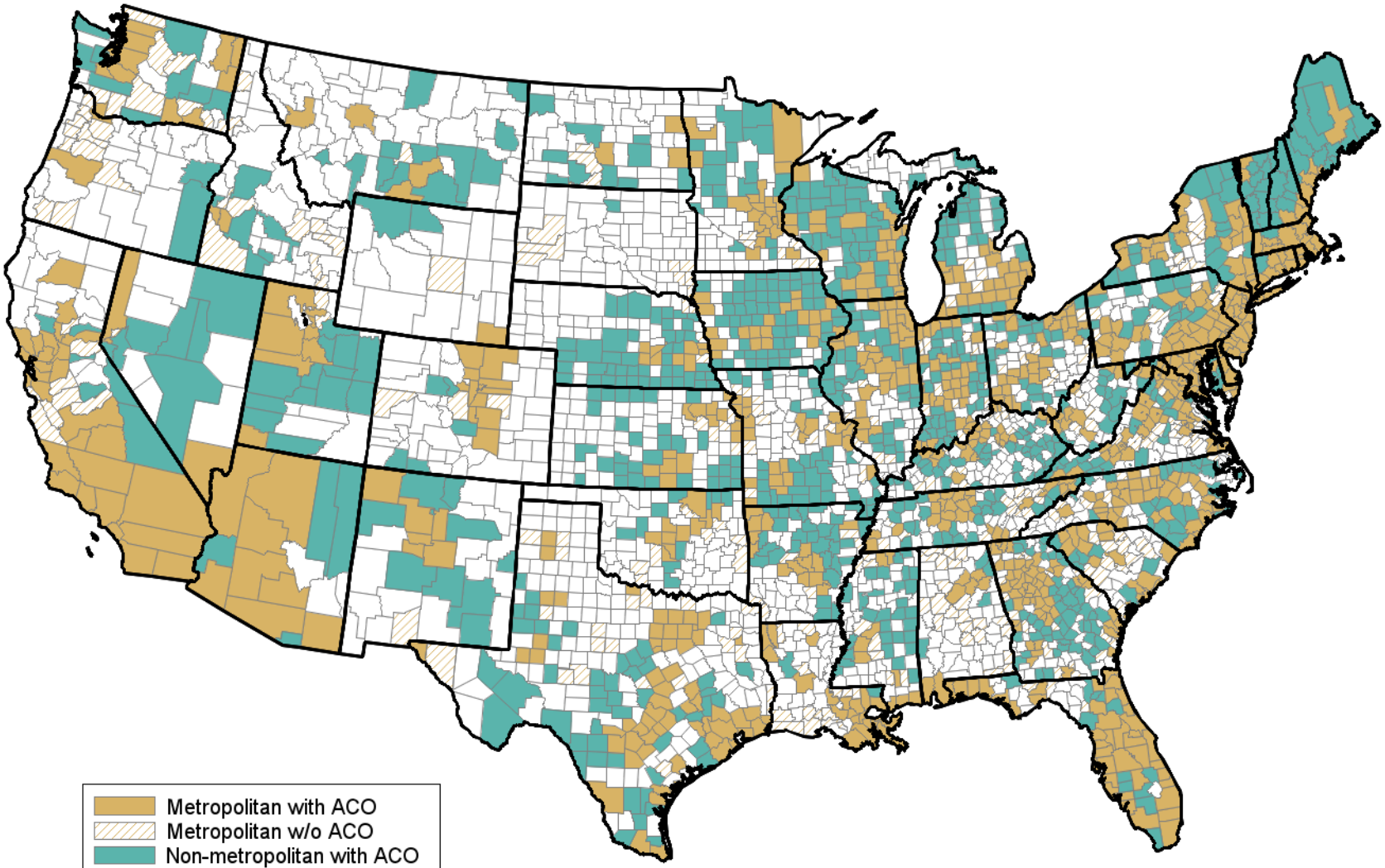

Counties have an 'ACO presence' when they contain the practice site of at least one participating provider.
Includes all active CMS ACOs as of August, 2015.
Produced by: RUPRI Center for Rural Health Policy Analysis, 2016.

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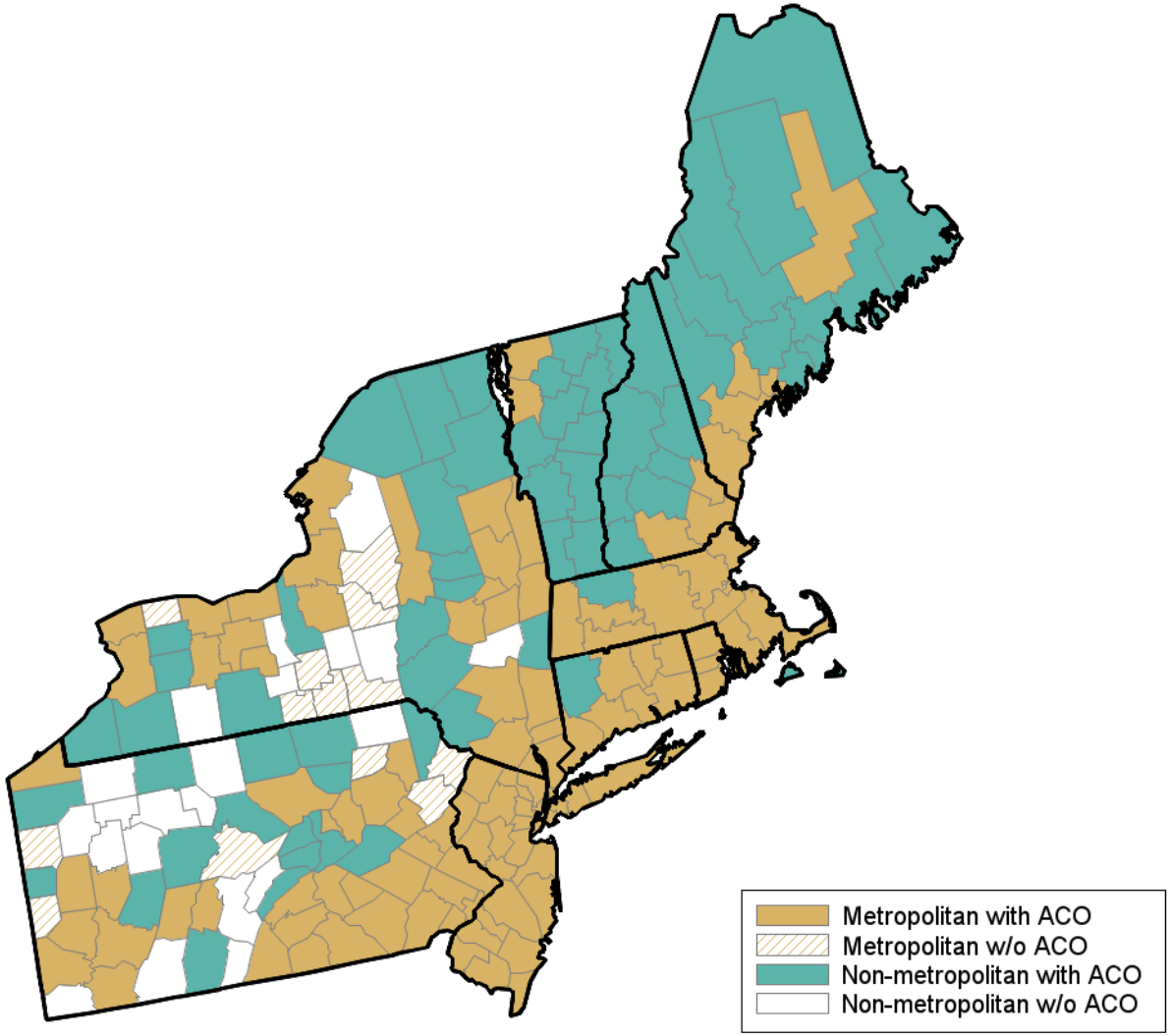
County Medicare ACO Presence

Northeast Census Region



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Medicaid Enrollment In Managed Care Organizations

- Nationally: 59.7%
- New Hampshire: 85.1%
- Vermont: 42.3%
- New York: 73.4%
- Pennsylvania: 77.7%

Reported as enrollment in Comprehensive Managed Care
Source: Centers for Medicare & Medicaid Services. *Medicaid Managed Care Enrollment and Program Characteristics* 2014.

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

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.

Insurance Coverage Changes

- Approximately 20 million newly insured as of Q4 2015 (compared to 2010): health insurance marketplace enrollment, Medicaid enrollment, employer-based insurance, purchase from traditional sources, effects of new rules
- National data for all adults show 7.2% increase in insurance coverage in rural, 6.3% in urban (Urban Institute data)
- Consequence: new payment contracts to negotiate for rural providers; role of deductibles and copays

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

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

Along Comes Health Insurance Marketplace

- Who is attracted, and issues of adverse risk selection into the new pool of lives
- Analysis of premiums shows disproportionate growth in rural places, less populated rating areas
- Fewer firms offering plans in rural counties
- As number of firms increases, premium increases slow

Source: AR Barker, TD McBride, LM Kemper, KJ Mueller. "Health Insurance Marketplaces: Premium Trends in Rural Areas." *Rural Policy Brief* RUPRI Center for Rural Health Policy Analysis. June, 2016

FFM Marketplace Enrollment, Rural vs. Urban

Northeast Census Region				
	Enrollment Growth, 2015-16		Enrollment as a Percent of Potential Market*	
	Rural	Urban	Rural	Urban
Maine	12.9%	11.9%	71.0%	61.2%
New Hampshire	3.3%	4.7%	60.8%	41.8%
New Jersey	-	13.5%	-	56.9%
Pennsylvania	-2.5%	-7.5%	39.8%	48.1%

*Uses Kaiser's state-level potential market estimates, scaled using SAHIE uninsured numbers (above 138% FPL) at the county-level to obtain rural/urban splits.

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FFM Marketplace Enrollment, Rural vs. Urban

Midwest Census Region				
	Enrollment Growth, 2015-16		Enrollment as a Percent of Potential Market*	
	Rural	Urban	Rural	Urban
Illinois	14.9%	10.6%	56.2%	54.0%
Indiana	-9.7%	-10.7%	38.8%	43.9%
Iowa	26.8%	18.7%	22.0%	24.2%
Kansas	12.9%	2.8%	32.9%	35.5%
Michigan	4.4%	0.6%	54.3%	47.1%
Missouri	13.9%	14.7%	44.2%	45.0%
Nebraska	21.7%	15.8%	60.8%	41.8%
North Dakota	18.0%	20.1%	37.6%	21.5%
Ohio	7.4%	3.2%	31.0%	35.6%
South Dakota	25.5%	16.9%	27.5%	28.1%
Wisconsin	12.1%	16.8%	54.8%	49.5%

*Uses Kaiser's state-level potential market estimates, scaled using SAHIE uninsured numbers (above 138% FPL) at the county-level to obtain rural/urban splits.

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FFM Marketplace Enrollment, Rural vs. Urban

South Census Region				
	Enrollment Growth, 2015-16		Enrollment as a Percent of Potential Market*	
	Rural	Urban	Rural	Urban
Alabama	14.2%	13.5%	39.2%	38.6%
Arkansas	12.7%	11.7%	28.8%	27.5%
Delaware	-	12.9%	-	44.9%
Florida	14.6%	9.1%	40.7%	57.6%
Georgia	12.3%	8.1%	42.7%	44.3%
Louisiana	20.0%	14.2%	41.3%	41.4%
Mississippi	9.5%	-0.5%	34.2%	40.3%
North Carolina	4.5%	10.8%	58.4%	58.5%
Oklahoma	16.3%	14.8%	30.3%	34.2%
South Carolina	5.1%	11.1%	46.1%	46.5%
Tennessee	12.1%	17.3%	42.6%	41.7%
Texas	13.3%	7.9%	33.4%	37.8%
Virginia	7.8%	9.8%	40.2%	42.1%
West Virginia	12.3%	11.1%	37.3%	36.5%

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FFM Marketplace Enrollment, Rural vs. Urban

West Census Region				
	Enrollment Growth, 2015-16		Enrollment as a Percent of Potential Market*	
	Rural	Urban	Rural	Urban
Alaska	6.5%	9.3%	47.8%	43.8%
Arizona	3.0%	-1.4%	29.4%	39.9%
Montana	8.4%	4.3%	57.8%	55.6%
Nevada	17.8%	20.0%	36.9%	53.9%
New Mexico	3.6%	5.3%	47.9%	42.4%
Oregon	31.3%	31.3%	54.4%	51.8%
Utah	20.4%	25.5%	49.7%	52.8%
Wyoming	12.6%	13.0%	42.1%	29.8%

*Uses Kaiser's state-level potential market estimates, scaled using SAHIE uninsured numbers (above 138% FPL) at the county-level to obtain rural/urban splits.

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Market Responses Shaping Rural Health

- Hospital closure: 73 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%

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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

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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 systems and alliances: Geisinger, Dartmouth-Hitchcock, Basset Health Care Network, MaineHealth, Catholic Health System

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

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

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.

What is a State Office to Do?

- Monitor and comment on changing landscape (i.e., NOSORH comment letter on multi-payer prospective budget)
- Monitor initiatives supported by CMS/CMMI
- Lead efforts in the state to transition to community-focused health improvement
- Assist providers in identifying sources of, and using, technical assistance

What is a State Office to Do?

- Open Discussion

For Further Information

Rural Health Value

http://ruralhealthvalue.org

The RUPRI Center for Rural Health Policy Analysis

http://cph.uiowa.edu/rupri

The RUPRI Health Panel

http://www.rupri.org

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