Rural Health: Finding Creative Solutions Together

Denver, CO

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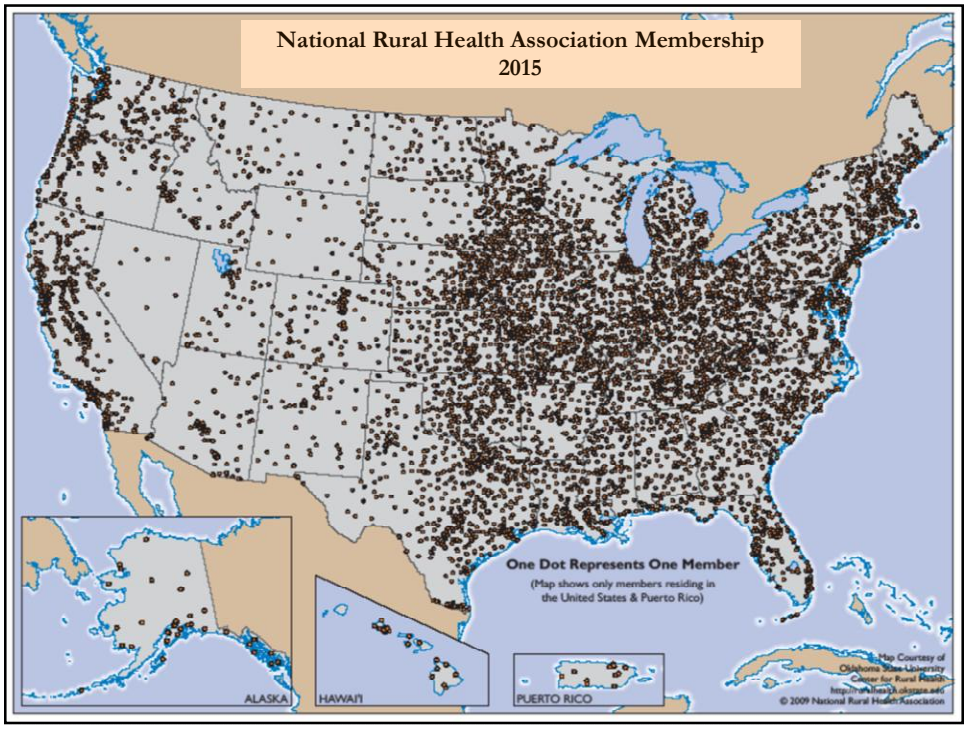
Improving the health of the 62 million who call rural America home.



Rural Overview

- 62 million patients rely on rural providers.
  - Population challenges
  - Geographic challenges
  - Cultural challenges
- Rural providers face health care delivery challenges like no other provider.
  - Workforce shortages
  - Fiscal constraints
- Rural providers and patients are disproportionately dependent on Federal Government.
  - Medicare, Medicaid
  - Appropriations
  - Regulatory Process
- Now, rural providers face unprecedented challenges from Washington, D.C.

Rural disparities/challenges

- War on Poverty in the 60's
- Rural Health Clinics –just turned 36 (1978), >4,500 RHC's nationwide
- Community Health Centers, created in the War on Poverty
- Advent of PPS 1983: 400 hospital closures
- Policy Response: SORH, Flex, MDH, CAH and LVH
- Rural serves more challenging populations:
- "Rural Americans are ***older, poorer and sicker*** than their urban counterparts… Rural areas have higher rates of poverty, chronic disease, and uninsured and underinsured, and millions of rural Americans have limited access to a primary care provider." (HHS, 2011)
- Disparities are compounded if you are a senior or minority in rural America.

Problems still exist…

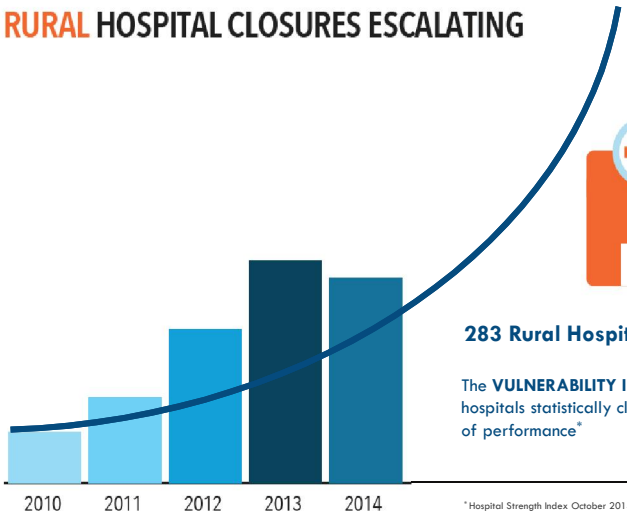
- *Health equates to wealth* according to Univ. of Washington Study, July 2013
- Key Finding:
- The study found that people who live in wealthy areas like San Francisco, Colorado, or the suburbs of Washington, D.C. are likely to be as healthy as their counterparts in Switzerland or Japan, but those who live in Appalachia or the rural South are likely to be as unhealthy as people in Algeria or Bangladesh.

A Metastasizing Crisis

- 37 rural hospital closures since Jan. 1, 2013
- 55 since 2010
- More closures in 23 months than total between 2003 and 2012 combined.
- Rate will likely double in 2015.

Vulnerability Index: Rural Health Safety Net **Vulnerable**

RURAL HOSPITAL CLOSURES ESCALATING

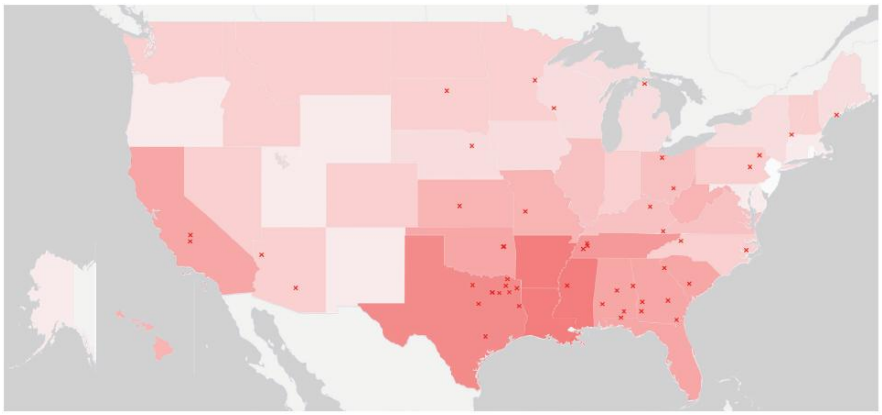


283 Rural Hospitals Vulnerable

The **VULNERABILITY INDEX™** identifies 283 hospitals statistically clustered in the bottom tier of performance*

* Hospital Strength Index October 2014

Vulnerability Index: Rural Closures and Risk of Closures



The **Vulnerability Index™** identifies **283** rural hospitals statistically clustered in the bottom tier of performance

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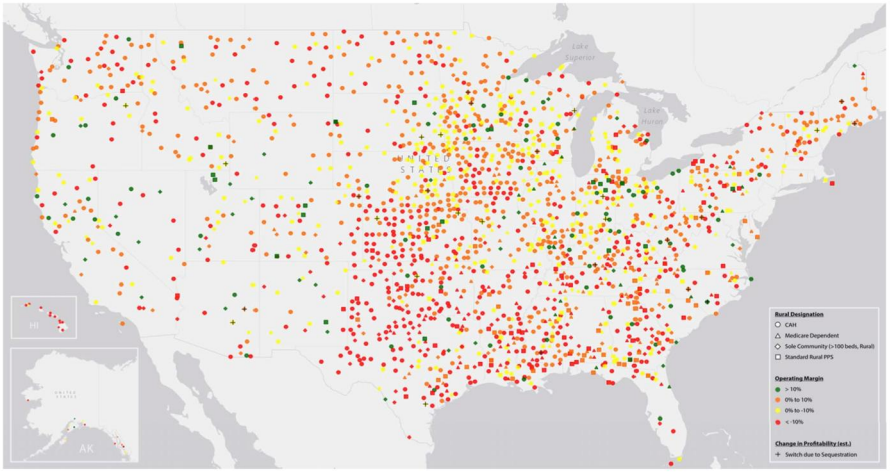
Sequestration **Impact** to Rural Hospital Profitability

SEQUESTRATION 2% CUT

Sequestration effects on Rural, Urban Hospitals in the United States

Estimated effects of a two percent Medicare sequestration on Rural Hospitals (Sole Community, Standard Rural PPS, CAH, Medicare Dependent)



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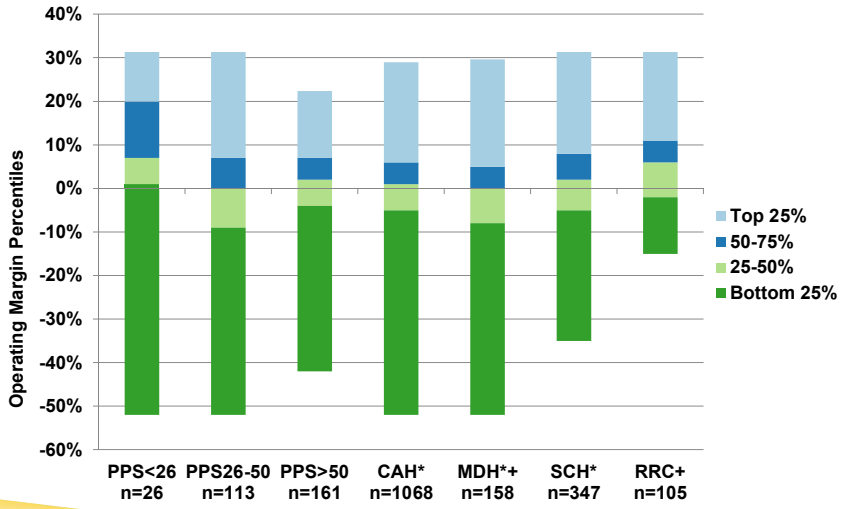
Operating Margin, 2013



*p<.05 to PPS<26
~p<.05 to PPS 26-50
+p<.05 to PPS>50

Operating Income / Operating Revenue

NC RHRP
NC Rural Health Research Program

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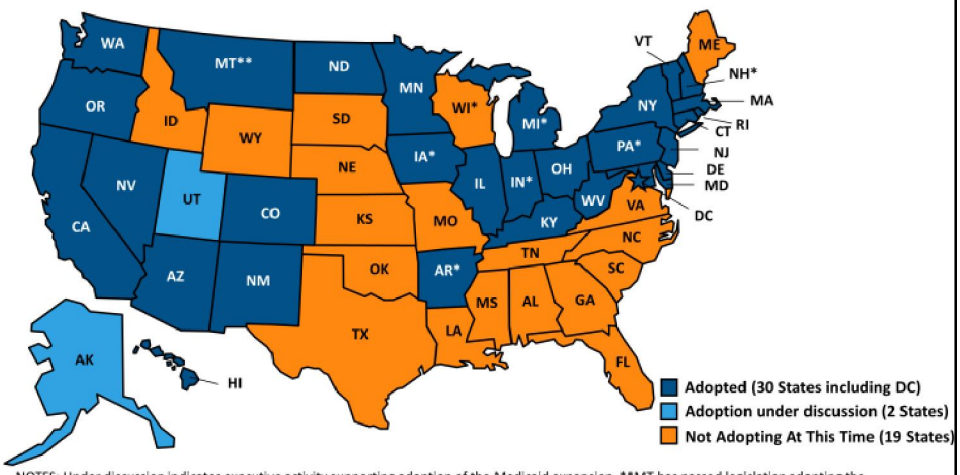
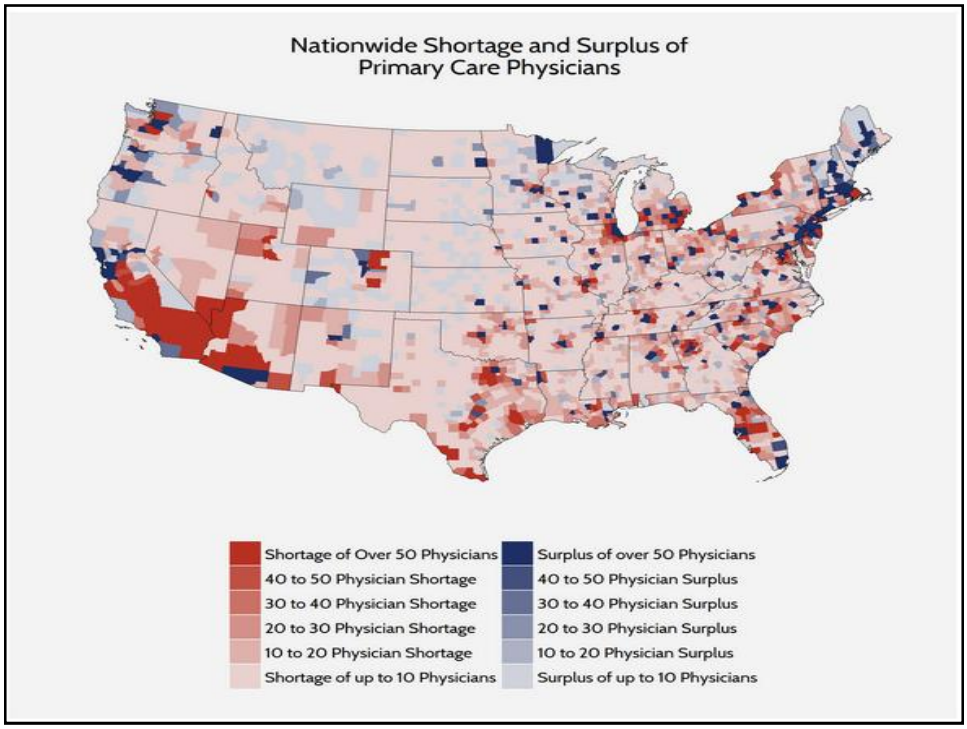
Current Status of State Medicaid Expansion Decisions



NOTES: Under discussion indicates executive activity supporting adoption of the Medicaid expansion. **MT has passed legislation adopting the expansion; it requires federal waiver approval. *AR, IA, IN, MI, PA and NH have approved Section 1115 waivers. Coverage under the PA waiver went into effect 1/1/15, but it is transitioning coverage to a state plan amendment. Coverage under the IN waiver went into effect 2/1/15. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.
SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated June 22, 2015.
http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

THE HENRY J. KAISER FAMILY FOUNDATION



The Save Rural Hospitals Act

Rural hospital stabilization (Stop the bleeding)

- Elimination of Medicare Sequestration for rural hospitals;
- Reversal of all "bad debt" reimbursement cuts (*Middle Class Tax Relief and Job Creation Act of 2012*);
- Permanent extension of current Low-Volume and Medicare Dependent Hospital payment levels;
- Reinstatement of Sole Community Hospital "Hold Harmless" payments;
- Extension of Medicaid primary care payments;
- Elimination of Medicare and Medicaid DSH payment reductions; and
- Establishment of Meaningful Use support payments for rural facilities struggling.
- Permanent extension of the rural ambulance and super-rural ambulance payment.

Rural Medicare beneficiary equity. Eliminate higher out-of pocket charges for rural patients (total charges vs. allowed Medicare charges.)

Regulatory Relief

- Elimination of the CAH 96-Hour Condition of Payment (See *Critical Access Hospital Relief Act of 2014*);
- Rebase of supervision requirements for outpatient therapy services at CAHs and rural PPS See *PARTS Act*);
- Modification to 2-Midnight Rule and RAC audit and appeals process.

Future of rural health care (Bridge to the Future)

- Innovation model for rural hospitals who continue to struggle.

Future of Rural Health: New Provider Type?

- Community Outpatient Hospital (COH) Core Services:
  - Traditional ambulatory/clinic services
  - Emergency Care (tele-emergency allowed/required)
  - Care Coordination and Disease Management
  - Transitional care (e.g. , observation, extended stay) capacity
  - EMS/Non-emergent Medical Transportation may be provided through PHC

Primary (core) Elements for Rural Design

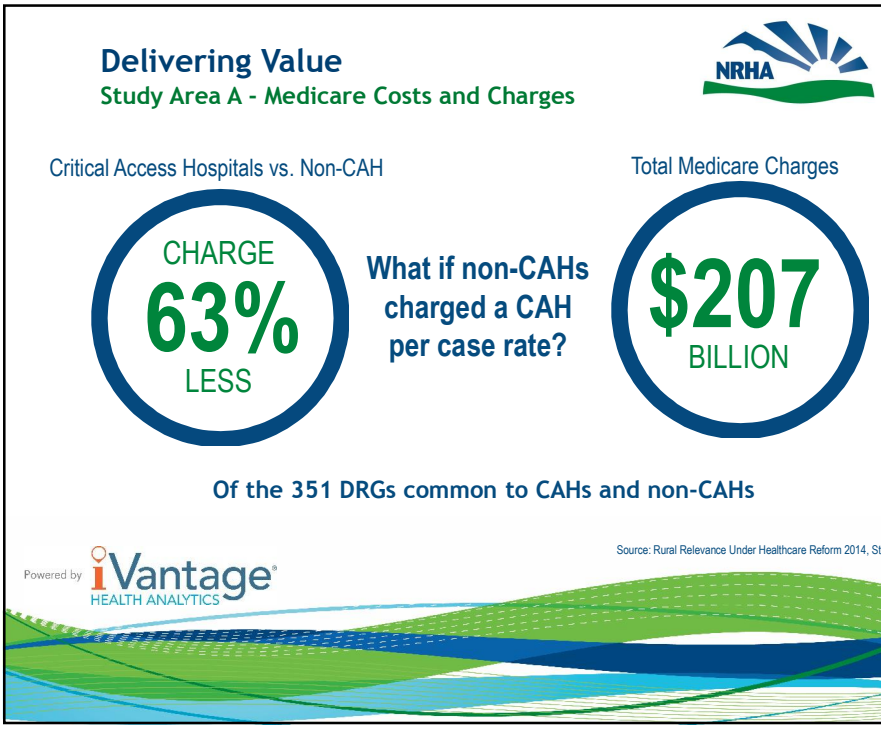
- Primary Care
- Ambulatory Services
- Emergent Care (EMS/non-emergent transportation/ER)
- Rehabilitative Services
- Behavioral Health
- Transitional Care (observation/swing bed, etc.)
- Pharmacy (community?)
- Oral Health
- Prevention/Wellness

Either provided directly or by agreement within or outside local rural system

Access is defined by service type and need as determined by community assessment. Core elements may require subsidy of some sort to provide same if market isn't providing. Services beyond core elements funded on fee schedule (market-based) systems

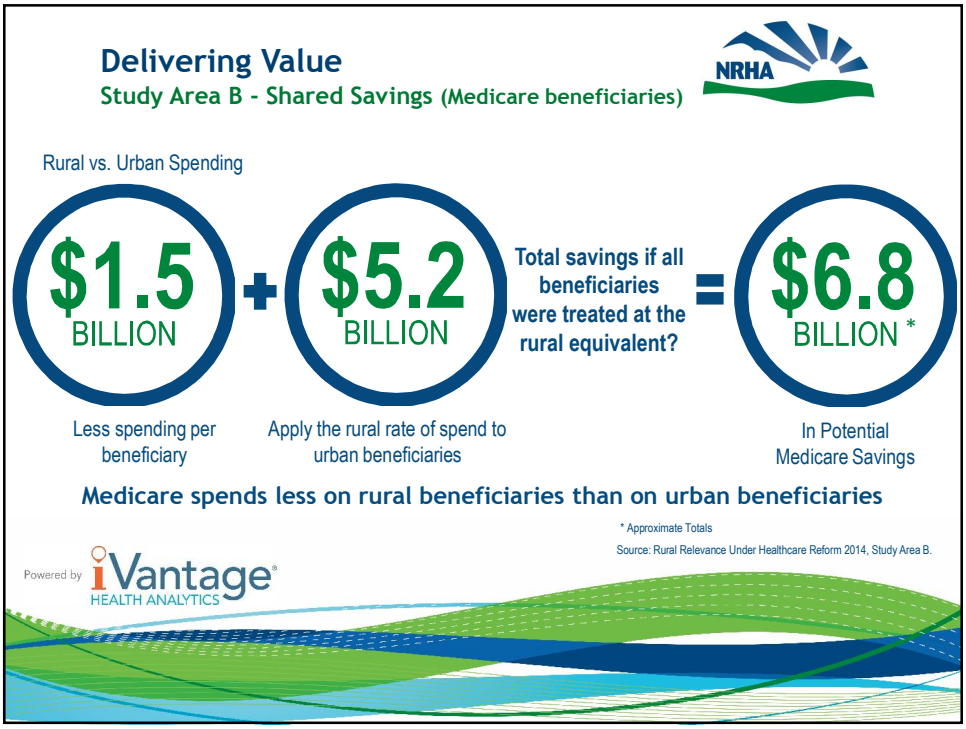
Delivering Value

Study Area A - Medicare Costs and Charges



Delivering Value

Study Area B - Shared Savings (Medicare beneficiaries)



Delivering Value

Study Area C – Hospital Performance

Who has the edge?

	Rural	Urban
• Quality	✓	
• Patient Safety	✓	
• Patient Outcomes	✓	
• Patient Satisfaction	✓	
• Price	✓+	
• Time in the ED	✓+	

Rural hospitals match Urban hospitals on performance at a lower price

Data sources include CMS Process of Care, AHRQ PSI Indicators, CMS Outcomes, HCAHPS Inpatient/Patient Experience, MedPAR, HCRIS

Source: Rural Relevance Under Healthcare Reform 2014, Study Area C.

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SGR Repeal and the Rest of The Story…..

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- Replaces it with a physician payment system based on “quality, value and accountability”
- Five year period of 0.5% annual FFS updates in transition to “new system”

SGR Repeal and……

- **Improves existing FFS through value over volume and ensuring payment accuracy**
  - Consolidates the existing 3 physician quality programs into a streamlined program that rewards providers who meet performance thresholds
  - Implements a process of payment accuracy
  - Incentivizes care coordination efforts for patients with chronic conditions
  - Introduces “physician-developed” clinical care guidelines to reduce inappropriate care
  - Requires development of quality measures and provides for reporting alignment across different payment programs

SGR Repeal and….

Incentivizes movement to alternative payment models (APM)

- Provides a 5% bonus to providers who receive a significant portion of their revenue from an APM or PCMH
- Participants need to receive at least 25% of the Medicare revenue through an APM in 2018-2019 and this threshold increases over time
- Establishes a Technical Advisory Committee (TAC) to review and recommend physician-developed APMs

SGR Fix Implications

Bottom line:

- Current plan leaves $141B between 2015 and 2025 unpaid for or in other words, added to the deficit
- Physicians pushed along to APMs and a value-based system, impact on hospitals and volume?
- RHC cost-based reimbursement are exempt
- Physician alignment a key reality

Sec. Burwell's Medicare Goals

- 30% of Medicare provider payments in APMs by 2016
- 50% of Medicare provider payments in APMs by 2018

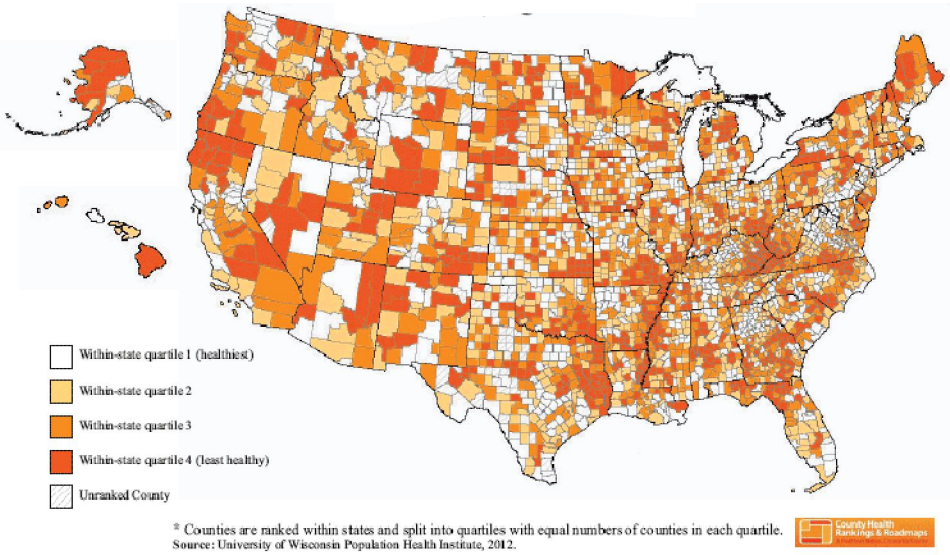
- 85% of Medicare fee-for-service payments to be tied to quality and value by 2016
- 90% of Medicare fee-for-service payments to be tied to quality and value by 2018

The Pop Health Review

- Preparing for the “new health care”
- Population Health
- Transition From Volume to Value
- Market Trends
- DSR and Reimbursement Models

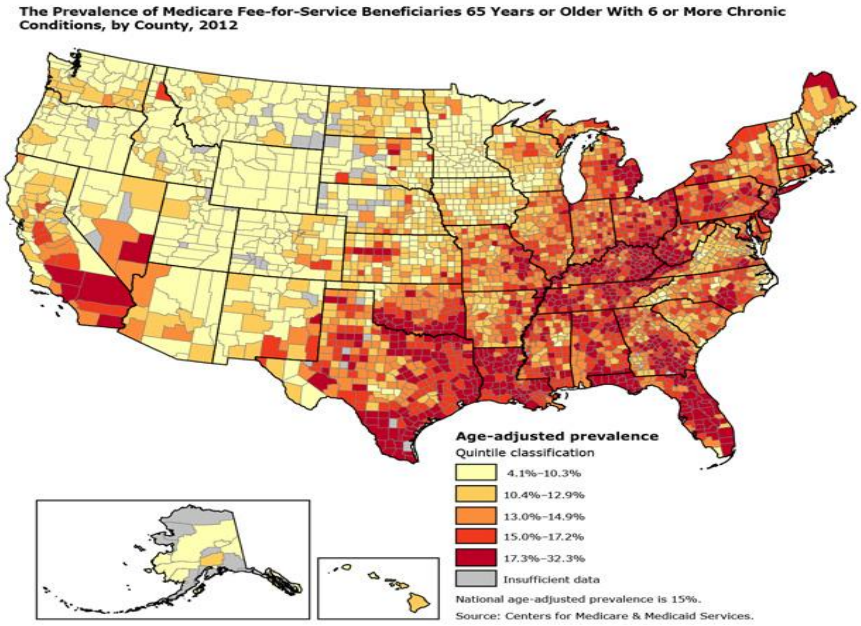
Transformation to Population Health Management

County Health Rankings



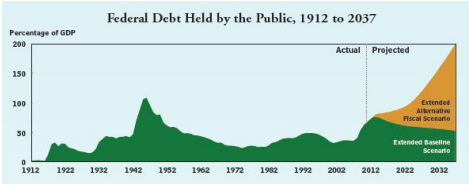
http://www.countyhealthrankings.org/

Prevalence of Medicare Patients with 6 or more Chronic Conditions

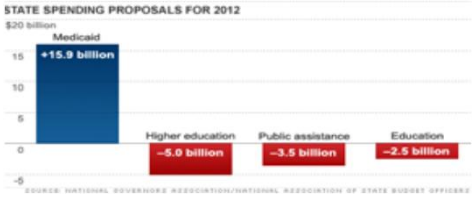


Market Pressures Increasing

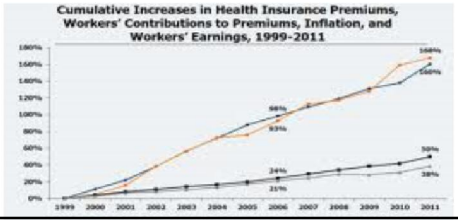
Federal



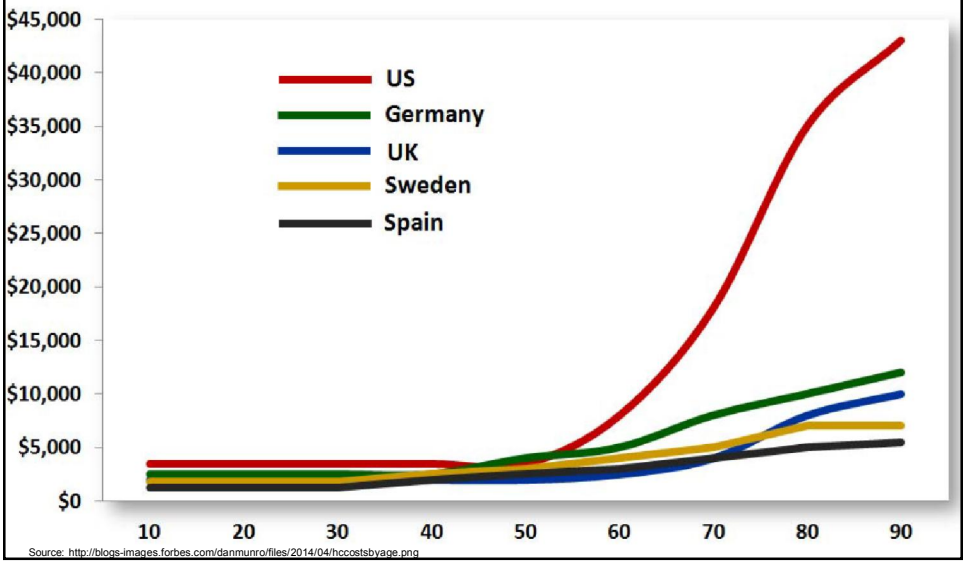
State



Employee/Commercial

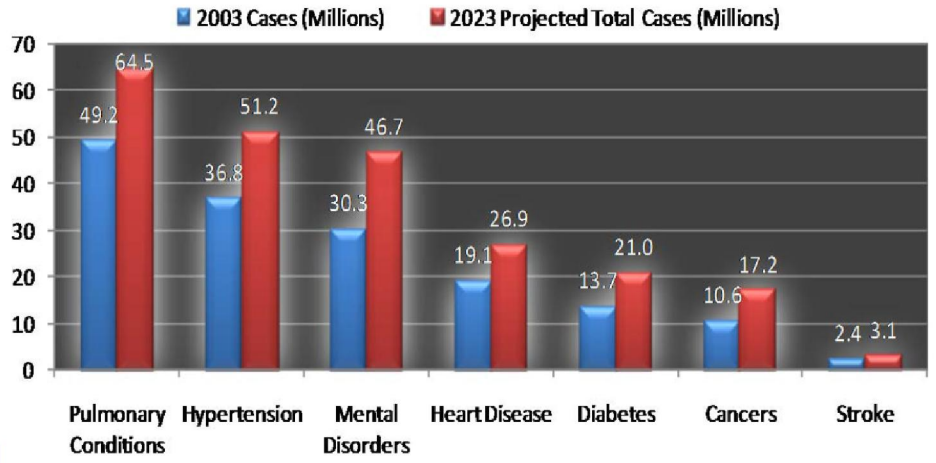


Industrialized Countries: Annual Spending by Age



Source: http://blogs-images.forbes.com/danmunro/files/2014/04/hccostsbyage.png

Chronic Disease Growth Projections

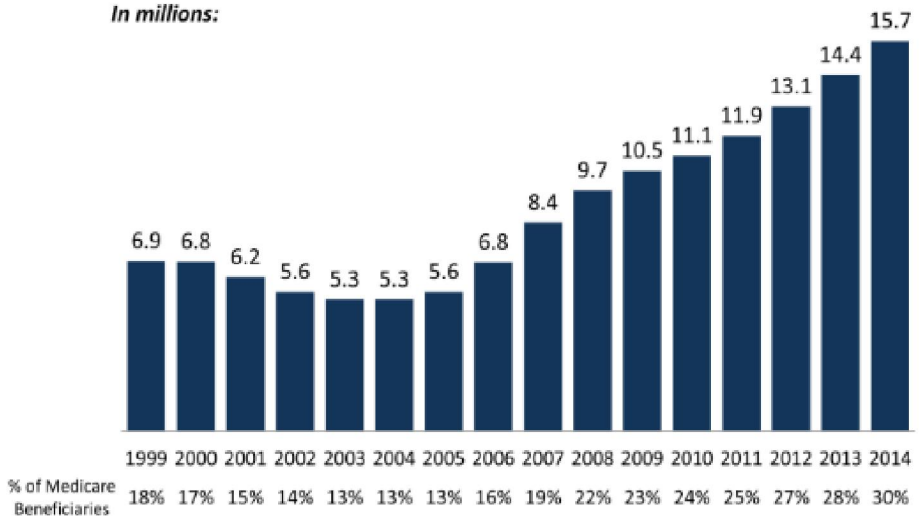


State of Healthcare 2010

Source: State of Healthcare 2010

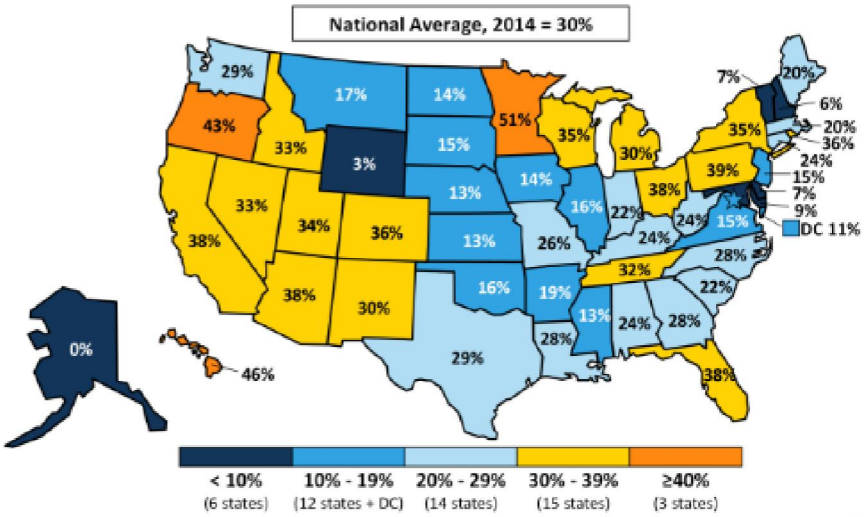
Exhibit 1

Total Medicare Private Health Plan Enrollment, 1999-2014



NOTE: Includes MSAs, cost plans, demonstration plans, and Special Needs Plans as well as other Medicare Advantage plans.
SOURCE: MPR/Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment files, 2008-2014, and MPR, "Tracking Medicare Health and Prescription Drug Plans Monthly Report," 1999-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is from April.

Share of Medicare Beneficiaries Enrolled in Medicare Advantage Plans, by State, 2014



NOTE: Includes MSAs, cost plans and demonstrations. Includes Special Needs Plans as well as other Medicare Advantage plans.
SOURCE: MPR/Kaiser Family Foundation analysis of CMS State/County Market Penetration Files, 2014.

Healthcare Transformation

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Current Fee for Service System

Value Based Payment Model

Integrating and coordinating Care Across Continuum
Aligning Incentives for Value and Quality
Reducing the Cost Curve

First Things First

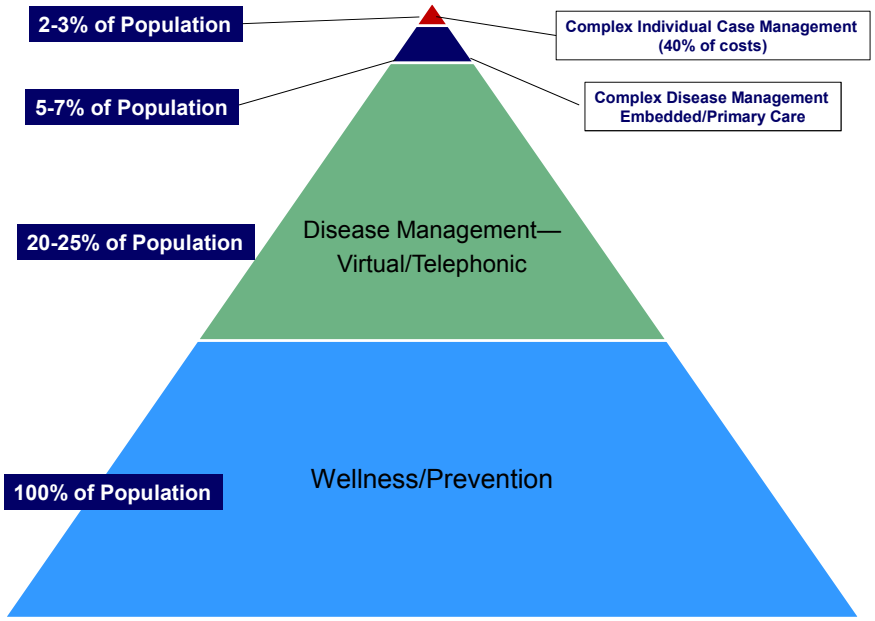
Care Redesign
- PCMH
- Clinical Integration
- Care Management
- Post-acute Care
- EHR
- Data Analytics

Care redesign must not outpace Changes in payment

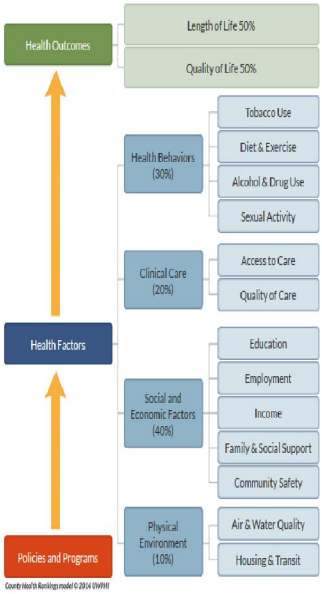
Population Health Transformation

New Payment Arrangements
- Care Transformation Costs
- Care Management Payments
- Shared Savings
- Episodes of Care Payments
- Global Payments

Care Management: Target Populations



Source: Joseph F. Damore, Premier Health Alliance, March, 2015



Determinants of Health

Four Stages to Population Health

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1. Preparatory → 2. Transformational → 3. Implementation → 4. Expansion

1. Preparatory
- Education
- Assessment
- Gap Analysis
- Operational Plan

2. Transformational
- Primary Care
- PCMH
- Clinical Integration
- Care management network
- Network development
- Health informatics

3. Implementation
- Defined population
- Payor partner
- Post-acute

4. Expansion
- Employee health plan
- Commercial arrangement
- Medicare
- Medicaid
- Employer contracting
- Uninsured

Source: Joseph F. Damore, Premier Health Alliance, March, 2015

Summary

- Rural Can Lead
- Nurses Can Lead in the following areas:
- Patient Centered Medical Homes
  - My preference: Person Centered Health Homes
- Care Management Programs:
  - High Risk Populations
  - Chronic Disease Management
  - Care Transitions/Post-acute Care
  - Episodes of Care
- Health Information Technology
  - EHR
  - Clinical Informatics
  - Claims Analytics/Predictive Modeling/Big Data
  - Care Management
- Patient Engagement/Satisfaction
- Leadership/Cultural Transformation

Questions?

THANK YOU

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