

Meeting Needs in Rural Health: Research, Action, Policy

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Presentation based on RUPRI Engagement: Research, Practice, Policy

- Research: Center for Rural Health Policy Analysis projects studying Accountable Care Organizations (ACOs) and hospital closure
- Practice: Rural Health Value, a collaboration with Stratis Health
- Policy: RUPRI (Rural Policy Research Institute) Health Panel

The ACO Landscape: Data from Medicare Shared Savings Program

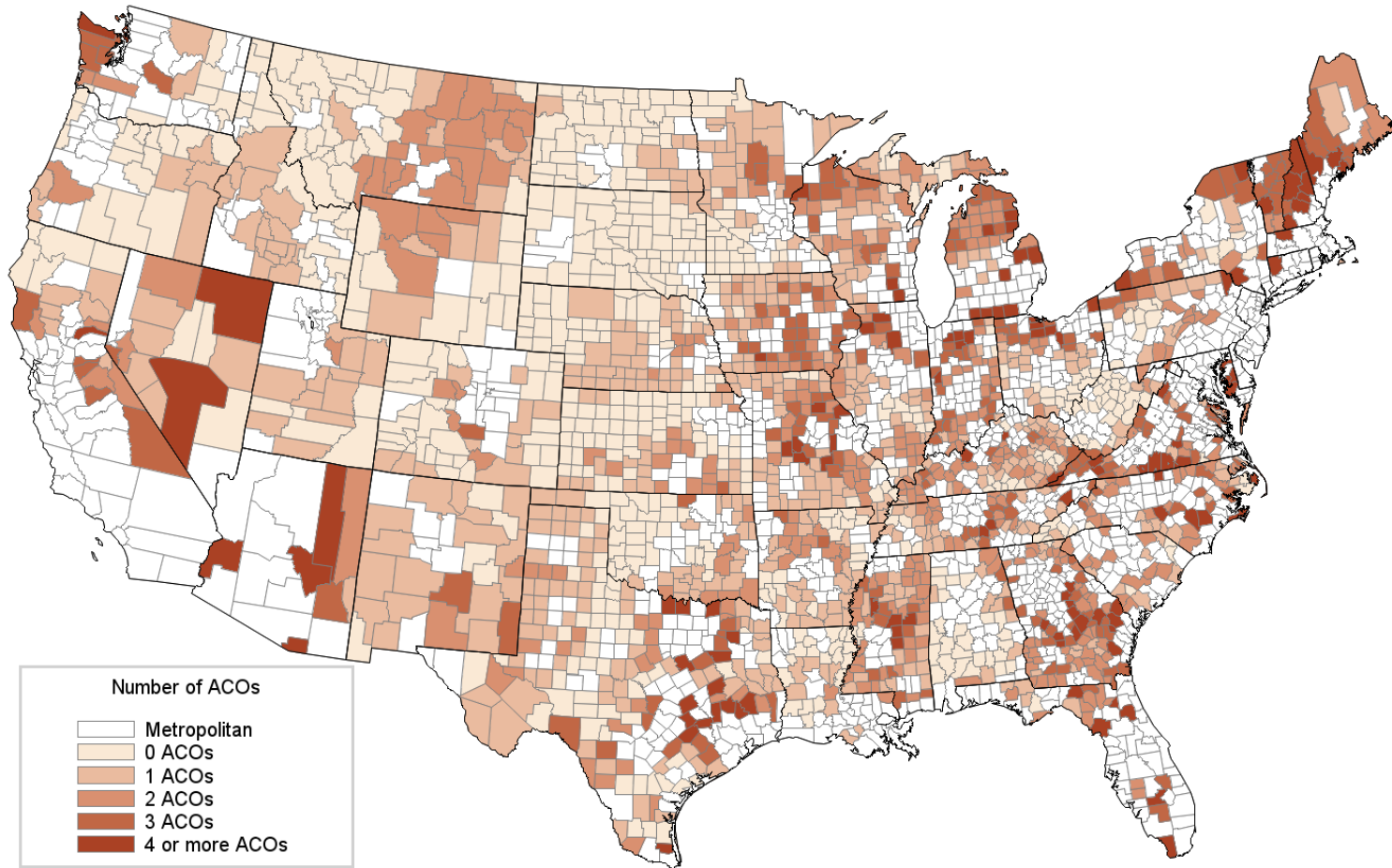
- January 2018 (new wave will be in July 2019)
- 421 CAHs are participating, 1,210 RHCs, 2,560 FQHCs
- ACO Composition: FQHCs/RHCs compose 36 ACOs
 - Physicians -- 171 (30%)
 - Hospitals, Physicians and other – 324 (58%)
- Overall quality score in 2016 was 94.65%, up from 83.08% in 2014

Source: CMS Medicare Shared Savings Program “Fast Facts”. January, 2018

The Spread of Accountable Care Organizations (ACOs) to Rural Counties

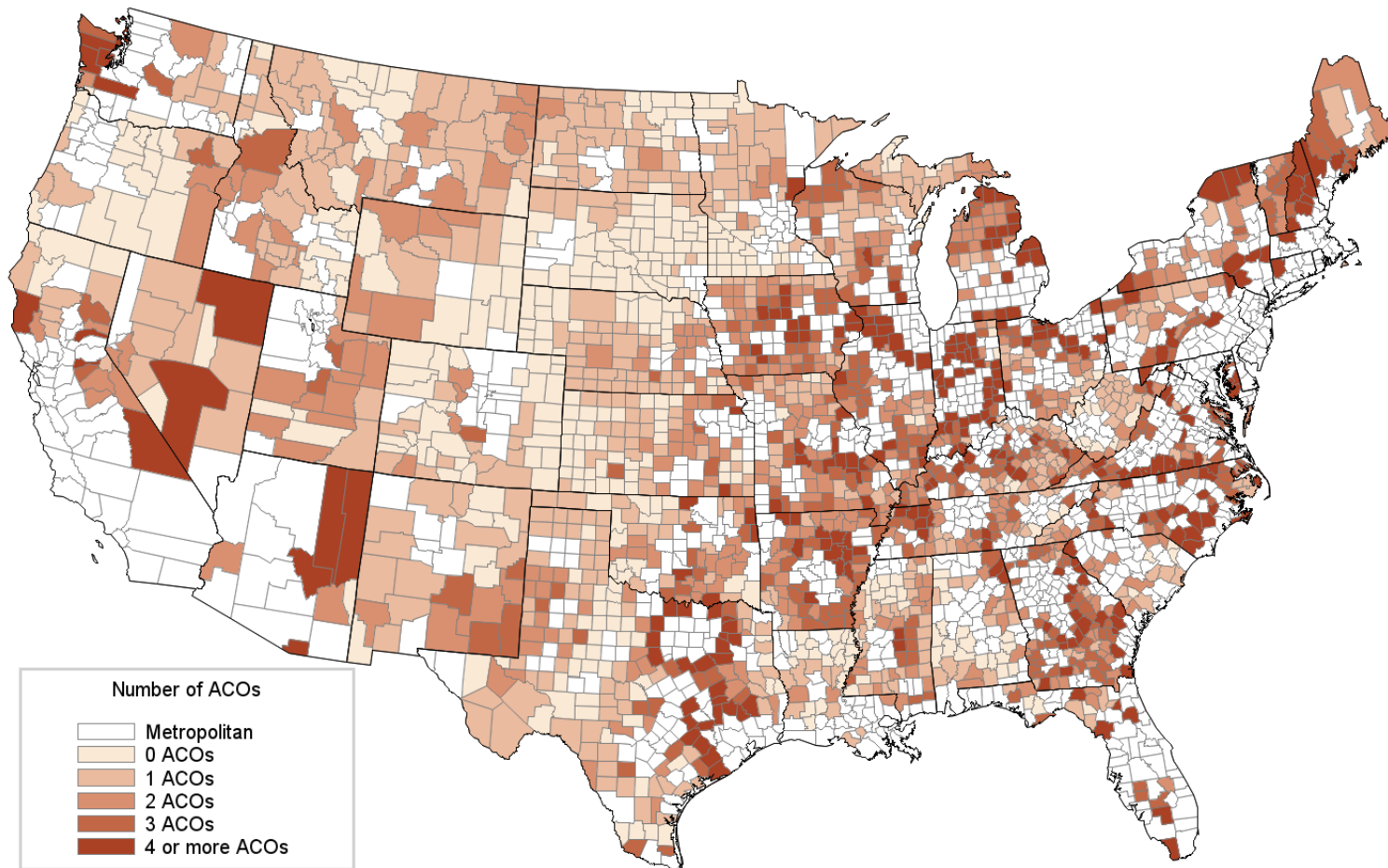
- Growth in non-metropolitan counties with 30% or more of beneficiaries attributed to ACOs: from 9.1% in 2014 to 22.3% in 2016
- Non-metropolitan counties with 3 or more ACOs with enrollment grew from 17.3% in 2014 to 39.7% in 2016

Medicare ACO Presence, non-Metropolitan Counties: 2014



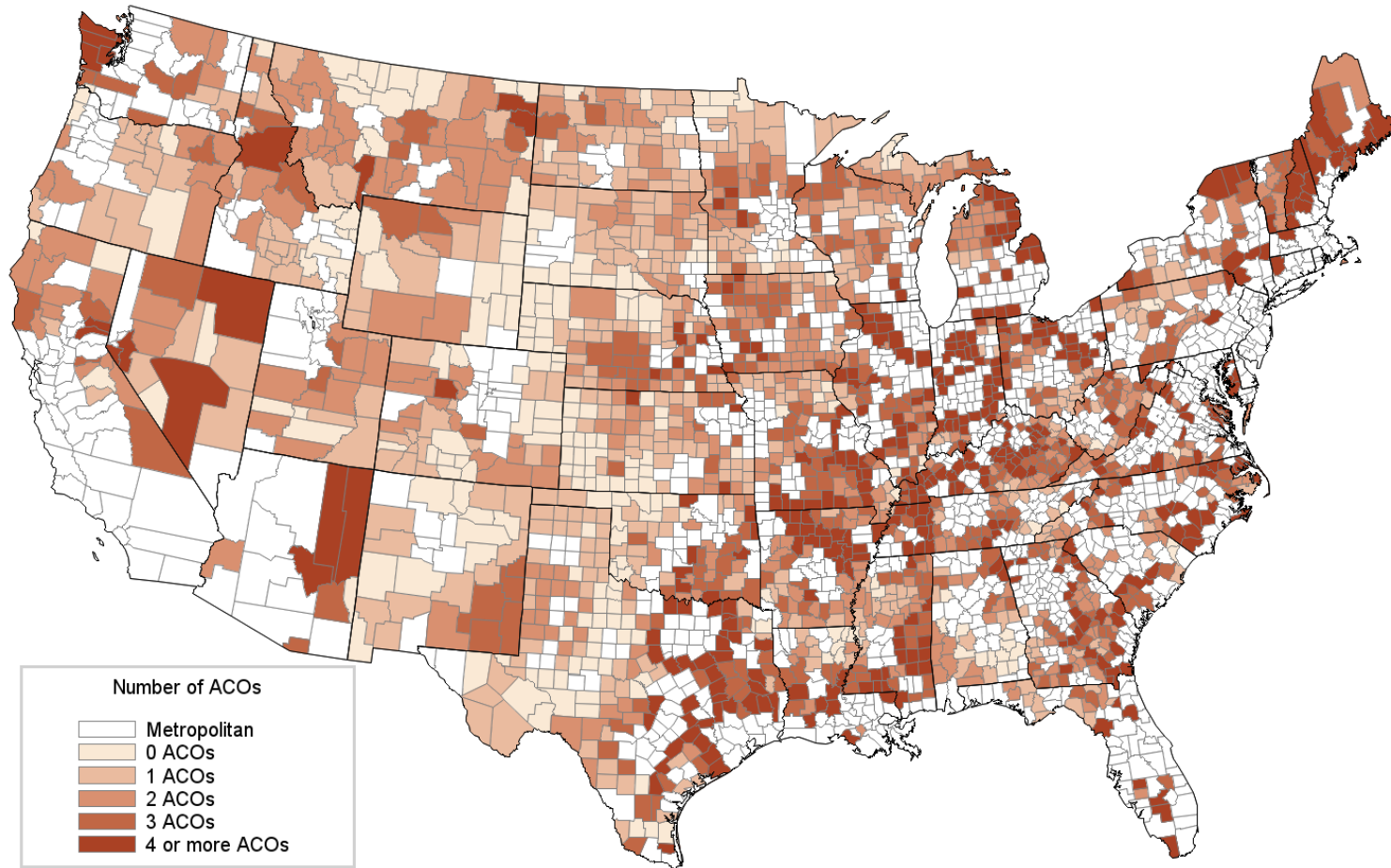
Produced by: RUPRI Center for Rural Health Policy Analysis, 2017.

Medicare ACO Presence, non-Metropolitan Counties: 2015



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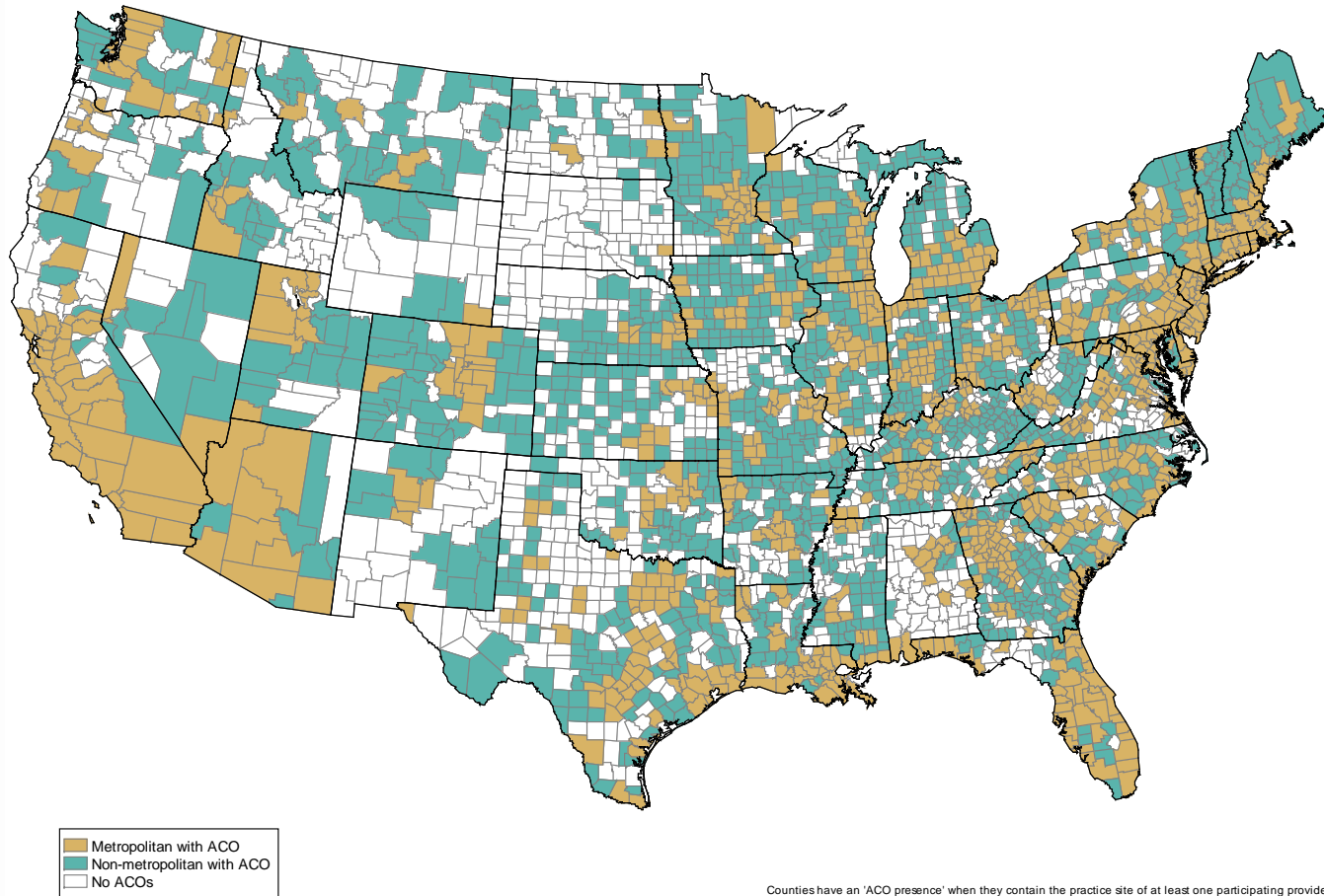
Medicare ACO Presence, non-Metropolitan Counties: 2016



Produced by: RUPRI Center for Rural Health Policy Analysis, 2017.

County Medicare ACO Presence

As of January 2017



Counties have an 'ACO presence' when they contain the practice site of at least one participating provider.
Includes all active CMS ACOs as of January, 2017.
Produced by: RUPRI Center for Rural Health Policy Analysis, 2018.

What Are We Learning?



- Rural ACOs are a mix of hospital-based, physician-based, FQHC-based, and blend
- The Advanced Payment ACO Model and now the ACO Investment Model have been demonstrations that attracted rural ACOs, especially AIM
- Rural ACOs may need extended time to fully develop care management systems and fiscal management strategies before accepting downside risk
- Variation exists among rural ACOs based on prior experience, engagement of providers across the care continuum, and participation in network arrangements

Results



- Improvements in quality performance from initial year to second year of participation in the program
- Rural ACOs perform better than urban in Care Coordination/Patient Safety, Preventive Health, and At-Risk Population domain scores
- 8 of 11 Rural ACOs participating in the Advance Payment Model generated savings
- OIG report in August, 2017 found a net reduction in Medicare spending across all ACOs, but concentrated in less than half of them

Factors that Contribute to Success in Rural ACOs

- Prior experience with multi-organizational collaborations
- Prior experience with the specific organizations in the ACO
- Strategic managerial and clinical leadership
- Shared governance
- Care coordination for targeted (diagnosis) patients
- Continuum of care (i.e. non acute-care included)
- Analytics and access to data

Source: Case studies of four high-performing ACOs

After the Hospital Closes: What We Are Learning

- Basis of our work is 26 hospital closures in 6 states: time line and geographic considerations
- Learning from coverage of the community and closure before and after
- In the process now of case study interviews
- Reporting here based on the literature/press and data analysis of the presence of healthcare professionals



What Happens in Health Professions Presence?

- For this analysis, use 75 hospitals that closed post 2010 for which we have up to 18 months post-closure data
- Overall plurality results: decrease in primary care physicians, increase in advanced practice providers, no dominant trend among specialty physicians
- Results hold up for both instances of closure without replacement and closures in which facilities repurposed

Source: Analysis of National Provider Identifier data 2009-2018

What are the System/Community Responses?

- Information here from our literature search in 26 instances across 6 states
- Three types of activity
 - Assuring access to emergency services
 - Developing (or not) new models of care delivery
 - Strategic choices of healthcare organizations and communities



Access to Emergency Services

- Keeping the emergency department open
- Upgrading equipment (ambulance) and personnel (EMTs) to facilitate stabilize and transport responses
- Using local fire departments more extensively
- Coordination with other facilities and communities



New Models of Care Delivery

- Restructuring/enhancing outpatient services and primary care clinics
- Could include modifying existing physical plant or new construction
- Use of observation beds where emergency care facility was maintained
- Urgent care centers developed
- Conversion to long term care facilities

Community Responses

- Seeking buyers from the hospital
- Negotiations with networks for merger/acquisition
- Consideration of tax increases to sustain local services
- Launching new programs to meet community needs – behavioral health, wellness program examples

Resources from Rural Health Value

- Check out the web site:
www.ruralhealthvalue.org
- New Innovator Profiles:
 - Predictive Analytics Shape Care Processes
 - Community Reinvestment Program
 - Community Care Integration
 - Behavioral Health Integration into Primary Care

Resources from Rural Health Value

- Update of the Value-Based Care Assessment Tool
- Report of the findings from a survey of rural health leaders: What do they want to know about value-based care and payment?
- Updates to the Catalog of Value-Based Initiatives for Rural Providers

RUPRI Health Panel's Opportunities for Advancing Rural Health

- Based on a review of what has been accomplished in recent years and there are gaps to address
- RUPRI Health Panel considered current and new ideas
- Across seven topical areas
- Following slides include all recommendations

Source: "Taking Stock: Policy Opportunities for Advancing Rural Health" RUPRI Health Panel. January, 2018. can access by section: <http://www.rupri.org/wp-content/uploads/TAKING-STOCK-2018.pdf>

Medicare Policy Opportunities

- Offer transitional support to rural providers during payment policy changes
- Allow for higher fixed costs per patient encounter in low-volume situations
- Include capital in infrastructure investments to redesign rural health care delivery facilities and support expansion of broadband capacity
- Develop and test alternative delivery models in rural communities

Medicaid and CHIP

- Maintain and expand incentives for states to lower eligibility criteria for Medicaid and CHIP
- Monitor impact of 1115 waiver programs on rural beneficiaries, providers, health plans, and communities
- Provide incentives and technical support to Medicaid agencies and rural providers to provide effective Substantive Use Disorders services
- Include rural beneficiaries, providers, and communities in Medicaid payment and delivery system innovations, and monitor innovation impact over time

Insurance coverage and affordability

- Maintain insurance reforms
- Consolidate rate areas
- Offer incentives to carriers to establish Multi-state plans
- Strengthen risk mitigation
- Encourage demand for marketplace plans

Quality

- Support development of rural-relevant quality measures
- **Develop comprehensive cross-agency approach to rural health care quality improvement and technical assistance**
- Offer quality initiatives specifically design to meet rural needs and opportunities

Health Care Finance and System Transformation

- Offer alternative pathways to rural provider inclusion in value-based payments
- Expand collaborative opportunities among rural providers
- Support expanded rural provider participation in CPOC+ and other similar models
- Consider low volumes in rural performance analyses
- Provide TA to rural providers



Health Care Finance and System Transformation

- Improve timeliness and transparency of demonstration evaluations
- Support care transitions and care coordination
- Monitor emerging research on the impact of social determinants on healthcare performance, and consider rural social risk factors in payment design
- Support telehealth expansion to extend rural health capacity and improve rural health care quality

Workforce

- Decentralize training programs into rural environments
- Target GME funding toward rural health care needs, including primary care
- Target federal funding of non-GME training programs to national health priorities
- Update payment policies to non-physician and patient support providers

Workforce

- Update payment policies to non-physician and patient support providers
- Align payer policies to rural service delivery circumstances
- Create a comprehensive workforce strategy and plan that aligns with the health goals of the nation

Population Health

- Ensure affordability of clinical and community-based preventive services
- Provide stable long-term funding to support locally-appropriate public health prevention programs
- Ensure availability of comprehensive and integrated services through policies that target workforce adequacy development to achieve health equity



Population Health

- Incent integrated preventive and clinical services
- Integrate population health goals into financing strategies and payment policy formulation

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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Collaborations to Share and Spread Innovation

- ✓ The National Rural Health Resource Center

<https://www.ruralcenter.org/>



- ✓ The Rural Health Information Hub

<https://www.ruralhealthinfo.org/>



- ✓ The National Rural Health Association

<https://www.ruralhealthweb.org/>



- ✓ The National Organization of State Offices of Rural Health

<https://nosorh.org/>



- ✓ The American Hospital Association

<http://www.aha.org/>

