American Hospital Association™

Advancing Health in America

AHA Events

37TH ANNUAL AHA RURAL HEALTH CARE | LEADERSHIP CONFERENCE

FEBRUARY 11-14, 2024 | ORLANDO, FL

SIGNIA BY HILTON ORLANDO BONNET CREEK

February 13, 2024

Session: Policy and Research Update: Financial Models for Rural Hospitals

Christina Campos, FACHE, *Administrator*, **Guadalupe County Hospital, Santa Rosa, N.M.**

Kristen Dillon, MD, FAAFP, *Chief Medical Officer*, **Federal Office of Rural Health Policy, HRSA, HHS**

Keith Mueller, *Director*, **RUPRI Center for Rural Health Policy Analysis, College of Public Health, University of Iowa**

George Pink, PhD, *Deputy Director*, **North Carolina Rural Health Research Program, University of North Carolina at Chapel Hill**

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37TH ANNUAL **AHA RURAL HEALTH CARE** | LEADERSHIP CONFERENCE

Having a Say in Shaping the Future: Adapting and Leading

Presentation in 2024 AHA Rural Health Care Leadership Conference
February 13, 2024, Orlando, FL

Keith J. Mueller, PhD
Gerhard Hartman Professor of Health Management and Policy
Director, RUPRI Center for Rural Health Policy Analysis

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Please note that the views expressed by the conference speakers do not necessarily reflect the views of the American Hospital Association.

Outline of Comments

Evolution of Payment Policy → Two Major Manifestations → Optimizing Success in New Environment

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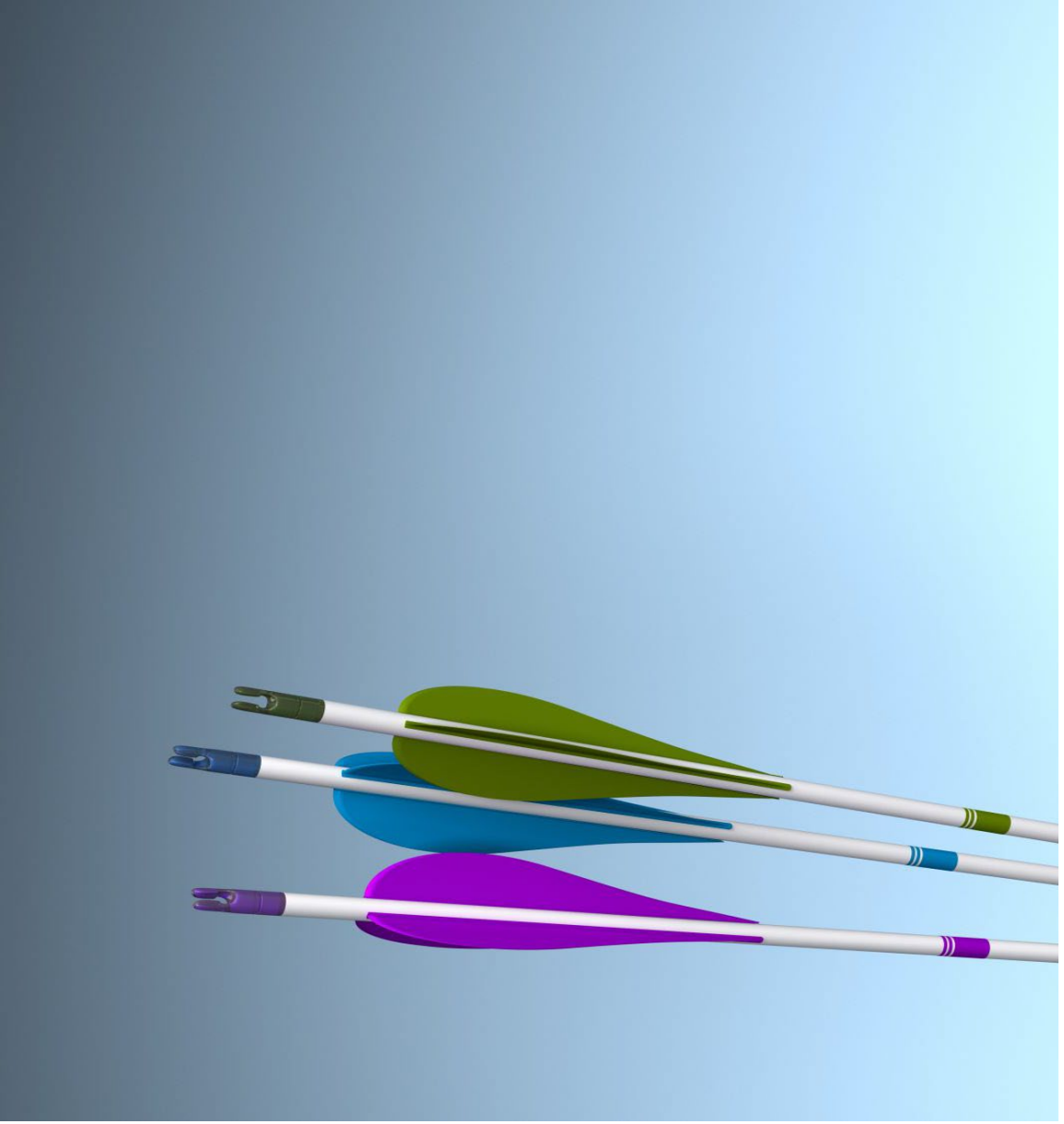

Changing Goals in Payment Policy

- 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 accelerate 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

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The Journey to Value-Based Care and Payment

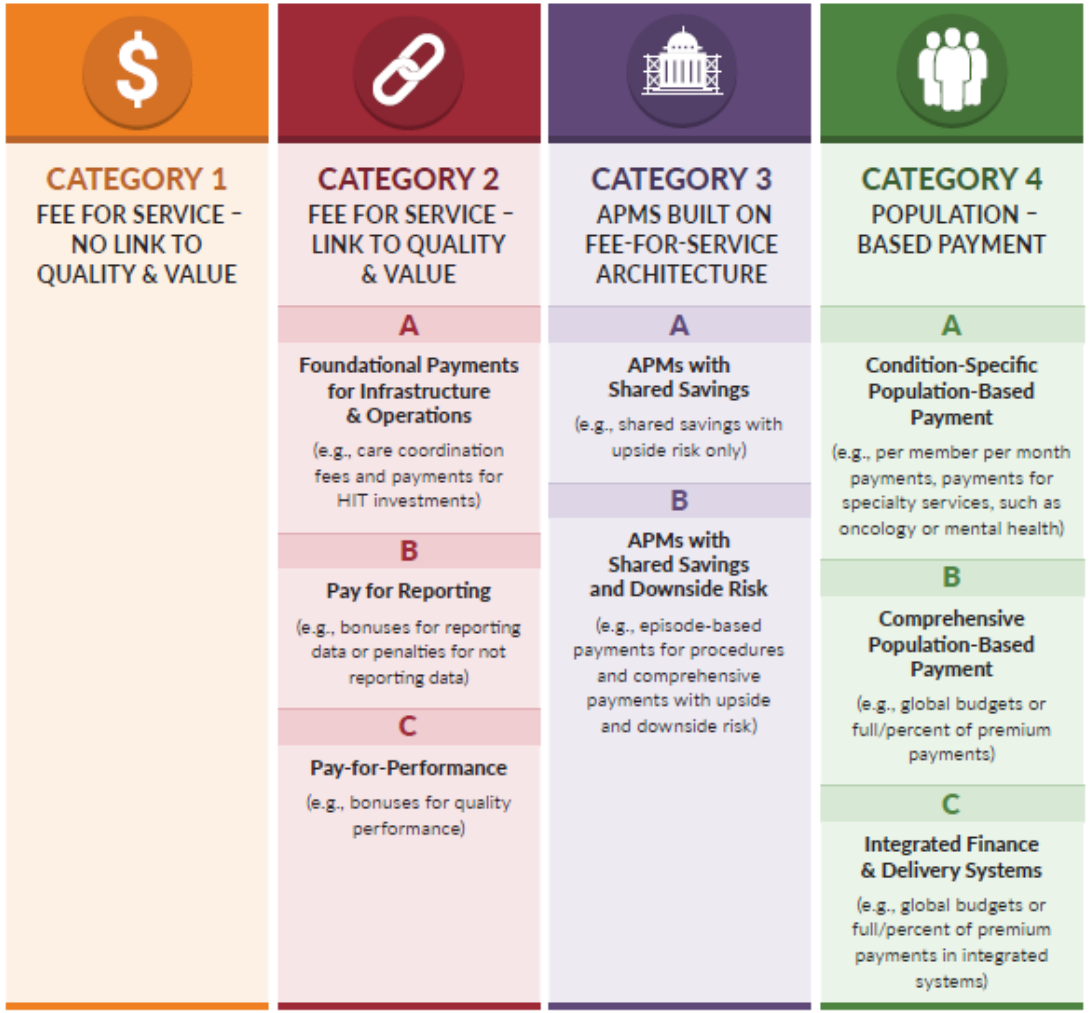
Predates the Patient Protection and Affordable Act, 2011 (ACA)

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

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



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

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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*

Part Two: Specific Approaches

- Medicare Advantage
- Shared Savings Program (Accountable Care Organizations)

Medicare and Medicaid Policy Shifts

- 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)
- 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

Medicare Advantage

REALITY IS THAT MA IS *PRIVATE INSURANCE WITHIN MEDICARE PARAMETERS*

ENROLLMENT INCREASING, MORE THAN 50%, WITH NEARLY 40% OF RURAL BENEFICIARIES

FEDERAL PAYMENT IS CAPITATED, BUT TO THE HEALTH PLANS

HEALTH PLAN PAYMENTS TO PROVIDERS VARIES

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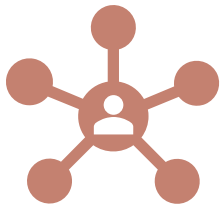
Medicare Advantage

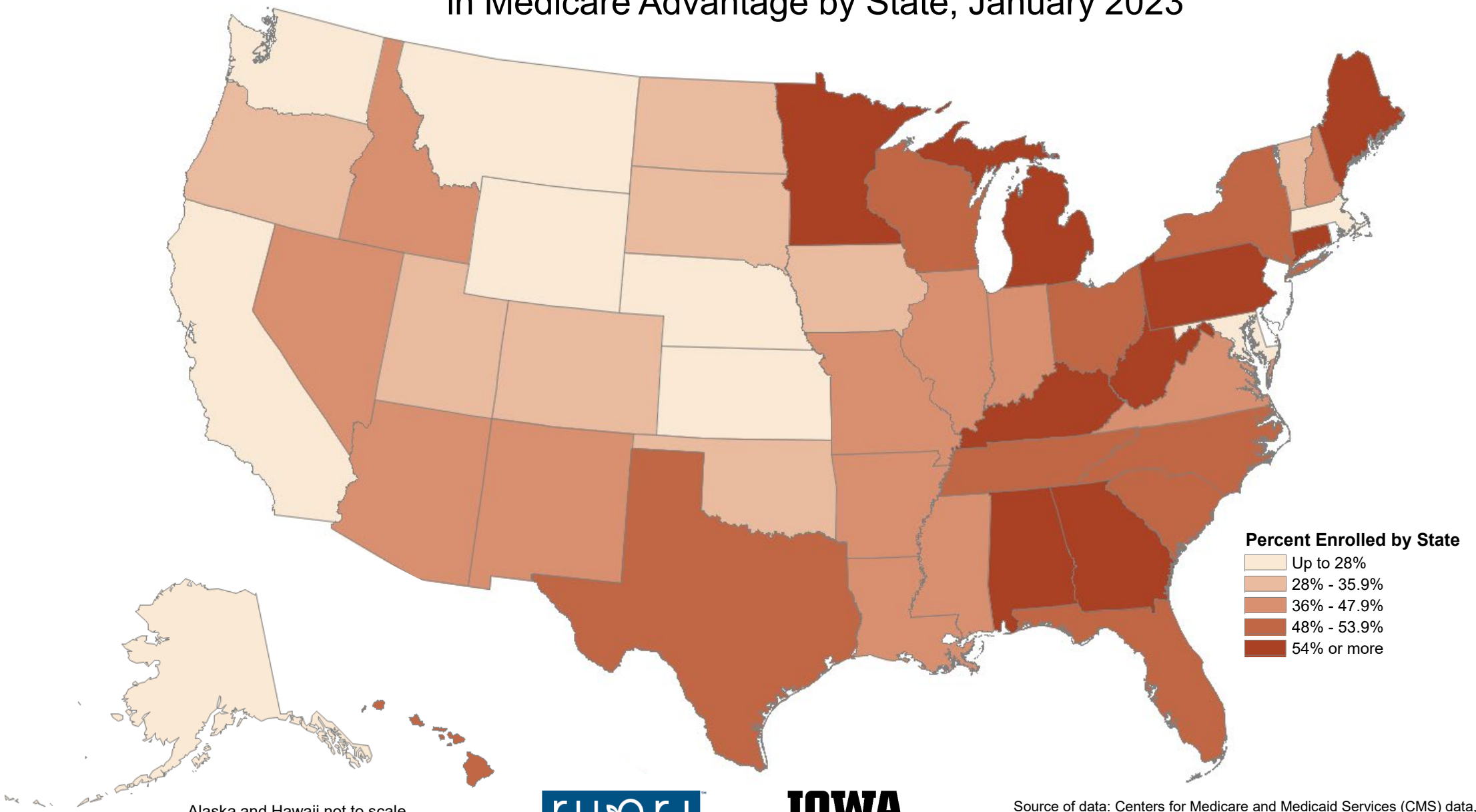
Attraction to enrollees: benefits, low premiums



Potential problems for enrollees: narrow networks, limited benefits

What does it mean for a “new world” in health care delivery and finance?

Percent of Eligible Non-Metropolitan Beneficiaries Enrolled in Medicare Advantage by State, January 2023



Alaska and Hawaii not to scale

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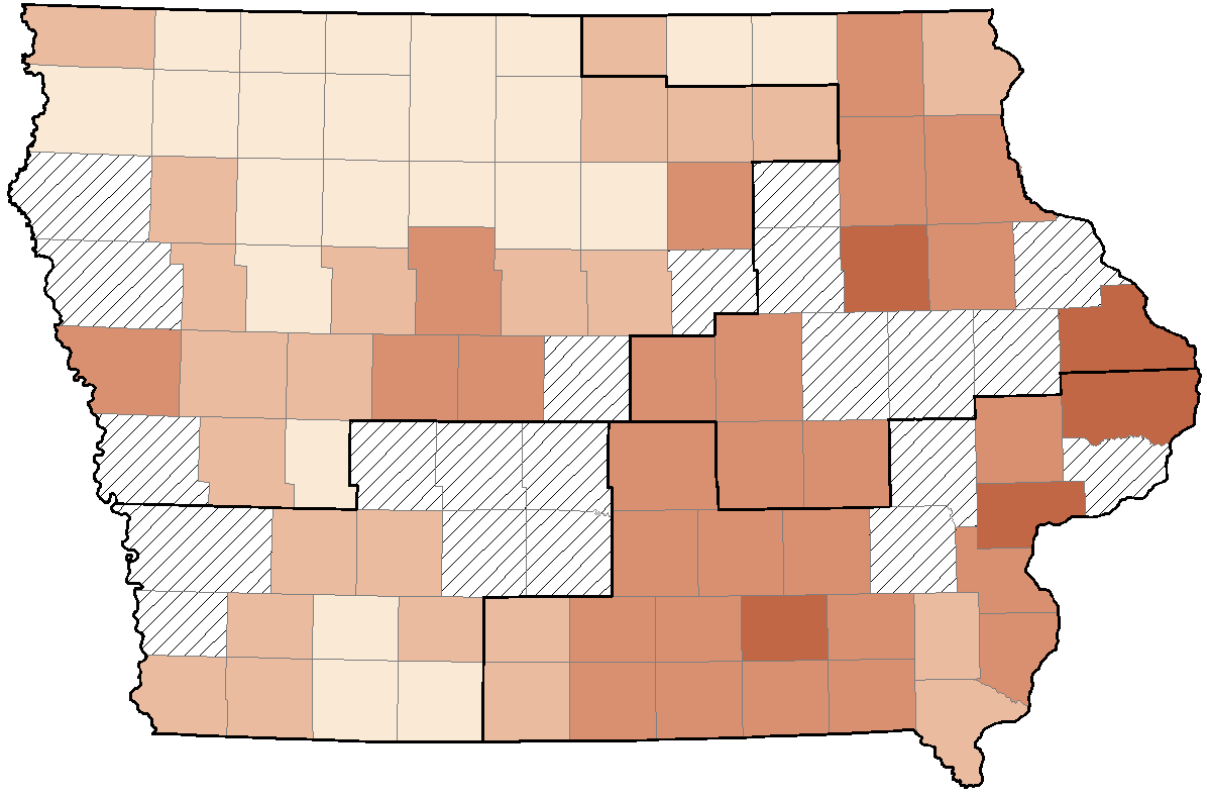
Source of data: Centers for Medicare and Medicaid Services (CMS) data, as of January 2023
Produced by: RUPRI Center for Rural Health Policy Analysis, 2023
Note: Delaware, New Jersey, and Rhode Island contain no non-metropolitan counties

Percent of Eligible Medicare Non-Metropolitan Beneficiaries Enrolled in Medicare Advantage and other Prepaid Plans: Iowa

2020

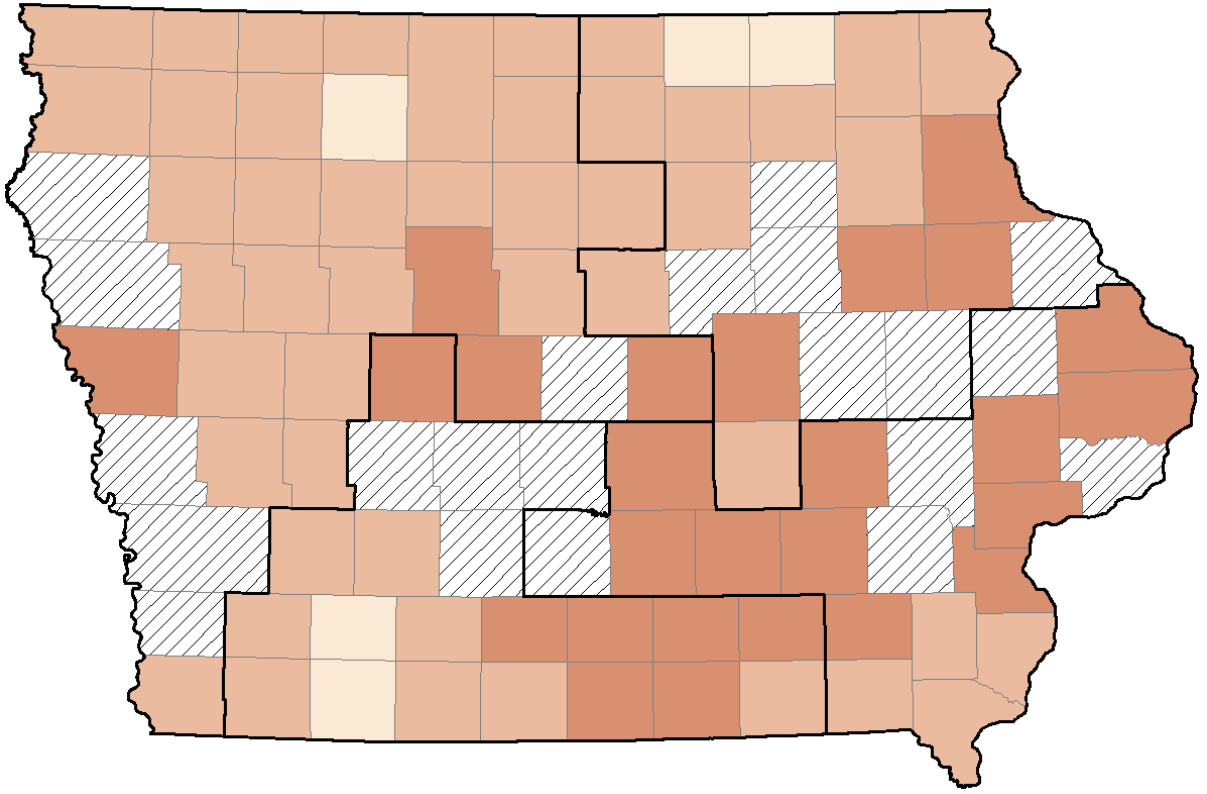


Percent Enrolled by County
- Less than 7.5%
- 7.5% - 14.9%
- 15% - 24.9%
- 25% - 34.9%
- 35% - 64%

116th Congressional Districts

Metropolitan counties

2023



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- 60% or more

118th Congressional Districts

Metropolitan counties

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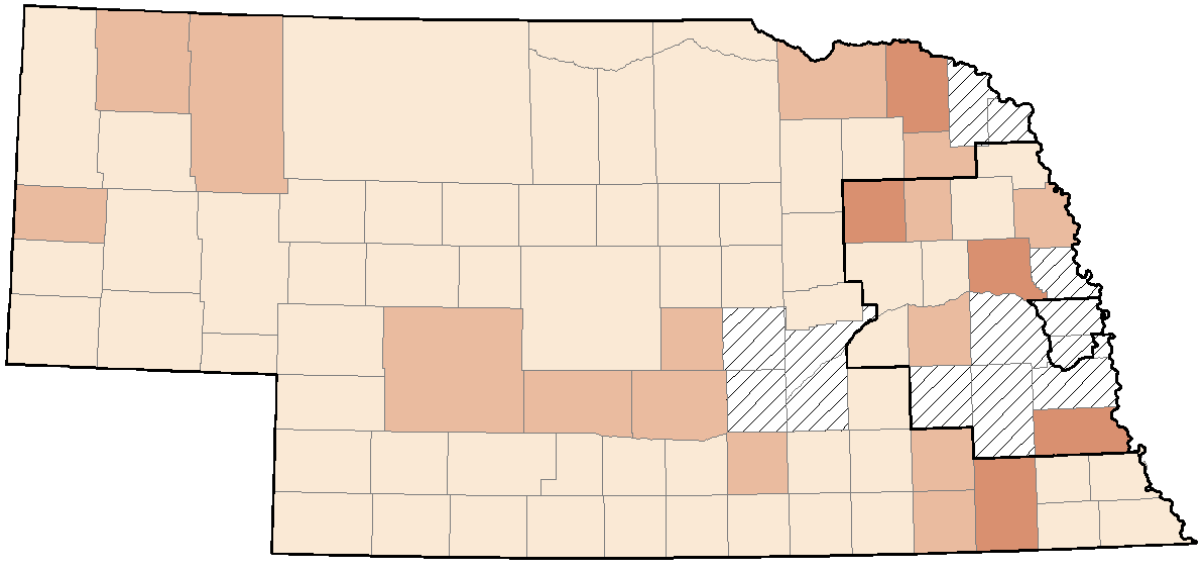
Produced by: RUPRI Center for Rural Health Policy Analysis
Source of data: Centers for Medicare and Medicaid Services (CMS)

Percent of Eligible Medicare Non-Metropolitan Beneficiaries Enrolled in Medicare Advantage and other Prepaid Plans: Nebraska

2020



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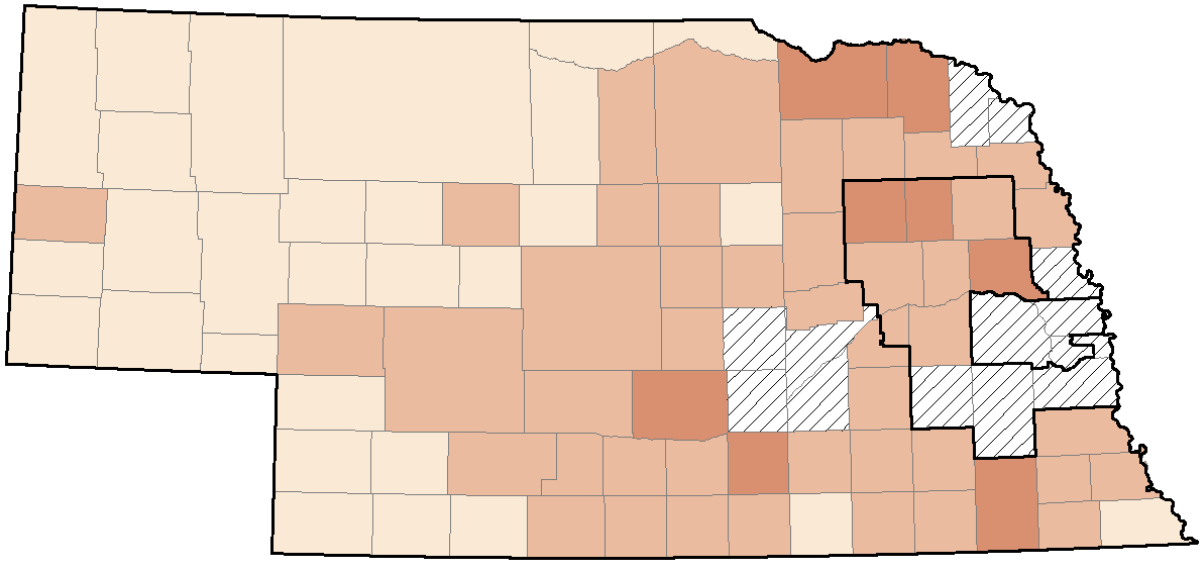
- Metropolitan counties

2023



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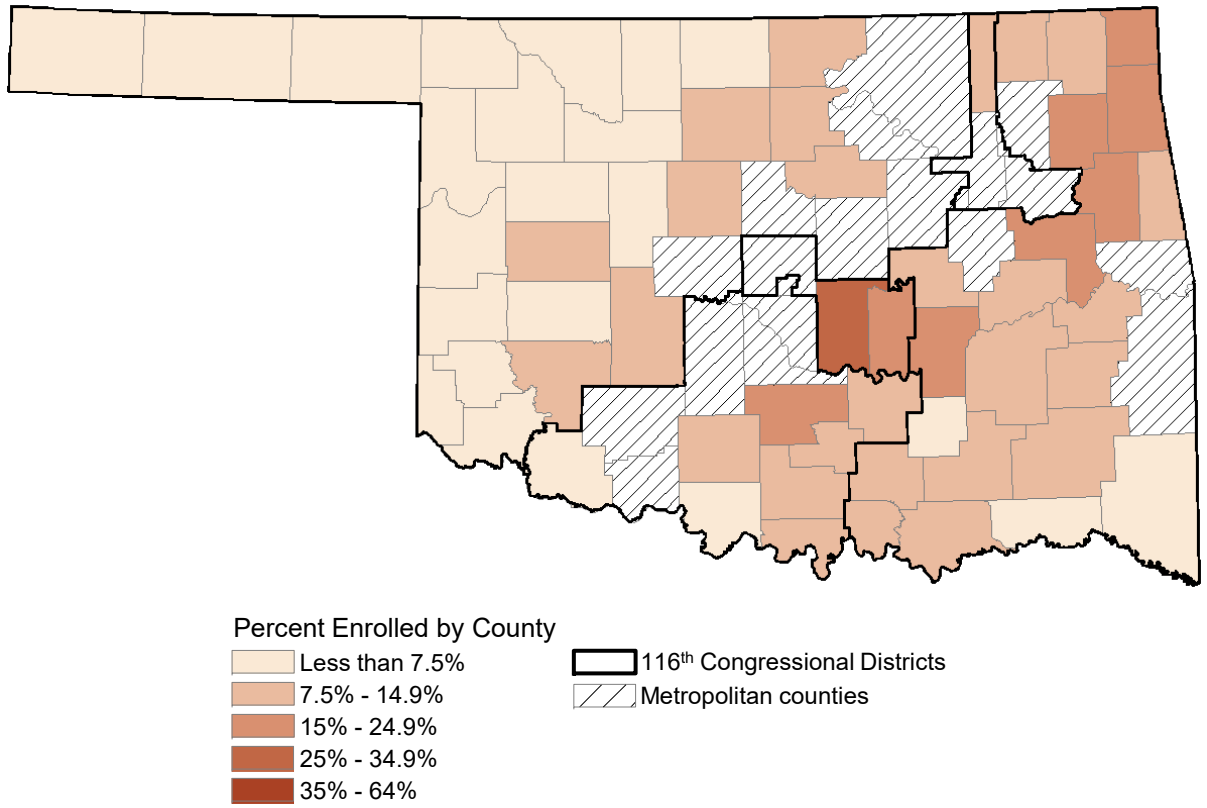
Source of data: Centers for Medicare and Medicaid Services (CMS)

Percent of Eligible Medicare Non-Metropolitan Beneficiaries Enrolled in Medicare Advantage and other Prepaid Plans: Oklahoma

2020



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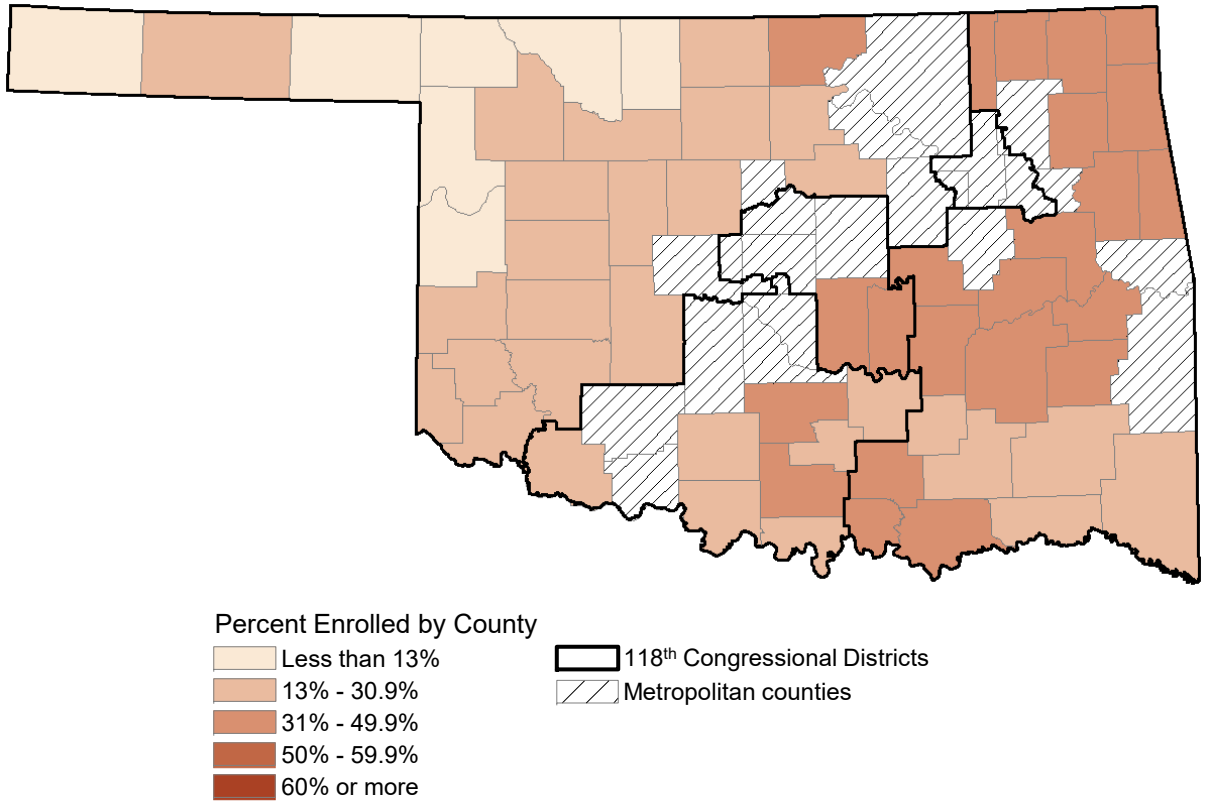

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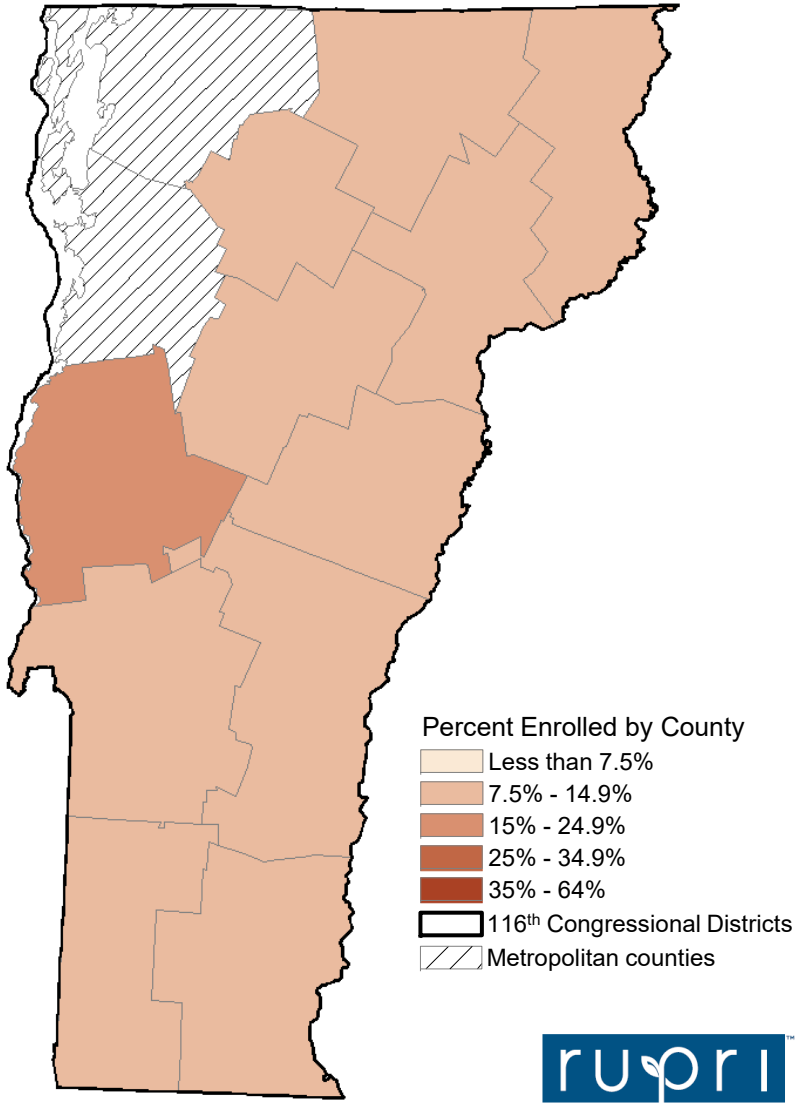
Source of data: Centers for Medicare and Medicaid Services (CMS)

Percent of Eligible Medicare Non-Metropolitan Beneficiaries Enrolled in Medicare Advantage and other Prepaid Plans: Vermont

2020



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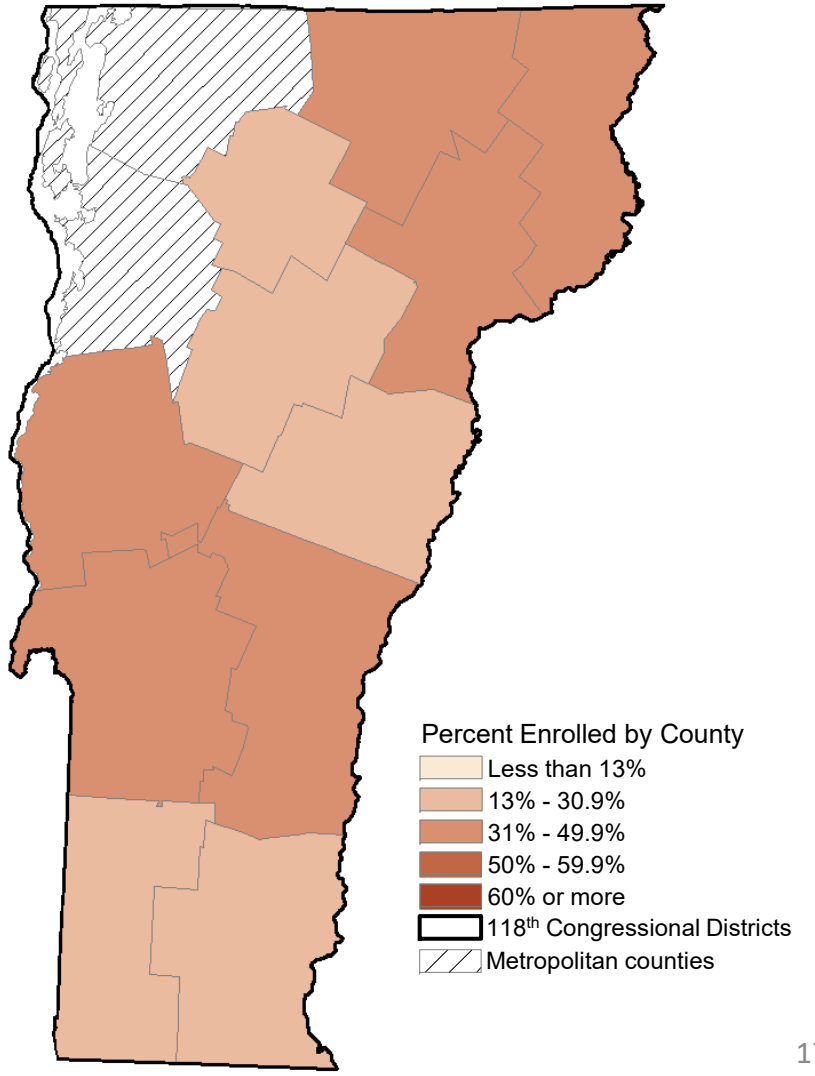
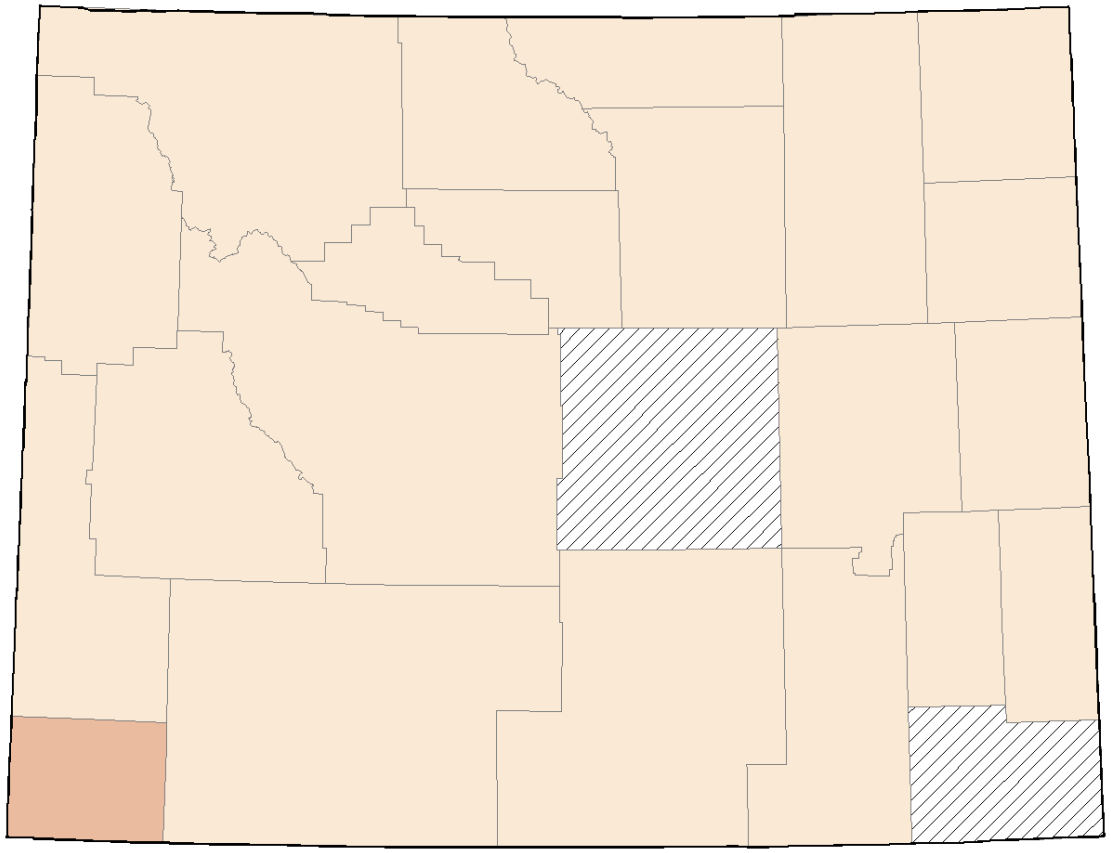


Produced by: RUPRI Center for Rural Health Policy Analysis

Source of data: Centers for Medicare and Medicaid Services (CMS)

Percent of Eligible Medicare Non-Metropolitan Beneficiaries Enrolled in Medicare Advantage and other Prepaid Plans: Wyoming

2020



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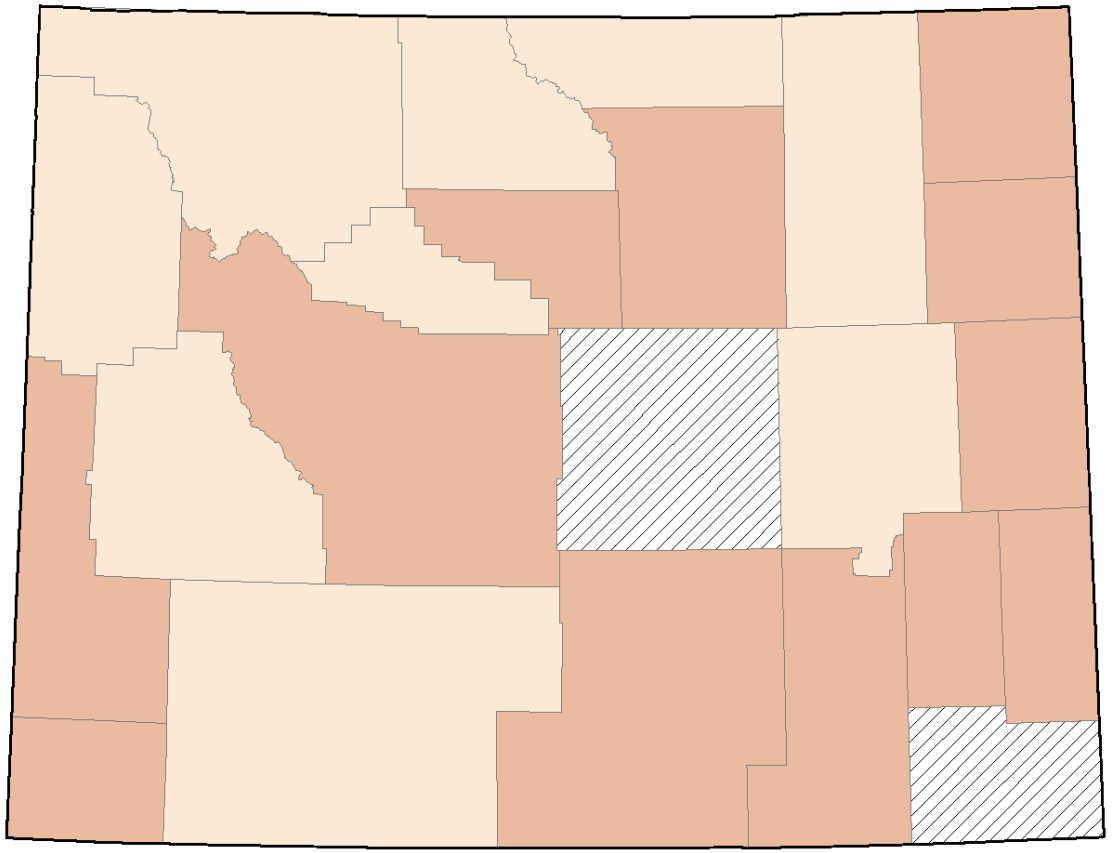

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Source of data: Centers for Medicare and Medicaid Services (CMS)

Questions about MA Plans

- Who are the plans in my area?
- What is their influence on my revenue?
- What is my experience with prior approval, denied claims, timely payment?
- What is their philosophy in negotiating payment?
- Can I negotiate a new value-based payment contract?
- What are the consequences of not accepting them as a third-party payor?

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

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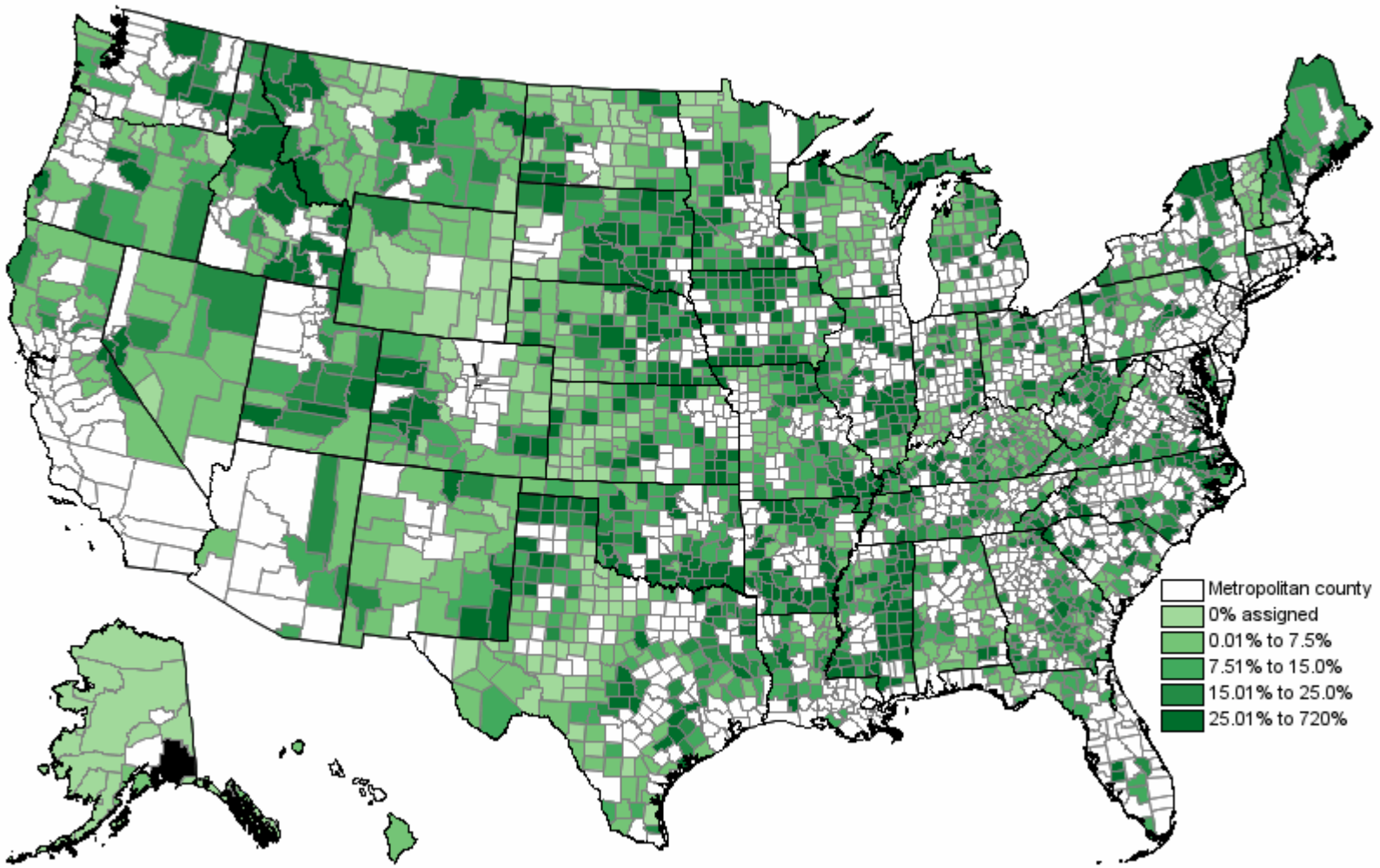
ACO Spread - 2023

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



Source: CMS - Medicare Shared Savings Program Fast Facts

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SSP Changes In 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%

SSP Changes In 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

Questions about ACOs

- Can my hospital benefit from a model that shares financial risk?
- Am I prepared to engage other entities (sometimes individuals) in my community in health teams?
- Are there other healthcare organizations (hospitals) in my state and region I should seek out in a network arrangement?
- Are there regional or national ACOs I should consider joining?

Part Three: Hospitals Leading the Way

- Incentives
- Delivery System Change

Aligning Incentives

Challenge of the legacy of encounter-based payment and volume-based incentives

Shift to enrollee-based payment and incentives to shift to lower-cost care

Value is achieving community-focused mission

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Delivery System Change: Possibilities

- Health teams, by any name (PCMH, PCHH, team) than incorporate clinical and non-clinical personnel
- Different sites of care, including more in-home
- Local networks that include community-based organizations
- Investments: from grant sources, from community foundations, from new payment design

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

Rural Health Value Resources

- Value-based Care Assessment tool: https://ruralhealthvalue.public-health.uiowa.edu/TnR/vbc/vbctool.php
- Social determinants of health opportunities guide: https://ruralhealthvalue.public-health.uiowa.edu/files/Understanding%20the%20Social%20Determinants%20of%20Health.pdf
- Care Coordination: A Self-Assessment for Rural Health Providers and Organizations: https://ruralhealthvalue.public-health.uiowa.edu/files/RHV%20Care%20Coordination%20Assessment.pdf

Rural Health Value Resources

Rural Health Value
UNDERSTANDING AND FACILITATING RURAL HEALTH TRANSFORMATION.

- Web portal for all resources: www.ruralhealthvalue.org
- Rural community engagement resource guide: https://ruralhealthvalue.public-health.uiowa.edu/files/Innovation-Profile-SERPA-ACO.pdf
- Profiles in innovation: https://ruralhealthvalue.public-health.uiowa.edu/InD/Profiles/

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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 Health Value http://www.ruralhealthvalue.org

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For more than 30 years, the Rural Health Research Centers have been conducting policy-relevant research on healthcare in rural areas and *providing a voice for rural communities in the policy process.*

Rural Health Research Gateway

The Rural Health Research Gateway ensures this research lands in the hands of our rural leaders.

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