Rural Health Trends, Reform and National Outlook

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Population

Age diversity	• Migration to urban • Older population
Rural economic health	• Loss of key economic sectors • Recession - rural employment lagging
Education	• Lower educational attainment
Payer mix	• Less insurance coverage • Increase reliance on Medicare and Medicaid
Health	• Leads to increased illness burden

Access

Health professional shortage in primary care	• Expanding: Psychiatrists, dentist, general surgeons, new mid-levels… • Distribution
Provider recruitment through loan repayment	• Retention: Recruitment going upstream to medical schools • Reform of general medical education (GME)
Building new independent rural health clinics	• Transforming safety net providers • Rise in rural health clinics linked to critical access hospitals
Support use of primary care mid-levels	• New workforce types: Dental therapists, community health workers, clinical pharmacists, care coordinators…
Primary medical services	• Prevention and behavioral change • Whole-person focused: Mental, dental, long-term care, end of life and social supports
Defined by direct in-person services	• Technology-enabled: Phone, email, mobile applications and other telehealth services

Quality

Visit-based Chart audit or claims	• Big data: Population health, all-payer claims database, health information exchange, ICD-10
National Accreditation Standards HEDIS & NCQA measures	• Disease registries, patient-centered medical homes, meaningful use and accountable care organizations
Feedback was provider / practice level	• Transparency: Open data sets, public reporting
Agency level	• Patient level: Readmission penalties and patient experience • Across systems: Care management, medication reconciliation; transitional care
Limited financial impact	• Significant impact with move to pay for quality outcomes

Payment

Fee-for-service	• Watch Medicare - tying 30 percent of Medicare payments to value through alternative payment models by 2016, and 50 percent by 2018 • Pay for performance • Capitated payments
Acute Relative value units	• New codes: Transitions and care coordination • Primary care-based • Rural ACOs
Contract negotiation vs cost-based	• Lean principals: Working professionals at the top of their licenses • Medicare and BCBS make payment data available
Medical-based	• Patient-based: Allowing for funding for prevention; social support and patient preference

Risks

Timing of payment reform	• Unclear how health systems shut down high volume and cost services and continue to survive in fee-for-service payment system
Remaining number of uninsured and increasing number of underinsured	• Both populations tend to pass on preventive services leaving chronic conditions untreated and at risk for costly adverse events
Access to insurance = access to preventive health care	• Belief that everyone has coverage leads to the elimination of alternative funds
Collapse of acute systems before prevention and primary care are significantly enhanced	• No real investment in prevention • Two years of 100% Medicare • New codes in FFS for coordinated care (excludes RHCs)

Risks

Rural dependency on government coverage	• Primary care, safety net systems and small rural hospitals lack resources for infrastructure upgrades
Push to serve high density, well insured urban areas	• Large, well-funded health systems are not rushing to create services for poor rural populations • CAHs closing while new facilities are built closest to the metro area
Technology	• EHRs are costly and become outdated • Sites have connectivity challenges and lack IT workforce • Telehealth requires payment and policy reform
Overreach	• Large systems buying up… • Capitation for unknown populations • Capitated ACO is not your 90s MCO

Risks

Health care workforce	• Policies remain aligned to support professional self-interest • Medical education remains unchanged
New tension within health care system	• FFS created no incentives to be interdependent • In new system, others' behavior will impact your bottom line • Rush for data and patients
Redundant new infrastructure	• Consider potentially repetitive software: Risk adjustment, care management, claims processing

Opportunities

Reduce poor quality and high costs that are unsustainable in an acute care model	• Most risk resides outside of rural providers who have to do a lot with a nickel • Creates an opportunity for a higher investment in rural if payment is made based on high quality provided for high-risk patients
Rural reliance on government insurance	• If Medicare and Medicaid transform in a similar fashion, rural providers could be much quicker to transform their practices
Health care workforce	• Opportunity for new lower cost professions to significantly improve quality and reduce cost of care

Opportunities

Team-based care	• Increased access directly or through technology to comprehensive teams
Increased investment in wellness	• Healthy eating, active living, early screening and intervention, and disease management
Increasing attention to social supports	• Recognition and investment in social supports that improve health, such as housing, education and employment opportunities • Rural providers can serve key leadership roles within their communities

Opportunities

Reduced administration	• If all payers are no longer truly FFS, then could see significant reduction in administrative costs and burden
Transparency	• Increasing employer and consumer choice • Reduction in fraud
Patient engagement	• Increased recognition of patient role • Rural providers have deep, personal and meaningful intergenerational relationships with their rural families

THANK YOU

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