

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?



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

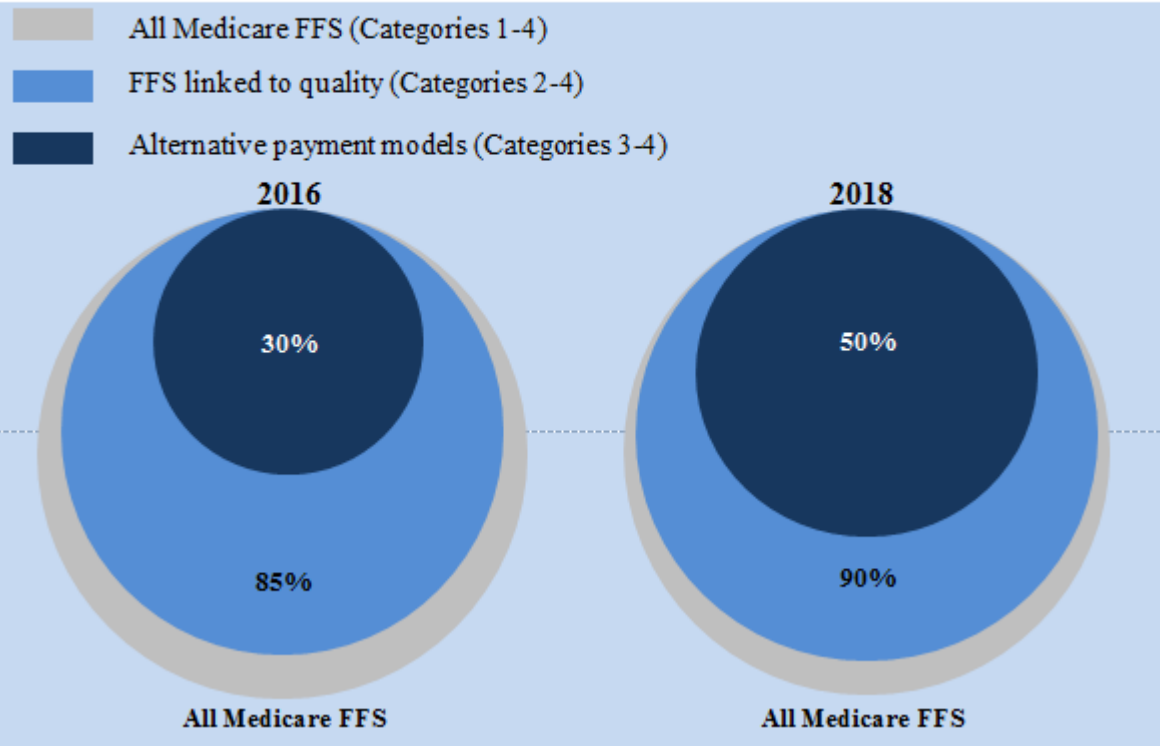
Source of this and following slides: CMS Fact Sheets available from [cms.gov/newsroom](https://www.cms.gov/newsroom)

Illustration of Move to Population-Based Payment

Payment Taxonomy Framework					
		Category 1:	Category 2:	Category 3:	Category 4:
		<i>Fee for Service—No Link to Quality</i>	<i>Fee for Service—Link to Quality</i>	<i>Alternative Payment Models Built on Fee-for-Service Architecture</i>	<i>Population-Based Payment</i>
Description		<i>Payments are based on volume of services and not linked to quality or efficiency</i>	<i>At least a portion of payments vary based on the quality or efficiency of health care delivery</i>	<i>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</i>	<i>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)</i>
	Medicare FFS	<ul style="list-style-type: none"> Limited in Medicare fee-for-service Majority of Medicare payments now are linked to quality 	<ul style="list-style-type: none"> Hospital value-based purchasing Physician Value-Based Modifier Readmissions/Hospital Acquired Condition Reduction Program 	<ul style="list-style-type: none"> Accountable care organizations Medical homes Bundled payments Comprehensive primary care initiative Comprehensive ESRD Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model 	<ul style="list-style-type: none"> Eligible Pioneer accountable care organizations in years 3-5

Shrinking Band of Traditional Payment

Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018



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

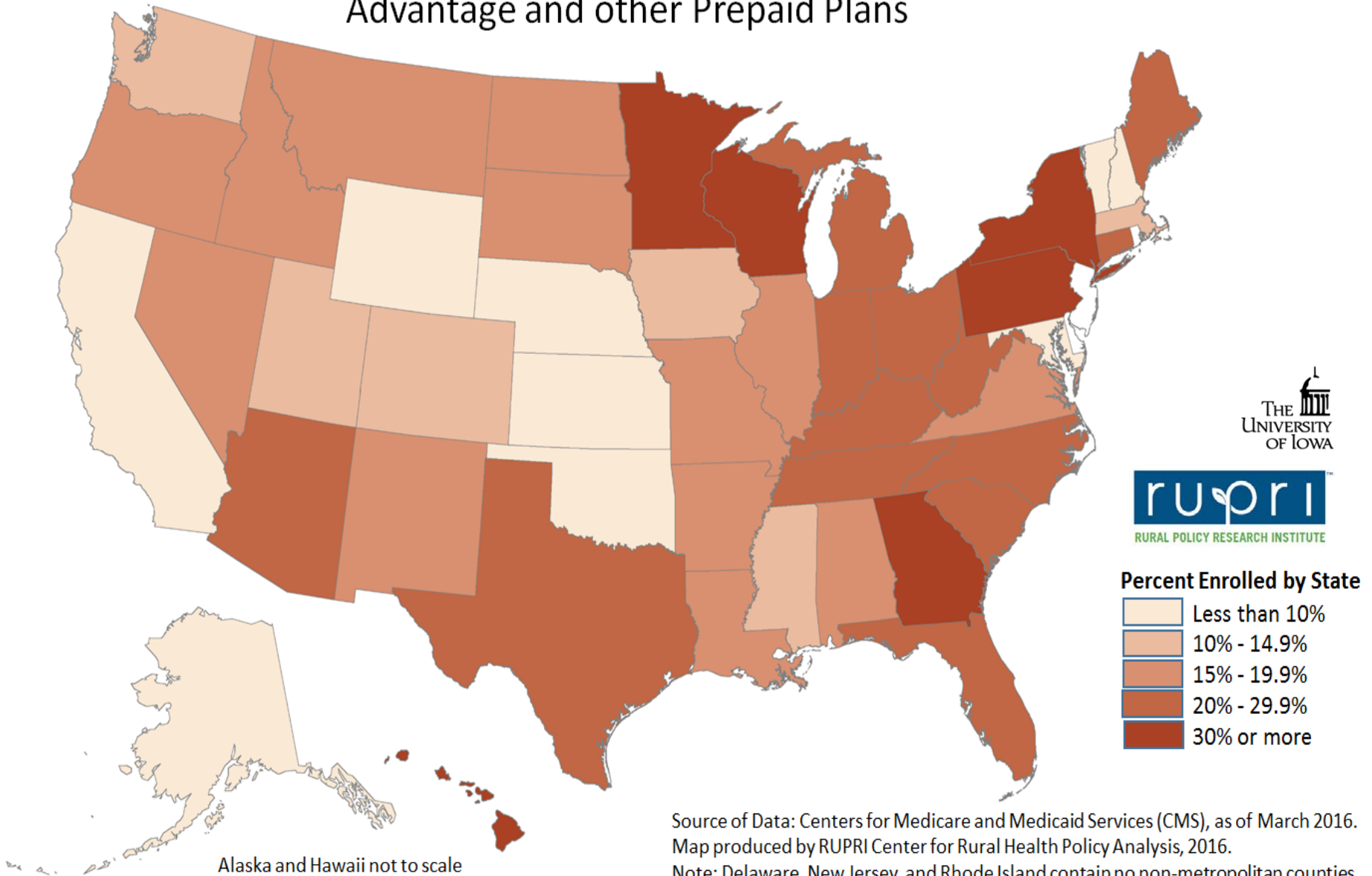
- Medicare Advantage
- Medicare Accountable Care Organizations

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

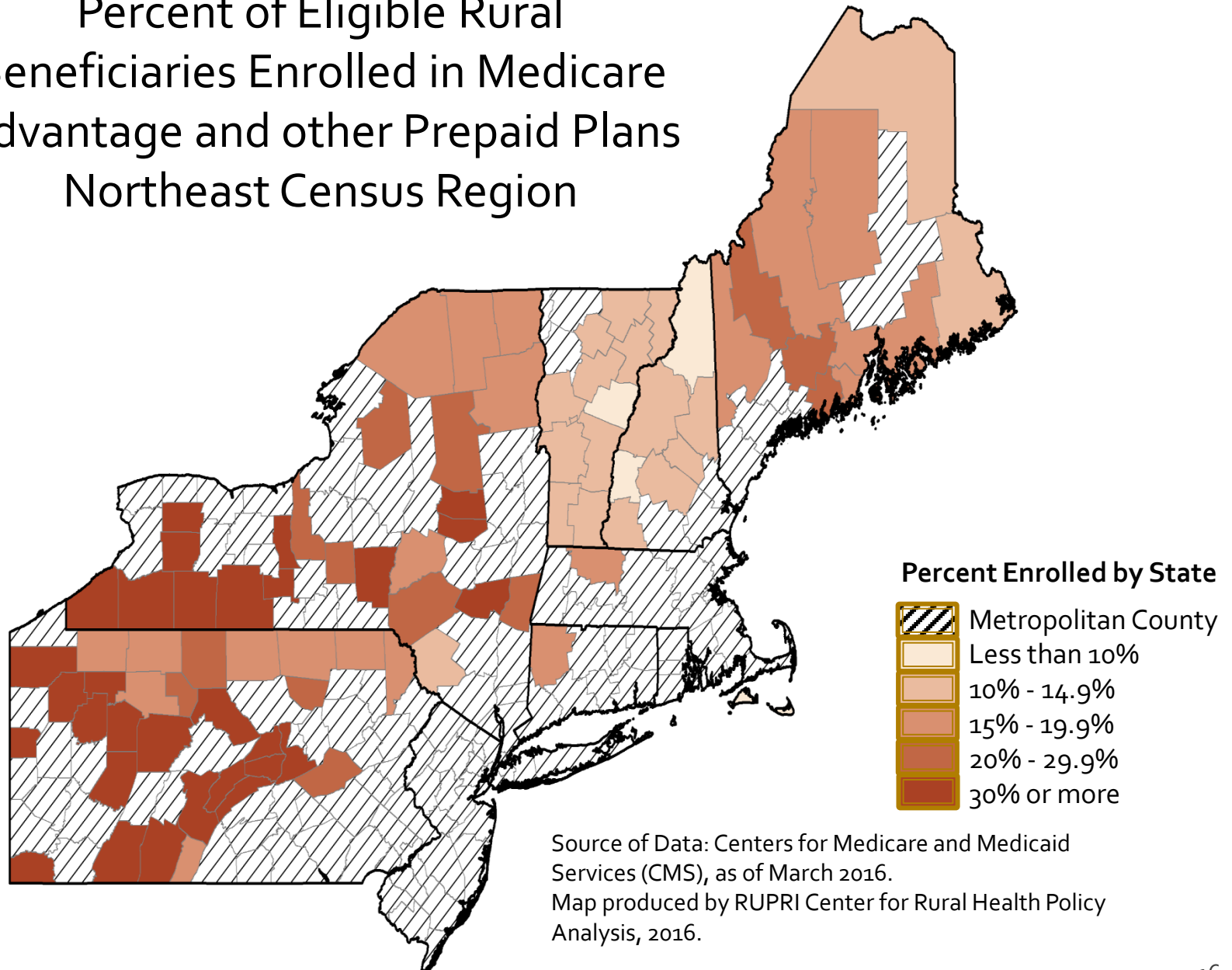


Percent Enrolled by State

- Less than 10%
- 10% - 14.9%
- 15% - 19.9%
- 20% - 29.9%
- 30% or more

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



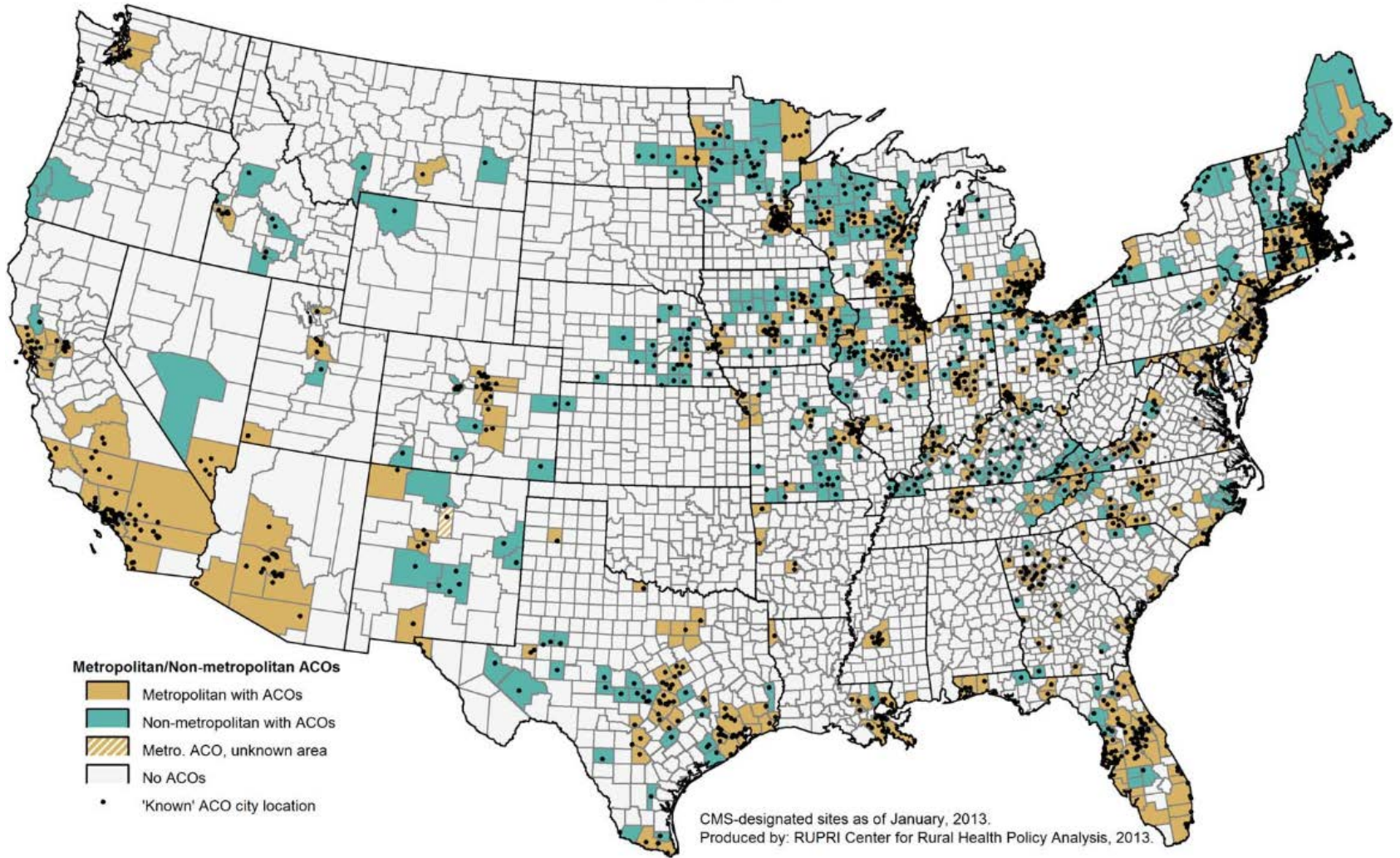
The Continuing Spread of ACO Presence in Rural Places



By the Numbers ...

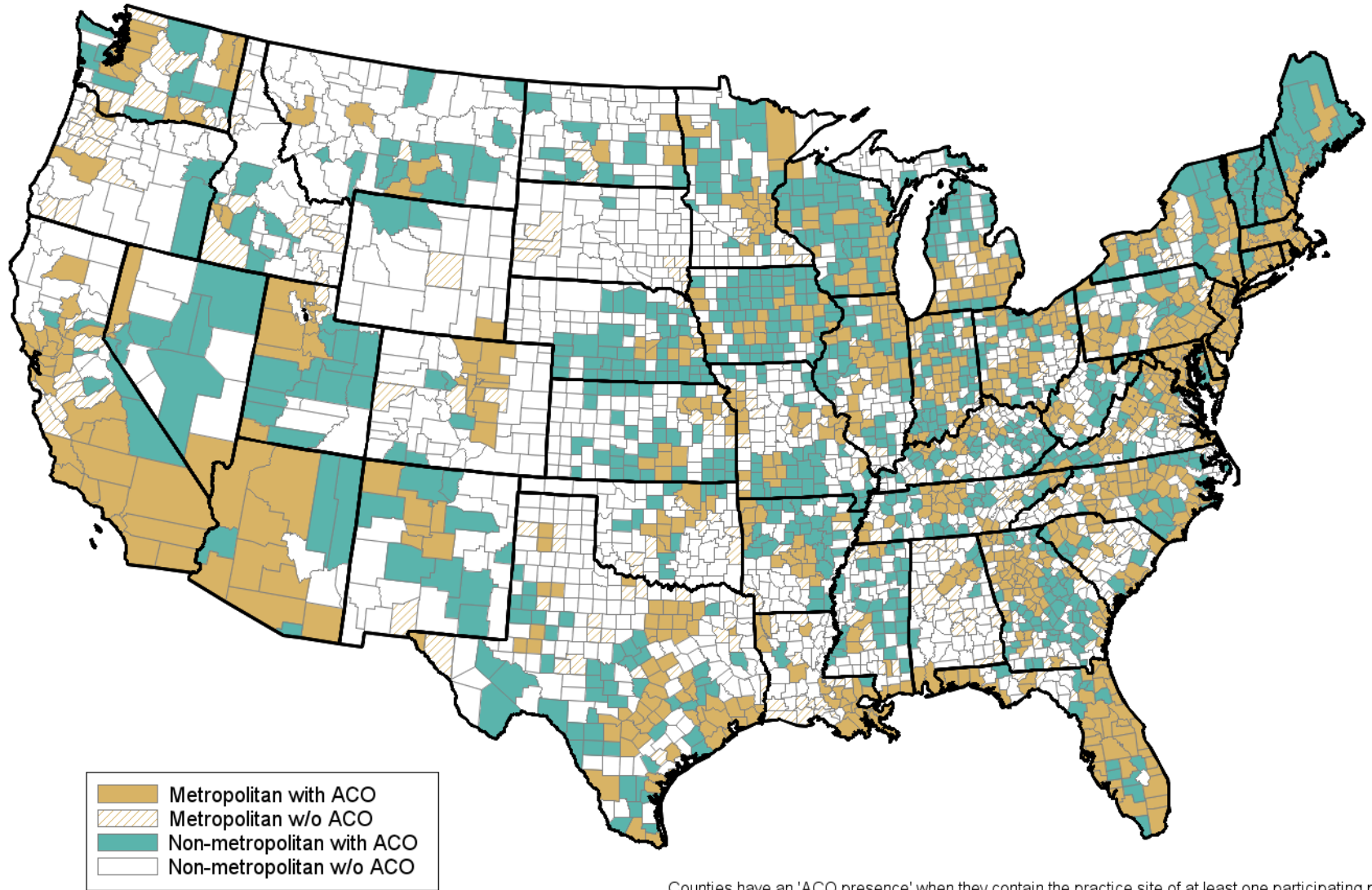
- ACOs operate in 72.0% of metropolitan counties, 39.7% of non-metropolitan counties
- 7.6 million beneficiaries now receiving care through ACOs
- Rural sites in all four census regions

County Medicare ACO Presence Continental United States



County Medicare ACO Presence

Continental United States

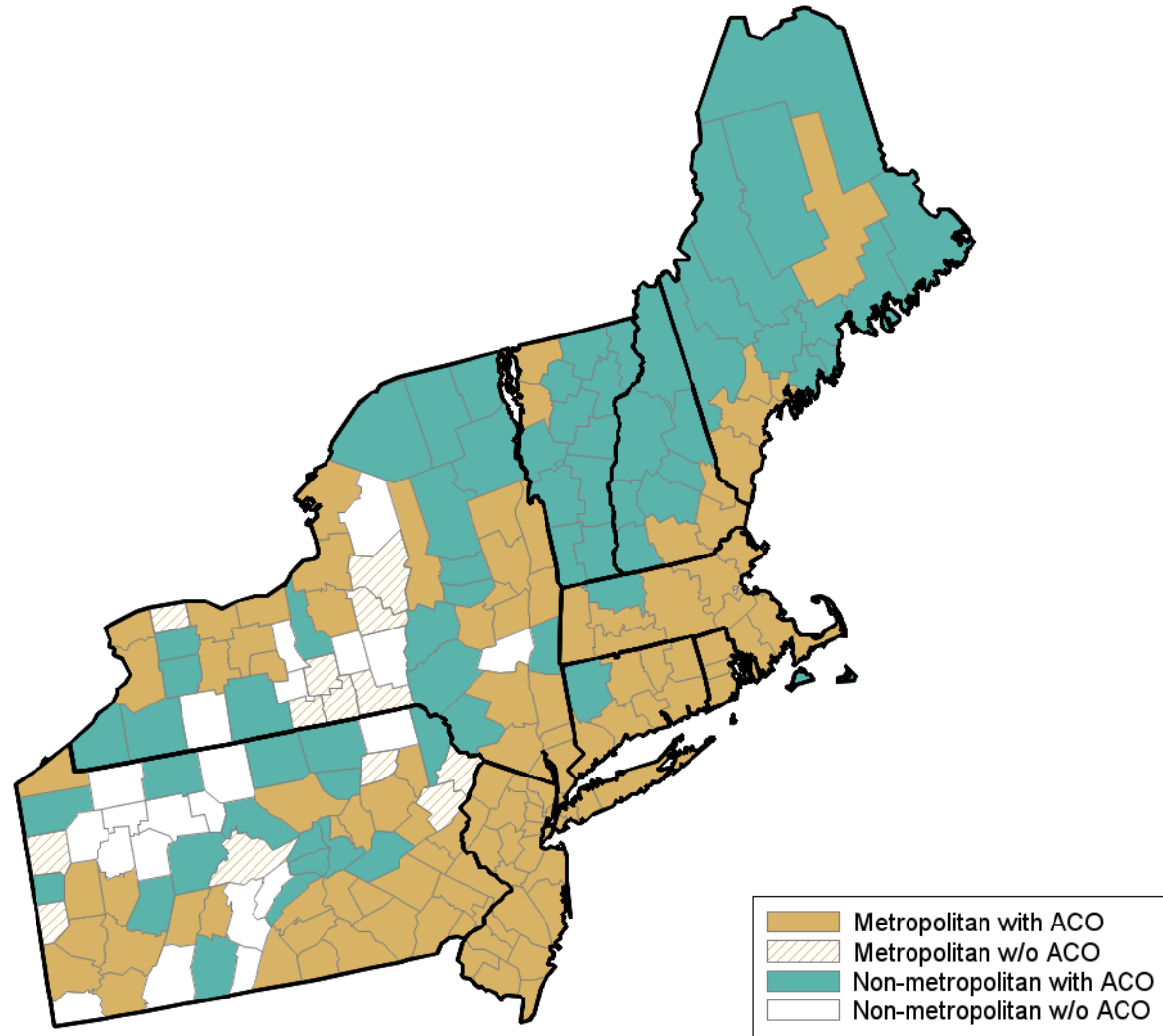


Counties have an 'ACO presence' when they contain the practice site of at least one participating provider.
Includes all active CMS ACOs as of August, 2015.

Produced by: RUPRI Center for Rural Health Policy Analysis, 2016.

County Medicare ACO Presence

Northeast Census Region



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.

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.

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.

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%

*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.

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.

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%



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



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?



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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