2023 RURAL HEALTH CARE SYMPOSIUM SACRAMENTO

Rural Hospital Closures and the Drive Toward Value

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AGENDA

1. Closures
2. Value-Based Payment
3. Advanced Payment Models
4. Examples from the Field
5. You Can't Go it Alone

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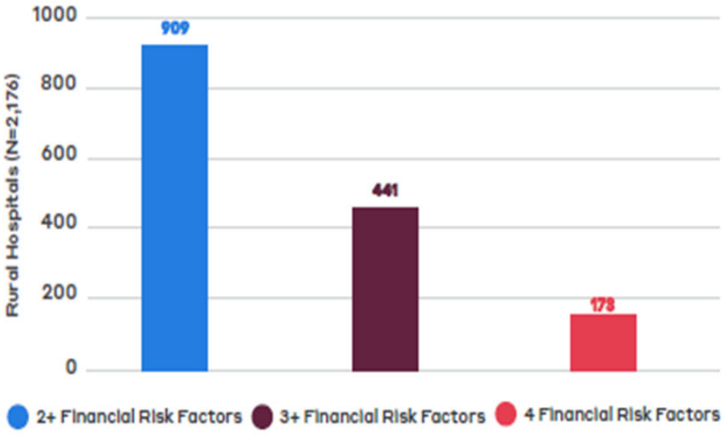
Financial stress affects rural hospitals, 2017-2020

Rural Health Safety Net Under Renewed Pressure as Pandemic Fades

CHARTIS



Bipartisan Policy Center

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Understanding the triggers driving hospital closures

Longstanding Pressures:

- Low reimbursement
- Staffing shortages
- Low patient volume
- Regulatory barriers
- COVID-19 pandemic

Inflation:

- Labor
- Drugs
- Supplies
- Equipment

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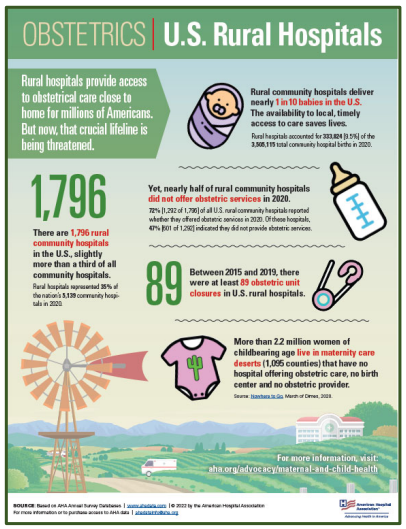
What happens when a rural hospital closes?



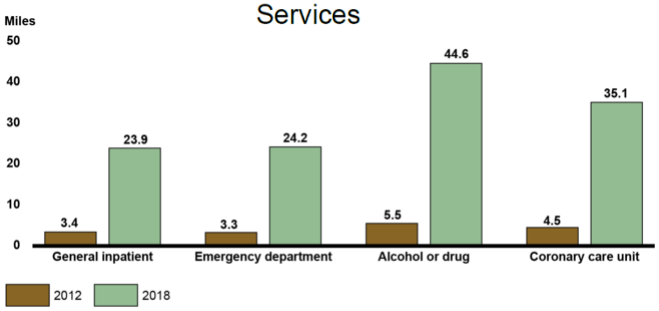
United States Government Accountability Office

Report to the Ranking Member, Committee on Homeland Security and Governmental Affairs, United States Senate

December 2020

RURAL HOSPITAL CLOSURES

Affected Residents Had Reduced Access to Health Care Services



Source: GAO analysis of data from the Department of Health and Human Services and North Carolina Rural Health Research Program. | GAO-21-93

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Did You Know?

- Rural America includes approx. 63 million people, about 19% of the population and 97% of the geographic area of the USA
- There are 1,796 rural hospitals that support nearly 1.7 million jobs
- Every dollar spent by a rural hospital produces another $2.27 of economic activity
- A typical critical access hospital employs 197 community members
- Rural hospitals handle more than 18.5 million emergency visits
- Rural hospitals support 1:12 jobs in the U.S. and $220B in economic activity

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Hospital Value-Based Purchasing

Hospital VBP Domains & Relative Weights

Domain	Weight
Safety	25%
Clinical Outcomes	25%
Efficiency and Cost Reduction	25%
Person and Community Engagement	25%

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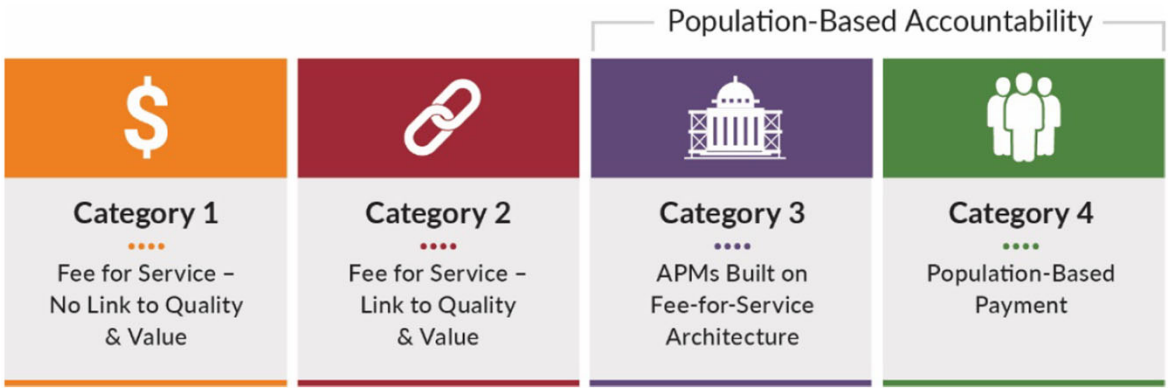
Learning Action Network APM Framework At-a-Glance



40.9% of health care dollars in a composite of Categories 3 & 4 representing approximately 238.8 million Americans and 80.2% of the covered population.

HCP LAN
Health Care Payment Learning & Action Network

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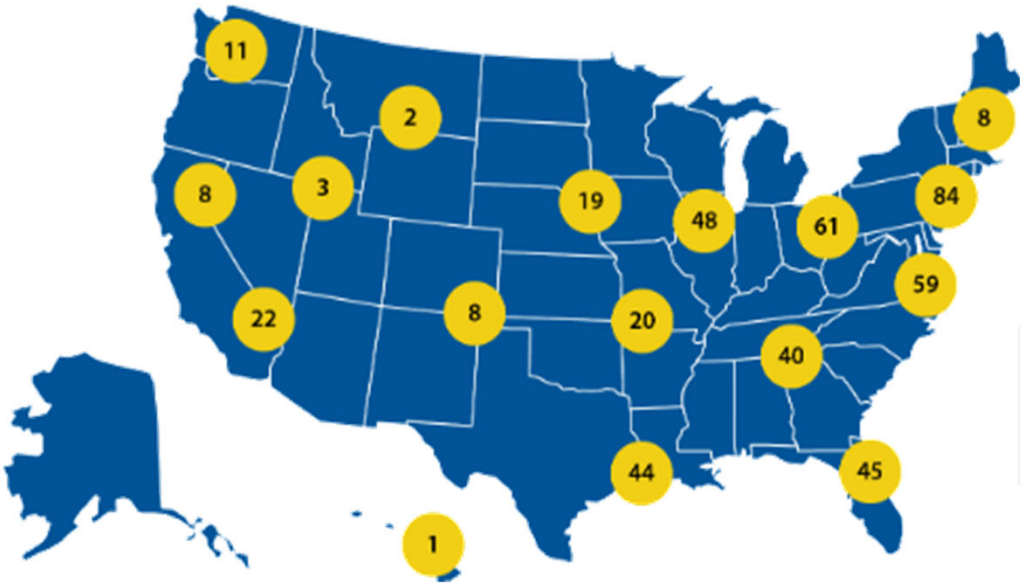
ACOs: The Vanguard of Value-based Payment



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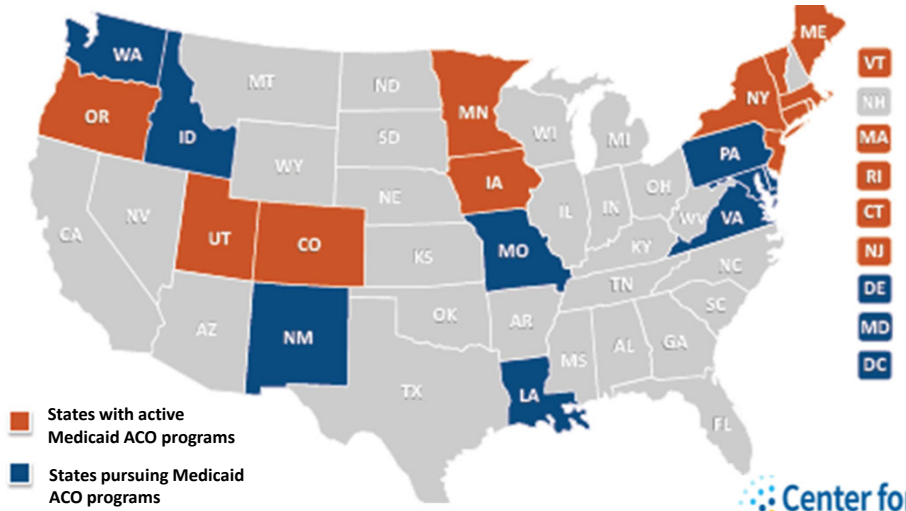
State Medicaid Accountable Care Organization Programs

Effective February 2018



Center for Health Care Strategies

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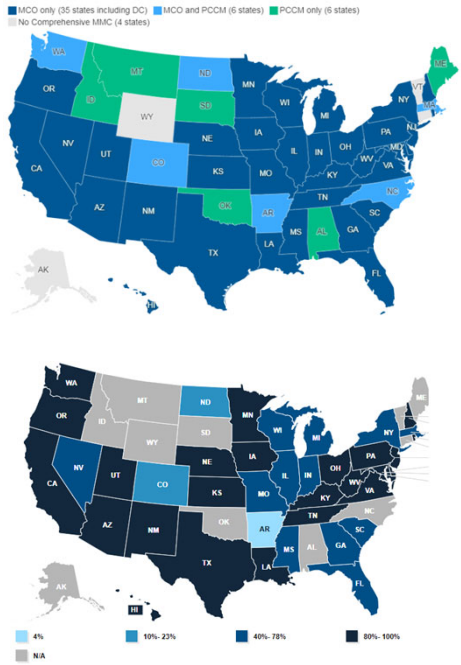

Medicaid Managed Care

As of July 2021, 41 states, including DC, contract with comprehensive, risk-based managed care plans to provide care to at least some of their Medicaid beneficiaries.

Five firms accounted for 50% of all Medicaid MCO enrollment.

As of July 2020, 57 million or 72% of all Medicaid beneficiaries received their care through comprehensive risk-based MCOs.

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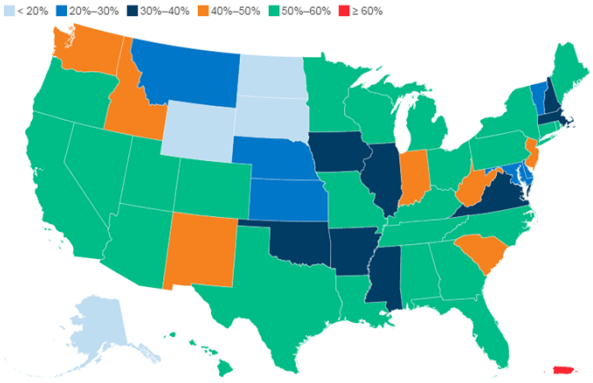
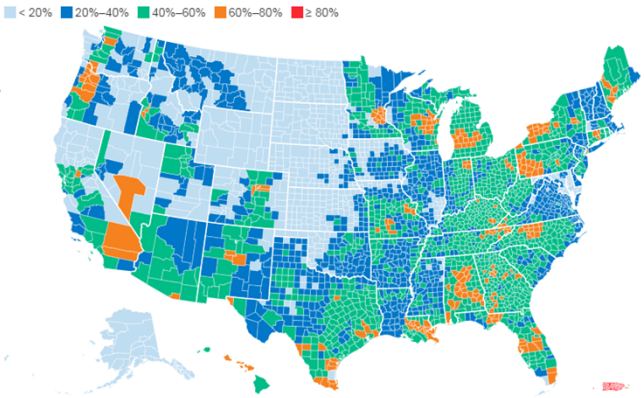
Medicare Advantage

Share of Beneficiaries Enrolled in Medicare Advantage in 2022, by State



Medicare Advantage Penetration, by County, 2022



KFF
HENRY J KAISER FAMILY FOUNDATION

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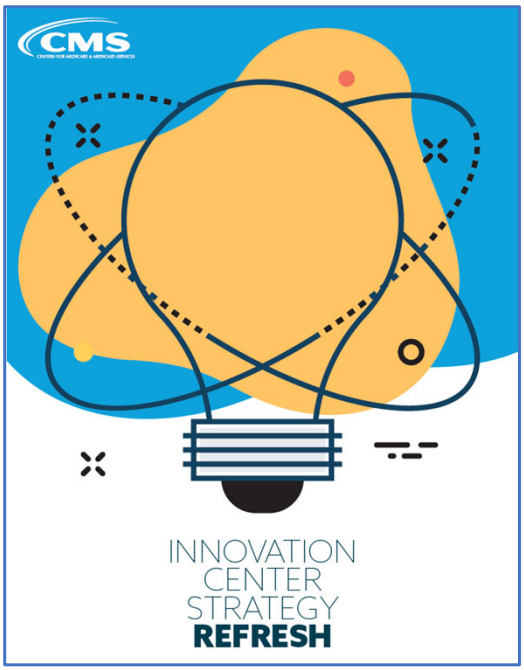


Innovation Center Strategic Objective 1: Drive Accountable Care

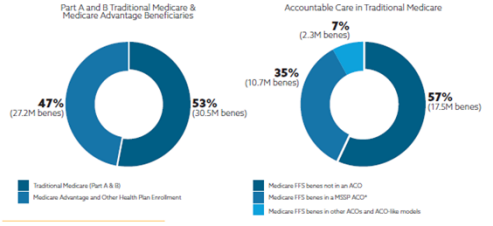
DRIVE ACCOUNTABLE CARE

Aim:
Increase the number of people in a care relationship with accountability for quality and total cost of care.

Measuring Progress:
- All Medicare beneficiaries with Parts A and B will be in a care relationship with accountability for quality and total cost of care by 2030.
- The vast majority of Medicaid beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030.

The key feature of accountable care is to give all participating providers the incentives and tools to deliver high-quality, coordinated, team-based care that promotes health, thereby reducing fragmentation and costs for people and the health system. Depending on the model or program and their respective requirements, accountable entities could include physician group practices, hospitals, and other health care providers. Medicare Advantage (MA) plans, Programs of All-Inclusive Care for the Elderly (PACE), or even Medicaid managed care plans. In 2020, 67% of Medicare beneficiaries enrolled in Part A and Part B were in MA plans or were attributed to an accountable care organization (ACO) through either a CMS Innovation Center model or the Shared Savings Program (See Figure 2).[8,9]

Figure 2. Medicare Beneficiaries in Accountable Care Relationships (2021).



8 Medicare Payment Advisory Commission (MedPAC). (2020). "A Data Book: Health Care Spending and the Medicare Program."
9 Medicare Payment Advisory Commission (MedPAC). (2020). "A Data Book: Health Care Spending and the Medicare Program."

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Advance Investment Payments

Payment Amount Methodology
(42 CFR § 425.630(f))
	• One-time upfront fixed payment of $250,000
	• Additional quarterly payments
	  ○ Up to 2 years (amount based on beneficiary attributes, including Area Deprivation Index (ADI) score, Medicare Part D low-income subsidy (LIS), and dual eligible status)
	  ○ Up to $45 per beneficiary per month
	  ○ 10,000 beneficiary cap for quarterly payments

Permitted Payment Uses
(42 CFR § 425.630(e))
	• Improve the quality and efficiency of items and services furnished to beneficiaries by investing in:
	  ○ Increased staffing
	  ○ Health care infrastructure
	  ○ Provision of accountable care for underserved beneficiaries, including addressing social determinants of health
	• ACOs must publicly report their spend plan and actual spending amounts each year
	• ACOs are encouraged to work with Community Based Organizations (CBOs)

ACO Realizing Equity, Access, and Community Health (REACH) Model

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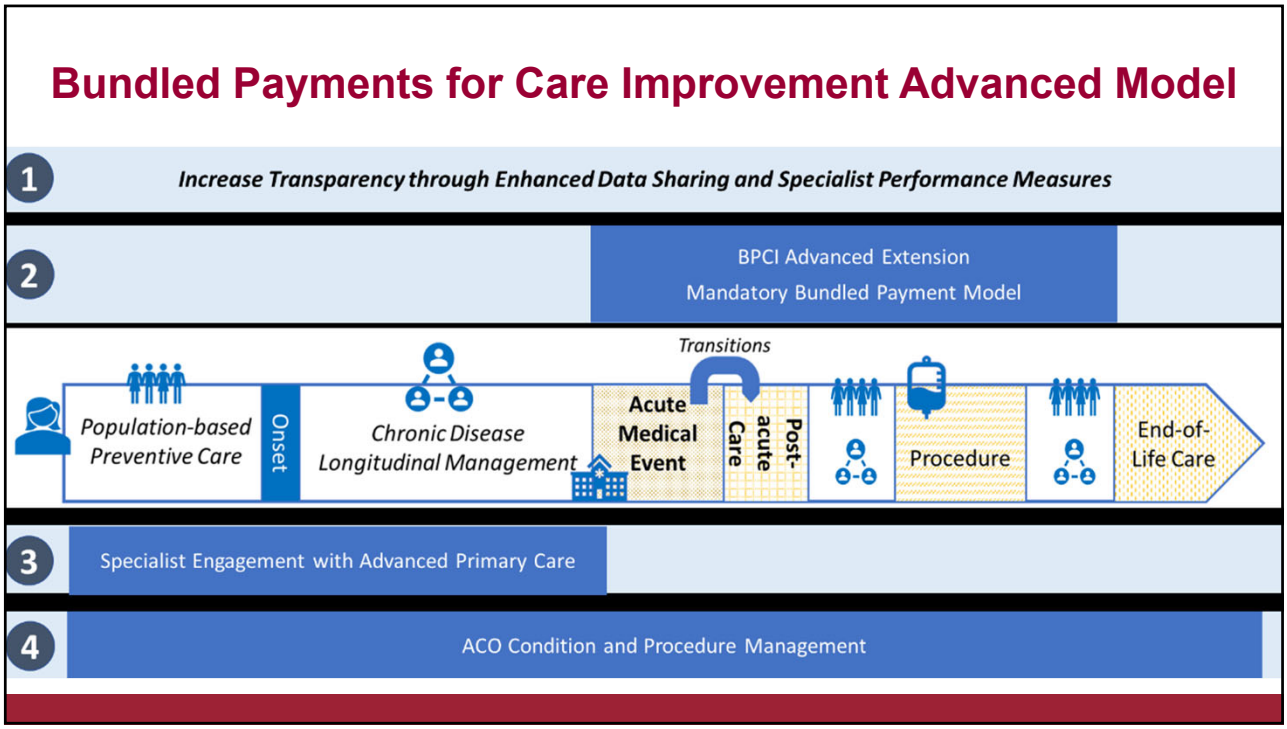
Bundled Payments for Care Improvement Advanced Model
1
Increase Transparency through Enhanced Data Sharing and Specialist Performance Measures
2
BPCI Advanced Extension
Mandatory Bundled Payment Model
Transitions
Population-based Preventive Care
Onset
Chronic Disease Longitudinal Management
Acute Medical Event
Post-acute Care
Procedure
End-of-Life Care
3
Specialist Engagement with Advanced Primary Care
4
ACO Condition and Procedure Management

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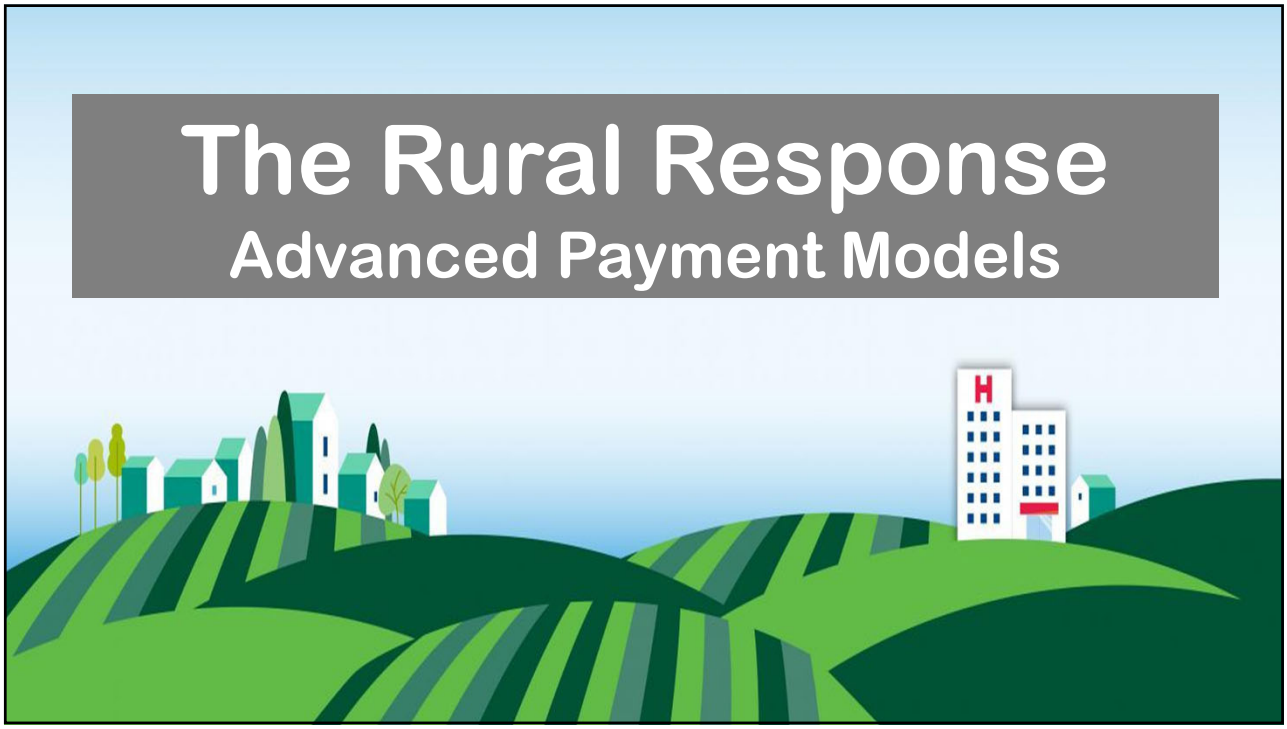
The Rural Response
Advanced Payment Models
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Illinois Rural Community Care Organization

Statewide Rural Accountable Care Organization

IRCCO was established in 2014 and as an ACO in 2015 as an investment model and in 2018 as a MSSP

- **Membership includes 27 rural and CAHs, 55 RHCs and FQHCs and over 500 medical providers.**
- **Offering pre-payment of shared savings in both upfront and ongoing per beneficiary per month payments**

Added incentive comes from participating in the BCBS-IL Intensive Medical Home (IMH) program

- **Beneficiaries with complex and chronic health conditions**
- **Financial support to the IMH provider based on the number of BCBS members enrolled**
- **Based on claim information filed with BCBS**

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Preparing in Advance for VBP: 8 Practical Steps

ICAHN
Illinois Critical Access Hospital Network

1. **Annual Well Visit** – Medicare pays for the visit
2. **Care Coordination** – Medicare will pay for chronic care management
3. **Transitional Care Management** – Hospital practices can bill for discharge planning of Medicare beneficiaries that go home
4. **Advanced Care Planning** – Hospitals can bill professional fees for physician providing advanced care planning (Advanced Directives)
5. **Prevention Procedures** – performing mammograms, colonoscopies, A1C testing for diabetes, other preventive programs
6. **Tracking Specialty Care** – Knowing the referral patterns of your practitioners
7. **ED Visits** – Monitoring repeat ED visits
8. **Coding** – Conduct a coding audit to evaluate if you are capturing acuity codes

These are all interventions and services hospitals/clinics can do today without being in an ACO or fully invested in value-based care programs.

– Pat Schou, CEO, ICAHN

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Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models

Regional Budget Payment Concept

The Centers for Medicare and Medicaid Services is seeking input on the feasibility of regional multi-payer prospective budgets as a potential payment model and potential for rural areas.

Stage: Ongoing

CMMI global budgets/all payer models

All-payer model	Novel test	Medicare flexibility
 Maryland	Hospital global budgets to decouple hospital revenues from volume and incentivize prevention and wellness	Allow global budgets to determine Medicare payment amounts to Maryland hospitals
 Vermont	ACOs at scale statewide to incent value and quality under the same payment structure throughout the delivery system	OneCare Vermont is currently the sole ACO operating in the state..
 Pennsylvania	Hospital global budgets for rural hospitals and a deliberate plan to improve quality and efficiency across services and service lines	Allow global budgets to determine Medicare payments to participating Pennsylvania rural hospitals

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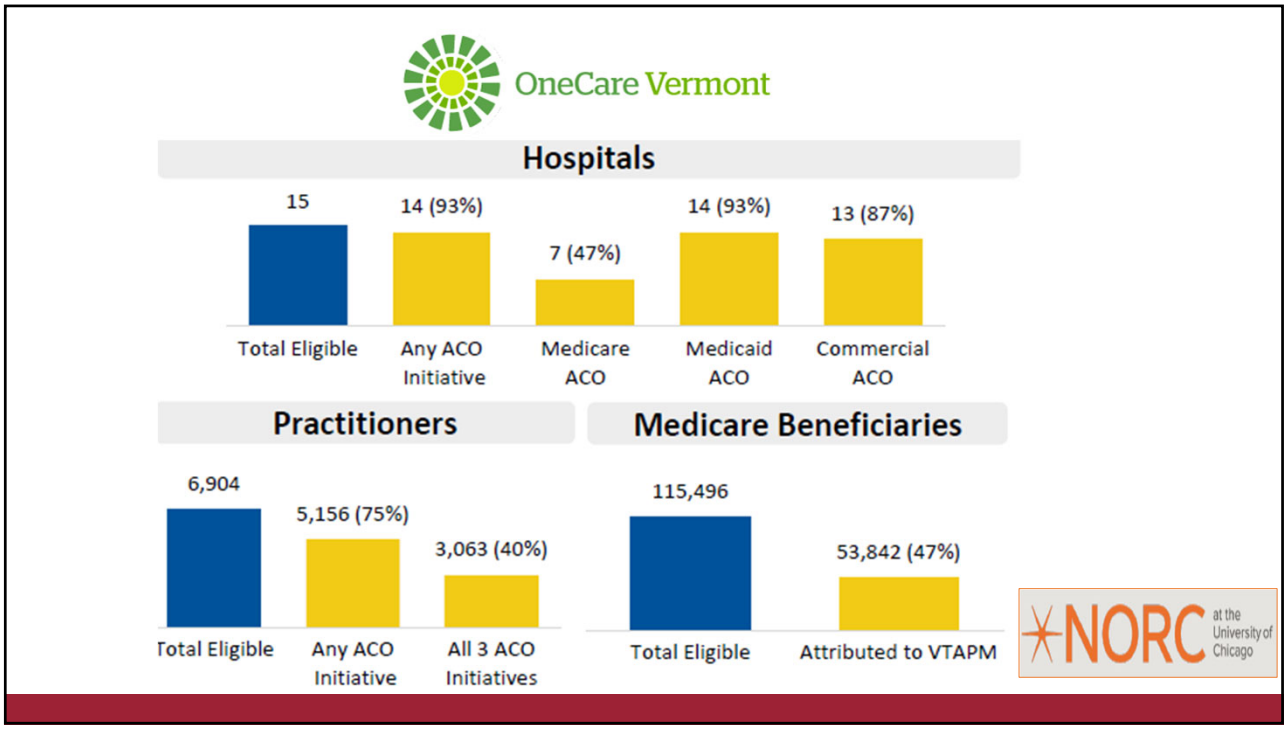

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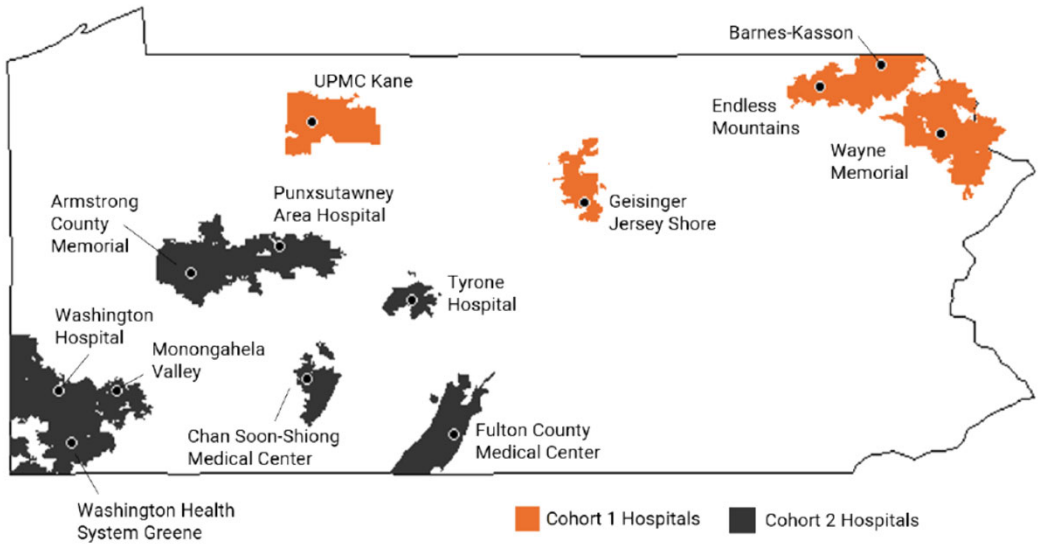
Pennsylvania Rural Health Model



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Attributes That Make Global Budgets Attractive

- Guarantee a predictable revenue flow for the hospital and flexibility to allocate resources efficiently under the budget constraint
- Are well-suited for rural or relatively isolated hospitals that serve well-defined patient populations
- Can be applied to a group of hospitals that dominate a region
- Can help control year-over-year hospital expenditures through the regulation of allowed annual budget updates
- Can be adjusted to reflect demographically driven changes in demand for hospital services
- Are supportive of other budget-based efforts at cost reduction and health improvement, such as ACOs

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Community Health Access and Rural Transformation (CHART) Model

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models

CHART Model

This model aims to empower rural communities to develop a high quality care delivery system through new seed funding, payment structures, operational and regulatory flexibilities and technical and learning support.

Stage: Announced

Community Transformation Track

The CHART Model Community Transformation Track aims to catalyze modernization of rural health delivery systems through three pillars: Upfront funding, Operational Flexibilities, and APMs.

Investment & Transformation

Cooperative Agreement Funding	Transformation Plan	Capitated Payment APM
Seed funding to facilitate community transformation	Quality Strategy & Operational Waivers	Prospective & Predictable Bi-Weekly Payments

Impact

- Improved quality of care and health outcomes for rural beneficiaries
- Improved access to care for rural beneficiaries
- Increased financial sustainability for rural providers

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The Rural Response
Examples from the Field

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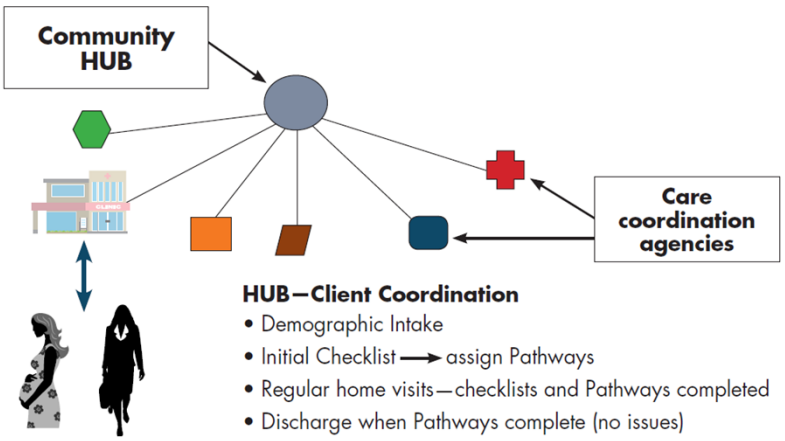
Improving Health and Wellbeing via Community Based Care Coordination

Winona Health

Winona Community HUB
Pathways to wellbeing

LiveWell winona
HEALTHY HABITS • BETTER LIVES

Regional organization and tracking of care coordination



HUB—Client Coordination
- Demographic Intake
- Initial Checklist → assign Pathways
- Regular home visits—checklists and Pathways completed
- Discharge when Pathways complete (no issues)

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Becoming a "Blue Zone" Advanced the Health of Klamath Falls, Oregon

SKY LAKES MEDICAL CENTER

Through collaboration with the Healthy Klamath Coalition, Sky Lakes Medical Center began a comprehensive effort to improve the health of the population culminating in the creation of Klamath Works and recognition as a Blue Zones Community for which they won the prestigious Robert Wood Johnson Foundation Culture of Health Prize.

CERTIFIED BY BLUE ZONES COMMUNITY BLUE ZONES PROJECT

KLAMATH WORKS Inc.

HEALTHY KLAMATH A CERTIFIED BLUE ZONES COMMUNITY™

Robert Wood Johnson Foundation CULTURE OF HEALTH PRIZE 2018 WINNER

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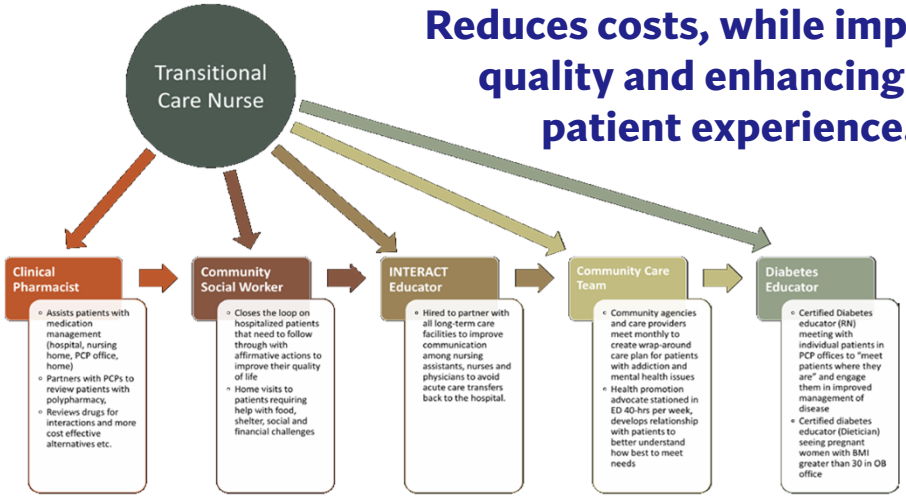
Southwestern Vermont MEDICAL CENTER

Transitional Care Nursing Program

Reduces costs, while improving quality and enhancing the patient experience.



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Feeding the Residents of Hardeman County Tennessee

West Tennessee Healthcare Bolivar General Hospital
Hardeman County Health Council

West Tennessee Healthcare™

UT EXTENSION
INSTITUTE OF AGRICULTURE
THE UNIVERSITY OF TENNESSEE

HARDEMAN COUNTY
COMMUNITY HEALTH CENTER

Hardeman County

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The Rural Response
You Can't Go it Alone

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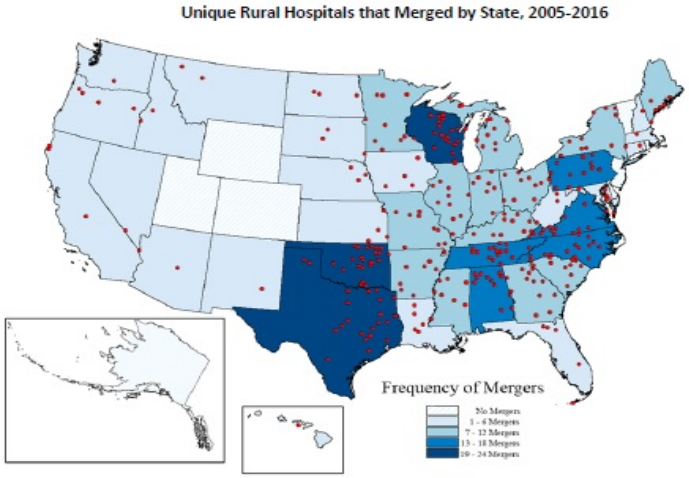
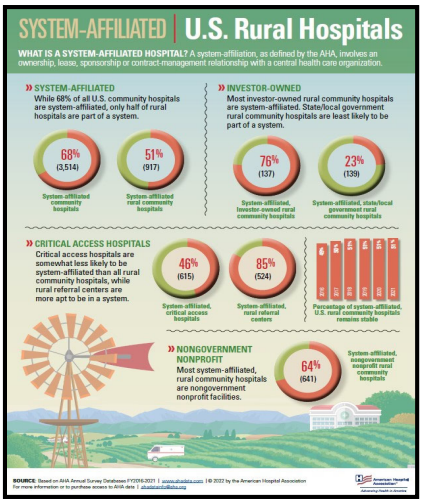
Affiliation

Telehealth (Hub & Spoke) → ACO/integrated network → Management agreement

Visiting Specialist → Service Line Joint Venture → Payer/Provider Joint Venture → Merger/ Acquisition





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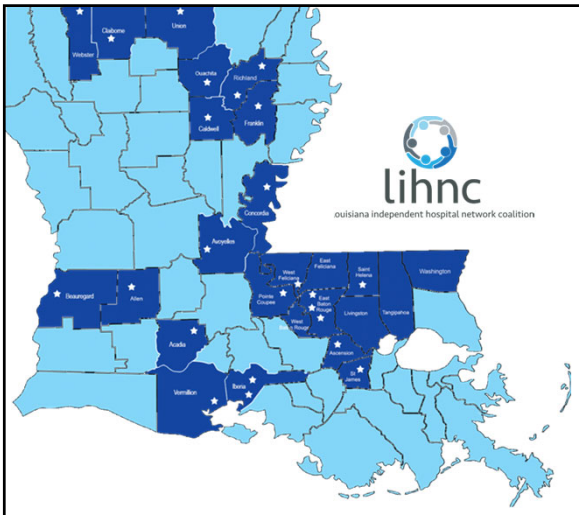

- Each remains independent, yet protected through an alliances structure
- Achieve economies-of-scale through joint purchasing and similar strategies
- Leverage current and future information technology investments
- Sustain members as they learn to thrive under new care models
- Develop care coordination and quality improvement using evidence-based clinical guidelines
- Work together to share opportunities and develop meaningful relationships

"Simply put, we seek to ensure our continued independence by forming interdependent relationships with other healthcare providers.
Pursuing integrated care delivery without integrating ownership."

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New Models of Payment and Delivery in Action

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Questions and Discussion

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Thank you

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