Center *for* Rural Health

Alternative Rural Hospital Models – 45 Years and Counting

Future of Rural Health Care Task Force

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Center *for* Rural Health

- Established in 1980, at The University of North Dakota (UND) School of Medicine and Health Sciences in Grand Forks, ND
- One of the country's most experienced state rural health offices
- UND Center of Excellence in Research, Scholarship, and Creative Activity
- Home to seven national programs
- Recipient of the UND Award for Departmental Excellence in Research

Focus on

- Educating and Informing
- Policy
- Research and Evaluation
- Working with Communities
- American Indians
- Health Workforce
- Hospitals and Facilities

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Why the Policy Interest in Rural Hospital Models and Improvement?

- **Costs** (Wage and Price controls in the 1970's, rampant health care inflation, HMO Act, PPS in 1983, Managed Care in 1990's – financial pressure)
- Rural hospital **closure crisis** in 1980's and 1990's
  - 140 rural hospitals closed from 1985-1988 (about 300 in the 1980's into the 1990's).
  - 160 rural hospitals closed from 1990-2000.
  - 130 rural hospitals closed from 2010-2020 (70% in non-Medicaid Expansion states).
- **Maintain access to health care** and the role of rural hospitals as a **hub for other services** (RHCs, LTC, Assisted Living, Basic Care, social services, and other aging services).
- Increase in **mortality** upon closure. (8-9% increase in year following closure, higher in Medicaid and minority populations)
- **Economic engine** in rural development (usually #1 or # 2 employer).
  - ND $6.4 million payroll impact for each CAH
  - $230 million impact statewide
  - 8,000 jobs statewide

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A Long History of Rural Hospital Conversion

- **1974** US DHEW **Limited Service Hospital Concept**
  - could use LPN not RN when no patients –exploratory paper
- **1987** **New York Rural Health Care Services Development Project**
  - conversion to another level of care from acute
- **1988** **National Rural Health Care Act of 1988**
  MedCAF (Medical Care Access Facility) – (limited service)
  - outpatient and inpatient,
  - 10 inpatient beds,
  - up to 2 days (48 hours),
  - use of PA/NP
- **1988** **Medical Assistance Facility (MAF)** Montana Medicare Demonstration (operated about 10 years)
  - Frontier < 6 people per square mile
  - 35 miles from a hospital
  - Up to 96 hours
  - Outpatient and inpatient, ED 4
  - Allowable cost reimbursement

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A Long History of Rural Hospital Conversion

- **1988** **Wyoming Medical Assistance Facility (MAF)**
  - State law, not Medicare demonstration.
  - Outpatient and inpatient, ED
  - 60 hours
- **1988** **California Alternative Rural Hospital Act**
  - Focused on community needs so each hospital could be different
  - Based on need could go beyond 96 hours (but generally 96)
- **1989** **Florida Emergency Care Hospital**
  - Inpatient and outpatient
  - 96 hours

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A Long History of Rural Hospital Conversion

- 1989 **Rural Health Care Transition Grant (1989-1992)**
  - Senator Durenberger – MN demonstration, Blandin Fd, CRH needs assessment
  - 3 year federal program
  - "transition" to different services or service arrangements
  - About 300 rural hospitals
  - 532 service adjustments
  - Hospitals received $50,000 a year
  - A number of ND hospitals
- 1990 **EACH/PCH (Essential Access Community Hospital/Primary Care Hospital) Grant Program**
  - Consortia of EACH with PCH
  - EACH – larger rural hospital at least 75 beds
  - PCH – 6 beds – allowable cost
  - PCH – 72 hours
  - 9 states approved including ND, but only 7 funded

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A Long History of Rural Hospital Conversion

- 1999 **Critical Access Hospital (CAH)**
  - BBA of 1997 (also created Flex program to provide TA)
  - Allowable cost reimbursement
  - Outpatient and inpatient, ED –formal agreements with PPS
  - 96 hours
  - 25 beds or less
  - 35 miles distance
- 2010 **Frontier Community Health Integration Project (FCHIP)**
  - Included in ACA
  - Started in 2016 (4 years) – supported by CMMI
  - ND, MT, NV awarded (AK and WY eligible but did not apply)
  - 65% of rural is frontier (NV stipulation- Senator Reid)
  - 10 CAHs from 3 states (3 in ND – Bowman, Elgin, and Watford City)
  - Service modifications in skilled nursing care, telehealth, and ambulance) - flexibility

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New Models to be Explored – Rural Health Policy – Payment and Delivery System Innovation

- **COH Community Outpatient Hospital – 2015**
- **REACH Rural Emergency Access Community Hospital - 2017**
- **Global Budget –PA 2018**
- **CHART Community Health Access and Rural Transformation Model -2020**

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Community Outpatient Hospital -COH

- Part of the ***Save Rural Hospital Act*** – Senate Finance. Introduced in 2015. Supported by NRHA.
- **What is a COH? Delivery System Innovation**
  - Paid on an allowable cost basis of 105%. (growing concern about viability of continuing with allowable cost).
  - CAHs that convert to COH can convert back to CAH.
  - < than 50 beds – PPS and CAH could convert.
  - Generous **grant program** to assist with population health and movement to value-based payment models (NRHA is exploring fusing with global budget). $12-15 million in grants, maybe $50 million, $650,000 per COH)
  - **Observation beds,** Outpatient, ED-24 hour access –be Level IV Trauma (based on CHNA can have skilled nursing, home health, infusion services, hospice, swing beds, and other.)
  - **NO INPATIENT**

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Rural Emergency Access Community Hospital (REACH)

- Delivery system innovation
- Senator Grassley (IA) Chair of Senate Finance and Senator Klobuchar (MN)
- NO INPATIENT
- NO GRANT PROGRAM
- Has observation beds
- Outpatient, ED and other services
- Outpatient and ambulance transport reimbursed at 110% of allowable costs
- Previously a CAH or rural PPS (< 50 beds)
- Can convert back to CAH or PPS
- Level IV trauma

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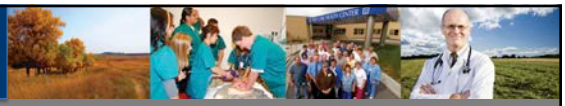

Global Budgets – A Possible New Policy for Payment

- **What are global budgets? Payment Innovation**
  - Alternative payment model – movement away from fee-for-service to a multi-payer model with a yearly budget based on historic net revenue.
  - Prospectively paid each month, predictable revenue stream.
  - GB is based on inpatient and outpatient revenue general over a 3 year period.
  - Must include Medicare, Medicaid, and commercial insurers (agreement).
  - Greater emphasis on what rural hospitals do well in addressing community needs – **emphasis on population health, social determinants of health, care coordination, prevention,** focus on using CHNA to target services (behavioral health).
  - Provisions for catastrophic unanticipated increased costs
- **Maryland since 2010 and Pennsylvania CMS Demonstration supported by CMMI**
- PA – 30 rural hospitals some are CAH - $25 million CMS for 4 years (performance period is 6). Started 2018.
- PA -Yearly payment increase pegged to state GDP (average 3.8% over 8 years).

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CHART Community Health Access and Rural Transformation Model -2020

- CMMI
- Guidance week of September 14, 2020.
- Significant payment and delivery system change and reform.
- Another volume to value process targeted at rural America.
- CMMI "rural markets are more likely to be subject to challenges: hospital closure, financial barriers, and workforce constraints." (also transportation, limited plan choices, and narrow health plan networks).
- CMMI "the current volume-based system will not address these issues." Need: Community-based solutions to realign service delivery, meet unique community needs; solution built on previous successes that adopt value-based models.
- Two options:
  - **Community Transformation Track**
  - **ACO Transformation Track**

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Community Transformation Track

- $75 million upfront investment in 15 rural communities ($5 million each) to develop local transformation plans.
- CMS providing regulatory and operational flexibility, technical assistance, and payment restructuring to participating hospitals from a volume system to one of “stable, monthly payment.” (global budget concept, “capitated payment amount” -CPA)
- Lead Organization – a single entity comprised of a single county or set of contiguous or non-contiguous counties of census tracts. Must be rural.
- Lead Organization can be a state Medicaid agency, SORH, local public health departments, IPA, and Academic Medical Centers. Work with hospitals.
- Cooperative Agreement funding up front. $2 million of the $5 immediately. Rest contingent on progress.

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Community Transformation Track

- CPA prospectively set annual payment to hospitals – stable revenue with incentives to reduce fixed costs and avoid readmissions.
- Operational and regulatory flexibility – Medicare waivers (CDM incentives to patients and cover cost of patient transportation).
  - Waive certain CoP
  - Waive 3 day inpatient stay prior to admission to SNF
  - Telehealth expansion
  - Post discharge visits
  - Care Management Visits
  - CAH 96 hour rule
- Lead Organization develop and convene Advisory Council
- Participating hospital must be acute care, CAH, special rural designation
- State Medicaid is a required partner –sub-recipient of CA funding.

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ACO Transformation Track

- CMS to select up to 20 rural-focused ACOs to receive advanced payments as part of joining Medicare Shared Savings Program. Build on success of ACO Investment Model (AIM).
- Majority of ACO providers/suppliers be in rural.
- Two Payment Streams for a CHART ACO:
  - One time upfront payment equal to a minimum of $200,000 plus $36 per beneficiary in the 5 year agreement period in the Shared Savings Program.
  - Receive a prospective per beneficiary per month payment (PMPM) equal to a minimum of $8 for up to 24 months.
- Letter of intent due January 18, 2020.
- Community Transformation Track for 15 communities would start Spring 2021
- ACO Transformation Track for 20 ACOs would start Fall 2021

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Contact us for more information

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