Rural Health Policy: Rural Health Within the US Health Policy Process

NURS 586 Rural Health Programs and Research

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UND College of Nursing and Professional Disciplines

Presented by Brad Gibbens, Deputy Director and Assistant Professor

1

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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2

2

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Todays Objectives:

1. To better understand the relationship between the rural setting and health policy.
2. To gain insight into current rural health policy issues.
3. To understand how health policy is developed.

3

3

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It is always about the community

This is what shapes rural health – viable health systems, access to quality health care, improving population health contributes to community health

4

4

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Rural Health- An Overview

- Rural Health focuses on **population health** –CHNA as a tool to understand and take action
- Rural Health focuses on **infrastructure** that contributes to population health
- Rural Health ***is not*** urban health in a rural or frontier setting
- Rural Health can be framed as a **health equity or fairness issue**
- Rural Health can be framed as **interdependent/collaborative** or community engagement
- Rural Health is dependent on **viable communities** and viable communities can include a strong rural health system inclusive of **community sectors**
  - Education, economic/business, government, faith-based, and health/human services
- Rural Health is changing – **"volume to value"** – new payment and delivery mechanisms designed to better address population health, improve care, and (just maybe) reduce or control costs.
- Rural Health exists in a larger **environment** which has an affect on the community and the rural health infrastructure; however, the **community can take action** (engagement) that in turn **impacts the environment.**

5

5

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Significant Areas of Interest Addressed in Rural Health Policy

- **Reimbursement/Payment/MONEY (System redesign)**
- **Health Workforce**
- **Health Care Quality and Performance** (also HIT) – relationship to health reform
- **Population Health –** significance within health reform –health policy relates to health status as does economic policy, housing, education, judicial, transportation
- **The Silos (Infrastructure)** – Hospitals (private for-profit, non-profit, specialty, rural including CAH, SCH, MDH); medical providers (primary care physician, specialty, PA, independent solo, small group, larger system, *PC with MH*) ; nurses (RN, APN, LPN); clinics (including for-profit and non-profit, RHC, FQHC, specialty); pharmaceuticals; oral health; mental health; behavioral health; EMS (including private for-profit and non-profit, EMTs and numerous types including community paramedic, *quality in EMS*); allied health; long term care (nursing homes or other settings like independent living, basic care, assisted living); aging (including aging services, nutrition, "money follows the person" or helping elders stay in non-institutionalized settings); human services; Medicaid; Medicare; CHIP; veterans; Native Americans (IHS, tribal health, more independence, *QSP*); health reform (insurance and health system reform, *"volume to value," CHART*); and MORE (We will discuss interest groups later)

6

Key Concepts in Health Reform

- **2 Primary Changes: Insurance** and **Health System Redesign**
- **Population health** – improve outcomes emphasize prevention, care coordination, less hospital admissions/readmissions, less inappropriate ED visits

- **Social determinants of health**
- **Volume to value** (changing how we pay for services to be less volume and more value – quality and outcomes)
- **Accountable Care Organization** (ACO) is an example: National Rural Accountable Care Consortium (Caravan Health – 7 ND CAHs) - 20% of ND CAHs are associated with an ACO
- Now we have the **CHART** option

7

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Population Health

"Health outcomes of a group of individuals, including the distribution of such outcomes within the group."(Kindig, *What is Population Health?*)

- Significant focus in health reform (ACA) –conceptual driver of health reform policy and "system redesign" – CMMI created by the ACA (ACO, CHART)
- Groups in a population health approach can be based on geography, race, ethnicity, age, language, or other arrangements of people
- Focus – Health Outcomes (what is changed, what are the impacts, what results?)
- What determines the outcomes (determinants of health)?
- What are the public policies and the interventions that can improve the outcomes?
- What is or can be done in a rural health system to address population health?

8

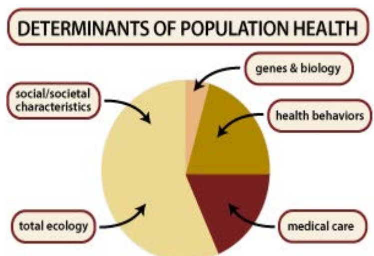
8

Population Health Provides the Best Definitional Framework

It focuses on measurable outcomes from multiple sectors

- Clinical outcomes
- Education levels
- Poverty rates
- Environmental factors

Creating a holistic picture of a community's health



9

Population Health in the Affordable Care Act

- **CMS Innovation Center** – development and testing of innovative health care payment and service delivery models (better care, better health, and lowered costs through improvements in the health system)
- Generate new models (in an experimental stage in health policy)
  - **Alternative Payment Models**
    - This is value based or movement from "volume to value" (care coordination)
    - Accountable Care Organizations (ACO)- Shared Savings is most common- 7 CAHs in ND (561 Shared Savings Medicare ACOs nationally) – saved Medicare $1.7 B in 2018
    - MACRA and MIPS (system change an alternative payment models – clinicians)
    - New in 2019 five new Primary Care Initiatives (PCI) – grow out of CPC+
    - Simultaneous focus on increase quality and lowering cost
    - Accepting risk – Trump administration is "risk on steroids"
    - CHART
- **BCBSND Blue Alliance**

10

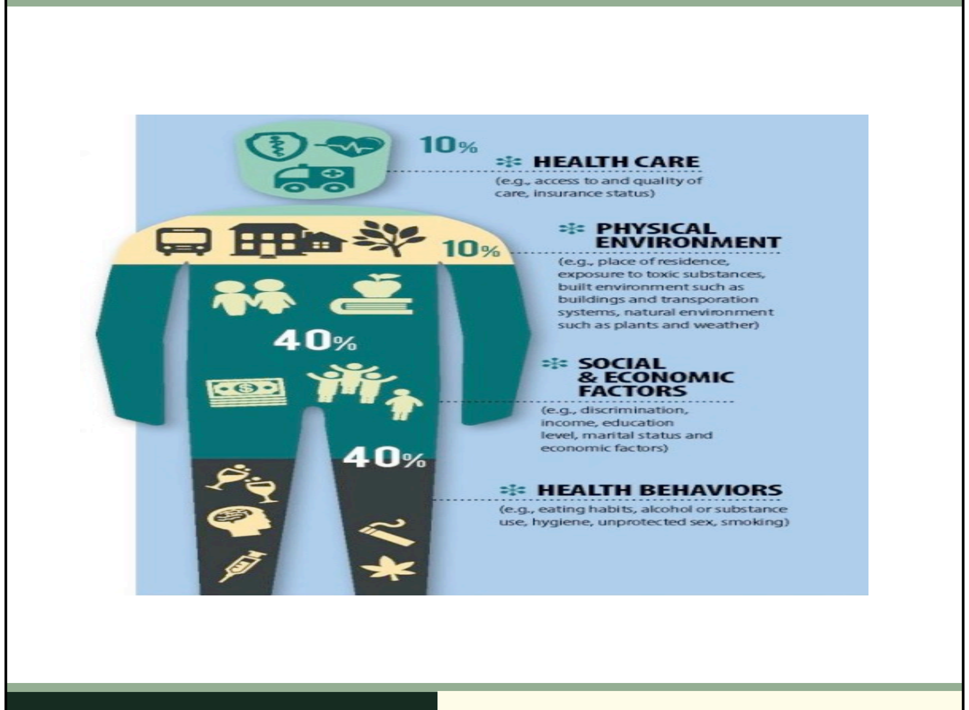
Social Determinants

World Health Organization definition:

"the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics."

11

11



12

ND CHNA Issues (2017-2019)

- Results below are for the 36 CAHs (CRH assisted 31 or 86%)
- 25 major themes
- 139 ranked needs (range 2 to 5 ranked needs per CHNA, average 3.9)
- Issues

Issue	Count
Substance Abuse (behavioral health)	30 CHNA
Mental Health	30 CHNA
Attracting and Retaining Young Families	16
Having Enough Child Daycare providers	11
Ability to Retain Primary Care Providers	11
Availability of Resources to Help Elderly Stay in Homes	6
Not Enough Jobs with Livable Wages	5
Cancer	4
Obesity	4
Affordable Housing	3
Bullying/Cyberbullying	3
Cost of Health Insurance	3
Access to Healthcare	1
Domestic Violence	1

13

13

How does the health policy process work to advance rural health concerns and needs or how does rural health work within the process or use that process?

14

Health Policy – The Formal Side

- **Executive – Legislative Process (Congress and the Federal Agencies)**
  - White House Rural Council to Strengthen Rural Communities (now **Task Force on Agriculture and Rural Prosperity** – Trump Administration)
  - Trump Administration's "**Rural Action Plan**" (August 2020)
  - Senate Rural Health Caucus – history in North Dakota - 1985
  - House Rural Health Care Coalition - 1987
  - Senate Finance, Senate HELP, Senate Energy and Natural Resources, S&H Indian Affairs, S&H Judiciary, House Ways and Means, House Energy and Commerce (Cramer), S&H Appropriations (Senator Hoeven), S&H Budget Committees (role of Senator Conrad)
  - Federal Agencies
    - **US Department of Health and Human Services**
      - ✓ HRSA and within it – Office of Rural Health Policy- SORH, FLEX, Rural Health Grants, Rural Health Advisory Council, Bureau of Primary Health Care – Community Health Centers, Bureau of Health Professions – healthcare workforce issues, Bureau of Clinician Recruitment and Services – National Health Service Corps
      - ✓ Centers for Medicare and Medicaid Services (CMS) – Medicare reimbursement and rules, CMS Innovation Grants for health reform
      - ✓ Indian Health Service (IHS). ACL (formerly AOA)- Nutrition and development
    - **USDA –** Rural Development program has Community Facility loan/loan guarantee/grant program for capital improvement
    - **USDHUD** – HUD 242 program for capital loans to rural hospitals
    - **Veterans Administration** – access to care, VA hospitals, VA CBOC (community based

15

Health Policy – The Informal Side

- **Setting the Agenda (prior to formal policy formulation and during development)**
  - **Advocacy**
    - **Interest groups play significant role**
      - ✓ Content experts – know the details – provide information (fact sheets, reports, meetings with staff, calls from staff)
      - ✓ Represent a point of view
      - ✓ Relied upon by policy staff – develop close working relationships
      - ✓ Interest groups want to be relied upon, "at the table"
    - **Important Rural Health Interest Groups**
      - ✓ National Rural Health Association (NRHA)
      - ✓ National Organization of State Offices of Rural Health (NOSORH)
      - ✓ RUPRI (other federally supported rural health research centers)
      - ✓ American Hospital Association (and state associations- NDHA)
      - ✓ State Rural Health Associations - NDRHA
      - ✓ American Medical Association (and state associations and subgroups)
      - ✓ American Nursing Association (and state associatons)
      - ✓ American Public Health Association (and state associations)

16

Health Policy – The Informal Side

- **Managing and influencing the agenda**
  - Control the information flow – resource to staff
  - Information – formal testimony, research, fact sheets but also behind the scene
  - Be honest and reliable (*VERY IMPORTANT is YOUR CREDIBILITY*) – your utility to staff is your reliability and your information
  - If you don't know say you don't know but will find out

- **Re-setting the agenda**
  - Continuous involvement with interest groups to prepare for next round
  - Continuous involvement with policy staff -- preparing them, helping them to see the implications of policy, determining what needs to be changed, provide evidence and data
  - Common questions –"What does this mean in North Dakota" "Is there an impact for us"

17

So Really, How Does Rural Health Policy Work or Happen?

- **Advocacy**
  - Interest groups determine their agenda – internal process "point of view"
  - Interest groups sometimes form alliances with others – share agendas, "back-scratching" – to build greater numbers
  - Message framing – what messages work on policy makers, what do they like to hear, what format or communication strategy works best
    - ➢ Research shows for rural message framing concepts like "fairness" and "interdependence" work
      - ✓ People who live in rural ND should have the same expectation for quality care as urban, have reasonable access to care - *fairness*
      - ✓ Rural providers use networks and collaborate – avoid duplication, efficiency, effectiveness –*interdependence*
      - ✓ Rural organizations tend to work together, health care as part of the social and economic fabric of a community - *interdependence*
      - ✓ Under ACA movement to outcome based or pay for performance frame as "merit pay" to providers
  - Redundancy and repetition of messages are "positive" in policy – say the same thing over and over, try to have others (alliance partners) say your message.
  - We emphasize community, people (patients/community members, fairness, collaboration, cooperation, and economic impact

18

Importance of Having Partners

- **Strength in numbers –** more voices with same message
- **Redundancy in policy can actually be good –** more voices, same message
- **An association if it is the primary advocate needs it members involved (elected officials like "real people") but also other associations and their members) –** CAH administrators on hill visits
- **Identify the commonality of issues and forge alliance around that subject – may be secondary for other association but can add to their message**
  - Hospital Association and SORH – rural health outreach grant funding
- **Need to be willing to make compromises –** more and more important
- **Willingness to support partner on their issues makes it easier for them to support you on your issues –** their primary is your secondary issue, and your primary is their secondary issue, "you got to give to get in politics"

19

So Really, How Does Rural Health Policy Work or Happen?

- **Role of Research**
  - NRHA works to create SRHC and HRHC leads to FORHP which creates research centers, SORH, Flex (also led to SRHA)
  - PPS and shakeout of rural hospitals came from lack of any national rural health infrastructure (no independent academically based rural health research centers)
  - CRH Bush grant on research led to the model FORHP used for research centers
  - First ORHP research centers in 1987 (CRH was first generation)
  - 8 Rural Health Research Centers and Policy Analysis Initiatives
  - **Rural Health Research Gateway – located at UND Center for Rural Health**
    - "One stop shop (located at CRH) for :Research projects, publications (peer reviewed, policy briefs, fact sheets, annotated literature reviews, maps, and other products.
    - IA (Rupri) Maine, Minnesota, North Carolina, South Carolina, Tennessee, Texas, and Washington
    - **Research topics: -81 separate research areas**
      - Abuse Aging Coronavirus Case Management CAH Disability
      - EMS Environmental and ag health Health disparities Health care access
      - Health care finance Hospitals Medicare Maternal Health Minority health
      - Nurse/NP Obesity Oral health Pharmacy Public health Quality
      - SDOH Telehealth Veterans Wellness Woman's health Workforce

20

Five Key Points on Policy Advocacy

- **Policy is a continuous process**
  - Congressional sessions begin and end, but the process of forming policy, influencing policy, changing policy, advocating for policy is ongoing
  - ACA is not the final Act in health reform – each Congress and President will make changes (every year multiple bills just on Medicare which goes back to 1965
- **Important to have partners, allies, coalitions, alliances– forge relationships, cultivate relationships – some short term, some long lasting**
  - Organizations similar and even dissimilar to your organization
  - Relationships with policy makers and staff
- **Extremely important to be a *resource* to policy staff**
- **Recognize there is a relationship between policy formulation and implementation with research and evaluation –** rural paid price in early '80's because no formal advocacy or policy structure
- **Important to have a legislative champion/advocate**

21

What are some examples of successful rural health policy?

22

Rural Health Policy in Action

- **Rural Hospital Flexibility Program – "Flex program"**
  - Purpose to provide TA to CAHs – deliberate policy to couple a new designation with a TA approach
  - Alliance of NRHA, NOSORH, AHA, SORHs, and State RHA
  - Each state worked with their congressional offices
  - 1st year grant for $200,000 went to SORHs in eligible states
  - Flex funded at $26 million a year
    - Grants to 45 eligible states
    - Flex Monitoring Team (RHRC research related to Flex and rural hospitals – evaluation leads to better data for congressional advocacy)
  - Flex is administered, like SORH, through FORHP
  - NRHA, NOSORH, and AHA push every year continued appropriation for Flex
  - CRH keeps in front of Congressional Offices

23

Rural Health Policy in Action

- **Rural Health and the Affordable Care Act**
  - Basically, every health interest group had a stake
  - NRHA position papers and fact sheets
  - Formed core set of expectations
    - Health workforce
    - Provider reimbursement
    - Protect (and even expand) rural safety net – CAH, RHC, CHC
    - Access for rural people – financial concerns, but also availability of providers and financial viability rural health providers
  - NRHA worked with AHA and NOSORH
  - State level work with congressional offices on needs and impact
  - CRH emphasized health workforce, safety net, availability of providers, and financial viability of rural health providers and systems

24

Rural Health Policy in Action

- **Rural Health and COVID-19**
  - Shut down in March 2020 of hospital outpatient and electives – about 2 months (no revenue) – Public Health hit hard, front line.
  - **CARES Act (NRHA and NOSORH advocate for funding and regs)**
    - CMS- Provider Relief Fund – about $68 Billion to hospitals ($11 B for CAH and RHC)
    - Medicare Accelerated Payment Program (loan and payback)
    - SBA -Paycheck Protection Program – also payback
    - HRSA -COVID SHIP - $3.2 million to ND CAHs
    - Telehealth waivers – location, payment, added services allowed, see patients in their home- (big push to keep this)
    - Waiver on 96 hour and 25 bed for CAHs if a surge
    - 3 day SNF rule
    - PPE and testing to the states
    - ND SORH and Flex money to help CAHs manage the dollars
  - Focus going forward on rural health policy – try to keep what we like – telehealth

25

Rural Health Policy in Action

Alternative Hospital Models

- 1974 – USDHEW – paper on using LPN not RN if 0 census
- 1987 - New York Rural Health Care Services Development Project
- 1988 National Rural Health Care Act of 1988
  MedCAF (Medical Care Access Facility) service)
- 1988 Medical Assistance Facility (MAF) Montana Medicare Demonstration (operated about 10 years)
- 1988 Wyoming Medical Assistance Facility (MAF)
- 1988 California Alternative Rural Hospital Act
- 1989 Florida Emergency Care Hospital
- 1989 Rural Health Care Transition Grant (1989-1992)
- 1990 EACH/PCH (Essential Access Community Hospital/Primary Care Hospital) Grant Program
- 1999 **Critical Access Hospital (CAH)** (intended to be transition)
- 2010 Frontier Community Health Integration Project (FCHIP)

26

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

- COH Community Outpatient Hospital – 2015 (bill)
- REACH Rural Emergency Access Community Hospital – 2017 (bill)
- Global Budget –PA (started in 2018
- CHART Community Health Access and Rural Transformation Model -2020 (NEW)

27

27

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

28

28

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.

29

29

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.

30

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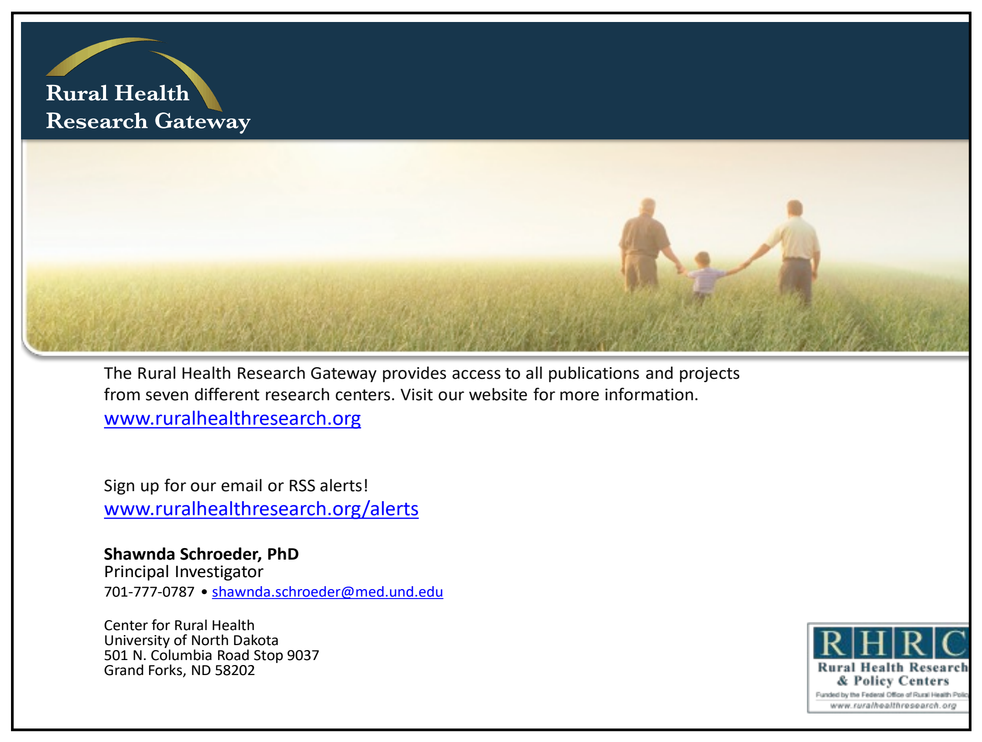

31

32

33

33

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Contact us for more information!

1301 North Columbia Road, Stop 9037
Grand Forks, North Dakota 58202-9037
701.777.2569 (desk for Brad)
Brad.gibbens@med.und.edu
701.777.3848 • ruralhealth.und.edu

34

34