Politics, Reform & Rural Health Care:

Impacts of Today's Health Policy Decisions

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“Connectedness” will be the key strategic priority for rural health care going forward.

- More important than facilities, technology, or breadth of services offered

Multiple policy arenas

- MN Legislature, Governor
- MN Departments of Health and Human Services
- Congress and Obama administration
- CMS, AHRQ

- **Don’t assume coordination among policy makers**

MN Legislature & Governor

- 2009 session faced $4.5 billion shortfall after several years of hospital payment cuts
- Legislature cut $54.5 million (with federal matching funds)
- Governor eliminated GAMC beginning July 2010 ($381 million)
- Governor promising more health care cuts through unallotment

MN Legislature & Governor: Rural impacts from '09 session

- Statewide safety net is fraying
- Medicaid rates: almost 16% below '02 costs
- Past focus on expanding coverage has shifted to cutting government's costs
- Prepare for more rapidly escalating uncompensated care
  - Economy creating more uninsured
  - Premium costs creating more underinsured (HSA plans)
  - Government cuts creating more insured with poor reimbursements (Medicaid rate cuts)
  - GAMC cuts will create more uninsured

State health care reform

- 2008 legislation being implemented by MN Departments of Health & Human Services
- Health care homes
- Baskets of care
- Provider peer grouping
- Standard quality measures, incentives

Health care homes: Rural impacts

- **Care coordination fees might not cover costs of certification**
  - Often a small number of eligible state public program enrollees in rural communities
  - Certification requirements will add cost
  - Expect approximately $50 per member per month

Baskets of care: Rural impacts

- **Single payment to drive collaboration**
  - Multiple providers under one payment
  - Facilities with high volumes will gain market leverage, but will need other providers to fill gaps
  - Who is the shopper? Individual patient? Insurance plan? Employer?
  - Rural providers can leverage geography, low-cost services to collaborate with high-volume facilities

Provider peer grouping: Rural impacts

- **Redefining peers and competitors**
  - "Total relative cost of care" for aggregate services and specific procedures
  - Peers may not be local; competitors may not be local
  - Perception of value will impact patients' and payers' decisions, especially with State of MN website
  - Perception of value will impact relationships with other providers, physicians

Provider peer grouping, cont.

- **Troubling development from 2009 legislative session**
  - DHS required to develop method to use provider peer grouping data to determine provider eligibility for payments from state health programs
  - Bottom 10% precluded unless they demonstrate improvement
  - Details unknown, but troubling indication that peer grouping website will morph into payment, not just transparency

Quality measures & incentives: Rural impacts

- **Comparing Granny Smith to Honey Crisp**
  - Standard measures will simplify and reduce reporting burdens
  - Quality measures will be more transparent
  - Negotiations and PR will become tougher for poor results leading to more organizations dropping services with lower volumes or poor stats

Federal Reform

- **Payment reforms**
- **Insurance expansions**
- **Tax policy changes**
- **Workforce**

Federal Reform: Payment reforms

- **Value-based purchasing:** Could lose all/part of withhold based on aggregate performance on multiple measures
- **Bundles:** Could lose all/part of withhold based on all providers' performance in episode of care for patient
- **Readmissions:** Could lose all/part of withhold if previous year's avoidable readmission rates were unusually high
- **Geographic disparities:** Could lose all/part of market basket update if overall costs are higher than national/regional benchmarks

Rural impact of payment reforms

- **Most payment reform proposals exclude critical access hospitals**
  - Some include demonstration projects
  - Most payment reforms focused on PPS hospitals, and physician collaborators
  - Payments unlikely to increase; payments designed for savings to CMS
  - Impacts on small, rural hospitals will be indirect, but real
- **Significant cuts to DSH, medical education payments proposed**

Federal Reform: Insurance expansions

- **National insurance exchange**
  - Individual, small employer plans
  - Minimum benefit sets
  - Guaranteed issue and renewal
- **National plan option** (controversial)
- **Mandates**
  - Children (at least), individual (likely), employer (maybe?)
- **Medicaid reforms**
  - Possible national, fully funded MA program
  - Minimum reimbursements tied to percentage of Medicare
- **Allow uninsured, 55+ year-olds to buy in to Medicare**

Rural impact of insurance expansions

- **National insurance exchange:** more patients covered by national plans
- **Mandates:** more people insured, but with less rich benefit sets
- **Medicaid reforms:** could shift debate at state from GAMC
- **Medicare:** higher percentage of cost-based reimbursement for CAHs

Federal Reform:
Tax policy changes

- **Increased pressure on hospitals' tax-exempt status**
  - Proposals for minimum uncompensated care thresholds for 501(c)(3) hospitals
- **Cap value of health benefits subject to tax exemption**

Rural impact of tax policy changes

- Open question whether CAHs will be exempt from charity care thresholds
- Many hospitals losing some or all tax-exempt advantages
- Reduction in patients with benefit-rich plans

Federal reforms: Workforce

- **Primary care bonus**
  - 5% or more bonus for office, nursing home and home visits
  - Available to providers with 60% of services in specified ambulatory settings (health professional shortage area)
  - 5 years beginning 2010
- **General surgery bonus**
  - 5% or some other amount above FFS
  - Newly defined rural general surgeon scarcity area
- **Redistribute unused GME slots**
  - 80% of unused spots redistributed; 75% of which would be allocated for primary care or general surgery for 5 years
  - Rural teaching hospitals with <250 beds excluded

Rural impact of workforce reforms

- Increased reimbursement rates to help recruit, retain primary care and general surgeon doctors
- Some increase in subsidized medical education slots for rural physicians
- Setbacks if medical education funds for teaching hospitals are cut

Themes from state and federal reforms

- Higher reimbursements or new health care funding unlikely
- Reforms and transparency will push payers to Medicare-benchmarked payments
- Federal reforms exclude CAHs; state reforms apply across-the-board
  - Future federal reforms increasingly likely to focus on CAHs

Sense of “connectedness” will change decisions for . . .

- Patients and loyalty to community hospital
  - Same for employers, local communities
- Physicians
  - Employed by hospital
  - Part of basket/bundle with hospital
  - Quality measures connected with hospital and vice versa
- Other health systems
  - Part of basket/bundle with rural hospital
  - Rural hospital as referral base for high-volume procedures
  - Line-of-service integration opportunities

Hospitals that can't create or maintain "connectedness"

- Price & quality shopping fragments service volumes
  - Patients, payers scatter, pick-and-choose services
  - Physicians concerned about transparency change referral patterns, or where they choose to practice
- Bundles lead to "capturing" all related services, not referring. Unconnected providers lose revenues (e.g., swing beds)
- If bundle-offering or connected providers achieve efficiencies, transparency will speed up loss of market share as consumers and payers make cost-based decisions

Best opportunities for rural health care

- **Capitalize on geography, connect with bundle payment system**
  - Collaborate where patients want local services and bundle-offering providers want outsourcing (rehab, post-acute care)
  - Wellness, prevention, trauma and lower-capital expense services
  - Price services to bundle-offering providers with recognition of Medicare PPS rates as benchmark

Best opportunities, cont.

- **Maintain independence while connecting with centers of excellence on line-of-service basis**
- **Use new transparency, data to adjust referral patterns, provider connections to improve quality, cost scores**

Questions
&
Discussion