

HEALTHCARE TRANSFORMATION COUNCIL OF IDAHO
PROPOSED WORKGROUP:
SOLUTIONS FOR IDAHO RURAL/FRONTIER MEDICAL COMMUNITIES
CENTER FOR MEDICARE AND MEDICAID INNOVATION DEMONSTRATION PROJECT
October 17, 2019

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Situation: In Idaho, 1 in 4 people live in a rural community. Health care disparity is a major problem in rural communities due to lack of resources, access and financial instability. Based on 2017 cost report data, 12 out of 27 Idaho critical access hospitals (CAH) have negative operating margins; and rural providers are strapped with heavy responsibilities and little ability to morph their practices to efficiently and innovatively manage the needs of their communities. Implementing value-based strategies focused on outpatient systems alone can threaten CAH financial stability. These efforts present unique challenges and do not encourage the changes needed to transform the delivery system as a whole. Among these challenges are meeting demographic needs of our rural communities, with characteristics focused on older populations, low income, long distances to travel, shrinking job market, and provider shortages, just to name a few. Conversely, any solution solely focused on critical access hospitals are not sufficient either.

Over the coming months, the Center for Medicare and Medicaid Innovation (CMMI) will be considering creative proposals for rural and frontier health program solutions based on elements learned from existing models in Pennsylvania, Maryland, and Vermont. Idaho healthcare must be represented in this innovative opportunity.

Background: The national focus on value-based care strategies has predominantly addressed the urban/suburban markets. At a recent rural health convening, Adam Boehler, former head of CMMI, spoke about the strategy chasm between urban/suburban and suburban/rural and rural/frontier communities citing “while we have focused on 85% of the country in more densely populated areas, now more than ever is there the need to direct our attention to the 15% of this country in rural and frontier areas who also will benefit from our transformational efforts.” With this in mind, CAHs and rural ambulatory delivery systems are at the core of these conversations. They generally represent the lifeline for health as well as being the core economic driver in fragile rural communities.

Value-based strategies successfully shift dollars from inpatient care to ambulatory care. This can provide the opportunity to drive creative solutions for unique rural issues. CAHs are directly affected early in the shift, at a time when many are already struggling to remain open. Further, the providers in rural medical communities have significant challenges to deliver care not necessarily faced by their colleagues in urban areas where resources are more available, and recruitment of newly needed skills is less of a problem. Educating, developing and redeploying existing staff to participate in delivery system changes is both crucial and an ingenious way in which to leverage true talent in rural settings. In addition, the potential for repurposing existing facilities for new services or uses also creates a community win-win option. Achieving the triple aim in rural communities relies on patients at the center of care. Where is that more prevalent than in rural/frontier Idaho?

Without a value-based approach, hospitals and outpatient providers that do participate in transformational work are penalized with lower revenues and less of an ability to implement some of the essential strategies deployed by their counterparts in larger communities or larger systems. Doing the right thing can translate into escalating the vulnerability of the rural delivery system.

Assessment: New alternate payment models being tested or implemented across the country can help stabilize rural hospitals and outpatient delivery systems. Some have been initiated or advanced in Maryland and Pennsylvania providing on-going, routine, scheduled payments over the course of a year through global budgets. This strategy helps to alleviate cyclical changes and the financial focus on volume of services that occur in fee-for-service models. Other models seek to create rural health networks in pursuit of aligned healthcare resources which may include contracting with value based networks to create a higher level of coordinated care, management of patient populations and improved use of scarce resources, all while affording rural residents increased opportunities for care close to home and their known support systems. With successful collaborative management, the goal is to stabilize, transform, and improve care delivery and effectively produce savings. The ways in which care can be transformed, contracts can be developed, and savings can be shared are restricted by regulations and policies that hinder alternative financial support for facilities such as CAHS. At the same time, with limited provider resources, the fragility of their financial models do not allow for testing opportunities on a hospital-by-hospital or community-by-community basis. The opportunities for participating in numerous models are severely limited because value based networks struggle with how to incorporate rural communities without doing them financial harm. When rural health care providers and organizations can participate in value based initiatives, payments and/or shared savings can be used to continue the transformation of the delivery system and support initiatives to address social determinants of health. An Idaho solution would incentivize and afford opportunities for the hospital and ambulatory system to reduce cost and make innovative delivery system changes focused on improving population health. Idaho has options but not without shoring up our rural/frontier health care delivery infrastructure.

With the impending CMMI announcement, we have a unique opportunity to convene stakeholders to develop a plan for creating a uniquely defined global budget model for rural delivery systems involving CAHs and outpatient providers to stabilize and allow for reinvention of health care delivery that addresses unique rural issues in Idaho. We also have the opportunity to evaluate offerings to be considered by CAHs and others in rural communities that could be funded through other resources. This model also allows for rural innovation that may not occur under regulatory or financial constraints, such as chronic care management, crisis intervention, transitional care management, post-acute strategies, and other services, to develop Idaho-specific solutions.

Recommendation: It is recommended the Healthcare Transformation Council of Idaho (HTCI) convene a workgroup to develop an Idaho solution for care delivery in our rural and frontier communities and with our CAHs. This workgroup would be charged with developing a solution to be submitted to CMMI for consideration as a demonstration project, when the opportunity becomes available. HTCI has committed to statewide efforts to advance telehealth and a goal of achieving 50% of healthcare payments in value-based arrangements by 2023. Finding a path to stabilizing and transforming valuable resources in our rural communities is as important as anything we could be doing for Idaho residents, communities, providers, and health care.