Disruption and the Rural Response

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Rural Hospital Closures

CAHs account for 35% of rural hospital closures 2010- present

Challenging Patient Mix

Rural hospitals treat a patient population that is often older, sicker and poorer compared to national averages.
Low Patient Volume

- Rural hospitals have experienced sharper declines in occupancy rates, from 49% in 2009 to 42% in 2015. With average occupancy rates near 40%,

<table>
<thead>
<tr>
<th>State</th>
<th>Urban</th>
<th>Rural</th>
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</thead>
<tbody>
<tr>
<td>National</td>
<td>64.00</td>
<td>42.77</td>
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<tr>
<td>IA</td>
<td>62.38</td>
<td>24.32</td>
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</tbody>
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- Low occupancy was associated with higher risk of hospital closure.
Challenging Payer Mix

- Rural hospitals are more likely to serve a population that relies on Medicare and Medicaid.
- Section 50205 of the Bipartisan Budget Act of 2018 provides for an extension of the MDH program for discharges occurring on or after October 1, 2017, through FY 2022.
Changes in Health Care Delivery
Across the United States, numerous health care services previously provided on an inpatient basis are now offered in outpatient settings.
Coverage
Individuals without adequate health insurance and those with plans that have high out-of-pocket expenses often cannot pay for emergency and other acute health services, leaving providers with higher rates of uncompensated care.
A Call to Action

Challenges Facing Rural Hospitals & Communities
Community Health Workers

Advanced Primary Care Practices
- Physicians
- Nurse Practitioners
- Physician Assistants
- Nurses
- Office Staff
- Behavioral Health Specialist
- Chronic Care Coordinator

Community Health Team
- Administrative Core
- Community Connections Team
- Support and Services at Home (SASH) Team

Functional Health Team

Community
- Community-Based Services (e.g., mental health, employment services, senior, adult education & training)
- Healthier Living Workshops
- Chronic Disease Support Groups
- Chronic Disease Self-Management Programs

Broader Healthcare Community
- Pharmacists
- Medical Specialists
- Physical Therapy, Occupational Therapy, Speech Therapy
- Hospital (Inpatient & Emergency Room)
- Chronic Disease Education
- Long-Term Care

Centers For Disease Control And Prevention
Before:
North Georgia Medical Center
Ellijay, GA

After:
Piedmont Mountainside Hospital
Emergency Services

Since opening, the ED averages about 30 patients a day and in 6 months’ time has seen over 5,000 emergency visits. Additionally, PMH is working collaboratively with the local Gilmer County EMS/ambulance service to ensure patients are transported to the most appropriate facility for their patient care needs. As a community-focused hospital, PMH recognized their immediate need and acted to expand its services in Gilmer County and deliver the same level of patient-centered care expected of the Piedmont name. Now, patients in Ellijay requiring admission or transfer will follow the same process as they would if they were entering PMH’s emergency room in Jasper.
Since this freestanding ER is the first of its kind in Georgia, each and every governing body had to conduct their own due diligence.

- State Fire Marshall - approved
- State Architect – approved
- Certificate of Occupancy - received
- State Board of Pharmacy and DEA - approved
- State Lab Inspection – approved
- Cahaba/Centers for Medicare & Medicaid Serv – approved
- State Licensure Division – approved

Time approved to build a freestanding ER and appeals were fully dismissed was 20 weeks. Construction to opening, after all necessary approvals, was 21 weeks.

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May 23, 2016
- Piedmont received State’s approval to move forward with the first freestanding ER in the State on May 23, 2016.

Oct 5, 2016
- After several State hearings, WellStar withdrew their appeal Oct 5. State dismissed Gilmer Co appeal Oct 18, since they were silent.

Nov 16, 2016
- State Architect finally released decision Nov 16 for Piedmont to begin construction on ER. Decision was delayed due to Gilmer Co appeal.

Nov 21, 2016
- NGMC termination to Cahaba/CMS received Nov 21.

Dec 5, 2016
- DEA inspects pharmacy on Dec 5.

Jan 9, 2017
- Construction was completed on Freestanding ER in 9 weeks.

Jan 18, 2017
- State Board of Pharmacy approves pharmacy for services.

Feb 16, 2017
- Cahaba/CMS approves Piedmont’s Medicare claims number

Mar 6, 2017
- State Lab Director inspected & approved lab for services.

Mar 27, 2017
- Cahaba/CMS termination to NGMC received Nov 21.

Mar 27, 2017
- State Lab Director approved lab for services.

Apr 3, 2017
- ER opened for patients

State visited Mar 22, and approved license Mar 27.
ACO Investment Model (AIM)

- AIM supported smaller and rural ACOs by investing start-up funds in 2015 and 2016.
- 47 AIM ACOs began in 2015 and 2016.
- AIM ACOs reduced the cost of care by $82.8 million and maintained excellent quality.
- Outperformed higher risk programs like Pioneer ACOs and Next Generation ACOs:
  - AIM saved $22.70 PBPM
  - NextGen ACOs saved $18.20 PBPM
  - Pioneer ACOs saved $20.00 PBPM
IRCCO was established in 2014 and is an ACO in 2015 as an investment model and in 2018 as a MSSP

- Membership includes 24 rural and CAHs, 4 independent physician practices, RHCs and FQHCs.
- 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
CMMI global budgets and all-payer models

CMMI provides custom, state-specific Medicare flexibilities to test novel models in return for state accountability on both all-payer cost growth and population health measures.

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<tr>
<th>All-payer model</th>
<th>Novel test</th>
<th>Medicare flexibility</th>
<th>State accountability</th>
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<tbody>
<tr>
<td>Maryland</td>
<td>Hospital global budgets to decouple hospital revenues from volume and incentivize prevention and wellness</td>
<td>Allow global budgets to determine Medicare payment amounts to Maryland hospitals</td>
<td> Scale targets to disseminate reforms across states’ payers and providers</td>
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<td>Vermont</td>
<td>ACOs at scale statewide to incentivize value and quality under the same payment structure throughout the delivery system</td>
<td>Provide a custom Medicare ACO model, based on CMMI’s NextGen ACO model</td>
<td> All-payer financial targets to ensure state’s healthcare costs across payers grow at a sustainable level</td>
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<tr>
<td>Pennsylvania</td>
<td>Hospital global budgets for rural hospitals and a deliberate plan to improve quality and efficiency across services and service lines</td>
<td>Allow global budgets to determine Medicare payments to participating Pennsylvania rural hospitals</td>
<td> Medicare financial targets to maintain fiduciary duty to Medicare beneficiaries and the Trust Fund</td>
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<td> Population health targets to tie success to actual improvements in the health and quality of care for residents</td>
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When disaster strikes 24/7/365
Questions and Discussion
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