

Medicare Value-based Payment Reform: Priorities for Transforming Rural Health Systems

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In January, 2015, Department of Health and Human Services (HHS) Secretary Burwell announced new goals and timelines for moving Medicare reimbursement from fee-for-service to value-based payment. These payment changes are driving delivery system reforms (DSR) by making health care organizations more accountable for patients' health as well as population and community health. Payment and delivery system reform, however, is concentrated in urban centers, and Medicare rural payment policies that were designed to strengthen rural health providers and systems are now complicating payment and delivery system reform in rural areas. The inclusion of rural providers in Medicare payment reform is critical for the program and for the 23 percent of Medicare beneficiaries who reside in rural areas. Rural Medicare beneficiaries should have the same opportunity as their urban counterparts to benefit from payment reform's positive effects including strengthened primary care, embedded care coordination, and improved clinical quality.

In this brief, we describe five recommendations to facilitate rural inclusion in value-based payment and delivery system reform:

- 1) Organize rural health systems to create integrated care.
- 2) Build rural system capacity to support integrated care.
- 3) Facilitate rural participation in value-based payments.
- 4) Align Medicare payment and performance assessment policies with Medicaid and commercial payers.
- 5) Develop rural appropriate payment systems.

RECOMMENDATION: Organize rural health systems to create integrated care.

Expanding Medicare alternative payment models to rural providers requires significant investments for modifications to the rural delivery system to achieve HHS goals. The following recommendations build on the key components of the Panel's framework for a high performing rural health system, emphasizing the strengthening of the system's primary care infrastructure, establishing ACO arrangements, and building systems for population health and community health improvement.

- **Expand the development of comprehensive primary care practices such as PCMHs.**
Start-up grants (i.e., funding from State Innovation Model awards), technical assistance programs (i.e., Practice Transformation Network under the Transforming Clinical Practice Initiative awarded by the Center for Medicare and Medicaid Innovation, CMMI), and payment policies that support primary care practice transformation and expansion are necessary to meet the goals of patient-centered and comprehensive, coordinated care.
- **Expand patient referral networks (e.g., primary care to specialty care) based on value.**
Rural hospitals and other providers may need technical assistance to demonstrate and improve healthcare value delivered locally, including new rural relevant measures of quality and value.

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- ***Expand rural involvement in Accountable Care Organizations (ACO).***
Policymakers should continue to review ACO requirements (e.g., risk approaches, patient attribution) to accommodate rural participation.
- ***Create alternative payment and delivery system models to enable rural hospitals to transition from a financial reliance on inpatient care to outpatient and other essential services.***
Rural providers dependent on inpatient care for financial success will need an organizational, service, and financial bridge to “right size” and re-align their service mix. Alternative care model examples include the Rural Emergency Acute Care Hospital Act (S. 1648) and Title IV of the Save Rural Hospitals Act (H.R. 3225).
- ***Support primary, acute care integration with long-term supports and services and end-of-life care.***
Demonstration programs and technical assistance are needed to enable rural providers to develop care integration models that encompass the full continuum of care, including skilled nursing, nursing facility, home health, home and community based health and social support services, end of life services such as hospice.
- ***Support new healthcare provider and non-clinical entity partnership development.***
Rural providers should have access to community collaboration processes and models, including programs to train leaders to initiate and maintain collaborations with outside entities, to support partnership development with non-medical providers (e.g., behavioral health, public health, care coordination, human services).
- ***Support new governance models that recognize new partnerships and the continuum of care.***
Rural providers, and their communities, should be provided models and facilitation expertise to move toward new shared and collaborative decision-making arrangements that strengthen community-based systems of care.

RECOMMENDATION: Build rural system capacity to support integrated care.

Rural healthcare providers and systems face challenges of historically low patient volumes and low Medicare and total margins that restrict ability to invest in new facility configuration, information technology, and high-speed connections to facilitate use of telehealth. They also have not developed management staff skilled in new techniques of data analysis and use of information systems (including financial systems) needed to transition to new payment systems. The following policy recommendations help overcome those disadvantages.

- ***Provide low-cost capital to rural providers demonstrating need.***
Public programs providing capital assistance (including the USDA rural development programs) should target rural providers demonstrating need for capital to achieve the transition to value-based payment and require an implementation/evaluation plan to measure results.
- ***Provide technical assistance for transitions to value-based care.***
Federal grant programs (including portfolios of the Health Resources and Services Administration and the Center for Medicare and Medicaid Innovation) should support technical assistance to rural providers ready to transition to new payment systems, and demonstration programs should support steps toward transitions, such as testing new financing models.
- ***Develop a new healthcare workforce to serve the continuum of care.***
Payment policies should encourage use of healthcare professionals engaged in comprehensive population health management. Technical assistance to provide new healthcare professional training, aligning training payments to the new health systems and otherwise providing grants to establish new workforce programs will be needed.

- ***Develop team- and non-visit-based care strategies.***
Increase the reach of publicly supported programs (including community health worker training through support from CMMI’s State Innovation Models (SIM), and in the programs offered through Teaching Health Centers and Area Health Education Centers (AHECs)) that provide training and practice in interdisciplinary settings based in primary care.
- ***Support development and implementation of population health data management platforms and skills.***
Rural providers should be offered incentives, through demonstration programs and payment systems, to invest in (and use) population health management software, and the staff training and skills needed to effectively use the technology tools.

RECOMMENDATION: Facilitate rural participation in value-based payments.

Rural providers will need to assess the financial implications of payment changes (e.g., effects on ability to finance operations), which requires new modeling tools, different measures than those historically used, and new approaches to financial risk based on populations served.

- ***Develop and disseminate financial risk assessment tools.***
Rural providers should have access to accounting and modeling technical assistance during payment transitions, including tools that help them understand the impact of change and tools and processes to move from current payment formulae to new methodologies, retaining both during a transition.
- ***Develop rural-appropriate healthcare value measures.***
Measures of healthcare value used by Medicare should incorporate specific indicators found to be relevant to rural providers, including those endorsed by the National Quality Forum.
- ***Assist rural providers implement performance measurement and reporting systems.***
Reporting agencies such as Medicare should develop rural appropriate performance measurement and reporting tools and technical assistance should be made universally available to rural providers.
- ***Support research to identify proven population health and financial risk management strategies.***
Research funds should prioritize development and testing of new population health and risk management strategies to ensure appropriateness for rural providers.

RECOMMENDATION: Align Medicare payment and performance assessment policies with Medicaid and commercial payers.

Medicare policies should work in tandem with other payers to promote change. For example, as Medicare continues its engagement with ACOs, these efforts should align with private-based ACOs and the development of Medicaid ACOs. The same can be said for payment to PCMHs. Specifically the Medicare program can:

- Determine policies for ACO qualification and shared savings that can be modeled by others or aligned with others including state Medicaid programs.
- Develop policies that recognize special circumstances in rural communities to support medical homes including availability of community healthcare workers.
- Work across payers and programs to standardize performance (e.g., quality, cost) indicators and reporting requirements to reduce burden for providers, particularly rural providers, for example by using common reporting forms and processes.

- Set a pathway from FFS to population-based payment that includes funds needed to maintain access during the uncertain transition time period.

RECOMMENDATION: Develop rural-appropriate payment systems.

A “glide path” from volume-based to value-based payment is required. The following payment strategies will expedite the transition to new payment systems without jeopardizing rural access to essential health care services.

- ***Create incentives for rural providers to report rural-appropriate performance measures.***
Incorporate incentives into current payment policies that encourage rural providers to provide data to develop and report rural-appropriate measures needed in anticipation of value-based purchasing models.
- ***Implement the previously authorized value-based purchasing demonstration program for CAHs.***
The goals of Section 3001 of the ACA should be met, even if implemented through demonstration authority and general funds available through that authority. To avoid adding risk to providers essential for access, the program should initially not include down-side risk.
- ***Support hybrid payment systems during transition to value-based payment systems.***
Support the transition from current cost-based reimbursement systems (e.g., for CAHs and RHCs) to value-based payment systems by allowing temporary hybrid payment systems that continue to cover fixed costs but with incentives to achieve better health and healthier communities.
- ***Reward, and/or make an allowable cost, activities likely to advance HHS goals.***
Currently nonallowable costs that could be reclassified to allowable in order to advance HHS goals may include activities supporting the goals used by CMS in its Request for Information.
- ***Savings from implementing new payment policies under Medicare should be used to strengthen the rural health infrastructure, including increasing primary care payment, with emphasis on preventive health services.***
Retention of shared savings by local health care organizations could be increased when those organizations commit the savings to strengthening local infrastructure, with emphasis on retaining primary care through payment incentives.

CONCLUSION

HHS’s goals to shift from fee-for-service payment to alternative payment systems and payment that is based at least in part on quality could well be the “tipping point” that drives nearly all healthcare payment and care delivery toward value, including in rural areas. Rural provider inclusion in payment and delivery system changes is crucial if health equity is to be achieved. We should expect and encourage widespread healthcare delivery system change in response to the new payment paradigms. Facilitating that change through policies that recognize the special circumstances facing rural providers is critical if payment policy changes are to have the intended effect of moving healthcare delivery closer to a high performance rural healthcare system.