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Innovations in Rural Health System Development: Moving Rural Health Systems to Value-based Payment

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Innovations in Rural Health System Development

Moving Rural Health Systems to Value-Based Payment

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Rapid changes in health care payment and delivery systems are driving health care providers, payers, and other stakeholders to consider how the current delivery system might evolve.

This series of briefs profiles innovative rural health system transformation models and strategies from Maine and other parts of the United States. The aim is to assist rural communities and regions to proactively envision and develop strategies for transforming rural health in the state. In preparing these briefs we consulted experts, interviewed key informants, and reviewed the professional and research literature to find robust and innovative models and strategies that could be replicated in rural Maine.

PROMISING STRATEGIES:

- Accountable Care Organizations 2
- Medicaid Accountable Communities..... 5
- Additional Financial Models..... 6

INTRODUCTION

How we pay for health care has critical implications for health care quality, access to care, and the cost of services in the health system. Currently there is intense interest in moving health care payment systems away from models that create incentives for providers to provide more care (i.e. increase volume), to ones that reward value—services that are both efficient and high quality. The Affordable Care Act contains many provisions designed to implement or test innovative, value-based Medicare and Medicaid payment models, including accountable care/shared savings (Accountable Care Organization (ACO) models), bundled payments, and health homes initiatives. In addition, states, including Maine, are participating in State Innovations Models (SIM) grants or other innovation models from the Center for Medicare & Medicaid Innovation (CMMI) that are testing new approaches to paying for health care services.

FIGURE 1: Medicare ACO Models

■ **MSSP:** The Medicare Shared Savings Program, established by the Affordable Care Act, rewards ACOs that lower their growth in health care costs while meeting performance standards on quality of care and putting patients first. ACOs that achieve certain financial and quality benchmarks receive some of the money that Medicare has saved on the ACOs' patient population.

■ **Advanced Payment**

ACO: In this model, which is targeted to small and rural providers, a subset of MSSP participants receive up-front payments (variable or fixed depending on the ACO).

■ **Next Generation ACO**

Model: This is an initiative for ACOs that are experienced in coordinating care for populations of patients. It will allow these provider groups to assume higher levels of financial risk and reward than are available under the current Pioneer Model and MSSP.

■ **Pioneer ACO model:**

This model is designed for providers and health systems that are very advanced with substantial care coordination capacity. It is no longer accepting new applications, in favor of the Next Generation model.

MSSP program participants can also participate in the **ACO Investment Model (AIM)** which is specifically targeted to rural and underserved areas. In this model, ACOs are able to obtain an up-front payment from Medicaid reflecting their expected savings. This can help providers build care management and other capacity necessary to be successful as an ACO.

For many rural health care providers, participating in innovative payment initiatives can be challenging. For example, many lack the necessary infrastructure, including having care management staff and systems and the ability to use their electronic health record (EHR) data to monitor the care of their patients. In addition, many rural providers do not meet the thresholds for participation because of their lower patient volume. And finally, many of the new incentive-based payment arrangements do not work with current Medicare and Medicaid cost-based rural hospital and other payment arrangements.

Notwithstanding challenges, there are a growing number of examples of rural health care providers participating in innovative payment initiatives. The following examples of payment innovations in rural areas illustrate the range of options available to communities and health care providers. In general, these and other examples indicate that while wholesale changes in payment systems are challenging in rural communities, getting started with incremental steps that build the capacity and experience of rural providers is possible and indeed essential.

PROMISING STRATEGIES Accountable Care Organizations (ACOs)

ACOs are groups of doctors, hospitals, and other health care providers, who voluntarily agree to contract with Medicare, Medicaid, or other payers or health plans to provide efficient, high quality care to an attributed population of patients.¹ Figure 1 describes the variations in Medicare ACO models.

The payment arrangements for each of these ACO models differs considerably in terms of whether and how providers are rewarded or penalized for meeting quality and cost targets. In general, rural providers and health systems participating in the Medicare MSSP program continue to be paid on a fee-for-service basis and are limiting their financial risk by only seeking shared savings rewards.

There are considerable barriers to rural providers participating in ACO models. These include:

- Many rural providers' service delivery areas do not meet the minimum Medicare threshold of 5,000 beneficiaries. Some may meet the threshold initially but risk falling below it if a provider drops out.
- Rural physician practices and hospitals have fewer resources to put toward the upfront investments in infrastructure and personnel needed to effectively manage patients' care.
- The financial overhead of running an ACO (for the EHR and other reporting systems, as well as care coordination) may be a deterrent, especially for practices with a heavier focus on primary care and fewer specialists (where there is greater potential for achieving savings and improving quality).
- It may be harder to find staff in rural areas who are qualified to fill care coordinator and other positions that an ACO requires.
- Rural providers may also have a harder time complying with the necessary rules and regulations.

EXAMPLES OF ACO MODELS

BEACON HEALTH:

An ACO in Rural Maine

Beacon Health, part of Eastern Maine Healthcare Systems (EMHS), is operating at the forefront of innovations in value-based purchasing. Beacon Health's ACO began as a Pioneer ACO in 2012, but is now part of the Next Generation ACO Model, which allows providers to assume a greater level of risk but also greater savings than are possible under the standard MSSP. The Next Generation Model also moves participants toward capitated payments (fixed monthly Medicare payments based on the number of beneficiaries in the ACO, regardless of whether or not they seek care), and contains some Medicare benefits enhancements, such as a waiver of the rule that requires a three day hospital stay before Medicare will cover the cost of a skilled nursing facility. Beacon Health is also part of the Center for Medicare & Medicaid Services' AIM initiative, which encourages ACOs to form in rural and underserved areas, and encourages current MSSP ACOs to transition to arrangements with greater financial risk. The Beacon Health ACO includes Critical Access Hospitals (CAHs) affiliated with EMHS, as well as other rural hospitals. Finally, Beacon Health is a MaineCare Accountable Community, although at present only a few network practices are participating.

Beacon Health's participation in the Medicare Next Generation ACO and AIM models is enabling them to invest in the development of their care coordination infrastructure. Nurse care coordinators are being embedded across the Beacon Health network in practices (including practices associated with CAHs and other rural hospitals) with the expectation that they will help reduce readmission rates, increase patient engagement in their health, and improve communication with patients and practices.

The inclusion of rural providers—CAHs and primary care practices—in Beacon Health is part of a larger strategy of enabling these rural providers to develop capacities that will allow them to survive in the rapidly evolving health care system. Beacon Health president Michael Donahue notes that CAHs are developing approaches designed to help them keep their doors open with increased volume, especially in swing beds. Together with its affiliated CAHs, Beacon Health is examining which core services are crucial to have locally, keeping patient care in the community, at the CAH, and which services are best handled by larger facilities.

Donahue and others have suggested that allowing CAHs to have a global payment structure from Medicare, even if only as a pilot program for several years, would allow them to invest in key infrastructure and personnel, to help move their hospitals away from inpatient-centered care and fee-for-service payments. It would also give them the flexibility and resources to forge connections with social services, transportation, behavioral health, and other local services that are part of the bigger population health picture in their communities. He noted that connections with other service providers is an essential strategy for reducing unnecessary admissions and readmissions, and achieving better patient outcomes and quality of life. As an example, he cited Blue Hill Memorial Hospital's relationship with Healthy Peninsula, a local community health program, which might be a model for other small rural communities and their CAHs.

THE MAINE COMMUNITY ACO:

A Statewide Rural ACO

The Maine Community ACO (MCACO) is a partnership of FQHCs in rural Maine. Established in 2012, MCACO is one of 119 MSSP ACOs nationwide, and the only one in Maine that qualified for shared savings based on its 2015 performance on quality standards

and pre-set financial benchmarks. The shared savings amount to nearly a million dollars, which will be distributed back to the participating health centers. In interviews with Lisa Letourneau, the executive director of Maine Quality Counts, MCACO leadership noted that focusing on high-risk admissions, as a means of both improving quality and reducing costs, is a key factor for success.² In particular, MCACO data suggested that two conditions, heart failure and COPD, were associated with the greatest number of potentially avoidable hospital admissions and readmissions. Dedicated care coordination and patient self-management education have contributed to improvements in care for these conditions. MCACO practices also leverage the Medicare Annual Wellness Visit to get to know patients better and to flag the ones with particularly high health care needs and complex illnesses. MCACO has invested in site-level clinical leadership and committed to maintaining a continuous focus on quality. The sharing of best practices across practice sites is also cited by MCACO leadership as a key strategy for patient-focused quality efforts that lead to improved outcomes and lower costs.

THE ILLINOIS RURAL COMMUNITY CARE ORGANIZATION:

A Statewide Rural ACO

Illinois Rural Community Care Organization (IRCCO) is comprised of 25 CAHs and their associated physician practices and clinics located in rural communities across Illinois. It operates as a limited liability company established by ICAHN, the Illinois Critical Access Hospital Network. IRCCO's participating organizations are serving 30,000 Medicare beneficiaries. Like Beacon Health, IRCCO is part of the AIM initiative, which encourages ACOs to form in rural and underserved areas, and encourages current MSSP ACOs to transition to arrangements with greater financial risk.

Participants in IRCCO receive pre-payment of shared savings in both upfront and ongoing per beneficiary per month payments. Potential uses of AIM funding include investments in infrastructure and hiring of staff to oversee the implementation of care coordination efforts. IRCCO members are required to financially support the costs of organizing and running the organization in the first two years. Added incentives for providers come from IRCCO's participation in the Blue Cross Blue Shield of Illinois (BCBSIL) Intensive Medical Home, which is "an enhanced model of primary care focusing on the high-risk chronic care beneficiaries. IRCCO is paid for nurse care management services and providers are reimbursed based on the number of BCBSIL members enrolled based on claims information."³

Early efforts have focused on building the infrastructure and processes necessary to function as an ACO, including appreciating the need for culture change in many participating organizations, and education about the importance of reducing costs and improving outcomes. Moving forward, IRCCO will concentrate its efforts on care coordination and care transitions, particularly for patients with chronic illness. Four IRCCO workgroups are collaborating to address topics such as unnecessary emergency department visits, hypertension, congestive heart failure, and Medicare annual wellness visits. IRCCO is also leveraging funds provided by the Medicare Rural Hospital Flexibility Grant Program (the Flex Program) to establish cohorts of CAHs to develop care coordination processes and standards of practice for specified chronic diseases. Although there are still challenges to be addressed (such as improving health information technology capacity and implementing care coordination systems), IRCCO has brought rural hospitals together to begin to expand their capacity to participate in value-based payment models.

PROMISING STRATEGIES

Medicaid Accountable Communities

An Accountable Community is a Medicaid ACO model adopted by states as a state Medicaid program option. Maine's Medicaid program (MaineCare) has an Accountable Communities program through which it contracts with coalitions of health care providers who, as in an ACO, can share in savings for their population. Achieving shared savings in the Medicaid Accountable Community model is contingent on meeting quality targets.⁴ There are two shared savings/risk models that require different levels of MaineCare enrollment (under and above 5,000 patients), and core and optional services that any Accountable Community must provide. The savings are calculated as a percent of the benchmark total cost of providing care, compared to the actual cost of providing care, with the percent set by the population size of the Accountable Community.⁵ At present, the model pays providers on a fee-for-service basis. It is an "upside-only" model, with the potential for shared savings but no downside financial risks for providers.

KENNEBEC REGION HEALTH ALLIANCE:

A Medicaid Accountable Community

Kennebec Region Health Alliance (KRHA) was formed in 1997 as a physician-hospital organization consisting of MaineGeneral Medical Center and members of its medical staff. Kennebec County is its primary service area, although it also has practices in six additional counties.

KRHA has participated in the MaineCare Accountable Community initiative since its inception. The Accountable Community started small, initially with just the MaineGeneral-owned practices, and then expanded to any member of the KRHA that wanted to join. There are currently 25 practices in the Accountable Community serving about 20,000 patients. KRHA was already participating in many care management models, including patient centered medical homes/health homes, behavioral health homes, and care management teams, and the opportunity to be an Accountable Community offered a way to align those multiple initiatives to potentially reduce MaineCare utilization at MaineGeneral. Dr. Barbara Crowley, executive vice president at MaineGeneral and the president of KRHA, noted that, on average, 22 out of the 192 beds at MaineGeneral are occupied by a Medicaid patient (not Medicare or private pay), and that reducing that number, even by one, through Accountable Communities and other care coordination initiatives, would have a significant impact on the bottom line.

KRHA's Accountable Community has been in place for three years. It has focused its care coordination services on children with multiple behavioral and physical health needs. The initiative has paid particular attention to helping behavioral health providers follow evidence-based practices. They are looking to develop targeted case management for the children in the Accountable Community, with care coordination and improved communication between different providers and agencies. Greater financial rewards and challenges will come when the Accountable Community increases its attention to aging, blind, and disabled adults, whose care carries the largest financial burden in Medicaid. In the first performance year, the Accountable Community is close to achieving shared savings payments, less than 0.2% away from the target for total cost of care.

PROMISING STRATEGIES

Additional Financial Models

CARY MEDICAL CENTER AND PINES HEALTH SYSTEM:

Sharing Financial Resources and Specialists

Cary Medical Center (Cary), a 65-bed acute care hospital in Caribou, Maine, and Pines Health Services (Pines), a community-based, multi-specialty physician practice and Federally Qualified Health Center (FQHC) serving Aroostook County, have a long-standing, mutually beneficial relationship in which they share resources to ensure that the community and the hospital have adequate primary care and specialty staff to maintain a sustainable health system. According to Pines CEO James Davis, each organization is made stronger by serving the community together.

Pines was founded by Cary 31 years ago, in an era when hospitals were looking to add non-acute care entities to offer a wider range of services. Over time, Pines has become a large multi-specialty physician group with more than 40 providers divided about evenly between primary care and specialists. Although it is unusual for an FQHC to have specialists, their presence (technically outside the FQHC grant) allows patients to access needed services quickly within the same system. This arrangement functions well due to the strong, ongoing relationship with Cary, which maintains an agreement to exchange services and staff. Pines' status as an FQHC allows for better reimbursement for publicly insured and uninsured clients, and has allowed Pines to be less financially dependent on Cary.

Cary and Pines collaborate to create workable budgets for Pines. Pines' providers generate about 80-85% of Cary's revenues. In return, Cary provides Pines \$2 million annually in community benefit payments to support primary care, and an additional \$5 million that enables Pines to recruit specialists. In rural Maine, it would be very difficult for a specialist to be successful with a purely office-based practice, but the relationship with Cary offers specialists access to a hospital-based practice as well. Pines currently employs specialists in areas such as ophthalmology, urology, gynecology, and general surgical services.

Ongoing financial pressure on hospitals to improve quality and reduce costs creates challenges and opportunities in this arrangement. Capitalizing on its primary care resources, Pines is working closely with the hospital to decrease emergency room use; Davis estimates that a third to a half of all emergency department visits could be dealt with in primary care settings, where patients would get more comprehensive, ongoing care at a lower cost to the system. The hospital, in turn, works with MaineCare patients to enroll them in Pines or other practices so they have a medical home and continuity of care.

SUMMIT PACIFIC MEDICAL CENTER, WASHINGTON STATE:

Taking the First Steps

Summit Pacific Medical Center (SPMC) is an independent, public hospital district CAH in Elma, Washington, serving about 25,000 people in the western part of the state. Faced with serious financial problems several years ago, SPMC re-focused its attention on growing its primary care, emergency care, and other outpatient services, de-emphasizing its in-patient services. At present, about 90 percent of SPMC's revenue comes from outpatient services.⁶ Although they are licensed for 24 inpatient beds, SPMC CEO Renee Jensen notes that they only staff 10 beds. Instead, they have grown their primary care clinics from one to three, with a new wellness center currently being built to compliment their current hospital facility which opened in 2013. SPMC's focus on primary care and other prevention services comes

from their assessment that the community needed a greater emphasis on preventing chronic diseases. Their wellness focus also includes integration of behavioral health services with primary care, and targeted community health improvement initiatives. The new wellness center will include primary care, behavioral health services, a cultural transformation hub, and both traditional and non-traditional therapies.

SPMC is actively seeking ways to transition from volume-oriented, fee-for-service and cost-based payment models to value-based payment arrangements. SPMC has partnered with two local Medicaid Managed Care Organizations (MCOs) to create a value-based contract that takes into account the size and limitations of the rural provider and community. It includes funding for care coordination services and mental health providers, infrastructure support for SummitCare (a major wellness initiative at SPMC), and financial bonuses for reaching five quality metrics. The quality metrics were chosen to be easy to collect and relevant to the community. SPMC will have access to the MCOs' data, which it hopes to use to monitor how well they are doing in reaching quality and cost targets.

SPMC also participates in a Medicare Shared Savings ACO program. In order to build its capacity to participate effectively in this program, SPMC is working on increasing the internal medicine activities of the hospital, using hospitalists who do patient consults in the primary care clinics. The hospitalists are able to handle much of the specialty care that would otherwise result in transfers out of the community, to a larger regional tertiary hospital; when referrals are necessary, SPMC's hospitalists look to send patients to partners with the best value care. By keeping care in the community, SPMC increases the revenue and patient volume for both internal medicine and the primary care clinics.

Jensen advises that any CAH planning for the transition from volume to value-based health care start with incremental steps that lay the necessary groundwork, including an assessment of the facility's capacity to deliver value-based care. She advises that hospital leadership needs to be fully on-board and that physician champions are key for making sure that projects are embraced.

For more information:

<http://cph.uiowa.edu/ruralhealthvalue/files/ProactivelyPursuingVBP.pdf>

PRIMEWEST HEALTH, MINNESOTA:

County-owned Health Care Plan

PrimeWest Health is a rural, county-based health care plan owned and governed by 13 counties in rural Minnesota. Formed in 1997, PrimeWest Health provides health insurance coverage to county residents who qualify for the state's Medicaid and other medical assistance programs. PrimeWest Health currently manages and pays for services for over 36,000 people. The network of providers in the county-based purchasing plan includes medical, behavioral, allied health, and social service providers.

PrimeWest Health launched its Accountable Rural Community Health (ARCH) program in 2008 as an early Accountable Communities model that incorporates the principles of shared risk and savings between the health plan, PrimeWest, and its provider network. ARCH seeks to integrate rural health care providers with local public health and social service providers, through a patient centered medical home approach and other initiatives. ARCH established three financial incentives as part of the movement to realign health care provider incentives: capacity development grants (e.g., grants to establish additional oral health clinics in high

demand areas), pay-for-performance bonuses, and paid shared savings if overall health care (including public health and social services) costs are reduced and quality is improved. In addition, health care provider contracts specify quality improvement targets that providers are expected to meet.⁷ ARCH seeks to reduce preventable illnesses and utilization, including avoidable hospitalizations, and reduce unnecessary health care costs.

For more information:

- <https://www.primewest.org/aboutus>
- <http://cph.uiowa.edu/ruralhealthvalue/files/PrimeWest.pdf>

IMPLICATIONS

Considerations for Application in Maine

- Rural providers affiliated with health systems in Maine are participating in ACO and other value-based payment arrangements, though most are doing so using traditional payment arrangements (e.g. fee-for-service and cost-based reimbursement). Although not representative of all rural providers in the state, their experience with building care management and other capacities should be instructive to others.
- Payment alone is insufficient for transforming rural health care systems. As several of the examples discussed here indicate, rural providers and communities need to carefully assess the health care needs and resources in their community and their region to determine how best to organize and deliver services in a financially sustainable system.
- Like others around the country, Maine's rural communities and providers may lack the capacity and patient volume to engage in value-based payment and delivery system transformation initiatives. Partnerships among rural healthcare providers can help build sufficient capacity and patient volume to participate in these arrangements.
- The experience of rural providers in Maine and across the country indicates that practical, incremental steps, such as working on efficiency improvements, are essential for building capacity for participating in value-based payment arrangements.

Despite the growing adoption of new value-based payment models, for the reasons mentioned above, only a minority of rural providers and communities are participating in these arrangements. From the perspective of some rural administrators, this is just fine. Others, however, have noted that by not participating, rural health providers and the communities they serve are missing the opportunity to modernize and improve their capacities to better serve their patients.⁸ In the absence of new, more comprehensive payment reform that recognizes the realities of rural health systems, rural communities and providers can focus on preparing incrementally for the future by becoming more efficient, building stronger care management and other capacity, and carefully assessing services to ensure a financially sustainable future.

Resources on the challenges of rural ACOs:

- <https://www.ruralhealthinfo.org/community-health/care-coordination/3/aco-model-implementation-considerations>
- <https://www.ruralhealthinfo.org/rural-monitor/rural-aco-leaders-speak/>
- <https://www.public-health.uiowa.edu/rupri/publications/policybriefs/2015/Rural%20ACO%20Development.pdf>
- <http://www.ncmedicaljournal.com/content/77/4/271.full>

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