

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

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## PURPOSE

In recognition of unsustainable healthcare cost growth and suboptimal delivery system performance, the Patient Protection and Affordable Care Act of 2010 (ACA) contains provisions that redesign healthcare payment and delivery. ACA payment change provisions are driving delivery system reform by making healthcare organizations more accountable for patients' health as well as population and community health. The result has been the development of delivery systems that strengthen primary care, embed care coordination and management, and begin to address social determinants of health. However, payment and delivery system reform efforts to date have been concentrated in urban centers, with little attention paid to how they might be applied in rural health systems. Therefore, in this paper we examine the implications of Medicare payment reforms for rural providers and health services. We offer policy recommendations to facilitate rural inclusion in value-based payment and delivery system reform.

### Key Findings and Recommendations

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.

## BACKGROUND

### *Payment Policy Reform Goals*

In January 2015, Department of Health and Human Services (HHS) Secretary Burwell announced ambitious goals for transitioning Medicare payment policies from volume-driven fee-for-service (FFS) arrangements to systems that promote and reward value.<sup>1</sup> In her statement, Secretary Burwell announced a goal of shifting 30 percent of traditional, or FFS, Medicare payments to alternative payment models by the end of 2016, and 50 percent by the end of 2018.<sup>2</sup> This goal will

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<sup>1</sup> U.S. Department of Health and Human Services. (2015, January 26). "Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value." Retrieved from <http://www.hhs.gov/news/press/2015pres/01/20150126a.html>

<sup>2</sup> These include alternative payment models built on fee-for-service architecture and those that are population-based. See <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html>.

be achieved through investment in advanced primary care medical home models, alternative payment models such as Accountable Care Organizations (ACOs), new bundled payment models for episodes of care, and integrated care demonstrations for beneficiaries dually eligible for Medicare and Medicaid. Based on Medicare FFS spending estimates for 2018, more than \$214.7 billion will be spent through alternative payment models.<sup>3</sup> By 2018, HHS seeks to incorporate quality or efficiency measures into at least 90 percent of Medicare FFS payments, reflecting an estimated \$386.5 billion of Medicare spending. These goals set the pace and direction of delivery system reform that moves away from existing service volume-based arrangements.

The potential impact of payment reform on rural providers and health systems is largely unknown. New policies that change FFS payment systems could disproportionately affect rural providers because a smaller percentage of beneficiaries in rural counties than in urban counties are in Medicare Advantage plans (22 percent vs. 33 percent, respectively), indicating a higher proportion of beneficiaries in rural counties are under Medicare FFS.<sup>4</sup> On the other hand, because rural providers represent a small percentage of total Medicare FFS spending,<sup>5,6</sup> Medicare could theoretically meet its goal of 90 percent of payment being linked to quality without including many rural providers in payment reform. Rural providers who did not participate in payment reform, however, would forego the benefits of new payment incentives as well as the ability to demonstrate quality and value to potential partners, payers, and patients. This paper will spotlight Medicare payment changes and the implications for rural providers of pursuing delivery system reform.

### ***Medicare Payment Policies Driving Delivery System Reform***

Goals for shifting Medicare payment to value create the backdrop for a delivery system changing from one focused on increasing service volumes (including incentivizing high volumes of services with the highest payments) to one focused on improving the health of beneficiaries and populations. HHS's goals for Medicare payment reform are based on a desired set of outcomes:

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<sup>3</sup> The Board of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. (2015, July 22). *2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. Retrieved from <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2015.pdf>

<sup>4</sup> Henry J. Kaiser Family Foundation. *Medicare Advantage Enrollees as a Percent of Total Medicare Population, State Health Facts*. Retrieved from <http://kff.org/medicare/state-indicator/enrollees-as-a-of-total-medicare-population/>

<sup>5</sup> iVantage Health Analytics. (2014, April 22). *Rural Relevance Under Healthcare Reform*. Executive Summary.

<sup>6</sup> Medicare Payment Advisory Commission. (2014). *A Data Book: Health Care Spending and the Medicare Program*. Retrieved from <http://www.medpac.gov/documents/publications/jun14databookentirereport.pdf>

“better care, smarter spending, healthier people.”<sup>7</sup> While the HHS goals are represented in terms of percentages of total provider Medicare FFS expenditures, the use of value incentives makes the Medicare program a critical payment system reform player, especially among rural providers whose patient mix is often disproportionately Medicare beneficiaries. Further, other payers often follow Medicare’s lead in payment policy, compounding the impact (opportunities and risks) on rural providers. Three major payment reform frameworks and policies are summarized below.

1. HHS established a framework for moving to value-based Medicare payments that includes four models:
  - Category 1 describes payments based on service volume only, with no link to quality or efficiency performance standards.
  - Category 2 links a portion of FFS payments to the quality or efficiency of care delivered.
  - Category 3 links some payment to the effective management of a population or episode of care. In Category 3, HHS still pays for unique services, but providers participate in shared savings and/or shared risk. Examples of these models include ACOs (including Medicare Shared Savings Programs), bundled payments for episodes of care, and advanced patient-centered medical homes (PCMHs).
  - Category 4 pays clinicians and organizations not by service volume, but more globally by the number of persons effectively and efficiently served by the healthcare organization.<sup>8</sup>
2. Medicare already incorporates the Hospital Value-Based Purchasing (VBP) program for prospective payment system hospitals that are not part of alternative payment models. Under the Hospital VBP program (which qualifies as a Category 2 payment model) Medicare rewards (including not invoking penalties for readmissions) hospitals for the quality of care provided to Medicare patients, not just volume of services and procedures. Incentives are linked to how closely hospitals follow best clinical practices, and how well hospitals enhance patients’ experiences of care.<sup>9</sup>

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<sup>7</sup> Centers for Medicare & Medicaid Services. (2015, January 26). *Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume*. Fact Sheet. Retrieved from <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html>

<sup>8</sup> Ibid.

<sup>9</sup> Centers for Medicare and Medicaid Services. (Updated March 9, 2012). Hospital Value-Based Purchasing Program. Frequently Asked Questions. Retrieved from <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/HVBP-FAQs.pdf>

3. The recently passed Medicare Access and CHIP Reauthorization Act (MACRA, Pub. L. No: 114-10) revamps Medicare physician payment, and is another example of a Category 2 payment model. Within MACRA, the Merit-based Incentive Payment System (MIPS) expands and harmonizes physician quality measurement programs. Those programs include the value modifier based on quality measures that was first implemented in 2015. Payment will be partially based on physician performance measures within the MIPS framework and will be applied to all Medicare FFS physician payments. This program drives physicians in FFS payment from Category 1 to Category 2.

These major payment reform frameworks and policies will substantially alter how care is delivered for all Medicare beneficiaries and will ultimately affect system performance, though the path to a redesigned and improved healthcare delivery system may be different for urban and rural providers.

### ***Policy Conundrum***

Current Medicare rural payment policies that were designed to strengthen rural health providers and systems are complicating payment and delivery system reform in many rural areas. A series of policy actions beginning nearly 40 years ago has provided significant support to rural communities experiencing healthcare provider shortages and to rural hospitals and other healthcare providers in financial distress (e.g., Rural Health Clinics [RHCs] and Federally Qualified Health Centers [FQHCs]). The Rural Health Clinic Services Act of 1977, for example, was enacted in part to address an inadequate supply of physicians serving Medicare patients in rural areas,<sup>10</sup> and allows enhanced reimbursement rates for providing Medicare and Medicaid services.<sup>11</sup> Critical Access Hospital (CAH) designation was created in the 1997 Balanced Budget Act in response to a series of hospital closures, with the intention of both reducing the financial vulnerability of some rural hospitals through cost-based reimbursement and improving access to health care by keeping essential services in rural communities.<sup>12</sup> While addressing issues specific to rural places and ensuring a rural safety net, these policies now inhibit provider and system participation in new payment

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<sup>10</sup> Centers for Medicare and Medicaid Services. (2014, August). Rural Health Clinic. Rural Health Fact Sheet Series. Retrieved from <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/RuralHlthClinfctsht.pdf>

<sup>11</sup> Rural Assistance Center. Rural Health Clinics (RHCs). Frequently Asked Questions. Retrieved from <https://www.raonline.org/topics/rural-health-clinics>

<sup>12</sup> Rural Assistance Center. Critical Access Hospitals (CAHs). Frequently Asked Questions. Retrieved from <https://www.raonline.org/topics/critical-access-hospitals>

models. Low margin rural providers have fewer resources to both fund and sustain the transformations necessary to be successful under new payment models. Transitioning from current cost-based rural provider payment systems to new payment models with performance incentives and rewards that involve greater operational and financial risk will be daunting for many rural providers. In most cases, however, delivery system and payment reform occurs iteratively, often starting with performance reporting (with or without rewards). Payment reform follows once providers have developed the capacity and infrastructure for performance reporting and management. In the long run, the Medicare program will benefit from rural provider capacity-building, reporting, and incentive alignment that ensure continued local access to essential services for Medicare beneficiaries.

## **RURAL IMPLICATIONS OF MEDICARE PAYMENT REFORM**

As is widely acknowledged, how health care is paid for has a profound effect on how healthcare providers invest in, organize, and deliver care. The momentum for healthcare reform, advanced and accelerated by the ACA, stems in part from the recognition that payment reform is central to achieving changes in the healthcare delivery system required to improve system performance. Alternative payment models and value-based payments, if properly designed and implemented, should advance one or more of HHS's desired outcomes (better care, smarter spending, healthier people), and ideally, all three of them simultaneously.

While HHS goals articulate the positive outcomes of value-based payment arrangements—better care, smarter spending, and healthier people—the risks of these payment models for both rural and urban providers are less clear and far more uncertain. The risks to rural providers are especially high in communities where only a few providers comprise the entirety of the health system. Aligning reformed payment arrangements with existing cost-based payment policies (e.g., CAHs or RHCs) in rural places is also more complex than in urban places. Furthermore, barriers to rural participation in delivery system reform include statutory exclusions (such as minimum beneficiary assignment of 5,000 for Medicare Shared Savings Program eligibility), lack of appropriate measures that account for low volume and range of services available, limited capital and financial resources for investment and assumption of risk, and workforce shortages.

Delivering truly value-based care depends upon having clinically integrated networks (across conditions, settings, and networks of providers), financial alignment and integration among



providers, and new team-based models of care delivery, all of which require substantial investments in time, money, and human capital. Transitioning to value-based care delivery is more challenging in rural places because of scarce resources, limited numbers of providers, small population centers, and the potential exposure to financial losses from poor risk management. That said, we believe there are ways to configure and implement alternative payment models to effectively balance risks and opportunities for rural health systems to achieve the benefits and rewards inherent in new payment policies.

Developing payment reform models that recognize the special circumstances of rural providers and health systems is key both for the sustainability of rural health systems and for the Medicare program. Payment reform is driving the development of new provider relationships critical to successful care coordination; ensuring that rural providers maintain local market share will require new and/or expanded provider relationships. Developing new provider relationships and delivery system models could also help rural providers access resources needed to build care management, telehealth, and other capacities to participate in new payment arrangements.

In 2013, the RUPRI Health Panel advanced an idea and framework for building “high performance” rural health systems.<sup>13</sup> A subsequent paper outlined steps and strategies to help rural health systems transition to high performance systems.<sup>14</sup> To further the Panel’s intent to inform the development of high performing rural health systems, this paper identifies and assesses the opportunities for implementing Medicare payment reform in rural health systems including how implementation of payment reform creates opportunities for improving rural healthcare delivery systems. Our goal is to offer ideas and strategies for ensuring that rural providers and communities who can legitimately be a part of value-based payment arrangements are included. Value-based payment may not be feasible in frontier rural health systems, consequently these important exceptions are not addressed in this paper.

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<sup>13</sup> Mueller, K. J., Coburn, A. F., Lundblad, J. P., MacKinney, A. C., McBride, T. D., Watson, S. D. (2011). *The High Performance Rural Health Care System of the Future*. Retrieved from Rural Policy Research Institute website: <http://www.rupri.org/wp-content/uploads/2014/09/The-High-Performance-Rural-Health-Care-System-of-the-Future.pdf>

<sup>14</sup> Alfero, C., Coburn, A. F., Lundblad, J. P., MacKinney, A. C., McBride, T. D., Mueller, K. J., Weigel, P. (2014). Retrieved from Rural Policy Research Institute website: <http://www.rupri.org/wp-content/uploads/2014/11/Advancing-the-Transition-Health-Panel-Paper.pdf>

## GOALS

Effective implementation of Medicare payment reform in the rural context requires a clear understanding of the core features and capacities of a high performance rural health system. Medicare payment and delivery system reform initiatives, as well as those introduced by private payers and Medicaid programs, should articulate both a desired healthcare system construct and the desired healthcare system outcomes (i.e., better care, healthier people, and smarter spending).

High performing health systems identify and manage patients based on their individual conditions and needs. Patient support systems, care coordination, and chronic disease management—often conducted by nonclinical staff members and partners—follow patients into the community and home and consider community conditions that affect health. Supporting people experiencing chronic disease should be a well-articulated component of a redesigned delivery system.

Adequately financing and designing essential services at the primary care level is critical, and includes medical, dental, behavioral health, and care coordination. Care coordination should be integrated horizontally (in an integrated primary care system) and vertically (with other systems) as a key component of a well-functioning health system.<sup>15</sup> Early detection and follow up in behavioral health, for instance, is a critical part of healthcare management at the lower end of the cost curve and requires particular attention in both design and payment reform.

Ultimately, there must be a focus on population health. The upstream causes of poor health greatly impact downstream healthcare costs in terms of public and private investments and the cost to families and individuals. Yet new rewards or incentives for providing preventive and social support services are still greatly undervalued compared to services for invasive procedures and testing. Creating appreciable incentives for preventive and social services coordination provides a significant opportunity to assist with cost management over time.

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<sup>15</sup> Alfero, C., Coburn, A. F., Lundblad, J. P., MacKinney, A. C., McBride, T. D., Mueller, K. J., & Weigel, P. (2014). *Advancing the Transition to a High Performance Rural Health System*. Retrieved from Rural Policy Research Institute website: <http://www.rupri.org/wp-content/uploads/2014/11/Advancing-the-Transition-Health-Panel-Paper.pdf>

## RURAL DELIVERY SYSTEM REFORM POLICY RECOMMENDATIONS

The payment transition from volume to value is already producing delivery system changes as evidenced by rapid adoption of PCMH and accountable care models. The implications for rural provider participation in those changes, or avoidance of those changes, are profound. Our recommendations are summarized below.

### 1. Organize rural health systems to create integrated care.

Expansion of Medicare alternative payment models to rural providers will require 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 strengthening 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 [TCPI] 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. Payment for participation in shared savings plans and programs similar to the Comprehensive Primary Care Initiative that integrates a defined payment model with a specific primary care practice redesign model will favor development of comprehensive primary care practices such as PCMHs over the long run.
- ***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. As primary care providers increasingly assume accountability for care delivered locally and at a distance, they should develop referral networks of hospitals, specialists, and procedures that are based on evidence of value rather than traditional referral patterns or local loyalties.
- ***Expand rural involvement in ACOs.***  
Rural providers must be proactive in identifying and pursuing ACO participation and work to align their primary care and other services with ACO expectations. 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.***

Inpatient care is a critical component of the financial sustainability of rural hospitals and health systems. With continuing pressure to reduce costly inpatient volume, rural providers dependent on inpatient care for financial success will need an organizational, service, and financial bridge to “right size” and realign their service mix. Alternative care models, such as the Rural Emergency Acute Care Hospital Act (S. 1648) proposed by Iowa Senator Grassley and Title IV of the Save Rural Hospitals Act (H.R. 3225) proposed by Representatives Graves of Missouri and Loeb sack of Iowa, are designed to help rural hospitals evolve to new service and financial models while ensuring local access to essential healthcare services.

- ***Support primary, acute care integration with long-term supports and services and end-of-life care.***

Rural providers need demonstration programs and technical assistance to develop care integration models that encompass the full continuum of care, including skilled nursing, nursing facility, home health, and home- and community-based health and social support services. Likewise, models for expanding and integrating end-of-life services such as hospice are needed to achieve the goals of payment and delivery system reform.

- ***Support new healthcare provider and nonclinical entity partnership development.***

Rural providers should have access to community collaboration processes and models, including programs that train leaders to initiate and maintain collaborations with outside entities and to expand partnership development with nonmedical providers (e.g., behavioral health, public health, care coordination, human services). Because they have a community focus, rural providers are in an advantageous position to develop community partnerships with organizations such as social services and public health; however, the process for doing so may not be widely known. New partnerships will be needed to provide the comprehensive care required for population health improvement.

- ***Support new governance models that align with new partnerships and the continuum of care.***

Traditional and separate local governance models, such as separate hospital and public health boards, are not conducive to the new partnerships required under alternative

payment models in rural places. Changing governance structures can be challenging. 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.

## **2. Build rural system capacity to support integrated care.**

Rural healthcare providers and systems face challenges of historically low patient volumes and low Medicare/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 these challenges.

- ***Provide low-cost capital to rural providers demonstrating need.***

Public programs providing capital assistance (including the USDA rural development programs) should target rural providers who demonstrate a need for capital to achieve the transition to value-based payment and require an implementation/evaluation plan to measure results. For example, the HHS Office of the National Coordinator for Health Information Technology is partnering with the U.S. Department of Agriculture in a rural health financing initiative. The human and capital resources required to transition from volume-based to value-based healthcare delivery are considerable, and through grants, low-cost loans, and capacity building, both philanthropic and government agencies could assist rural providers during the transition.

- ***Provide technical assistance for transitions to value-based care.***

Federal grant programs (including portfolios of the Health Resources and Services Administration and CMMI) 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. Value-based care and management strategies (including population health management and financial risk management) will require new healthcare provider skills and infrastructure. The transition will likely favor well-capitalized healthcare systems and/or healthcare systems with value-based care experience. Many rural providers have neither large capital reserves nor value-based care experience.

- ***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. New expectations of lower cost and comprehensive population health management will require new healthcare professional types such as health coaches, care coordinators, and community paramedics. Although developing the relationships to effectively utilize new healthcare professional types may be straightforward in rural areas, the additional cost (even if low) to already financially stressed rural providers may be challenging. Payments should be aligned with the cost-savings goals, thereby creating incentives for a different cost structure. 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. Consideration could be given to building a primary care-based system that improves care coordination during changes to existing graduate medical education policies.

- ***Develop team-based 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, and in the programs offered through Teaching Health Centers and Area Health Education Centers) that provide training and practice in interdisciplinary settings based in primary care. Despite the increased need for primary care providers, primary care providers alone cannot significantly improve population health. New strategies that add team-based care (including care coordinators, care navigators, health coaches, social workers) to the traditional office visit will be needed. Programs that develop teamwork, such as TeamSTEPPS,<sup>16</sup> should be made widely available.

- ***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. Managing the health of a population (or a "panel" of patients) requires managing and integrating multiple data sets to support population health improvement, including but not limited to clinical records and administrative data such as claims. The information technology platforms required to support population health efforts could be developed de novo or could be incorporated into

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<sup>16</sup> Agency for Healthcare Research and Quality. TeamSTEPPS®: Strategies and Tools to Enhance Performance and Patient Safety. Retrieved from <http://www.ahrq.gov/professionals/clinicians-providers/index.html>

existing health records, and in either case, must also be accompanied by the necessary staff skilled in information technology and data analytics.

### **3. 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. The accounting required to assess and manage financial risk in a mixed payment model (e.g., FFS, shared savings, bundled payments, or partial capitation in any combination) is complex. New financial modeling tools will be required that may be beyond the capabilities of rural providers.

- ***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. Payment for healthcare value requires measurement of the various components of healthcare value—simplified within the framework of better care, smarter spending, and healthier community resource use. Thus, valid and reliable healthcare value measures will further develop and evolve. Those measures should be pertinent to the care delivered by rural providers and recognize the statistical reliability challenge of low volume rural situations. The National Quality Forum has made significant progress toward identifying the issues and measures important to rural providers.<sup>17</sup> Sustained effort is required to develop measures appropriate to rural settings.

- ***Assist rural providers in implementing 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. To receive value-based payment, healthcare providers must

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<sup>17</sup> National Quality Forum Rural Health Committee. (2015). *Performance Measurement for Rural Low-Volume Providers*. Final Report. Washington, DC: National Quality Forum.

demonstrate the delivery of value-based care. This may be more challenging for rural providers with less experience collecting, measuring, and reporting performance data.

- ***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. Population health management and financial risk management are relatively new strategies, especially for rural providers currently focused on volume-based payment and volume-based care.

#### **4. Align Medicare payment and performance assessment policies with Medicaid and commercial payers.**

Aligning payment policies and incentives across public and private payers will be critical to achieving the Medicare program's payment reform goals. Following the emerging all-payer models of Maryland, Vermont, and other states, Medicare policies should work in tandem with those of 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. Medicare is positioned to take a lead role in linking payment to healthcare value, and as such, 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 PCMHs, 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.***

#### **5. Develop rural-appropriate payment systems.**

A rural "glide path" from volume-based to value-based payment is needed. The following payment strategies will expedite the transition to new payment systems without jeopardizing rural access to essential healthcare services.



- ***Create incentives for rural providers to report rural-appropriate performance measures.***

Incentives should be incorporated 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 who are essential for access, the program should initially not include down-side risk.

- ***Support hybrid payment systems during transition to value-based payment systems.***

The Centers for Medicare & Medicaid Services (CMS) should support the transition from current cost-based reimbursement systems (e.g., for CAHs and RHCs) that were initiated to secure essential services in low-population areas by including payment for fixed costs (including personnel to care for patients in emergency rooms, and operating facilities) in value-based payment systems through temporary hybrid payment systems that continue to cover fixed costs, but with incentives to achieve better health and healthier communities. The new hybrid payment would facilitate reducing volumes of unnecessary services and increase use of the least costly alternatives without threatening access to essential services. Maintaining stable payments during a transition will allow providers time to alter their cost structures to support value-based outcomes.

- ***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. These activities include:

- Promoting health equity and continuity
- Social and community involvement
- Achieving health equity
- Emergency preparedness and response
- Integration of primary care and behavioral health

- ***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 healthcare organizations could be increased when those organizations commit the savings to strengthening local infrastructure, with emphasis on retaining primary care through payment incentives.

## **SUMMARY**

A series of policy actions beginning nearly 40 years ago has provided support to rural communities experiencing healthcare provider shortages and rural healthcare providers burdened by infrastructure inadequacies to ensure access to essential healthcare services. While addressing issues important to rural economies, and bolstering a rural safety net, these policies now inhibit participation in new healthcare payment models. HHS's goals to shift 50 percent of FFS payment to alternative payment systems (including PCMHs, ACOs, bundled payments, and integrated care demonstrations for dual-eligible beneficiaries), and 90 percent to 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. To rural providers, the barriers to delivery system reform may seem formidable, yet rural provider inclusion in payment and delivery system changes is crucial if health equity is to be achieved. Furthermore, Medicare is not the only payer adopting payment reform strategies. Since at least some rural providers, including CAHs and FQHCs, have demonstrated an ability to adapt to new payment policies, 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.