

TOWARD A HIGH PERFORMING RURAL HEALTH CARE SYSTEM: KEY ISSUES AND RECOMMENDATIONS FROM RURAL HEALTH CARE SYSTEM INNOVATORS

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PURPOSE

On December 6-7, 2018, the Rural Health Policy Research Institute's (RUPRI) Health Panel convened a meeting in Washington, DC, of rural health leaders from around the country to discuss strategies and models for rural health care system innovation. In addition to the Health Panel, meeting participants included state and community leaders with firsthand knowledge of diverse, innovative health financing and service delivery initiatives as well as national rural health experts and stakeholders. The Health Panel identified the participating rural health care system innovators based on their groundbreaking approaches to health care financing and service delivery.

The meeting objectives were as follows:

- To understand the policy and practice levers at a local, state, and national level that support or hinder local innovation as implemented in the models represented in this discussion
- To recognize the uniqueness of each model while understanding the components that make it applicable and scalable to other rural communities
- To specify attributes, design considerations, and program and community characteristics that are relevant across the models

This paper summarizes the key themes and recommendations that emerged directly from the structured conversations during this two-day meeting. The Health Panel hopes this summary can inform ongoing national and state policy discussions of strategies for strengthening and sustaining rural health care systems.

INTRODUCTION

Rural health care systems are under considerable financial stress due to changing economic and health market conditions and other factors. As of March 1, 2019, 97 rural hospitals had closed since 2010.¹ The increasing rate of rural hospital bankruptcies and closures is a symptom of a growing problem, but it does not tell the whole story. Rural nursing homes, emergency medical systems, and other critical providers also face financial, staffing, and other challenges that threaten an already fragile health system in many rural communities. Notwithstanding these challenges, some rural health clinicians and systems are successfully adapting by changing what they do and how they do it. What does their experience tell us about successful rural health care system transformation models and the necessary ingredients for achieving sustainable changes in rural health care delivery?

On the first day, we asked the rural innovators to discuss their strategy or program, identifying the key innovations in their approach. We also asked them to identify factors that have facilitated or hindered the design, implementation, or operation of their initiative(s). On the second day, we solicited and discussed recommendations for both incremental and broad-based policy changes and strategies that might facilitate wider adoption or sustainability of the innovative models that were presented on the first day.

While the diversity of innovative strategies, programs, and models defies an easy summary of "lessons learned," the innovators agreed that "incentives and relationships matter." From that common perspective, the Panel extracted three themes common to many of the innovations:

- Innovative rural models employ flexible financing strategies that incentivize greater collaboration and care coordination across different service systems;
- Initiation and implementation of innovation is effectively supported by infrastructure, including locally based structures, collaborative leadership models, adequate workforce, and data capacity; and
- Innovations have governance and accountability frameworks that support sustained engagement of participating organizations and stakeholders, facilitate transparency, and enable participants to track progress.

In the remainder of this paper, we summarize innovators' observations related to each of these themes, with examples drawn from the innovative rural initiatives profiled in the meeting. In addition, we offer policy recommendations suggested by the meeting participants.

FINANCING RURAL HEALTH CARE SYSTEM INNOVATION

Innovative rural models employ flexible financing strategies that incentivize greater collaboration and care coordination across different service systems.

Innovation strategies and models featured in this meeting demonstrated the critical importance of financing as a driver of sustainable innovation. Current health system financing strategies, including cost-based payment and categorical funding approaches, silo services and fragment care, making a transition to value-based service models more difficult. Innovators reported that these funding approaches make collaborative partnerships among health and social service agencies at the community level more challenging. Current financing strategies also value treatment over prevention and impose regulatory rules, such as the three-day hospital stay requirement for skilled nursing care, that inhibit whole person care. While innovative financing strategies vary considerably, there was broad agreement on their importance to successful innovation.

Flexible financing models allow health, social service, and other organizations and providers to design and deliver services that are more responsive to the health and wellbeing needs of rural residents.

Flexible financing strategies, such as capitation and other types of more global payment, allow health care providers to design and deliver services based on a calculus of how to use personnel and organize services to achieve the best outcomes for patients. Managed care organizations, including those participating in Medicare Advantage and Medicaid programs in many states, have utilized capitation payment arrangements for this purpose for many years. Although smaller populations and lower patient volumes can present challenges in designing these strategies (e.g., statistical variation in patient risk in small populations makes it hard to achieve accurate payment rates), the innovators gave examples of counties and aggregations of counties effectively using capitated payments to achieve local priorities for health system transformation. For example,

- **PrimeWest Health** is a health plan owned by 13 counties in western Minnesota. PrimeWest provides innovative health plan options for residents in the service area counties who are eligible to enroll in Minnesota's Families and Children, MinnesotaCare, Minnesota Senior Health Options, Minnesota Senior Care Plus, or Special Needs BasicCare programs. PrimeWest is organizationally integrated with county public health and social services agencies—agencies that play key roles in addressing members' social determinants of health, behavioral health, and community health needs—within the medical model. For

providers, PrimeWest offers a shared savings model that includes prospective patient attribution, which they view as “training wheels” to capitation.

- **Moda Health**, an Oregon-based health plan, created an LLC organization to launch the eastern Oregon Coordinated Care Organization (CCO), which operates within the framework of Oregon’s Medicaid waiver program. With six equity partners, including 10 hospitals, seven of which are Critical Access Hospitals, covering five health districts, the CCO operates as a health plan/provider partnership with a value-based, shared savings financing model. With savings, the CCO has been able to invest in primary care and care management capacity and infrastructure improvements. According to the innovators, these investments are the result of the CCO recapturing local health spending and achieving savings.
- The **Pennsylvania Department of Health** and the Center for Medicare & Medicaid Innovation launched the Pennsylvania Rural Health Model in 2017 as a comprehensive, statewide pilot project to improve access to care delivery and population health outcomes. Under the voluntary pilot project, which ends in December 2023, as many as 30 rural Critical Access and acute care hospitals across the state that opt-in are paid a fixed all-payer global budget that is set in advance for inpatient and outpatient services. This multi-payer, global budget model is designed to give rural hospitals greater flexibility to innovate with services that address the health of Pennsylvania’s rural communities, rather than restricting payment to individual services or cases.

Innovators noted the importance of flexibility in financing models to facilitate investment in management capacity, which in turn affects the success of new models. Initial investment in demonstration projects could also meet this need.

Innovative financing models support investments in the care management infrastructure.

In addition to the Eastern Oregon CCO example above,

- Since 2010, Vermont’s **Blueprint for Health** has led efforts to facilitate and support the state’s primary care providers to transition to the patient-centered primary care model. Because Vermont is a participating state in the Centers for Medicare & Medicaid Services’ Multi-Payer Advanced Primary Care Practice Demonstration, Medicare, Medicaid, and private insurers provided financial support to help practices transition to the advanced primary care practice model. The state has since developed a statewide Accountable Care Organization (ACO) model that, with an §1115 waiver, is transitioning to an all-payer global payment model.

In addition to these examples, the Panel heard that innovative financing models also enable service system collaboration. These models allow using initial investment dollars and ongoing investment to support services other than direct patient care.

Innovative financing models incentivize collaboration across service systems with the aim of whole person care.

- In northeastern Vermont, the CEO of the **Northern Vermont Medical Center** collaborated with local leaders to form Northeast Kingdom Prosper (NEKprosper.org) to tackle the core problem of poverty in the region. Using the state’s Accountable Health Communities model, NEKprosper is working with Vermont’s ACO and the Medicaid program to create a new source of financing for local innovation (including a local trust fund). In 2016, Northern Vermont Medical Center partnered with other local service providers to win a Vermont

Health Care Innovation Project subgrant to create flexible funding for integrated care. A substantial number of essential services and types of equipment are not covered by Medicare or Medicaid, posing problems for lower-income patients in Northeastern Vermont. The subgrant provides money to patients who can't afford items or services that would improve their health.

The Panel also heard from participants that innovative financing allows for different means of meeting patient needs after breaking the link between payment and predetermined clinical services.

Innovative financing models allow effective use of personnel, including greater use of peer support models, community health workers (CHWs), and interprofessional team-based care.

- Starting in 2012, the **Southeast Health Group** (SHG) in Colorado implemented the TIPPING Point project (Total Integration, Patient Navigation, and Provider Training project). With funding from the Center for Medicare & Medicaid Innovation, the project is using health navigators to increase access, improve quality, and reduce the cost of health care delivery for the highest Medicaid and Medicare users. SHG partnered with a local community college, Otero Junior College, to implement a CHW certificate program to support training for health navigators and to provide the potential for adoption of a statewide CHW curriculum through the 13 colleges in the Colorado Community College System. Over time the project has negotiated with the Medicaid program for reimbursement at \$53 for up to a 15-minute contact between a CHW and a Medicaid client. This support has helped sustain CHW positions and has enabled the program to continue to grow.

Lastly, rural innovators described private sector funding that helps smaller, rural providers transition to value-based payment models.

Private sector funding can help mitigate the investment burden and risk necessary for smaller, rural providers and health systems to participate in an ACO and other value-based payment models.

- Founded in 2014, **Aledade** partners with primary care physicians and small primary care practices to build and lead ACOs. Aledade operates ACOs across 18 states and in partnership with more than 330,000 patients in more than 300 practices. Using private equity capital, Aledade helps small rural practices absorb risk (both short- and long-term); Aledade, rather than the provider practice, is the financial backstop for risk. This support allows smaller practices that might not otherwise participate in value-based payment models to join a one-sided risk ACO model and transition to a two-sided risk ACO.

Recommendations for Regulatory Changes to Support Rural Innovation

- Waive coinsurance requirements for chronic care management services.
- Develop CPT code, determine RVU value, and provide payment for palliative care.
- Develop CPT code, determine RVU value, and provide payment for CHW services.
- Allow concurrent care for office visits, chronic care management, and Medicare Annual Wellness exams.
- Allow concurrent hospice and curative care.
- Allow Critical Access Hospitals to include community health investments as allowable costs for cost-based reimbursement.
- Update home health “homebound” requirements to reflect travel hardship.

Recommendations for Payment Redesign to Support Rural Innovation

- Structure primary care payment to cover the cost of team-based coordinated and comprehensive care.
- Create new, rural-appropriate, facility designations (and payment systems).
- Expand demonstrations of total-cost-of-care payment methods that incorporate both medical care payments and human service payments.
- Create a rural hospital fixed asset buy-back program to allow facility repurposing and right-sizing.
- Implement a public utility payment model (or “standing grant”) for essential, low-volume, rural community services.
- Expand global budget models to additional areas and health care organizations.
- Align payment systems across payers, under current methodologies.
- Mandate that all payers participate in new state-supported payment systems.
- Risk-adjust payments for social determinants of health.

CREATING INFRASTRUCTURE TO SUPPORT RURAL HEALTH CARE SYSTEM INNOVATION

Initiation and implementation of innovation is effectively supported by infrastructure, including locally-based structures, collaborative leadership models, and workforce and data capacity.

The rural innovators reported that infrastructure matters, specifically the infrastructure components of locally based structures, collaborative leadership models, and workforce and data capacity.

Innovators noted that locally based models have enabled them to leverage new or existing structures to advance their goals and programs. Structures may be formal (such as county-based purchasing and ACO structures) or informal (such as medical legal partnerships and long-term/post-acute care linkages). The “local” nature means that the structures reflect unique community needs or opportunities and are likely to be cross-sector, not only health care.

Locally based structures foster cross-sector collaboration and buy-in, and innovations can stem from required activities, such as community health needs assessments, when done in meaningful ways. Many of the rural innovators frame rural health innovation as an economic development issue, not only in terms of hospital jobs but more broadly the economic health of the community.

- **First Health Care of the Carolinas** developed transition care clinics as a place to provide care upon discharge from the hospital for patients who could not get an appointment with a primary care provider within 72 hours. The transition clinics offer proactive, intensive support for 30 days after hospital discharge, a time when patients are most vulnerable.
- **PrimeWest** created a county-based purchasing program in Minnesota, bringing payers, providers, and consumers together in a new structure governed by commissioners from the 13 participating counties, and serving as the managed care plan for Medicaid and Medicare, integrating public health and county social services.

While excellent leadership has long been recognized as a hallmark of well-run organizations and as supporting innovation, the rural innovators emphasized the importance of *collaborative* leadership,

and the associated resource commitment, to transforming care and payment, especially when regional planning and finance reforms are not yet present.

Collaborative leadership is best realized and sustained when governance structures enable partners to work effectively together. Collaborative leadership also fosters opportunities and decisions to reinvest any savings or cost reductions in the community.

- **Northeast Vermont Regional Hospital** launched Northeast Kingdom Prosper, bringing together decision makers and leaders from seven other organizations representing housing, aging, and behavioral health to tackle poverty.
- The leaders at **Lakewood Health System** in Minnesota committed to offer palliative care services, and established a new multidisciplinary team with the patient in the center. With a collaborative leadership approach, they moved palliative care from the ICU to the community, engaging home care and long-term care in service delivery.

Rural innovators shared how they deliberately and creatively expanded their capacity to meet changing and emerging health needs in their communities, emphasizing workforce and data. In terms of people capacity, they have expanded services and support through new training, new roles, and new approaches (such as peer support, patient navigators, and care coordination). A valuable lesson is that low-tech but high-touch innovations can be highly effective.

Innovations in rural care delivery and payment require robust health information exchange, the capacity for data analytics, and data integration or aggregation across multiple sites and electronic health records. Rural innovators develop mechanisms that enable shared data analytic capacity across rural health care organizations that have the need but neither the capacity nor expertise to do it on their own. Rural innovators find and take advantage of technical assistance and support from outside entities.

- **Southeast Health Group** in Colorado integrates mental health with primary care, and developed a peer specialist role and a training certification program to advance their efforts. The peer specialists, often Medicaid beneficiaries who have had the lived experience of substance abuse and recovery, are deployed to work with the homeless population in the community.
- **Aledade**, an ACO aggregator, brings together small rural practices in enough volume to become an ACO. They offer intensive data analytics and health information exchange support, empowering practices to understand their patient population and make data-informed decisions about the care they deliver. Their participating practices typically start as a Medicare ACO but move to other payers, and often begin by taking on one-sided risk but are eventually able to take on two-sided risk.

Recommendations for Regulatory Changes to Support Rural Innovation

- Develop rural-relevant quality measures and demonstration participation requirements.
- Harmonize quality measures and programs across payers.
- Amend regulations that impede collaborations, e.g., self-referral laws, anti-inurement laws, and FQHC ownership requirements.
- Facilitate data access and analysis designed to improve health care quality and efficiency (i.e., eliminate data blocking).

Recommendations for Public Investment to Support Rural Innovation

- Expand broadband capacity (greater than 25 MBPS speed) to rural residences and health care organizations.
- Provide data analytic capacity to under resourced rural health care organizations to improve health care quality and efficiency.
- Incorporate long-term services and supports, and home and community-based services, in rural health care planning.
- Fund programs to educate community-based boards of trustees/directors about value-based care and payment.
- Fund technical assistance to hospitals and public health agencies for developing and implementing community health needs assessments.
- Fund innovative health professions programs in health professions training, including interdisciplinary training and community-based care approaches, hospice, palliative care, and advance care planning.

PROMOTING GOVERNANCE MODELS THAT SUPPORT INNOVATION

Innovations have governance and accountability frameworks that support sustained engagement of participating organizations and stakeholders, facilitate transparency, and enable participants to track progress.

To make change and sustain transformation, rural innovators emphasize the need for a “big picture” framework, which often entails new approaches to governance and accountability. Multiorganization, and ideally multisector, strategy, development and decision-making support of innovation is needed, especially in the current environment in which financial incentives are less available to rural organizations. Establishing transformation approaches that align with local needs is an important aspect of organizational planning. Instead of “chasing the dollars,” planners should choose an approach or approaches that meet needs identified in community health needs assessments or other locally derived data, recognize regional differences and cultural diversity, and leverage the workforce and expertise available across the health care continuum and with community-based organizations.

A rural community or health care organization that seeks to innovate also needs to establish goals, understand specific targets for care delivery improvement or payment change, and monitor progress toward goals and targets. Governance and accountability models should include a shared commitment to timely and transparent progress metrics that will enable local leaders and stakeholders to understand whether progress is being made toward the health outcomes and/or the cost savings desired.

Some of the rural innovators considered building a solid business case for innovation to be an essential step in rural health transformation; others spoke of the importance of policy leaders participating in state executive and legislative branches and of developing opportunities and abilities to engage in policy advocacy to drive and sustain innovation.

- **Moda Health** in Oregon, as a Medicaid managed care organization and a Coordinated Care Organization, integrates benefits and services, including medical, dental, and behavioral health. Their structure provides local control and accountability, underpinned by joint health plan and provider organization ownership. They monitor 17 quality metrics and maintain a per capita growth rate not to exceed 3.4%.

- The **Vermont Blueprint for Health** grew out of a shared policy goal between the legislative and executive branches to focus on strengthening primary care in the state. They began with a patient-centered medical home model, supplemented it by sharing in the cost of local community health teams, and have moved to an all payer approach to Medicaid. While participation in their model is compulsory for payers, it is voluntary for providers, yet almost all primary care practices are participating. They track their progress locally and at the state level on three core measures: access to primary care, deaths due to suicide and opioid use disorder, and chronic disease prevalence.

In the governance realm, rural innovators also offered a cautionary note about the increase of mergers and acquisitions among rural health care organizations (e.g., hospitals, clinics, long-term care facilities). While affiliation with a larger regional or urban-based health system can bring more resources and stability, doing so may risk diminishing local governance and decision-making control at the local level, which can impede efforts to drive innovation specific to the local community.

Recommendations for Public Investment to Support Rural Innovation

- Combine health and human services funding demonstrations so that planning and payment have a community focus, not a beneficiary or enrollee focus.
- Create a structure and rationale for balancing rural health investments (e.g., a “base closing commission” for rural health).
- Facilitate and approve community/regional-based insurance plans and governance.
- Fund exploratory regional gatherings to discuss the organization and delivery of rural health services.
- Allow county-based or region-based health care management, purchasing, and payment models.
- Monitor health care organization mergers and acquisitions to assess changing governance, such as strategic control, resource allocation, and disinvestment.

CONCLUSION

Despite the seemingly dire circumstances in rural health care delivery and payment, including hospital closures and workforce and access challenges, rural innovation is occurring throughout the country. The RUPRI Health Panel convened rural innovators in December 2018 to learn from their experiences and to gather policy ideas and recommendations.

The financing, infrastructure, and governance themes that emerged reflect the essential ingredients necessary to support and sustain rural health care delivery and payment innovation. The themes and examples lead to specific policy recommendations, as shared by the rural innovators, that facilitate and/or overcome current barriers to innovation in rural health.

The Health Panel hopes this summary can inform ongoing national and state policy discussions of strategies for strengthening and sustaining rural health care systems and the innovations in care delivery and payment that can help advance a high performing rural health care system.

REFERENCES

ⁱ North Carolina Rural Health Research Program (2019). "97 Rural Hospital Closures: January 2010 - Present." North Carolina Rural Health Research Program. Retrieved February 28, 2019, from <http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>.