



How to Design Value-Based Care Models for Rural Participant Success: A Summit Findings Report

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Executive Summary

In late July 2020, the Rural Health Value team convened a two-afternoon virtual summit of rural participants in value-based care (VBC) models and programs to identify elements of VBC payment models important to rural participants. Due to the national reach and broad scale of the Centers for Medicare & Medicaid Services (CMS) and the Center for Medicare & Medicaid Innovation (CMMI), summit participants participated in a variety of CMS programs or CMMI models. A number of ideas, challenges, and opportunities emerged in the facilitated discussion, reflecting the experiences of the participants in VBC models to date. The resulting analysis and synthesis by the Rural Health Value Team identified six VBC model design, implementation, and operation themes that can facilitate or hinder rural health care organization participation and success in VBC models:

- Rural-Oriented Design
- Model and Program Alignment
- Upfront Infrastructure Investment
- Rural Relevant Planning and Care Delivery
- Flexibility and Timing
- Information Technology and Data

The Rural Health Value team categorized specific recommendations from summit participants pertinent to each theme that would support successful rural application and participation in VBC models. The summit recommendations should be used by VBC model designers and supporters to improve the viability, relevance, and likelihood of achieving rural health care organization participation and success in VBC models.

Summit Overview

For the past decade, the transition from volume-based health care and payment to value-based health care and payment has been widely tested through a range of demonstration programs. Health care value implies the concurrent priorities of better patient care, improved population health, and smarter spending. Seeking to lower cost, value-based payment systems tend to shift financial risk from payers to health care organizations through, for example, shared savings programs and global budget demonstrations. Rural health care organization participation in value-based payment arrangements has been limited by:

- structural and eligibility barriers (e.g., restrictions on participation based on facility type),
- a predominantly fee-for-service payment system that makes it difficult to shift only part of care delivery and payment to be part of models,
- low patient volumes that often do not generate adequate numerators and denominators for evaluation purposes, and
- inadequate financial stability and reserves required for risk assumption.

To help inform value-based model and program development and implementation, a national summit of rural value-based experts identified elements of value-based care (VBC) payment models that support or hinder rural engagement and success. Sixteen summit discussants from across the country, participating in 10 CMMI value-based payment models and 4 CMS programs, engaged in two 3-hour sessions of facilitated virtual discussion focused on elements of VBC payment models that support or hinder rural engagement and success, and recommended potential steps to improve rural VBC model design. Improving rural VBC models facilitates broader participation in care delivery and payment innovations, thereby enabling rural residents to benefit from comprehensive and patient-centered care, and stabilizing and sustaining the rural health care delivery system. The results and recommendations from the discussion are synthesized in this report. The summit was convened and facilitated by Rural Health Value, a national initiative funded by a cooperative agreement from the Federal Office of Rural Health Policy (FORHP) with the RUPRI Center for Rural Health Policy Analysis and Stratis Health.

Models and Programs Represented by Summit Participants

- Frontier Community Health Integration Project (FCHIP)
- Frontier Extended Stay Clinic (FESC)
- Quality Payment Program (QPP)
- Comprehensive Primary Care Plus (CPC+)
- Home Health Value-Based Purchasing (HH VBP)
- Skilled Nursing Facility Value-Based Purchasing (SNF VBP)
- Pennsylvania Rural Health Model (PA RHM)
- Maryland Total Cost of Care (TCOC)
- Vermont All-Payer ACO
- Accountable Health Communities (AHC)
- Next Generation ACO (NGACO)
- Medicare Shared Savings Program (SSP)
 - Advance Payment Model (APM)
 - ACO Investment Model (AIM)

Summit Purpose

The goal of the Rural VBC Model Design Summit is to make broad recommendations, based on summit participant input, to inform model design by providing insight into model features or elements that tend to make models effective and successful in rural areas, or conversely, tend to make rural health care organization participation and success challenging. More specifically, summit findings are designed to be practical and actionable by those who design, implement, and support value-based innovations in rural. . The summit themes and recommendations presented below are not intended as a critique of any individual model. Rather, the summit purpose was to capture information from a structured dialogue regarding rural participation in a range of models and programs as an opportunity to learn from rural experiences and identify themes and recommendations of use to policymakers and program staff going forward. As such, this report and recommendations are intended to be informative and actionable for a number of audiences.

Audiences for these summit proceedings include organizations that design and implement VBC programs, such as CMMI, Medicaid and commercial payers, and those who advise or support VBC model designers, including stakeholder organizations and advisory commissions. CMMI has sponsored multiple VBC and payment demonstrations, models, and programs over the past decade. Many Medicaid and commercial payers structure VBC contracts that align or build on CMMI models and programs. CMMI tests “various payment and service delivery models that aim to achieve better care for patients, better health for our communities, and lower costs through improvement for our health care system.”¹ A CMMI model may be considered for extension or expansion through rule-making (authorized by the Patient Protection and Affordable Care Act to do so without statutory change) if the model achieves improved quality and cost neutrality, reduced cost and quality neutrality, or improved quality and reduced cost.²

Participant Input Themes

The Rural Health Value team synthesized the summit discussion into six themes. In this section, each theme is described, and summit participant recommendations are bulleted.

1. Rural-Oriented Design

Rural health care organizations and communities are different from their urban counterparts. Patient volumes are lower; human and financial resources may be limited; and rural populations tend to be older, sicker, and poorer.³ If not specifically considered during VBC

¹ Centers for Medicare & Medicaid Services. The Innovation Center. Accessed November 2, 2020.

<https://innovation.cms.gov/>

² Centers for Medicare & Medicaid Services. The Innovation Center. Accessed November 2, 2020. <https://innovation.cms.gov/media/document/chart-model-overview-webinar-slides>

³ American Hospital Association (2019) Rural Report: Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to High-quality Affordable Care. Accessed November 25, 2020.

<https://www.aha.org/system/files/2019-02/rural-report-2019.pdf>

model design and implementation, these rural characteristics may deter rural health care organization participation in VBC models and limit likelihood of success. For example, sizable beneficiary enrollments necessary for model analysis may be unavailable to many rural providers. Summit participant recommendations include the following:

- Engage rural health experts and act based on their input early in the development process to inform model design and support model implementation.
- Streamline model application process to reduce time and resource burden.
- Recognize the unique challenges of low volumes in performance expectations.
- Employ meaningful and appropriate comparisons for data benchmarking.
- Use recommendations from the National Quality Forum MAP Rural Health Workgroup during model design and performance expectation determination.⁴
- Recognize the relative differences between costs directly attributable to patient care (variable costs), costs of infrastructures required to support patient care regardless of patient volume (fixed costs), and costs necessary for readiness to deliver care anytime (standby costs).
- Recognize that while potentially avoidable utilization reductions will reduce payer expenditures, such cost-reduction strategies will only reduce hospital variable costs (at least in the short-term). Variable costs represent a small percentage of rural hospital costs.
- Consider models that engage the continuum of care and the rural community (e.g., long-term services and supports, public health, and community-based organizations).

2. Model and Program Alignment

Multiple models, programs, and systems are operating concurrently in many communities, such as hospital global budgets, accountable care organizations, and the physician fee schedule. At times, requirements, goals, and/or incentives conflict, making success in multiple systems difficult, especially for under-resourced rural health care organizations. For example, Rural Health Clinic and Critical Access Hospital cost-based reimbursement makes it difficult for those organizations to participate in VBC models built on a global budget or a fee-for-service payment system without a “hold harmless” caveat. As one summit participant said, “Don’t let federal programs get in the way of federal programs.” Summit participant recommendations include the following:

- Align model implementation and performance expectations across multiple payment systems.
- Align all payers within the same model redesign, such that rural VBC model participants need not manage different and sometimes misaligned care and payment systems with limited capacity to do so.

⁴ National Quality Forum. MAP Rural Health Workgroup. Accessed November 2, 2020. http://www.qualityforum.org/MAP_Rural_Health_Workgroup.aspx

- Minimize competing demands of model participants, regulators, elected officials, and others by creating consistency in expected outcomes.
- Ensure that regulatory change in one model does not conflict with existing regulations or regulatory change in another model.
- Link financial risk to performance other than cost savings (if financial risk is mandated).
- Do not place essential local services at financial risk, including primary care, public health, and EMS.⁵
- Apply financial risk only to aspects of performance controlled by model participants.
- Consider models that do not rely on fee-for-service.
- Include population health improvement as allowable costs on cost reports.
- Reduce innovation and alignment barriers through regulatory waivers.

3. Upfront Infrastructure Investment

In general, rural health care organizations are under-resourced, both in financial reserves and human capital. The application process, implementation, and operation of many models is resource-intensive, such that rural health care organizations often have difficulty planning and implementing, let alone succeeding in, value-based models. For example, many models require additional staff for data collection and reporting. As one rural hospital CEO asked, “Can’t we implement a new program that doesn’t require a new position?” Summit participant recommendations include the following:

- Minimize new and additional staff and financial requirements.
- Provide upfront infrastructure investment to under-resourced rural health care organizations.
- Provide technical assistance during model application (grant-writing), implementation, and operation.

4. Rural Relevant Planning and Care Delivery

VBC models are often designed for use by large and/or urban care delivery and management systems. However, subspecialists, sophisticated population health management, or advanced data analytic capacity present in large and/or urban systems are often unavailable in rural areas. For example, many bundled payment models require non-rural subspecialist participation. On the other hand, rural health care organizations may more readily engage interdisciplinary teams, innovative health care roles (e.g., community health workers or community paramedics), and community-based organizations. Summit participant recommendations include the following:

- Encourage joint planning among community health stakeholders through program requirements for joint activities or participation in community-wide organizations.

⁵ Mueller, K. J., & MacKinney, A. C. (2006). Care Across the Continuum: Access to Health Care Services in Rural America. *The Journal of Rural Health*, 22(1), 43–49. Accessed November 2, 2020. <https://doi.org/10.1111/j.1748-0361.2006.00010.x>

- Incentivize interdisciplinary team-based care and use of innovative health care roles.
- Include innovative care delivery options during model development and implementation, such as telehealth and hospital-at-home.#

5. Flexibility and Timing

Significant differences between rural health care organizations and their urban counterparts, and between rural health care organizations themselves, suggest a need for model flexibility during planning, operation, and transition. Model flexibility should be weighed against the often-competing demand of model consistency for later model analysis. Model participants should have an opportunity to transition to similar and successful programs following model completion. For example, the SSP served as a transition opportunity for both the APM and the AIM following model completions. Summit participant recommendations include the following:

- Reduce time from model creation to model implementation.
- Establish model durations that are reasonably sufficient to achieve desired outcomes.
- Allow flexibility to adjust the model based on new information and to improve likelihood of success.
- Include a transition to programs that continue successful parts of the model or allow a smooth transition to model substitution.
- If a model requires that participants assume financial risk, allow greater model flexibility as financial risk is increased.
- Maintain regular communication between participants and project officers to facilitate adaptation and change as data and experience inform the model.

6. Information Technology and Data

Rural health care organizations may not have access to sophisticated information technology required for effective population health and financial risk management. Even when adequate information technology is available, performance data feedback that is delayed or absent severely limits an organization's ability to improve clinical care and reach expected model outcomes. For example, health information exchange capacities vary significantly state to state and health system to health system. Summit participant recommendations include the following:

- Adjust model expectations based on rural data reporting, access, and analysis limitations.
- Align quality measurement and reporting across models and programs.
- Provide timely and actionable performance data to allow appropriate participant responses designed to improve outcomes.
- Bring clarity and consistency to the unit of payment and reporting (e.g., National Provider Identifier for individual clinicians and groups versus Tax Identification Number for clinic sites).

- Support health information exchange capacity and implementation for improved care coordination.

Community Health Access and Rural Transformation (CHART) Model⁶

On September 15, 2020 (after the VBC Model Design Summit), CMMI announced the CHART Model. The CHART Community Transformation Track is a seven-year VBC model that provides cooperative agreement funding for up to 15 Lead Organizations to develop rural community VBC systems. Rural communities will include either a single county or census tract or a set of non-contiguous rural counties or census tracts. If not the Lead Organization, the State Medicaid Agency must partner with the Lead Organization and must be a funding subrecipient of the Lead Organization. The Lead Organization will develop a Transformation Plan that addresses community health needs, improves access, and lowers cost. Participating hospitals will be paid with a Capitated Payment Amount rather than through a cost-based reimbursement or prospective payment system. Inpatient and outpatient hospital services are included in the Capitated Payment Amount, but not physician services. Distinct from the CHART Community Transformation track, a CHART ACO Transformation Track will be detailed in 2021.

CMMI states that CHART aims include the following:

- “Increase financial stability for rural providers through the use of new ways of reimbursing providers that provide up-front investments and predictable, capitated payments that pay for quality and patient outcomes;
- Remove regulatory burden by providing waivers that increase operational and regulatory flexibility for rural providers; and
- Enhance beneficiaries’ access to health care services by ensuring rural providers remain financially sustainable for years to come and can offer additional services such as those that address social determinants of health including food and housing.”⁷

Some of the Rural VBC Model Design Summit recommendations are addressed in the CHART Model. For example, model duration is seven years, a payment system other than fee-for-service is offered, and community-wide planning is required.

⁶ Centers for Medicare & Medicaid Services. CHART Model. Accessed November 2, 2020. <https://innovation.cms.gov/innovation-models/chart-model>.

⁷ Ibid.

Conclusion

Rural people, places, and providers are fundamental to the U.S. health care system. In the transition from volume to value, rural stakeholders should have the opportunity to test and learn from new VBC models to advance patient care, community health, and smarter spending. Lessons learned should then be studied, adapted, and spread in rural America. The Rural Health Value team and the Rural VBC Model Design Summit participants hope the recommendations provided in this report will be useful to CMMI and others as they continue to develop and implement rural VBC models.

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Model	Organization	Participant	Participant Geography
FCHIP	University of Southern Maine Montana Health Research and Education Foundation Montana Health Research and Education Foundation	John Gale Casey Brewington Victoria Cech	ME MT MT
QPP	Alliant Health Solutions	Kimberly Rask	Regional
AIM ACO and MSSP	Michigan Center for Rural Health	John Barnas	MI
AIM ACO and MSSP	Caravan Health	Tim Gronniger	National
AIM ACO and MSSP	Caravan Health	John Findley	National
AIM ACO and MSSP	Illinois Critical Access Hospital Network	Pat Schou	IL
MSSP	South East Rural Physicians Alliance	Joleen Huneke	NE
PA RHM	Pennsylvania Department of Health, Office of Rural Health Redesign	Janice Walters	PA
CPC+	First Street Family Health	Meggan Grant-Nierman	CO
FESC	Southeast Alaska Regional Health Consortium (previous)	Patricia Atkinson	AK
Maryland TCOC	Shore Regional Health	Ken Kozel	MD
HH VBP	Healthcare Provider Solutions	Melinda A. Gaboury	TN
Vermont All-Payer ACO	Green Mountain Care Board	Alena Berube	VT
SNF VBP	Leading Age National	Nicole Fallon	National
Accountable Health Community	Rocky Mountain Health Plan	Kathryn Jantz	CO
Next Gen ACO	UnityPoint Health	Pamela Halvorson	Regional
Observer/Funder	Federal Office of Rural Health Policy	Paul Moore	National
Observer/Funder	Federal Office of Rural Health Policy	Sarah Heppner	National
Observer/Funder	Federal Office of Rural Health Policy	Lawrencia Afagbedzi	National
Observer/Funder	Federal Office of Rural Health Policy	Kerri Cornejo	National
Observer/Funder	Federal Office of Rural Health Policy	Craig Caplan	National

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