

National Rural Health Association Policy Brief



Demonstrations and Pilots: Rural Centric Transformation

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I. Background

Demonstration and Pilot projects are an efficient and effective way to try different business or health care models for the purpose of changing the way health care is delivered.

As per the Rural Health Information Hub, a Department of Health and Human Services – HRSA funded website for rural health providers, "The healthcare delivery system is undergoing dramatic change, with an emphasis on finding new approaches and organizational frameworks to: improve health outcomes, control costs, and improve population health". Historically, Federal funding for pilot or demonstration projects have been awarded to and completed by larger health care organizations or larger urban areas.¹

Because, most early adopters of new care models have been large, urban-based integrated delivery systems, less is known about how these changes and environmental factors will affect rural healthcare delivery systems. Rural healthcare providers are often paid outside of the traditional prospective payment systems and fee schedules, and there is less known about how new and emerging models might function in rural communities. As a result, policy makers and rural providers need to better understand the implications of new and emerging models for low-volume rural settings.¹

II. Statement of the Issue

Rural healthcare is unique, and it is not enough to look at the effect change in pilots and demonstrations performed outside of a rural setting. The need for rural centric transformation initiatives is immediate because the challenges facing rural communities are unique and a one-size-fits all mentality will no longer work. Therefore, this policy paper will illustrate why there needs to be intentional and increased funding of rural centric innovation in demonstration projects and pilot programs.

III. Analysis of Current Relevant National Policy

A search of national policies on rural demonstration projects uncovered a June 2012 policy brief from the National Advisory Committee on Rural Health and Human Services (NARHHS), entitled, “Rural Implications of the Center for Medicare and Medicaid Innovation”.¹ This policy brief discusses the potential for CMS demonstrations to specifically address rural needs and The NARHHS Committee offers recommendations specific to encourage the expansion of rural demonstrations.

This brief published on June 2012 outlined six recommendations for The Center for Medicare and Medicaid Services’ (CMS) Center for Medicare and Medicaid Innovation(CMMI) that was established under the Affordable Care Act. The CMMI’s statutory purpose is to “test” innovative payment and service delivery models to reduce program expenditures under the applicable titles while preserving or enhancing the quality of care furnished to Medicare, Medicaid, and Children’s Health Insurance Program(CHIP) beneficiaries.

Some of the recommendations specifically addressed ways to expand the number of rural projects being proposed and funded. They included focusing on rural centric transformative policies such as:

- Encouraging applications from rural providers by offering advice and technical assistance in preparing applications
- Establish a group of rural advisors within CMMI Innovations Advisors to ensure a rural voice and appropriate measurement systems for rural health care
- Develop incentives for evaluation and measurement to encourage collaboration between urban and rural

Since over 50 million people getting their care at 1,327 Critical-Access Hospitals and 3,950 Rural Health Centers experimentation and testing of approaches specific to rural settings is needed if reform of the whole system is to be achieved.²

These recommendations reflect an increased recognition that what works in urban health care settings cannot be applied to rural settings without testing it in lower-volume and lower population areas. “There is ample evidence that the failure to consider the unique needs of rural America has, in the past, led to unintended disparities between medical care systems in urban and rural areas.”

Also increasing at the federal level, is the DHHS’s Federal Office of Rural Health Policy

which has funded the Rural Health Value Program which has as its focus, “ to understand how new health care delivery and financing systems affect rural communities and providers”.²

In addition, the Rural Health Information Hub’s website contains a section entitled, “Why Rural-specific Demonstration Projects Are Needed” which describes the reasons for funding rural demonstration projects and the wide range of rural-specific funding opportunities.³

IV. Analysis of Current NRHA Policy Positions Relevant to the Issue

“Rural Hospital Participation in the Medicare Shared Savings Program” ***NRHA Policy Paper Adopted February 2013***

The adoption of the Rural Hospital Participation in the Medicare Shared Savings Program (MSSP) Policy Brief pointed out the disadvantage that rural providers had in applying for incentives to improve care, improve patient health and lower costs. Specifically, providers in rural areas were not eligible to apply because they didn’t have enough volume in their rural practices and their affiliate providers were not eligible. Therefore, this incentive program left most rural providers the opportunity to alter their delivery systems and take advantage of financial incentives for health care reform.⁴

Consequently, “A final rule issued in June 2015 included modifications to program regulations to facilitate participation by Accountable Care Organizations of the MMSPP that include rural providers.”⁴

Following are some of the results from MSSP adoption by Caravan Health’s Accountable Care Organizations rural providers from 2016:

- Average net savings of nearly \$1.1 million per ACO.
- Average savings of \$101.32 per Medicare beneficiary.
- A perfect (100 percent) quality reporting score achieved by each ACO in its first year of program participation, and an average year two quality score of 96 percent.⁵

As evidenced by the results above, rural providers can succeed in achieving savings for Medicare beneficiaries while increasing quality scores as evidenced by the MSSP program and its results.

NRHA Request for Information (RFI) the CMS Innovation Center (Innovation Center) New Direction

Dr. Alan Morgan, CEO National Rural Health Association

A Request For Information(RFI) was issued by CMS' Innovation Center for feedback on a new direction to "promote patient-centered care and test market-driven reforms that empower beneficiaries as consumers, provide price transparency, increase choices and competition to drive quality, reduce costs, and improve outcomes" ⁶ In response, NRHA CEO Alan Morgan responded with two positions of the NRHA.

First, he advocated for a focus on rural centric transformation initiatives that could be the catalyst for future legislative changes that would aid rural hospitals. Dr. Morgan, citing the two demonstration programs that operated between 1991-1994(EACH-RPCH and MAF) and became the catalyst for legislation that created the Critical Access Hospital designation. The current proposed legislation of creating a new Medicare payment designation, the Community Outpatient Hospital will ensure access to emergency care and allow hospitals to offer outpatient care that meets the health needs of the community

Second, the NRHA advocates for the testing of a new model of healthcare delivery that focuses priority on rural areas by creating a unique value-based purchasing program with Critical Access Hospitals. In this model, would implement payment incentives tied to performance on: Evidence-based care, mortality, safety, patient experience, care coordination and spending.⁷

V. Data Analysis of the Need for Rural Demonstration Projects

Due to significant differences in the characteristics of rural compared to urban, demonstration and pilot projects must be awarded that test care and payment models on community demographics and characteristics that are specific to rural areas.

Rural areas have significant challenges from urban areas as evidenced by the following statistics. This list is not comprehensive but merely outlines the substantial differences that would significantly affect the application of demonstration and pilot projects tested in urban areas and applied to rural areas.

Mortality Inequity

The mortality rate is higher among people who live in rural areas compared to those who live in urban areas. Although mortality rates are decreasing overall, the gap between urban and rural mortality rates is steadily rising (Figure 1) with the most remote areas (non-core) having the largest gap.⁸

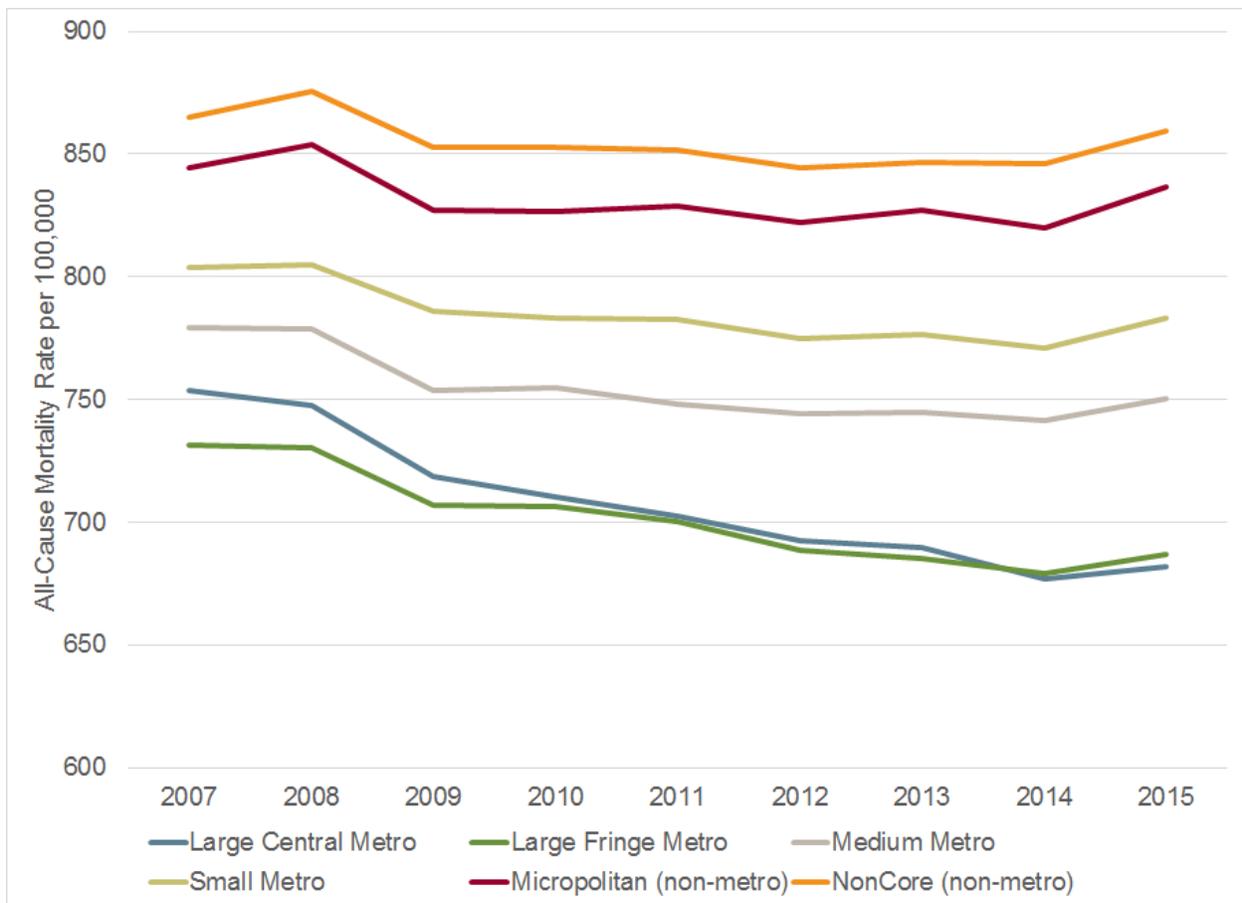


Figure 1 All-Cause Mortality Rate by NCHS Urban-Rural Status, per 100,000 Persons, Age Adjusted

Health Disparities

In general, rural residence tend to be older, more likely to be overweight or obese, sicker, and have a higher rate of disabilities.⁹

Rural residents suffer disproportionately from chemical dependency. Across all demographics and age levels have higher smoking rates, higher rates of alcohol abuse and the current opioid problem in rural America is deemed as an “epidemic” in comparison to their urban counterparts.^{10,9}

In 2014, many deaths among rural Americans were potentially preventable, including 25,000 from heart disease, 19,000 from cancer, 12,000 from unintentional injuries, 11,000 from chronic lower respiratory disease, and 4,000 from stroke.⁹

Lack of Adequate Health Care Coverage

Rural residents do not enjoy the high rates of employer-provided coverage that their urban counterparts have. In fact, with respect to insurance coverage:

- Rural residence are less likely to be employed, more likely to have a disability, and more likely to be in poverty or low-income.
- Private medical insurance coverage is 3% less and uninsured rate is higher in rural areas. Medicaid helps fill this gap in private coverage, covering nearly one in four (24%) nonelderly individuals in rural areas.¹¹

Transportation Barriers

Access to care is also a concern for rural residents. Public transit is either non-existent or very limited. When public transit is available, 90% or more rural transit providers requires a reservation and cannot be summoned on demand limiting options for people who need to make unscheduled visits to health care providers, grocery stores or other activities of daily living.¹²

Adequate Access to Rural Provider and Workforce Obstacles

- The healthcare workforce in rural America is less educated than in urban.¹³
- There are more physicians available in metropolitan areas compared to rural areas to serve residents. i.e. there are 53 physicians to serve a metro population of 100,000 compared to 40 to serve the same size population in rural areas.¹³
- Because of small inpatient census and payer mix, rural hospitals face unique challenges trying to stay open. From 2005 to July 2016, 118 rural hospitals closed permanently with an additional 7 closing and later reopened.¹⁴ Leaving communities without access to primary care.

VI. Next Steps

As illustrated in this policy brief by the evidence presented there is a need for demonstration and pilot projects in rural areas need to be increased. If significant changes in health care delivery and funding are to be made on a national scale, then demonstration and pilot projects must be tested that cover rural as well as urban areas.

Rural centric transformation can only occur if the following recommendations are followed which include:

1. Increase Rural Applications for Demonstration and Pilot Projects

More rural applications for state and federal agencies offering demonstration projects and pilot programs should be encouraged by offering advice and technical assistance to rural facilities in the preparation of applications.

2. Rural Advisory Members Should be Included on Selection Committees of Rural Projects

Whenever possible, selection and advisory committees that award demonstration and pilot projects should include rural advisors to ensure a rural voice and establish measurement systems that are relevant to rural health care.

3. Rural Demonstration and Pilot Programs are Evaluated with Rural Metrics not Urban

Evaluation of urban-rural demonstrations should be on a systematic basis so small increases in rural costs are offset by system-wide quality improvement. This could also include developing specific evaluation and measurement incentives to encourage collaboration across urban and rural lines which would include a preference during grant scoring.

4. Implement a “Plug and Play” Model for Rural Demonstration and Pilot Projects

Encourage small, rural health care providers to participate in demonstration and pilot projects by streamlining applications processes, implementation and reporting requirements, etc. by offering simple, easy-to-follow instructions void of “government” speak that are easily understood by those working in rural healthcare.

5. Support CMS Payment Reform

Value-Based Purchasing

To transform clinical and financial models at Critical Access Hospitals, implement a new model of Value-Based Purchasing that improves the quality of healthcare and the patient’s experience of care while simultaneously reducing inpatient and outpatient costs in rural communities.⁷

Community Outpatient Hospital

Moving away from volume-based payment for inpatient to a “Community Outpatient Hospital(COH) Medicare designation will help to ensure the future of medical services in rural communities. “The COH will ensure access to emergency care and allow hospitals the choice to offer outpatient care that meets the population health needs of their rural community.”¹⁵

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