



NRHA Policy Paper: Volume to Value Transition for Rural Health Systems

Kim Breidenbach, MD, MPH, Tammy Moore, ARNP, DNP

I. Introduction

The transition from volume-based payment models to value-based payment models is gaining momentum nationwide as a strategy for controlling costs, improving quality and patient/provider experience, and improving population health. Medicare payment policy has been a major driver of value-based payment reform beginning in 2015. With the 2015 Medicare and CHIP Reauthorization Act, the Department of Health and Human Services (HHS) announced its intention to rapidly expand its use of quality measures in Medicare payment structures.¹

Value-based payment models are evolving from standard fee-for-service payment with quality-based bonuses/penalties into more complicated assessments of cost, quality, and health outcomes also known as alternative payment models (APMs). The Centers for Medicare and Medicaid Services (CMS) continues to develop and expand its APM demonstration projects. The newest phase of evolution requires participating entities to share profits or losses for the total cost of care. The Center for Medicare and Medicaid Innovation (CMMI) is testing the concept with two models: enhanced payment for primary care services, known as primary care first, or a “prospectively determined revenue stream” for a defined population of patients, known as direct contracting.^{2,3} The models are becoming ever more complex as they evolve, building upon what has come before. There is concern that rural facilities will not be able to keep pace with evolving models, having largely been excluded from earlier, simpler models. CMMI is beginning to test rural-specific payment models such as the Pennsylvania Rural Health Model. It is essential to develop such models with deliberate attention to the uniqueness of rural organizations and their current place in the value-based payment landscape.

If rural health organizations are going to be successful in new CMS reimbursement models, they will have to adapt their delivery systems. Private insurers and some Medicaid plans are also requiring demonstration of value to receive payment. Some states have elected to move to 90 percent of payments tied to value-based care activities by 2021.⁴ There are characteristics unique to rural health care that, if leveraged, would bolster transition to APMs, primarily their strength providing primary care services. With many rural organizations currently receiving cost-based Medicare reimbursement, facilities are able to cover the cost of their low-volume/high-cost care, but such care does not necessarily create value. Rural facilities must ensure they are strengthening the foundation of primary care services that meet the needs of their communities. In many cases this requires right-sizing their organization to leave low-volume/high-cost services to tertiary facilities.² Rural health care organizations need to keep pace with the volume-to-value transition to avoid being left behind as value-based payment models becomes the prevailing reimbursement structure.



II. Foundations for rural health care success in value-based payment models

Primary care

In an episodic, fee-for-service payment model (sickness model of care), care is most often sought after evidence of disease or injury. The fee-for-service model lends itself to a focus on diagnosis and treatment and rewards ancillary testing, procedures, hospitalization, and evaluation in higher-cost areas like emergency departments. It puts relatively little emphasis on prevention, management, and care coordination, which are key functions of primary care. Primary care has been reliably linked to lower total cost of care and improved health outcomes for individuals and communities – the same stated goals of the movement toward value-based payment models.⁵ Indeed, a recent analysis of Medicare Shared Savings Program data concluded that “a strong foundation of advanced primary care as embodied in the patient-centered medical home is critical to the success of care delivery reforms.”⁶ Rural health care facilities’ natural role in the health care landscape is to provide access to comprehensive, team-based primary care.⁷

As an example, using registered nurses as care coordinators who are equipped to help patients navigate the health care landscape has demonstrated cost-effectiveness and statistical reductions in avoidable hospitalizations, emergency department use, and readmissions to inpatient units.⁸ This is achieved through activities like medication reconciliation and addressing social resource gaps such as transportation barriers. Studies in the use of RN care coordinators with Medicaid patients have demonstrated RN care coordination serves those with chronic illnesses, but there is also benefit from coordinating preventative care for patients who have yet to experience disease.⁸

Rural communities will benefit when rural health care organizations increase their primary care footprint. Value-based payment models designed to support this type of rural growth may incentivize them to do so.

Rural health networks

Rural health care facilities are already working within networks in order to make best use of limited resources. In the sickness care model, care coordination with other health care institutions is required to connect patients to advanced treatment modalities and specialist care. As a result, relationships between rural facilities and larger tertiary centers already exist. Collaborative networks among rural health care facilities allow participants to share resources and innovations and create economies of scale. Examples of such networks exist at the state level and have proven to be effective for quality improvement, cost reduction, and community engagement.⁹ Success in value-based payment models will require coordinated and collaborative work with other local



and regional health care facilities, social services, and community-based organizations. Additionally, this collaborative model will provide opportunities to develop broader value-based care contracts. As such, rural health care facilities can leverage existing networks and collaborations to support their transition to value-based payment models.

Rural health care facilities as anchor institutions

Rural hospitals serve as the cornerstone of their communities, and closure of these facilities places rural communities at risk. Alternatively, a strong health care organization may provide significant contributions to well-being in rural areas along with the addition of jobs and access to care for its members. Spending on health care in rural communities positively impacts local economies, and the presence of a health care organization may assist in attracting new businesses. On average, a critical access hospital can sustain a payroll exceeding \$6 million with employment of 140 people.¹⁰ As such, rural hospitals may be the largest employer in their region, with the health sector constituting 14 percent of total employment.¹⁰

From this position as anchor institutions, rural health care facilities can influence local policy such as economic and housing policy, which can shift the social determinants of health in the region.¹¹ They can also influence the well-being of the surrounding community by partnering to fill social service gaps within communities.^{12,13} Already deeply embedded in the community, rural health care facilities are in an excellent position to affect health at the population level.

It is necessary that rural health care facilities thrive within value-based payment systems to avoid the loss of this vital resource. Closure of a rural health care facility will compromise a wide range of health-related services. Foremost it limits access to primary care, emergency care, and specialty care provided onsite or remotely from networked clinicians. It also removes a key partner in the work of evaluating and responding to social and behavioral health needs in order to promote community health. Finally, hospital closure can place an economic strain on the community, which correlates with diminished health.

III. Barriers to rural health care success in value-based payment models

Restricted opportunities to participate

Thus far, rural health care facilities' uptake of value-based payment models is lower than urban counterparts. For example, analysis of 2017 data from the CMS Quality Payment Program shows that 7.8 percent of non-metropolitan primary care clinicians participated in one of Medicare's APMs, 31.7 percent participated in the mandatory merit-based incentive payment systems (MIPS), and 60.5 percent did not participate in



any type of quality payment program because they were MIPS exempt based on low volume or low allowed charges thresholds.¹⁴

CMS and HHS recognize that rural health care facilities face barriers to participating in value-based payment models. Indeed, the decision to exclude small practices from MIPS was made to avoid undue quality reporting burden. However, raising the low-volume thresholds in 2018 has further limited the number of rural primary care clinicians required to participate.¹⁵ In addition, rural health clinics, federally qualified health centers, and critical access hospitals are also unable to participate in some of Medicare's APMs because of the current reimbursement model used in those locations.^{16,17,18} Exclusion from federal value-based programs is impeding many rural health care organizations' ability to transform by decreasing opportunities for early learning in quality improvement and data reporting.¹⁷

Technical barriers

In the absence of federal mandates, rural health care organizations are voluntarily transitioning to value-based care delivery systems. Some are able to participate in value-based payment demonstrations through Medicaid or private insurers. Even when opportunities for transformation are present, rural health care organizations may face barriers to success. The most commonly cited barriers can be broadly categorized as 1) limited resources and expertise and 2) inadequate infrastructure needed to create value-driven change.

Limited resources: ^{16,17,19}

- Time: Less likely to have staff members with time dedicated to monitoring and pursuing performance improvement strategies such as care coordination and chronic disease management.
- Human capital: Less likely to have staff members with expertise in quality improvement, population health management, systems change.
- Money: Less able to absorb upfront cost associated with updating expertise and infrastructure and expanding staff time for value-based care activities.
- Informatics: Less ability to access and use data to guide decision making and resource utilization.

Inadequate infrastructure: ^{16,17,19}

- Electronic health record (EHR): Depending on capabilities, may hinder the ability to identify risk and value and report performance data.
 - Data accuracy requires documentation accuracy by providers.



- Data accuracy requires a reliable method for extracting data from the EHR.
- Data reporting requires a method for transmitting data from EHR to health system users and to payors.
- Lack of interoperability between and among reporting entities.
- **Broadband access:** Inadequate broadband access limits patient engagement in their own health care and rural health systems' ability to demonstrate electronic exchange of information, as required by MIPS.
- **Financial risk assessment tools:** Limits the ability to understand the financial implications of incorporating new payment models into existing financial structure.
- **Population health management tools:** Limits the ability to understand the risk profile of a panel of patients and direct resources appropriately.
- **Limited patient ability to utilize electronic access to services due to unsophisticated personal technology.**

Technical barriers are critical to overcome because they limit a rural health care facility's opportunity to create and demonstrate their value to the public and prospective payors and partners.¹⁷ In addition, facilities that are required to report quality data to CMS but are unable to do so because of technical barriers will begin receiving negative payments from CMS. These penalties are set to increase over time, placing additional financial burden on often already strained organizations.

Rural-relevant quality measures

Even when rural health care facilities have the opportunity, expertise, and resources to participate in value-based payment models, such facilities may still contend with performance measures that do not effectively measure and reward value in the rural setting. The Department of Health and Human Services contracted with the National Quality Forum (NQF) to define the issues around measuring rural health care quality and recommend a set of rural-relevant quality measures. These reports, published in 2015 and 2018, identified three criteria by which quality measures used for rural value-based payment should be evaluated.^{18,20}

First, NQF recommends that the measures be cross-cutting, meaning they apply in multiple settings to a wide range of patients and practices. Examples of cross-cutting measures include advanced care planning, weight assessment/nutrition counseling, and medication reconciliation. Second, rural-relevant measures should be resistant to low case volume in order to avoid invalid or unreliable results. Third, quality measures should address transitions of care because many rural facilities do not provide high-



acuity or highly specialized care. Rather, they are responsible for connecting patients to higher levels of care when appropriate. This requires collaboration between rural facilities, emergency medical transport services, and tertiary care centers to create value within cooperative networks.²⁰

There are additional factors impacting accurate measurement of rural health care quality such as access to care, aging rural populations, poorer populations, and more risky behaviors such as smoking and inadequate exercise. There is no consensus about whether or how to include these factors when defining rural health care value.^{17,18,20} Rural-relevant health care quality measures are necessary to accurately determine rural health care value.

Financial reliance on episodic care

Rural health care facilities that focus on episodic care have been financially vulnerable within the sickness model of care. In recognition of financial vulnerability, CMS created the critical access hospital designation in 1997, which offers cost-based payment schemes within the fee-for-service model but still leaves hospitals heavily dependent on volumes.²¹ Regardless, 121 rural hospitals have closed since 2010.²² Reduced ED visits and fewer admissions to inpatient units are tenets of value-based care. Decreasing those revenue streams creates increased pressure to be profitable in other service lines in order to stay solvent.

Some health systems have responded by building up primary care as the focal point for cost savings and improved quality and have been financially successful in the volume-to-value transition.²³ However, during the transition, most facilities can withstand two to five years of limited income until the shift to new payment income is realized. Facilities attempting to bridge the span from fee-for-service to value-based payment must be able to withstand the financial implications of emergency department and inpatient reduction in volume. Bridging the financial chasm from fee-for-service to a payment model that incentivizes quality of care is essential to the success of rural provider organizations.

Innovation in rural health care organizations provides opportunities for financial viability in the changing marketplace. However, financial risk accompanies transformative change. Rural health care organizations may be nimble enough to change swiftly but reluctant to do so if the financial risk is too great, if the organization cannot confidently assess the risk, or if the risk is not mitigated by a diversified financial portfolio. The Pennsylvania Rural Health Model is one example of an early attempt to promote population-focused medical care using a global budget to minimize financial risk.

IV. Conclusion



Rural health care facilities need to adapt their health care delivery systems to be successful in the evolving payment landscape. In order to transition from volume-based to value-based care delivery, rural health care facilities must have the opportunities, tools, and resources to participate in value-based payment models that recognize the unique characteristics of rural systems. Rural health care facilities have advantages that when properly supported can yield success in controlling costs, improving quality and patient/provider experience, and improving population health for rural Americans.

V. Policy recommendations

1. Modify policy/regulations to allow CAHs, RHCs, and FQHCs to participate in federal advanced payment models without excessive financial or administrative burden.
2. Develop hybrid payment schemes for CAHs, RHCs, and FQHCs that allow for some ongoing cost-based reimbursement during a transitional period to value-based payments in order to incentivize transformational change and ease the financial risk.
3. Authorize CMMI to immediately develop demonstration projects designed for rural health care facilities that reward comprehensive primary care. Such demonstration projects should include:
 - a. Human-centered design approach that works for end users.
 - b. Technical assistance to develop comprehensive primary care programs that include behavioral health and community integration.
 - c. Tools to support transitional financial risk management.
 - d. Tools to support population health management.
4. Align reporting systems and requirements among Medicare, Medicaid, and commercial payers to ease the reporting burden for performance measures and promote interoperability.
5. Identify and implement rural-relevant performance measures.



References List

1. MACRA: MIPS & APMS. Centers for Medicare and Medicaid Services website. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html>. Accessed November 12, 2019.
2. Primary Care First Model Options. Centers for Medicare and Medicaid Services website. <https://innovation.cms.gov/initiatives/primary-care-first-model-options/>. Accessed November 12, 2019.
3. Direct Contracting Model Options. Centers for Medicare and Medicaid Services website. <https://innovation.cms.gov/initiatives/direct-contracting-model-options/>. Accessed November 12, 2019.
4. Paying for value. Washington State Health Care Authority website. <https://www.hca.wa.gov/about-hca/healthier-washington/paying-value>. Accessed August 12, 2019.
5. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *The Milbank Quarterly*. 2005;83(3):457-502.
6. Jabbarpour Y, Coffman M, Habib A, et al. Advanced primary care: a key contributor to successful ACOs. Patient-Centered Primary Care Collaborative and the Robert Graham Center. <https://www.pcpcc.org/sites/default/files/resources/PCPCC%202018%20Evidence%20Report.pdf>. Published August 2018. Accessed November 29, 2019.
7. Mueller KJ, Alfero C, Coburn AF, et al. Primary care: the foundation for a high performance rural health care system. Rural Policy Research Institute Health Panel. <http://www.rupri.org/wp-content/uploads/Primary-Care-The-Foundation-for-a-High-Performance-Rural-Health-Care-System.pdf>. Published July 2018. Accessed November 12, 2019.
8. Khullar D, Chokshi D. Can better care coordination lower health care costs? *JAMA Netw Open*. 2018;1(7):e184295. doi:10.1001/jamanetworkopen.2018.4295
9. Helseth C. Rural health networks prove there is strength in numbers. Rural Health Information Hub website. <https://www.ruralhealthinfo.org/rural->



- monitor/rural-health-networks-strength-in-numbers/. Accessed November 12, 2019.
10. Doeksen GA, St Clair CF, Eilrich FC. Economic Impact of Rural Health Care. National Center for Rural Health Works. <http://ruralhealthworks.org/wp-content/uploads/2018/04/Summary-Economic-Impact-Rural-Health-FINAL-100716.pdf>. Published October 2016. Accessed Dec 2, 2019.
 11. Health outside hospital walls. Rural Health Value website. <https://ruralhealthvalue.public-health.uiowa.edu/files/Whole-Person%20Care.pdf>. Published July 2016. Accessed November 12, 2019.
 12. Medical-legal partnership addresses social determinants of health. Rural Health Value website. <https://ruralhealthvalue.public-health.uiowa.edu/files/FirstHealth-Medical-Legal-Partnership-2017.pdf>. Published September 2017. Accessed November 12, 2019.
 13. Rural health network thrives on innovation in whole-person care. Rural Health Value website. <https://ruralhealthvalue.public-health.uiowa.edu/files/Whole-Person%20Care.pdf>. Published February 2019. Accessed November 12, 2019.
 14. MacKinney AC, Ullrich F, Mueller K. Primary care clinician participation in the CMS Quality Payment Program. *RUPRI Center for Rural Health Policy Analysis*. Brief 2019-3. 2019. <https://rupri.public-health.uiowa.edu/publications/policybriefs/2019/QPP%20Participation.pdf>. Accessed May 9, 2019.
 15. Salako A, MacKinney AC, Ullrich F, Mueller K. Changes to the merit-based incentive payment system pertinent to small and rural practices. *RUPRI Center for Rural Health Policy Analysis*. Brief 2018-6. 2018. <https://rupri.public-health.uiowa.edu/publications/policybriefs/2018/MIPS%202018.pdf>. Accessed May 9, 2019.
 16. Rural healthcare quality. Rural Health Information Hub website. <https://www.ruralhealthinfo.org/topics/health-care-quality>. Accessed May 9, 2019.
 17. Mueller KJ, Alfero C, Coburn AF, et al. Medicare value-based payment reform: priorities for transforming rural health systems. Rural Policy Research Institute Health Panel. http://www.rupri.org/wp-content/uploads/FORHP-comments-km-DSR-PANEL-DOCUMENT_PRD_Review_112315.clean-4_sn-3.pdf. Published November 2015. Accessed June 13, 2019.
 18. Performance measurement for rural low-volume providers. National Quality Forum Rural Health Committee.



- https://www.qualityforum.org/Publications/2015/09/Rural_Health_Final_Report.aspx. Published September 14, 2015. Accessed June 13, 2019.
19. Gale J, Hansen A, Hartley D, Coburn A. Pilot testing a rural health clinic quality measurement reporting system. Maine Rural Health Research Center. PB-62. 2016. <http://muskie.usm.maine.edu/Publications/rural/RHC-Quality-Measurement-Reporting.pdf>. Accessed June 13, 2019.
 20. A core set of rural-relevant measures and measuring and improving access to care: 2018 recommendations from the MAP rural health workgroup. National Quality Forum. https://www.qualityforum.org/Publications/2018/08/MAP_Rural_Health_Final_Report_-_2018.aspx. Published August 31, 2018. Accessed June 13, 2019.
 21. Critical Access Hospital MLN Fact Sheet. Centers for Medicare and Medicaid Services website. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CritAccessHospfctsh.pdf>. Published July 2019. Accessed Dec 2, 2019.
 22. Rural hospital closures. The Cecil G. Sheps Center for Health Services Research website. <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>. Accessed Dec 2, 2019.
 23. Proactively pursuing value-based payment. Rural Health Value website. <https://ruralhealthvalue.public-health.uiowa.edu/files/ProactivelyPursuingVBP.pdf>. Published May 2016. Accessed May 9, 2019.