Alternative Payment Methods for Rural Areas

Making the Case for Appropriate Methods

Health Care Learning and Action Network

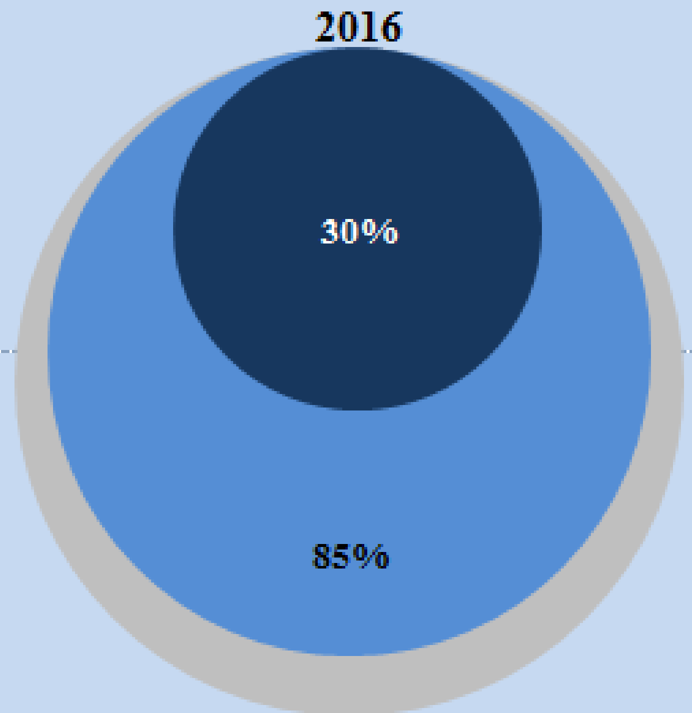
- **A new DHHS Health Care Learning and Action Network (HCLAN) has been announced. The Network will accelerate the transition to more advanced payment models by fostering collaboration between HHS, private payers, large employers, providers, consumers, and state and federal partners.**
- **Input from rural stakeholders has been requested.**
- **NOSORH prepared and submitted comments after discussion and review by several committees.**
- **The comments and recommendations may be useful in other policy discussions, both at the federal and state level.**

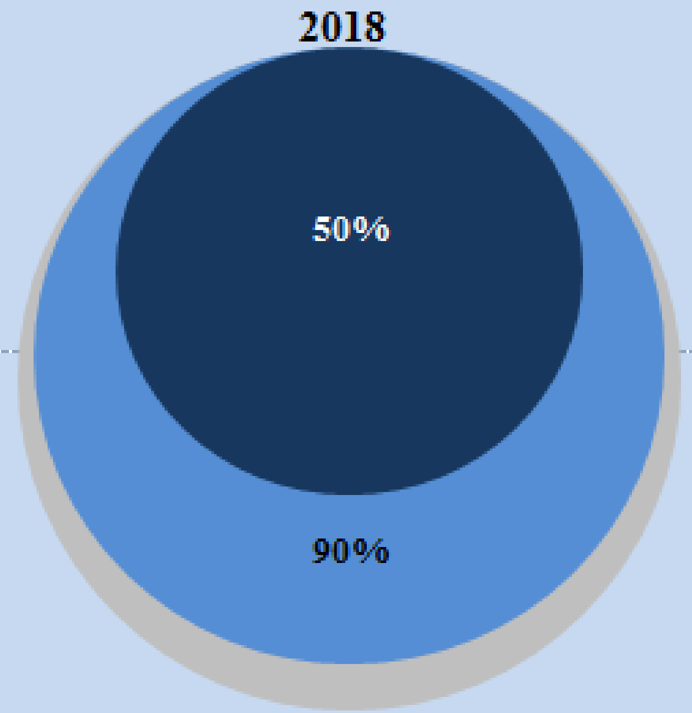
DHHS Payment Taxonomy

- **Framework**: HHS has adopted a framework that categorizes health care payment according to how providers receive payment to provide care:
  - **Category 1** - fee-for-service with no link of payment to quality.
  - **Category 2** - fee-for-service with a link of payment to quality. Includes hospital performance-based payment programs.
  - **Category 3** - alternative payment models built on fee-for-service architecture. Includes bundled payments, medical homes and some ACOs.
  - **Category 4** - population-based payment. Includes Pioneer ACOs.
- **Target**: ***Value-based purchasing*** **includes payments made in categories 2-4. The DHHS policy aim is to shift payments away from fee-for-service, increasing accountability for both quality and total cost of care,**

Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018

- All Medicare FFS (Categories 1-4)
- FFS linked to quality (Categories 2-4)
- Alternative payment models (Categories 3-4)





DHHS Alternative Payment Goals

- **DHHS has set as its goals:**
  - **30 percent of Medicare payments in alternative payment models (categories 3 and 4) by the end of 2016, and**
  - **50 percent in categories 3 and 4 by the end of 2018.**
- **This will be achieved through investment in:**
  - **alternative payment models such as Accountable Care Organizations (ACOs),**
  - **advanced primary care medical home models,**
  - **new models of bundling payments for episodes of care, and**
  - **integrated care demonstrations for beneficiaries that are Medicare-Medicaid enrollees.**
- **Overall, DHHS seeks to have 35 percent of Medicare payments in value-based purchasing categories 3-4 by 2016 and 50 percent by 2018.**

Comments: Appropriate Payment Approaches

- <u>PPS and CBR are important for assuring rural health access</u>.
  - For many rural health providers Cost-Based Reimbursement (CBR) or Prospective Payment System (PPS) payment methodologies for core services assure provider financial stability.
  - Without stable and well organized rural health systems it will be impossible to achieve the three goals of Better Care, Smarter Spending, and Healthier People for rural populations.
- <u>Category 3 APMs – building on PPS and CBR – are particularly applicable in rural areas</u>.
  - Supplemental payment approaches, building on PPS and CBR, can help achieve health reform goals without destabilizing rural health systems.
  - This would be similar to medical home payments made to FQHCs, supplementing PPS payments for core services.

Appropriate Payment Approaches - 2

- **APMs in rural areas should emphasize incentives.**
  - Inappropriate assumption of risk by rural health providers could destabilize the rural health system.
  - This is consistent with the National Quality Forum recommendation that rural health providers require incentive payments, but not penalties.

- **Some rural health providers can assume risk, but should do so carefully.**
  - The Rural Health Reform Initiative In Oregon permits CBR eligible rural hospitals to transition to other payment methods.
  - It requires a thorough financial assessment before that transition.
  - It monitors financial stability an ongoing basis after transition, looking for signs of financial stress.
  - It permits the rural hospitals to be moved back into CBR if the alternative payments threaten their financial stability.

Comments: Care Coordination and Service Integration

- Care coordination and service integration in rural areas helps achieve health reform goals.
  - Coordination of care for rural residents improves health, improves service outcomes and reduces costs.
  - This includes micro-integration approaches as defined by IHI – care coordination provided directly to rural residents.
  - It also includes macro integration – development of multi-provider rural health networks – Such as rural ACOs and the FCHIP.
- Rural care coordination is cost-effective.
  - There is evidence of its value for special needs populations – 'hot-spotting' – as well as general populations.
  - Non-clinical coordinating services play a key part in this.

Care Coordination and Service Integration - 2

- **Care coordination can include:**
  - **Care Transition Management,**
  - **Chronic Disease Management,**
  - **Pregnancy Management,**
  - **Early Childhood Health Improvement. and**
  - **Behavioral Health Management.**

Comments: Care Coordination and Service System Structure

- **Care Coordination can be based at individual rural providers or in community-based networks.**
  - **Community-care of North Carolina (CCNC) is a Medicaid-supported statewide effort doing both.**
  - **CCNC has demonstrated improved health outcomes, improved service effectiveness, and cost savings of about 3:1.**
- **Rural health care coordination / service integration does not require consolidation with urban systems.**
  - **Consolidation with outside health systems can lead to disinvestment in rural health systems and a shift of core services to locations outside of rural communities.**
  - **There is value in local self-determination and ownership of rural health systems and in the development of rural-specific coordinated services.**

Comments: Payment Structure

- **Alternative payment methods for integrating services can take several forms.**
  - **APMs can include payments to providers for clinical care management and payments to coordinators and community health workers for non-clinical services.**
  - **APMs can include different risk-adjusted payments for different populations – e.g. $5-$10 per person per month for the general population and $200-$300 per person per month for chronically ill people.**
- **Evaluation of APMs should include global cost analysis, not just costs to health insurers and government health coverage programs.**
  - **Global costs include the costs incurred by patients, including co-pays and the costs of transport to service sites.**
  - **While it is challenging to assess costs not linked to a payment system, evaluation methodologies can be used to calculate travel cost and other savings.**

Specific Recommendations to HCLAN

- **Rural Impact Accountability: All APM demonstrations , including regional demonstrations, should account for outcomes in rural populations.**
- **Rural-Specific APM Demonstrations: DHHS should support additional APM demonstrations specific for rural-based health systems.**
- **Rural Specific Care Coordination Demonstrations: DHHS should encourage the development of rural care coordination and service integration demonstrations.**
- **Evaluation Based on Global Cost: DHHS should evaluate APM demonstration savings based upon both payer and patient costs, including estimated travel cost savings .**
- **Uniform Payment Methodologies: DHHS should promote uniform payment methodologies across multiple payers.**