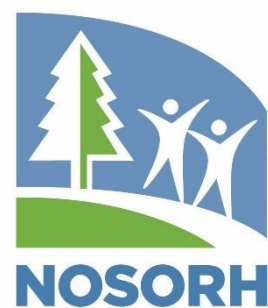


ENGAGING STATE OFFICES OF RURAL HEALTH & RURAL HEALTH CLINICS IN VALUE-BASED CARE

July 2017



National Organization of
State Offices of Rural Health

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INTRODUCTION

In an effort to support State Offices of Rural Health (SORHs) working with Rural Health Clinics (RHCs), the National Organization of State Offices of Rural Health (NOSORH) RHC Committee has produced this toolkit on value-based care (VBC). The focus of this toolkit is on providing resources for SORHs and RHCs to assess their current capacity for taking on value-based care work, information on the initiatives happening around the country, and examples of states tackling these issues with and for their RHCs. This is an opportunity for SORHs to connect with other states working on value-based care, learn from each other, and enhance their engagement with RHCs in their own states to take on this critical work. SORHs may use existing capacity and capabilities to build in value-based care work with their RHCs, as outlined in this toolkit.

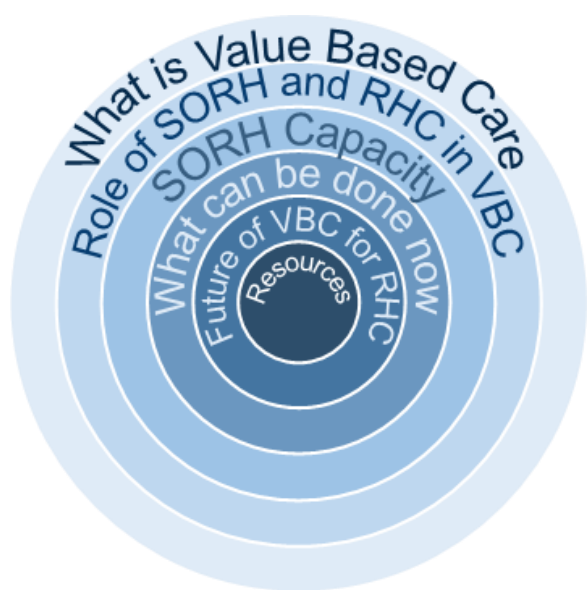
There are multiple definitions value-based care encompasses (including everything from targeted initiatives that address reimbursable payment reform supported by CMS, to simple care coordination activities), and NOSORH has developed this toolkit to include the broadest range of work. Regardless of definitional boundaries and terminology, there is plenty of work SORHs can coordinate with their RHCs to improve the value-based delivery of care, and the underlying payment structures that impact care delivery, access, and costs.

RHCs across the United States are faced with the growing need to adapt to new initiatives, payment structures, and value-based systems in order to make the move from volume to value. The main challenges RHCs face are the potential administrative burdens, financial risk, and few opportunities for reimbursement.

How to Use This Toolkit

This toolkit is organized by going from a broad contextual picture, and hones in with increasingly specific information for SORHs. The image to the left is a representation of the organization of the toolkit.

At the beginning of each new section, you will find the corresponding ring highlighted to orient you to the appropriate section. Also note that this graphic is interactive, and the mini version (right bottom) will take you back to the table of contents, and the larger version of this graphic will take you to the section of your choice by selecting the appropriate label.



You will also find examples of what states and SORHs are doing in VBC with their RHCs throughout the toolkit, look for the call-out boxes (example to the right) woven into the body of the toolkit for these examples.

*State/SORH
Example.*

Lastly, wherever there is a specific action or activity a SORH can take on for VBC, you will see this arrow (below) and highlighted text. These are specific recommendations for SORHs who are able and looking to engage in VBC initiatives or projects.

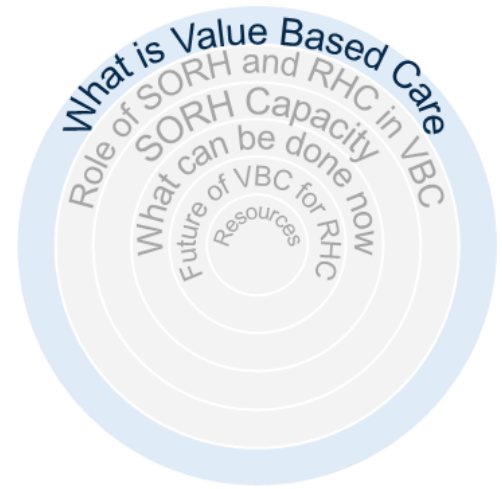


Sample recommendation

ACKNOWLEDGMENTS

It is important to recognize Mannat Singh, MPA, for being the principal architect for the writing and compilation of this resource. NOSORH also wants to thank the many SORHs who shared their insights and examples of their work with RHCs. Special thanks are also due to national expert organization leaders and others for sharing their resources and expertise including:

Capitol Associates, Inc.
Colorado Rural Health Center
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Federal Office of Rural Health Policy
Iowa Office of Rural Health
Office of Health Policy and Performance Improvement, Ohio Department of Health
PrivaPlan
Massachusetts Office of Rural Health
Michigan Center for Rural Health
Minnesota Office of Rural Health
Missouri Office of Rural Health
North Carolina Department of Health and Human Services
North Dakota Center for Rural Health
Oregon Office of Rural Health
Quality Health Associates of North Dakota
Rhode Island Office of Rural Health
South Carolina Office of Rural Health
Vermont Office of Rural Health
Varela Consulting Group
Washington Office of Rural Health



WHAT IS VALUE BASED CARE

What is Value-Based Care

Value-based care refers to the departure from a system in which providers were paid for the number of healthcare services provided (e.g., tests, visits, procedures), to a focus on an approach designed around patients, for improved health, quality delivery of care, and lower cost of care. In rural communities, the way healthcare is delivered is often dependent on the financial position of the local healthcare facilities. With limited resources and staff, rural hospitals and clinics should (and in some cases, already are), examine the various forms of value-based care that they can implement in order to remain viable and sustainable in a consistently changing environment. The shift from volume to value is happening, and there are reforms in place that the rural community can take advantage of.

Value-based care focuses on:

- Provider payment incentives that reward value rather than volume
- Models of care delivery that coordinate and integrate clinical services for both patients and communities, with a focus on prevention and wellness
- Information sharing that creates transparency on the cost and quality of care to support better decision-making by providers and consumers

Providing care based on value instead of volume has proven difficult for rural communities, due to their smaller size, lower volume of patients, financial vulnerability, and they are subject to specific statutory requirements and are not always included in new incentivized initiatives. However, rural providers have shown that they can match (and

sometimes exceed) performance with urban providers, and can also benefit from the greater efficiencies, different incentives, and improved quality of care that value-based care initiatives require. With the assistance and facilitation from their SORHs, RHCs can take part in this critical work.

These reforms must be understood within the context of Medicare and Medicaid.

Medicare and Medicaid

Clinics with RHC status receive enhanced reimbursement rates for providing Medicare and Medicaid services. The original legislation was designed to address rural specific issues and create a rural safety net. However, over the last few years, these policies have created potential barriers to entry for rural providers and systems to participate in new payment models (due to lower margins, fewer resources, greater risk, for example). Because rural populations tend to be older, sicker, poorer and have less access to employer based health insurance than their urban counterparts, therefore, a higher proportion of these populations rely on and are eligible for Medicaid and Medicare. Due to Medicaid expansion efforts over the last few years in some states, its importance has grown in rural areas, making it a potential driver for value-based care efforts.

Value-based care in Medicare focuses on shifting a portion of traditional Medicare payments from fee-for-service (FFS) to payments that incorporate performance metrics. [The Medicare Access and CHIP Reauthorization Act of 2015 \(MACRA\)](#) replaces the old reimbursement formula with a new pay for performance program for Medicare Part B FFS. For more information on MACRA and issues surrounding rural participation later in this toolkit, [click here](#). MACRA establishes new ways to pay physicians for caring for Medicare beneficiaries, includes new funding for technical assistance to providers, funding for measure development and testing, and enables new programs and requirements for data sharing. MACRA's value-based payment programs are known as the Quality Payment Program, which allows providers to participate either through the Merit Based Incentive Payments System (MIPS) or Alternative Payment Models (APMs).

Similarly, value-based care in Medicaid is encouraging the move from the standard fee for service to the use of managed care and other integrated care models. Because the traditional FFS inherently rewards volume, it is chronically fragmented, and lacks coordination. In reaction to these issues, Medicaid is expanding its use of managed care and other service and delivery and payment systems in order to improve beneficiary access to care, improve the quality of care, increase the Medicaid budget predictability, and reduce Medicaid spending. On April 25, 2016, the Centers for Medicare & Medicaid Services (CMS) issued a [final rule](#) on managed care in Medicaid and the Children's Health Insurance Program (CHIP). The rule supports state value-based care efforts, strengthening consumer experience and key consumer protections, strengthens program integrity by improving accountability and transparency, and aligns key rules with those of other health coverage programs.

Additionally, CMS is making progress on healthcare affordability and quality, including the launch, facilitation and work towards:

- [Medicare Quality Payment Program](#)
- [Comprehensive Primary Care Plus](#) and the [Next Generation Accountable Care Organization](#) (please note: participation is somewhat limited in these initiatives due to separate payment systems for RHCs)
- [State Innovation Models Initiative](#) and [Medicare-Medicaid Financial Alignment Initiative](#)

Broadly speaking, value-based care is improving how providers are paid, the way care is delivered, and the way information is distributed in order to create better care delivery, smarter spending on health care, and a healthier system overall.

Value-based care includes:

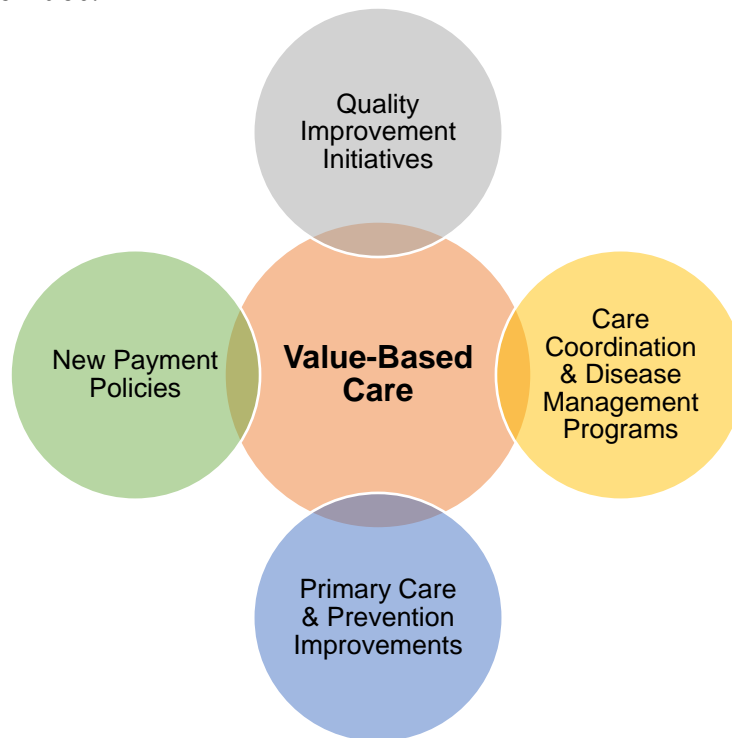


Figure 1: Value Based Care Categories

Quality Improvement Initiatives

Clinics of all sizes and geographies across the United States are facing the increasing need to adapt to new initiatives that incentivize providers through public reporting, financial reward or penalties, to demonstrate performance based on measurable indicators. While not all of the new initiatives are relevant to RHCs, the National Quality Forum identified performance measurement challenges for rural providers. This [report](#) recommends making participation in CMS quality measurement and quality improvement programs mandatory for all rural providers by allowing a phased approach and developing rural-relevant measures.

Colorado. The Colorado Rural Health Center engages their Rural Health Clinics in quality improvement efforts, communicates those efforts, shares best practices throughout the state, and uses the information in monthly educational calls and outreach.

NOSORH released [learning modules](#) to provide education and technical assistance focused on evaluating performance and quality in the RHC setting. Learn more [here](#).

Quality improvement options leading to value-based care include:

- CMS Quality Payment Program
- Accountable Care Organizations
- Chronic Care Management Reimbursement
- Hospital Outpatient Quality Reporting Program
- Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)
- Medicare and Medicaid EHR Incentive Meaningful Use Program
- Patient Centered Medical Homes
- National Rural Health Clinic Quality Project

Care Coordination and Disease Management Programs

Care coordination is the deliberate organization of patient care activities between multiple participants, facilities, levels of care, or treatment options in order to facilitate the best delivery of those care services. Disease management programs focus on the improvement of the system of chronic conditions for high risk, high cost patients. Value-based care can improve care coordination and disease management by:

- Encouraging the integration and coordination of clinical care services
- Improving population health
- Promoting patient engagement through shared decision making

North Dakota. SORH and QIO are working collaboratively to create opportunities for crossover objectives between ACOs and RHCs in ND with their Population Health Collaborative efforts.

- Encouraging innovative approaches to care (for example, assisting RHCs in transitioning to patient centered medical homes)

New Payment Policies

New payment policies are planned to move the traditional model of healthcare reimbursement of fee for service (providers getting paid by the number of visits and tests ordered for a patient), to new models that incentivize provider payments based on the quality, or value, or care they provide.

Incentives related to value-based care include:

Washington. Has developed value-based payment methodologies in Medicaid for FQHCs and RHCs, for example, with flexible payment incentives and care delivery models for CAHs. Washington is also working to develop an ACO with its rural hospitals. [Learn more here.](#)

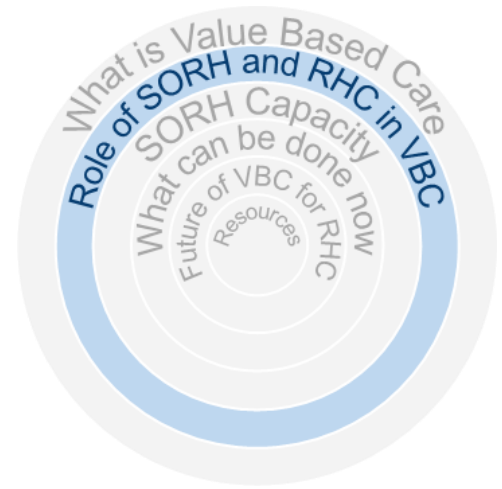
- Promoting value-based payment systems (testing new alternative payment models, increase linkages)
- Bringing proven payment models to scale
- Fostering demonstration projects to identify improvements to Medicare and Medicaid payments, working with the private sector to expand accountable care and other models proven to work
- Rewarding value and care coordination rather than volume and care duplication – pay providers for what works
- Providing incentives to local areas to implement integrated service delivery systems

Primary Care and Prevention Improvements

There is considerable evidence that comprehensive, coordinated primary care with well-targeted interventions can improve outcomes and reduce the cost of care and encourage prevention activities. Primary care and prevention improvements in value-based activities include:

- Participating in wellness and public health activities in communities
- Expanding scope of practice to compensate for workforce shortages
- Expanding of delivery options, use of non-traditional settings for care delivery
- Working with provider reimbursement rates – incentivize the delivery of comprehensive care through the use of rates based on quality/outcome measures
- Adopting of prevention programs
- Educating patient populations about Medicaid and Medicare programs and providers





ROLE OF STATE OFFICES OF RURAL HEALTH IN VALUE-BASED CARE

SORHs can support their RHCs by helping them learn from each other and be engaged in policy and other collaborative activities related to value-based care.

About Rural Health Clinics

SORHs should consider the implications of independent versus provider-based RHCs. Provider-based RHCs are owned and operated as an essential part of a hospital, nursing home, or home health agency participating in a Medicare program. RHCs operate under licensure, governance, and professional supervision of that organization, and most provider-based RHCs are hospital owned. Independent RHCs are free standing clinics owned by a provider or provider entity. Independent RHCs may need significantly more assistance than provider-based RHCs. There are currently over 4,000 RHCs with approximately 57% provider-based RHCs and 43% independent RHCs. They may be owned and/or operated by a larger healthcare system, but do not qualify for or have not sought provider-based merit. More than half of independent RHCs are owned by clinicians.

Partnerships with SORHs have been found to be helpful in all phases of community program development, especially in the early development and outreach efforts. SORHs can do many things, including providing seed funding, technical assistance, outreach, and facilitation of stakeholder meetings.

RHCs can benefit from participating in value-based care because RHCs often already provide services in alignment with the goals of VBC. Examples include:

- Primary care physicians provide a wider array of services to accommodate the needs of the community, as a result of the lower choice and competition typically characteristic of healthcare in rural areas
- Rural physicians are trained/experienced with family practice
- Rural communities are concentrated - patients are less scattered among multiple delivery systems
- Rural health care delivery often includes establishes teams of care providers
- Many rural communities are involved and engaged in health care access and delivery

The spectrum of potential involvement (shown in the below diagram) varies from those who lack awareness and education about the external incentives, to those who are too financially vulnerable to participate, to those who would welcome the potential transition as validation of their performance. Most are likely somewhere in the middle – searching for a way to participate, but unable to ascertain exactly how.



This is where the SORHs can step in. The diagram above highlights that the SORH can get involved at every level of competency and capability.

Opportunities

Plenty of work is currently underway with rural value-based care, despite the challenges in the public and private sectors. In the public sector, new payment models (such as the Accountable Care Organization (ACO) Investment Model), patient centered medical homes, State Innovation Model (SIM) programs, community transformation grants, value-based purchasing practices, and workforce initiatives are attempts to improve rural care.

The CMMI SIM initiative provides financial and technical support to states to develop and test state-led, multi-payer health care payment and service delivery models that will improve health systems performance, increase quality of care, and decrease costs for Medicare, Medicaid, and CHIP beneficiaries. At least 15 of the 20 "Model Testing States" (states supported to implement their State Health Care Innovation Plans) are pursuing initiatives that involve rural providers. [Learn more here.](#)

In May of 2016, NOSORH released a report on the Role of SORHs with State Innovation Models (SIM). [Learn more here.](#)

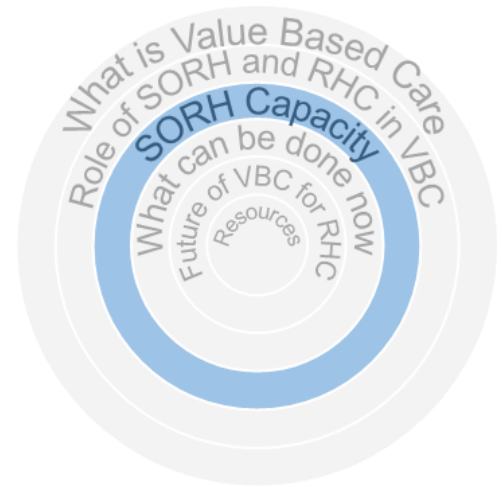
Because rural providers tend to rely heavily on Medicare/Medicaid, which when combined with low volumes limits financial capacity, a more sustainable path for rural providers could include the opportunity for limited or one-sided risk, and broader adoption and alignment of alternative payment models across payers (including Medicare, Medicaid, and private insurers). Also, workforce shortages, both in terms of number of providers and specialties represented, make it difficult for rural facilities to meet value-based care objectives and the quality standards attached to payments. In addition, state investments in system reform, as limited financial resources put rural communities on unequal footing.

When considering SORH interventions to engage RHCs in value-based care to address these challenges, opportunities for SORHs and RHCs may include the following:

- Promoting rural provider participation in ACOs and patient centered medical homes, which may create opportunities for more formal and informal collaborative partnerships
- Encouraging care coordination, which will be critical to make new delivery models successful
- Promoting community partnerships

SORHs can help empower communities to strengthen and maintain the best possible health care using existing resources, provide up to date health systems information and technical assistance, build strong partnerships to meet local and regional needs, be the single point of contact for all regional issues related to health care, and provide incentives to local areas to implement integrated service delivery systems.





STATE OFFICE OF RURAL HEALTH

CAPACITY CONSIDERATIONS

SORHs can be the facilitators of collaboration for activities in the domains of:

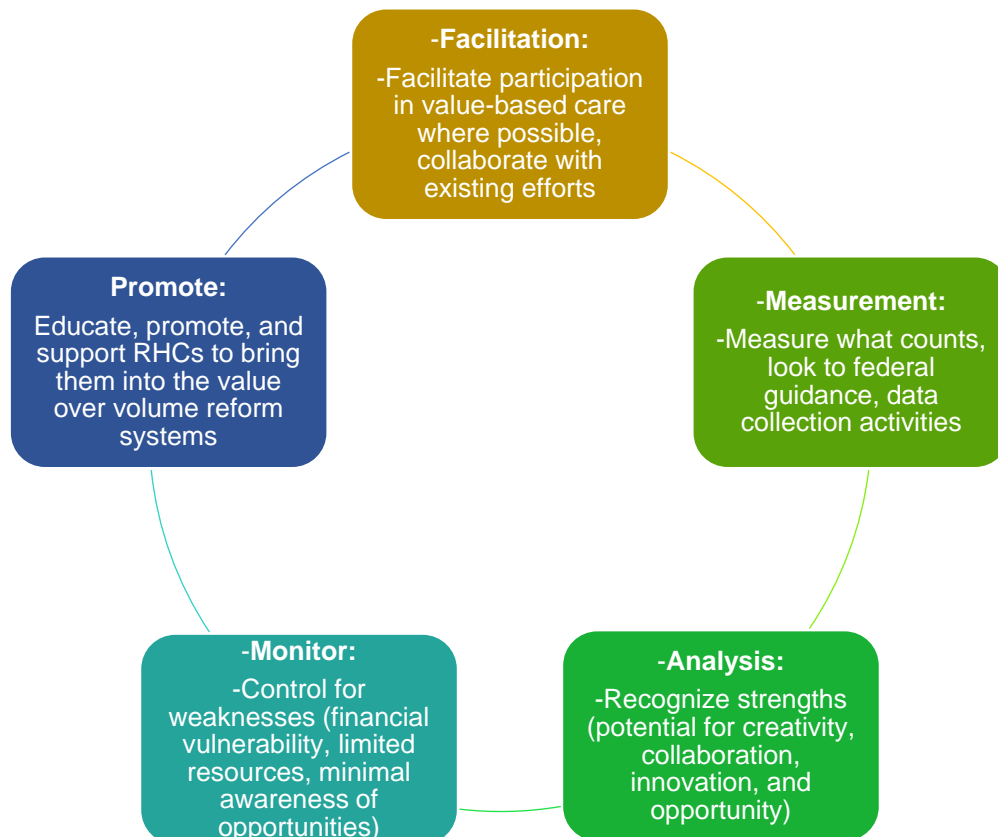


Figure 2: SORH Capacity

Facilitation:

Facilitate participation in value-based care where possible, collaborate with existing efforts

- Assist in preparation for value-based care through:
 - Education
 - Improved channels of communication
 - Encouraging financial collaboration
 - Building regional networks/co-ops and cohorts for sharing resources
 - Providing grants/TA to plan for value-based care
 - Make payment reform a priority
- Convening interested parties
- Creating partnerships
- Providing training resources, and approving training programs

Ohio. Offers workshops, conferences, meetings, and events to promote and provide resources and technical assistance to rural communities working to enhance existing systems of care, and create opportunities for new delivery system reform initiatives.

- Convene meetings, conferences, educational forums with technical experts to teach RHCs about value-based care, inform them about new legislation, and highlight upcoming opportunities

Promote:

Educate, promote, and support RHCs to bring them into the value over volume reform systems

- Advocate for the RHCs' full participation in value-based care
 - Accountability to goals rather than traditional outcomes
 - Alleviation of barriers to participation due to low volume and financial vulnerability
 - Recognition of workforce issues

South Carolina. The SCORH meets with the Medicaid managed care plans quarterly, brings attention to things they need to be aware of, and meets with local Medicaid offices to coordinate with them. Together, the SCORH and Medicaid discuss quality, claims issues, non-covered benefits, for example. The SCORH has built an excellent relationship with their state Medicaid offices in order to be an advocate for their RHCs.

- Assist in eligibility issues and the speed of system development and adoption

Monitor:

Control for weaknesses (financial vulnerability, limited resources, minimal awareness of opportunities)

- Educate RHCs about delivery system options, and how they can engage in alternate models of care
- Assist in securing funding for participating in value-based care (grants, contracts with insurance providers or employers, for example)
- Conduct value-based care readiness assessments, provide self-assessments
 - Survey RHCs to see if and how they are ready to pursue or prepare for value-based care activity
- Provide information and education about Health Information Technology (HIT), Health Information Exchanges (HIE), and Electronic Health Records (EHR) to rural communities

Colorado. The Colorado Rural Health Center conducts outreach to their Rural Health Clinics by assessing business practices (building and maintaining strong foundation for clinics) to determine their ability to participate in delivery system reform activities.

Analysis:

Recognize strengths (potential for creativity, collaboration, innovation, and opportunity)

- Get involved with strategic discussions on reimbursement to incentivize providers and facilities
- Begin and participate in licensure/scope of practice discussions to address workforce issues
- Participate in national programs that promote, facilitate, and assist states in achieving value over volume with value-based care activities. For example, the National Academy for State Health Policy has an annual [“Value-Based Payment Academy: Advancing Value-Based Payment Methodologies for Federally Qualified Health Centers and Rural Health Clinics”](#) where states are selected to participate to get support in transforming how care is paid for and delivered. They will receive 12 months of targeted technical assistance to support the development and implementation of value-based APMs. Current participants selected for the 2015-2016 year are:
 - Colorado
 - Hawaii
 - Michigan
 - Nevada
 - Oklahoma

- Washington DC

Measurement:

Measure what counts, look to federal guidance, data collection activities

- Evaluation and data collection
- Facilitate the collection of data for RHCs in order to:
 - Inform advocacy efforts
 - Manage and measure outcomes, providers, and service utilization
 - Help identify opportunities for more effective and coordinated care
 - Track progress on initiatives
- Collect data on:
 - Quality measures
 - Outcome benchmarks
 - Healthcare Effectiveness Data and Information Sets (HEDIS)
 - Consumer experiences and perceptions of quality
 - Public reporting for health plan performance
 - Data from Meaningful Use activity
- Assist in the creation of cohorts of RHCs to conduct research, develop projects, and monitor programs
- Creating transparency on cost and quality information
- Bringing electronic health record information to the point of care for meaningful use
- Using HIT to support evidence-based medicine and improve patient care through reporting of health outcomes
- Working with electronic health record (EHR) vendors to build practice-based tools and reporting
- Incorporate quality reporting and data aggregation tools into a health information exchange platform

Other Coordination Activities

Some SORHs are engaging their RHCs in programs centered around Patient Centered Medical Homes (PCMHs), care coordination, quality improvement, and patient satisfaction. These programs can be implemented when SORHs actively:

- Seek funding sources to accomplish this work
- Build strong partnerships to meet local and regional needs
- Facilitate accreditation processes
- Partner with other state agencies to coordinate the work being done with the RHCs in the state

South Carolina. The SCORH, with the SC Center for Practice Transformation, are transforming primary care practices as Medical Homes. Roughly 120 practices with >520 providers have obtained NCQA recognition (56 nurse practitioners are recognized as practicing in a PCMH, and 56 physician assistants). Organizations in South Carolina are working together to support the development of the medical homes, and there's growing alignment to support practice transformation (for Meaningful Use, EHR implementation, etc.). Additionally, SC Medicaid incentivizes practices to pursue PCMH recognition (\$0.50, \$1.00, \$1.50, \$2.00 PMPM for pursuit, Level I, Level II, and Level III).

Technical Assistance Opportunities

It is critically important to seek out technical assistance opportunities in value-based care, to help states and RHCs finance efforts in value-based care activities. Below are three of the largest opportunities for states to secure technical assistance:

- National Association of Rural Health Clinics (NARHC) Technical Assistance listserv: [sign up here](#), Technical Assistance Calls, and [past webinars](#).
- [Transforming Clinical Practice Initiative \(TCPI\)](#): Round two, updated September 2016, will provide up to \$5 million to two awardees over the next three years to leverage primary and specialist care transformation work and learning to catalyze the adoption of Alternative Payment Models on a large scale. Support and Alignment Networks 2.0 represents a significant enhancement to the TCPI network, and will help clinicians prepare for the new [Quality Payment Program](#). The results of the TCPI work may provide insight into how RHCs need to transform their care to improve quality outcomes, improve health and reduce costs. For more on the current TA announcement, and the awarded networks, see [here](#).
- MACRA: \$100 million in technical assistance, \$20 million each year over the next five years, was awarded to [11 organizations](#) to provide technical assistance to MIPS eligible clinicians in small practices, rural areas, and practices located in geographic health professional shortage areas (HPSAs), including IHS, tribal, and urban Indian clinics.

North Dakota. ND SORH uses TCPI to assist the Practice Transformation Networks to conduct their practice assessments.

Organizations for SORH Collaboration and Outreach

When engaging RHCs as outlined in this toolkit, SORHs should take advantage of the existing networks within their states. Some of these networks and organizations may be looking to work with RHCs, or may already be doing so. SORH can encourage the building of state teams of different organizations. Some state-based organizations to reach out to include:

North Dakota. Partners, frequently works with Great Plains Quality Improvement Office, who has a good relationship with the Rural Health Clinics. Developed network of trusted partners – hospital association, medical association, other state based organizations to take on: Regional Extension Centers, MACRA/MIPS, Meaningful Use, EHR activities, apply for Technical Assistance, ACO work, TCPI, Practice Transformation Networks.

- Primary Care Office: the role of the PCO in value-based care could include a focus on collaboration for access of care issues, safety net concerns, and intersections between health agencies and community health centers.

➡ Find your PCO and talk to them about RHC participation in value-based care.

- Primary Care Associations: State and regional PCAs are a great resource for collaboration, as they are able (through HRSA) to provide technical assistance and training to potential and existing health centers and other safety net providers, support the development of health centers, and enhance the operations and performance of health centers.

➡ Reach out to your state or regional PCA, and talk to them about RHC participation in value-based care.

- Quality Improvement Organizations: QIOs work under the direction of CMS to assist providers with quality improvement and to review quality concerns, which creates great potential for SORH-facilitated collaboration in CMS value-based care initiatives.

Colorado. Has partnered with the state's QIO to apply for MACRA technical assistance funds, as it made more sense for the QIO to help with the rural health clinic engagement as that is their domain.

➡ Contact your QIO to see what they're working on, and how they're engaged with the state's RHCs.

- CMS Regional Office Rural Health Coordinators: The CMS Regional Office Rural Health Coordinators provide technical, policy, and operational assistance on rural health issues.



[Find the list of coordinators here](#), on the CMS Rural Health Open Door Forum website.

The Rural Health Open Door Forum (ODF) addresses issues for RHCs, Critical Access Hospitals, and Federally Qualified Health Centers, including questions related to clinical practice and CMS payment systems.

- **State Rural Health Associations:** SRHAs naturally unite diverse groups within state representing a broad variety of rural constituencies dedicated to preserving and improving rural health care. SRHAs are grassroots organizations, conduits for networking and coalition building, rural health advocates, educators, and resource coordinators. As the unified voice for rural health, the SRHA is a great resource for RHC engagement and assessments.



[Find your State Rural Health Association](#), and see what collaborations in value-based care can be taken on in the state.

- **Rural Health Clinic Associations:** Provide communication channels among RHCs, provides information specific to RHCs, work as advocates to support and strengthen RHCs, offer technical assistance, educational opportunities, and work to improve the quality of healthcare.



[See if your state has a RHCA](#), and contact them for potential value-based care opportunities.

Flex Program

The Medicare Rural Hospital Flexibility (Flex) Program provides funding to states to encourage the development of cooperative and coordinated systems of care in rural areas by partnering Critical Access Hospitals, Emergency Medical Services (EMS) providers, clinics, and practitioners to increase quality of care, and create opportunities for efficiencies. The Flex Program supports Critical Access Hospitals (CAHs) to promote quality and performance improvement including:

- Stabilizing finances;
- Integrating emergency medical services into health care systems;
- Incorporating population health; and
- Fostering innovative models of health care.

Under the Flex Program, the Medicare Beneficiary Quality Improvement Project seeks to improve the quality of care provided in CAHs by voluntarily reporting measures not

Michigan. The Michigan Flex Program has developed a Rural Health Clinic Quality Network (RHC QN) that meets quarterly. Measures have been developed and rural health clinics are submitting to a benchmarking tool. The measures are tobacco cessation, controlling high blood pressure and body mass index (BMI) screening and follow up. 33 RHCs are participating in collecting the measures and over 65 RHCs are active in the RHC QN.

required by CMS. States coordinate technical assistance based on the needs of hospitals in their state.

Within the Flex program, while mainly focused on Critical Access Hospitals, a SORH's role may include involving RHCs by:

- Assisting with community health needs assessment efforts
- Assisting with community paramedicine outreach efforts
- Encouraging stakeholder involvement
- Ensuring data collection and evaluation efforts

For information on state flex programs, please see:

- State Flex Profiles: <https://www.ruralcenter.org/tasc/flexprofile>
- Flex Fundamentals guide: <https://www.ruralcenter.org/tasc/flex-program-fundamentals>
- Flex Program main page: <https://www.ruralcenter.org/tasc/content/flex-program>

Potential Levels of Technical Assistance SORH can Provide to RHCs

Limited

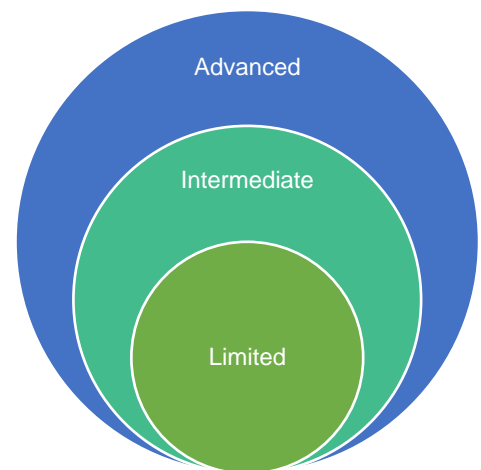
This level of TA is for small SORH, with limited resources and staff, there are some possibilities for how to engage RHCs in value-based care. One is to find a Medicaid resource, with expertise in Medicaid billing for RHCs – this is of great value to the RHCs because it's tough for national organizations and even consultants to cover the issues surrounding Medicaid.

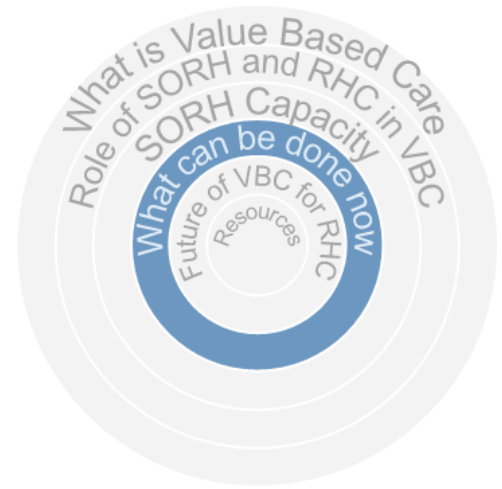
Intermediate

This level of TA is for a SORH with more staff and resources. Some activities could include putting on a state conference, or other educational forum that goes over benefits, government programs, nonprofit grants, or other activity related to VBC. Whether that conference is in combination with the State Rural Health Association or RHC association, be sure to have information about RHC workshops and other state level organizations that can help in education, outreach, and advocacy for value-based care.

Advanced

This is for a large, well-funded and supported SORH that has the capacity to take on a full range of activities including cost reports, helping clinics conduct surveys and apply for certification or accreditation of advanced payment models, collaborate with existing value-based care networks to increase rural inclusion, and act as a state level resource for all value-based care for rural clinics.





WHAT CAN STATE OFFICES OF RURAL HEALTH & RURAL HEALTH CLINICS DO Now

As a SORH, what can be taken on right now with the RHCs? The following are examples of value-based care activities that states are leveraging, with RHC participation (if not actively participating, anticipating and preparing for value over volume changes). It is important for each state to determine the activities and delivery system reform work they take on based on local expertise, capacity, and needs.


State Medicaid

South Carolina. Medicaid expert/advocate: SCORH meets with Medicaid managed care plans quarterly, bringing attention to things they need to be aware of with regard to RHCs. They also meet with local Medicaid office to share information and concerns, and to have conversations about quality, claims issues, and things that aren't being covered.

SORHs play a critical role in defining project scopes, managing projects, supporting successful transformations and innovations, investing in local and regional priorities, and coordinate and consolidate the multiple available sources of support for RHCs. Some of the ways SORHs can engage RHCs with state resources to participate in value-based care are:




Where possible, have a Medicaid expert on staff (or on-call), dedicated to Medicaid reforms for RHCs.




Identify state priorities, expand Medicaid alternative payment models, designed to enable rural health delivery system to meet state-based priorities, emphasize accountable systems, enhance collaboration and integration of care


Washington. “With strong support from these clinics and hospitals, the state will introduce a value-based alternative payment methodology in Medicaid for FQHCs and RHCs and pursue flexibility in delivery and financial incentives for participating CAHs. The model will test how increased financial flexibility can support promising models that expand care delivery options such as email, telemedicine, group visits and expanded care teams.” [Learn more here.](#)




Promote the expansion and development of integrated and comprehensive primary care using start up grants, cooperative agreements (such as the State Innovation Model funding awards), technical assistance programs (like TCPI), and in general payment policies that support transformation and expansion




Expand value-based payment and care (for example, through a patient centered medical home)




Work with Medicaid to support community health worker training, teaching health centers, and Area Health Education Center (AHEC) programs that provide training – and collaborate with these organizations to engage the RHCs



Support and help facilitate the development and implementation of population health data management platforms and skills, health information exchanges, electronic health records – RHCs should be offered education about federal and state incentives through demonstration programs and payment systems



Advocate for, provide education, and promote rural specific reporting standards and payment approaches (common indicators for rural providers, assist in implementing performance measurement and reporting systems, align and make transparent Medicaid managed care data and performance)



Use the National Resource Center’s RHC listserv

Transforming Clinical Practice Initiative

The Transforming Clinical Practice Initiative (TCPI) is designed to help clinicians achieve large-scale health transformation. It promotes broad payment and practice reform in primary and specialty care, promote care coordination between providers of services and suppliers, establishes community-based health teams to support chronic care management, and promotes improved quality and reduced cost by developing a collaborative of institutions to support practice transformation.

North Dakota. ND SORH uses TCPI to assist the Practice Transformation Networks to conduct their practice assessments.

Rural Considerations

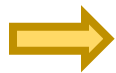
Within the TCPI exist [Practice Transformation Networks](#) (PTNs), which are peer-based learning networks designed to coach, mentor, and assist clinicians in developing core competencies specific to practice transformation. These networks are to include at least 20 percent participation from clinicians in rural and underserved areas, and provide them with technical assistance in quality improvement and reporting programs. SORHs with PTNs in their state can contact their respective networks and collaborate to engage their RHCs where appropriate. Below is a list of PTNs across the country.

- Arizona Health-e Connection
- Baptist Health System, Inc.
- Children's Hospital of Orange County
- Colorado Department of Health Care Policy & Financing,
- Community Care of North Carolina, Inc.
- Community Health Center Association of Connecticut, Inc.
- Consortium for Southeastern Hypertension Control
- Health Partners Delmarva, LLC
- Iowa Healthcare Collaborative
- Local Initiative Health Authority of Los Angeles County
- Maine Quality Counts
- Mayo Clinic
- National Council for Behavioral Health
- National Rural Accountable Care Consortium
- New Jersey Innovation Institute
- New Jersey Medical & Health Associates dba CarePoint Health
- New York eHealth Collaborative
- New York University School of Medicine
- Pacific Business Group on Health
- PeaceHealth Ketchikan Medical Center
- Rhode Island Quality Institute
- The Trustees of Indiana University
- VHA/UHC Alliance Newco, Inc.
- University of Massachusetts Medical School
- University of Washington
- Vanderbilt University Medical Center
- VHQC
- VHS Valley Health Systems, LLC
- Washington State Department of Health

In addition to the PTNs, the TCPI created [Support and Alignment Networks](#) (SANs) that support the recruitment of clinician practices serving small, rural, and medically underserved communities and play an active role in the alignment of new learning opportunities. SORHs should also contact these networks within their respective states to collaborate on recruiting rural clinics into the TCPI. Below is a list of SANs.

- American College of Emergency Physicians
- American College of Physicians, Inc.
- HCD International, Inc.
- Patient Centered Primary Care Foundation
- The American Board of Family Medicine, Inc.
- Network for Regional Healthcare Improvement
- American College of Radiology
- American Psychiatric Association
- American Medical Association
- National Nursing Centers Consortium

Support and Alignment Networks, Version 2.0, will provide up to \$10 million over three years to leverage primary and specialist care transformation to catalyze the adoption of Alternative Payment Models (APMs). Represents a significant enhancement to the TCPI network expertise and will help clinicians prepare for the proposed new Quality Payment Program, which CMS is implementing as part of bipartisan legislation.



SORHs should look at the existing PTNs and SANs (and check back for the second round of SANs) to see if there is an opportunity to work with their RHCs to increase rural inclusion.

Patient Centered Medical Home

Patient Centered Medical Homes (PCMH) is a model of the organization of primary care that delivers the core functions of primary health care. A PCMH is comprehensive, patient-centered, offers accessible services, coordinates care, and demonstrates a commitment to quality and safety.

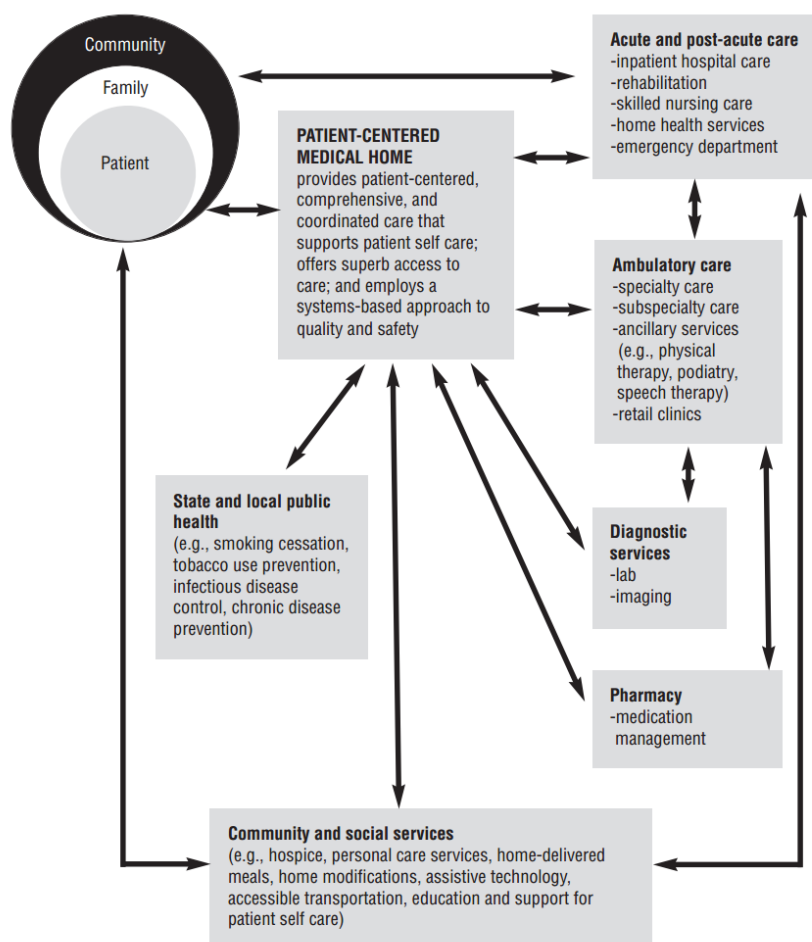


Figure 3: PCMH Agency for Healthcare Research and Quality (AHRQ) "Coordinating Care in Med Neighborhood", 2011

The practices that PCMH have to adopt in terms of coordination of care, follow through, and training of providers is an improved way to deliver care. While some SORHs engage in PCMH activity without full participation/designation from their RHCs, there are measurable benefits of learning these best practices, processes, techniques, and tools.

Although no federal support program currently exists to assist RHCs in gaining recognition as a PCMH, they are eligible to do so. The PCMH model of care generally requires that a patient have a continuing relationship with a healthcare team that coordinates patient care to improve access, quality, efficiency, and patient satisfaction.

Colorado. Approximately 5 of Colorado's Rural Health Clinics are PCMH certified through NCQA. The Colorado Rural Health Center facilitated these efforts, helping the clinics check off the hundreds of requirements and supporting the work for PCMH.

Moving in this direction, regardless of achieving PCMH recognition, makes sense for RHCs as they will be better positioned for providing value-based care.

An example of a rural PCMH that achieved Level 3 PCMH recognition (the highest recognition available by the National Committee for Quality Assurance (NCQA)) is the Crete Area Medical Center Physician's Clinic (CAMC), an RHC in Crete, Nebraska. One specific advantage CAMC noted in their PCMH process is that they had implemented EHR prior to beginning the PCMH process, and their biggest challenges related to issues of cost and data. With the Level 3 recognition they now focus on: enhancing patient access, managing patient populations, planning and managing care, providing community resources, coordinating care with other facilities and improving performance. For more about this PCMH, see the resources below.

According to evaluative studies, the push for rural facilities to adopt the PCMH model is a result of:

- Growing shortages of primary care providers
- Increasing prevalence of chronic disease
- Fractured and disconnected delivery systems
- The need to better manage patient care
- Opportunity to refocus the central role of primary care
- Some states are now requiring PCMH for Medicaid reimbursement

Advice for RHCs (who have the biggest challenges and struggles in obtaining PCMH recognition) includes:

- Target key clinical and operational areas and develop protocols and procedures that directly impact clinical performance (such as focusing on meaningful use of EHR)
- Implementing continuous quality improvement systems
- Enhancing patient access
- Improving practice performance on key metrics
- Publicly reporting quality data

PCMH Legislation Examples.

Arkansas – requires Qualified Health Plans offered on the Arkansas exchange to participate in an initiative, which includes assignment and support for PCMH for providers.

Maryland – has a law that requires the state's five major carriers of fully insured health benefit products to participate in the Maryland multi-payer patient centered medical home program.

Montana – has a law requiring the insurance commissioner to rely on a council of stakeholders to create standards for the PCMH Act, qualify health care providers and insurers to participate, and promote the program.

[Learn more about PCMH Legislation](#)



SORHs should take this opportunity to assist RHCs in transforming to the PCMH model by encouraging them to follow the above strategies, to position themselves in a healthcare world that is moving from volume to value.

Accountable Care Organizations

An Accountable Care Organization (ACO) is an organization of health care providers, that is accountable for the quality, cost, and overall care of Medicare beneficiaries assigned to the ACO. Participants include group practice physicians and professionals, networks of physicians and professionals, partnerships of joint venture arrangements of physicians, professionals, or hospitals, or hospitals employing physicians and professionals, and other organizational structures as approved by the Secretary of HHS. ACOs are required to have a sufficient number of primary care physicians for the number of assigned beneficiaries (5000 at a minimum), they must participate for a minimum of three years, and have a formal legal structure.

ACO Investment Model

As a rural friendly example, the ACO Investment model encourages ACO development in rural and underserved areas. Of 43 new participants, 35 have at least 65 percent of delivery sites in rural areas, and 24 have 85 percent or more of their delivery in rural areas.



Figure 4: CMS, map of ACO Investment Models

For more on the ACO Investment Model, see the CMS Innovation Center website for fact sheets, frequently asked questions, eligibility, and a list of participants:

<https://innovation.cms.gov/initiatives/ACO-Investment-Model/>

How Rural Health Clinics Can Participate

Massachusetts. CMS is working towards finalizing Massachusetts' request for the restructuring of its 1115 waiver that transforms MassHealth from a mix of fee-for-service and Medicaid managed care to a system of provider-led ACOs operating in partnership with community-based organizations. [Learn more here.](#)

ACOs establish incentives for healthcare providers to coordinate care among different settings – hospitals, clinics, long-term care – when working with individual patients. ACOs are rewarded when they meet certain performance standards by CMS, who has also published regulations that help

doctors and hospitals coordinate care through ACOs (with specific provisions to increase the participation by rural providers). RHCs are able to participate in the Medicare Shared Savings Program and become an ACO, or join an existing ACO. However, there are specific requirements regarding beneficiary assignment that must be met by the ACO.

CMS recognizes the unique needs and challenges of rural communities and the importance of rural providers in assuring access to healthcare. RHCs, and other facilities such as critical access hospitals and federally qualified health centers, play an important role in health care by serving as the safety net

providers of primary care and other health care services in rural and other underserved areas for low-income beneficiaries. CMS has regulations to allow doctors, hospitals, and other health care providers to better coordinate care for Medicare patients through ACOs, including provisions designed to increase rural participation in the Shared Savings Program. A final rule was issued in June 2015, and included modifications to program regulations to facilitate participation by ACOs that include rural providers.

Colorado. Approximately 30 of Colorado's Rural Health Clinics are signed up with the Regional Care Collaborative Organization for the Accountable Care Collaborative.

Things SORH should consider when helping RHCs join a Rural ACO

- Governance questions
- Creation/maintenance of leverage with payers and referral network
- Claims data
- Waivers
- Recognition as high value provider

Chronic Care Management

The Chronic Care Management (CCM) service provides payment of care coordination and care management for a beneficiary with multiple chronic conditions within the Medicare Fee For Service Program. Medicare will not make duplicative payments for the same or similar services for beneficiaries with chronic conditions already paid for under the various CMS advanced primary care demonstration and other initiatives, such as the Multi-Payer Advanced Primary Care Practice (MAPCP) or the Comprehensive Primary Care (CPC) Initiatives. As CMS implements new models or demonstrations that include payments for care management services, or as changes take place that affect existing models or demonstrations, it will address potential overlaps with the CCM service and seek to implement appropriate payment policies.

CCM scope of services include:

- Structured data recording
- Care plans
- Access to care
- Case management

Beginning January 1, 2016 Medicare pays RHCs separately under the Medicare Physician Fee Schedule (PFS) under the American Medical Association Current Procedural Terminology (CPT) code 99490 for non-face-to-face care coordination services furnished to Medicare beneficiaries with multiple chronic conditions, and RHCs were able to bill for CCM. RHCs can bill for CCM services when an RHC practitioner furnishes a comprehensive evaluation and management visit, annual wellness visit, or initial preventive physical examination to the patient prior to billing the CCM service, and initiates the CCM service as part of this visit. Effective January 1, 2017 RHCs can provide general supervision for this service. Additionally, CCM services:

- Can be billed in addition to all-inclusive encounter rate
- Requires at least 20 minutes monthly of care coordination activity “directed by a physician or other qualified health professional,” and patients must have two or more chronic conditions expected to last 12 months or until death of the patient
- A patient centered care plan must be in place, as well as case management services and EHR technology



SORHs should take this opportunity to coordinate with their RHCs to educate them about CCM, track the new regulations and changes, and promote a CCM initiative.



FUTURE OF VALUE-BASED CARE FOR RURAL HEALTH CLINICS

The opportunity for RHCs to provide value based care is growing under various payers including Medicare, Medicaid, and the private insurance market. In Medicare, there is a growing recognition that RHCs desire to participate more in quality reporting and recent provisions by CMS may make this possible.

In 2015, when the Department of Health and Human Services announced new goals and timelines for moving Medicare reimbursement from fee for service to value-based payment, these reforms focused predominantly in urban centers. Inclusion and participation from rural providers in Medicare payment reform is critical to make system-wide changes across the country – rural health systems should be organized to create integrated care. Rural system capacity needs to be built up in order to support integrated care, rural facilities should be offered facilitated participation in value-based payments, and larger systems should work to develop rural-appropriate payment systems.

Currently, in order to emphasize value over volume, value-based care relies on existing pricing systems, and on encouraging more participation in alternative value-based payment systems (especially from rural providers).

Challenges

- RHCs are paid an inclusive rate for qualified primary care visits rather than under the physician fee schedule. Thus, they do not typically report quality data under the Physician Quality Reporting System (PQRS) nor is there a mechanism to require their reporting under the new Merit-based Incentive Payment System (MIPS) -

making RHC participation in value-based care physician payment systems voluntary, and sometimes without incentive.

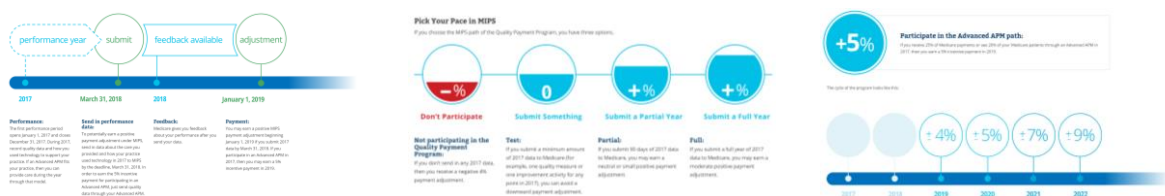
- Even with voluntary reporting under MIPS, RHC claims reports do not accurately reflect cost when there is more than one service.
- Challenges for participation in alternative payment models include restrictions based on patient assignment and cost attribution in ACOs, and the fact that rural providers have lower volume, inadequate access to data for price setting, and fewer partners to engage in integrated delivery systems (making efficient bundling a challenge)
- RHC payments are not counted towards the 5% lump sum bonus that qualified providers receive for participating in an Alternative Payment Model.

Preparing for the Quality Payment Program

[The Quality Payment Program](#) was authorized by MACRA, which ended the Sustainable Growth Rate Formula. QPP improves Medicare with a focus on quality and patient health. QPP provides tools and resources to help give patients higher quality health care, with two tracks to choose from:

- Advanced Alternative Payment Models (APMs): When planning to participate in an Advanced APM, through Medicare Part B RHCs may earn an incentive payment for participating in an innovative payment model.
- The Merit Based Incentive Payment System (MIPS): When participating in traditional Medicare Part B, RHCs are exempt and anything billed under a clinician under the fee schedule would be subject to low volume exemptions.

For an in depth, visually based (screenshots below), interactive walk-through of the entire QPP system please follow this link: [The Quality Payment Program](#)



RHCs are exempted from participating in QPP and will not be affected by QPP payment adjustments at this time. However, physician and other clinicians that provide Part B services and submit claims using the [1500 form](#) may be required to participate. For a list of common questions you may have about the MACRA final rule and how RHCs are impacted, please see NARHC's ["RHC Guide to the MACRA Final Rule."](#)

Quality Measure Development Plan

The CMS Quality Measure Development Plan (MDP), required by MACRA Section 102, is a framework to build and improve quality measures for clinicians that will support the transition to MIPS and Advanced APMs.

Starting in performance year 2019, clinicians could qualify for incentive payments based in part on participation in Advanced APMs developed by non-Medicare payers, such as private insurers or state Medicaid programs. This is a critical thing for SORHs to pay attention to, as it establishes the likelihood that the rest of the health insurance system (including self-funded) may adopt similar programs (so even as facilities drop out of Medicare, these payment models may apply).

The proposed rule also establishes the Technical Advisory Committee to review and assess additional physician-focused payment models suggested by stakeholders. The performance year to calculate payment adjustments that begin in 2019 is the 2017 calendar year.

One point to note that is if RHCs get a good “score,” they could convert to non-RHC status, if they choose to do so.

SORHs can step in here to assist RHCs who are looking to measure their performance, and in the event of a good score, convert to non-RHC status.

Fee Schedule Legislation

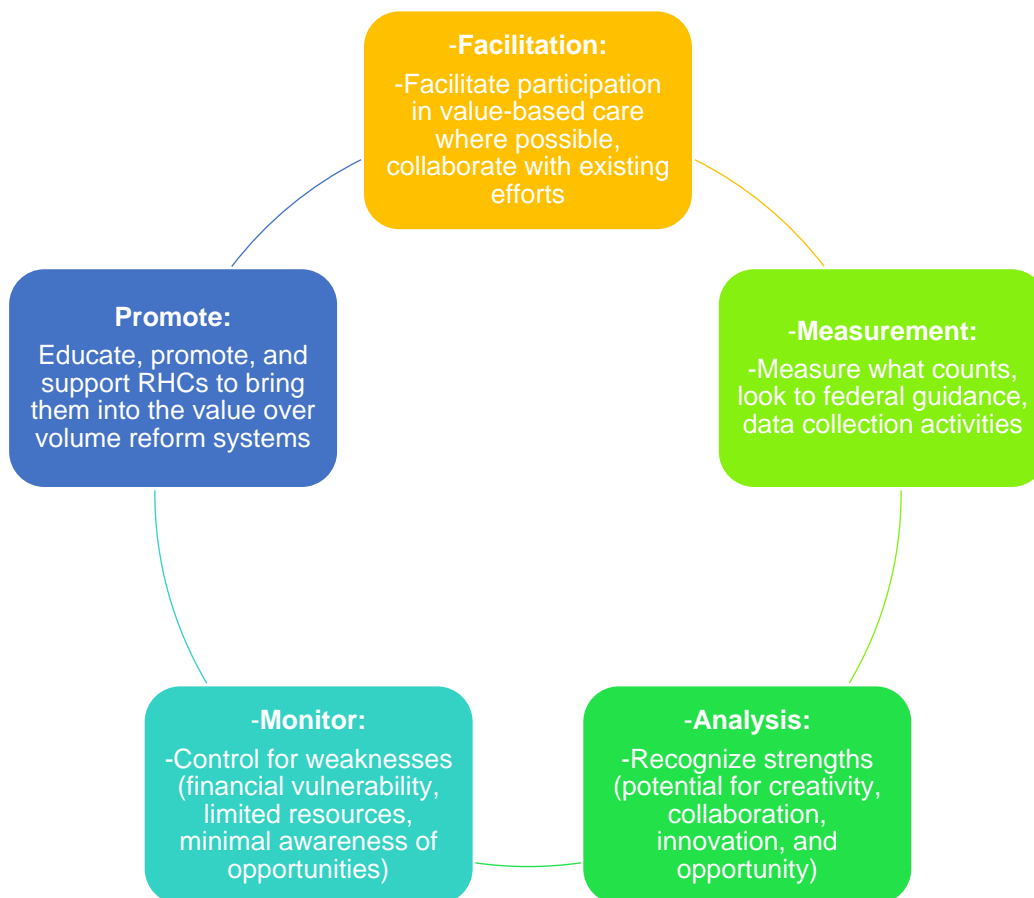
When looking to value-based care, SORHs can support RHCs by tracking, educating, and updating their clinics on changes in fee schedules. This is an opportunity for SORHs to engage RHCs. To prepare for this SORHs should know what issues their RHCs are facing, and how this can translate to comments on the federal level based on their state’s priorities.



CONCLUSION

RHCs face significant challenges in a quickly and perpetually changing healthcare environment – due to their size, financial vulnerability, potentially low-volume, and unique health care needs that vary by rural community. Despite these limitations, RHCs will be able to work towards value-based care goals – if provided with the education, support, and resources that the SORHs can offer. SORHs should encourage collaboration, system affiliation, make full use of existing capacity to educate RHCs, and test out models of care. Ultimately, when RHCs are engaged in value-based care, broad health care transformation is possible.

In short, SORHs should attempt to work on:



Examples of what SORHs are Doing Now

The following SORH and state based information was obtained through research and key stakeholder interviews.

COLORADO	
SORH	<p>Colorado Rural Health Center</p> <p>An independent, non-profit, membership-based organization that serves as the SORH for Colorado. Offers programs and services to ensure that rural communities have access to adequate healthcare.</p>
VBC Work	<p><i>Why Value-based care?</i></p> <ul style="list-style-type: none"> • Recognize the importance of participating in value over volume, to prepare for . • All the pieces are interconnected; the head is not removed from the body. • True integration is difficult, but critical • Critical for RHC sustainability, access to care <p><i>What do you do in Value-based care?</i></p> <ul style="list-style-type: none"> • Outreach to RHCs: through RHC assessments, which assesses business practices (building a strong foundation for clinics) to determine their ability to participate in value-based care initiatives • Engage RHCs in quality improvement efforts: most basic efforts up to full spectrum capacity (and communicating those efforts); share best practices, and use information in monthly educational calls/outreach • Provide leadership through SORH grant (have to collect a lot of those states about rural as part of the SORH grant), way to reach out/partner with public health (Flex grant, CHIP grant) • Empower RHCs to tell their story, not just to policy makers but to community leaders (especially as things transition more to primary care as opposed to inpatient hospital care). • National Rural Health Day – an opportunity to reach out to RHCs, provide education, facilitate collaboration, and make meaningful connections. • Colorado QIO applied for MACRA funds, CRHC will collaborate for RHC participation and engagement • Approximately 5 of Colorado's RHCs are PCMH certified through NCQA. The Colorado Rural Health Center facilitated these efforts, helping the clinics check off the hundreds of requirements and supporting the work for PCMH. • Approximately 30 of Colorado's RHCs are signed up with the Regional Care Collaborative Organization for the Accountable Care Collaborative. • Advocate for RHCs by getting engaged with Medicare and Medicaid on the statewide level to be able to express RHC-specific concerns, work with insurance exchanges and rates on behalf of RHCs, work with the All Payer Claims Data • Sharing what is happening in and out of state; collaborating with other states; gathering information about rules and regulations, what the barriers are for RHCs doing integrated care • Taking the pieces of delivery system form piece by piece to pull together the bigger picture (to not overwhelm RHCs, and overburden them)
IOWA	
SORH	<p>Iowa State Office of Rural Health (IASORH)</p>

	Helps rural communities and organizations identify and resolve issues, and build rural health infrastructure. Provides rural health advocacy and outreach, coordination of rural health resources, and consultation to communities and health care providers in rural Iowa communities. Part of the Bureau of Oral and Health Delivery Systems, which in turn is part of the Iowa Department of Public Health.
VBC Work	<p>The SORH is a federal-state partnership to help rural communities and organizations identify and resolve issues and build rural health infrastructure. The office provides rural health advocacy and outreach, coordination of rural health resources and consultation to communities and healthcare providers in rural Iowa communities.</p> <p><i>Materials developed by SORH include:</i></p> <ul style="list-style-type: none"> • Iowa National Rural Health Day Poster • Iowa Rural/Agricultural Health and Safety Resource Plan • Iowa Population Density Map • Iowa Rural Health IT Collaborative White Paper • Federal Rural Health Grant Resources • Iowa Rural Health Update <p><i>Value-based care, Current Activity</i> With a recent leadership change, the IASORH is working on reigniting work on value-based care and RHC participation in those efforts. Iowa is in the process of contacting all of their RHCs, using a newsletter to promote education and outreach on value-based care activities, polling RHCs on their respective communities' priorities (such as education and technical assistance needs).</p> <p><i>Value-based care Related Activity</i></p> <ul style="list-style-type: none"> • Center for Rural Health and Primary Care Advisory Committee • History of involvement in RHC participation in PCMH, as promoted by the Behavioral Health Department • Strong SIM program • Patient Advisory Committee

MASSACHUSETTS

SORH	<p><u>MA State Office of Rural Health</u></p> <p>The Massachusetts (MA) State Office of Rural Health (SORH) builds partnerships in order to increase access to health services, develop better systems of care, and improve the health status of rural communities.</p> <p>Major areas of activity include:</p> <ul style="list-style-type: none"> • Collection and dissemination of rural health information through a variety of means. • Coordination of rural health networking activities within the state and region. • Provision of technical assistance for planning, development, and implementation of local rural health projects and initiatives. • Providing leadership to strengthen local, state, and federal partnerships and secure additional resources to improve rural health. • Administration of the MA Rural Hospital Programs including the Medicare Rural Hospital Flexibility Program and the Small Rural Hospital Improvement Program. • Administration of Massachusetts' participation in the National Rural Recruitment and Retention Network (3R Net). • Leadership and coordination for special rural initiatives such as rural healthcare systems transformation, telehealth including telemedicine, community based behavioral health services, community engagement strategies and community coalition development, healthcare quality, operational, and financial improvement, the development of community based health safety net services and new models of rural healthcare, healthcare workforce
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	recruitment and retention, sexual assault and family violence services, oral health, primary stroke services, and EMS.
VBC Work	CMS is working towards finalizing Massachusetts' request for the restructuring of its 1115 waiver that transforms MassHealth from a mix of fee-for-service and Medicaid managed care to a system of provider-led Accountable Care Organizations (ACOs) operating in partnership with community-based organizations. http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/masshealth-innovations/mass-health-restructuring-overview-document.pdf

MICHIGAN

SORH	<p>Michigan Center for Rural Health (MCRH)</p> <p>Serves as the Michigan State Office of Rural Health and the Michigan State Rural Health Association. Coordinates resources and activities statewide, collects and disseminates information concerning rural health issues, promotes recruitment and retention of health professionals, and strengthens state/local/federal partnerships. Sponsors the Rural EMS Leadership Academy. Maintains maps and lists of CAHs and RHCs.</p>
VBC Work	<p><i>Specific Value-based care Work</i></p> <ul style="list-style-type: none"> • MCRH is working with Caravan Health, formerly the National Rural ACO. • Greater Michigan Rural ACO • Southern Michigan Rural ACO • 22,000 Medicare beneficiaries across the 2 ACOs • Goal: ensure the beneficiary spend amount (assigned per ACO) is below the target number <p><i>What role did MCRH play?</i></p> <ul style="list-style-type: none"> • MCRH provided support to rural communities, initial outreach and communication as needed about value-based care opportunities. • MCRH serves as the state based executive director for both ACOs in agreement with Caravan Health • Performs the functions surrounding the board activities, works with Caravan Health to set the agenda for calls and keep everything moving forward • Vetting of value-based care opportunities, for example: Decided to move forward with the ACO model as it was "too good to be true" – one-sided loan program, if you don't have shared savings and don't want to continue after three years the model doesn't have to pay the financial support back (vetted model/system using attorneys, key stakeholders) • Held a series of launch meetings where the whole program was rolled out to the community, board, providers, and leaders in value-based care – kept the focus on quality metrics <p><i>The benefit of RHC participation</i></p> <ul style="list-style-type: none"> • As mandates, requirements, and new regulations come down the pipeline, using these years to learn, voluntarily participate and report, gives RHCs and the rural communities time to learn the foundation that will be the future of value over volume • As part of the rural ACOs, RHCs are required to: hire care coordinator to work with high flyers (identify them and target them for interventions), learn to manage those populations, and report on ACO defined metrics • Due to RHC participation, and with Medicare Shared Savings the communities involved in the ACOs here are given a "clean status" for their patient populations (who are then attributed to them), and each of those communities are charged with learning how to manage that data (once in their systems), and have to build the infrastructure to manage that system • Given claims data for attributed Medicare lives, and once merged with EHR valuable data can be obtained, used, drilled down; gives the opportunity to really learn about each of the populations

	<ul style="list-style-type: none"> ACO supports the care coordinator role, under Medicare shared savings where there was a payment structure that supported it (upfront, per member per month); payments went to infrastructure <p><i>What other role does MCRH play in value-based care in general in Michigan?</i></p> <ul style="list-style-type: none"> Provided education, workshops Leverage experience from other value-based care work Vetting of different value-based care opportunities As a nonprofit, has the ability to be nimble, flexible, adaptable, and a trusted source of information and initiative facilitation
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MINNESOTA

SORH	<p>Minnesota Department of Health – Office of Rural Health and Primary Care (ORHPC)</p> <p>Provides technical assistance for clinics and hospitals, works to recruit and retain health professionals, and promotes access to quality health care for rural and underserved urban Minnesotans.</p>
VBC Work	<p>Minnesota's Integrated health Partnerships (IHP) program is a Medicaid ACO demonstration that uses a shared savings payment arrangement based on total cost of care calculation and quality metrics. Individual IHPs are expected to develop coordinated service delivery models and are encouraged to address the social determinants of health at the community level. In September 2014, Minnesota released a request for proposal for a new demonstration project called the Accountable Communities for Health (ACHs), where local entities will engage in population health improvement activities and work toward prevention-based health. ACHs must identify a target population (based on geography, resource use, marginalized status, or health condition) and a population based prevention project to implement. ACHs can take a variety of forms, and must include partnerships with community residents, provider organizations, local public health departments, and at least one ACO. To evaluate the effectiveness, the state plans to compare the ACOs that adopted ACH models with those that did not. Learn more here.</p>

NORTH DAKOTA

SORH	<p>North Dakota State Office of Rural Health</p> <p>Helps North Dakota's rural communities build healthcare services through collaborations and initiatives. Works with hospitals and facilities, Medicare Rural Flexibility Program, Small Rural Hospital Improvement Program, and grant development assistance. A division within the University of North Dakota's Center for Rural health.</p>
VBC Work	<p>ND SORH partners and frequently works with Great Plains Quality Improvement Office.</p> <p><i>Great Plains Quality Improvement Office</i></p> <ul style="list-style-type: none"> Has good relationships with the RHCs Partners frequently with SORH Developed network of trusted partners – hospital association, medical association, other state based organizations Works closely with actual value-based care participants, collaboratively with other state-based partners including SORH Worked with RHCs EHR use <p><i>Value-based care Activities for SORH + QIO</i></p> <ul style="list-style-type: none"> MACRA/MIPS – work closely together for the next few years <ul style="list-style-type: none"> Using CMS sponsored materials Look to NOSORH for guidance

	<ul style="list-style-type: none"> <ul style="list-style-type: none"> ○ Plan on being train the trainer ○ Conducting education with the primary care association • Supporting Practice Transformation Networks: practice assessments, environmental scan, discover immediate needs of the practice; transform the practice and prepare them to become an ACO and work with the alternative payment models • TA: working together to obtain TA opportunities related to reporting, MIPS, and the ability of RHCs to participate in ACO model • Getting/providing educational opportunities on all value-based care activities • Shares resources with other states: South Dakota, Kansas, Nebraska • Practice Transformation Networks <ul style="list-style-type: none"> ○ Use TCPI to assist the PTNs with their practice assessments ○ Participate in calls, discuss with their members, run the assessment through the practice assessment tool, score it and upload to CMS ○ Practice assessment tool linked to change package toolkit (different change package area, different strategies to address the variety of possible gaps) ○ 6-month interval follow up for assessments ○ Work in parallel with SORH efforts to engage RHCs in PTN ○ Educational/opportunity referrals • ACO <ul style="list-style-type: none"> ○ Primary Care ACO ○ Working together on reporting requirements – what are the practices already gathering, what types of data are they already collecting, how can it be shared ○ Finding opportunities for dual use of data/reporting across initiatives ○ Working together with ACO and RHCs to work on population health collaborative work, opportunity for crossover objectives
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OHIO

SORH	<p>Ohio State Office of Rural Health (OHSORH)</p> <p>Works to strengthen rural healthcare delivery systems across Ohio. Coordinates rural health initiatives statewide by collecting rural health information, coordinating resources, providing technical assistance, and encouraging recruitment and retention. Includes a rural health listserv.</p>
VBC Work	<p>Goal: help strengthen rural health care delivery systems by creating focal point for coordinating rural health initiatives statewide. Improves rural health care delivery systems through programs and activities related to its five essential functions</p> <p><i>Functions</i></p> <ul style="list-style-type: none"> • Collecting and disseminating rural health information • Coordinating resources and activities statewide • Providing technical assistance to meet rural community health needs • Encouraging recruitment and retention of health professionals in rural areas • Strengthening state and federal partnerships <p>Leveraged several significant partnerships locally, statewide and nationally to improve rural health care delivery systems.</p> <p>Implement workshops, conferences and meetings, work to provide resources and technical assistance to rural communities working to enhance existing systems of care.</p> <p><i>Activities that Facilitate Value-based care</i></p> <ul style="list-style-type: none"> • Rural Health Conference <ul style="list-style-type: none"> ○ RHC Quality Network Project - Project goal: lay ground work for RHC quality network to collect quality measures and allow for benchmarking, in order to help participating clinics measure and improve overall performance • RHC Practice Management Training Materials

	<ul style="list-style-type: none"> • SORH maintains statewide rural health listserv to distribute quarterly enewsletter, other periodic emailed announcements regarding funding opportunities, upcoming events, other resources. • Quarterly newsletter • Webinars • Rural Health Day <p><i>Value-based care Related Activity</i></p> <ul style="list-style-type: none"> • Center for Rural Health and Primary Care Advisory Committee • History of involvement in RHC participation in PCMH, as promoted by the Behavioral Health Department • Strong SIM program • Patient Advisory Committee
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RHODE ISLAND

SORH	<p>Office of Primary Care and Rural Health</p> <p>Addresses health disparities created by lack of access to high quality health care due to financial, cultural, and geographic barriers.</p>
VBC Work	<p>Rhode Island developed a new payment and delivery system model, called the Accountable Entity model through 1115 waiver authority, in which provider-led Accountable Entities will operate under shared risk contracts with the state's Medicaid managed care plans. Accountable Entities are responsible for all Medicaid services including behavioral health and long-term care, and will incorporate providers of mental health, substance use, and long-term care services.</p> <p>http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/AE%20Pilot%20Application.pdf</p>

SOUTH CAROLINA

SORH	<p>South Carolina Office of Rural Health (SCORH)</p> <p>Seeks to improve the health status of rural and underserved people throughout the state through advocacy, education, and assistance to providers, communities, and policy-makers.</p>
VBC Work	<p><i>General Value-based care Activities</i></p> <ul style="list-style-type: none"> • RHC listserv for education, outreach, information dissemination • "Rural Focus" • Engage providers with two webinars a month regarding PCMH and Delivery of Care • Offers workshops – education on different initiatives • Webinars: Grant Writing Institute • Annual conference: reaches many RHCs across the state; provided education on MACRA, CCM, Individual Medicaid rules for the state • Advocacy activity: Medicaid expert • TA: received grant from SC school of medicine for onsite TA for RHCs <p><i>Specific Value-based care Activity</i></p> <ul style="list-style-type: none"> • PCMH alliance: in collaboration with several payers within the state • Getting ready to host annual meeting (with speakers to provide education on MACRA/MIPS) • Opportunity for varied education/outreach, ensure everyone is on the same page with regards to standards for becoming a PCMH, ensure there are no redundancies in statewide efforts to improve care delivery • Help practices become PCMH with use of quality coach within practices to help fill out applications (with local Blue Cross Blue Shield (BCBS), Medicaid, DHHS)

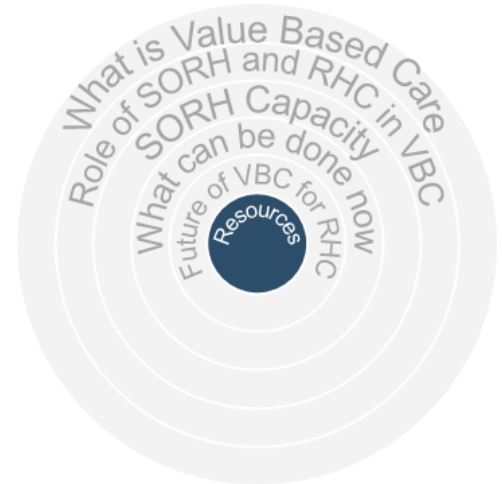
	<ul style="list-style-type: none"> ○ BCBS South Carolina has a program for recognized practices (with three component payment system that includes traditional FFS, PMPM for care management fee, and a performance based bonus; and a focus on chronic disease) • SC Medicaid incentivizes practices to pursue PCMH recognition (from \$0.50 to \$2.00 PMPM for pursuit through Level III recognition) • Advocacy: meet with Medicaid managed care plans quarterly, bringing attention to things they need to be aware of with regard to RHCs; meet with local Medicaid office to share information and concerns as well; have conversations about quality, claims issues, things that aren't being covered
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VERMONT

SORH	<p>State Office of Rural Health and Primary Care</p> <p>The Office of Rural Health and Primary Care works with and supports small rural hospitals, clinics and health care providers to improve access to primary care, dental and mental health care for all Vermonters, especially the uninsured, underserved and those living far from larger medical centers.</p>
VBC Work	<p>All-Payer ACO Model. CMS is working with Vermont to finalize their All-payer ACO Model. This model is a unique opportunity for CMS to partner with a state to incentivize health care value and quality, with a focus on health outcomes, under the same payment structure across all significant health care payers (including Medicare, Medicaid, and commercial payers) and the majority of providers throughout the care delivery system. The state will use updated flexibilities in its 1115 waiver, in addition to state innovation funding and waiver authority provided under Innovation Center, to design an all-payer ACO. This is a major step in federal and state efforts to align how health care is delivered.</p> <p>http://hcr.vermont.gov/content/vermont-all-payer-aco-model-agreement-1115-global-commitment-health-waiver</p>

WASHINGTON

SORH	<p>WA State Office of Rural Health</p> <p>Washington State Office of Rural Health supports its communities by:</p> <ul style="list-style-type: none"> • Connect with federal and state grants and resources. • Connect with other rural communities (in state and national). • Facilitate and support community collaboration and healthcare planning
VBC Work	<p>Has developed value-based payment methodologies in Medicaid for FQHCs and RHCs, for example, with flexible payment incentives and care delivery models for CAHs. Washington is also working to develop an ACO with its rural hospitals. http://www.hca.wa.gov/about-hca/healthier-washington/paying-value "With strong support from these clinics and hospitals, the state will introduce a value-based alternative payment methodology in Medicaid for FQHCs and RHCs and pursue flexibility in delivery and financial incentives for participating CAHs. The model will test how increased financial flexibility can support promising models that expand care delivery options such as email, telemedicine, group visits and expanded care teams."</p>



RESOURCES

Introduction

How to Use this Toolkit

What is Value-Based Care

Medicare/Medicaid

[The Medicare Access and CHIP Reauthorization Act of 2015 \(MACRA\)](#)
[Final Rule, Issued April 25 2016 by CMS for managed care in Medicaid ad CHIP](#)
[Medicare Quality Payment Program](#)
[Comprehensive Primary Care Plus](#)
[Next Generation Accountable Care Organization](#)
[State Innovation Models Initiative](#)
[Medicare-Medicaid Financial Alignment Initiative](#)

Quality Improvement Initiatives

[Report with phased recommendations to make participation in CMS quality measurement/improvement mandatory for all rural providers](#)
[NOSORH Learning Modules for quality/performance evaluation](#)

Care Coordination and Disease Management Programs

New Payment Policies

[Washington State ACO with rural participation](#)

Primary Care and Prevention Improvements

Role of the State Offices of Rural Health in Value Based Care

Opportunities

[CMMI State Innovation Model](#)
[NOSORH Module on SORHs and State Innovation Models](#)

Capacity Considerations

[Value-Based Payment Academy: Advancing Value-Based Payment Methodologies for Federally Qualified Health Centers and Rural Health Clinics](#)

Other Coordination Activities

[National Association of Rural Health Clinics \(NARHC\) TA listserv](#)

[NARHC past webinars](#)

[Transforming Clinical Practice Initiative \(TCPI\)](#)

[Quality Payment Program \(QPP\)](#)

[Awarded QPP Networks](#)

Technical Assistance Opportunities

[MACRA QPP Technical Assistance](#)

[MACRA Quality Improvement Direct Technical Assistance](#)

Organizations for State Office of Rural Health Collaboration/Outreach

[Find your Primary Care Office](#)

[Reach out to your state or regional Primary Care Association](#)

[Contact your Quality Improvement Organization](#)

[List of CMS Regional Office Rural Health Coordinators](#)

[Identify your State Rural Health Association](#)

[See if your state has a Rural Health Clinic Association](#)

Flex Program

[State Flex Profiles](#)

[Flex Fundamentals guide](#)

[Flex Program main page](#)

State Office of Rural Health Technical Assistance Potential

Examples of SORH Value Based Care Activity

[Colorado Rural Health Center](#)

[Iowa State Office of Rural Health \(IASORH\)](#)

[MA State Office of Rural Health](#)

- <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/masshealth-innovations/mass-health-restructuring-overview-document.pdf>

[Michigan Center for Rural Health \(MCRH\)](#)

- [Greater Michigan Rural ACO](#)

- [Southern Michigan Rural ACO](#)

[Minnesota Department of Health – Office of Rural Health and Primary Care \(ORHPC\)](#)

- <http://www.hrsa.gov/advisorycommittees/rural/publications/deliverysystemreform.pdf>

[North Dakota State Office of Rural Health](#)

[Ohio State Office of Rural Health \(OHSORH\)](#)

[Rhode Island Office of Primary Care and Rural Health](#)

- <http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/AE%20Pilot%20Application.pdf>

[South Carolina Office of Rural Health \(SCORH\)](#)

[Vermont State Office of Rural Health and Primary Care](#)

- <http://hcr.vermont.gov/content/vermont-all-payer-aco-model-agreement-1115-global-commitment-health-waiver>

[WA State Office of Rural Health](#)

- <http://www.hca.wa.gov/about-hca/healthier-washington/paying-value>

What can State Offices of Rural Health and Rural Health Clinics Do Now

Medicaid

[Sign up for NARHC-listserv](#)

Transforming Clinical Practice Initiative

Transforming Clinical Practices

Patient Centered Medical Home

Learn more about PCMH Legislation

Compliance Team, RHC & PCMH Accreditation:

http://www.thecomplianceteam.org/rural_health_clinic.aspx &

http://www.thecomplianceteam.org/physician_practice_medical_home.aspx

AAAASF RHC & PCMH Accreditation: <https://www.aaaasf.org/programs/medicare-programs/medicare-rural-health-clinics-program>

Are Rural Health Clinics Ready to Function as Patient Centered Medical Homes?

<http://www.nosorh.org/wp-content/uploads/2014/02/Are-Rural-Health-Clinics-Ready-to-Function-as-Patient-Centered-Medical-J.-Gale.pdf>

Defining PCMH <https://pcmh.ahrq.gov/page/defining-pcmh>

Successful rural PCMH case studies: <https://www.ruralhealthinfo.org/rural-monitor/rural-patient-centered-medical-homes/>

NCQA: <http://www.ncqa.org/>

Accountable Care Organizations

ACO Investment Model

National Rural ACC: <http://www.nationalruralaco.com/>

National Rural Accountable Care Consortium – presentation on rural strategy:

http://www.nationalruralaco.com/pdf/Webinar_RuralStrategy_ACO_vs_CIN_150403.pdf

ACO Rural Factsheet https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Rural_Factsheet_ICN907408.pdf

The Shared Savings Program final rules can be downloaded at <https://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf> (November 2011 final rule) and <https://www.gpo.gov/fdsys/pkg/FR-2015-06-09/pdf/2015-14005.pdf> (June 2015 final rule) on the Government Publishing Office (GPO) website. The Shared Savings Program was established January 1, 2012.

For information about applying to participate in the Shared Savings Program, visit

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavings> program on the CMS website.

ACO: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/Aco/>

Chronic Care Management

Medicare Learning Network, Chronic Care Management. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf>

CMS requires the use of certified EHR technology to satisfy some of the CCM scope of service elements: <http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms>

CMS Medicare Learning Network: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9234.pdf>

Rural Health Clinic Technical Assistance Series:

<https://www.hrsa.gov/ruralhealth/resources/conferencecall/index.html>

The Future of Rural Health Clinics and Value-Based Care

Preparing for the Quality Payment Program

[\\$100 million award announcement to help clinicians in individual or small group practices of 15 clinicians or fewer to participate in QPP](#)

[11 organizations funded by CMS for this TA opportunity](#)

[CMS: Educational materials, webinars, fact sheets](#)

MACRA FINAL RULE: <https://qpp.cms.gov/docs/CMS-5517-FC.pdf>

CMS RHCs Reporting Requirements FAQs: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-Reporting-FAQs.pdf>

RHC Guide to MACRA Final Rule: <http://narhc.org/latest-news/rhc-guide-to-the-macra-final-rule/>

A detailed overview of MACRA MIPS and APMs <http://www.nalashaa.com/macra-mips-apms/>

Small Practice Fact Sheet <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Small-Practices-Fact-Sheet.pdf>

Quality Payment Program <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program.html>
HHS Fact Sheet/Announcement re Future of DSR: <http://www.hhs.gov/about/news/2016/10/25/hhs-fact-sheet-delivery-system-reform-progress-and-future.html>

Quality Measure Development Plan

CMS Quality Measure Development Plan: Supporting the Transition to the Merit Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs).
<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Final-MDP.pdf>

Fee Schedule Legislation

NARHC Legislative Updates. <http://narhc.org/discussions-2/legislate-updates/>
Statutes/Regulations. <https://www.cms.gov/Medicare/Quality-initiatives-Patient-Assessment-Instruments/PQRS/StatuteRegulationsProgramInstructions.html>
RHC Center <https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html>

Conclusion

