

Expanded Opportunities for Participation in Advanced APMs NOSORH Comments

Overview:

While there has been significant participation of rural health systems and rural health service providers in Alternative Payment Mechanisms (APMs), there are a number of barriers preventing more extensive engagement. This limited participation is particularly unfortunate in that rural health systems can provide an excellent testbed for payment and service coordination reforms. APM demonstrations can be implemented in rural communities with participation of the entire local health system. The lessons from these demonstrations can be scaled up for use in other areas, where it might be more difficult to coordinate all health service providers.

There are a number of barriers to APM participation for rural providers. The barriers include: rural population health disparities, smaller service area populations, higher percentages of safety net and Essential Community Providers (ECPs), and smaller provider operating margins. These barriers are described in greater detail below, and specific recommendations are presented for addressing these issues.

It should be noted that the barriers may not be resolved by rural health provider participation in urban-based networks implementing APMs. Urban-based networks may not choose approaches which appropriately respond to the needs of consumers in rural communities. These approaches can lead to reduced health service availability, increased per patient costs and poorer health outcomes for rural community residents – impacts that can go unnoticed when balanced against the larger number of urban residents in an urban-based health care system. The recent decisions of the Mayo Clinic in Minnesota to reduce services in rural communities covered by its system are examples of how an urban-based health system can fail to meet the needs of rural community residents.

- https://www.politico.com/story/2017/11/16/mayo-clinic-rural-health-care-244955?lo=ap_b1

Recommendations for APM Opportunities In Rural Areas:

The National Organization of State Offices of Rural Health (NOSORH) has several recommendations for how CMS can increase opportunities for rural health systems and health service providers to participate in more advanced APMs. These are detailed below.

- **Issue – Small population numbers:** Rural health systems generally serve smaller populations than do urban systems. APM opportunities which require a high minimum number of patients may not permit participation of smaller rural health systems. Smaller health systems have demonstrated their ability to improve health outcomes and reduce cost for smaller populations – particularly when targeting the coordination of care for subpopulations with chronic disease. Creating APM opportunities for rural-based health systems serving smaller

populations can create additional demonstrations which can be scaled up for implementation in larger service areas.

Recommendation: Establish special APM opportunities for health systems serving smaller populations.

- **Issue - Rural community health disparities:** There are health disparities in rural communities which need to be addressed by APMs. Many rural communities have older and sicker populations than do larger urban communities. In addition, Disproportionate Share Hospitals and Sole Community Hospitals in rural communities may deal with a poorer patient population. The National Quality Forum in its 2015 report ***Performance Measurement for Rural Low-Volume Providers*** addresses these issues and discusses appropriate risk-adjustment responses that can be implemented in response to rural disparities.

Recommendation: Establish appropriate risk-adjustment mechanisms for APMs in rural communities. These mechanisms should address performance and payment adjustments appropriate for poorer, older and sicker populations in some rural health care systems. Risk adjustment will be particularly important when establishing appropriate population-based payment mechanisms.

- **Issue – Care transitions between rural and urban health systems:** Many specialty services are not available locally for rural community residents. These services must be accessed through referral from local health providers, or in some cases, through telehealth arrangements. Without good coordination of health services rural residents may be delayed in receiving needed specialty services, leading to poorer outcomes and higher per patient costs.

In addition, if there is poor coordination between remote specialty service providers and rural community providers, there may be poor follow-up care in the home community. This is particularly important for effective discharge planning from a remote hospital. Without good home community coordination unnecessary hospital readmissions become a problem. The National Quality Forum addresses the importance of coordinated care transitions for rural community residents in its 2015 report ***Performance Measurement for Rural Low-Volume Providers***.

Recommendation: Establish APM opportunities which specifically support appropriate linkages between rural health systems and urban-based specialty care providers and hospitals. There is opportunity for both general linkages and for specific types of linkages, such as coordination around the needs of chronically ill rural community residents.

- **Issue: Risk assumption** - The health system in many rural communities includes important safety net and Essential Community Providers (ECPs), including: Critical Access Hospitals (CAHs), Sole Community Hospitals (SCHs), Disproportionate Share Hospitals (DSHs), Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). Many rural communities are in shortage areas, with an inadequate supply of key health services. Many ECPs are lower-volume/higher unit cost service providers and may be operating on small margins. They may find it difficult to assume significant financial risk associated with APMs.

One of the aims of rural health policy is to maintain service capacity in these areas. This policy aim recognizes that the loss of local capacity can result in poorer health for the rural population and higher costs – as patients must incur the cost of travel to out of area locations and will likely delay care when faced with this barrier. In addition, a rural community which loses part of its ECP infrastructure may find it impossible to replace, and could face permanent loss of needed service capacity. It is important to establish APM payment arrangements which can support this policy aim.

Recommendation 1: Establish new opportunities for Category 3-A APMs geared to rural areas. These upside-only shared savings arrangements can be established at a smaller scale, emphasizing care coordination for rural community residents. Multiple models exist which have indicated important health improvement and cost savings outcomes – particularly for individuals with chronic illnesses.

Recommendation 2: Establish flexible APM opportunities which allow participating providers to assume limited risk but transition back to upside-only mechanisms if appropriate. Coordinated Care Organizations in Oregon have established this type of mechanism. Small hospitals in rural areas are permitted to take on risk as part of the CCO system, but are subject financial stress test monitoring. If financial sustainability of the facility is called into question they are permitted to transition back to an upside only payment mechanism.