Center for Medicare & Medicaid Innovation initiatives to address rural health and health disparities

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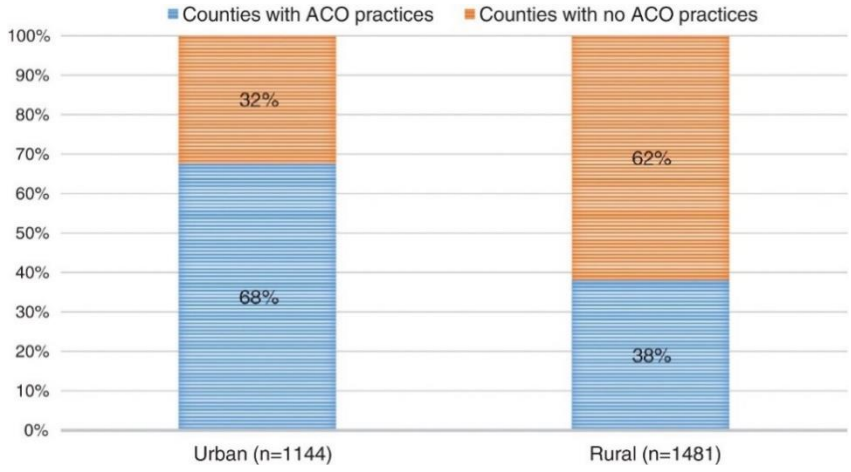
Introduction

Since its launch in 2010, the Center for Medicare & Medicaid Innovation (CMMI) has dedicated research, funding, and guidance to promote the adoption of value-based payer programs. Of note, Accountable Care Organization (ACO) Investment Model (AIM) funding supported rural providers who take part in the population health initiative.[i] This allowed rural organizations to better understand systematic changes needed within their health systems and communities to align with future reimbursement and Centers for Medicare and Medicaid Services (CMS) goals. CMMI programs are targeted to provide better care for individuals, lower costs, and improve the health of a population. In recent years, recognizing its relationship to health disparities, CMMI has committed to advancing health equity. This is evident in their inclusion of health equity in new payment models and pilot programs.

Figure 1. Proportion of urban and rural counties with any ACO practice presence.



Recently, CMMI has issued priorities to address the lack of growth within the Medicare Shared Saving Programs (MSSP) specifically related to rural and underserved populations. Rural practice participation in ACOs versus urban participation is shown in Figure 1. Notably, practices taking part in ACOs increased from 5.8 percent to 6.7 percent of the 251,752 practices in urban counties, compared with an increase from 2.7 percent to 4.9 percent of the 34,506 practices in rural counties.[ii]

The barriers that contribute to rural participation in ACOs are multifaceted. There is an urgent need to address the financial insecurity of rural health care providers and further explain how technical resources can enhance the financial viability of these programs in rural areas. Unique rural concerns are coupled with a shortage of specialty providers, limited behavioral health resources, and greater travel distance to receive health care.[iii] In addition to these issues, rural populations are aging faster than urban

populations, with higher rates of chronic disease and social determinants of health such as food insecurity, public transportation, inadequate infrastructure, and health-related activities.[iv] These challenges create a distinct opportunity for CMMI to make health-related programs become more rural-friendly.

Analysis of key rural value-based initiatives

This policy brief reviews three main national value-based initiatives to provide recommendations that may help rural providers. These initiatives will allow providers to participate in and sustain programs that move toward CMS' first strategic focus on health equity and attaining the highest level of health for all people. It will also briefly touch on one more initiative that uniquely utilizes telehealth, which is not addressed in the three main reviews. Accountable Health Communities (AHC), Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH), Community Health Access and Rural Transformation (CHART) track, and Frontier Community Health Integration Project (FCHIP) models all have objectives and goals they need to redesign and implement, along with operationalizing processes and policies to address rural health disparities. Two of these four initiatives – CHART and FCHIP – are dedicated to rural providers and communities.

Accountable Health Communities

The purpose of AHC was to address a critical gap between clinical care and community services in the current health care delivery system. This model was tested over five years (May 1, 2017 through April 30, 2022), and it aimed to address social determinants of health (SDoH) tests by screening for five health-related social needs (HRSNs) (housing instability and quality, food insecurity, utility needs, interpersonal violence, and transportation). Providing community navigation services assisted high-risk beneficiaries with accessing services and aligned partner involvement to ensure services had a positive impact on health care costs, improved health, and quality of care. The AHC model supplied funding to support infrastructure, planning, implementation, and staffing needs but not operational funding for these five HRSNs. The ACH model screened and identified vulnerable populations – for example, those that were navigation eligible were disproportionately likely to be low-income, racial and/or ethnic minorities, and individuals with disabilities on Medicare.[v]

Twenty-eight organizations participated in the AHC model. Sixty percent of the service area of the 28 organizations was in rural counties. However, the evaluation of outcomes for rural versus urban or suburban providers was not reported. Due to this, it is difficult to determine the impact this model had on the number of screenings, outcomes, and barriers in rural areas. One barrier to rural participation in the AHC model was that organizations had to screen 75,000 beneficiaries annually. This high threshold made it hard for rural providers or networks to participate alone.

Early outcomes indicate that ACH was highly effective in identifying higher costs and utilization of services for Medicare beneficiaries and that beneficiaries accepted navigation support for community services. While early reports showed a 9 percent reduction in emergency department visits among Medicare fee-for-service beneficiaries, the demonstration showed that resolution of HRSNs was low in the first year. Research and data also show that HRSNs need to be addressed to improve health. In a national comparison, individuals living in rural communities are generally poorer, have less education, and have one or more barriers to housing, transportation, healthy food, and safe drinking water.[vi] This model does not offer funding to provide important HRSNs and exists solely to help beneficiaries navigate

and align community organizations. As a result, access, health equity and outcome improvement will be minimal for rural communities.

ACO Realizing Equity, Access, and Community Health model

The ACO REACH model utilizes a redesigned Global and Professional Direct Contracting (GPDC) model to encourage providers to coordinate care for Medicare beneficiaries to address and advance health equity.[vii] Eligible providers were selected for the redesigned model in June of 2022, and this model will be administered for three years (2023-2026). This model tests a new payment design system that aims to better support the coordination of care and delivery for patients in underserved communities. Its focus is to promote provider leadership and governance by requiring more provider and beneficiary advocate board members and increasing participant vetting, monitoring, and transparency to protect beneficiaries.

Eligibility requirements are in place to allow rural participation. Eligible provider types range from individual, group, and network practices to hospitals and outpatient clinics, including critical access hospitals (CAHs), federally qualified health centers (FQHCs), and rural health clinics (RHCs). ACO REACH allows greater flexibility in the services that nurse practitioners (NPs) may authorize and certify. ACO REACH also requires participants to create a health equity plan to reduce health disparities, with the governing body comprised of 75 percent providers (or designated representatives) and two beneficiary advocates.

However, the payment model and funding approach are potentially an extreme barrier for rural providers. There are two payment and funding pathways - professional and global - and both are risk-sharing options. The professional pathway provides lower risk-sharing of 50 percent of savings and losses along with a monthly primary care capitation that is risk-adjusted, which is equal to 7 percent of the prior year benchmark. The global pathway provides 100 percent risk and savings arrangements along with two payment options: primary care capitation or total care capitation. This is a monthly risk-adjusted payment for 100 percent of the total cost of care provided by participants. On their own, rural practices do not have the adequate resources to support full, active engagement in an ACO and may need to participate within a larger network of providers.

Community Health Access and Rural Transformation model

CHART is a dedicated model for rural communities. Its aim is to allow innovative financial arrangements for participants to utilize operational and regulatory flexibility to realign how they coordinate and provide care to address health disparities.[viii] There are four cooperative agreement options and four different states in which organizations have been engaged since the December 31, 2022, pre-implementation period. The first performance period began January 1, 2023, and will run through December 31, 2028. CHART's operational and regulatory flexibility increases financial stability by supplying upfront and predictable capitated payments that incentivize the community's approach to care. It has a high focus on quality and patient outcomes. Waivers are provided to allow flexibility in regulatory and operational efficiencies that drive a proactive approach to care while adapting delivery. In addition, CHART increases access to services that address HRSN/SDoH.

CMS awarded cooperative agreements to four lead agencies. The cooperative agreements allow for upfront planning and establishment of infrastructure such as funding to recruit hospitals, development of a community transformation plan, and engagement of the state Medicaid agency and other aligned

payers. Another critical component of CHART is the role of the community lead organization(s). The community lead's role is to coordinate efforts to safeguard access to care and ensure all stakeholders' needs are accounted for in the development and implementation of the transformation plan. Participating hospitals received a predictable capitated payment amount (CPA) and opportunities for operation and regulatory flexibilities. This CPA replaces the hospital's FFS payments. By performance year two, each lead organization must include payer alignment with the state Medicaid agency. It is encouraged to include commercial payers too, but it is not required.

The benefits of CHART include its dedication to rural providers and communities that wish to take a proactive approach to population health. It allows options on how lead organizations may establish a geographic region. Some participants could be a single rural county or census tract. Other options may include contiguous or noncontiguous rural counties or census tracts. To support improved health outcomes in line with CMS/CMMI's strategic focus areas, it is imperative for this model to include state Medicaid agencies. This would allow for enhanced coordination of services through Medicare and/or Medicaid to address a wider range of HRSNs/SDoH. A potential barrier to this model is that the capitated payments are only for hospitals. Primary care, specialty care, behavioral health, and community service providers are important players to improve access, address health disparities, and lower health-related costs. If CPA or other funding mechanisms are not allowed for regulatory and operational improvements for non-hospital providers, it will be hard to sustain their involvement in this work.

Frontier Community Health Integration Project

FCHIP allows for enhanced payments and waivers of certain regulatory requirements for ambulatory services, skilled nursing facilities, and telehealth services.[ix] The goal of these increased payments and waivers is to test whether they would increase access to care and allow for better integration and coordination to reduce avoidable hospitalizations, admissions, and transfers. As a result, Medicare beneficiaries can receive care in their local communities. Initial results show positive outcomes and easily implemented initiatives for ambulatory and skilled nursing/nursing facilities, but telehealth initiatives and interventions have administrative and operational challenges. Participating CAHs indicated that the overall volume of Medicare telehealth encounters was too low to substantially impact financial performance.[x] A payment change or increase in capacity alone cannot significantly increase service demand.

Policy recommendations

CMMI demonstrations strategically focus on attaining the highest level of health for all people while reducing health costs. NRHA recommends that CMMI focus on and refine programs like AHCs, ACO REACH, CHART, and FCHIP to engage rural providers. For rural providers to actively participate, they will need technical and financial assistance to address planning and infrastructure needs, reduce barriers to entry, and increase sustainability. NRHA proposes that program modifications are concentrated on the areas listed below.

1. Rural-designed payment models

NRHA should advocate for models specifically designed for rural areas to acknowledge the unique aspects of rural health care. Currently, models with participation limitations need to be more attainable for many rural providers. For example, an ACO must have at least 5,000 Medicare beneficiaries assigned.

Given the population density of rural communities, an adjusted amount is necessary for increased rural provider participation to transition to a value-based payment model. A rural-designed payment model should also consider the increased financial risk for small, rural providers. Providers with a smaller patient population may need more financial reserves to cover losses during the transitioning process.

2. Support initial development and capacity building

To improve rural participation, CMMI should supply early investment in rural health systems and services. While the AHC model targets health-related social needs, it does not acknowledge the increased capacity needed to assist the influx of Medicaid beneficiaries with participating in health care and social services. Funding initial development will help providers meet staffing needs and integrate necessary population health tools to allow for effective and efficient coordinated care. This includes upfront investment in the infrastructure and capacity of organizations addressing health-related social needs. These are often small-scale community-based organizations, therefore additional staff and/or training to manage the number of referrals from clinical providers will be necessary for successful model implementation.

3. Required strategic planning

Transitioning rural providers to value-based care involves multiple aspects of planning and implementation. Specifically, these models include payers, local providers, community stakeholders, and organizations working collectively on population health and equity. Networks of care looking to implement new models should conduct formative work prior to execution. It is vital that these networks include Medicaid and/or managed care organizations to ensure that clinical-community linkages that address HRSNs/SDoH become and remain viable and reimbursable beyond the pilot funding period. Like HRSA's Rural Health Network Planning Grant, CMMI should require grantees to use funds from model demonstration to identify providers and key partners integral to implementation. Funds should also be used to establish governance and other structural aspects, such as reporting capabilities that are needed to support cross-agency collaboration.

4. Rural-focused technical assistance

Rural communities are not monolithic, and each presents different challenges when proposing a model that will increase participation and transition into value-based care. For this reason, models may need to be tailored specifically to rural providers and the communities they serve. CMMI should offer tailored technical assistance with financial and administrative support that focuses on driving rural implementation, increasing participation, and building confidence in cost savings and improved outcomes. This includes, but is not limited to, the integration of telehealth into rural health care systems and practices. As explored in this policy analysis, FCHIP experienced operational challenges in supporting telehealth integration. As small, rural health care providers have limited resources, helping with telehealth integration would prove beneficial, including support around electronic health record integration, broadband capability, telehealth equipment, and workflow and quality improvement activities. Technical assistance to support all aspects of these models, including those with telehealth components such as FCHIP, is critical to better support rural providers looking to increase access to care and reduce health disparities in their rural communities.

Similarly, we recommend that CMMI support rural providers with financial modeling. Understanding how models such as CHART impact present and forecasted operations related to payment changes for small, rural hospitals and other providers could help increase participation in these programs. CMMI should

provide technical assistance through an identified CMS contractor to support payment transformation and ensure demonstration fidelity across all participating sites.

Conclusion

CMMI has invested considerable amounts of time, money, and energy to create and implement value-based programs for all providers. Among all the different options, ACOs have been one of the most popular value-based programs. In the last few years, there has been a plateau or decline in use of these programs.[xi]

It is important for CMMI to give special considerations in model design to engage rural providers and populations. With added support, rural providers may increase their entry into these population health and value-based payment arrangements to improve their community's health, while reducing total health care spending and helping ensure health equity for all individuals.

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