National Advisory Committee
On Rural Health and Human Services

Options for Rural Health Care System Reform and Redesign

Policy Brief December 2012

***Editorial Note**: This policy brief is intended to serve as a companion to the report the National Advisory Committee on Rural Health and Human Services produced after its June 2012 meeting in Kansas City, Missouri. While the first paper used data-driven analysis to evaluate proposals currently under discussion to reform the rural health care safety net, this brief examines more broadly the options for rural health care infrastructure in a changing health care environment and reflects on the Committee's previous work around the Affordable Care Act.*

RECOMMENDATIONS

1. *The Committee recommends that the Secretary continue to promote the benefits of the ACA and broader health care reform and raise awareness among rural providers about provisions and models that account for the unique nature of rural health care demands and delivery.*

2. *The Committee recommends that the Secretary ensure that rural providers are engaged in ongoing discussions about health care reform and that these conversations recognize the necessary level of flexibility, stability, and support the current configuration of Medicare payment designations provides the rural health care system in a rapidly changing health care environment.*

3. *The Committee recommends that the Secretary work with the Congress to continue the FESC demonstration project beyond the program's scheduled expiration in April 2013 or seek to continue a form of the FESC demonstration under the authority of CMMI. This will help ensure a strong evaluation of the demonstration project given the low patient volumes that FESCs have encountered.*

4. *The Committee recommends that the Secretary encourage CMS to consider the full range of costs and savings, including those from private payers, avoided transfers, and prevented hospitalizations, when evaluating the FESC and F-CHIP demonstration projects.*

INTRODUCTION

The Affordable Care Act (ACA) includes a number of provisions and resources that have the potential to reform the American health care system with a renewed focus on quality and value while also helping to improve access, expand health care coverage, and begin to control rising health care costs. This legislation is part of a number of environmental changes which are reshaping health care delivery by shifting the emphasis from volume to value while slowing the growth of health care spending.

The Committee has identified several key concerns for rural communities as they confront potential changes envisioned in health care reform:

- The conflict between proposals to restructure the regulatory framework for rural safety net providers and the need to meet short-term fiscal goals;
- A lack of awareness among rural providers about the provisions within the ACA and other emerging national health care trends; and
- A need for further examination of new models and approaches which take rural considerations into account.

The Committee has spent the past few years studying the impact of key ACA provisions on rural communities and making recommendations to the Secretary on ways to address rural concerns. The future rural health care infrastructure should apply the programs and principles promoted in the ACA and broader health care reform to the unique features of rural health care: a high proportion of outpatient revenue, low acute-care daily census, and significant distance between rural hospitals and to urban care centers. During its past two meetings, the Committee conducted site visits and stakeholder discussions with a broad range of rural health care providers in Kansas, Missouri, and Texas, including hospital and clinic administrators, physicians, nurses, and post-acute and long-term care providers. Those dialogues on future health care reform helped inform the findings in this policy brief.

PROTECTING THE EXISTING RURAL HEALTH CARE SAFETY NET

The Committee observes both short-term and long-term issues for the state of the rural health care safety net. In the short term, the Committee is concerned about changes being discussed by national policy makers to the existing rural health care safety net designations under Medicare that have served an important role in stabilizing health care in rural communities over the past 25 years (see the companion policy brief). In particular, the Committee is concerned that short-term, incremental policy changes driven by budgetary concerns may disproportionately affect rural health care providers.

Many rural health care administrators expressed to the Committee their preference for the current system of rural-specific payment designations (e.g., Critical Access Hospitals, Medicare Dependent Hospitals, Sole Community Hospitals, Swing Beds, Rural Health Clinics, and Federally Qualified Health Centers) and explained the role these unique reimbursement methodologies play in making their facilities economically sustainable and therefore ensuring a consistent level of access in their communities. The Committee noted, however, that rural stakeholders did not believe the present patchwork system was the best of all possible alternatives, but preferred it because of the flexibility, familiarity, and stability it provides communities in designing the most suitable model of care for their unique population.

Although the Committee searched for immediate solutions that could provide cost savings in the short-term, it concluded that the existing web of rural-specific programs can work effectively as a whole to support rural health care needs while consideration continues about what the system should look like in the medium- and long-term. While the current system of Medicare payment designations for rural health care providers is not perfect and should be included in ongoing

discussions about health care reform, it does provide a necessary level of flexibility, stability, and support for rural health care infrastructure in a rapidly changing health care environment. Absent a broader vision for the reconfiguration of the rural health care system around value, care coordination, and access, it is unlikely that specific parts of the system could be reduced significantly or eliminated without damaging the entire system.

HELPING RURAL PROVIDERS ADAPT TO A CHANGING HEALTH CARE ENVIRONMENT

The Committee also observed, during some of its conversations, a lack of understanding among rural providers about the provisions and opportunities presented by ongoing health care reform, particularly those offered through the ACA, that are relevant to them. The Committee met with stakeholders who were not always aware of how they could benefit from new models of delivering care, such as the Shared Savings Program and Accountable Care Organizations (ACOs) or the Patient Centered Medical Home (PCMH). While there was general awareness of the concept of moving from a payment system based on volume to one based on value, many of the stakeholders were not sure how that shift might affect them. Others were not aware of efforts to improve quality or expand the primary care workforce or what the expansion of coverage might mean for their day-to-day operations.

The rural stakeholders were also not aware of new opportunities afforded through Medicaid §1115 waivers and demonstration projects for dual-eligible beneficiaries or quality and patient safety. While the Medicaid §1115 waiver is a state issue, there may be opportunities for U.S. Department of Health and Human Services (HHS) to ask states how their proposed waiver requests will impact rural communities.

The Committee recommends that the Secretary promote the benefits of the ACA to rural providers within a context that takes into account the unique nature of rural health care demands and delivery. Rural providers need to know how key provisions may affect them, but also the opportunities these provisions may offer them in helping to improve health care access and value. In particular, the increased emphasis on integrated, value-based care models, such as the ACO and PCMH, may create opportunities for more formal or informal collaborative partnerships between urban and rural providers to develop more seamless systems of care.

NEW MODELS OF HEALTH CARE DELIVERY FOR RURAL COMMUNITIES

The Committee supports the work of the Center for Medicare and Medicaid Innovation (CMMI) at the Centers for Medicare and Medicaid Services (CMS). The pilots and demonstrations supported under this ACA provision will help inform the redesign of health care delivery in both rural and urban areas. The Committee has previously made recommendations to the Secretary on how CMMI's work can best include rural communities (see the Committee's June 2012 brief: http://www.hrsa.gov/advisorycommittees/rural/publications/ruralimplicationjune2012.pdf).

To start thinking about the future of rural health care and answering the questions posed in the previous brief, the Committee examined two frontier demonstration projects currently being implemented by CMS, in consultation with the Health Resources and Services Administration

(HRSA): the Frontier Extended Stay Clinic (FESC)[1] and the Frontier Community Health Integration Project (F-CHIP).[2]

While the authorizing legislation for these demonstration projects predates the ACA, the Committee agrees that they may merit more attention. Even though the Committee is wary of adding more provider types to the patchwork system of rural health care infrastructure, it believes that these two models may be uniquely appropriate for some more remote rural areas as they transition toward a system that promotes quality over volume and global savings over episodic costs. It recommends that CMS continue these programs and consider expanding them beyond frontier areas; the findings from these demonstrations, like various CMMI projects, could help inform future policy development at HHS.

FESC and F-CHIP represent alternative models of health care delivery which attempt to provide cost savings by avoiding unnecessary transfers and initial and repeated hospitalizations. While the three-year FESC demonstration project has been authorized to run through April 2013, F-CHIP is still awaiting CMS' announcement regarding the design and implementation of the demonstration project. Despite being at very different stages, both of these projects have the potential to identify key principles for use in designing effective and efficient systems of health care for rural and frontier communities.

FRONTIER EXTENDED STAY CLINIC

The Committee feels there are relatively isolated communities in need of emergency care capability for which maintenance of a conventional inpatient facility, even a Critical Access Hospital (CAH), may not be appropriate due to exceptionally low population density and staffing, financial, and infrastructural constraints. The unique features of the FESC model might meet the needs of these communities. The Committee therefore recommends further development of this model.

THE ROLE OF FESCS IN DISASTER PREPARATION

Rural health care providers often play an integral role in emergency preparedness plans for their communities. The Committee heard from a health care system administrator in East Texas who maintained a Level I trauma center in his region because he believed there were no comparable options within a reasonable distance. As debate continues over the appropriate system of care for remote rural areas, policy makers should remain aware of the responsibility to ensure a minimum level of emergency capacity in rural communities. The Committee recognizes that this need may not always line up with the financial incentives in the fee-for-service system. By providing 24/7 emergency services in isolated areas, FESCs may be part of the answer to protecting public safety and maintaining cost-effective access to health care in regions unable to support a full-service hospital. However, such facilities may be inherently inefficient due to the high fixed cost of readiness.

[1] FESC was authorized in Section 434 of Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

[2] F-CHIP was authorized as the "Demonstration Project on Community Health Integration Models in Certain Rural Counties" in Section 123 of Public Law 110-275, the Medicare Improvements for Patients and Providers Act of 2008, and revised by Section 3126 of Public Law 111-148, the ACA.

Five remote clinics – four in Alaska and one in Washington[3] – are currently participating in the FESC demonstration. To be eligible for the FESC program, frontier clinics must be located at least 75 road miles away from the nearest hospital, or the nearest hospital must be inaccessible from the clinic by public roads. In addition to their normal clinic services, these five FESCs are authorized to keep patients for extended periods of time (up to 48 hours) and deliver 24-hour emergency and after-hours care not otherwise available in remote areas. Their service mix makes FESCs a unique provider type in rural, not quite a hospital but significantly more than a clinic. A preliminary assessment of the FESC model conservatively estimated that the FESC consortium saved almost $14 million in transfer costs by avoiding nearly 1,800 medical evacuations between August 2005 and September 2010.[4] The presence of a FESC has improved the quality of care in these frontier communities and provided residents with a sense of security knowing that a health care provider is always immediately available in emergency situations.[5]

The FESC demonstration is not without its challenges in terms of staffing and financial viability. Even with the demonstration-authorized Medicare and Medicaid reimbursement available in payments for each four-hour block of extended care, FESCs cannot cover their operating costs. Each clinic required an estimated additional $1 million per year over that same five year span (August 2005 to September 2010) to provide extended-stay and 24/7 emergency-level services. The Committee notes, however, that lack of information on reimbursement for FESC services by private payers may prevent a full cost assessment of the FESC program. Based on available data, the additional expense of providing these services totaled an estimated $25 million in operating costs across the five sites from August 2005 to September 2010. These additional expenses, on top of significant up-front investments in infrastructure and staffing, exceeded the almost $14 million in savings over that same five-year period.[6] An ongoing HRSA grant has helped to cover this shortfall.

While the Committee recognizes that the present configuration of this model may not be financially sustainable in the fee-for-service system, it is important that any final evaluation by HHS accurately accounts for savings in avoided high-cost transfers from remote areas and prevented hospitalizations at tertiary care centers, as well as for improved patient outcomes. The Committee recommends that the Secretary work with the Congress to continue the demonstration or seek to continue a form of the demonstration under the authority of CMMI. This will help ensure a strong evaluation of the FESC program given the low volumes experienced by the FESCs.

As the eligibility criteria are currently configured, the FESC project is largely an Alaskan demonstration. One HRSA study estimated that fewer than 10 clinics in the continental U.S. would meet the FESC distance/accessibility requirement.[7] To consider the potential of this

[3] The FESC in Washington is projected to be replaced by a 10-bed CAH by the end of 2012.
[4] MacKinney, C., Mueller, K., Ullrich F. and E. Shell. (Manuscript submitted for review). "Frontier Extended Stay Clinic Evaluation." *Rural Policy Research Institute, Center for Rural Health Policy Analysis*. This study was funded by the Southeast Alaska Regional Health Consortium, with support from the Federal Office of Rural Health Policy.
[5] MacKinney et al. (Under review). "Frontier Extended Stay Clinic Evaluation."
[6] *Ibid*.
[7] Health Resources and Services Administration, Office of Rural Health Policy. (2004). "Modeling The Frontier Extended Stay Clinic Conditions of Participation and Reimbursement Methodologies." U.S. Department of Health and Human Services. ftp://ftp.hrsa.gov/ruralhealth/FESCModelingProject.pdf. This study was funded by a grant

model beyond Alaska, HHS may want to examine possible changes to the distance/accessibility eligibility thresholds. To make this payment designation a viable option for more rural and frontier communities, CMS could consider using the authority of CMMI to modify the eligibility requirements and the payment structure for this provider type after the three-year demonstration ends. Also, instead of simply modifying the distance requirements to expand eligibility, CMS could consider implementing the FESC model where emergency medical evacuation costs are the highest and creating a shared savings component with downstream and upstream providers.

Distance and duration of stay are not the only parameters that need to be considered for FESCs. Policy makers should also contemplate the intensity of care delivered to patients. The FESC may be able to provide a broader range of services more akin to a full-service emergency room. The Committee would caution HHS that the relatively simple "load and go" (immediate transfer) or "extended stay" (patient monitoring) models may not fit this provider type. Instead, the typical care model at FESCs could involve a short period of very intensive and expensive work to stabilize and monitor patients before they can be transferred.

If the FESC demonstration is continued or expanded, CMS may want to gather more data about the relative intensity of the full range of potential services provided at FESCs and compare their service mix to CMS emergency room data. This comparison may provide policy makers with a better understanding of the level of fixed costs for high-intensity services relative to lower intensity services, such as observation, and what that might imply for FESCs in ensuring appropriate patient stabilization and transfer.

If sufficiently reimbursed, conversion to an extended-stay clinic could be an attractive and more cost-effective alternative for struggling CAHs which already, on average, receive 72 percent of their revenue from outpatient care and are forced to absorb negative operating margins on their underutilized inpatient beds.[8] However, further analysis is needed to determine the cost and service implications of eliminating inpatient care while retaining emergency and monitoring services either in communities that do no currently have a hospital or in those communities where the CAHs may not have enough patient volume to be economically viable. The Committee is not advocating that some CAHs should become FESCs, but rather that more flexibility is needed in order to best meet beneficiary need.

FRONTIER COMMUNITY HEALTH INTEGRATION PROJECT

The legislation authorizing F-CHIP directs CMS and HRSA to design a demonstration project that will "(1) explore ways to increase access to, and improve the adequacy of, payments for acute care, extended care, and other essential health care services…[and] (2) evaluate regulatory challenges facing such providers and the communities they serve." To be eligible for this demonstration, a CAH must be located in a county in Alaska, Montana, North Dakota, or Wyoming with a population density of less than six people per square mile. The CAH must also have an average acute-care daily census of five patients or fewer and offer at least one of the following: home health, hospice, or physician services. Seventy-one CAHs in the four states currently meet these criteria.

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from the Federal Office of Rural Health Policy, Contract No. 03H11626601D.

[8] North Carolina Rural Health Research and Policy Analysis Center. Presentation to the National Advisory Committee on Rural Health and Human Services, June 14, 2012. Data current as of December 31, 2010.

BUDGET NEUTRALITY FOR DEMONSTRATION PROJECTS

The legislative authorization for FESC and F-CHIP requires HHS to ensure that the demonstrations are "budget neutral," or that "aggregate payments" from HHS do not exceed what would have been spent had these programs not been implemented. As the Conditions of Participation for F-CHIP are developed and the FESC program is evaluated, the Committee advises that CMS' calculation of budget neutrality should account not only for the cost of the individual payment changes, but also for their overall effect on the health care system, including the cost to beneficiaries. In rural health care especially, up-front costs can lead to a range of upstream and downstream savings that may be difficult to gauge accurately on a system-wide scale.

The Montana Health Research and Education Foundation proposed establishing a series of local 'Frontier Health Systems' that would aggregate all patient volume within a service area into one integrated health care organization under a common system of regulations and cost-based reimbursement. The local 'Frontier Health Systems' would also implement pay-for-quality and budget-neutrality incentives to demonstrate that higher-quality care can be provided at a lower cost in their service areas.[9] The Committee will continue to monitor the progress of the F-CHIP demonstration to determine whether it can be a viable model for improving health care access and continuity of care in frontier areas served by CAHs.

The 71 low-volume CAHs eligible for F-CHIP together account for $179 million in overall Medicare spending and serve disproportionately elderly communities where nearly half of residents report living with at least one chronic illness and the need for long-term care can financially and logistically strain rural and frontier health care systems.[10] Given appropriate flexibility and guidance, the small scale and high number of chronically ill patients may allow these systems to achieve immediate cost-savings using innovative strategies of care coordination that could potentially be replicated on a larger scale in other rural areas. The Committee encourages CMS to consider this program a type of 'Frontier ACO' that can generate shared savings by developing the resources and partnerships to support patients with the highest need across the continuum of care.

CONCLUSION

The Committee affirms the need for both stability and flexibility in rural health care and rules that are simple, consistent, and fair for all rural providers. The patchwork system of designations for rural hospitals has been a vital source of support to the varied needs in rural health care infrastructure over the past 25 years. While the Committee has concluded that no plan for

[9] Montana Health Research and Education Foundation. (September 2011). "Framework for a New Frontier Health System Model: A Proposal to Establish a New 'Frontier Health System' Provider Type and Conditions of Participation." This report was funded by the Federal Office of Rural Health Policy, Cooperative Agreement No. H2GRH199966.

[10] Montana Health Research and Education Foundation. (June 2012). "White Paper #1: Referral, Admission and Readmission Patterns." This white paper was funded by the Federal Office of Rural Health Policy, Cooperative Agreement No. H2GRH199966.

reform that it has reviewed can offer significant change without jeopardizing the entire system, it agrees that the utility of these rural provider types should be continually reexamined as the basis of the U.S. health care system continues to shift from volume to value. The challenges of this transformation also bring opportunities for innovation and integration of which many rural providers are uniquely well-suited to take immediate advantage, if given adequate flexibility and support.

Future models of care should encourage increased collaboration and system affiliation, where appropriate, and incent and reward health care providers that achieve cost-efficiencies across the continuum of care. The rural-relevant demonstration projects under the authority of CMS and CMMI can provide a wide range of options for rural health care providers contemplating the viability of system redesign for their communities. To start thinking about the future of rural health care, HHS should make full use of its capacity to educate rural stakeholders and test out new models of care. Because no two rural areas are the same – and nearby populations can be vastly different – each community should be provided a variety of options and resources as they consider what level of health care is appropriate for them in a changing health care environment.