



National Advisory Committee On Rural Health and Human Services



Rural Implications of the Center for Medicare and Medicaid Innovation

Policy Brief June 2012

Editorial Note: In 2012, the National Advisory Committee on Rural Health and Human Services will focus on the rural implications of key provisions from the Patient Protection and Affordable Care Act through a series of policy briefs with policy recommendations that will be sent to the Secretary of the U.S. Department of Health and Human Services.

INTRODUCTION

The Center for Medicare and Medicaid Services' (CMS) Center for Medicare and Medicaid Innovation (CMMI) was established under Sec. 3021 of the Affordable Care Act.¹ Its statutory purpose is to "test innovative payment and service delivery models to reduce program expenditures under the applicable titles while preserving or enhancing the quality of care furnished" to Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries. In selecting models to be tested, the Secretary is directed to identify those where there is evidence that the "model addresses a defined population for which there are deficits of care leading to poor clinical outcomes or potentially avoidable expenditures." The Committee is interested in ensuring that rural providers and the patients they serve are represented in this unique opportunity.

Recommendations

1. The Committee recommends that the Secretary direct CMMI to offer preliminary advice to rural facilities on the suitability of project ideas and offer ongoing technical assistance to them during the preparation of applications.
2. The Committee recommends that the Secretary direct CMMI to extend the FQHC Advanced Primary Care Practice demonstration to include RHCs in order to broaden the impact of the program on rural areas.
3. The Committee recommends that the Secretary direct CMMI to establish a group of rural advisors within the Innovation Advisors program to help assure the direction of the Center includes a rural voice, and to help establish measurement systems that are relevant to rural health care.
4. The Committee recommends that the Secretary direct CMS to develop specific evaluation and measurement incentives to encourage collaboration across urban and rural lines, including an urban-rural collaboration preference during grant scoring.
5. The Committee recommends that the Secretary encourage the evaluation of urban-rural demonstrations on a systematic basis so that small increases in rural cost may be offset by system-wide quality improvement.
6. The Committee recommends that the Secretary direct CMS to review and implement the Committee's 2011 recommendation that CMS fund quality and cost incentive payments for rural hospitals from actuarially projected savings resulting from increased efficiency.

¹ H.R. 3590, 111th Congress: Patient Protection and Affordable Care Act (2010) (enacted).

CMMI has the new authority to expand successful demonstrations through formal rule making without the need for changes in the law, allowing CMS to speed expansion of successful payment and delivery system changes nationwide. The budget neutrality specifications do not require neutrality as a condition for approving a demonstration, only for continuing or adopting its provisions to the Medicare program. It appears that this authority – which the Secretary shares with the actuary of CMS – is intended to allow the Secretary to initially spend money on necessary infrastructure and to look at budget neutrality broadly, in the context of system-wide improvements.

During its February meeting, the National Advisory Committee on Rural Health and Human Services met with experts in the field, including the Director of CMMI, Dr. Richard Gilfillan, and discussed the rural implications of CMMI. This policy brief focuses on the potential opportunities for rural to be a strong partner in efforts to create a higher quality, more efficient health care system for all Americans.

The Committee believes that CMMI leadership is aware of the need for system wide improvements that include rural. The Committee is encouraged by the recent announcement of the Innovation Awards since many of the 26 initial awards had a rural focus or dimension. This is a good sign for the future as previous offerings were heavily weighted towards models that require volume and payment levels characteristic of urban areas. Demonstrating improved service and payment models is made more complicated by the fact that there are many material differences between urban providers and organizations that provide care in rural areas. There are several categories of health care facilities that are reimbursed through payment mechanisms that differ, sometimes substantially, from those payment systems typically utilized in urban settings. These include Federally Qualified Health Centers (FQHC), Medicare Dependent Hospitals (MDH), Rural Health Clinics (RHC), Rural Referral Centers (RRC), Sole Community Hospitals (SCH), and Critical Access Hospitals (CAH). These rural provider types have distinct staff, infrastructure, resource and payment model considerations.

There are over 50 million individuals residing in rural America, the majority of whom receive their care from the 1,327 CAHs and 3,950 RHCs located there. If rural America is to be included in these reforms, there is no alternative to finding unique ways to achieve in rural areas the kinds of improvements CMMI looks to achieve in urban settings.

The Committee's view is that no single approach can possibly succeed in producing the system-wide change that the Affordable Care Act envisions and demands. In the past, efforts by Congress and the U.S. Department of Health and Human Services (HHS) has succeeded in creating a diverse set of alternative health care organizations (i.e., RHCs, CAHs, etc.) to allow Medicare to work in rural areas. The Committee believes that experimentation in new health care models must continue to embrace this recognition of diversity if improvements in quality and efficiency are to be experienced throughout our nation's health care system.

There are a few significant implications in the Committee's view:

- System-wide improvement will likely occur if CMMI recognizes the need for different approaches in urban and rural settings.

- Taking an all-inclusive approach to improvement requires CMMI to look at budget neutrality not urban-by-rural, but in terms of the needs and resources across larger regions and populations served by the Medicare program as a whole.
- Consideration must be given to innovative payment models that are regional in nature and that support the goals of collaboration, care coordination and integration of social, physical and behavioral health.

Specifically, the Committee believes that improving the quality of care in rural areas may well require increased investment in the staff and infrastructure needed for education, care coordination, and full participation in new health care models. The Committee also believes that the law, as written, gives the Secretary and the CMS Actuary the authority to look at budget neutrality broadly. For example, the Secretary and the CMS Actuary could conclude that rural and urban models, operating together, would produce an overall improvement in the quality and efficiency of the health care delivery system even if, in fact, additional expenses were incurred to fund infrastructure improvements in rural settings, so long as overall savings were achieved.

DISCUSSION AND RECOMMENDATIONS

Current Activities. The Committee has reviewed CMMI's efforts to date and identified some demonstrations that specifically target rural integration, as well as others where there are potential opportunities for greater rural inclusion. The Committee understands that not every constituency will be equally represented in each demonstration and appreciates the tremendous pressures that CMMI is under to rapidly test, evaluate and scale these models. At the same time, the Committee knows that if rural facilities and providers are not included in these demonstrations, CMMI's work cannot result in the system-wide change envisioned by the ACA. The Innovation Awards offer opportunities to address this concern.

In reviewing the current efforts of CMMI, the Committee has found that the Partnership for Patients initiative, the Health Care Innovation Challenge, and the Advance Payment Accountable Care Organization (ACO) model specifically encourage and solicit rural participation. The Committee appreciates the concerted effort CMMI has made to include rural in these demonstrations. However, concerns of low rural participation remain because of the methods used to determine successful applicants and the onerous nature of the proposal-writing process. Proposal writing, especially for federal opportunities, has increasingly become the province of organizations with highly qualified professionals specifically trained in grant writing. For the most part, rural providers and health systems cannot compete with this kind of expertise. They do not have dedicated staff to work on grants for federal programs. CMMI has, in some cases, dealt with this problem by employing a two-tier system in which one page summaries are submitted for evaluation by CMMI staff and organizations are invited to complete longer proposals on the basis of these summaries. The Committee recommends that CMMI expand the ability for rural facilities to receive preliminary advice on the suitability of project ideas and, if the idea appears promising, that CMMI offer ongoing technical assistance during the preparation of applications.

Additionally, the Committee believes that the FQHC Advanced Primary Care Practice demonstration and the Advanced Payment ACO model could be modified to better support rural inclusion. The Committee believes that the FQHC demonstration should be extended to RHCs to

broaden the impact of the program on rural areas. While the Committee appreciates the rural work of the Maine and Iowa Pioneer ACOs, it also believes that the \$80 million cap on the Advanced Payment ACO program could benefit from flexibility depending on the specific situation of the rural hospital network. The Committee notes that a network with several small, rural hospitals could exceed this cap, but would still find advanced payment necessary to coordinate changes throughout the network.

Operational Changes. Looking forward at the ongoing operation of CMMI, the Committee has identified a number of operational changes that might increase rural participation. The Committee acknowledges that aspects of these ideas are embedded in CMMI's current approaches but it believes these changes need to be recognized explicitly if they are to produce enough rural participation to ensure success in systematic reform.

First, CMMI should use rural-specific measures when evaluating rural performance, rather than measures designed to evaluate large urban health care providers. For assistance in developing these measures and other demonstrations, CMMI should establish a group of rural advisors. This rural-specific panel could be built off the Innovation Advisors program. It is important that people with rural experience and perspective be at the table during the earliest design and priority setting phases of CMMI's work. In addition, while CMMI has made efforts to encourage collaboration with rural providers within its group of grantees, the Committee believes that this does not go far enough to incentivize participation with rural providers. Because of higher costs and different operating structures in rural areas, it is easy for larger systems to avoid integration with rural providers. The Committee recommends that specific incentives should be developed to encourage collaboration across these two groups. CMMI should include a preference in their grant scoring criteria, when appropriate, for applicants who include rural providers in their projects.

Many rural programmatic disparities arise from the inherently smaller number of beneficiaries in rural areas. First, the small sample size makes it more difficult to produce reliable statistics and measurement and, second, possible savings are lower on both a population and per-patient basis. However, it is possible for a successful system reform idea – ACOs for instance – to be evaluated systematically to show both quality and cost savings. Even though these programs may generate significant savings in populous areas but not in rural areas, the Secretary has the authority to aggregate the quality impacts and savings of an urban-rural demonstration. The participation of some rural facilities may require upfront investments in infrastructure, such as health IT systems. By evaluating the programmatic idea across both urban and rural participants, the possible small increases in rural costs would be negated and allow for systematic change. The Committee recommends that the Secretary allow and encourage the evaluation of urban-rural demonstrations on a systematic basis.

Finally, over the past year, the Committee has issued recommendations to the Secretary and CMMI that could be considered for future demonstration projects. In the September 2011 white paper, "Value-Based Purchasing Demonstrations for Critical Access and Small PPS Hospitals," the Committee discussed structural problems with the expansion of quality reporting programs to rural hospitals. In many cases, the hospitals most put at risk from systematic changes are the hospitals that cannot afford to volunteer and be included in demonstrations. To encourage

preliminary testing among hospitals with the least available resources, strong positive incentives to encourage at-risk hospital involvement must be developed. Accordingly, the Committee recommended that CMS fund the quality and cost incentive payments for rural hospitals from actuarially projected savings resulting from increased efficiency. The Committee recommends that the Secretary direct CMS to review this recommendation for inclusion into a rural demonstration project.

CONCLUSION

There is ample evidence that the failure to consider the unique needs of rural America has, in the past, led to unintended disparities between medical care systems in urban and rural areas.² The Committee believes that the attempt to achieve system-wide change must recognize the differences between urban and rural systems and resources, and develop approaches that can narrow the gap. This result cannot be achieved without an honest look at what costs must be incurred in rural areas to improve the infrastructure of the entire system. It makes little sense to pretend that savings are achievable in every setting. In fact, the Committee notes that the budget neutrality language in the law is written broadly, presumably to enable the Secretary to take a system-wide view of costs and benefits. The Committee looks forward to additional Innovation Award announcements since they may offer the best opportunity to examine rural system redesign in a way that informs future HHS policy.

In addition to creating and expanding new, effective health system models, CMMI must be careful to avoid unintended consequences resulting from not fully testing these models before deploying them nationally. The Committee recommends that rural testing occur prior to the imposition of new models in rural areas. One need only look at the introduction of inpatient PPS in the late 1980's and the subsequent closure of hundreds of rural hospitals to understand the importance of rigorous evaluation in the rural context.

The creation of CMMI presents an unprecedented and exciting opportunity for the entire U.S. healthcare system. We have the opportunity to fix the inefficiencies that have been accumulating for decades and build a healthcare system for the future. For this systematic change to occur, every part of the system must be included in setting this new direction. The future may regard this as a missed opportunity if we do not capitalize on this unique moment in time to rework our strategy towards improving the health of all Americans.

² Poley, Stephanie, and Thomas Ricketts. *Fewer Hospitals Close In the 1990's: Rural Hospitals Mirror This Trend*. Rep. Chapel Hill, NC: Cecil G. Sheps Center for Health Services Research, 2001.