Rural Value-Based Care – The Payer Perspective

Rural Health Value Summit Report

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For more information about the Rural Health Value, contact:
University of Iowa | College of Public Health | Department of Health Management and Policy
www.RuralHealthValue.org | cph-rupri-inquiries@uiowa.edu | (319) 384-3831

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Introduction

Rural Health Value is a partnership of the RUPRI Center for Health Policy at the University of Iowa and Stratis Health and is federally funded to facilitate the transition of rural healthcare organizations, payers, and communities from volume-based to value-based health care and payment models. Activities include:

- Convene groups to synthesize and share insights that enhance rural value-based care and payment.
- Develop actionable tools and resources to support rural value-based care and payment.
- Interpret health policies related to rural value-based care and payment.
- Highlight and disseminate best practices in rural value-based care and payment.
- Share experiences from rural healthcare organizations delivering value-based care.
- Infuse the rural perspective in organizations designing, implementing, and evaluating value-based care and payment.

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In July 2024, Rural Health Value (RHV) convened a virtual Summit of professionals and executives from national and regional health care payer organizations to share and explore insights, innovations, successes, and challenges in rural health value-based care (VBC) contracting.

Recognizing the importance of engaging payers to support the ecosystem more broadly for change, the intended outcome of the Summit was to inform efforts to help rural health care organizations better understand the perspectives of payers – building bridges between rural health care organizations and payers to advance value-based payment in rural places.

Summit participants included representatives and members from Association of Health Insurance Plans (AHIP), Alliance of Community Health Plans (ACHP), and the National Association of Medicaid Directors (NAMD), along with health insurance experts experienced in VBC contracting. The RHV team developed and used a series of questions (provided to the participants prior to the Summit) to facilitate a structured discussion. The rich discussion is synthesized below, starting with a discussion of challenges and solutions followed by suggestions for rural health care organization leaders from the Summit participants.

Challenges

Summit participants discussed the challenges of payer organizations when serving rural beneficiaries. Challenges identified included geographic distance and travel time to health care organizations (HCOs), ensuring contracts with rural HCOs are in place to meet state or other network adequacy requirements, limited broadband coverage and the consequent inability to engage members through technology, the prevalence of health-related social needs in many rural populations, and workforce challenges in rural HCOs.

Summit participants also considered what factors made contracting and provider relations different with rural organizations. Participants noted that most rural communities have fewer health care and health-related resources such as subspecialty clinical services, transportation options, robust electronic health records, ready access to quality and cost data, and adequate analytic capabilities. The negative effects of underdeveloped rural resources are often compounded by lack of rural experience in VBC contracting. Furthermore, and importantly, rural

HCOs lack the scale (attributed patients) to garner payer attention and smooth the statistical impact of outliers. Because of the risk associated with minimal scale, and frequently thin operating margins, rural health care organizations are typically risk averse. Therefore, they are fearful that VBC contracts will disrupt current revenue streams without an adequate replacement.

Summit participants identified some of the challenges and barriers to engaging rural health care organizations in VBP contracts including capacity, resources, technology, and data variability among rural HCOs. Medicaid and Medicare payment rates (both Traditional Medicare and Medicare Advantage) are comparatively low, putting pressure on commercial payer payments to make up for inadequate government payments. Additionally, many rural HCOs have cited recent poor experience in contracting with Medicare Advantage plans. When multiple VBC contracts are in place, they are uncoordinated and thus difficult for rural HCOs to effectively manage, particularly when there are a small number of patients spread across multiple payers that have varying contract structures and requirements.

Potential Solutions

After discussing rural-specific challenges to VBC contracting, Summit discussions turned to potential solutions for HCOs and payers to explore, categorized below.

- **Scale** – Rural HCOs can collaborate and pool patient populations to build scale that draws payer attention and reduces statistical variation during performance measurement.

- **Access** – Payers and rural HCOs can consider opportunities to partner for development of centralized training and employment for community health workers, patient navigators, and/or health interpreters to help ensure access to services in rural communities. Payers can support supplementary services that may be limited, such as mobile dental clinics.

- **Alignment and transparency** – For VBC to be successful, alignment and transparency are needed across health systems and health care teams. For example, even though VBC payment might be sent to an HCO, one of the participating payers also sends letters to individual clinicians detailing their team's contribution to the HCO's VBC payment.

- **Regulatory flexibility** – Payers and HCOs need flexibility for non-traditional payments (e.g., short-stay hotel and air conditioners) to help address patient's unmet health related social needs.

- **Time and trust** – Payers may need to use a phased approach (i.e., "crawl-walk-run") to support trust and development of rural HCO capacity for VBC over time. One payer participant shared that they started by providing incentive and a per member per month payment for rural clinics that became certified medical homes. Once medical homes were established, the payer moved contracts into shared savings arrangements, then to shared saving and shared-risk contracts.

- **Keeping incentives local** – Payers are encouraged to ensure that VBC support and payments are distributed locally to rural HCOs, and that providing appropriate services locally is supported. Models are less effective when distant health systems retain incentive payments at the system level, encourage patients to leave their community for care that is available locally, or pull shared savings out of state.

Recommendations

The Summit concluded by asking the participants what they would like HCOs to know about VBC contracting. Participant suggestions were categorized and are summarized below.

Strategic Actions

- Rural HCOs can collaborate to achieve independence through interdependence – to build capabilities, scale, resources. Recognize the collective power of rural HCOs, especially as related to network adequacy requirements for payers.
- Rural HCO leaders should consider care-team wellbeing and resiliency and how VBC contracts can help support recruitment and retention of clinicians and staff. For example, work with payers to see what resources they can offer to help reduce provider burden.
- Identify and develop local administrative and clinical VBC champions who can help the organization consider the clinical benefits of VBC, not just the financial risk (benefits from a focus on improved clinical quality and on illness/disability prevention and health promotion).

Operational

- Pay as much attention to administrative staff succession (e.g., CEO, CNO, CFO) planning as to clinical staff recruitment and retention.
- Ensure complete and accurate coding on all claims to receive credit for work done and ensure accurate risk adjustment.
- Access state and federal resources that are available for education and capacity development such as financial, operational, and quality improvement supports. (e.g., State Offices of Rural Health and the Federal Office of Rural Health Policy).

Contracting

- Seek adaptive VBC payment models that include glidepaths allowing gradual assumption of risk. Do not enter contracts without reasonable expectation of success.
- Request cost and quality data analysis from payers, noting that HCOs and payers are both interested in high quality and low cost. For example, ask for capitation modeling which would be a significant change for Rural Health Clinics and Federally Qualified Health Centers.
- Review network adequacy standards, beyond time and distance; and use them as leverage in negotiations with payers.

Discussion Questions

1. In considering priorities in contracting and provider relations, are conversations different with rural organizations (if yes, how)?
2. What do you find most challenging in serving members who are in rural communities?
3. What challenges and barriers have you faced in engaging rural health care organizations in VBP contracts?
4. What are examples of VBP arrangements that have worked well with rural?
5. What do you (as a payer) want rural health care organizations to know regarding value-based contracting?
6. Is there anything else you would like to add?

Summit Participants

- Mollie Gelburd, AHIP
- Alicia Berkemeyer, Arkansas Blue Cross Blue Shield (AHIP member)
- Josh Jorgensen, ACHP
- Ginny Whitman, ACHP
- Joel Ulland, UCare (ACHP member)
- Jodi Schwabe, Security Health (AHCP member)
- Brad Wolters, Security Health (AHCP member)
- Diane Hasselman, NAMD
- Olivia Alford, Maine Medicaid (NAMD member)
- Robin Richardson, Moda Health
- Sean Jessup, Moda Health
- John Naylor, Cibolo Health
- Lori Nelson, Cibolo Health
- JT Douglas, West Health