GOOD GOVERNANCE CASE STUDY

An Online Series by **The Governance Institute®**

Rural Providers Band Together

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Rural Providers Band Together

Organizations Profiled

Morris Hospital, Morris, Illinois
Ridgecrest Regional Hospital, Ridgecrest, California
Reid Health, Richmond, Indiana

Lynn Barr, M.P.H., *Founder and Chief Transformation Officer, NRACO*
Earl W. Ferguson, M.D., Ph.D., *Cardiologist and Board Member, Ridgecrest Regional Hospital*
Craig Kinyon, *President and CEO, Reid Health*
Kimberly Landers, M.S., RN, NEA-BC, *Chief Nurse Executive, Morris Hospital*
James A. Suver, *Chief Executive Officer, Ridgecrest Regional Hospital*

Statement of Interest

Recent changes in payment methodologies have taken a toll on rural hospitals. According to the National Rural Health Association, 53 rural hospitals have closed since 2010 and 283 more are at risk of closure. As U.S. healthcare shifts towards value-based purchasing, rural providers have generally been left out of the process, with few opportunities to gather data on the quality of care and use that data to improve services.

Now some rural hospitals are joining together to participate in Medicare's Shared Savings ACO Program. Through these innovative alliances, they hope to gain knowledge, skills, and experience that will prepare them for population health management and value-based purchasing.

Organization Profiles

Morris Hospital in Morris, Illinois, is an 89-bed rural hospital 60 miles southwest of Chicago. It is based in a town of 14,500, with outreach to a dozen surrounding towns. The hospital has the smallest Level II trauma center and the smallest cath lab with 24-hour STEMI coverage in the state. It has 30 employed physicians in small clinics who are part of its ACO. In addition, Morris Hospital invited local independent physicians to join the ACO. Two have chosen to participate, and serve on the ACO steering committee.

Ridgecrest Regional Hospital in Ridgecrest, California, is a 25-bed critical access hospital located just east of the southern Sierra mountain ranges. It includes a nursing home with 125 skilled beds, as well as four clinic locations offering primary care, obstetrics, pediatrics, podiatry, dentistry, surgery, orthopedics, cardiology, gastroenterology, and dermatology. The clinics are staffed by about 30 physicians who are fully affiliated with the hospital through professional service agreements.

Reid Health in Richmond, Indiana, is an independent regional healthcare organization serving east central Indiana and west central Ohio. It includes a 217-bed hospital on the main campus and a trauma center, as well as Reid Physician Associates, a wholly owned network of 76 physicians and 40 advanced practice providers. Reid's service area includes about 280,000 people, and last year the hospital had 11,500 admissions and 48,256 emergency room visits. In order to improve access to specialized care, Reid offers telehealth services and virtual visits in six locations for services including cardiology, oncology, psychiatry, and pulmonology.

Reid Health has its own ACO and Morris Hospital and Ridgecrest Regional Hospital are both participants in National Rural ACO II, which includes eight communities, located in four different states: California, Illinois, Indiana, and Iowa. The eight participants in National Rural ACO II are:

- Virginia Gay Hospital, Inc. (DBA Vinton Family Medical Clinic, Urbana Family Medical Clinic, Van Horne Family Medical Clinic, and Atkins Family Medical Clinic)
- Iowa Specialty Hospital-Clarion
- Belmond Community Hospital (DBA Iowa Specialty Hospital-Belmond, Belmond Clinic, and Hampton Clinic)
- Fayette Memorial Hospital Association, Inc. (DBA Fayette Regional Health System)
- Morris Hospital
- IATROS MD, SC (DBA Allen Medical Center)
- Howd Medical LLC (DBA Dana J. Howd, M.D.)
- Ridgecrest Regional Hospital

Rural Providers Band Together

The U.S. healthcare system is going through dramatic transformations, and until recently rural hospitals have been left out of the process. While other physicians are gathering quality data and preparing for value-based payments, in general, rural providers have been exempt. Urban physicians and hospitals are forming accountable care organizations (ACOs) designed to offer coordinated care ranging from preventive services and primary care to hospitalization and skilled nursing care. However, a healthcare organization needs to be responsible for 5,000 lives in order to form an ACO, and very few rural hospitals can meet that standard.

In 2013, an informal network of rural hospital CEOs and leaders of federally qualified health centers began exploring ways to cope with these problems. They decided to form the first National Rural Accountable Care Organization (NRACO) to work cooperatively and discover new ways rural hospitals and physicians could work together to begin to participate in the new payment models. "Our goal is to increase rural providers' market share and sustainability by managing population health, while using these systems to improve community health, patient satisfaction, and to reduce unnecessary costs," said Lynn Barr, M.P.H., NRACO's Founder and Chief Transformation Officer. "Our job is to try to bring everybody together, share our experiences and knowledge, and then communicate with CMS so we can help develop these new payment models in ways that really make sense for us and for our communities."

Part of the solution is to form collaborative working relationships among several communities so that together they serve enough patients to clear the threshold needed to form an ACO. NRACO formed its first shared savings ACO during 2013, and it began operating in 2014, combining nine hospital members in three states.

Did those hospitals have something in common? A shared philosophy, common cultural background, or perhaps some historical connection? Not at all, said Barr, laughing. "What they had in common was that they were all trying to figure out how they were going to survive."

But how could they make this ACO spread out over three states work? Forming an ACO is an expensive, technically difficult, and time-consuming process, requiring significant investments for electronic health records, care coordinators, data analysis, and extensive training in new ways of working together. How can rural providers afford to form an ACO?

First, they leverage the resources available in rural communities. People who work in rural hospitals are often willing to take on extra responsibilities—someone pulls together a steering committee, someone else recruits volunteers, the churches agree to host health fairs and patient support groups.

In addition, NRACO spreads administrative costs over all the different hospitals participating in the ACOs. It selects a single data warehouse and puts all the data in it. No one is competing with each other; everyone is trying to learn together, so they don't mind sharing data.

NRACO's not-for-profit arm is responsible for convening discussions among rural hospitals, educating them about possible next steps to improve the quality of care, and working closely with CMS and other payers to define rural-appropriate value-based payment models. In addition, its for-profit arm provides technical services for the ACOs, including claims data access and analysis, evidence-based medicine leadership, care coordination coaching, and support for meeting governance, legal, and compliance standards.

"All our ACOs have similar operating agreements, legal documents, processes, and procedures," Barr said. "We can achieve real economies of scale and simplify the program by shifting the administrative burden onto a central organization."

NRACO keeps its costs as low as possible. For each hospital, the cost for applying to the program is $25,000. During participation, the cost is $10,000 a month plus one dollar per member

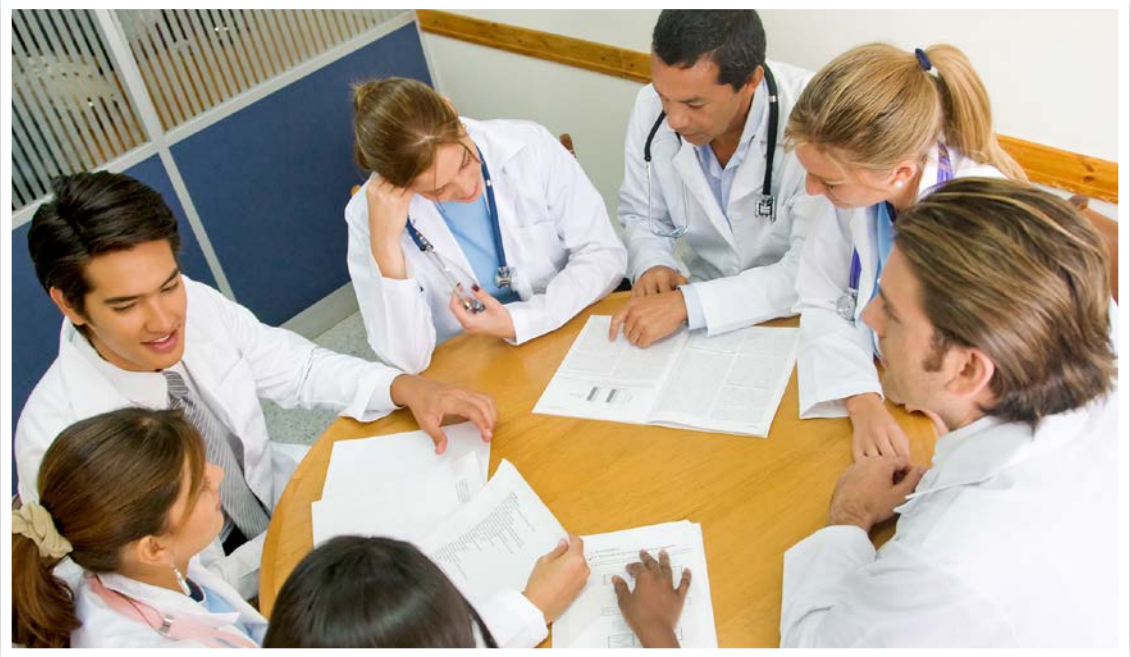
per month. When there are shared savings, the hospitals will receive their percentage of the savings. Ten percent of the payment will go to NRACO to be reinvested in needed infrastructure. The remainder is distributed to ACO participants, and each community then distributes the shared savings it receives to its ACO professionals.

Throughout 2014, interest in the NRACO program continued to build. Thirty rural healthcare organizations combined to form five additional ACOs in nine states, which began functioning in 2015. They included 28 rural and critical access hospitals, 42 rural health clinics, 12 federally qualified health centers, and nine private physician practices. In most cases, the rural hospital sponsored the program and invited local providers to join at no charge.

The NRACO process supports hospitals in forming ACOs at much lower cost than if they tried to do it on their own. CMS estimates that the cost of starting and running an ACO is about $4.2 million. The 2014 and 2015 NRACO participants have invested millions in order to form their ACOs, but only at about one-third of the cost projected by CMS. Even at this reduced rate, the cost of participating in an ACO was prohibitive for most rural providers.

During 2015, CMS offered grants totaling $114 million in direct support for rural hospitals that choose to collaboratively form ACOs, plus about $228 million in direct technical support (through Practice Transformation Network grants) for rural providers to start moving into value-based payment models. It offered to prepay expected savings, allowing organizations to participate without putting any of their own capital at risk. If the ACO has shared savings, CMS will reclaim the money and use it for other programs. If the ACO does not have any shared savings, CMS forgives the loan and it becomes a grant.

This was a unique opportunity, and more than 300 rural health systems in 41 states decided to take advantage of it. A detailed administrative process took place, including site visits, discussions with physicians and governing boards, and contractual agreements, with formal ACO applications that went to CMS on July 31. Probably only about half of the 300 applicants will qualify. They will form about 25 ACOs, which will start functioning in 2016 (if they are approved by CMS and its Center for Medicare and Medicaid Innovation).



What Is the Medicare Shared Savings Program?

The Medicare Shared Savings Program was established by the Affordable Care Act as a new approach to the delivery of healthcare to facilitate coordination and cooperation among healthcare providers. The program combines three related goals:

- Better care for individuals
- Better health for populations
- Lowering growth in expenditures

ACOs are groups of doctors, hospitals, and other healthcare providers that come together voluntarily to offer coordinated, high-quality care to their Medicare patients. Coordinated care means that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. This requires excellent communication among physicians, hospitals, and nursing homes. It requires well-designed electronic health records to reduce unnecessary testing.

The Medicare Shared Savings Program is designed to offer an "on-ramp" for organizations to gain expertise in population management. When an ACO succeeds in delivering high-quality care while also spending healthcare dollars more wisely, it shares in up to 50 percent of the savings it achieves for the Medicare program. Under the most common Shared Savings Program, ACOs do not share in any losses. However, a few ACOs have chosen to participate in two-sided agreements, with the potential for increased gains when there are savings and for shared losses when there are losses. At present, there are 404 Shared Savings Program ACOs, with 7.3 million assigned beneficiaries in 49 states, plus Washington, D.C. and Puerto Rico.

NRACO's Shared Savings ACO Program offers rural hospitals benefits most of them cannot access in any other way. Most importantly, they can access a complete data file on their Medicare patients. For the first time, they can view every service delivered to their patients, including diagnoses, charges, rendering providers, and more. In addition, Stark, anti-kickback statute, patient inducement, and antitrust restrictions are waived.

Each ACO is responsible for reporting 37 quality measures based on four quality domains, and shared savings payments are adjusted based on quality of care. The four domains are:

- **Patient/caregiver experience**, based on CG-CAHPS survey data such as the patient's rating of the doctor, access to specialists, how well doctors communicate, and shared decision making.
- **Care coordination/patient safety**, based on the percentage of patients readmitted to the hospital within 30 days after discharge; admission rates for patients with ambulatory care sensitive conditions such as heart failure, COPD, and diabetes, which generally can be treated outside the hospital; and other related measures.
- **Preventive health**, which is based on a range of immunizations and screenings, as well as capturing documented interventions.
- **At-risk populations**, which looks at measures related to control of specific chronic conditions such as high blood pressure, heart failure, coronary artery disease, and diabetes.

For its first performance year, an ACO satisfies the quality standard when it reports this data accurately. During the second and third years, quality performance benchmarks are phased in and become a factor in evaluating the ACO.

One special problem for rural hospitals is that the data that reaches them about their patients is incomplete, in that the files only include "attributed patients." Under the ACO model, each ACO

accepts responsibility for an "assigned" or "attributed" Medicare patient population. This patient population is used as the basis for establishing and updating the financial benchmarks and quality measures used to analyze the ACOs efforts to improve care and reduce costs. So, which patients were assigned to each ACO matters a great deal, and rural hospitals often find a substantial fraction of their patients has gone missing.

CMS uses a two-step method to assign patients, based on how many primary care services were offered through ACO physicians and other professionals who deliver primary care. However, a significant percentage of rural patients are seen by nurse practitioners and physician assistants. The Affordable Care Act requires that CMS only assign patients to an ACO if they have seen a physician from that ACO at least once in the prior year. Senator Maria Cantwell (D-Washington) recently introduced legislation that would remove this physician visit requirement. According to Barr, the legislation would likely double the number of patients that are attributed to rural ACOs.

Rural ACOs Offer Opportunities Plus Lots of Work

In February 2015, HHS Secretary Sylvia Burwell announced an accelerated timeline for the transformation of traditional Medicare payments to the new value-based payment systems. "For the first time, we're going to set clear goals and establish a clear timeline for moving from volume to value in the Medicare system," Burwell said. "Our first goal will be for 30 percent of all Medicare payments to be on alternative payment models by 2016 and to reach the tipping point of 50 percent by 2018. These models will be based on how well providers care for their patients, instead of how much care they provide....Our second goal is for virtually all Medicare fee-for-service payments to be tied to quality and value in some way, at least 85 percent by the year 2016 and 90 percent by 2018, so most providers will be tying at least some of their payments to value."

These changes will have a dramatic effect on rural providers, who until now have generally been exempt from these programs. To reach the stated goals, ultimately rural provider payments will have to be tied to quality and value measures. "We've seen these changes reflected in documents from CMS and also from the Office of Rural Health Policy, asking for comments on how rural providers should be paid for population health," Barr said. "It's important for us to engage in these conversations."

Nationally, Medicare costs for rural beneficiaries are about 10 percent lower than costs for urban beneficiaries. "Rural states tend to be more efficient with healthcare dollars," Barr said. "Even within the same state, Medicare costs for rural beneficiaries run about 3.5 percent lower than urban beneficiaries, but this information is not widely available. Rural providers need to enter programs where they can gather and publish cost and performance data, so others will understand that we are high-value providers. We have to be able to tell that story, because we face the greatest threat to our sustainability if the market believes we have high costs and low quality."

Forming an ACO means lots of work, Barr warns. "When you join a rural ACO, you'll have to work hard to provide better care for your community. Rural providers are already providing the best care they know, but this approach means redefining workflow and processes. It means doing proactive care, reaching out, getting people in for annual wellness visits, doing more preventive screenings, and following up when needs arise. For example, as a country we do a poor job of screening for risk of falls. If we did more, we could prevent some people from breaking their hips."

Similarly, ACOs will face expanded work providing new kinds of support for rural physicians, forming teams that work together to be sure patients receive and understand the information and services they need to stay as healthy as possible.

Twenty percent of patients account for 80 percent of healthcare spending. There is a great deal of evidence that by doing care coordination, hospitals can reduce healthcare spending in that top tier of patients. Each community participating in the rural ACO program is setting up a care coordination program. NRACO offers technical support that includes drafting the job description, training for the care coordinator, and the needed infrastructure and information on how to bill for care coordination using new Medicare codes.

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—Lynn Barr, M.P.H., Founder and Chief Transformation Officer, NRACO

At present, rural healthcare is extremely fragmented. Barr cites an example: one of the smallest NRACO members has 174 attributed patients and those patients have received care from 75 different Part A facilities during the last two years. When rural patients need to seek specialized care outside their own communities, they are often unsure how to find reliable, effective care. A care coordinator could use claims data to identify those who need help, and then help these patients find high-quality care, often closer to home, with better communication links with their primary care providers.

"These patients are getting many services outside the community that they could obtain within the community," Barr said. "On average we currently have a 35 percent share of claims for attributed lives, and theoretically we could have a 70 percent share." This is important because rural providers have cost-based reimbursements, and costs are divided by the number of patients seen. If the volume of attributed patients goes up, costs per patient go down.

According to the World Health Organization, 2013 average per capita healthcare spending in the United States is $9,146 per person per year, including out-of-pocket costs, prescription and over-the-counter medications, and so on.[1] A small town of 10,000 people spends about $90 million a year in healthcare. "That is what rural communities need to start managing," Barr said. "Right now there is something wrong with the payment system. We do the lion's share of the work, but most of the money leaves our community. When we develop a population health program and manage that budget more effectively while also offering better care, we should be able to keep more of the premium dollar."

Three Hospitals See Strong Reasons for Forming Rural ACOs

Ridgecrest Regional Hospital was involved in NRACO discussions from the beginning and joined National Rural ACO II, part of the 2015 cohort of rural ACOs. "We don't actually know whether we're going to see any shared savings or not during the first years," said James A. Suver,

1 World Health Organization, Global Health Expenditure Database (available at http://apps.who.int/nha/database).

Chief Executive Officer. "This program helps us start to get good at population management. By learning from other hospitals, and developing standardized case management protocols, we will develop a new skill, one that most rural hospitals don't have."

Earl W. Ferguson, M.D., Ph.D., a Cardiologist at Ridgecrest Regional Hospital, serves on the Ridgecrest board. He was the Interim Medical Director for NRACO during its formative stages. "NRACO seemed like a really useful idea because rural hospitals just don't get the attention they deserve, and they have unique needs," he said. "We had some presentations given to the Ridgecrest board about the basic concept, and the whole board was supportive."

Training programs from NRACO have been extremely valuable, Ferguson said. "The NRACO Chief Medical Officer and other staffers came out to train people about how do you really put all of this together—what do you concentrate on and how do we build a system that's going to work effectively? That's a very, very big task."

For example, the training included information about what a care management program does, how to select a care manager, and ways to engage patients. NRACO supplies a range of tools, templates, and lists to aid in mastering these new ways of looking at healthcare services. Community care coordinators are sent to a specialized training program to teach them how to reach and motivate patients to improve their health. They work together in peer communities to learn from each other about what works in the rural environment. They meet weekly with NRACO coaches to identify patients who need help and overcome barriers to better care at lower costs.

"The sharing of best practices has been extremely valuable," Suver said. "In particular, we receive physician support when the Chief Medical Officer for NRACO is available to speak with our doctors as necessary. It's really important that doctors hear information from other doctors, and especially from doctors who already have experience with population health management."

Morris Hospital decided to join a rural ACO last summer, after putting together a feasibility study on its options related to Medicare beneficiaries. "We call 2015 our learning year," said Kimberly Landers, M.S., RN, NEA-BC, the hospital's Chief Nurse Executive. "We want to learn how to manage health outside the four walls of our hospital. We believe in order to do that we need assistance from a company like NRACO to teach us the mechanics and the metrics. Joining NRACO means we will access our data and have opportunities to discuss data and possible strategies with other like-sized hospitals."

One of the first challenges for the hospital, she said, was explaining to patients what an ACO is and what it means for them. Considerable effort went into putting up signs at ambulatory clinics, speaking with physicians, writing letters, and explaining to patients "why we're calling them to follow up, why we want them to have diagnostic tests, why we are checking to see if they picked up their medications, why we're making home visits. We explain that 'we want to make sure you stay healthy and stay out of the hospital.'"

At this point, heart failure, COPD, and diabetes are the top three diagnoses where the hospital feels it can affect readmission rates and emergency department use. Morris Hospital has been focusing on readmission rates since 2012, and has seen a 4 percent decrease between 2012 and the end of 2014.

When patients need help in order to keep a doctor's appointment, the hospital is able to offer a ride thanks to volunteer drivers and nine minibuses (supported by the hospital foundation). They serve patients within a 12-mile radius throughout the week for all healthcare-related transportation needs.

This year, Morris Hospital hired a master's-level RN as its care coordinator. "She is the hub and everybody else forms the spokes," Landers said. The hospital has about 2,500 ACO patients,

and the care coordinator is currently focusing her efforts on the top 50 in terms of readmissions and high resource consumption. She keeps a record of success stories about patients who received small services that help them stay healthy, such as home care, oxygen, or pharmacy deliveries. She shares these stories at monthly meetings with staff and providers, and during visits to each of the ambulatory clinics. She works with front desk staff, clinical assistants, and RNs so everyone understands the quality measures, and what data must be included in the record.

Recently, she visited a home just a few blocks from the hospital and found a COPD patient who didn't have enough tubing for her oxygen tank, so she disconnected it in order to move around the house. "All we needed to do was get her longer tubing; otherwise she was taking it off and then having these episodes," Landers said. "Sometimes a trained eye looking at a situation from a different perspective can solve the problem quickly and inexpensively."

"We don't actually know whether we're going to see any shared savings or not during the first years. This program helps us start to get good at population management. By learning from other hospitals, and developing standardized case management protocols, we will develop a new skill, one that most rural hospitals don't have."

—James A. Suver, Chief Executive Officer, Ridgecrest Regional Hospital

Morris and Ridgecrest have partnered with six other communities to form an ACO. In contrast, Reid Health is large enough to create its own ACO. One reason Reid decided to form an ACO was that it was already doing many of the things that lead to success under an ACO structure. "You don't just go into an ACO and suddenly become ACO-like," noted Craig Kinyon, President and CEO of Reid Health. "First you have to show that you have the ability to stratify utilization, and that you can focus on high utilization issues and deal with them, because that's where your opportunities are in an ACO."

About four years ago, Reid began working to reduce readmissions and care more effectively for people with chronic diseases. Reid sent RNs to the homes of people who it determined were at risk for readmission, patients with chronic conditions such as asthma and heart failure. "Nurses are very good investigators," Kinyon said. "They ask many questions, they see where the disconnects are, they fill in some of the blanks. Then they work with the physician and discharge planners on how to develop an effective discharge plan to make sure people don't get readmitted. The change we made was to consider that the role of our clinical staff was not bound by the walls of Reid Health."

Reid also had extensive wellness, prevention, and health promotion programs. In addition, for the past two years, Reid has been sending a physician or nurse practitioner to round daily at three local nursing homes, with the ability to alter prescriptions as needed. "It's been a mutually beneficial relationship," Kinyon said.

Because Reid was already doing so many things designed to support people with chronic conditions and reduce unneeded readmissions, joining the NRACO program was a straightforward decision. "We said, 'we're already doing all of this. Now we have an opportunity to gain credit for the savings that we're creating,'" Kinyon said. "Our plan is to continue what we're already doing, and improve on it, but now under the ACO arrangement we have an opportunity to receive a partial dividend for the work and resources we're putting into this."

Supported by NRACO—Moving Towards the Future

NRACO has contracted with Lightbeam Health Solutions to offer its population health platform to the NRACO network. Lightbeam uses a comprehensive data warehouse to aggregate disparate clinical and payer data, delivering actionable information directly to each community to improve outcomes and reduce costs. This means it pulls together information from many providers—outside labs, other hospitals, and other physicians—all based on the Medicare billing file. It also means that ACO physicians can look up a patient and see whether they got prescriptions filled and where they obtain other aspects of their care.

One important part of the NRACO process is that during its monthly meetings each participating hospital reviews its financials. Hospitals today are still basically paid on a fee-for-service basis, with adjustments around the edges. While they prepare for the future environment of value-based purchasing, and develop programs that coordinate care and keep patients healthy, at the same time they need to bring in sufficient funds right now to keep their doors open. Starting in 2016, NRACO plans to partner with financial consultants who will help member hospitals review their financial data in greater detail using sophisticated analytic methods.

The Medicare Shared Savings Program is a way for rural hospitals to aggregate lives and start learning how to offer population-based healthcare. Barr sees this as the first step in a progression that might also include similar shared savings programs with private insurers. Once hospitals are confident in their ability to manage a population, they could consider self-insuring their own employees and creating co-branded or provider-based insurance programs for employers and for their communities. "Over time, we think this is the future for payments for rural care," she said. "We're not really focused on ACOs; we're really about developing population health management as a future payment stream for rural communities. The Medicare Shared Savings Program is a great place to start."

Suver agrees. Ridgecrest is based in a rural area, but it is about 100 miles from urban areas with extensive medical networks. He expects that as Ridgecrest participates in the shared savings ACO this will open the door to additional opportunities. "One reason we're doing it is that we want to work with insurance companies," Suver said. "We want to be able to say, 'We can help reduce your overall cost for your members; we can do population management.'"

Some of the leaders who think and write about population health tend to picture it functioning most effectively in urban areas, for large groups of people, served by large organizations. Can population health function equally well in rural areas, with a sparse population and relatively few medical services?

"We believe that no one is in a better position to manage healthcare at the most effective level than the rural hospital, which sees the majority of patients in town, and has the majority of doctors," Suver said. "I think we can actually do it better, because we tend to have long-term relationships with our patients. We're smaller, and we can be nimble. We can identify the frequent flyers in our ER."

We asked some of the organizations we interviewed whether they have advice for rural hospitals that haven't embarked on these new forms of organization. "First, you can't keep thinking that this is just going to go away," Suver said. "I talk with peers who believe we're going to weather this, that there will always be a need for an acute care hospital in our community. My perspective is that as we move to a more ambulatory market, if you don't get good at population management, you will fail."

"The rural hospital shared savings program is a no-lose situation," Kinyon said. "There is very little risk, and there's an opportunity to get back a portion of your savings. If you believe that this is where the market is going, that increased emphasis on quality indicators will put a growing

share of your reimbursement at risk, then you need to adapt and change. If you can't control utilization, you're really dying a slow death."

"This program is a good way to test the waters," Suver added. "By pooling our efforts with so many people, we've been able to get the infrastructure built and still have a sustainable economic model while we develop skills at population health."

"If you join a rural ACO you will own and govern it," said Barr. "That means quarterly board meetings, but it also means that you drive the decisions. You'll create leverage with your payers and your referral network. You'll control your rate of change and you'll be recognized as a high-value provider, which will be very important to your future sustainability."