

# EXPLORING OPTIONS TO DEPLOY CAPITATED PAYMENTS TO ENHANCE PRIMARY CARE IN RURAL SETTINGS

**CASE STUDY | DECEMBER 2020**

## KEY TAKEAWAYS

1. Efforts to move providers towards greater risk adoption go back decades. The fee-for-service funding model that is the basis for the vast majority of provider payments has been challenged as a sustainable payment system. There is growing interest in capitated payment models as a means for predictable upfront payment. Several newer models that leverage “prepayment” or population-based payments have shown promise in strengthening the financial stability of the health care system.
2. Capitated payments can be a way to attract and sustain primary care providers in rural communities. These models require a shift in provider mindset and an organizational infrastructure that supports new, innovative ways of delivering care.
3. No two rural communities are the same, thus payment or delivery models should allow considerable flexibility to encourage accessible, relevant and quality care that improves patient outcomes and population health.
4. Any capitated payment model that is introduced into a rural market should be service-specific enough to avoid major disruptions in revenue to other care providers in the same community OR incorporate the totality of health care providers who serve the market.

This case study highlights examples of capitated payment agreements that serve to increase the use and improve the quality of primary care services in rural communities. These arrangements are deployed at several levels of care management and delivery in the public and private sectors, with payment to parties such as managed care organizations (MCOs), Community Health Workers (CHWs) and physicians. Most of these models are enmeshed in larger, multi-agreement payment models and serve as an example of how to leverage capitated payments for specific services in conjunction with other payment methodologies such as fee-for-service, pay-for-value, and global budgeting.

## BACKGROUND

### The Need for Rural Primary Care

There is an increased focus on ensuring local access to care for the 20 percent of the population who live in rural areas. Rural providers and hospitals are under pressure to meet these needs but are struggling to maintain access in the face of a unique set of persistent and emerging challenges, including geographic isolation, sicker populations, and a higher payer mix of Medicare and Medicaid beneficiaries, hospital and clinic closures, and physician workforce shortages.

Per the Centers for Disease Control and Prevention, rural Americans are at a higher risk of death from heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke than urban Americans. Furthermore, rural populations are smaller and more dispersed, making it challenging to deliver coordinated, timely, and effective care—a trial further complicated by the fact that less than 10 percent of physicians

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practice in rural communities. Since 2010, 133 rural hospitals have closed, and additionally, the Government Accountability Office (GAO) reports that between 2013 and 2017, more than twice the amount of rural hospitals closed than in the previous five-year period—an indication of a worsening trend. The impact of these closures is profound, with some communities experiencing a reduction in services offered and others losing total access to care when neighboring clinics close as well. Moreover, in 2016, 63 percent of rural health clinics were either provider-based or hospital-owned, meaning that hospital closures could impact access to primary care services. Hospital closures also impact workforce shortages, as approximately two-thirds of the nation’s primary care health professional shortage areas were in rural or partially-rural areas.

Primary care services provided by the hospital may still remain available to communities that have experienced a hospital closure. In over one-third of communities where hospitals were converted to alternative care facilities, there was an increase in the number of primary care physicians. Additionally, while there is an overall shortage of physicians in rural areas, other health professionals such as primary care nurse practitioners, primary care physician assistants, and family medicine physicians are steadily increasing in rural communities.

Still, the need for diversified health care access points for rural health care delivery is more critical now than ever, and increasing and sustaining primary care access in rural communities is a crucial component of overall rural health improvement strategies. Primary care providers are essential for preventive health care services and the identification of early-stage chronic diseases within communities. Alternative and innovative payment models are one way of attracting and supporting primary care providers in rural areas, including capitated payment models. Primary care providers will need to manage care differently, which includes not only reorienting clinical and operational staff away from a utilization-driven model to a total-cost-of-care model but also ensuring that the organization has the appropriate data analytics and care management infrastructure in place.

## Definitions

The classification of “rural” and definitions for “primary care” and “capitation” can vary across stakeholder groups. For this paper, the following expanded definitions for rural communities, primary care, and capitated payments will be used:

**Rural Communities:** While the U.S. Census Bureau does not have a formal definition for “rural,” rural areas in the United States encompass all populations, housing, and territory not formally designated an “urbanized area” or “urban cluster.” The Federal Office of Rural Health Policy (FORHP) accepts all non-Metro counties as rural in combination with an algorithm for determining rurality called the Rural-Urban Commuting Area codes. With this two-stage identification system, the FORHP designated 57 million people as “rural” following the 2010 census, approximately 18% of the total population. The Centers for Medicare & Medicaid Services (CMS) allows hospitals to reclassify as a rural hospital if designated criteria are met; therefore, some hospitals that are considered rural for Medicare purposes may not be regarded as rural under FORHP criteria.

**Primary Care:** The American Academy of Family Physicians defines primary care<sup>1</sup> as “The care that is provided by physicians specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom or health concern not limited by problem origin, organ system or diagnosis.”

**Capitated Payments:** Capitated payments are a form of population-based payment in which providers receive a fixed payment per person to cover all health care services over a specified time. This payment is risk-adjusted and typically tied to quality and patient outcome metrics.

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## A BRIEF OVERVIEW OF **PRIMARY CARE, CAPITATION AND RURAL HEALTH FOCUSED MODELS** IN THE UNITED STATES

To fully understand how current capitated payments and similar arrangements have evolved, it is useful to examine how first-generation payment or care models that leveraged capitated payments were structured. The following models have focused on primary care, rural communities and/or incorporated a type of capitation-style payment in their broader strategy and have spanned both public and private payers:

### Primary Care Models

Models to transform and improve health care through primary care have been evolving for years, including the Primary Care Medical Home (PCMH). PCMH delivery systems are organized around five pillars: comprehensive care, patient-centeredness, coordinated care, accessible services, and quality and safety. Several private and public payers have implemented various PCMH pilots around the country. The most recent of these models in the public arena is: Comprehensive Primary Care Plus (CPC+), initiated in 2017 through CMS's Center for Medicare & Medicaid Innovation (CMMI). CPC+ is a national primary care medical home (PCMH) model that aims to strengthen primary care via a regionally-based multi-payer payment reform and care delivery transformation strategy in two practice tracks. It is comprised of three payment elements: the care management fee, a performance-based incentive payment, and payment under the Medicare Physician Fee Schedule. Currently, there are 79 public and private payers and 3,070 practices participating in CPC+ across 18 regions in the U.S. Over 15 million patients have been served by the practices that began CPC+ in 2017. An evaluation conducted after the first year of the model's implementation found that 93 percent of participating practices reported that CPC+ improved care quality.

### Systems of Care That Leverage Capitation or Capitation-style Payments

**Accountable Care Organizations** (ACOs) are groups of physicians, hospitals, and other health care providers that organize voluntarily to provide coordinated, high-quality care to their patients. In 2016, CMMI implemented the Next Generation ACO Model that included the introduction of a new payment arrangement, the "All-Inclusive Population-Based Payment" (AIPBP). The AIPBP estimates total annual expenditures for care provided to aligned beneficiaries by AIPBP-participating providers and suppliers and pays the projected amount to the ACO in a monthly AIPBP payment. CMMI also launched the ACO Investment Model (AIM) in 2015, a model of shared savings that provides both upfront payments and ongoing per beneficiary per month payments, to encourage new ACOs to form in rural and underserved areas where there had been little ACO activity. CMS supports the Medicare Shared Savings Program, which allows providers and other patient care suppliers the chance to organize into an ACO that agrees to be held accountable for the quality, cost, and experience of care for a given Medicare fee-for-service beneficiary population.

The Vermont All-Payer ACO Model is an example of a tailored, state-wide test of an alternative payment model. Payers throughout the entire state – Medicare, Medicaid and commercial health care payers – incentivize Vermont providers to improve care coordination and collaboration with community based-providers, made available by \$9.5M in start-up investment funded by CMS. This payment model provides an opportunity for Vermont and CMS to work closely together to improve the health outcomes and transform health care for the entire state by implementing the same payment structure for the majority of providers throughout the state's care delivery system.

**Global budgets for hospitals**, such as the 2014 Maryland Global Budget Revenue and 2017 Pennsylvania Rural Health Model, supply a fixed amount of funding for a specified population over a defined period of

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time. The purpose of global budgeting is to control the amount of money a hospital can spend, thereby limiting the total money spent on health care within a system. This is accomplished by setting and leveraging a comprehensive and inclusive budget that introduces flexibility for hospitals to manage and allocate resources. In the Maryland model, the goal of global budgeting was to reduce Medicare expenditures; in the Pennsylvania Rural Health Model, global budgets are being deployed to create a sustainable business model for rural hospitals. The global budget model is less dependent on service volume than traditional FFS and can be used to produce a wide array of outcomes. The Maryland and Pennsylvania models are just two examples of the application of global budgeting at a state level, although global budgets can be scaled up or down with variation in how the global budget is determined, paid, and reconciled.

### Another approach that utilizes capitation or capitation-style payments

**Health Maintenance Organizations** (HMOs) were developed in the 1930s and grew to their peak between the 1940s to 1970s, culminating in the passage of the HMO Act of 1973 by President Richard Nixon. The basis of HMO payments were prepaid, comprehensive care coverage, which today can manifest as payment in a fixed amount per patient, per month from the HMO to physicians – similar to a capitated payment. HMOs can also deploy other forms of payment to cover services. Capitation-style payments are only one such form of provider payment to deliver services to beneficiaries.<sup>2,3,4</sup>

### Rural-Focused Models That Employ Capitation

**Community Health Access and Rural Transformation** (CHART) model was announced in 2020 by CMMI to improve rural Americans' health outcomes and reduce rates of preventable diseases. The new model will provide funding from CMS to rural communities through two tracks: one to build care systems through a "Community Transformation Track" and a second will allow providers to participate in value-based payment models on an "Accountable Care Organizations (ACO) Transformation Track." The Community Transformation Track will designate up to 15 Lead Organizations to represent a rural Community, which must meet the FORHP's definition of rural mentioned above to be eligible for participation. The ACO Transformation Track will be comprised of up to 20 CMS-selected, rural-focused ACOs who will receive advanced payments as part of joining the Medicare Shared Savings Program. The purpose of the CHART model is to test if upfront investments, capitated payments, and operational and regulatory flexibilities will allow rural health care providers to improve access to high-quality care while reducing costs. CMS announced a Notice of Funding Opportunity for the Community Transformation Track in mid-September of 2020, and a Request for Application for the ACO Transformation Track will be offered in early 2021.

The **Pennsylvania Rural Health Model**, implemented in 2017 by CMS and other participating payers, provides global hospital budgets in the form of a fixed amount of revenue, set in advance, to cover all inpatient and hospital-based outpatient service to 13 hospitals located throughout rural Pennsylvania. The purpose of the Model is to test whether global budgets will enable participating hospitals to invest in quality and preventive care, in addition to tailoring their service offerings to best serve their communities. The Model's performance will be measured over six years, with the first performance year beginning in 2019 and the final performance year concluding in 2024. Participating hospitals must deliberately plan changes to improve quality and coordinate care and present a Rural Hospital Transformation Plans to governing entities in Pennsylvania and CMS to continue participation in the model. Participating hospitals must also continuously seek and incorporate feedback from community stakeholders.

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## SELECTED EXAMPLES OF **CURRENT CAPITATED PRIMARY CARE MODELS**

We identified models across different payers and regions that leveraged capitated payments for primary care or preventive services. Most of these models are still emerging, with many being implemented for less than five years, but they have yielded valuable lessons to be applied to future capitation models for primary care.

### Public Payer

**Prepaid Minnesota Health Care Program (PMHCP):** This model is a managed care alternative to traditional fee-for-service that provides select medical vendors contracts on a prepaid capitation basis. PMHCP enrollees are eligible for comprehensive preventive, diagnostic, therapeutic, and rehabilitative health care services provided by or arranged to be provided by the contracted MCO. In addition to Medicaid populations, PMHCP serves Medicare-eligible seniors through the Minnesota Senior Health Options (MSHO) program. In order to qualify, beneficiaries must be eligible for the Prepaid Medical Assistance Program (PMAP), be over the age of 65, residing in the service area, and have Medicare Parts A and B. MSHO enrollees receive Medicare and Medical Assistance services from their chosen MCO, including home and community-based services for seniors who are eligible for Elderly Waiver Services.

In 2016, the Minnesota Medicaid program insured approximately 1 in 5 Minnesota residents, and 807,000 individuals were enrolled in MCOs. Each enrollee averaged six primary care visits, three outpatient mental health visits, and filled more than 15 prescriptions. The MCOs responsible for these covered lives were paid capitated payments. These capitated payments covered traditional primary care services and also offered payment for additional services such as mental health visits and dental care, which are typically services carved out of coverage for adult patients. This expansion of coverage allows for a greater focus on the total health of patients and broadens the horizons of what can be considered “primary care”, which traditionally has not included these services under the “primary care” umbrella for adult patients.

There are limited evaluation studies for all programs encompassed in the PMHCP, but in a 2016 study, researchers found that Medicaid-Medicare dual-eligible seniors aged 65 and older served by the MSHO program had greater primary care physician use and lower inpatient hospital and emergency department use. Additionally, this study found that MSHO enrollees were slightly more likely to live in rural areas of the state.

**Oregon Primary Care Association (OPCA) Alternative Payment Model:** In 2012, the Oregon Primary Care Association (OPCA), in partnership with Oregon community health centers and the Oregon Health Authority, developed the Alternative Payment and Advanced Care Model. Under this model, fee-for-service Medicaid reimbursement for health centers is converted to a per-member, per-month capitation payment. The model emphasizes addressing the root causes of illness and well-being for patients by using thorough population health-based approaches. All participating clinics agreed to a three-year commitment to cover all sites and all patients; services not covered under the alternative payment model (APM) included mental health, dental, and obstetrics services.

In a report published after year one, OPCA found that the model achieved budget neutrality. The early findings showed there was no need for additional funds to be made available for reconciliatory payments for services that were provided to patients outside of the initial APM payments. Clinical quality indicators were holding or improving, and there were signs of improvement in total health care utilization. This makes APM a viable alternative to fee-for-service models as it covered all necessary and utilized services sought by patients without creating a need for additional, over-budget payment.

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**Hidalgo Medical Services**, located in Lordsburg, New Mexico, employs capitated contracts to offer Community Health Worker-driven patient support services at a fixed rate. Hidalgo contracts with Medicaid MCOs that participate in New Mexico's Centennial Care (Medicaid) program.

Hidalgo was one of several Federally Qualified Health Center's that deployed community health workers paid by MCOs on a capitated basis to improve community health and increase engagement with primary care. The program has now seen a 4:1 return on investment in high-need, high-cost patients, mostly through decreased emergency department and hospital visits for non-hospital care, lower prescription drug costs, and increased use of primary care services.

### Private Payer

**Providence Medical Group and Providence Health Plan:** Oregon-based Providence Medical Group rolled out primary-care capitation arrangements across all of its lines of business with the Providence Health Plan in 2018, including commercial and Medicare Advantage plans, as well as plans contracted by the Public Employees' Benefit Board and Oregon Educators Benefit Board. The agreement provides risk-adjusted, per-member, per-month amounts to cover primary care services to improve physician engagement and increase patient attribution. The arrangement also covers services that are typically not covered in primary care settings, including patient education from clinical pharmacists, social needs addressed by care managers, and behavioral health concerns treated by psychologists. The integration of services to address social determinants of health and incorporate patient education make this model a noteworthy example of innovation in primary care using a capitated APM to drive better health outcomes.

## LESSONS LEARNED FROM CASE STUDIES TO APPLY TO NEW PRIMARY CARE PAYMENT MODELS IN RURAL SETTINGS

To provide quality care and address the diverse needs of rural populations, the following lessons should be considered when constructing a payment model for primary care in rural areas:

1. Rural primary care systems and the utilization of **capitated payment arrangements** seek to expand the scope of primary care by testing and incorporating services that are not traditionally reimbursed in a primary care setting. These added services include programs that address preventive services as well as non-medical needs that impact a patient's health status and overall well-being. These services can be covered using a capitated payment agreement that is deployed as part of a larger, multi-agreement payment model and ideally allows the system to respond to unique community needs with greater flexibility and access. For example, the Hidalgo model incorporates Community Health Worker-driven support services.
2. **Capitated payment models, and other alternative payment models** that move away from traditional fee-for-service arrangements, offer a protective factor for rural providers and systems whose utilization may be unpredictable or heavily disrupted due to catastrophic events, such as the COVID-19 pandemic or future natural disasters.
3. In order for **capitated payments to be actionable in rural communities**, the following should be noted about payment arrangement design: stop-loss arrangements should be defined and put into practice in order to ensure appropriate risk mitigation; payment should be tied to quality and outcome metrics measured using actionable data; payment amounts should cover a sufficient volume of the population and provide a reasonable payment rate for the community.

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4. Leveraging tools such as **community health needs assessments**, or similar evaluations, should be encouraged to ensure that covered services will enhance the quality of care, promote better overall health within the population and avoid payment for unnecessary care. In this way, provider networks can offer high-value care that better serves the community without having to prioritize low-value, high-reimbursement care offerings in order to increase revenue.
5. A future payment model should encourage community organizations to **collaborate and better coordinate care**. Effective collaborations could increase the population size covered by the model, which in turn spreads and lowers the risk.
6. Any model that shifts risk to hospitals or clinicians must allow for a **sufficient “ramp-up” period**, during which providers and systems can learn how to manage risk and operate under a risk-based payment arrangement. Furthermore, these models should supply providers and systems upfront financial resources and sufficient technical support to monitor and evaluate the payment agreement. Additionally, models that incorporate capitation may not involve all levels of the organization; providers in one organization may participate in both value and non-value-based models depending upon the service.
7. **Patient support** should be a continued priority in capitated payment arrangements so that a full spectrum of technology and services can be utilized appropriately. These include telehealth services and a patient portal that can aid patients in managing their own health, monitoring chronic disease and improving access for remote populations.

## ANNOTATIONS

1. Paraphrased for clarity
2. Most HMOs continued to deploy fee-for-service and per-case payments to care delivery groups, even if employers paid the HMO on a capitated basis
3. HMOs have also deployed a staff model, in which physicians are employees of the HMO and provide care in the HMO’s facilities
4. Value-based incentive payments have also been deployed in HMOs, most notably as part of the AMP Commercial HMO in California
5. “Medical vendor” is the term used by the State of Minnesota to describe contracted organizations participating in the model

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