Serving Rural America: Health Insurance Providers at Work

There are numerous health-related challenges facing rural areas of the U.S., including geographic isolation, an aging population, and a shortage of providers and hospitals, especially as rural hospitals close at unprecedented rates.[1] People living in rural communities experience higher rates of chronic conditions, including diabetes, obesity, and mental and behavioral health disorders in children, and residents are at higher risk of injury and complications from substance use disorder (SUD).

Unfortunately, access to care in rural regions is decreasing, as closures and mergers of rural hospitals are affecting millions of Americans across all states and regions. Rural hospitals provide the primary access point to care for many of the 60 million people living in rural communities, and the rate of closure – faster than at any other time – raises great concerns for rural residents, even triggering a Congressional hearing in March 2019.

There are many reasons for these hospital closings and mergers, including:

- financial challenges associated with serving remote regions with low patient volume;
- difficulties staffing in these regions; and
- increasing severity of patient conditions.

These and other challenges prevent patients from always getting the care they need—and it creates opportunities for health insurance providers to innovate in the ways that care can be delivered to rural residents.

Below are five case studies that spotlight the work of eight insurance providers working in four states to address the challenges of rural health in America. These case studies feature innovative approaches to health care delivery, financing, and community engagement and exhibit the leadership of health insurance providers in delivering high-quality, affordable, accessible care to all Americans, including those in rural areas.

Through Maryland Pilot Program, CareFirst Promotes Efficiency, Quality in Rural Hospitals

With an estimated 21% to 39% of health care costs associated with wasteful spending,[2] states have begun looking for new ways to stabilize the finances of rural hospitals.

In 2010, Maryland chose to replace the traditional fee-for-service model in rural hospitals with a model using "global budgets." For Maryland hospitals in rural areas, the model uses a Total Patient Revenue (TPR) or fixed hospital revenue approach to determine the costs associated with treating local communities. At the 8 participating hospitals, the global budgets covered all inpatient and outpatient services provided by the hospital.

The model was developed by the Maryland Health Services Cost Review Commission to provide hospitals with a financial incentive to manage their resources efficiently and effectively. Each hospital that participated in the program had a fixed revenue budget which created incentives to reduce the length of stay, ancillary testing, unnecessary admissions and readmissions, and improve efficiency.[3] By reducing unnecessary procedures and tests, the hospital retained their full fixed revenue budget.

Several papers have been published reviewing the program, with the researchers seeing decreases in outpatient admissions, emergency department admissions rates, non-emergency department admissions, and outpatient clinic visits and services.[4] While the research indicates that length of stay did not decrease and there has yet to be indications that the TPR model reduced costs,[5] the rising cost of care was controlled—CareFirst found costs to have grown at a slower pace than in non-participating rural hospitals. Additionally, rural access to care was expanded dramatically, as the all-payer model ensures that all hospitals are covered by plan networks.

Following the completion of the TPR demonstration period, Maryland moved all non-rural hospitals in the state to a Global Budget Revenue (GBR) model, which, though not identical to the TPR, follows a similar approach in using a global budget to increase efficiency and slow cost growth. CareFirst continues its work with the state to stabilize and support

1 https://www.gao.gov/assets/700/694125.pdf
2 https://www.mass.gov/files/documents/2016/07/rq/2013-cost-trends-report-final.pdf
3 https://hscrc.state.md.us/Pages/init_tpr.aspx
4 https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05366
5 https://onlinelibrary.wiley.com/doi/10.1111/1475-6773.13162

the statewide GBR payment model. The model has resulted in reduced readmissions and complications and improves quality of care. In its leadership role, CareFirst promotes aligned incentives for hospitals, physicians, and health insurance providers, and encourages the use of medical home models to further incentivize efficiency.

But CareFirst's rural health initiatives do not end with the expansion of the global budget payment model. They remain a champion of rural health access in Maryland and are working to create programs to best serve those in need of care. The insurance provider was among the first plans to support reimbursement for services delivered via telehealth, which is especially relevant in rural areas. Today, they connect rural hospitals with Johns Hopkins Health System and other academic medical centers to ensure that patients have access to the best practitioners across the state, regardless of geography.

CareFirst has also created programs to address behavioral health needs in rural areas around the state. Emergency departments are flooded with behavioral health issues that should be treated in appropriate behavioral health settings, not hospitals. CareFirst is dedicated to helping to address these shortcomings and promote quality behavioral health care.

Similarly, emergency rooms are overcrowded throughout the state, and CareFirst has helped the state in creating programs that prioritize primary care. In rural areas especially access to primary care is particularly important. To address primary care needs, CareFirst helps fund nursing education support programs, where nurses and nurse educators can connect to expand access to care in rural parts of the state.

Maryland has long explored unique approaches to health care, which led to the creation of the all-payer waiver model where all commercial and public payers pay similar rates. The flexibility of the model later influenced the innovative TPR model for rural health care. By seeking to maximize access to care and encourage efficiency, Maryland has created a scalable, sustainable model that could be beneficial to other states facing similar challenges.

Pennsylvania Health Insurance Providers Launch New Model to Save Rural Hospitals

Highmark, Gateway Health, Geisinger Health Plan, Medicare, and UPMC Health Plan participate in the Pennsylvania Rural Health Model, an innovative project launched in January 2019 and designed to buoy the finances of rural hospitals in the Commonwealth. In this project, spearheaded by the Pennsylvania Department of Health, the five insurance providers collaborate to provide more consistent funding through global payments to rural hospitals.[6]

To provide more predictable financing to hospitals in rural areas, the insurance providers each contribute to a global budget for the hospital, where the insurance provider determines a single payment based on the expected volume of transactions instead of paying for individual services. To create consistency in global payment design, the Department of Health created requirements for how insurance providers calculate the payments to hospitals, including parameters on the services to be included and excluded from the global payment as well as the type of data to be collected.

The participating insurance providers evaluated historical claims data from the participating hospitals and tracked trends in hospital utilization. The insurance providers determined a dollar amount for each hospital based on how each plan's members used the hospital. Based on these amounts, each hospital created a "Transformation Plan," which addressed the challenges faced, defined opportunities to provide better care, proposed how to link patients with primary care providers, and listed available community resources for patients.

The insurance providers will follow a traditional fee-for-service model for the first year of the project, with a gradual move towards capitation and value-based care. By the third year of the project in 2021, hospitals will use data analysis to improve efficiency and reduce avoidable hospitalization and admissions. By this point, payments will be tracked against targets, with the hope that the budgets will be reduced with each year of the program.

As the program progresses, insurance providers will adjust their budgets to account for demographic changes, age factors, and to ensure consistency.

6 https://www.health.pa.gov/topics/Health-Innovation/Pages/Rural-Health.aspx

As part of their participation in the project, hospitals will have access to additional resources, including technology assistance and access to vendors, to sustain the model for years to come. The state oversight of the Model helps the hospitals manage their funds and spend in appropriate areas, such as avoiding duplication of hospital programs between nearby facilities.

Citing the success seen in similar models from other states such as Maryland, the participating insurance providers believe this innovative model will preserve rural hospitals in the state. Even early in the program, there are already five participating hospitals in the first year of the project and it is expected to grow to 18 hospitals by Year 2 and 30 in Year 3.

California Health & Wellness Tackles Rural Health Challenges By Bringing Care Directly to Patients

California Health & Wellness, a wholly owned subsidiary of Centene Corporation, began serving Medi-Cal members in California in 2013 in 19 rural counties. To best serve members in geographically-isolated areas, California Health & Wellness created a comprehensive rural health program which utilizes local community health workers. The California MemberConnections program is an integral part of the company's care management program, where local MemberConnections Representatives, also referred to as health plan navigators, are hired to serve as liaisons between the insurance provider and its members.

This program is designed to engage rural members in new ways, with targeted outreach for members who may be in need of services, including post-discharge from the hospital or following the delivery of a baby, for example. Under the program, health plan navigators go directly to patients who may be in need, unsolicited, often following a hospitalization or emergency department visit. The program targets high-risk, vulnerable populations. The MemberConnections Representatives help members navigate the health care landscape more easily, by encouraging increased use of primary care.

Ensuring a quality member experience does not happen by accident. California Health & Wellness requires MemberConnections Representatives to undergo 500 hours of training in the field. That training includes time in specialty areas, including clinical documentation, communications, trauma-informed care, and motivational interviewing--skills that can be used to deliver appropriate, culturally-informed programs to their members.

The company emphasizes cultural connections and recruits individuals from the communities it serves, underscoring the importance of working with people who understand the challenges being faced. Health plan navigators speak the same language, hail from the same regions, and understand the communities based on lived experiences.

California Health & Wellness also focuses on a "whole person" approach to care and helps members address the additional challenges beyond traditional health care needs, known as the social determinants of health (SDOH). When the MemberConnections Representative meets with a member, they are asked about housing needs, transportation issues, and food insecurity—and resources are delivered where appropriate. For instance, MemberConnections Representatives will wait in line at a food pantry on behalf of a member and California Health & Wellness partners with non-profits to ensure that member needs are addressed via appropriate referrals.

Unfortunately, hospitals and care providers are not always located in areas that are convenient for rural members. Finding the appropriate care provider can prove challenging for members, which is why telehealth and other virtual care services can be extremely important--and the "boots on the ground" can help create the pathways through which technology can succeed. Health plan navigators help members set up the technology, show them how to use the services, and help them connect with an appropriate provider.

California Health & Wellness' MemberConnections program has created a blueprint for others to proactively address rural member needs and can serve as a model for care delivery in rural communities.

Health Net Uses Volunteer Network of "Promotores" to Address Equity in Rural Health

In rural Madera County, California, the largely Latino population suffers from many health challenges common to much of rural America. Residents have difficulty navigating the health care system and are in need of community and social services to address critical social determinants of health such as food insecurity, transportation issues, and connecting with local school districts. These residents are underserved, due to a shortage of providers and culturally- and linguistically-appropriate services.

Health Net, a subsidiary of Centene Corporation, is addressing these challenges head-on. Through their Promotores Health Network, the health insurance provider works in close partnership with members of the community and is taking a whole health approach to assisting at-risk individuals. "Promotores de Salud" (Health Promoters) are local residents trained by Health Net who volunteer to help other locals navigate the health care system. The Promotores network has used a grassroots strategy as the main pillar of its system navigator model to boost access to local resources and deliver culturally relevant education.

Health Net trains Promotores de Salud in a variety of health topics relevant to their communities, including what local services and resources are available for those in need. They also participate in community activities and engage local residents, with the goal of informally learning about the health needs and priorities of the communities.

Health Net supports their Promotores by analyzing HEDIS and other data to find where the biggest opportunities lie, and to identify members who could benefit most from the program. The Promotores then serve as the necessary link to the community, helping with education, referrals, and care navigation. Madera County, for example, has a large migrant population whose needs include culturally-relevant education on asthma, diabetes, women's health issues, health screenings, and healthy diet.

The program was originally created as part of the U.S.-Mexico Binational Health Exchange, which gave both countries the opportunity to learn about how health care is delivered in their neighbor country. These experiences informed the creation of the Promotores program. Health Net adopted the best practices of similar programs in Latin American countries, from which many Madera County residents have roots. Through this model, community leaders acting as Promotores were able to build trust with members and expand the scope of the program. Data collected by Health Net support this "trust" factor as well, with the insurance provider seeing significantly higher participation in education programs hosted with the Promotores than those without.

One challenge has been collecting the information needed to evaluate long-term outcomes and scalability. Additionally, there is no state funding available to support such programs, though Health Net and other MediCal payers support creating standards for training Promotores and others engaged in similar work.

Member satisfaction and engagement with the program are both high – indicating success at this early stage. Currently, there are 56 active Promotores that participate in meetings and coalitions on behalf of Health Net, including 17 "core" members who the company actively deploys to key communities and neighborhoods. The Promotores program is also active in East Los Angeles, where a similar model of health promotion and education is delivered to urban populations.

Moda Health Creates Coordinated Care Program Encompassing Medical, Behavioral Health, Dental Services for Rural Residents of Oregon

Several years ago, Oregon redesigned the way Medicaid Managed Care is delivered. Prior to the re-alignment, medical, behavioral health, and dental services were all separate, with different contracts, providers, payment streams, and incentives, with only marginal ties to the communities they served. The challenges of delivering health care to Medicaid beneficiaries were especially significant in rural communities. Access to primary and specialty care, treatment arising from the opioid crisis, and rapidly rising costs are all issues residents of rural areas face.

In 2012, then-Governor John Kitzhaber received a new Section 1115 waiver from the federal government to create Coordinated Care Organizations (CCOs). The waiver required Oregon to keep spending growth at 3.4%—2% below

the traditional spending of high-quality Medicaid Managed Care plans—improve quality of care, and engage local communities to better manage the health of members in the state. The waiver allowed Oregon to avoid reducing provider reimbursements or benefits, traditional means of addressing funding issues. Moda Health, in partnership with Greater Oregon Behavioral Health, Inc. (GOBHI), created the Eastern Oregon Coordinated Care Organization (EOCCO) out of this initiative.

The Eastern Oregon CCO is one of 15 CCOs in the state. EOCCO covers 12 rural and frontier counties across a geography of over 50,000 square miles. The 12 counties have a population of just 250,000. Of this population, 25% are on Medicaid and are served by EOCCO. Rather than maintaining siloed benefits, the CCO provides services for medical, behavioral health, and dental. To engage providers, the CCO offered equity to care providers—4 large hospital systems in Eastern Oregon signed on with the CCO. Moda, GOBHI, and two other partners (an independent physician association and a Federally-Qualified Health Center) each own a portion of the EOCCO along with the provider partners. Each entity shares in the risk proportional to their ownership.

To best serve rural communities, the CCO had to establish trust through the providers with roots in the area. Moda is a Portland-based insurance provider, so to build buy-in from their partners they agreed to reinvest savings back into the community providers. EOCCO also convenes 12 Local Community Advisory Councils (LCACs)--one for each county--which helps identify specific needs for each community. A Regional Community Advisory Council helps inform broader strategies. EOCCO provides community benefit initiative funding to each LCAC annually. EOCCO hired the Oregon Rural Practice-based Network Research Network (ORPRN), part of Oregon Health and Science University, to administer implementation of projects selected by the LCACs. ORPRN evaluates projects and provides technical assistance, as well as add a layer of accountability.

One area of focus has been the social determinants of health, including nutrition, housing, and access challenges—especially behavioral health access. Moda has led a VeggieRx program to help local stores stock fresh fruits and vegetables and provides vouchers to members to buy these healthy foods. EOCCO also has funded housing initiatives for low-income residents and helped fund a warming station to provide a sanctuary from cold winter nights. EOCCO has worked closely with community health workers, certified by the state, who can be vital in helping connect with communities and address the social determinants.

The opioid epidemic remains a significant challenge for Oregon, with insufficient pain centers, limited resources, and overwhelmed primary care providers. A group of clinicians, including pharmacists, dentists, primary care physicians, and psychiatrists, make up the Regional Opioid Prescribing Group, which helps inform recommendations for how to address the opioid crisis. Initiatives include: organizing waiver training to prescribe medication assisted treatment, convening community and provider forums, creating new utilization management criteria for tapering opioids, creating online pain education programs, and creating an advisory group within the Eastern Oregon CCO to help with complex patients. EOCCO has also removed barriers to prescribing buprenorphine, suboxone, and naloxone to facilitate access to treatment.

In creating the Eastern Oregon CCO, the equity partners created three pillars for the new organization—the sharing of savings back into local providers and communities, investing in primary care, and reinvestment of quality metric funds received from the state. Investing in primary care was a key strategy in addressing access shortages in rural parts of the state and to meet quality metric goals. In eastern Oregon, primary care providers are largely employed by health systems, and by engaging the health systems, primary care providers are also aligned with EOCCO's initiatives. Primary care providers are held to high quality standards. The state uses 18 quality measures to evaluate care, of which each CCO must meet their target on 75% of the measures to earn 100% of their available quality pool funding. The majority of the money earned is then reinvested back into community providers. By aligning incentives, EOCCO has been able to create a successful, sustainable model for Medicaid care delivery in rural areas.

Though great strides have been made in delivering care to rural communities, integration of services can still be improved and access can still be expanded, especially for behavioral health. To address some of these issues, EOCCO recently became a member of Project ECHO, a delivery model which connects providers virtually via a hub-and-spoke model.

In 2020, EOCCO will be launching the CCO 2.0 model, with a five-year renewal from the state. A new emphasis will be placed on the social determinants of health and health equity, housing supports and services, and other more explicit investments through the existing infrastructure, network of providers, and community connections.