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Evaluation of the Texas Organization of Rural & Community Hospitals Clinically Integrated Network

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List of Exhibits

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Introduction

Most healthcare payers offer alternative payment models (APMs) that incentivize quality of care and improved health outcomes while reducing costs. The Centers for Medicare & Medicaid Services set a goal of having all Medicare Fee-for-Service (FFS) beneficiaries and a majority of Medicaid enrollees in accountable care relationships by 2030.[1] Commercial payers, including Medicare Advantage plans and Medicaid Managed Care Organizations, also offer APMs often with financial incentives for meeting quality metrics.[2] However, rural provider participation in APMs has lagged behind that of urban providers. Barriers to rural participation include low volumes, lack of financial resources to invest in upfront costs, and limited capacity to analyze data to optimize participation.[3]

The Texas Organization of Rural & Community Hospitals (TORCH) was established in 1990 as a membership organization of rural hospitals and partners with the goal of addressing the needs, interests, and issues affecting rural healthcare in Texas. Recognizing the need for independent rural hospitals in Texas to prepare for APMs in Medicare and Medicaid, TORCH launched the TORCH Clinically Integrated Network (TORCH CIN) in 2021. A CIN is a group of providers, hospitals, and/or healthcare entities that join together to deliver coordinated care, increase efficiency, and manage costs. CINs contract with payers on behalf of their provider networks, aligning payment incentives with the goal of improved health outcomes and cost savings through APMs.

The TORCH CIN is one of the only rural hospital-focused CINs in the country, bringing together independent rural hospitals and their affiliated primary care providers. Since its initial launch with nine participants, the TORCH CIN has grown to 32 participating hospitals—rural acute care hospitals and critical access hospitals (CAHs)—and their affiliated rural health clinics (RHCs) and primary care practices as of spring 2024.

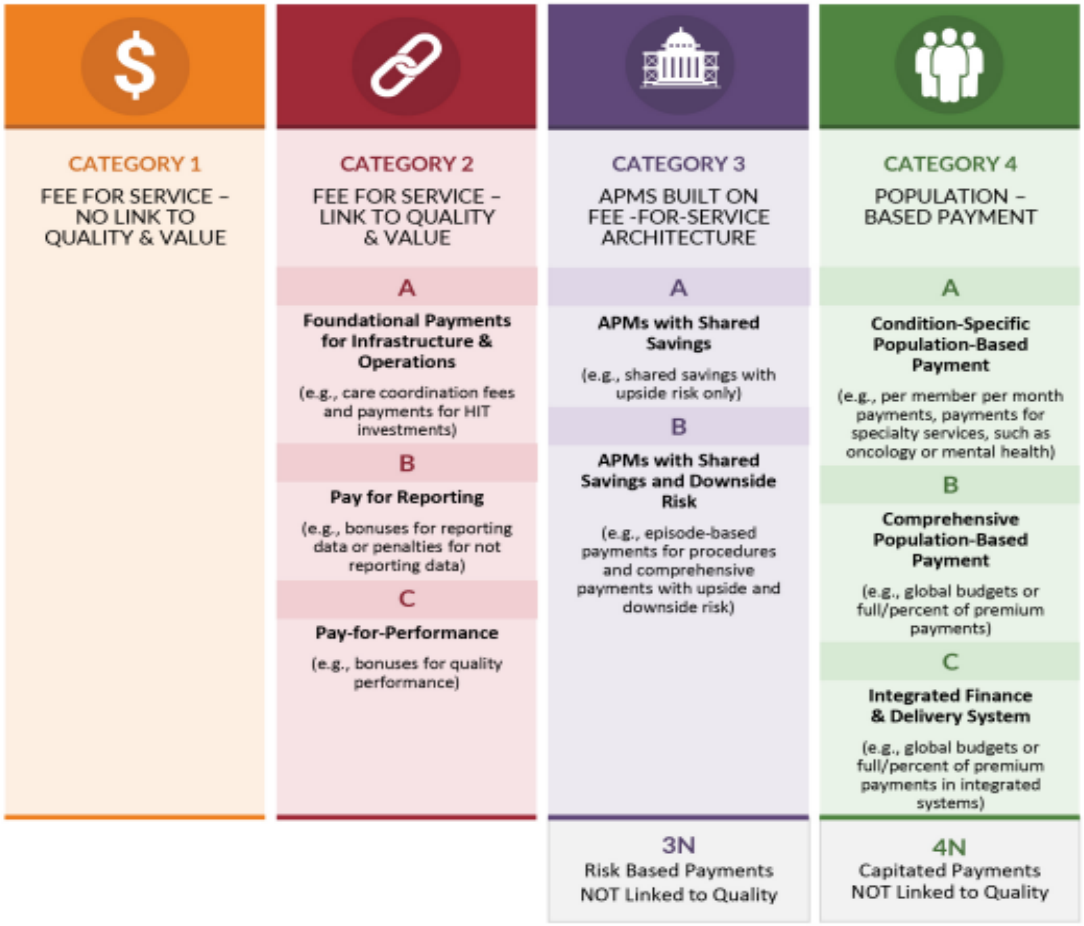
In September 2023, the NORC Walsh Center for Rural Health Analysis and the Texas A&M Rural and Community Health Institute (ARCHI) partnered with the Episcopal Health Foundation (EHF) to conduct an evaluation of the TORCH CIN. The goal of the evaluation is to provide recommendations that support TORCH and the CIN to establish a high-performing statewide network that builds strategic capabilities and brings value to patients, providers, payers, and rural communities.

We conducted 29 key informant interviews with 33 individuals between January and March 2024 to gather insights on strengths and opportunities for the TORCH CIN to facilitate success for rural providers in value-based care arrangements. Interviews included a sample of five key informant types: participating hospital administrators (n=13), non-participating hospital administrators (n=1), CIN leadership (n=4), and payers/payer partners (n=5). We also conducted interviews with subject matter experts involved with rural-relevant APMs outside of Texas (n=6). Additional information about the evaluation methods is included in **Appendix B**.

Background

Value-based care is a broad term describing payment and delivery models with financial incentives linked to quality of care.[4] Value-based care includes APMs, or payment models with incentives to provide high-quality, cost-efficient care.[2] The Health Care Payment Learning & Action Network (HCP-LAN) developed an Alternative Payment Model Framework (**Exhibit 1**), which is often used to describe financial arrangements in healthcare, ranging from fee-for-service with no link to quality (Category 1) to population-based payments (Category 4).[5] Between 2018 and 2022, the percentage of healthcare payments tied to APMs increased across all payers. In 2022, almost 60% of payments were reported to be linked to category 2, 3, or 4.[6]

Exhibit 1. Health Care Payment Learning & Action Network (HCP-LAN) Alternative Payment Model Framework



SOURCE: HCP-LAN Alternative Payment Model (APM) Framework White Paper: Refreshed 2017

Historically, various types of provider networks have brought together multiple providers and hospitals to help encourage and support the move to value-based care. For example, physician-hospital organizations (PHOs) and independent practice associations (IPAs) aimed to align incentives and negotiate contracts with payers. As payment models have shifted from fee-for-service to value-based care, the formation of clinically integrated networks (CINs) and accountable care organizations (ACOs) provided additional opportunities for enhanced care coordination and integrated care among network providers. While CINs and ACOs have similar goals, an ACO contracts on behalf of a network of providers to participate in APMs specific to original Medicare. As an example, ACOs participate in the Medicare Shared Savings Program in which the ACO is held accountable for quality and costs of an assigned Medicare fee-for-service (original Medicare) population and must comply with standards set by CMS. The CIN engages in collective negotiations with different payers for a network of providers. Most CINs do not contract directly with CMS for participation in Medicare Shared Savings Programs, instead they find a preferred partner ACO or create a separate entity specific to original Medicare APMs. The participant network composition in an ACO favors primary care and while a CIN should aim to have a more comprehensive network of specialists in addition to primary care providers. CINs leverage APMs and incentives aimed at cost control, quality enhancement, and patient satisfaction. To navigate antitrust laws and allow these joint negotiations with payers, a CIN must demonstrate that activities are clinically integrated and designed to benefit patients avoiding violation of anti-trust and anti-collusion laws. A provider group can contractually participate in both a CIN and ACO, usually with no overlap in payer contracts and APMs. A CIN may serve as a platform for independent providers to collaborate while safeguarding and maintaining their status as independent hospitals. Providers within the network can pool resources and expertise to achieve common goals without compromising their autonomy.

Technology and data aggregation play an important role in the development and success of a CIN. Along with care coordination across the continuum, this technology can assist in demonstrating clinical integration. Providers within the network share patient information, track outcomes, and identify opportunities for improvement using analytic platforms and technology tools (such as point-of-care, care management, and patient engagement solutions) to collect and aggregate data from electronic health records, health information exchanges, claims and other payer systems.

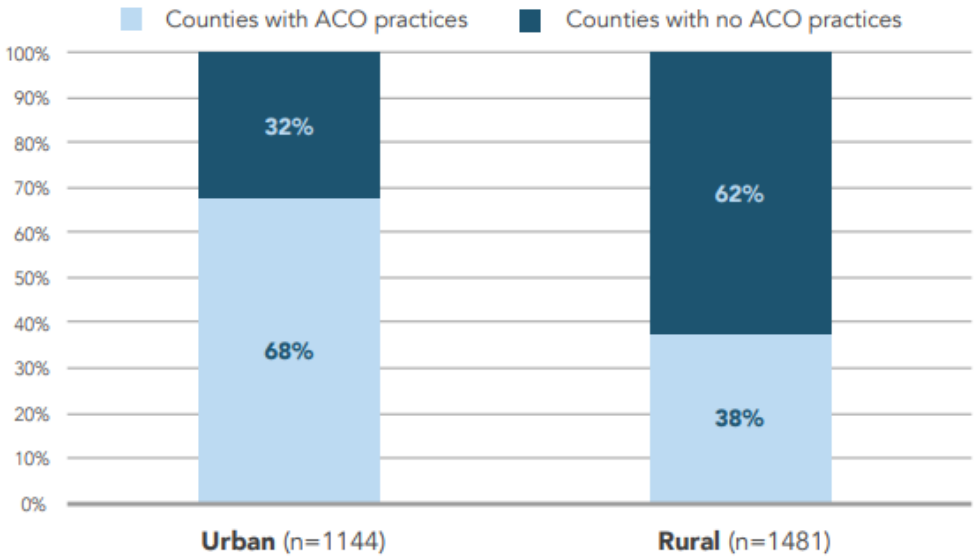
A CIN requires infrastructure to support the aligned effort to optimize care delivery. Common infrastructure components include:

- Care coordination
- Evidence-based clinical protocols
- Clinical decision support
- Performance monitoring and improvement
- Measurable outcomes
- Data aggregation and integration
- Network management, credentialing, and contracting

The transition from fee-for-service to value-based care requires a phased approach that includes simultaneous transformations in both contracted APMs and care transformation infrastructure. Without these components transforming in parallel, a CIN may find itself with extensive infrastructure but lacking supporting APMs or exposed to risks in APMs without the necessary infrastructure.

Rural adoption of value-based care (VBC) has lagged urban and suburban areas due to barriers and challenges in areas such as resources, program design, and population size. As noted by the National Rural Health Association and the Playbook of Voluntary Best Practices for VBC Payment Arrangements, rural counties are less likely to have ACO practices.[7,8]

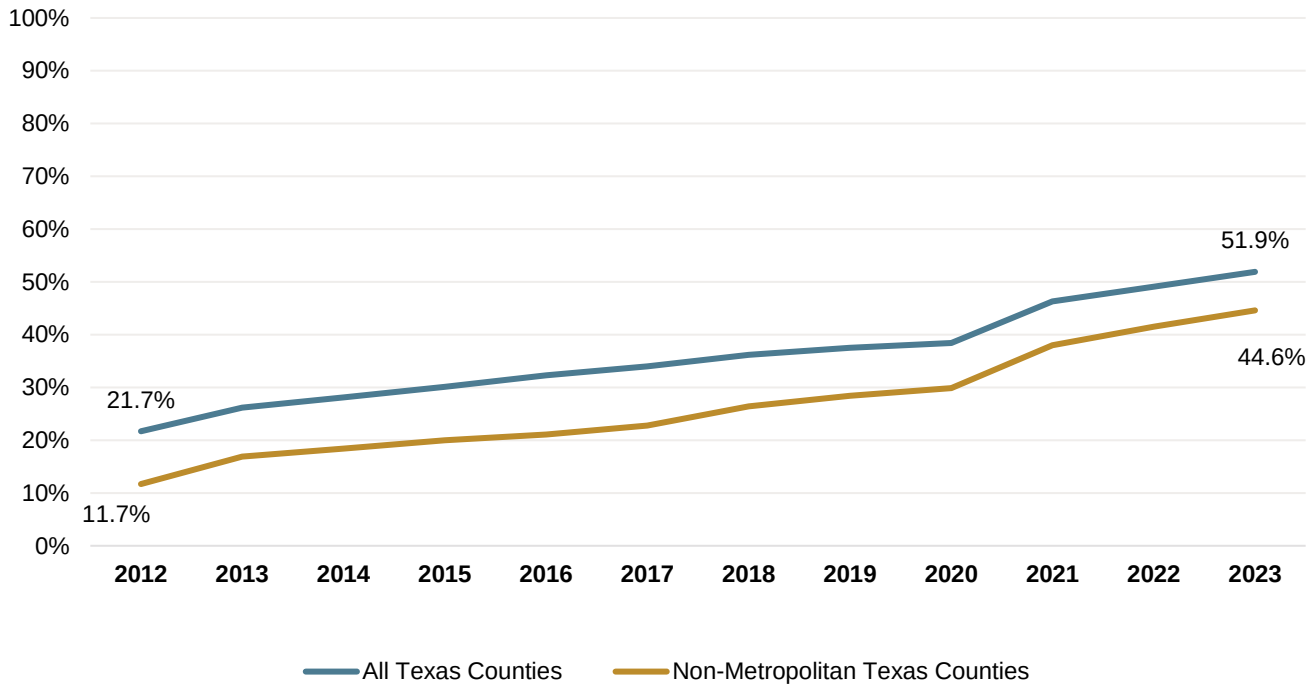
Exhibit 2. Proportion of Urban and Rural Counties with any ACO Practice Presence



SOURCE: AHIP, AMA, NAACOS. A Playbook of Voluntary Best Practices for VBC Payment Arrangements. 2024[7,8]

Increasing enrollment in Medicare Advantage plans is an additional indicator of the shift from volume to value. Medicare Advantage plans are incentivized to manage costs and improve outcomes. Texas has seen steady growth in Medicare Advantage enrollment among Medicare-eligible patients. **Exhibit 3** highlights the growing role of Medicare Advantage in rural Texas communities. This payer mix shift from original Medicare to Medicare Advantage has increased financial pressures in rural healthcare. It is essential to acknowledge the historical context of unique payment models in rural healthcare, such as cost-based reimbursement associated with original Medicare, which have supported access and sustainability. The growth of Medicare Advantage in rural areas poses significant financial threats to rural healthcare as contractual arrangements with CAHs usually do not involve cost-based reimbursement payments but rather payments based on a percentage of the Medicare fee schedule. Restructuring Medicare Advantage contracts and implementing new APM models are crucial steps to ensuring rural hospital viability, and the federal government plays a key role in facilitating this transition.

Exhibit 3. Percentage of Medicare-eligible Beneficiaries Enrolled in Medicare Advantage in Texas, 2012-2023



NOTES: Enrollment in Medicare Advantage plans as of March for each year. County classification is based on beneficiary county of residence. Non-metropolitan counties defined using the 2013 Urban Influence Codes.
SOURCE: RUPRI Center for Health Policy Analysis. Medicare Advantage National and State Enrollment Tables and Maps. https://rupri.public-health.uiowa.edu/maupdates/nstablesmaps.html.

The Texas Health and Human Services Commission (HHSC) has a history of investment in health reform. In December 2011, Texas received approval for a Medicaid 1115 waiver that included supplemental funding to support hospitals serving a large number of Medicaid and low-income patients, referred to as Disproportionate Share Hospitals. This waiver included the state administered Uncompensated Care Pool and Delivery System Reform Incentive Programs (DSRIP).[9] Twenty Regional Healthcare Partnerships (RHPs) across Texas received funding to conduct needs assessments and plan and implement infrastructure and redesign projects to address gaps in care for Medicaid enrollees and uninsured Texans. While the early years of the DSRIP program focused on investments in infrastructure (such as hiring/training staff and implementing care protocols), later years of the program focused on achieving service delivery and outcomes goals.[10] The initial five-year waiver was extended through September 2021. HHSC's Value-Based Purchasing Roadmap released in 2017 described how the Medicaid program, through the managed care organizations, would pursue reimbursement models that incentivize access, care coordination, improved health outcomes, and efficiency. In 2020, HHSC released a DSRIP Transition Plan outlining how it would continue health reform efforts without supplemental funding.[11] In 2021, HHSC released an updated Value-Based Payment Roadmap that described how to drive value-based care through managed care.[12]

In 2023, recognizing the need to address the financial and operational needs of rural hospitals across the state, the Texas Legislature appropriated $50 million to HHSC for fiscal years 2024-2025 to establish a grant program for rural hospitals. The grants are intended to address three key topics: rural hospital financial stability, obstetric readiness, and readiness to implement APMs.[13] In April 2024, two grant opportunities were announced.

- The Texas Rural Hospital Financial Stabilization Grants provide a tiered funding opportunity for two years. Eligible applicants are the sole licensed general hospital provider in the county, have 25 or fewer licensed beds, are classified as a rural hospital, and prove financial need. HHSC awarded $17 million in grant funding to eligible hospitals in 2024.[14]
- The Maternal Care Operations Grants are available to rural hospital applicants without formal maternal health-equipped facilities to fund opportunities for neonatal readiness and education.

It is anticipated the remainder of the appropriated $50 million will fund additional grant opportunities that align with and promote APM readiness. Findings from this evaluation may inform future efforts for the Texas Legislature and HHSC to prepare and support rural hospitals' participation in APMs.

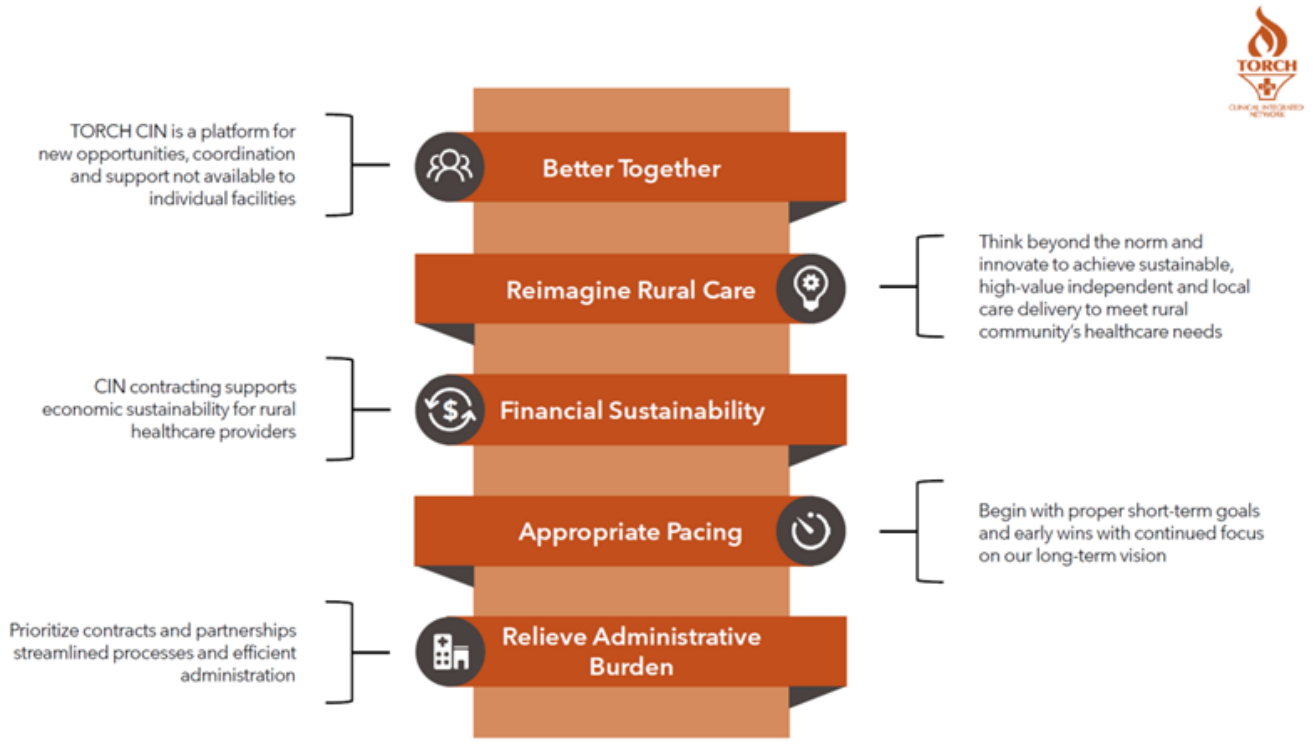
Evaluation Findings

In this section, we present findings from interviews and documents related to the TORCH CIN. In addition, we highlight opportunities and lessons learned from an environmental scan of rural VBC models and conversations with subject matter experts associated with other rural APMs across the United States in callout boxes.

TORCH CIN Structure and Activities

The TORCH CIN brings together small, mostly independent, rural hospitals to leverage their collective efforts to manage payer contracting, improve quality, and share resources and best practices. All interviewees described the CIN as a venue to be "better together." Participating hospitals also noted high levels of trust in the TORCH CIN and the TORCH CIN leadership to prepare them for success in value-based care arrangements. The TORCH CIN established a set of guiding principles in **Exhibit 4**.

Exhibit 4. TORCH CIN Guiding Principles

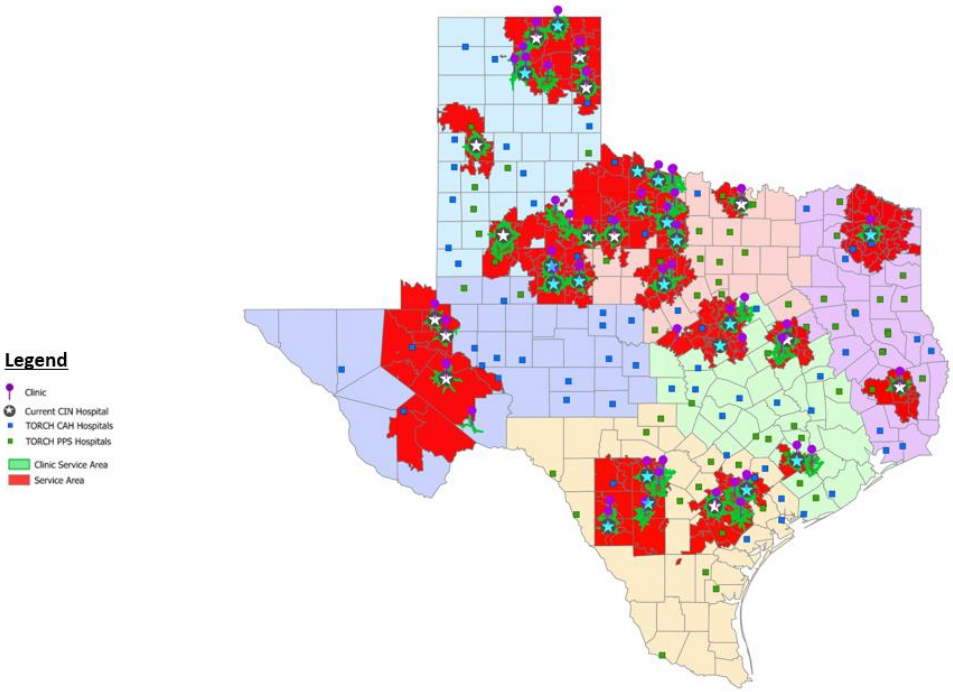


Source: TORCH CIN. September 2023.

The TORCH CIN's initial development was supported by funding from UnitedHealthcare**.** UnitedHealthcare approached TORCH to identify opportunities to enhance their engagement with rural hospitals. As one TORCH CIN leader noted, *"They wanted to fund goodwill, the things you need to build trust and hope that everyone comes together to do something that would be difficult to do alone."* TORCH CIN leaders also noted that UnitedHealthcare was transparent in their desire to increase their competitiveness and market share in rural areas. Following discussions with TORCH leadership, UnitedHealthcare provided initial funding to facilitate the development of the TORCH CIN.

The TORCH CIN was established as a legal entity (LLC) and launched with its initial nine participant hospitals in January 2021.[15] TORCH CIN leadership continues to recruit additional hospital participants to grow the network. As of April 2024, there were a total of 32 rural hospitals (8 acute care hospitals and 24 CAHs) participating in the CIN. A map of participating hospitals is included in **Exhibit 5**. Almost 700,000 rural Texans live in the counties served by these hospitals. While the TORCH CIN has no specific requirements for eligibility, all participants have an affiliated primary care practice (most often an RHC). Participating hospitals bring 60 RHCs to the TORCH CIN. Participants pay an annual membership fee of $100 in addition to any shared expenses.

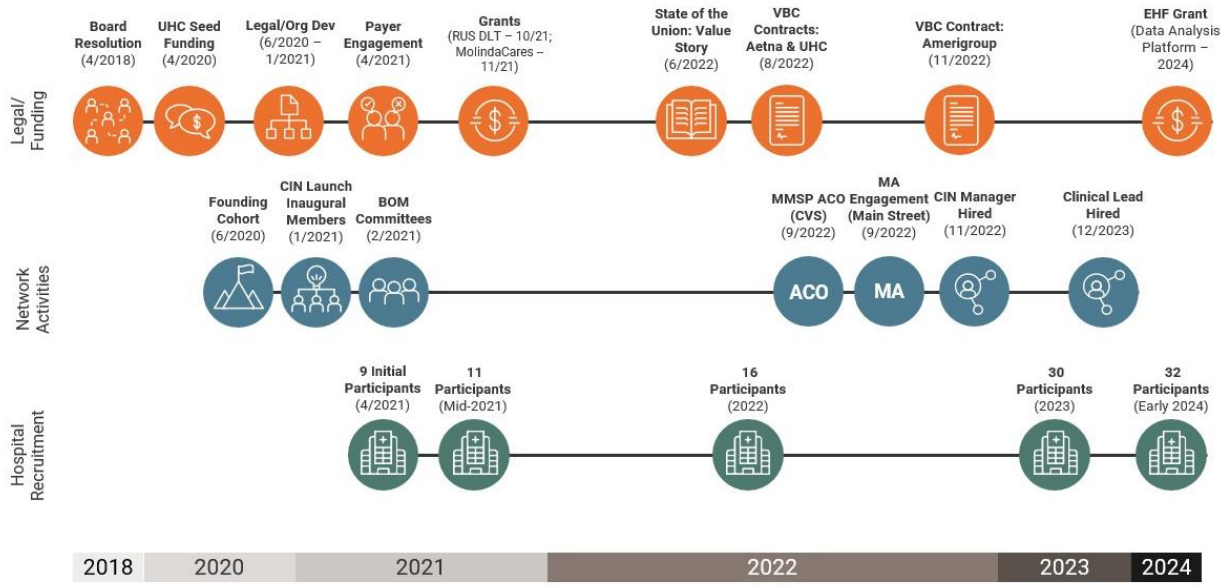
Exhibit 5. Map of Hospitals and Clinics Participating in the TORCH CIN



Notes: This map reflects the 32 hospitals and 60 clinics participating in the TORCH CIN as of June 2024.
Source: TORCH CIN. June 2024.

The TORCH CIN's Board of Managers is comprised of 7–9 appointed members: 5-7 hospital managers and 2 TORCH Managers. Two committees made up of select TORCH CIN participant representatives and TORCH CIN leadership—the Contracting & Distribution Committee and Clinical Quality Committee—advance the primary goals of the TORCH CIN. The Contracting & Distribution Committee oversees the payer contracts and develops incentive distribution models. The Clinical Quality Committee monitors quality measure performance and identifies and disseminates best practices. A timeline of the TORCH CIN's evolution through early 2024 is included in **Exhibit 6**.

Exhibit 6. TORCH CIN Timeline



SOURCE: Adapted from John Henderson. Texas Organization of Rural & Community Hospitals (TORCH) Clinically Integrated Network. Presented at: HHSC Value-Based Payment and Quality Improvement Advisory Committee (VBPQIAC); November 14, 2023. https://www.hhs.texas.gov/sites/default/files/documents/nov-2023-vbpqiac-agenda-item-4.pdf.

For participating hospitals, the TORCH CIN undertakes activities in five main areas: management of payer relationships, recruitment and onboarding of CIN participants, communication among CIN participants, monitoring quality improvement efforts, and sharing actionable data. Following are a brief description of these areas.

Management of payer relationships. The TORCH CIN has the authority to sign payer contracts on behalf of its participants. Many participating hospitals commented that this was their primary motivation for joining the TORCH CIN. Payers also value the TORCH CIN's role in bringing together independent rural hospitals to participate in their value-based care programs. For example, one payer considers the TORCH CIN a strategic provider, and the payer provides additional resources to the TORCH CIN, including individuals the TORCH CIN can contact for questions related to claims processing, member information, and clinical support.

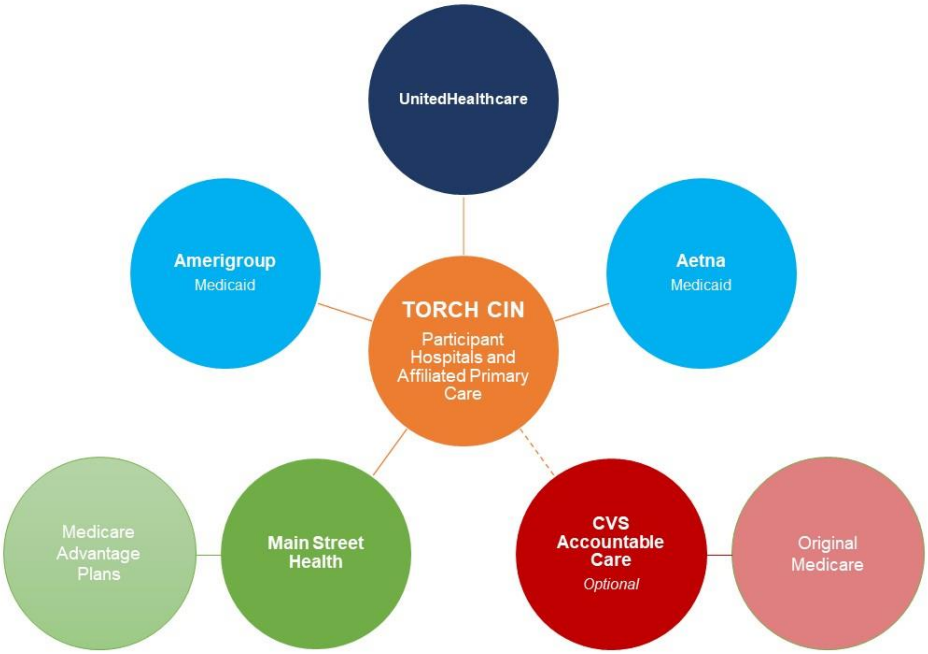
As of 2024, the TORCH CIN participates in value-based care programs with one commercial payer (UnitedHealthcare), two Medicaid managed care organizations (Aetna and Amerigroup), Medicare Advantage plans through Main Street Health, and original Medicare through a CVS Accountable Care Medicare Shared Savings Program ACO. Notably, the value-based care arrangements with Medicare Advantage and original Medicare are facilitated through management companies.

- Main Street Health is a value-based care company that partners with rural clinics and practices to manage care for Medicare Advantage patients. As part of this arrangement, Main Street Health employs a health navigator for each participating clinic or practice to facilitate prevention and

population health activities, including completion of comprehensive care assessments (CCA) and identification and fulfillment of care gaps.

- CVS Accountable Care (formerly Signify Health) manages an ACO in the Medicare Shared Savings Program with only upside potential for shared savings. The TORCH CIN participates in this program with providers from 11 other states (Florida, Idaho, Indiana, Iowa, Minnesota, Montana, North Carolina, North Dakota, Oregon, South Dakota, and Washington). CVS Accountable Care provides data infrastructure and educational resources to the TORCH CIN and participants to facilitate success in the ACO. TORCH CIN participants can opt in or out of participation in the CVS ACO. An overview of the TORCH CIN payer relationships is included in **Exhibit 7**.

Exhibit 7. TORCH CIN Payer Relationships



The value-based care contracts established by the TORCH CIN are an overlay to the existing contracts the participants have established with payers. These value-based contracts have only upside incentives with no downside financial risk. For example, Main Street Health provides a financial incentive for every CCA completed. Other payers may provide additional funding depending on established performance measures. These incentives provide additional support to participants and allow them to gain experience with value-based care.

The payers engaged with the TORCH CIN represent over 72,000 covered lives:

- Traditional Medicare: 26,725
- Medicare Advantage: 24,956
- Medicaid: 5,700 (estimate)
- Commercial: 15,000 (estimate)

Recruitment and onboarding of new participants. To recruit new participants, the TORCH CIN reaches out to potential hospital participants to provide a 30-minute presentation that describes the role of a CIN, the TORCH CIN's history and structure, and incentives. TORCH CIN leadership work closely with hospitals, answering questions, and ensuring potential participants are fully aware of the work involved with participation. Once a hospital agrees to join and the participation agreement is fully executed, the TORCH CIN provides the necessary information about the hospital to the payer partners to proceed with enrollment in the value-based care agreements. The TORCH CIN also connects new participants with Main Street Health, who begin orientation to their program, including the process for recruiting a health navigator. One participating hospital commented on the smooth process for onboarding:

> *"They are very organized, very on top of onboarding. It has made it absolutely easy for us and information has been requested from the TORCH CIN as well as Main Street, but it has all been easy to be able to fill out and get that data back. The process has been great, honestly, for implementation."*

Communications with participating hospitals. The TORCH CIN hosts quarterly and monthly roadmap meetings virtually. The CIN met in person at the TORCH Fall 2023 and Spring 2024 Conferences. Hospital participants valued these opportunities to learn from peers.

Beyond the meetings, the TORCH CIN communicates with participants regularly through newsletters and individual emails. Participating hospital leaders appreciated the regular communications and the TORCH CIN leadership's quick responses to questions. Further, they reach out to TORCH CIN leadership when there are issues or concerns with payers and appreciate that they now have a direct payer contact and are able to resolve issues more efficiently. TORCH CIN participants also noted the peer networking opportunities provided an additional benefit.

Monitoring of quality improvement efforts. The Quality Committee of the TORCH CIN monitors quality improvement measures across all contracted payers. The committee is led by a dedicated CIN leader who was hired in December 2023. Members include clinical and administrative leaders from participating hospitals and RHCs. The committee reviews progress on quality measures and shares best practices and

Lessons Learned from Other Rural Models: CIN Structure

Representatives from other CINs commented on the role of a CIN in allowing participating hospitals and clinics to remain financially stable as independent providers while being able to collaborate on payer contracting and quality improvement goals.

These experts highlighted the key role of primary care to improve quality of care, reduce avoidable utilization, and achieve success in value-based care models. For example, some CINs specifically engage Federally Qualified Health Centers to ensure alignment and shared incentives with primary care.

Another key strategy was multi-payer engagement and alignment. Multi-payer participation allows CINs in rural areas to scale programs to a larger proportion of the population in the areas served. Some CINs have invested in data platforms to aggregate data from members and payers.

lessons learned for improving care management and quality of care.

Through the TORCH CIN and partners, hospital participants have access to education and training related to quality-of-care goals, mostly offered by payers involved in the CIN. For example, Main Street Health provides education to care coordinators and practices about processes related to CCAs. CVS Accountable Care provides both in-person and virtual education opportunities related to improving rates of annual wellness visits. Other payers also offer education, resources, and clinical trainings. The TORCH CIN does not track the extent to which participants use the different educational opportunities. Because the learning opportunities are offered through different payers, one interviewee commented, *"There is some work to be done to figure out how to connect everything together."*

Share Actionable Data. The TORCH CIN reviews and shares data provided by payer partners. Data is provided by individual payers in various formats and is not aggregated to all covered lives. Main Street Health provides regular performance reports to the TORCH CIN and participating hospitals and clinics. CVS Accountable Care provides access to a data platform, and the TORCH CIN can customize reports within the platform as needed. Other payers provide outcomes on quality metrics quarterly.

Hospital Participation

We explored hospital engagement in the TORCH CIN, including prior experience with value-based care, motivation to join, decision to join, ongoing participation, perceived value, and goals for participation.

Prior Experience with Value-Based Care

Providers within the TORCH CIN had a varying level of experience with value-based care initiatives before joining the TORCH CIN. For some, involvement in managed care contracts, ACOs, and DSRIP programs offered valuable insights into APMs and activities related to quality improvement and population health management. Other providers had no experience in value-based care and joining the TORCH CIN was their first step into value-based care.

Those providers with prior experience reported challenges in getting funding for activities as well as in reporting, staffing resources, knowledge, and receiving incentives. They expressed a desire for a streamlined approach for reporting quality metrics and negotiating with insurance providers, which motivated them to join the TORCH CIN. The hospitals view the TORCH CIN as a good option, tailored specifically for rural providers, with a focus on quality, payer negotiating leverage, and collaboration. One hospital leader noted their prior experience with an ACO:

> *"[Our prior] ACO was starting to divest any interest in the critical access hospitals in the region that were part of that original ACO … I did not like that transition. It seemed like they were picking them off one by one. And on the flip side, TORCH does try to undertake some initiatives that are, I feel are for the greater good of community in rural hospitals in the state and I like the*

idea of the components of a CIN and what it could do for the state of Texas and for rural hospitals. And it's built for rural hospitals."

Overall, participating providers had diverse experiences with value-based care initiatives and sought better support and alignment with their needs through joining the TORCH CIN.

Motivation to Join the TORCH CIN

Participating providers were attracted to the TORCH CIN for various reasons, including the organization's focus on rural hospitals, perceived alignment with their needs, and the potential for enhanced negotiating power with payers and other financial benefits. Participants saw joining the CIN as a way to streamline operations, particularly in terms of reporting and contracting with multiple payers. Providers believe that the TORCH CIN will make it easier to navigate value-based care initiatives and help negotiate fair reimbursement.

"TORCH is a huge help to the rural hospitals. Merits to TORCH … the CIN is focused on rural hospitals; not a little fish in a big ol' pond like with other potential CINs."

Providers also see participation in the TORCH CIN as a commitment to delivering quality care and a means to further enhance clinical quality outcomes. They also stress the importance of sharing lessons learned, success stories, and provider education and minimizing administrative burdens to maintain focus on patient care. The desire to add value to patient care and potentially increase revenue streams motivates providers to join. Interviewees also felt like they provide high quality of care but that reporting and documentation requirements make it difficult to accurately demonstrate performance:

"Providing quality of care, that's our number one goal."

"We do a lot of quality care but because limitations in reporting or documentation, we'll we aren't getting paid. So I do think we'll see quality payments for measures that we're already doing just making sure it's getting captured."

For some participating providers, the TORCH CIN represented a new starting point in their journey with value-based care, offering potential solutions to previous challenges and a more collaborative approach to improving patient outcomes. They saw the CIN as a collaborative effort to address challenges specific to their rural setting and position themselves competitively in the evolving healthcare landscape. The TORCH CIN used the phrase "better together" in their recruitment and other outreach materials to capture the collective power of the CIN. This theme resonated across the interviewees' comments:

"I think bringing everybody under one umbrella is a plus as we were already dealing with multiple payer sources and to be able to do value-based care [with the CIN adds value], making reporting easier and as well as working on our contracts, making sure reviewing that what our contracts state for value-based care and what our reimbursement or incentive is in line with everybody else and we're not being underpaid. I liked having, I'm going to call it that, buying

power, in order to get as much as we can on those incentive payments. We did not consider any other CINs. Nope, we are a big, proponent or a big supporter of TORCH and so to be able to join with the TORCH CIN would be absolutely our number one priority."

Participants noted challenges with the value-based care experience, including limited resources and funding and gaps in understanding and implementation across different insurance providers and APMs. However, they felt the potential benefits of the TORCH CIN outweighed challenges with resource allocation and administrative burdens.

Leverage with Health Plans

For many participants, a primary motivation for joining the TORCH CIN included the ability to have leverage with health plans. Participating providers believed that being part of the CIN would provide them with better contracts and negotiation power with payers. Concerns and frustrations over the impact of Medicare Advantage on rural facilities drove the decision to seek alternative arrangements. The TORCH CIN aligns with the strategic goals of participating providers, particularly in terms of negotiating contracts collectively rather than individually and ensuring sustainability for rural facilities.

Providers have long-term goals to improve care quality and achieve better outcomes through the accumulation of clinical data, then leveraging this data for improved contracts with payers. They anticipate that over time, the evidence of providing quality care will strengthen their negotiating position. They also emphasized concerns about dynamics between rural providers and payers and expressed the need for payers to understand the unique challenges faced by rural hospitals. Providers hoped that by coming together as a group, they would garner more attention from payers and advocate for their specific needs. Engagement with the TORCH CIN was driven by the need for sustainability and better reimbursement rates, particularly in dealing with Medicare Advantage plans. Across multiple interviewees the motivation of "buying power" was noted:

"Being able to be with a TORCH CIN, that looks at everybody's contracts and making sure that we're getting paid for what we are doing and fair across the board was huge as well. Unless you're with somebody like TORCH CIN, you're not going to know that and you're going to be out by yourself trying to deal with that. To be able to have them review all of our contracts and be on top of that or have the value to have all of us in one group and have that buying power to get us better and incentive rate is amazing as well."

Decision to Join the TORCH CIN

Hospitals first learned about the option to participate in the TORCH CIN from a variety of settings: serving on the TORCH board, TORCH conferences, or educational sessions and presentations highlighting the benefits of CIN participation. The participating hospitals decision-making process to join the TORCH CIN involved engagement with key groups, including the hospital's governing board, administrative/leadership teams, and clinicians. While the hospital board approved the decision to join the CIN, the responsibility for the decision was often delegated to administrative leadership.

Overall, providers say joining the TORCH CIN is a strategic move to address the challenges faced by rural healthcare providers, particularly negotiating fair payer contracts and ensuring financial sustainability. The CIN offers support, expertise, and collective bargaining power that individual providers may lack when dealing with APMs and managed Medicare plans independently. Providers joined the TORCH CIN because of perceived benefits of improved negotiation power, streamlined operations, and enhanced quality of care from a CIN that is tailored to the needs of rural providers.

Ongoing Participation in the TORCH CIN

Participation in the TORCH CIN offers rural hospitals the opportunity to collaborate, address common challenges, improve quality of care, and potentially achieve financial benefits, all of which serve as compelling reasons for continued engagement. Participants valued that the TORCH CIN aligned with their organizational goals. Several factors contribute to the continued engagement of participants in the TORCH CIN.

- **Collective Group:** Participation in the TORCH CIN provides rural hospitals with a larger voice and increased influence in the healthcare landscape. Participants believe the TORCH CIN gives them a larger voice collectively, potentially increasing their negotiating power and ability to affect change. Participants also value that the TORCH CIN acts as an intermediary, facilitating connections and resolving issues for participating providers with payers and partners.
- **Networking and Learning Opportunities:** The TORCH CIN offers a platform for networking and learning from other providers and facilitates the exchange of best practices to improve quality of care.
- **Quality Improvement Support:** The TORCH CIN assists participating providers to meet quality measures and drive initiatives for improved care, patient outcomes, and satisfaction.
- **Financial Benefits:** While not yet realized by all participants, participants believe that joining the TORCH CIN may lead to financial benefits through improved care and efficiency. This potential for financial gain incentivizes participation, especially for hospitals facing economic challenges. Some participants were motivated to join the CIN due to concerns about the impact of managed Medicare on rural facilities. The CIN offers a platform to address these concerns collectively and advocate for the interests of rural hospitals.

Participating in the TORCH CIN aligns with the strategic goals of the organizations, especially in terms of improving quality measures, transitioning to value-based care, and negotiating with payers collectively.

Perceived Value of the TORCH CIN

The participants shared overwhelming support of the TORCH CIN and its leadership. The TORCH CIN offers value to participating providers, including training, data sharing, collaboration, and advocacy for rural healthcare interests. Participants see potential for long-term success and encourage others to join the TORCH CIN.

Training and Support Services. Participating providers receive training, resources, and support services from the TORCH CIN to improve care delivery transformation. The CIN is viewed as a platform for rural providers, offering opportunities for collaboration, shared learning, and leveraging collective efforts to improve patient care and negotiate with payers. This includes regular meetings (quarterly and monthly), webinars, conferences, and access to the CIN leadership team for questions and support. The TORCH CIN recently hired an additional team member to support monthly meetings. Most participants positively acknowledge the meeting cadence change and the need for more collaboration. However, some expressed the challenge of attending meetings on a regular basis and expressed support for additional communication methods, suggesting the TORCH CIN distribute meeting minutes, recordings, and newsletters. Other interviewees were not aware of when meetings occur because other team members attend or they did not know that the meetings were taking place.

Participants that joined the CIN in the first nine months of operations described challenges with the onboarding process, particularly with the contracted vendors. However, more recently, the CIN has improved this process. Newly onboarded participants engage with vendors in a phased approach rather than all at once. This change limits hospital confusion about the programs and vendors. Onboarding is also more manageable as participants have limited capacity and resources to implement multiple new initiatives. Participants who joined the CIN in the early stages, expressed concern with the vendors knowledge of rural settings and awareness of rural nuances like resource limitations. Recently added participants report the process has become smoother through close collaboration with CIN leadership, educational sessions, and ongoing support to ensure successful implementation. Participants commended the collaboration with the TORCH CIN leadership to engage and help assist in next steps.

Care Team and Provider Engagement. Healthcare providers and staff stay engaged with the TORCH CIN through frequent communications, meetings, and updates about CIN initiatives and performance. In addition, as part of the APM strategy the TORCH CIN contracts with Main Street Health to supply a health navigator in each clinic for the Medicare Advantage patient populations. Although providers had mixed reviews of this aspect of the model, the majority thought the navigators placed in clinics were a significant value-add for joining the TORCH CIN. Those who joined the CIN most recently were more likely to see the value of the Main Street navigators. Participants that joined the CIN when it was first formed or several months thereafter were not as satisfied with the navigators. Some participants noted that they ensure the navigators only work with Medicare Advantage patients to prevent them from converting original Medicare patients to Medicare Advantage. Provider satisfaction varied with some noting initial challenges or frustrations and others mentioning ongoing dissatisfaction. Providers particularly mentioned dissatisfaction with the Main Street Health CCA that must be completed to receive an annual completion incentive from Main Street. The dissatisfaction arises from the added administrative burden of completing the CCA, which they feel is not tied to improved patient outcomes and quality of care. Additionally, there are frustrations with coordinating onboarding meetings and meet-and-greets between Main Street Health teams and providers. Some participants expressed concerns about drop-in visits from Main Street Health team members that were not scheduled. Participants recommended sharing success stories and linking outcomes to initiatives to support improved provider satisfaction. One interviewee stated:

> *"[As a provider], you're asking them to round on patients at night, you're asking them to be on call and it wears them out. So I think something that ties in the provider education to why this will improve care would be very important for my providers … I don't want dangling a financial carrot to be the only motivator to get quality care."*

Data Sharing and Feedback. Participants reported differences in the amount of data they receive, use, and review. Several participants mentioned the inconsistent or incomplete data while others expressed gratitude for the data they receive from the TORCH CIN. Feedback mechanisms are in place for continuous improvement, with regular communication between providers and CIN leaders/administrators.

Short-term and Long-term Goals

Participants looked to the TORCH CIN to achieve better payments from Medicare Advantage and other payer plans and ensure sustainability for rural facilities that provide high-quality care. Participants described their short-term goals for the TORCH CIN as giving them a stronger voice in current payer negotiations, reducing administrative burden associated with payer contracts, streamlining processes, enhancing reporting and data, and achieving better rates through collective bargaining. Participants' long-term goals are to improve outcomes and demonstrate value to strengthen their negotiating position with payers, resulting in better contracts that sustain financial stability and even growth.

Short-term Goals

- **Improving Contracts:** Many participants believe that joining the TORCH CIN will eventually improve their financial stability by negotiating more favorable contracts with payers, such as with Medicare Advantage plans. As a step towards this long-term goal, participants are focused in the short-term on establishing baseline contracts with value-based incentives with no associated financial risk. Financial sustainability is both important now and in the future. Participants expect small financial short-term wins will lead to greater financial long-term sustainability.
- **Enhancing Reporting Quality:** Participants seek to improve reporting quality to ensure that they capture all measures accurately, thereby improving their chances to receive higher payments based on quality.
- **Streamlining Processes:** Participants believe the TORCH CIN's focus on facilitating the integration process will lead to quick implementation and operational efficiency.
- **Increasing Clinical Engagement:** Some participants express the desire for increased clinical engagement within the CIN to ensure that quality measures translate into tangible improvements in patient outcomes.
- **Accessing Data:** Access to aggregated clinical data can provide insights into performance and benchmarks compared to other facilities.
- **Preparing for Changes:** Participants anticipate shifts in payment models and aim to position themselves strategically within the CIN to adapt to these changes effectively. Although the shift to

APMs will take some time, participants value learning now as part of the TORCH CIN to prepare better for the future.

Long-term Goals

- **Demonstrating Quality Care:** Many participants aim to demonstrate the delivery of high-quality care through participation in the CIN.
- **Creating Financial Sustainability:** Participants aim for long-term financial sustainability by maximizing incentives and shared savings opportunities offered by the CIN.
- **Improving Care Coordination:** Participants seek to improve care coordination, ensure patients receive appropriate care, and reduce unnecessary costs associated with referrals and out-of-network services.
- **Enhancing Negotiating Power:** Participants aspire to increase negotiating power with payers as a collective group within the CIN, leading to better contract terms and reimbursement rates. As the CIN matures in operations and demonstrates high-quality care and cost savings, participants expect improved contractual rates to further assist the financial sustainability of their operations.
- **Forming Strategic Alliances:** Participants seek to form strategic alliances that can benefit their organizations in various aspects, including contract negotiations, care delivery transformation, and resource sharing.
- **Improving Quality:** Participants emphasize continuous quality improvement, with a focus on achieving better patient outcomes and optimizing clinical practices.

Despite challenges and uncertainties, participants see potential for the TORCH CIN's sustainability and scalability, especially in advocating for rural hospitals' interests and negotiating with payers effectively. Participants advise others to consider engagement with the TORCH CIN, emphasizing the benefits of collaboration, access to resources, and the potential for negotiating power with payers.

> *"If we're doing it correctly and I know we will … and the partnership with TORCH CIN is to have better quality for our patients … You'll start seeing that as far as preventative measures being done for these patients on a yearly or however often they need those and that is to have better quality for our patients. If we're doing our job then, we should see the financial benefit on the back end. Our CFO should be able to see that we are getting great incentive payments on the back end for doing what we need to do."*

> *"I think a long-term goal is high quality and fair rates. Being able to bypass what we in rural healthcare call the Medicare Advantage games, you know, the denial, the lack of pre-authorizations, whether you want to call it a gold card or whatever bypasses us, we just got to get around it because I don't have the bandwidth to pay for it. So being able to become more financially stable for the CIN, the increased Medicare Advantage population that we're seeing having a better financial outtake on those and not looking at them as deficits to our organization for or I guess not deficits. I don't want to have to pick, my patients or carriers based upon their ability to be in the sandbox with us. I think for the long-term goal is for having multiple Medicare*

Advantage plans be at the same table. Working towards a common mean versus working against each other. There's definitely an adversarial relationship between rural hospitals and Medicare Advantage. Short term, I guess, really work on some base benchmarks and baselines for the quality and for where we're headed. And helping, being a part of a bigger system without giving up our independence."

Reasons for Non-Participation

Not all eligible rural hospitals decided to participate in the TORCH CIN. We conducted one interview with an administrator who decided not to join the TORCH CIN. The interviewee expressed skepticism about the shift towards value-based care and Medicare Advantage plans, particularly due to the implications for critical access hospitals (CAHs). CMS maintains a different reimbursement methodology for CAHs, one that is designed to increase financial security and ensure that CAHs keep their doors open to serve their communities. In addition, the interviewee believed that contracting with Medicare Advantage plans contradicts the purpose of being a designated a CAH. The CAH designation provides cost-based reimbursement for original Medicare, whereas Medicare Advantage reimbursement does not reconcile payments to cost-based reimbursement. Financial challenges with Medicare Advantage are further exacerbated by denials, downgrading of services (e.g., inpatient to observation status), and delays in reimbursement. Concerns and questions remain regarding the role of the CAH designation with the increased enrollment in Medicare Advantage.

The non-participant also expressed the need to understand the CIN process better before committing. They wanted to first explore value-based care and alternative payment arrangements through smaller arrangements, such as engaging directly with Main Street Health, before committing to the concepts across a large patient population.

A key factor in the decision to participate in the CIN is to assess the amount of effort required compared to the potential benefits. The non-participating organization felt they needed a clearer indication that the effort would not outweigh the benefits.

Lessons Learned from Other Rural Models: Reasons for Non-Participation

Rural providers appreciate the financial stability provided by existing payment methods, namely cost-based reimbursement. APMs have experienced challenges recruiting CAHs to participate. CAHs were hesitant to risk losing a base of cost-based reimbursement.

The RHC reimbursement structure is not currently aligned with value-based care. As a result, RHCs are often excluded from participating in CMS Innovation Center models.

Overall, the decision not to join the TORCH CIN is driven by concerns about the compatibility of value-based care models, particularly Medicare Advantage plans, with the CAH designation and the organization's strategic goals. However, the interviewee said their organization is exploring smaller

approaches to value-based care and weighing the potential benefits against the effort required for participation prior to joining the TORCH CIN.

Payer Participation

The TORCH CIN seeks to engage public and commercial payers across multiple product types (original Medicare, Medicare Advantage, Medicaid managed care plans, individuals and employer plans, and qualified health plans). Through multi-payer engagements, the TORCH CIN intends to scale value-based care activities across a larger proportion of covered lives within their service areas and align incentives for quality improvement.

Payers described their goals of the TORCH CIN as improved quality of care. Payers reported engagement with the TORCH CIN is an opportunity to improve quality of care and reduce costs for members residing in rural communities. One payer noted, *"As we are looking at value-based programs, how do we integrate quality into these contracts and ensure that our members are directed to a provider who can provide quality service and close gaps."* In addition, payers noted the TORCH CIN allows them to efficiently address network adequacy requirements in rural communities.

Texas Medicaid's transition to value-based payment enhanced interest from Medicaid managed care organizations to partner with the TORCH CIN. In 2021 the Texas Delivery System Reform Incentive Payment Program Transition Plan described goals to shift managed care organizations from traditional Medicaid payments to value-based payments. As a part of this plan, Medicaid managed care organizations are required to establish at least 50% of their payments through an APM and at least 25% of payments through a risk-based APM. A representative from HHSC noted that the next phase of the APM Framework (see **Exhibit 1**) may provide special consideration for managed care organizations operating in rural areas who are increasing participation and engagement in APMs.

The TORCH CIN has improved relationships between participating hospitals and payers. TORCH CIN leadership meets regularly with payer representatives and has developed relationships that have increased payer understanding of the rural independent hospitals. Further, the TORCH CIN has been able to negotiate for better contracts on behalf of its participants. One notable win was negotiating with UnitedHealthcare to ensure all TORCH CIN participants are in-network for laboratory services.

Quality Measures and Alignment

As of April 2024, the TORCH CIN finalized value-based contracts across five payer programs. **Exhibit 8** provides an overview of the quality measures by program, categorized into three primary constructs: prevention and chronic disease management, preventive care for mothers and children, and medication management. More than half of programs (n=3) include quality measures related to preventive screening (breast cancer, colorectal, cervical) and controlling high blood pressure. The most frequently identified quality measure across programs is diabetes blood sugar control (n=4). There is less alignment across the other quality measures with fewer than two programs tracking each measure.

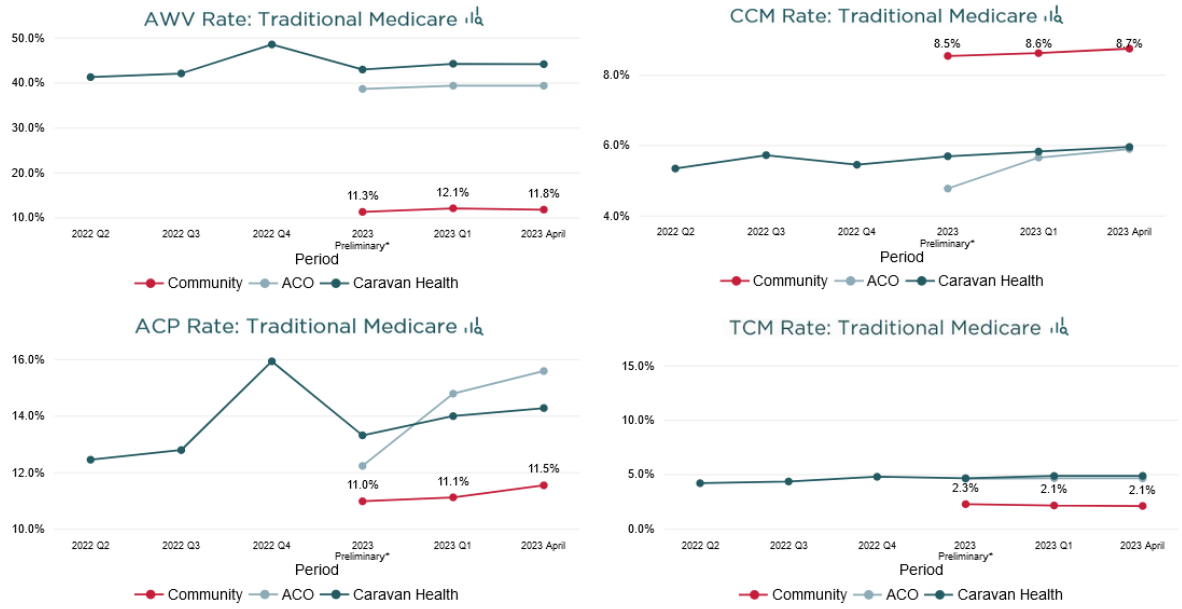
Exhibit 8. TORCH CIN Quality Measures

	Medicare (MSSP)	UHC Commercial	Amerigroup Medicaid	Aetna Medicaid	Medicare Advantage STARS Measures	Total
QUALITY MEASURES						
PREVENTION AND CHRONIC DISEASE MANAGEMENT						
Annual Wellness Visit/Annual Care Visits	√	√				2
Breast Cancer Screening	√	√			√	3
Colorectal Cancer Screening	√	√			√	3
Cervical Cancer Screening		√	√	√		3
Controlling High Blood Pressure	√	√			√	3
Diabetes Blood Sugar Control (HbA1c <8)	√	√		√	√	4
Diabetes Care - Eye Exam					√	1
Influenza Immunization	√	√				2
Osteoporosis Mgt in Women					√	1
Care for Older Adults - Pain Assessment					√	1
Care for Older Adults - Medication Review					√	1
Reducing the Risk of Falling	√					1
Tobacco Use: Screening and Cessation Intervention	√					1
Screening for Depression and Follow-Up Plan	√					1
PREVENTIVE CARE FOR MOTHERS AND CHILDREN						
Timeliness of Postpartum visit (PPC)			√			1
Timeliness of Prenatal Care (PPC)			√	√		2
Assessment/Counseling - BMI (WCC)			√			1
Assessment/Counseling – Nutrition (WCC)			√	√		2
Assessment/Counseling – Physical Activity (WCC)			√	√		2
Childhood Immunization Status – Combo 10 (CIS)				√		1
Appropriate Treatment URI – Total (URI)				√		1
MEDICATION MANAGEMENT						
Medication Reconciliation Post-Discharge					√	1
Medication Adherence for Cholesterol					√	1
Medication Adherence for Diabetes					√	1
Medication Adherence for Hypertension					√	1
Statin Therapy - Cardiovascular Disease					√	1
Statin Use in Persons with Diabetes					√	1

SOURCE: TORCH CIN Fall Workshop.

The TORCH CIN tracks quality measures with each payer. In 2023, the TORCH CIN exceeded their ACO performance measures for chronic care management, but lagged in annual wellness visits (AWVs), annual care planning (ACP), and transitional care management (TCM), as shown in **Exhibit 9**.

Exhibit 9. TORCH CIN ACO Performance Measures



*Note: The Preliminary 2023 time period is based on CY 2022 claims window using 2023 preliminary attribution. For additional examples of time period definitions, refer to the report definition found in the module selection screen.

SOURCE: TORCH CIN Fall Workshop.

As the TORCH CIN brings more focus to the quality measures through reporting to participants, it can facilitate care delivery improvements aligned with payer measures. While there are opportunities to improve performance on the quality measures shown in **Exhibit 10**, the TORCH CIN is still in the initial phase of clinical alignment.

Exhibit 10. TORCH CIN Quality Measure Performance

	Original Medicare			UHC Commercial			AMGP Medicaid		
	MSSP	2023 TCIN Self-Report	Target/2022 MSSP Avg	UHC	Current Rate 9-20-23	90th Percentile % Target	AMGP	Current Rate 8-24-23	NCQA 66th Percentile %Target
PREVENTION AND CHRONIC DISEASE MANAGEMENT									
Annual Wellness Visit/Annual Care Visits	√	14%	30%	√	9%	30%			
Breast Cancer Screening	√	39%	75%	√	57%	78%			
Colorectal Cancer Screening	√	41%	74%	√	37%	73%			
Cervical Cancer Screening				√	51%	80%	√	43%	61%
Controlling High Blood Pressure	√	61%	75%	√	10%	73%			
Diabetes Blood Sugar Control <8	√	17%	88%	√	10%	67%			
Influenza Immunization	√	28%	81%	√					
Reducing the Risk of Falling	√	1%	87%						
Tobacco Use: Screening and Cessation Intervention	√	28%	81%						
Screening for Depression and Follow-Up Plan	√	5%	74%						
MOTHERS AND CHILDREN PREVENTION									
Timeliness of Postpartum visit (PPC)							√	62%	80%
Timeliness of Prenatal Care (PPC)							√	75%	88%
Assessment/Counseling - BMI (WCC)							√	9%	83%
Assessment/Counseling – Nutrition (WCC)							√	4%	75%
Assessment/Counseling – Physical Activity (WCC)							√	4%	78%

SOURCE: TORCH CIN Fall Workshop.

Perception of Quality Measures

A few participating hospitals attributed quality measure tracking and reporting to moving care delivery transformation forward more quickly. Additionally, they noted that reviewing quality scores has helped them to adopt more of an ongoing "*care relationship with [their] patients*" rather than focusing solely on acute care. For example, one interviewee described how participation in the TORCH CIN serves as a motivating factor to achieve quality measure targets in primary care:

> *"[Participation in the CIN] was one of the things that prompted us to move forward with our quality initiatives in our clinics … we weren't doing annual wellness visits before we were with the CIN. If we were, they were only because they needed medicine renewed … now we schedule those and try to hit the CIN goal of 80%."*

Participating hospitals identified challenges associated with quality measure reporting and it is unclear the extent to which all participating hospitals review quality data. In theory, participating hospitals review quality scores both with payers and across the TORCH CIN to identify areas for improvement and understand how they compare to their peers on specific quality measures. However, participating hospitals did not report consistent review of quality data. Some interviewees also emphasized that it is difficult to measure quality in settings with small patient volumes. In such cases, one outlier could have a disproportionate effect on hospital outcomes.

Payers chose quality measures based on state priorities, member demographics, and quality gaps. Payers worked closely with clinical teams to identify quality measures that address population health needs identified at the state level. Quality measure determination was also based on the payer's patient population (e.g., well child visits for Medicaid, care for older adults for Medicare). Payers also identified quality measures to address identifiable care gaps (e.g., maternal care, behavioral health screening).

Quality Measure Alignment

TORCH CIN participants noted a lack of quality measure alignment across payers and programs. Without a consistent set of measures, it is difficult for participating hospitals to optimize and streamline quality measure tracking and reporting

Lessons Learned from Other Rural Models: Quality Measures

Representatives from other rural CINs highlighted the importance of quality measure alignment. One representative shared that quality measure alignment is the most important consideration when negotiating a value-based arrangement of CIN participants. The CIN seeks to develop a core set of measures across the network, and then offer monthly coordination calls led by a billing expert and the clinical oversight committee to ensure that hospitals and clinics have support around quality measurement. Another CIN explained that participants agree on a small set of primary measures that are aligned across payers and reported monthly, and then any other measures are considered secondary. Overall, other CINs have had success in prioritizing a few quality measures that yield the greatest outcomes.

processes. Substantial differences between Medicare and commercial payer programs magnify these difficulties. As one interviewee noted, "*[the payers] have the same initiatives, like wellness visits and documentation of comorbidities*," but each payer has its own forms and that creates confusion. Moreover, each program has different operational models, priorities, and goals and providers usually treat patients from several different payers. The lack of alignment across payers means participating hospitals must track over twenty quality metrics to meet quality goals.

The TORCH CIN leadership team views quality measure alignment as an essential consideration when negotiating contracts. However, often the list of quality measures is provided by the payer. While the TORCH leadership team engages the Quality Committee to prioritize the payers' lists, it can be difficult to harmonize the measure sets when there are significant differences across payers and programs. Despite these challenges, the TORCH CIN leadership team continues to work to achieve greater alignment.

Care Delivery Transformation

The transition to value-based care involves implementing care delivery strategies such as AWVs,[1] ACVs, and chronic care management[2] aimed at enhancing care coordination and improving preventive care measures. For example, Main Street embeds health navigators in participating clinics to enhance care coordination for complex care pathways and integrated CCAs into routine care. CVS Accountable Care emphasizes the importance of AWVs to ensure thorough patient evaluations and encourage preventive care and early detection of health issues.

These programs require substantial changes to practice workflows often leading to increased administrative tasks and additional staffing requirements without commensurate increase in reimbursement to cover the cost. This misalignment between increased resource needs and revenue impacts highlights the challenges in balancing cost and care quality. For example, the integration of these programs at one participating hospital was described as *"doubling the workload without increasing pay"* since it necessitated the hiring of additional nurses to manage the increased administrative burden.

Compensation models vary significantly across programs, contributing to discrepancies in perceived value among participants. For example, according to the contract with Main Street, participating clinics receive incentives for every CCA completed, while CVS Accountable Care encourages completion of AWVs and use of chronic care management, which are billable services for original Medicare.

Role and Impact of Main Street Health Navigators. Navigators assist in the management of care pathways and address broader social determinants of health (such as geography, socioeconomic

[1] AWVs are associated with improved rates of patients receiving preventive care services and lower health spending.[16]

[2] Chronic care management is associated with fewer hospitalizations and ED visits, increased patient satisfaction, and improved patient compliance with recommended therapies.[17]

factors, and healthcare literacy). The navigators help mitigate administrative burdens like paperwork and organizing patient data to allow nurses and physicians to focus more on direct patient care.

Navigator efforts during care transitions are essential in reducing readmission rates and improving overall patient outcomes. However, the implementation of navigators creates frustration for some patients who sometimes saw them as overly intrusive:

> *"... some of my patients haven't enjoyed [it]. 'I came in for the flu and now you're giving me the third degree on my determinants of health.' That's how that's being implemented. That's how Main Street is forcing this through."*

While these initiatives hold promise for improving patient outcomes through better care coordination and preventive care, they also present significant challenges regarding cost management and staff satisfaction. Care delivery transformation in the TORCH CIN involved a mix of strategic initiatives to improve patient outcomes through better care coordination and preventive care. The balance between enhancing care quality and managing operational efficiencies remains a delicate endeavor for healthcare providers.

Outcomes

Hospitals found that participating in the TORCH CIN resulted in a range of impacts on patient outcomes, highlighting both successes and areas for improvement. A notable achievement has been the high rate of AWV implementation, a sign of a significant shift towards preventative care strategies. The TORCH CIN aims to complete AWVs/ACVs for at least 65% of original Medicare and UnitedHealthcare patients, suggesting a proactive approach that has the potential to improve health outcomes.

Financial incentives and coordination improvements. Financial incentives, particularly for CCA completions, have also fostered positive changes. Main Street compensates for appropriate and timely completed CCAs, a practice that has motivated providers to meet quality metrics, thus aligning financial incentives with health promotion activities. One

Lessons Learned from Other Rural Models: Care Transformation

Representatives from other rural CINs highlighted factors that contribute to success when implementing new care delivery strategies.

Data-driven care coordination: One CIN suggested integrating claims data with electronic health records (EHR) to create detailed analytic dashboards that help providers visualize patient-level data to monitor health status and intervene proactively with high-risk patients.

Integrating team-based care models: One CIN emphasized that team-based care models that includes roles for RNs, licensed clinical social workers, and pharmacists, have improved patient outcomes and overall health while reducing unnecessary healthcare expenditures.

Educational programs and provider engagement: Other CINs offered providers training and educational resources on specific care transformation activities and facilitated opportunities for shared learning among providers to motivate engagement.

interviewee hopes that continued CCA implementation and improved coordinated care may lead to improved patient outcomes:

> *"As a rural facility, we send out to a lot of specialists and being able to better track and better coordinate care. Like, the CCA form brings back information that the family practice provider may or may not have gotten from the specialist; if they've made another diagnosis or if there's another other medications or procedures … that is good information that comes back to our doctor."*

Decline in clinical engagement. Initial enthusiasm for clinical integration and quality improvement among clinicians has declined over time. This waning engagement from key clinical staff, such as chief nursing officers and clinic administrators, has led to fewer shared practices and collaborative discussions and a diminished focus on patient care improvements. The lessened dialogue around clinical improvements underscores a disconnect between the TORCH CIN's structural advantages and its practical implementation in clinical settings. The lack of consistent emphasis on quality and clinical engagement, as well as inadequate measurement and tracking of outcomes, appears to be a significant barrier:

> *"… I was hoping from the clinical engagement that we'd have shared practices and we could share wins and losses and how we were able to make it happen. Just paying a provider to fill out a sheet that's about all you hear … you don't hear much about the outcomes. I think there's a … lack of measurement tracking."*

While the structural and financial benefits of TORCH CIN participation are evident, translating these into consistent clinical improvements remains challenging. The effectiveness of the TORCH CIN in enhancing patient care depends on overcoming significant hurdles such as sustaining provider engagement, effectively using performance data, and maintaining a focus on clinical quality. Addressing these challenges is critical for realizing the transformative potential of the TORCH CIN.

Facilitators and Barriers

Participating hospitals identified a variety of facilitators and barriers to participation in the TORCH CIN. Factors that facilitate success include transformative collaboration and shared learning, increased market power and financial incentives, recognition of value-based care as the future of rural healthcare, and support from the TORCH CIN leadership team. The most frequently identified barriers include clinician buy-in, staff and provider capacity, payer relationships, resource constraints, and patient-related challenges. Each facilitator and barrier are described in more detail below.

Facilitators

TORCH and TORCH CIN leadership. TORCH has over three decades of experience supporting rural Texas healthcare facilities. All 158 rural Texas CAHs are members of TORCH. Participating hospitals expressed a profound trust in TORCH and its leadership. The longstanding relationship between the

hospitals and TORCH has laid groundwork for strong connections and trust when choosing to join the TORCH CIN. When asked if they considered other CINs before joining, one participant responded, *"We did not consider any other CINs ... we are a big supporter of TORCH."* Participating hospitals identified the TORCH CIN leadership team as a key facilitator of success. Interviewees cited the leadership team's effective management, thoughtful support and guidance, and depth of experience in hospital administration. One interviewee emphasized the value in having leaders who were former hospital CEOs and therefore more relatable.

"The TORCH leader is great…He deserves to be on the rural Mount Rushmore."

– Interviewee

The leadership team acts as an intermediary between participating hospitals and payers, as well as among participating hospitals. Several participating hospitals highlighted that members of the leadership team are always willing and available to answer questions and are responsive to hospital needs. For example, the leadership team has coordinated webinars for both administrative and clinical staff. Overall, participants say the leadership team plays an integral role in supporting participating hospitals.

Transformative collaboration and shared learning. Nearly all interviewees noted that the TORCH CIN promotes collaboration among participating hospitals through mechanisms such as joint decision-making, data aggregation, and shared learning. Moreover, the concept of "better together" was highlighted by several interviewees who noted the power of the collective, particularly within rural healthcare settings where resources are limited. As one interviewee stated:

> *"I would advise anybody I know to join [the TORCH CIN] because I really think it is the only way that we are ever going to have the leverage to get things we want and be able to survive long-term. We have to use every collective effort that we can … everybody needs to talk and understand what's happening around them. The only way to do that is to be part of a collective and that to me is the best way to do it."*

This was emphasized by several other participating hospitals who credited the TORCH CIN with reducing administrative burden and facilitating more direct access to support from payers. For example, one interviewee described the administrative support the TORCH CIN provides during contract negotiation and payment tracking. Another interviewee explained that as a TORCH CIN participant they now have access to direct points-of-contact at several commercial payers which has led to faster follow-up and streamlined operations:

> *"When we have issues with certain payers, I have an individual because of the CIN that we can contact … and answers or follow up are a little bit quicker than when we weren't a part of the CIN and did not have those dedicated people to us."*

One participating hospital mentioned that another advantage of the TORCH CIN is the ability to aggregate data across many hospitals instead of just one or two hospitals. The interviewee pointed out that the CIN will be able to leverage the aggregated data for heightened negotiating power.

Participating hospitals also described formal and informal opportunities for shared learning as part of the TORCH CIN. One interviewee highlighted that "*every time we get together, we are sharing information. We are sharing problems, we are sharing successes, we are sharing what is working and what is not working, we are asking questions … I look forward to my meetings with the CIN."* Another interviewee compared the TORCH CIN to a "*support group*," indicating that they benefit from engaging with other rural hospitals who experience similar challenges. Ultimately, interviewees credit the TORCH CIN with creating a network of rural providers with whom to collaborate, learn, and share opportunities and lessons learned.

Increased market power and financial incentives. Several participating hospitals commented that participation in the TORCH CIN provides leverage during contract negotiations with payers. They attribute this to payers privileging a network of hospitals over a single hospital when negotiating contracts and determining incentive structures. Increased market power is particularly beneficial in rural healthcare settings where "*[hospitals] don't have the power to get somebody to come to the table and renegotiate a payer contract and maybe doesn't have the resources to make sure you are getting paid what you are supposed to be getting paid."* One interviewee explained that the TORCH CIN, as a collective, has a greater depth of expertise within value-based care than any individual hospital.

While TORCH CIN leadership noted that they have not yet achieved increased rates for TORCH CIN participants across payers, they have been able to secure preferred rates for laboratory and imaging services at specific outpatient centers for the TORCH CIN.

Participating hospitals recognize that the TORCH CIN is "*still in the early stages*" and will take time to grow. Interviewees spoke to potential benefits (such as financial incentives, shared savings), while also acknowledging that there is very little downside risk to participation. As one interviewee noted:

> *"All I have to lose is the fee to the CIN and that is nothing in the grand scheme of things … if [the CIN] does not work, then the small amount of risk to take for the potential benefits is worth it."*

As the TORCH CIN continues to work towards negotiating payment models under which all TORCH CIN participants see increased rates and shared savings, the shared sentiment across many participating hospitals is that participation in the TORCH CIN will lead to stronger financial incentives.

Recognition of value-based care as the future. The majority of interviewees recognize that value-based care models will continue to dominate the rural healthcare landscape. As such, participating hospitals view participation in the TORCH CIN as a way to maintain their independence while moving towards a culture of value-based care. One participating hospital explained:

> *"Value-based care is just going to become bigger and bigger and more important. Being able to be with a TORCH CIN, that looks at everybody's contracts and makes sure that we are getting paid for what we are doing and fairly across the board is huge. Unless you're with somebody like TORCH CIN, you're not going to know that and you're going to be out by yourself trying to deal with that."*

Another participating hospital noted that they were interested in learning more about value-based care and saw joining the TORCH CIN as an opportunity to learn from individuals with knowledge in that area. Similarly, some participating hospitals view participation in value-based care models as less burdensome as part of a CIN. Ultimately, the transition to a value-based care environment has facilitated hospital recruitment into the TORCH CIN.

Barriers

Participating hospitals also identified barriers that affect TORCH CIN implementation.

Clinician buy-in. Several participating hospitals identified clinician buy-in as a barrier to participation in the TORCH CIN. More specifically, interviewees explained that it can be difficult to convince clinicians to focus on quality reporting when they have limited capacity. One interviewee mentioned that clinicians question the benefit of participation given that they have seen no additional compensation. As such, they view participation as "*extra work*." An interviewee explained that "*if [clinicians] could see [quality reporting] as helping with billing or reimbursement [it would help], but at this point it is not.*"

Another interviewee echoed this, stating:

> *"[Clinicians] want to take care of patients. They don't really care about the rest of it as long as they get paid. Finding a way to convince providers would be the best thing, because then of course, that makes it easier."*

Participating hospital leaders continue to identify ways to adapt clinicians' workflows to fit quality reporting more seamlessly into their routine. They also seek to build clinical engagement through additional education and training.

Staff and provider capacity. Participating hospitals also report challenges associated with staff and provider capacity. Already

Lessons Learned from Other Rural Models: Clinician and Staff Buy-in

Representatives from other rural CINs highlighted strategies to engage clinicians and staff. Recommendations include:

- Ensure that hospital leadership actively promotes and supports participation in the CIN.
- Highlight successes and "early wins" to demonstrate how value-based care improves patient outcomes.
- Use shared savings to reward front-line staff for their role in promoting value-based care (e.g., celebratory lunch, new scrubs).
- Delegate work from clinicians to other care team members, slowly and incrementally, so quality measure tracking and reporting does not fall exclusively on clinicians.

stretched thin, staff and providers have limited bandwidth to address preventive care (e.g., mammograms, colonoscopy, pap smears) or chronic care management. As one interviewee described, this is particularly challenging during flu season:

> *"[Asking about preventive care] when a patient broke their arm versus at an annual wellness visit is creating some of the hostility with providers … because again, we are in the flu season and do you really want to do 12 of these things on top of seeing 36 flu RSV and COVID [patients], because that's what we're asking them to do."*

Tracking quality data in the electronic health record is an additional burden. With many providers treating over 25 patients in a day, they do not have sufficient time to track relevant data. As such, clinicians rely on support staff who are already overburdened. To address this, one participating hospital mentioned hiring an additional staff member specifically to support quality measure reporting.

Payer relationships. Participating hospitals identified a variety of challenges related to their relationships with payers, including payer priorities, inconsistencies across payers, and challenges with Medicare Advantage. The perception that payers prioritize profit over quality of care has led to distrust among some participating hospitals. Additionally, participating hospitals have experienced challenges collaborating with payers to implement improved processes and workflows. One interviewee mentioned frequent programmatic changes made by payers, some of which were not appropriate in particular settings. Other interviewees highlighted challenges associated with network adequacy standards; in some cases, network adequacy allowances lead to in-network care for rural residents being delivered by providers outside the rural communities.

Participating hospitals also reported inconsistencies across payers that make it difficult to implement standardized workflows and reporting systems. These inconsistencies include patient assignment and attribution models that differ payer to payer and the administrative burden to work with the payer to have the patient re-assigned. The lack of "a consolidated approach" across payers for quality measures, data, reporting requirements, and priorities creates frustration among participants. One interviewee summarized the challenges:

> *"Nothing is the same [or] consistent [across payers] which makes it difficult because you're trying to achieve different successes. I don't think everybody's on the same page on what success is or priorities. It definitely makes it difficult when you have all the different payers. There's so many different metrics and then every year they make changes to it as well and you got to keep up with those and it's hard when you don't have consistency."*

In addition to inconsistencies across payers, participating hospitals also highlighted challenges specific to contracting with Medicare Advantage. Specifically, the incentive and reimbursement structure does not align with the payment structure for CAHs or RHCs. Interviewees described issues with prior authorization, denials, and payments when interacting with Medicare Advantage that impact their ability to "*survive*" within the current healthcare landscape.

Resource constraints in rural areas. Several interviewees spoke to challenges related to implementing value-based care programs in resource-constrained settings. In many cases, participating hospitals have limited workforce, infrastructure, and financial resources to support the shift towards value-based care. Interviewees described severe workforce shortages, particularly following the COVID-19 pandemic, that have made it nearly impossible to devote staff time to quality reporting (versus direct patient care). One interviewee highlighted staffing concerns, noting that their Vice President of Clinical Operations frequently steps in for nursing staff due to staffing constraints.

In addition to staffing challenges, some participating hospitals identified infrastructural and financial challenges that are disproportionately prevalent among rural hospitals:

> *"We struggle, everybody's struggling just to be able to make ends meet and part of that is because we try to do what's right for patients and we're not just so focused on the dollars … You've got big hospitals making millions, and we're just barely scraping by and it just doesn't make a lot of sense … they were telling me about the antibiotic reporting that we are going to do and it's going to cost $18,000 for the software. And I'm like, well, who's going to pay for that? Where's that money supposed to come from?"*

Participating hospitals would benefit from additional resources to support participation in value-based care programs. For example, additional staff support (such as population health navigators) and funding for infrastructure development would help rural hospitals navigate the shifting context.

Patient-related challenges. A few interviewees mentioned that they struggle with patient compliance around AWVs and preventive screenings (e.g., colonoscopies, mammograms). They explained "*there is not anything that holds the patient accountable for having an A1c or getting a mammogram or stopping smoke, but [the clinician] gets penalized if [a patient] does not get [an A1c or mammogram or stop smoking]*." Similarly, participating hospitals noted that patients have expressed frustration around the increased frequency with which they are asked questions related to chronic care management and various health behaviors. Patients need additional education around not only the importance of chronic care management and preventive care, but also the reasons for recent changes in typical care delivery and what to expect moving forward.

Unintended consequences

Interviewees identified two unintended consequences related to their participation in the TORCH CIN. First, with the growth of chronic care management, some participating hospitals have opted to outsource chronic care management due to workforce shortages. One interviewee described this shift, noting *"there was a lot of confusion with our patients being contacted by a doctor that was not their doctor and they did not know it was from [their doctor's office] and it created issues."* This was echoed by another interviewee who expressed concern that the additional questions that patients are asked may be impacting patient satisfaction.

Second, a few participating hospitals noted that value-based care programs can be difficult to implement in settings with small patient volumes due to the disproportionate impact that outliers have on overall quality metrics. For example, in small, rural healthcare settings, having one patient who is non-compliant could have a significant impact on incentive payments. In larger healthcare settings, an outlier would have a negligible impact on payment.

Sustainability

Participating hospitals, payers, partners, and CIN leadership expressed optimism about the sustainability of the TORCH CIN. Interviewees described opportunities to grow through onboarding of additional hospitals, clinics, and payers. The TORCH CIN recognizes it is in the early stages of the CIN and does not anticipate achieving cost savings immediately; rather, the CIN provides a runway for rural hospitals and clinics to build the experience and efficiency to be successful in value-based care. Participating hospitals expressed a need for sufficient financial incentives to support this transformation.

Participants expressed concerns about rural hospital viability in a value-based environment and the need for payers to recognize the realities of rural healthcare delivery. Hospitals across Texas are experiencing financial stress, with 22 hospital closures since 2010.[19] Participating hospitals and clinics noted low volumes, provider shortages, and limited opportunities to reduce costs. One interviewee commented:

> *"It's a balance of maintaining access to care and maintaining viability. That's a complicated question. Ideally, you have the volume and the payer mix and the supplemental payments to make it work. That's where folks need work towards. Some communities are losing population, so they may already be at the bare minimum."*

APMs for rural hospitals and clinics must design appropriate measures and expectations to maintain access to care.

Financial sustainability of the TORCH CIN is also a concern for future growth and operations. The TORCH CIN financial operations are funded primarily by grants and initial investments from participating payers, in addition to minimal participant membership fees. The TORCH CIN would be operating at a loss of approximately $500,000 per year in the current state of operations without the support of grants and other investments.

Lessons Learned from Other Rural Models: Sustainability

Other rural CINs and ACOs commented on the time and resources required to achieve sustainability. Previous research has found that physician-led and smaller ACOs are more likely to achieve shared savings. Further, ACOs usually take up to three years to generate any shared savings, as time and experience in the ACO is linked to these savings.[18]

Other rural CINs and ACOs commented on the importance of demonstrating value to payers by meeting population health needs (e.g., mental health) and consistent quality performance. Multi-payer participation and alignment is important for scaling care delivery changes to a greater proportion of patients served, accelerating sustainability.

The TORCH CIN is working towards a path of financial sustainability, but it will take additional years, additional payer contracts, and increased hospital participation to achieve a self-sustained business model.

CIN leadership also noted that sustainability will require additional financial investments in infrastructure to facilitate success in value-based contracts. One key capability will be a data analytics platform to provide a comprehensive overview of all payer metrics and progress on each. A data platform can be used to better support participants in achieving quality metrics. Further, it would allow the CIN to share outcomes with payers and other partners.

At the hospital and clinic level, interviewees commented on the need to better understand value-based care and further enhance care delivery initiatives to achieve success with APMs. As one interviewee noted, *"There is surface level understanding. Most people don't have a deep enough understanding of what APM is and what it takes from the ground levels up to be sustainable."*

Recommendations

Building a CIN and the infrastructure to support network engagement and improve quality of care requires a phased approach with considerable start-up costs. As a CIN demonstrates value to payers through enhanced care delivery, it can grow and progress along the spectrum of value-based care toward greater risk (**Exhibit 1**). This progression can then unlock greater financial opportunities through incentive payments and new APMs, thus providing funding for CIN operations and to participating providers. However, moving too fast across the APM categories, can be detrimental for a CIN.

Ideally, in the initial two to three years of the CIN's formation, a CIN should establish the fundamental foundation needed to optimize clinical and financial performance before venturing into contracted APMs associated with financial risk. During these early years, operational funding does not stem from payer contracts, and needs to be secured from external sources such as grants, sponsors, or participants. Insufficient funding during this crucial period can hinder the growth and success of the CIN.

Once the foundational CIN infrastructure is in place and existing alternative payment contracts achieve some level of success, the CIN can consider transitioning to risk arrangements. These risk arrangements offer increased financial incentives tied to cost reduction, utilization management, and improved health outcomes. This increased potential funding of risk arrangements can help sustain CIN operations and facilitate incentive payments to participants.

Ultimately, the CIN's sustainability hinges on its transition to risk-based arrangement and the significant financial benefits they offer. Preparing for and obtaining risk arrangements takes substantial upfront commitment in terms of operational structure, costs, and participant engagement. To drive profits and significant incentives to support rural sustainability, it is essential to embrace risk and achieve success in risk arrangements.

The recommendations outlined below lay the groundwork for the TORCH CIN and its progression along the spectrum of APMs. For effective implementation of the recommendations, external funding mechanisms must be obtained. Although current non-risk APMs employed by the TORCH CIN add value by improving and demonstrating quality care, they do not add enough financial value to secure rural health sustainability.

Recommendations for the TORCH CIN

Based on the findings of this report, the evaluation team offers the following recommendations for the TORCH CIN:

Enhance access to timely and actionable utilization and quality data. A key strategy for success in value-based care is timely and actionable utilization and quality data. The TORCH CIN should identify a strategy for data aggregation to support the CIN participants. To do so, the TORCH CIN will need to define its immediate and long-term needs. Analytic platforms are a costly investment. Identifying and prioritizing immediate use cases can aid in selection of data needs and tools reducing initial implementation costs and building a foundation for continuous growth as data priorities expand. Data aggregation efforts should consider all potential data sources that can inform the TORCH CIN's goals, including payer claims data, electronic health records, admissions, discharge, transfer (ADT) or health information exchange (HIE) feeds, and other files as available. While hospitals and clinics may benefit from point-of-care tools, the TORCH CIN will need to evaluate costs for such platforms for participants using different EHRs. Data analytics technology should align reporting requirements for the TORCH CIN, as well as with participant reporting requirements (including Quality Payment Program [QPP], Medicare Beneficiary Quality Improvement Project [MBQIP]) for added value and increased usefulness of the technology.

Develop and implement a performance improvement strategy. TORCH CIN participants expressed a need to focus on select quality measures to concentrate care delivery efforts on the areas of greatest potential impact. The TORCH CIN Quality Committee should select annual performance goals based on three to five measures across payers and set quarterly targets for participants. Long-term efforts to align performance goals across payer contracts can facilitate participant engagement and investment in care delivery changes. To support these efforts, the evaluation team recommends taking inventory of clinic resources and best practices for achieving goals. A care team approach to value-based care is key to success.

The TORCH CIN needs to consider providing a care management team to support the CIN's populations and create efficiencies especially with dispersed patient populations. Relying on hospitals and clinics to obtain, staff, and manage their own employed care managers has several inefficiencies and challenges. A CIN employed team can act as a coordinated extension for the care teams that already exist in clinics. As an alternative to a CIN employed team, the TORCH CIN might consider delegating coordinated care management services to a management company to optimize patient engagement and outreach, especially at clinics with insufficient care management staffing. Care teams

can assist with AWVs and pre-visit planning adding value and support for clinics and providers. Developing short-term and long-term staffing plans for the TORCH CIN is essential, taking into account roles related to care management, care coordination, referral coordination, quality improvement, practice transformation, data analysis, and other related services. The staffing plan and ratios should be aligned with contract requirements and population growth projections on an annual basis.

Participants and the TORCH CIN Quality Committee should capture success stories resulting from care delivery efforts and share these stories with front-line teams to maintain motivation and momentum. The TORCH CIN Quality Committee should support participants in forming or enhancing clinic-level multi-disciplinary performance improvement committees, which should include physicians, advance practice providers (APPs), nurses, medical assistants, and managers. The TORCH CIN should identify and appoint clinical champions to spearhead performance improvement and communications with participants and providers. These participant-level initiatives can be supported by clinical care guidelines, protocols, and care plans developed by the TORCH CIN Quality Committee to ensure performance meets standards for clinical integration, thereby promoting consistency and quality in care delivery across the network.

Focus on contract negotiations and growth. As noted previously, contract negotiations should consider a short-term and long-term growth strategy.

> **Short-Term.** The TORCH CIN should explore leveraging payer and publicly available hospital transparency files to gain a competitive edge for increased negotiating capabilities, improved market visibility, and greater access to rate benchmarks. There may be opportunities to strengthen Medicare Advantage strategies by partnering with carefully selected payers and brokers that align with TORCH CIN objectives. As a first step, the TORCH CIN could create a payer grid by gathering payer and plan details, population size, and market share from participants to create a catalogue of participating hospitals. This information can be used to develop a growth roadmap for expansion by payer and patient population within the TORCH CIN, alongside necessary operational infrastructure and milestones to support success in these contracted APMs.
>
> ***Long-Term.*** The TORCH CIN should explore potential capabilities to serve as the mediator between Medicare Advantage and participants, similar to the role Main Street Health currently plays. Furthermore, through a collaborative engagement with stakeholders such as payers and, state and federal legislator, the TORCH CIN has an opportunity to innovate and devise new APMs that lead to rural healthcare sustainable and viability. Taking steps to earn URAC's Clinically Integrated Network Accreditation may enhance the TORCH CIN's competitive negotiation power, increase peace of mind on antitrust matters, and serve as a roadmap for ongoing improvement. The TORCH CIN may also consider contracting as a "wrap" network for employers seeking healthcare access in rural communities. The TORCH CIN could also assess the need and viability of partnering with other CINs in adjacent service areas to develop a larger Texas network for employers. For example, AR NetPartners is a network that brings together multiple CINs to serve the entire state of Arkansas, giving employers more coverage and

options to help improve health plan costs. Arkansas Health Network is also URAC dually accredited with CIN and Care Management.[20] Ultimately, the TORCH CIN will need to plan for the transition from pay-for-performance and shared savings models to risk arrangements, taking into consideration budget impacts and potentially the need for stop-loss insurance.

Invest in network management. Opportunities for network enhancement include improved onboarding and communication strategies. With an established participant base and the potential for expansion, the TORCH CIN should now develop a well-defined onboarding plan. This plan should incorporate best practices for integrating new participant groups, evaluating their performance, and assisting them in their performance as necessary before joining the larger CIN's metrics. A phased approach to onboarding can help mitigate fluctuations in performance metrics when new participants join the TORCH CIN. Other opportunities to enhance communication and collaboration include:

- Hosting at least one annual meeting with participants to establish and communicate the CIN's strategy, goals, and expectations.
- Providing on-demand access to participant and TORCH CIN performance and data reports, best practices, strategies, presentations, meeting minutes, newsletters, Q&As/blogs, community forums, and other announcements through an online CIN platform.
- Sharing success stories and addressing barriers and challenges across all CIN participants.
- Engaging clinicians across the TORCH CIN through initiatives such as hosting an annual conference that includes physicians and providers.
- Reinforcing the purpose and vision of the CIN, along with outlining contracting plans and milestones necessary for growth and successful execution of value-based contracts to provide clarity and direction for participation.
- Establishing biannual check-ins with all participants to gather feedback about contracted partners and vendors to ensure alignment with expectations.
- Administering anonymous surveys followed by discussions to review feedback to improve vendor performance.
- Collecting data on net promoter scores and ratings to gain valuable insight into participant satisfaction and areas for improvement.

Recommendations for the Texas Legislature and HHSC

The Texas Legislature made a large investment in fiscal years 2023-2024 appropriating $50 million to support rural hospitals. The HHSC is currently determining the additional, new grant opportunities to support APM readiness. Continued investments can further enhance financial stability of rural hospitals as the role of value-based care programs expand. The evaluation team offers the following recommendations for the Texas Legislature and HHSC:

Provide grants or develop APMs to specifically support the needs of rural healthcare providers. In shared savings arrangements, rural providers are asked to make significant financial and operational

investments with no guarantee of financial benefit. Already operating with narrow margins, rural providers have limited ability to make those investments. The TORCH CIN and its participants would benefit from short-term grants or other funding to develop infrastructure and skills needed for success in HHSC's APM strategy. The initial investment would support the TORCH CIN's long-term sustainability while advancing HHSC's goals.

Recognizing the financial constraints of rural providers and hesitancy to take on financial risk, HHSC should encourage payers to provide care management payments to support improved care coordination and outcomes. For example, HHSC can encourage managed care organizations (MCOs) to pay for chronic care management, expand access to remote patient monitoring, or support other services to address medical and social needs outside of a hospital or clinic setting. HHSC may also consider encouraging MCOs to provide funding for care management as part of APM contracting with providers. Care management funding could be incorporated into APMs as a per member per month payment (PMPM) to providers to support operations to achieve improved quality goals. These types of arrangements offer larger PMPM rates in year 1 and either slowly decline annually or become at risk based on outcomes and performance.

Provide funding for technical assistance. The TORCH CIN and other rural Texas providers require technical support to navigate the complexities of rural healthcare delivery, particularly in the transition to value-based care models. This support is essential for rural communities which face unique challenges, including limited resources, workforce shortages, and infrastructure constraints. Investing in technical assistance from organizations with expertise in rural healthcare, value-based care, and working with providers and payers in rural areas is crucial to address the specific needs and challenges of CINs and rural providers in Texas. In addition, the TORCH CIN would benefit from technical assistance that supports expert clinician leaders or consultants in value-based care. This might include clinician-to-clinician support, monitoring, and performance improvement discussions.

The Center for Medicare and Medicaid Innovation (Innovation Center) within CMS continues to develop new APMs, such as the recent Transforming Episode Accountability Model (TEAM), ACO Primary Care Flex Model, and Transforming Maternal Health (TMaH) model. Access to expertise that can monitor, evaluate, and strategically provide guidance for participation in these new models will ensure the TORCH CIN remains informed and focused on new opportunities. Pennsylvania's Rural Health Redesign Center and Vermont's Green Mountain Care Board have shown that support from an independent entity can offer valuable resources to both providers and payers. They can provide guidance, resources, and strategies tailored to the rural context and operations of the CIN, thereby facilitating successful implementation of value-based care initiatives and CIN sustainability. Examples of independent entities include consulting firms, seasoned CIN leaders who serve on an advisory board, academic centers that specialize in rural healthcare and value-based care, and clinical champions with track records in value-based care. By the Texas Legislature allocating funding for technical assistance, the TORCH CIN and rural Texas providers have access to expertise and resources necessary to navigate the transition to value-based care effectively. This investment not only

enhances the quality of care but also strengthens the sustainability and resilience of rural healthcare, ultimately improving health outcomes for Texas' rural populations.

Provide funding to support the TORCH CIN operations. The TORCH CIN's current participation represents 20% of rural Texas hospitals and participation is growing. The 32 participating hospitals provide access to almost 700,000 rural Texans living in the counties they serve. Hospitals operating with narrow margins have limited funds to invest in the infrastructure for the TORCH CIN. Funding for infrastructure would allow the TORCH CIN to invest in the tools needed to succeed in value-based care. For example, the North Dakota Legislative Assembly appropriated $3.5 million to stand up the Rough Rider High-Value Network, a CIN comprised of 23 independent critical access hospitals across the state. Infrastructure needs can include but are not limited to network development and management, care coordination, quality improvement, utilization and clinical management, point-of-care and other health information technology, data analytics and quality reporting costs. All of these needs have resource, staffing, and vendor solution components that require substantial financial investment on the part of the CIN and its participants.

Strengthen data sharing requirements and funding. Texas has made progress in developing a statewide Health Information Exchange (HIE) and facilitating care coordination and quality improvement. HHSC provides incentives for Medicaid providers to participate with local HIEs, who then connect with HHSC. Strengthening data sharing requirements can further enhance the use of the HIE to benefit patients receiving care in Texas. However, rural providers may not be able to bear the costs for the data systems necessary for greater engagement with the HIE. The Texas Legislature could consider grant opportunities or other funding to support the costs for rural providers to participate in the HIE.

Additionally in the rapidly evolving landscape of digital transformation, rural hospitals and clinics face unique challenges when selecting, funding and effectively leveraging innovation to enhance care delivery poses unique rural challenges. The lack of access to expert advisors, resources, and funding hinders the adoption of efficient and quality-driven solutions. The TORCH CIN would be positioned to propel an enhanced regional approach to rural healthcare innovation, if funding for these technology solutions existed.

Promote rural collaboration and partnerships. Network adequacy standards for Medicaid and commercial payers, established by the Texas Department of Insurance, set different expectations for rural and non-rural areas. Opportunities exist to improve these standards to encourage payers to contract with rural healthcare providers. Some network adequacy standards allow telehealth exceptions and exemptions to cover rural areas, and payers are not required to contract with the local rural healthcare providers. As a result in-network care for rural residents may be delivered by providers outside the rural communities. The Texas Department of Insurance can enhance adequacy standards for rural counties to promote both parties to come together in negotiations.

Interviewees noted the need for payers to better understand rural healthcare payment mechanisms and finance. The Texas Legislature could fund HHSC to host and facilitate learning collaboratives with the

TORCH CIN, rural healthcare providers, payers, community-based organizations, and other key partners to develop and enhance relationships that help serve rural communities. Other models, such as the Pennsylvania Rural Health Model, have achieved success with monthly payer-provider calls and semi-annual payer-provider summits. These opportunities encouraged one payer to meet regularly with rural hospital participants to develop ways to transform care delivery and meet patient health and social needs. This collaboration helped build the payer's understanding of rural healthcare.

Reduce Medicaid quality measure burden. The large number of quality measures tracked across payers creates an undue burden on rural providers with limited capacity for data collection and analysis. To enhance the ability of the TORCH CIN to improve quality and reduce costs, a focused list of quality measures that remain consistent over time can lead to greater quality improvement in key areas. HHSC should consider aligning managed care organization (MCO) measures with Medicare Advantage and traditional Medicare measures when possible to reduce the quality reporting burden for participants and the TORCH CIN. HHSC should also consider reducing the number of reported quality measures to reduce administrative burden for rural healthcare providers and free up capacity to make care delivery changes.

Improve MCO patient assignment. In APMs, the TORCH CIN and its participants assume accountability for quality, cost, and satisfaction for a defined Medicaid patient population. The HHSC should evaluate the assignment of Medicaid patients to providers and align current methods with best practices in value-based care. Rural providers report issues when Medicaid patients get assigned to providers with whom they have no historical visits or cannot engage effectively. Matching a patient population with the most appropriate provider is crucial for successful engagement and management of the patient's health. This matching (referred to as assignment, attribution, alignment, enrollment, or other industry terms) aims to accurately define the population as part of the APMs for the TORCH CIN participants. Various assignment models exist and sometimes best practices for assignment use multiple methods to assign patients. Engaging patients in their health and assuming accountability for the cost and quality of their care becomes challenging when providers cannot reach patients or patients refuse to visit providers. While administrative processes often exist within Medicaid MCOs to reassign patients, providers have expressed frustrations regarding the administrative burden, timeliness, and the likelihood of patients returning to their panel months later.

Additionally, the HHSC should explore incentives to encourage patients to visit their primary care providers (PCPs). Incentivizing patient engagement can support providers in their efforts and enhance the success of APMs in achieving increased quality and reduced costs. Similar to Medicare Advantage and the Medicare Shared Savings Program, structures and programs that incentivize patients to receive primary and preventive care should be considered for Medicaid populations.

Conclusion

Rural providers and CAHs face challenges when navigating APMs. To ensure continuity of care in rural communities, payers, providers, policy makers, and other stakeholders must recognize the challenges and opportunities inherent in adopting APMs in rural areas. This is especially true amidst the evolving payer landscape, notably with Medicare Advantage. Addressing rural APMs for Medicare Advantage involves restructuring Medicare Advantage contracts with CAHs and implementing new Medicare Advantage APM models. The federal government must serve as a stopgap in this transition. It is essential to acknowledge the historical context wherein rural institutions operate under unique payment models designed to provide healthcare access and sustainability in rural America. Medicare Advantage penetration rates in rural communities have quadrupled since 2010.[21] As Medicare Advantage penetration rates increase in rural areas, rural providers face significant financial risks given that the Medicare Advantage commercial insurers often do not recognize or support the CAH designation and payment structure in contracts. This shift is widening the gap to financial sustainability and jeopardizing the viability of rural healthcare, triggering seismic effects in these vulnerable aging rural communities.

In the transition to APMs, it is important to understand the unique assets and barriers of rural healthcare delivery, reflected in the creation of CAH designations in the past. Historically, rural providers have limited capital to invest in new payment and delivery models. Investment of time and resources to build the infrastructure to be successful under new models is essential. While such changes are significant and require time, they are indispensable for the long-term viability of rural healthcare.

With these considerations in mind, the growth and maturity of the TORCH CIN offers a promising avenue to harness new APMs that foster improved outcomes and sustainability. Through collaborative engagement with the TORCH CIN, there is an opportunity to innovate and design new APMs in partnership with policymakers and payers like the CMS Innovation Center, Medicare Advantage, MCOs, and other payers. It is paramount to construct a financial framework that not only promotes high-quality care but also recognizes the unique challenges faced by rural healthcare, thus safeguarding its sustainability.

Appendix A: Value-based Care Models Reviewed (Subset)

Model Name	Brief Description	CIN (Yes or No)	Rural Relevance
ACO Realizing Equity, Access, and Community Health (REACH) Model	CMS has redesigned the Global and Professional Direct Contracting Model (GPDC) Model to advance health equity and encourage health care providers to coordinate care to improve the care offered to people with Medicare. The ACO REACH model makes changes to the GDPC model in three key areas: 1) Advancing health equity by testing an innovative payment approach to better support care delivery and coordination for patients in underserved communities including a focus on reducing health disparities, 2) Promoting provider leadership and governance through increased board representation requirements for providers and beneficiary advocates, and 3) Protecting beneficiaries with more participant vetting, monitoring, and greater transparency. There are currently 122 participating ACOs and 1 participating payer (Medicare FFS).	No	Rural Included
Bryan Health Connect	Bryan Health Connect (BHC) is a Physician-Hospital Organization (PHO) that works closely with all participants to assist and support their independence in an ever-changing healthcare environment. BHC believes connected care is better care. They offer payers and employers a broad, high-quality, cost-effective network of independent and employed providers. BHC also has an Accountable Care Organization (ACO) within the PHO. This subset of the membership is committed to working collaboratively to deliver team-based and highly integrated care for select government and commercial value-based agreements. There are currently 24 ACO participants and participating payers include Medicare, Medicaid, and select commercial payers.	No	Rural Included
Community Care Alliance	Community Care Alliance (CCA) exists to support rural health practices, critical access hospitals, and rural hospital systems, arming care teams to operationalize the business of healthcare and focusing the clinical team on providing the highest level of patient care. CCA specializes in supporting rural healthcare including primary care, specialty care, critical access hospitals, rural hospital systems, oral care, and behavioral health. There is no longer a need to carry the burden of reimbursement or the complexity of operationalizing value-based care alone when you join our network. There are currently	Yes	Rural Only

Model Name	Brief Description	CIN (Yes or No)	Rural Relevance
	18 participating hospitals and participating payers include Medicare, Medicaid, and select commercial payers.		
Community Care Partnership of Maine Accountable Care Organization	Community Care Partnership of Maine (CCPM) is an ACO formed in 2015. CCPM leverages the predictive analytics platform which sits on top of Maine's statewide health information exchange to identify patients at risk for a health crisis or issue and to improve approaches to care delivery across the organizations in the ACO. There are currently 9 participating federally qualified health centers (FQHCs) and three community hospital systems. Participating payers include Medicare, Medicaid, and select commercial payers.	No	Rural Included
Illinois Critical Access Hospital Network	The mission of the Illinois Critical Access Hospital Network (ICAHN) is to strengthen critical access and small, rural hospitals through collaboration. ICAHN makes it their overarching goal to preserve access to rural healthcare while improving the vibrancy and viability of the communities served. ICAHN ensures appropriate funding and financial resources, promotes efficient use of information technology services for the network and members alike, maintains and further develops specific-type peer networks, activities, and listservs that promote hospital operational efficiencies and connectivity, offers ongoing educational opportunities and resources, and develops and offers shared services that offer value to members. There are currently 59 participating hospitals.	Yes	Rural Only
Montana Health Plus	Montana Health Plus is improving population health, providing a formal statewide system of care, increasing optimal clinical outcomes and decreasing overall healthcare costs for people in Montana regardless of income or coverage status, by providing integrated, high-quality, patient-centered care in a network of community-based health centers to the citizens of the State of Montana and private and public payers. There are currently 14 participating community health centers and participating payers include Medicare and select commercial payers.	No	Rural Included
Pennsylvania Rural Health Model	The Pennsylvania Rural Health Model seeks to test whether care delivery transformation in conjunction with hospital global budgets increase rural Pennsylvanians' access to high-quality care and improve their health, while also reducing the growth of hospital expenditures across payers, including Medicare, and improving the financial viability of rural Pennsylvania hospitals to improve	No	Rural Only

Model Name	Brief Description	CIN (Yes or No)	Rural Relevance
	health outcomes of and maintain continued access to care for Pennsylvania's rural residents. There are currently 18 participating hospitals and 6 participating payers (Medicare FFS and 5 commercial payers).		
Rough Rider Network	Through the Rough Rider High-Value Network, critical-access hospitals join forces on clinical and operational fronts, amplifying the accessibility, affordability, and quality of care in North Dakota's rural communities. The Rough Rider Clinical Integration Network (CIN) was established to further enhance their collaborative efforts. This empowers their member hospitals to offer continuous care to patients across the network, from surgery and ophthalmology to mental health and obstetrics. The CIN's Clinical Integration Committee, comprising a practitioner from each member hospital, supervises all clinical and quality initiatives. There are currently 23 participating hospitals, 37 RHCs, and 4 FQHCs. Participating payers include Medicare, Medicaid, and select commercial payers.	Yes	Rural Only
The Rural Collaborative	The Rural Collaborative was formed in 2003 by eight rural public hospital districts in Washington State and has since grown to 26 members. Shared savings and reduced costs through interdependence has created significant financial advantages for our small, rural hospitals, which translates into their ability to better serve their communities. At the Rural Health Collaborative, members actively support one another, sharing ideas and working collectively to achieve excellence in rural healthcare for their communities.	No	Rural Only
Vermont All-Payer ACO Model	The Vermont All-Payer ACO Model offers ACOs in Vermont the opportunity to participate in a Medicare ACO initiative tailored to the state and provided Vermont a funding opportunity announcement for $9.5M in start-up investment to assist Vermont providers with care coordination and bolster their collaboration with community-based providers. Under the Vermont All-Payer ACO Model, the state commits to achieving statewide health outcomes, financial, and ACO scale targets across all significant healthcare payers. CMS and Vermont expect to work closely together to achieve success. There are currently 14 participating hospitals and 3 participating payers (Medicare FFS, Medicaid, and 1 commercial payer).	No	Rural Included

Appendix B: Evaluation Methods

The evaluation included an environmental scan, primary data collection, and a review of secondary data provided by the TORCH CIN. The environmental scan included a systematic search of grey literature to identify other value-based care models involving rural providers. Primary data collection included Zoom interviews with participating and non-participating TORCH hospitals, TORCH CIN leadership, payers, and partners. We also interviewed subject matter experts, specifically those involved with other rural value-based care initiatives outside of Texas. For the quantitative approach, we reviewed quality measure outcomes provided by the TORCH CIN to describe the population served and outcomes of the CIN. The evaluation sought to answer the following questions:

1. What initially motivated rural Texas hospitals to participate in CIN? What factors encourage their ongoing participation?
2. How do participating hospitals and payers perceive the value of the CIN? What do they see as the short-term and long-term benefits?
3. Does CIN foster a “better together” trust among participating rural providers?
4. Why did non-participating rural Texas hospitals choose not to participate in CIN? What factors may encourage them to participate?
5. What factors influenced payors to engage with the CIN?
6. How has the CIN changed incentives to drive care delivery transformation?
7. How are payers aligned to encourage care delivery transformation?
8. Have hospital participants observed any unintended consequences (positive or negative) of participating in the CIN?
9. What specific improvements or changes do hospital participants suggest for enhancing the effectiveness of the CIN?
10. Are the CIN’s care coordination and population health management programs reaching vulnerable and chronically ill populations?
11. How does participation in the CIN impact patient care and patient outcomes?
12. How has participation in the CIN affected providers’ professional satisfaction? Does the CIN affect provider recruitment and retention?
13. What factors have been key to the CIN’s success?

14. What infrastructure and capabilities are needed to support the CIN's sustainability and rural hospital readiness to participate in alternative payment models?

15. What do participants and partners see as the future of the CIN?

Environmental Scan. We conducted an environmental scan to identify and learn from previous alternative payment and care delivery models that have operated in rural settings. This scan aimed to extract lessons that are applicable and adaptable for the CIN and was carried out concurrently with the qualitative data collection. The environmental scan included a literature review of innovative delivery and payment models, including demonstration models and proposed models. The scan itself comprised both targeted and broad systematic reviews of the resources and literature related to the models. We used grey literature sources (e.g., Rural Health Value, Rural Monitor, National Rural Health Resource Center) to identify published and unpublished models; and searched targeted sources likely to contain relevant material, including evaluations and systematic reviews. The team assessed these models for applicability and adaptability for the CIN and identified experts associated with the examined models to participate in key informant interviews.

Primary Data Collection. We conducted 29 key informant interviews with 33 individuals between January and March 2024. The interviews provided insights on the strengths and opportunities for the CIN to facilitate success for rural providers in value-based care arrangements. Interviews were conducted virtually and in-person, and included a sample of five key informant types:

- Participating hospital administrators (n=13)
- Non-participating hospital administrators (n=1)
- CIN Leadership (n=4)
- Payers (n=5)
- Subject matter experts (n=6)

We used a semi-structured discussion guide for interviews to ensure maximum flexibility to gather input from respondents, while also capturing comprehensive and consistent information from each respondent. A senior member of the team facilitated each interview using the semi-structured discussion guide, and a research associate took detailed notes during each interview. Each interview was recorded with the participants' consent to ensure the accuracy of our notes.

Qualitative Analysis. The team created a codebook to guide qualitative analysis. First, we developed an initial set of codes using the interview guides and research questions. Then, multiple team members coded the first interview and met to discuss areas where code application was unclear or inconsistent. We identified and made any necessary revisions to the codebook. We continued to update the codebook with emerging themes throughout the analysis.

The team conducted thematic analysis of the data, employing both inductive and deductive methods, to identify relevant themes and areas of convergence and divergence across interviewees.

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