Rural Health Panel
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May 13, 2016

Request for Information on Concepts for Regional Multi-Payer Prospective Budgets
Electronic submission to RegionalBudgetConcept@cms.hhs.gov

The Rural Policy Research Institute Health Panel (Panel) was established in 1993 to provide science-based, objective policy analysis to federal policy makers. The Panel is pleased to offer comments regarding CMS' Request for Information regarding Concepts for Regional Multi-Payer Prospective Budgets.

The Panel understands that CMS will receive comprehensive comments from a wide variety of sources. Our focus will be on rural-specific issues in the Request for Information. Rural people represent approximately 20 percent of the U.S. population – over 60 million Americans. Furthermore, Medicare beneficiaries represent a greater percent of the population in rural areas than in urban areas. Thus, Medicare policy is extremely important to rural people, places, and providers. The Panel is very pleased to see CMS' interest in how a prospective health care budget might work in rural areas.

The Panel has used the same numbering system for CMS questions and Panel comments as used in the original Request for Information.

SECTION II: QUESTIONS ON PROSPECTIVE BUDGET METHODOLOGY

1. Please comment on whether and how a prospective budget could be determined for a geographic area and the type of geographic area that such a budget would be suited for.

The Panel recommends that geographic areas be determined based on service areas, not geopolitical boundaries. Give the importance of primary care as the foundation for a coordinated delivery system focused on patient-centered, community-based care, we recommend geographic definitions be appropriate aggregations of primary care service areas.

2. Please comment on possible financial arrangements, including an attribution methodology that CMS could consider for Medicare, Medicaid and other payers to determine the prospective budget; the types of services and categories of spending that could be included or excluded in a prospective budget; and provider risk sharing relationships that could be supported within this concept. Please comment on whether CMS should include or exclude spending for Medicare Parts A, B and D, as well as payment systems/schedules (for example, Inpatient Prospective Payment System and Physician Fee Schedule), and whether all or only selected Medicare beneficiaries in a defined geographic area should be included.

The Panel recommends that all payers be included in a prospective budget. Similarly, Medicare Parts A, B, and D should be included as well. This strategy will tend to preclude cost-shifting and allow population health interventions to be applied for <u>all</u> patients, spreading infrastructure investment most efficiently and caring for a population most effectively. Generally, all Medicare beneficiaries should be included, however CMS may wish to exclude some groups such as those receiving end-stage renal disease services.

3. Additionally, how could participating providers be held accountable for total cost of care? How participating payers could be held accountable to the requirements of a prospective budget concept?

The Panel believes that not all participating providers will have the population size nor the financial experience to be accountable for the *total* cost of care (i.e., costs as measured by total spending, not individual fee-for-service payments for specific encounters). This is especially true among small rural providers. Although strategies such as stop-loss insurance and/or risk corridors mollify some financial risk, total cost of care accountability requires certain insurance mandates (e.g., financial reserves) and financial risk management expertise that may be unavailable to rural providers. Furthermore, smaller rural populations may be inadequate to efficiently spread new fixed population health management costs. Therefore, we recommend that rural providers be provided the opportunity to responsibly contribute to the management of a prospective budget. Please see transition strategy recommendations to follow.

4. Please comment on how the prospective budget would be determined for Medicare, Medicaid and other payers and the necessity or feasibility of a state or independent organization to negotiate and set the global budgets for participating providers. What would be the roles and responsibilities of this organization? What resources and expertise would be necessary for this organization to set prospective global budgets across multiple payers? Would this organization need to be able to set rates for services? Do states require legislative authority to establish the authority for this organization to set global budgets or rates and for the organization to hold the providers accountable for these budgets?

The Panel notes that Maryland's Health Services Cost Review Commission (HSCRC) was given "broad responsibility regarding the public disclosure of hospital data and operating

performance and was authorized to establish hospital rates to promote cost containment, access to care, equity, financial stability and hospital accountability. The HSCRC has set rates for all payers, including Medicare and Medicaid, since 1977 and has largely achieved the key policy objectives established by the Maryland legislature. In recent years, the HSCRC has devoted considerable resources toward the development and implementation of payment-related initiatives designed to promote the overall quality of care in Maryland hospitals."[1] In our discussions with one small rural Maryland hospital, the HSCRC appropriately considers unique rural health care delivery issues. We feel that CMS could promote this all-payer model to additional states.

5. Please comment on the appropriate data, data sources, and tools to support data aggregation and data sharing, for the purposes of setting multi-payer global budgets, assessing quality and population health metrics, and measuring effectiveness of this concept.

The Panel and other rural health care experts have long noted the importance of rural provider inclusion in quality measuring and reporting programs. In fact, the Panel has previously recommended that CAHs be included in a modified Value-Based Purchasing program.[2] That said, the rural spectrum of services is somewhat different than urban services. Quality measures should reflect those difference. In addition, low patient volumes can challenge quality assessment statistical reliability. Therefore, we strongly recommend that CMS use rural designed and appropriate quality measures, and use statistical techniques (e.g., rolling averages or regionally consolidated data) to ameliorate statistical reliability challenges associated with low volumes.

Rural providers may not have available sophisticated data analytic tools to make informed decisions about population-based health care and financial risk management. Therefore, the Panel recommends that CMS pay particular attention to disseminating accurate and timely health care (and ideally human services) utilization data for all persons (regional population) attributed to a particular provider, but also provide data analytic tools and education at low or no cost to providers managing population health and a prospective budget.

6. Please comment on adjustments to a prospective budget that would need to be made over time, accounting for shifts in market share, population size and other market changes that could occur. Additionally, please comment on how a budget could handle boundary issues such as patients seeking services outside of the defined region.

The Panel notes that Maryland's experience with the *Total Patient Revenue* system has been generally positive, successfully adjusting global budgets based on historical cost of care trends. Factors such as service area population size change, health care condition risk-

[1] The Maryland Health Services Cost Review Commission. http://www.hscrc.state.md.us/. Accessed May 2, 2016.
[2] Rural Policy Research Institute Health Panel. CMS Value-Based Purchasing Program and Critical Access Hospitals. January 2009. http://www.rupri.org/Forms/CAH_VBP_Final.pdf. Accessed May 2, 2016.

adjustment, and Medicare Economic Index effects should be considered. Equitable budget adjustments will be particularly important in rural areas where service volumes are low and/or financial margins are low.

7. Please comment on appropriate quality measures for a prospective global budget that emphasize improvement in health outcomes and population health for Medicare and Medicaid beneficiaries and those covered by other payers. How could this concept incentivize quality improvement? How could CMS obtain multi-payer alignment on these measures? How could CMS encourage the reporting of performance measures on the most important priorities while minimizing duplication and excess burden?

The Panel strongly recommends that CMS support and encourage continued rural health quality measurement analysis work by the National Quality Forum. NQF's "Performance Measurement for Rural Low-Volume Providers" report presents 14 recommendations from a multi-stakeholder Committee that was tasked to address these and other challenges of healthcare performance measurement for rural providers, particularly in the context of CMS pay-for-performance programs. The resulting recommendations can help advance a thoughtful, practical, and relatively rapid integration of rural providers into CMS quality improvement efforts."[3] In its national role and with its broad influence, CMS should additionally support standardization of health care quality measures across payers and accrediting agencies, provide additional technical assistance and reporting tools to under-resourced providers, and develop strategies that ensure universal provider inclusion in quality measurement, reporting, and transparency. In this way, CMS can minimize performance measurement and reporting duplication and reduce excess measurement and reporting burden.

8. How could CMS monitor and address unintended consequences under this concept, such as providers limiting access to care, inappropriate transfers, delay of services, or cost shifting?

This is an important concern that is not unique to rural providers. If all payers are included at uniform rates, then cost-shifting should be dramatically reduced. With a global prospective budget, the risk-managing organization will be incented to utilize the highest-value provider. However, the Panel wishes to emphasize that certain low volume or economically disadvantaged rural areas may not be able to provide *essential* services locally (e.g., public health care, emergency medical services, emergency care, primary care, rehabilitative care, and post-acute care) with payment based on historic fee-for-service rates. Therefore, the Panel recommends special payment policy consideration for a limited number of rural places to ensure reasonable access to essential health care services.

[3] National Quality Forum. Rural Health Report. http://www.qualityforum.org/Publications/2015/09/Rural_Health_Final_Report.aspx. Accessed May 2, 2016.

Access to health care services is of fundamental importance to rural people and places where travel burdens, geographic isolation, ethnic/cultural difference, and other barriers to health care are particularly acute. Therefore, the Panel recommends that CMS specifically include broad assessments of access in its quality and/or patient experience measurement and reporting system. Please see the Panel paper "Access to Rural Health Care – A Literature Review and New Synthesis" for details regarding assessing health care assess.

SECTION III: QUESTIONS ON POTENTIAL PARTICIPANTS AND POPULATION HEALTH ACTIVITIES

9. Please comment on the types of providers or the provider characteristics that could be interested in participating in this prospective budget concept. Please comment on whether participation among all providers within a region would be necessary for the concept to be successful.

The Panel recommends broad inclusion of providers committed to deliver value-oriented care. Participation among a variety of acute health care and health-related services providers is necessary to realize care coordination and management that improve population health and eventually reduce costs. Prospective budgets should include also post-acute care providers. The Institute of Medicine noted that geographic variation in health care expenditures was primarily due to post-acute care cost differences.[4] Programmatic shifts toward value-based payment should include both rural and urban providers (and multiple specialties) to deliver population-based quality. However, level of risk-bearing may vary by provider type. For some essential providers, down-side risk may be inappropriate. Instead, essential providers should be incented for delivering clinical quality and patient experience.

10. Please comment on how to incorporate population health activities in this concept. What are population health activities that could be included in a prospective budget that providers could be responsible for? How could the concept encourage collaboration among the community, including representation from patients and families, local government, non-hospital healthcare organizations, and non-healthcare organizations to determine these population health activities? How could CMS encourage participating providers to work with non-hospital providers and organizations to successfully manage the care, and the budget, for a defined population of beneficiaries?

The Panel is very pleased to see CMS's attention to local health-related collaborations. Medical care, public health activities, social services, mental and behavioral health care, and long term services and supports should be integrated to improve both physical health and social determinants of health. These collaborations are essential to population health improvement and efficient health care (and health-related service) resource use. Initial

[4] Committee on Geographic Variation in Health Care Spending and Promotion of High-Value Care. *Interim Report*. National Academies: Institute of Medicine. 2013.

prospective budget programs should include population health outcomes amenable directly to medical care. However, CMS should strongly encourage program rules that mandate local shared budgeting authority among health care providers, human service providers, patient/family organizations, and agencies implementing public health programs. CMS should provide technical assistance to support budget management and data sharing between organizations. CMS should develop and promote demonstrations that begin to combine health care and health-related services funding. Traditional relationships within rural communities will provide an excellent opportunity for CMS to test new collaborative governance models and blended funding streams.

11. Payer participation beyond Medicare FFS is critical in order to align incentives under a prospective budget and avoid cost shifting among payers. CMS is seeking input on how best to promote multi-payer participation of payment incentives and performance measurement. How could CMS encourage participation by other payers?

The Panel agrees with CMS that payer-participation beyond Medicare FFS is essential. This is especially important in rural areas where already low volume infrastructure cost and risk-bearing issues would be worsened if only Medicare FFS were involved in a prospective budget. The Panel encourages CMS to review the Maryland All-Payer system history for strategies that might be adaptable to other states. Furthermore, the Panel believes that standardized performance measurement and reporting standards (as recommended in comment II.7 above) for all payers and accrediting agencies can serve as an important step toward a cohesive delivery system. CMS should encourage the use of common reporting forms and processes.

SECTION IV: QUESTIONS ON POTENTIAL RURAL SPECIFIC OPTION

12. Should Critical Access Hospitals be included in a prospective budget concept and if so, how could Critical Access Hospitals be included? Please comment on whether there are special considerations for Critical Access Hospitals to be included in a prospective budget concept.

The Panel recommends that Critical Access Hospitals (CAHs) be included in a prospective budget that recognizes the challenges of providing care to rural populations. For example, prospective budgets will need to recognize the fixed "stand-by" costs necessary for emergency readiness or volume surges. As noted above, certain rural providers (such as CAHs) may not have the patient volume, organizational infrastructure, or risk-management experience to manage a total cost of care. Therefore, CMS should design program latitude that encourages CAHs to responsibly contribute to management of a prospective budget if not manage it solely. One alternative may be a stratified risk approach for CAHs, where a funding baseline is provided to cover fixed costs, and variable cost coverage is provided via value-based incentives.

The transition from cost-based reimbursement to a prospective budget deserves careful CMS consideration. CAHs require a financially reasonable "glide path" during the payment transition to ensure that access for rural beneficiaries and patients is not critically reduced. Maryland's *Total Patient Revenue* system allows hospital charge flexibility to maintain adequate cash flow during volume fluctuations, yet still requires year-end budget accountability. During the transition from Medicaid cost-based reimbursement to prospective payment in Oregon, the State employed a transition payment system in which CAH revenue increased less with volume increases, but decreased less with volume decreases. In effect, this new transitional payment system reduced financial losses associated with inpatient volume declines due to care management, but did not significantly reward inpatient volume increases.

13. What are the resources, support, or other features of the model that would be necessary in order to include rural acute care hospitals or Critical Access Hospitals in this concept? Would certain types of rural hospitals be better able to manage down-side risk than others? How could risk be structured to ensure Medicare savings, but also allow the rural acute care hospitals or Critical Access Hospitals to be successful?

The Panel believes that the prospective budget concept is an intriguing model that might help CAHs improve patient care and community health. However, due to unique rural situations such as low patient volumes and financial risk management inexperience, technical assistance or infrastructure support for CAHs (and rural networks) will be initially necessary to implement a prospective budget system that includes CAHs and other rural providers. Larger CAHs may have greater capacity to manage downside risk, but all rural hospitals should be given the opportunity to participate in this model through a phased-in approach that minimizes risk initially for all rural providers, and eliminates risk permanently for certain essential rural providers. As an alternative to down-side risk bearing, essential rural providers should be incented to employ care management and other techniques likely to reduce per capita costs.

The Panel believes that CMS payment and regulatory policies should consistently support better patient care, improved population health, and smarter spending while concurrently recognizing the value of reasonable access to care. Yet, data are not readily available to help health care leaders make informed decisions about which providers deliver the 3-part aim best, including lowest total cost for an episode of care (Part A, B, and D). Thus, CMS should support research, and make available the appropriate claims data and analytic tools, to thoroughly understand total cost of care comparisons at different hospital types.

14. What are ways for CMS, the rural acute care hospitals, or the Critical Access Hospitals to align partnerships with larger health care institutions to provide support such as specialty care, information technology and quality improvement tools?

The Panel notes that rural provider alignment with larger systems is essential to care for beneficiaries and other patients throughout the entire continuum of care. Telehealth should be encouraged through payment and regulatory policies. Electronic health record interoperability should be mandated in federal policy and inter-professional communication facilitated by robust health information exchanges. Joint ventures and other alignment models should be encouraged through demonstrations and regulatory relief (as in the Medicare Shared Savings Program). CMS should consider incentives for larger hospitals to work with CAHs and other rural providers such as increasing primary care reimbursements, including reimbursements for non-physician primary care providers. CMS should support templates and processes for developing inter-organizational "service agreements" between CAHs and larger institutions that memorialize what conditions and which patients should be cared for locally or at a distant facility. Multiple service agreements, pertaining to common clinical conditions, designed to ensure that patients receive the right care, at the right place, at the right time, will reduce the risk of inappropriate transfer or inappropriate local admission.

15. How could CMS best measure total cost of care and quality outcomes for individuals and population health for rural acute care hospitals or for Critical Access Hospitals?

For those conditions that both rural and urban providers treat, quality measures should not differ by geography. Similarly, population health metrics are important regardless of geographic location. However, the rural service mix is different than the urban service mix. Furthermore, certain communities may discover unique local conditions that deserve measurement and improvement. Importantly, the Panel recommends that various health care providers, including CAHs, be encouraged to work together to identify regionally important population health measures and identify each provider's role in advancing regional population health.

The Panel believes calculating total cost of care (with data analysis needs outlined in comment IV.13 above) will help quantify the value of robust local primary care. Robust primary care utilizes strategies from the patient-centered medical home model (coordinating and managing care with other providers and health-related community services) to realize optimal clinical quality, improved population health, and wise resource use. Thus, for effective rural inclusion in a prospective budget designed to ensure Medicare savings, primary care reimbursement should be increased. The Oregon Coordinated Care Organization program is illustrative. In the three years since program inception, the State of Oregon has met its target of reducing Medicaid spending growth to less than 3.4 percent. Per-member per-month spending on outpatient care was lower by 2.4 percent. However, outpatient spending trends masked a 19.2 percent increase in spending on primary care services.[5] Thus, greater investment in primary care resulted in reduced total cost of care.

[5] McConnell, JK. Oregon's Medicaid Coordinated Care Organizations. *JAMA*. Volume 315, Number 9. March 1, 2016.

16. For rural acute care hospitals and for Critical Access Hospitals, many services are appropriately referred or transferred to other facilities. How could appropriate versus inappropriate transfers or services provided be identified or monitored? How could this concept improve access to services not readily available in these rural areas?

The Panel believes that increased use of telehealth and service agreements (as outlined in comment IV.14 above) will help ensure appropriate transfers. Incentivizing telehealth consultation prior to transfer may help reduce inappropriate transfers. In addition, telehealth use throughout a patient's treatment course may provide access to services less commonly available in rural areas. Service agreements mutually designed by local and distant providers will help ensure that local services are used appropriately and that transfers occur appropriately. The Panel recommends designing service agreements based on health care value rather than based on historic referral patterns of convenience or tradition. Ensuring service agreement presence, assessing compliance with agreement terms, and measuring provider/patient satisfaction with transfer decisions may be one way to monitor for transfer appropriateness.

Thank you for the opportunity to comment on the CMS Request for Information on Concepts for Regional Multi-Payer Prospective budgets. For further information from the RUPRI Health Panel, please contact:

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