



May 13, 2016

Centers for Medicare & Medicaid Services,

SUBJECT: Request for Information on Concepts for Regional Multi-Payer Prospective Budgets

To Whom it May Concern:

The National Organization of State Offices of Rural Health (NOSORH) is the membership association of the fifty State Offices of Rural Health. Our mission is to work with the fifty State Offices of Rural Health to improve health in rural America. State Offices of Rural Health are anchors of information and neutral observers and conveners for rural health. They support collaboration, information dissemination and technical assistance to rural communities and health care providers across the nation including critical access hospitals, certified rural health clinics, oral health and other providers. More importantly their technical assistance efforts have been key to engaging critical access hospitals and other rural providers in voluntary quality reporting.

NOSORH submits these comments to ensure the unique needs of these rural providers and their important role in improving care for millions of rural Americans is understood.

Thank you for the opportunity to comment. If we can provide additional information on the impact of proposed regulations for rural and underserved communities please feel free to email [teryle@nosorh.org](mailto:teryle@nosorh.org) or call for assistance.

Sincerely,

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Executive Director  
National Organization of State Offices of Rural Health

## **NOSORH Comments - Request for Information (RFI) on Concepts for Regional Multi-Payer Prospective Budgets**

### **Overview:**

The National Organization of State Offices of Rural Health (NOSORH) strongly supports the efforts of the Centers for Medicare and Medicaid Services (CMS) to establish Regional Multi-Payer Prospective Budgeting demonstrations throughout the nation. NOSORH believes that such methods can be effective in rural areas and can provide incentives which lead to:

- improved health outcomes
- effective/efficient health treatment
- appropriate service utilization
- cost containment, and
- improved access to service for rural residents.

In rural areas it is particularly important that any payment system provide financial stability to low-volume rural health service providers/facilities. It is also important that any such system support efforts to fill gaps/shortages in the rural health system. NOSORH believes that appropriate Regional Multi-Payer Prospective Budgeting demonstrations in rural areas can achieve these goals. NOSORH urges CMS should to avoid a 'one-solution fits all' approach in establishing regional payment demonstrations and offers these comments highlighting issues which should be addressed in creating approaches for rural America.

### **General Comments:**

Section IV of the RFI *Questions on Potential Rural Specific Option* limits itself to exploring how Critical Access Hospitals and other rural acute care hospitals can effectively participate in regional multi-payer prospective budgeting methodologies. Supplementary questions in Sections I-III of the RFI also reference consideration of issues limited to rural hospitals. NOSORH believes that this is an overly narrow focus for regional multi-payer prospective budgeting demonstrations. NOSORH believes that demonstrations can be established in **rural health service areas** for **integrated networks of providers**. This could include - in addition to hospitals - private practices, rural health clinics, community health centers, home health services, and other appropriate providers. NOSORH believes that the questions of all the RFI sections need to be asked for entire rural health systems, not just rural hospitals.

NOSORH believes that rural health systems can be an effective test bed for alternative payment methods. In many rural communities it would be possible to enlist the entire provider community in a demonstration effort, something not easy to accomplish in larger urban communities. The inclusion of all providers would permit a clear assessment of the impact of an alternative payment method on health system performance and on the sustainability of an adequate health system.

### **Special Considerations for Rural Areas:**

NOSORH believes that successful Regional Multi-Payer Prospective Budget demonstrations can be established in rural areas, but that these demonstrations will need to respond to the special circumstances that exist in these communities. NOSORH has identified several considerations particularly important for rural health systems and has recommended approaches that will help make prospective budgeting demonstrations more successful. These are described below.

**Permit Flexible Definition of Rural Health Service Areas:** Local health care providers are in the best position to understand the patterns of the local health services market. **Regional rural health networks should be permitted broad leeway in defining rural health service areas for Regional Multi-Payer Prospective**

**Budget demonstrations.** As long as these service areas are non-discriminatory, local designation of the service area should be the rule.

Should they be needed, there are several standardized service area definitions that may be used as a starting point for definitions of these areas. The Dartmouth Atlas of Health Care has comprehensively mapped the United States into Primary Care Service Areas (PCSAs) based upon patterns of hospital admissions. These PCSAs are accepted by the Health Resources and Services Administration (HRSA) for various uses. HRSA also commissions state Primary Care Offices to specify comprehensive Pre-defined Rational Service Areas (PRSAs) as a locally defined alternative to PCSAs. Either of these definitions could be used as the building blocks in the specification of rural health service areas for APM demonstrations.

**Permit Flexible Definition of Health Provider/Facility Networks:** The Maryland All-Payer model is largely directed at hospitals and their associated services. Expansion of the approach to include other providers is relatively new territory, and there is much to be explored, particularly in rural areas. **Different configurations of rural health provider networks should be permitted** as Regional Multi-Payer Prospective Budget demonstrations, **including networks with hospitals, private practices, rural health clinics, community health centers, home health services, and other appropriate providers.** These networks should be locally defined.

It should be noted that HRSA has shown the success of different provider/facility network configurations in its **Rural Health Network** and **Rural Health Services Outreach** demonstration programs. The flexibility of these programs should be duplicated in the Regional Multi-Payer Prospective Budget demonstration to permit exploration of global budgeting for different types of provider networks. This could include global budgeting for primary care services, global budgeting for hospital and home health services, and global budgeting for outpatient and clinical preventive health services.

**Permit Flexible Combinations of Participating Payers:** Not all regional rural health networks will be able to gain the participation of all health payers in a prospective budgeting demonstration. Participation by payers will not be mandated, and individual payers must be recruited by the service network. Depending upon the area, different combinations of payers may be willing to participate. **Regional rural health networks should be allowed to conduct multi-payer demonstrations with whichever combinations of payers they are able to arrange.** These networks should be allowed to include Emergency Medical Services, an important component of rural health networks.

**Permit Limited Service Scope for Rural Prospective Budgets:** Many rural health systems do not include a comprehensive set of services for local residents. Patients may need to be referred outside the service area for specialty/subspecialty services. Similarly, they may need to be admitted into inpatient facilities in remote areas. These external services are not within the control of the local service system, and should not be included within the global budget for the rural provider network. Neither should performance measures associated with these external services be used in evaluating the rural health network. **The Regional Multi-Payer Prospective Budgeting demonstration should permit global budgeting limited to the service scope of rural health system.**

**Emphasize Payment Incentives for Rural Hospitals and Providers:** For Critical Access Hospitals (CAHs), rural acute care hospitals and other rural providers participating in rural health network prospective payment demonstrations, it will be important to **establish a system of payment which emphasizes performance improvement and which doesn't force inappropriate risk assumption** on fragile rural health care facilities. This is in line with the recommendations of the National Quality Forum (NQF) in its September 2015 report entitled **Performance Measurement for Rural Low-Volume Providers**. In that report NQF recommends an incentive system which emphasizes achievement and improvement for rural providers, limiting the downside penalties for the low-volume safety net in rural areas. A fuller description of relevant NQF recommendations is included in the Summary section of these comments.

There are several models of appropriate mechanisms for managing risk assumption. In Oregon's efforts to achieve health reform the Oregon Health Authority (OHA) examined how CAHs could participate in alternative payment methodologies. OHA is considering use of a decision tree analysis which, based upon assessment of several indicators, will determine whether a CAH is financially stable enough to take on downside risk. As part of this process there would be regular reviews of hospital financial health and consideration about whether the CAH should be shifted back from alternative payment mechanisms. This is the type of procedure which will be useful in building downside risk into rural payment mechanisms.

**Make Provision for Adjustment of Prospective Budgets in Areas of Service Shortage:** In a health system where there is an adequate supply of health services prospective budgets could be based upon current consumer expenditures and provider revenues. All this changes, however, when there are significant health services gaps or shortages. To the degree that there are significant service shortages, consumers may be unable to get the services they need, and their use of services may be at lower than appropriate levels. In these situations prospective budgets based upon current expenditures and revenues will be lower than the budgets needed to successfully meet local needs. Prospective budgeting must include adjustment provisions that permit local health systems to increase capacity to meet local needs.

This type of adjustment is particularly important for rural areas. Many rural communities are in primary care Health Professional Shortage Areas (HPSAs) designated by HRSA. In these HPSAs there is typically less than half the primary care supply needed to meet the needs of local residents. For example, HRSA might recognize the need for six full-time primary care physicians in an area to meet the basic needs of all residents. A true prospective budget for primary care in this area should reflect the costs of operating a six physician practice. If there are only three physicians, basing a prospective budget on their current revenues would likely understate the true cost of providing needed services.

Initial prospective budgets for rural health systems in shortage areas can be established based upon the existing service capacity. There should be provision, however, for **expansion of the base budgets to allow addition of new providers so that shortages can be eliminated**. Prospective budget expansions could be made contingent upon system expansions with regular reviews of service system capacity. This would allow the regional multi-payer model to support the expansion of access to health services in shortage areas.

**Include Regional and Inter-Regional Care Coordination Services in Demonstrations:** Care coordination services are important for improved performance of rural health systems. These services include a range of different activities including medical home services, referral management, and targeted services for high risk and chronically ill patients. These services can assure continuity of care within a region as well as continuity of care between local care providers and out of area providers. This latter, inter-regional coordination is particularly important in rural areas where many services are provided on out-of-area referral. Inter-regional care coordination includes discharge planning from out-of-area facilities so that patients can be effectively reintegrated upon their return to the local service system.

Multiple demonstration projects have shown the importance of care coordination for rural health. In many instances interventions by non-clinical personnel have led to improved health outcomes, reductions in inappropriate service use, reductions in unnecessary hospitalizations and reduced total service cost. Community Care of North Carolina (CCNC) is an excellent model of regional efforts to provide coordinated care. CCNC has shown its ability to improve health system performance, including a reduction of health care costs.

**Funding for care coordination should be included as part of a regional prospective budget.** This will likely be an add-on to the current cost of care. The CCNC model may be a good model for how this can be done. Under the CCNC model, funds are derived as a set-aside from the overall Medicaid budget. CCNC supports community-based care coordination as well as coordination payments to individual providers. The use of provider payments and shared care coordinators appears to be an effective combination. As mentioned previously rural health networks have fewer in-region specialty resources than do urban-based networks. The regional rural health network must appropriately coordinate specialty care referrals as well as out of area hospital referrals. As part of this care transition coordination **there needs to be a mechanism to monitor the appropriateness of out of area referrals to guard against inappropriate transfers and cost-shifting.** This includes monitoring of hospital discharges from out of area facilities. Good outcomes require that patients returning to the community from distant specialists and hospitals be reintegrated into the local service system.

**Include Funding for Population Health as Part of a Regional Prospective Budget:** There are a range of wellness, prevention and health education services which can improve the health of a rural population. These services can be broadly targeted for the general population or more narrowly targeted to populations at higher risk for poor health. In addition, wellness, prevention, and health education services can be targeted to keep those with chronic disease or disability as healthy as possible, reducing unnecessary use of treatment services.

Population health services for the general population include clinical preventive services, routine screenings, and general health education. While some of these services can be delivered in a clinical setting, others are more cost-effective when delivered to groups or target markets as a whole. Many of these services are delivered by county or state-based public health agencies, and funded under the Preventive Services Block Grant, the Maternal and Child Health Block Grant and categorical grant programs of the Centers for Disease Control and Prevention. The activities may be conducted by staff of public health agencies separate from staff in a regional rural health network. This separation of funding and delivery makes it more difficult to integrate general population health improvement services as part of a multi-payer regional prospective budget demonstration.

A separate set of population health services can be targeted for the at-risk population, including pre-diabetics, individuals with high cholesterol, overweight and obese individuals, smokers and those with elevated blood pressure. These services can include specialized health education, screening and clinical services designed to help them manage their risk conditions. Population health services can be tailored for the at-risk patients of a rural regional health network and included in a prospective budget demonstration.

Population health services can also target those individuals with chronic disease or disability. These services can include specialized health education, monitoring and appropriate clinical services. A discussion of these services is included in the previous section describing care coordination.

Investments in population health can be very cost-effective, particularly in the long run. For this reason **NOSORH recommends that spending for population health be included in prospective budgets for regional multi-payer demonstrations.** Funding for population health in rural communities is generally inadequate to meet community health needs on a comprehensive basis. NOSORH recognizes that additional funding above currently funded levels will be required. Funding will need to be directed both to clinical settings and to a separate population health staff shared by members of the rural health network. This model can include, but must go beyond a medical home model.

**NOSORH recommends that, at a minimum, rural health networks be encouraged to include population health services directed to at-risk and chronically ill patients served by a regional rural health network.** This approach will ensure a good return on the investment in population health. In addition, **NOSORH recommends that, to the degree possible, prospective budgets include support for population health activities directed at the general rural population, to be coordinated with the efforts of the local public health infrastructure.**

#### **Summary:**

NOSORH's recommendations are consistent with the recommendations of the National Quality Forum (NQF) in its September 2015 report entitled **Performance Measurement for Rural Low-Volume Providers.** In this report NQF sets out multiple considerations for alternative payment methods if they are to be effective in rural communities. Specifically, NQF recommends:

- Encouragement of voluntary groupings of rural providers for payment incentive purposes;
- Development of rural specific performance measures and comparison standards; and
- Use of payment programs emphasizing performance incentives over penalties.

NOSORH's recommendations extend the thinking included in NQF's findings. NOSORH believes that the principles developed by NQF in its deliberations should be used by CMS in the development of guidelines for Regional Multi-Payer Prospective Budget demonstrations in rural areas. These principles provide insight into what would be successful in Rural America.