NOSORH

National Organization of
State Offices of Rural Health

May 25, 2018

Centers for Medicare & Medicaid Services

Subject: Request for Information on Direct Provider Contracting Models

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 on quality improvement, efficiency and access to care, among many other topics. State Offices of Rural Health are dedicated to ensuring the health and vitality of rural communities and health care providers across the nation including critical access hospitals, certified rural health clinics, oral health and other providers.

NOSORH believes that Direct Purchase Contracting between payers and providers has substantial potential for rural and frontier communities. NOSORH believes that DPC is an approach which, if properly implemented, can lead to improved cost-effectiveness in health services for rural/frontier community residents. DPC can readily be implemented in many rural/frontier communities for both Medicaid and Medicare enrollees. In addition, given the number of private insurers who are also Medicaid managed care contractors, DPC can also be extended into the private insurance market.

Thank you for the opportunity to comment. If we can provide additional information on the impact of proposed regulations for rural and underserved communities and the providers who serve them please feel free to email teryle@nosorh.org or call for assistance.

Sincerely,

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NOSORH Comments on CMS Request for Information Related to Direct Purchase Contracting

Overview

On April 23, 2018 the Centers for Medicare and Medicaid Services (CMS) issued a Request for Information (RFI) seeking input on how Direct Purchase Contracting (DPC) between payers and primary care or multi-specialty group practices might be implemented. CMS is seeking comment to inform potential testing of this approach within the Medicare fee-for-service (FFS) program, Medicare Advantage, and Medicaid programs. In this communication the National Organization of State Offices of Rural Health (NOSORH) makes specific comment and recommendation related to this RFI.

For DPC to be successfully implemented in rural/frontier communities NOSORH believes that CMS must take into account the unique circumstances of rural/frontier health systems. In the comments presented below NOSORH highlights key factors which should be considered and suggests specific approaches for assuring that a DPC demonstration will be successful in rural/frontier communities. The comments emphasize the use of DPC for primary care, but the recommendations can be extended to its use for multi-specialty practices.

Key Considerations and Recommendations

Size of Demonstration Project Population: NOSORH believes that DPC can be implemented in fairly small rural communities, particularly where the demonstration is for both Medicare and Medicaid populations. Where Medicare ACOs are geared to enrolled populations of at least 5,000 individuals, successful direct purchase contracting for primary care services could be implemented for enrolled populations measured in the hundreds.

NOSORH recommends that CMS be flexible on the minimum enrolled population requirements for DPC pilot and demonstration projects. Consideration of small demonstration project population will permit appropriate participation of rural projects.

Eligible Demonstration Project Applicants: NOSORH believes that payment innovations such as DPC should help sustain the capacity of local rural health systems. In line with this **NOSORH recommends that smaller community-level and multi-county groups of providers - including private practices, Federally Qualified Health Centers and Rural Health Clinics - be the focus of any DPC demonstration.**

NOSORH also believes that the greatest potential for successful DPC is in primary care including: family/general practice and the primary care specialties of pediatrics, obstetrics/gynecology and general internal medicine. Consistent with this **NOSORH recommends that CMS give priority to primary care focused applicants in any DPC demonstration.**

Provider Risk Assumption and Incentives: NOSORH believes that both risk-assuming and risk-insulated DPC demonstration projects can be successful. The most significant project cost savings will come from reductions of preventable hospitalization, transport and emergency department use. As a result, it is generally less important to put outpatient practitioners at risk for the cost of their services. Instead, it will be more important to **link payment incentives to the reduction of total costs for their patients**. These upside incentives can be established without putting outpatient practices at inappropriate risk. It should be noted that the reduction of inappropriate service use will often be associated with improved health outcomes. Some practitioners may be willing to assume some level of downside risk. Given the fragility of the health service system in many rural and frontier communities, however, it may not be beneficial in the long term to encourage the potentially inappropriate assumption of risk.

NOSORH recommends that CMS permit both risk-assuming and risk-insulated DPC demonstrations. NOSORH also recommends that CMS promote demonstrations with incentives linked to the reduction of preventable costs and the improvement of health outcomes.

Categories of Clinical Service in Demonstration: Rural health systems can contain very different mixes of services. These differences are most pronounced between small-town rural areas and large-town rural areas. Some local rural health systems may be limited to general/family practice services. Other local rural health systems may have significant capacity, including all primary care specialties and key medical sub-specialties. Some rural health systems may have only limited local radiologic and laboratory capacity, while others may have substantial capabilities. For evaluation purposes it will be useful to compare the performance of DPC projects covering similar mixes of services.

NOSORH recommends that CMS define separate clinical service categories for its DPC demonstration program. One category could be for practices that exclusively offer family/general practice services. A separate category could be for practices with a mix of primary care specialties. A third category could cover practices offering non-primary care medical subspecialties. Different levels of laboratory and radiologic services can be established as options, as well as different levels of pharmaceutical services.

It should be noted that there likely will be a different cost of care associated with projects in different clinical service categories. For example, practices which include specialties and subspecialties, where practitioners command higher compensation than family practitioners, will generally be more costly. This can increase the base cost of a demonstration project. Similarly, decisions to include a wide range of pharmaceuticals in the base operations of a project can have a substantial impact on its overall cost. This is particularly true for drugs needed by individuals with chronic disease.

Given the wide range of possible services that might be included in a demonstration project, **NOSORH recommends separate evaluations for each project category.** This approach may provide insight into which service mixes have the greatest potential for successful DPC.

Special Consideration for Maternity Care: The inclusion of maternity care in a demonstration project can create special challenges and complications. These must be considered in the implementation of any Medicaid DPC demonstration. The inclusion of maternity care will significantly add to the average cost of a primary care practice. The World Health Organization recommends that pregnant women have at least 8 prenatal care visits. Recommendations for prenatal visits in the United States can exceed this number. In this manner, during pregnancy, the utilization and cost of services by pregnant mothers can greatly exceed the typical use and cost of services by other patients. In addition, inclusion of prenatal care in a practice's offered services can substantially increase the cost of its malpractice coverage. The malpractice increase is normally independent of whether the practice also performs deliveries.

NOSORH recommends that CMS create a special category of DPC demonstration for those proposed projects which seek to include Medicaid or private insurer maternity care. There are many potential positive impacts for such projects. Some research has shown that for every dollar invested in high quality prenatal services, there can be as much as a five-fold return on investment. Much of the savings will be in the reduction of low-birthweight births with their concomitant inpatient and specialty service costs. Investments in prenatal care for high risk pregnancies are particularly effective. A DPC model which includes maternity care can be a valuable outcome of the proposed demonstration program

Inclusion of Non-Clinical Services in Demonstration: Non-clinical services can contribute to reduced health care costs and improved patient health. These services include both **practice-based patient services** such as those in a primary care health home, as well as **community-based health worker services**. These two categories of service can assure both continuity of health care for patients as well as social supports addressing the determinants of health. NOSORH believes that a combination of both practice-based care coordination and community-based patient support will produce the best results – both in terms of cost containment and improved health outcome.

The experiences of Community Care of North Carolina provide evidence for the potential of this combined approach. Medicaid funding supports a per-beneficiary per-month payment to practices for care coordination of their Medicaid patients. Medicaid funding also supports funding for community-based patient support services. Evaluation has shown that these combined services are a cost-effective addition to Medicaid-covered clinical services.

NOSORH recommends that CMS permit the inclusion of both practice-based and community-based non-clinical services as part of the demonstration, with sufficient funding to assure adequate levels of these services.
It should be noted that Medicaid has supported a large number of care management efforts with capitated payment for non-clinical and clinical care management. A summary of some of these can be found at the following link:

https://www.urban.org/sites/default/files/publication/66136/309064-Medicaid-Managed-Care-Payment-Methods-and-Capitation-Rates.PDF

The lessons of these efforts should be considered in any DPC demonstration.

Payment Risk Adjustment Mechanism: NOSORH believes that it is important to have risk-based adjustments to any per-beneficiary per-month payment rates used in DPC demonstrations. These should take into account the requirements of high-risk and high service use patients and the resulting differences in service cost. The risk adjustments can be applied to both clinical and non-clinical services. The risk adjustments can also be made for maternity care patients and patients with chronic conditions, including diabetes, heart disease, and high blood pressure, COPD, emphysema, and HIV infection.

Accordingly, **NOSORH recommends that CMS establish a risk-adjusted payment methodology for DPC demonstrations. NOSORH also recommends that CMS be flexible in its approach to risk adjusted payments to accommodate a range of potential payment innovations.**

Adjustments for Underserved Areas: Areas with shortages of providers present a special challenge for health service innovation. When demand for health services significantly outstrips the capacity of local providers, these providers must triage service requests. Often this leads to a difficult choice – a provider must either provide limited care to many patients or provide comprehensive care to fewer patients. In any demonstration seeking to reduce overall patient cost and improve health care outcomes the special challenges of underserved areas must be taken into consideration.

Underserved areas are a particular concern for rural health. While only about 20% of the US population lives in rural areas, **more than half of all rural/frontier counties are designated**, in whole or in part, as primary care Health Professional Shortage Areas (HPSAs). For a DPC demonstration to be successful in underserved rural/frontier areas, NOSORH believes that special payment and evaluation accommodations need to be implemented.

NOSORH recommends that CMS establish special payment consideration for DPC demonstration projects in underserved areas. NOSORH also recommends that CMS establish separate performance targets for DPC demonstration projects in these areas.

It should be noted that CMS currently recognizes the unique needs of underserved areas with special fee-for-service payment mechanisms. These mechanisms include the Medicare physician bonus payments for physicians providing services in Health Professional Shortage Areas. Similar adjustments for any DPC demonstration would be a natural extension of this approach.

Comprehensive Cost-Savings Measurement in Project Evaluation: NOSORH believes that the measurement of cost savings in a DPC demonstration project should recognize a ***comprehensive*** set of measures. The assessment of a project's cost savings should not be limited to outpatient service savings. Cost-saving measures should include savings resulting from reductions in preventable hospitalization, emergency department use, transport – both emergency and non-emergency - and pharmaceutical costs. The accurate measurement of savings from preventable transport is of particular importance for rural communities. The analysis of cost reduction should drill down and separately

examine preventable costs for different groups of high-risk or high-cost enrollees, including those individuals with chronic diseases.

NOSORH recommends that CMS, in its evaluation of primary care DPC projects, establish a preventable cost measurement schema that includes a comprehensive range of health care cost savings. NOSORH also recommends that cost-saving assessment be conducted for key project subpopulations, including rural/urban residents and individuals in different high-risk, high-use categories.

Measurement of Consumer Cost-Savings: NOSORH believes that the measurement of health service cost should include **total** cost – the cost borne by both service providers ***and*** consumers. This is important for accurate evaluation of rural DPC projects. Rural residents have significant transport costs not faced by urban residents – travel costs required to utilize a health service. This is particularly true for those services, such as specialty services, which are only available through travel outside of the local community. It is not uncommon for rural residents to face a two-hour roundtrip drive to secure outpatient specialty services. This can often mean a personal travel expenditure exceeding co-pay cost of the medical visit.

Consumer-paid transportation costs are generally left out of analyses of health service cost. These transport costs are borne by the individual, and are generally not reflected in payment data. The exception is for ambulance, safe-ride and air transport services, which may be reimbursable by Medicaid and some private coverage.
NOSORH recommends that CMS include an estimate of consumer-borne preventable transport costs in the evaluation of the cost-effectiveness of DPC demonstrations.