NOSORH Comments on Direct Contracting - Geographic Population-Based Payment Model Option

Overview:

The Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services recently released a Request for Information (RFI) related to the Direct Contracting - Geographic Population-Based Payment (PBP) Model Option of its new accountable care initiative. This RFI seeks additional input from the public regarding their perspectives on specific design parameters for the Geographic PBP model option.

The National Organization of State Offices of Rural Health (NOSORH) was established in 1995 to assist State Offices of Rural Health (SORH)s in their efforts to improve access to, and the quality of, health care for over 60 million rural Americans. All 50 states have a SORH, and each SORH helps their state's rural communities to build effective health care delivery systems.

NOSORH sees potential for rural health care providers in several of the options set out in the latest CMS initiative including the Geographic PBP option. NOSORH is supportive of the direction signaled in the new programs. NOSORH views the options in the initiative as generally consistent with the ***CMS Rural Health Strategy***. In that document CMS commits to applying a 'rural lens' in the assessment of its programs and policies. The Strategy seeks to find ways to *improve service delivery and payment models in rural areas* and to *improve access to services and providers for residents of rural communities*. NOSORH believes that there are several ways that the options, including the Geographic PBP model, could potentially improve rural health service access and rural health system capacity and rural health system stability. NOSORH provides these comments to help provide a rural perspective on the possibilities of the proposed geographic population-based payment model.

NOSORH believes that rural health systems can provide a ***natural test bed for Geographic PBP*** approaches. When compared to complex systems in urban areas, the smaller size of the rural health systems permits more likely participation of all health care providers within a geographic service area. In addition, the smaller health system size makes it simpler to make changes to improve practice operations. Finally, the smaller number of a rural area's participating patients will make measurement of performance outcomes easier.

In a recent policy statement entitled "Putting our Rethinking Rural Health Strategy into Action", CMS Administrator Seema Verma summarizes progress on the CMS Rural Strategy. She describes how the Geographic PBP model is envisioned to include rural areas.

> "One of the new payment models, ***the Direct Contracting model, includes an option for innovative organizations to take on financial risk in a defined region, which could be an option to support rural transformation of care***.

> Driving accountability to a local level empowers communities to devise strategies to meet their unique health care needs. We are ***seeking public comment through a new Request for Information and welcome your insights on how to ensure the Geographic Option of Direct Contracting works for rural areas***."

This comment was encouraging for NOSORH and its constituents. It aligns with the NOSORH belief that Geographic PBP models are a good potential fit for some rural areas. It was with some disappointment, however, that we noticed the following requirement delineated in the Geographic PBP:

> "CMS intends to allow an applicant to propose a target region for CMS approval, subject to certain requirements, including but not limited to that ***the target region must have a minimum of 75,000 Medicare beneficiaries residing within the target region***, yield or exceed minimum savings targets in the form of a discount which we currently contemplate would be on the order of 3-5%, align with administrative (e.g., city, county) and/or statistical (e.g., MSA) geographic units, and factor in the natural boundaries of the target region and health care seeking patterns of the Medicare FFS population within that region."

NOSORH believes that these constraints may seriously limit the participation of rural health providers, and that the minimum beneficiary threshold will eliminate many rural areas which might otherwise participate. NOSORH recommends that that this minimum threshold be modified to a much lower level. It submits these comments in the knowledge, based upon Administrator Verma's statements, that the Geographic PBP can be adjusted to fit the needs of rural areas.

NOSORH has additional concern, however, that certain aspects of the proposed Geographic PBP approach may not reflect the realities of rural health systems. NOSORH is concerned with the issue of downside risk assumption. While downside risk assumption is reasonable for some rural providers, inappropriate downside risk assumption may be unacceptable to financially fragile rural providers. NOSORH is concerned that the general outlines of the model do not adequately address the special performance challenges of health service shortage areas. Health system performance can be compromised by health service shortages and measurement of performance should be adjusted to take this into account.

NOSORH believes that some changes can make the Geographic PBP direct contracting approach a better fit for rural areas. NOSORH's observations and recommendations are detailed below.

Issue: Rural Service Integration With External Health Care Providers

Analysis: As discussed previously, rural areas are natural candidates for implementation of ***geographic area population-based payments***. There are generally a smaller number of providers in a rural area than in urban areas, and it can be easier to

restructure both systems of care and administrative operations. Coordination of care between rural health care providers and local human services will generally be less complex than it might be in urban areas with multiple social service offices. Some rural communities may have only one local hospital, making it easier to make improvements to admission and discharge processes. This is particularly important for preventing unnecessary readmissions. With these advantages, rural areas can be an attractive testbed for population-focused payment systems.

While rural areas have an advantage in coordinating care within the rural health system, they face a major challenge in ***coordinating care with outside service providers***. Rural area health systems must establish coordination mechanisms both with ***out of area specialists*** and with ***out of area hospitals***. Without effective coordination with these external health care systems, performance improvement and accountable care for rural areas are not possible.

Many rural areas do not have key specialists, particularly those specialists required for the treatment of chronic illness and disability. Patients must receive specialty care from key out of area providers, including cardiologists, gastroenterologists, urologists, pulmonologists, rheumatologists, and endocrinologists. ***Coordinated specialty care plans*** must be established that link local providers in rural areas with external specialists. This is necessary to assure optimum patient outcomes. Local providers must have referral arrangements with a range of out of area specialists. Local providers must also have complete information on the diagnostic tests and treatments received by their patients from external specialists. Finally, local providers must have full information on the specialist treatment plans for their patients and a clear definition of how they will participate in follow up care for their patients in the home community. Without these arrangements, continuity of patient care is not possible. When rural community providers and external specialists are not part of the same health care system, special processes must be established.

In a similar manner, local providers must have coordination procedures with external hospitals. Local hospitals in rural communities often have limited scopes of inpatient services. Inpatient specialty services, such as orthopedics, specialty surgery, and cardiac interventions, will often require referral to out of area facilities. ***Coordinated inpatient care plans, including integrated discharge plans*** must be established between external hospitals and local providers in rural communities. This is necessary to assure optimum patient outcomes. Local providers must have complete information on services delivered to their patients in out of area hospitals. They must have full information on discharge plans and must be able to coordinate those plans with the patient's overall plan of care in the home community. Finally, local providers must have a clear definition of how they will participate in follow up care for their patients, including how they will coordinate with any home health care. Without these arrangements the risks of discontinuous care, poor patient outcomes and unnecessary hospital readmissions are increased.

Recommendation: NOSORH recommends that CMS ***include requirements for service integration with external providers and facilities*** as part of its guidance for rural health systems participating in Geographic PBP demonstrations. NOSORH also

recommends that CMS build the cost of these new coordinated systems into the payment rates for these demonstrations.

Issue: Value-Based Payment and Health Provider Shortage

Analysis: Most CMS value-based payment schemes do not include ***consideration of the impact of health provider shortages***. This blind spot extends to all five of the payment alternatives in the new initiative. These demonstrations implicitly assume the availability of an adequate service supply for the Medicare eligible population. In truth, many parts of the country have health service shortage, including critical shortages of primary care. Federally designated Health Professional Shortage Areas (HPSAs) are documented as having less than half the primary care services needed for an area's population. Many HPSAs are rural, and the lack of access in these areas is a particular concern.

Health provider shortage has direct impact on patient outcomes and service performance. Being unable to meet the needs of all local residents, providers in shortage areas must make decisions that reduce demand to meet available supply. Some providers prioritize one group of patients over others. For example, higher reimbursements of private insurance may lead a provider to give priority to these patients at the expense of Medicare or Medicaid patients. Other providers triage patients based upon acuity of health problems. This can lead to a reduction of preventive screening and clinical services for healthier patients. Ultimately the result is delayed or foregone care for some patients.

Delayed or foregone care in shortage areas results in a level of ***suboptimal service utilization for patients*** that is lower than service utilization for patients in areas with an adequate service supply. This means that both the *historical outpatient service utilization* and the *historical service cost* for a population in a shortage area are distorted and appear lower than the figures for an equivalent population outside of a shortage area. The use of an artificially lower baseline will distort a value-based performance assessment.

Delayed or foregone care can mean that patients are sicker when they finally arrive for services. Sicker patients can require more extensive and costlier care. This can raise the total cost of care for patients compared to similar patients outside shortage areas. This distortion creates an additional challenge for value-based payment schemes.

Some patients in a rural shortage area may respond to the lack of local service capacity by seeking part of the care they need from providers outside the local community. This consumer behavior can create a special challenge for Geographic PBP. Under the Total Care Capitation payment mechanism CMS will be responsible for the cost of this care provided outside of the geographic region. This will create a distortion in the true cost of care for local residents covered by Medicare.

A more serious problem for Geographic PBP would be created when rural health systems in shortage areas make efforts to increase their capacity to provide services. Under a shortage, some patients will not seek the care they need. With more capacity available locally, patients will increase their utilization of these services. This will appear as an increase over the baseline utilization for these patients and may lead to an increased cost of care. The increased cost of care for Medicare patients could result in financial loss for providers under the Geographic PBP. This can create a situation where, paradoxically, local providers are penalized for expansions that better meet local needs.

Recommendation: NOSORH recommends that CMS make adjustments to the Geographic Population-Based Payment Model Option that ***reflect the impact of health provider shortages*** and ***provide incentives to improve shortage area service capacity.***

Geographic PBP systems must recognize the impact of health provider shortage on patient utilization. On the one hand, the utilization and health status baselines of participating patients should be adjusted to reflect the effects of health service shortage. In addition, both capitated payments and performance penalty/bonus payments should be adjusted for these shortages. Finally, special payment mechanisms should be added to give providers an incentive to increase the capacity of their practices to meet local demand. Without such incentives, local residents, including Medicare beneficiaries, will continue to receive levels of care inadequate for their needs. This runs counter to CMS efforts designed to improve health and reduce the total cost of health care.

Issue: Appropriate Assessment of Savings and Losses

Analysis: NOSORH believes that CMS should, in the development of the Geographic Population-Based Payment option, reflect three key factors important to rural health systems:

- **Savings/loses should be linked to services provided:** Savings and losses should be limited to those which are *directly attributable* to the participating providers. Total cost of care is not a realistic reflection of savings and loses for many rural health systems. The total cost of care for rural area patients may depend on the decision-making of external specialty providers and hospitals, who are not participants in the accountable care demonstration. To hold participating rural health care providers accountable for those decisions would be inappropriate.

- **Risk assumption by rural providers should be limited:** Losses assumed by rural health systems cannot be so great as to threaten the continued provision of services in rural areas. Many rural health systems are financially fragile. Arrangements which require assumption of 100% of losses by rural providers may challenge rural service sustainability. Rebuilding a rural health system from

scratch is very costly. Any loss arrangement which reduces rural health system sustainability runs counter to the aims of the CMS Rural Health Strategy.

- **Cost of care calculations should include patient costs**: Calculation of the total cost of care must include the costs which accrue to patients in the use of that care. Cost of care cannot be limited to the costs borne by Medicare, insurers, or other third party payors. This is particularly important in rural communities where patients must often assume significant costs of transportation to access health care. The cost of this transportation can be substantial, and efforts that reduce unnecessary travel are an important part of total cost reduction. For example, the use of remote home monitoring and telehealth by rural patients can reduce office visits and substantially reduce the total cost that would be accrued otherwise.

The payment mechanisms currently outlined by CMS for the Geographic Population-Based Payment Model Option may not fully incorporate these considerations. The Total Care Capitation payment mechanism can lead to appropriate attribution of benefits and risks, but there is no limitation of risks that might threaten rural health system sustainability. In addition, that payment mechanism does not incorporate consideration of the patient component in health care cost.

Recommendation: NOSORH recommends that ***CMS implement a flexible set of payment mechanisms*** more accommodating of the realities faced by rural health systems. This should include mechanisms that account for *savings of patient costs* and approaches that *limit risk for fragile rural health systems*.

NOSORH also recommends that CMS consider alternative payment approaches, including ones based upon the global payment demonstrations in Maryland and Pennsylvania. An approach which *combines a global base budget with incentives for improved outcomes, performance and cost containment* might be a good fit for rural areas.

Summary:

NOSORH believes that a Geographic Population-Based Payment mechanism can be crafted that is appropriate for rural areas and rural health systems. The current plan to limit participating target regions to those with 75,000 Medicare beneficiaries ***must be changed to permit participation of rural areas with much lower numbers of Medicare beneficiaries***. In addition, to be successful in rural areas, NOSORH believes that a Geographic PCP mechanism must:

- Provide appropriate resources to assure a service supply adequate to meet local demand.
- Provide adequate resources for coordination of care between rural health systems and out of area health care providers.

- Provide appropriate incentives for optimal service utilization, improved patient health, and reduced cost, including consideration of patient cost.
- Eliminate inappropriate financial risk that would threaten rural health system sustainability.