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May 13, 2016

Andy Slavitt

Acting Administrator

Centers for Medicare and Medicaid Services

Hubert H. Humphrey Building

200 Independence Avenue, SW, Room 445‐G

Washington, DC 20201

**Re: Center for Medicare and Medicaid Innovation: Request for Information on Concepts for Regional Multi-Payer Prospective Budgets**

Dear Administrator Slavitt:

The National Rural Health Association (NRHA) is pleased to respond to the request for information (RFI) regarding the Center for Medicare and Medicaid Innovation (CMMI) concepts for regional multi-payer prospective budgets. We appreciate your continued commitment to the needs of the 62 million Americans residing in rural and underserved areas, and look forward to our continued collaboration to improve health care access and quality.

The National Rural Health Association (NRHA) is a non-profit membership organization with more than 21,000 members nation-wide that provides leadership on rural health issues. Our membership includes nearly every component of rural America’s health care infrastructure, including rural community hospitals, critical access hospitals, rural clinics, doctors, nurses and patients. We work to improve rural America’s health needs through government advocacy, communications, education and research.

NRHA shares CMS’s overall goals of a multi-payer approach in order to improve quality, including population health outcomes, and providing participating providers clear revenue expectations which will lead to transforming the health status of rural communities. Rural populations and their providers of care are faced with challenges that cannot be ignored and will be detailed herein. However, NRHA urges CMS to commit to designing or expanding State Innovation Model (SIM) demonstration projects to a regional multi-payer approach, including Medicare, and meaningfully include rural providers into such demonstrations. NRHA will work with CMS to design a demonstration based on a multi-payer regional budget approach such that it will achieve the desired goals we all share.

Having committed to our desire to work with CMS on a project of this nature, NRHA has observations on a multi-payer approach and what needs to be taken into account in order to design an effective program First, the overall financial viability of rural hospitals is a particularly pressing concern due to continued Medicare cuts that have resulted in negative Medicare margins. This has resulted in seventy-two rural hospital closures since 2010. Right now, 673 additional facilities are vulnerable and could close—this represents over 1/3 of rural hospitals. The rate of closure has steadily increased since sequester and bad debt cuts began to hit rural hospital - - resulting in a rate six times higher in 2015 compared to 2010. Medical deserts are appearing across rural America, leaving many of our nation’s most vulnerable populations without timely access to care. When these rural hospitals close, communities lose access to necessary local emergency services.

Secondly, while a predictable revenue stream is a useful tool for rural hospitals, it is only useful to these hospitals if it clearly outlines what services are to be provided, properly establishes a budget sufficient to provide the necessary care, provides sufficient flexibility to achieve the goals of better value care, and works within the whole system of health care. The new payment system must take into account the special characteristics and vulnerabilities of rural hospitals and communities. If the system is properly developed, rural hospitals are a natural fit for a multi-payer system developed through CMMI since the majority of rural communities serve a large portion of Medicare and/or Medicaid patients. The inclusion of the Veterans Administration (VA) eligible veterans is an important component as well, since rural Americans are disproportionately represented in this population and these rural veterans face greater challenges than urban peers in receiving the necessary care to which they are entitled. Finally, because the lack of insurance choice in rural America is often problematic for rural patients, the development of a multi-payer system may make the process of integrating all payers (or at least the majority of payers) less complicated.

Third, the development of the program must include extensive consultation with researchers that have or can empirically study the impact of the very divergent types of rural facilities. Specifically, it is important to understand the sustainability needs of the very different types of rural facilities, such as, rural PPS hospitals; critical access hospitals; hospitals that are geographically diverse; frontier hospitals; hospitals that financially struggle; and hospitals that serve disproportionately poor and sick populations.

Fourth, it is also important to understand that buy-in from payers is not enough to make this concept work. Ultimately, community buy-in including providers, patients, and community leaders will be necessary for success. Any system developed would need to gain voluntary community support before participation could be successful. Tools for meaningful Community Health Needs Assessment (CHNA) would be a process that is an important foundation to a multi-payer concept. This process will require not only presenting an overview of how the program is intended to work (or how it worked for others) but would need to demonstrate how it would be a viable option for that specific community. Community buy in will require the availability of comprehensive tools for the communities to determine reasonable good faith estimates of the financial aspects specific to their community. Even more importantly, there will need to be a clear methodology for the community to understand the clinical implications including an understanding of what service lines would be retained and how the entire scope of care would be preserved.

However, the question is not just for a single community, the concept of the regional budget requires the determination of what is included in that region. The regional definition must take into account the available health care resources, the geographic spread of patients, and the payer mix of each facility. What works in one area may not be appropriate in another. Since the regional budget would be a CMMI demonstration, a single definition is not required. NRHA urges CMMI to utilize its flexibility to allow communities and regions to self-define, for some that may be an MSA or a referral area, for others it will involve agreements between facilities and communities to cover the broad spectrum of care needs. In the end, this flexible approach will allow CMMI to test various approaches and to determine what methods work in what circumstances. This flexible approach would not require uniform geographic or population sizes, though the size of the population, sociodemographic factors, and the scope of the area to be served must be taken into account when determining the budget for the facility and region. Flexibility will also allow for a robust methodology for taking into account transient populations such as seasonal agricultural workers or retired populations that split their time between two locations.

Getting the budget right is essential to allowing regional multi-payer budgets to be successful in rural America. The hospital budgets must ensure that facilities are paid and financed fairly, looking holistically at all of the applicable payers including federal, state and local resources, private payers and patients such that the health of the population can be improved. In determining the prospective budget, the first question that must clearly be answered is what is included in the budget. Hospital payments have been focused on inpatient care. It is currently through inpatient care that hospitals cross-subsidize other necessary services including lab services and emergency care. However, the practice of medicine is moving away from such intensive needs for inpatient care, resulting in a payment system out of line with clinical care. The move to a prospective budget should avoid reliance on a single type of care in order to cross subsidize others.

Fifth, providing access to care, especially preventive services and ongoing care for chronic disease, will likely result in savings; NRHA is concerned about a desire to quickly realize these savings. The March 2016 MedPAC report indicated that “average Medicare margins are negative, and under current law they are expected to decline in 2016.” For rural hospitals that serve patients that are on average older, sicker, and poorer than their urban counterparts, these negative Medicare margins mean negative overall margins. Negative margins will continue to lead to increasing hospital closures. One-third of rural hospitals are currently vulnerable to closure and 72 rural hospitals have already succumb to that vulnerability and closed. Rural hospital profits are down since 2012 while urban hospitals profits are on the rise. The Median MDH is operating at a 2% loss, an unsustainable situation. CMS cannot continue to cut payments to these essential providers and expect them to be able to maintain operation at such a loss, especially in a multi-payer system which would eliminate necessary cross subsidization. While there are some rural hospitals that are more profitable than others, as a whole rural facilities are not able to take on down side risk in this environment.

Though savings may ultimately result from this program this should not be the primary focus and absolutely cannot be the focus in the beginning when hospitals are being asked to invest in costly population health infrastructure – demonstration of reorganizing care for better health outcomes, which should ultimately lead to better value for the health care dollar.

Sixth, the budget must clearly establish what is expected for that budgeted amount. The term population health is a buzz word in health care, however, to move from conceptual discussions to actual programmatic implementation it needs to be very clear to all involved what is included in the term. What is often discussed as population health includes components well outside the traditional field of “health care” including personal factors (such as genetics and health related choices such as diet and exercise), environmental factors (such as clean air and water), and social factors (such as availability of housing and food). While some of these factors are within the control of a provider of population based health, it is important that robust socio-demographic risk adjustment is achieved. It is insufficient to simply look at historic health care usage in many rural communities, since lack of access to care is consistently identified as the number one challenge in rural America. In underserved communities, increased usage and diagnosis of disease is often a sign that population health is actually beginning to improve. Therefore, this sort of change should be expected and rewarded, or at least appropriately compensated though risk adjustment. Determining who is included in the population, then properly risk adjusting is the cornerstone of allowing a population health system to work.

The ultimate goal of the budget, however, must including ensuring local access to necessary care. To allow for improved population health, there must be sufficient resources to provide prevention, primary care, chronic disease management, emergency services and other essential services to improve the health of the population served. The budget amount must take into consideration the higher cost of providing care in rural America including the difficulty in recruiting and retaining a health care and IT workforce, lack of economies of scale, and overhead costs spread among fewer patients. Additionally, when considering population health it is important to consider the cost of providing care to a geographically dispersed population. In order to reach certain populations, the care will need to go to the patient. This cost of community programs and outreach will be higher when the service area is larger.

Seventh, the Maryland program, cited as a model, utilizes a Sustainable Growth Rate (SGR) mechanism to ensure savings, and limit cost growth. Unfortunately, this sort of method of limiting cost growth has proven problematic without a more nuanced system to ensure that care can be provided at the budgeted level. As previously discussed, providing population health is more expensive in rural areas for a variety of reasons including the fact that rural populations are older, sicker, and poorer than their urban counterparts, with a greater chronic disease burden. Additionally, the population’s geographic dispersion and low volume adds additional costs because offering services in a central location may not be sufficient to actually reach some high cost populations. While appropriate risk adjustment and valuation is a complex task, it will be a necessary cornerstone of success. The task is not insurmountable; researchers have developed a number of tools to estimate the necessary costs and similar tools could be created for this purpose (see for example, Estimated Costs of Rural Freestanding Emergency Departments, Findings Brief, NC Rural Health Research Program, November, 2015.)

Eight, Critical Access Hospitals (CAH) are an important component of providing access to care in rural communities and should be included as a part of the multi-payer payments, with a clear understanding of the purpose and history of the CAH program. The CAH system was created to protect vulnerable rural hospitals that have higher costs due to their rural nature. As we saw with the plethora of the closures occurring in the 80s and 90s, without the CAH system rural access to hospitals and necessary care is dramatically decreased. These rural facilities are unable to take advantage of economies of scale, since they are by definition a low volume provider. Additionally, these facilities often serve as safety net providers for a vulnerable population that cannot travel the long distances that would be required to receive necessary care at larger hospitals. As with all rural facilities, the ultimate budget for these facilities must take into account the higher cost of doing business in rural areas, as well as the additional wage premium that is often required to get the necessary workforce to operate a rural hospital.

Once the region and population are defined and the budget is developed, the model must provide extensive flexibility to allow hospitals to succeed within the new paradigm. Flexibility should be broad and include a variety of areas including the ability to use telemedicine, provide space in the hospital for visiting specialists, and allow staffing flexibility including use of advance practice nurses and physician assistants and an increased role of rural EMS as well as other providers as appropriate. The necessary level of flexibility must extend well beyond simple changes within the traditional hospital (including CAHs) paradigm. Success can only truly be achieved by moving away from an all-or-nothing, one size fits all model where a community either is able to sustain a hospital (based on generating a sufficient volume that encourages a ‘heads in beds’ mentality) or resulting in the community losing direly needed local access to health care services. Flexibility will promote cost and operational efficiencies and provide value in the provision of local and regional services, while allowing facilities to best serve their community.

Rural Medicare beneficiaries already face a number of challenges when trying to access health care services close to home. Seventy-seven percent of rural counties in the United States are Primary Care Health Professional Shortage Areas while nine percent have no physicians at all. Rural seniors are forced to travel significant distances for any care. On average, rural trauma victims must travel twice as far as urban residents to the closest hospital. In an emergency every second counts! As a result of these disparities, 60% of trauma deaths occur in rural America, even though only 20% of Americans living in rural areas. But the situation is poised to get even worse with a third of rural hospitals on the brink of closure.

Tenth, and as mentioned before, any change in provider type will require extensive flexibility in services provided and should be focused on the needs of the community. These needs should be determined through a data driven community needs assessment. This assessment must examine the status quo, including the current services provided in the community, current patients, and how any changes would impact that population. Importantly, the assessment must go beyond the status quo and look to patients not currently receiving care at the local hospital, both those receiving care elsewhere and those forgoing care, and those services currently not offered locally. This process must be data driven and transparent to the community in order to achieve the necessary community buy-in. This data must be utilized to help determined the services the facility is responsible for providing within the scope of the budget. More importantly, all of this information must be available early enough in the process to allow communities to make a well-informed decision regarding whether or not to participate.

However, simply because a need is identified within the community does not mean the facility must provide that service. For example, a community may have an identified behavioral health or substance abuse need within the community but be unable to recruit providers to meet that need within the community. While this information should be discussed in the community needs assessment, participation in the program should not be contingent on expanding a particular service line. However, the flexibility to expand and contract service offerings must be available during annual renegotiation of contracts, allowing a community to expand service lines in the future as community needs or resources change. The process of expanding a service line must include a robust methodology for determining the potential patient population and the costs to allow the facility to make the transition successfully. Additionally, there must be a process in place for a process in case the reality is not in line with the theoretical costs. This process must be straightforward and provide a rapid response to allow for changes when necessary.

Indeed, there needs to broadly be a straightforward and rapid appeals process for hospitals when any major variance occurs, for example a major flu epidemic or a natural disaster that moves population into or out of the provider area.

When a community needs assessment determined that a community may not require the full scope of hospital services such as inpatient care, but still need preventive and primary care, chronic disease management, and emergency services, this model should provide sufficient flexibility to allow for local access to care though a new provider type. One potential outline of this new provider type is the Community Outpatient Hospital (COH) outlined in more detail in H.R. 3225, the Save Rural Hospitals Act. This provider type does not have inpatient capacity but does have a 24/7 Emergency room and provides needed outpatient services. Use of a multi-payer system is additionally beneficial to ensure the expanded coverage provided by the additional provider type is available to patients covered by the whole spectrum of insurance providers. However, to create this new provider through a CMMI demo it is essential that there are sufficient safeguards in place including a methodology for ensuring appropriate state and federal licensure and certification since requirements must be changed or waived in order to create the new provider type and the ability to revert to their previous provider type at any time.

In determining the appropriate payment for this new provider type, excellent research has already been done, for example the Estimated Costs of Rural Freestanding Emergency Departments by the NC Rural Health Research Program[[1]](#footnote-1). It also should be noted that part of what is being paid for with an emergency room is capacity to care for a patient when local emergency care is needed, therefore, examining it from a perspective of simply cost is not always an appropriate viewpoint.

This potential new provider type highlights the need to examine the whole spectrum of care for patients to ensure a change in the payment structure does not leave a gap in the safety net for rural communities. Partnerships with larger facilities are potential component, however, the spectrum must also include an examination of EMS and patient transportation and post-acute care. Lower levels of care, which are the same types of providers as those providing post-acute care, are an especially important group to consider. Provider waiver of the requirement of a three day inpatient hospital stay may allow patients to remain in their community but providing sufficient support through skilled nursing facilities or home health. However, the limited availability of home health care in rural areas due to the payment methodology not sufficiently reimbursing for the extensive travel time and distance should also be considered. Partnerships and transfer agreements should be included as a part of the annual negotiation of the contract for the following year, including agreements to provide visiting or telehealth providers, especially for specialty care. CMS can assist in fostering relationship however, the communities and hospitals must be the ultimate arbiters of the arrangements. The agreements should clearly delineate responsibilities for the patient population, especially if responsibility for the population is shared. Furthermore, partnerships with larger facilities should be about providing access to care not available in the local community, and not on moving patients further from their home to receive care that could be provided locally.

Eleventh, as a part of multi-payer budget it will be necessary to have a system for monitoring for unintended consequences, both to the hospital and to patients, including a relief mechanism when unintended consequences are found. While NRHA supports having appropriate measures to monitor quality and value, it is essential that any measures selected are appropriate for low-volume and rural providers. CMS should adhere to the recommendations in “Performance measurement for rural low-volume provider: Final report by the NQF Rural Health Committee” dated September 14, 2015, which strongly recommends that rural providers are not exempt from this program. This report was created pursuant to HHS requesting the National Quality Forum to convene a multi-stakeholder Committee to identify challenges in healthcare performance measurement for rural providers and to make recommendations for mitigating these challenges, particularly in the context of CMS pay-for-performance programs, though the concepts are largely transferable. The need to create rural relevant measures does not mean the creation of separate measures for rural.

One option is the use of continuous variables. Measuring an aspect of care using a continuous variable rather than a binary variable may require a smaller sample size to detect meaningful differences between hospitals. Examples would be assessing the time until a medication is given rather than just whether or not a medication was given or measuring the number of preventive services received rather than whether or not preventive services were received. Note, however, that care should be taken when considering such measures for rural providers (particularly timing measures), as such measures would be sensitive to outliers and because the environmental context could potentially invalidate comparisons between providers.

As is important for all hospitals, it is also important to as much as practicable to limit the number of measures and to provide timely and actionable feedback to hospitals. Both the data and the interpreted results must be readily provided to hospitals to allow them to continually track and be assured of where they stand. The system must be very open and transparent and include an opportunity for the hospital to interact with CMMI with questions and concerns regarding their data and the interpretation. Additionally, the selected measures should be in line with other programs including Meaningful Use and MIPS, reducing the overall burden of data collection as much as possible.

Finally, it is important to learn lessons from similar programs including those involving different payers. The Medicare waiver for the Maryland program should be extensively reviewed. the passage of a bill recently in the Maryland House of Delegates regarding the impact of the global budget program on rural hospital as well as placing a moratorium on the conversion of rural hospitals to a different provider type, highlight the need for further study of the impact of this prior to utilizing the Maryland program as a model. Rural hospital administrators of Maryland hospitals have reported there are a number of issues that need to be addressed in how the program works for rural including an understand commonalities and challenges of rural, transportation issues, health status risk adjustments, rural cultural issues and resistance to receiving health care (including resistance to purchasing insurance, or receiving government assistance provided in the Affordable Care Act), how the payment models differs from for rural, and the impact of higher beneficiary costs for receiving care in rural. It is particularly important to note that Maryland is an affluent state that is able to step in to keep hospitals open. Other states will with a larger number and percentage of rural hospitals and tighter state budgets will be unable to serve as a relief valve.

While we appreciate your focus on the Maryland Multi-Payer Model as a possible paradigm to emulate**,** we also urge CMMI to look at the global payment methodology in place for Oregon’s 1115 Waiver Medicaid Demonstration Program[[2]](#endnote-1) as well as its accompanying State Innovation Model Grant**[[3]](#endnote-2)** that is designed to bring additional payers including -- Medicare dual eligibles[[4]](#endnote-3) and public employee health plans -- into the model. This transformation model is instructive, important, and deserves your attention for many reasons, including the fact that it has been successfully implemented in a state with a high number of rural providers. It has markedly improved health care quality for patients.[[5]](#endnote-4) It maintains an essential focus on the integration of funding and care for physical health, mental health/addictions services and dental health. It has provided a successful pathway for the participation of even the state’s most rural and remote hospitals and providers, and for the transition of those facilities off of Medicaid cost-based reimbursement an on to an alternative payment methodology, while preserving local access.[[6]](#endnote-5) The Oregon model, in place since 2012, has seen a successful start with the Medicaid, Medicare dual eligible patients, and public employee populations, and state health care leadership are working to extend the model to commercial plans going forward. We ask that you explore this model as you consider the pilot program structure.

Thank you for the chance to offer a response to this RFI on the concept for regional multi-payer prospective budgets. We very much look forward to continuing our work together to ensure our mutual goal of improving quality of and access to necessary care in rural America. If you would like additional information, please contact Diane Calmus at dcalmus@nrharural.org, or 202-639-0550.

Sincerely,



Alan Morgan

Chief Executive Officer

National Rural Health Association

1. Estimated Costs of Rural Freestanding Emergency Departments, Findings Brief, NC Rural Health Research Program, November 2015 [↑](#footnote-ref-1)
2. https://www.oregon.gov/oha/OHPB/Pages/health-reform/cms-waiver.aspx [↑](#endnote-ref-1)
3. https://www.oregon.gov/oha/OHPR/Pages/sim/index.aspx [↑](#endnote-ref-2)
4. http://www.oregon.gov/oha/healthplan/ContractorWorkgroupsMeetingMaterials/DUALS%20TA%20TOOL%20Exec%20Summ%20%20Resources.pdf [↑](#endnote-ref-3)
5. https://www.oregon.gov/oha/Metrics/Documents/2015%20Mid-Year%20Performance%20Report%20Executive%20Summary.pdf [↑](#endnote-ref-4)
6. http://www.oregon.gov/oha/pages/rhri.aspx [↑](#endnote-ref-5)