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

The comments in this PDF are in response to the Center for Medicare and Medicaid Innovation's Request for Information, "Request for Information on Concepts for Regional Multi-Payer Prospective Budgets". As noted in the Request for Information, CMS stated that we may publically post the comments received, or a summary thereof. The CMS Innovation Center received these comments in the form of an email message or letter.

From: Boucot, Mark G.
To: CMS Regional Budget Concept
Subject: Regional Budget Concept
Date: Wednesday, May 4, 2016 8:40:37 AM
Attachments: image003.jpg

CMS

May 4, 2016

I am writing to you on behalf of Garrett County Memorial Hospital (DBA Garrett Regional Medical Center (GRMC)) in support of the Maryland Waiver and global budgets as a payment mechanism for hospitals.

With a population of 32,000 residents, Garrett County is designated as a Health Provider Shortage Area (HPSA) and is a federally designated Medically Underserved Area (MUA). The hospital is located in Oakland Maryland, which is the county seat for Garrett County. GRMC is a rural hospital with the longest standing experience in the State of Maryland operating under a global budget since 1987, otherwise known as Total Patient Revenue (TPR). The TPR system of payment has afforded GRMC with long-term financial stability, with rewards for quality of care and safety. As a result, quality and safety indicators for GRMC are above the state average:

- Being an early adopter of TPR, GRMC has the lowest readmission rate in the state: GRMC = 7.6%; STATE Average = 12.9%. Pursuant of quality driven by the system, GRMC has had the lowest readmission rate in the state for several years.
- The system has accounted for revenues related to the management of chronic diseases, fostering a community approach to resources and utilization, which has driven down the total cost of care. The GRMC Potentially Avoidable Utilization Revenue is lower than the state average: GRMC = 10.9%; STATE = 13.5%.
- GRMC is by far the lowest case mix adjusted charge per case in the state: GRMC = $10,294/case; STATE = $14,805/case
- GRMC has demonstrated improvement in its benchmarks for hospital acquired conditions and dramatically improved its mortality index because of incentives built into the Maryland model.

One of the central mechanisms for the Maryland Waiver's success has been the regulatory agency, known as the Health Services Cost Review Commission (HSCRC). The hospital's partnership with the HSCRC has helped to improve access to healthcare services that are high quality and cost effective. This agency has assured that all payers in the state participate from the inpatient perspective which has protected this rural hospital from narrow networks, as well as set level rates for inpatient payments to the relative economic indices of each geography. Furthermore, the system precludes the ability to cost shift, therefore working as a forcing function to reduce the costs of delivering healthcare. It is my belief that the total cost of healthcare would be lower when adopting such a system in a unified way across a geographic region.

Another essential element for success in such a paradigm is a community health coalition of

Healthcare providers of services to address the specific needs in each community. Care management is enhanced by coalitions that integrate previously disparate entities such as primary care physicians, local health departments, social services, homeless shelters, transportation services, and health clinics. This coalition, known as the Health Planning Council in Garrett County is also comprised of community stakeholders and people that utilize health care services. The Health Planning Council for Garrett County is based at the Garrett County Health Department and is partially funded by the hospital. It has had success in areas such as pediatric dentistry, chronicdisease management, behavioral health services, strategic planning, smoking cessation and communication to the community. However, at this time in the Maryland system, financial risk is borne solely by the hospitals to reduce the total cost of care, however is now beginning to expand into skilled nursing facilities and other providers such as behavioral health. Spreading the risk shouldimprove the quality of care and reduce overall healthcare costs.

Furthermore, data management is the key and data gathered from the State of Maryland's Health Information Exchange (HIE) is integral to data driven decision making, along with monitoring the success of initiatives put in place to reduce the overall cost of care.

Finally, as an administrator with direct experience operating a hospital under global budgets, I humbly recommend that the payment system model be unified for an entire geographic service area, or state etc. In other words, a unified system of global budgets is important and should not be considered for just one segment of the industry such as rural hospitals only. The reason is that a geographic area may end up with misaligned incentives. What happened with GRMC in its formative stage of global budgets is as follows: GRMC was operating on a global budget, while all of its competitor hospitals were operating under a fee for service paradigm. The result was that GRMC maintained financial stability, but was not incentivized to develop services needed for the community. The result was that competing hospitals were much more aggressive about developing services for more specialty health care services. As the volumes at GRMC reduced for many years under a global payment system, the it's financial viability remained stable. However, patients had to travel for services and the hospitals that were relatively close grew volumes in the fee for service environment. From a financial perspective, GRMC was dis-incentivized to create the access to care and grow services, therefore people from the region had to travel longer distances for specialty healthcare services.

I sincerely hope these comments are helpful. If you have any other questions related to my comments, or feel that I can be of further service, please feel free to use my contact information below to reach me.

Best Regards,

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Alaska Primary Care ASSOCIATION

May 2, 2016

Andrew M. Slavitt
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Re: Request for Information on Concepts for Regional Multi-Payer Prospective Budgets

Submitted electronically via: RegionalBudgetConcept@cms.hhs.gov

The Alaska Primary Care Association (APCA) is a private, 501(c)(3) membership organization of ! laska's "safety-net" primary care providers. The PC's mission is "helping to create healthy communities by supporting vibrant and effective community health centers" in Alaska. Our membership includes federally-designated §330 Community Health Centers (CHCs) that serve all Alaskans, and focus particularly on providing primary care services to those who are underinsured, uninsured, and live in medically underserved areas.

The APCA welcomes the opportunity to submit comments in response to the Request for Information (RFI) on Concepts for Regional Multi-Payer Prospective Budgets. Our comments will focus on *Section III: Questions on Potential Participants and Population Health Activities*, particularly how CMS should encourage population health activities and community collaboration.

Alaska, the largest state in the union, may also be one of the most complicated in terms of its health care system. The most robust and far-reaching Alaska Tribal Health System operates here, with vertically integrated, patient-centered, coordinated care. The Non-Tribal system is also resilient, having to endure long distances and foreboding geography, harsh weather, and very high costs. By and large, the Alaska health care system is built upon a fee-for-service basis, with wide variation in capacity from one location to the next, and dependent on a range of resource availability.

To have ! laska's disconnected health care system transform to value-based payments and population health will require: *transition time* and *infrastructure; pilot* projects and *demonstrations;* and changes tailored to the *unique* needs of *frontier* Alaska, and a strong *Tribal* health system.

Alaska legislators, the Alaska Department of Health and Social Services, and countless stakeholders worked numerous hours to produce a Medicaid redesign bill this session. The resulting Senate Bill 74 contains what many believed was necessary – a layered and phased-in approach to significant change in payment and delivery reform here.

SB 74 has a foundation of primary care for all Medicaid participants, and primary care case management for patients with chronic conditions or complex social determinants of health, which often give rise to reactive, more expensive care (for example, high utilization of the hospital emergency department).

Alaska will be embarking on a process to define a State Plan Amendment (SPA) for the Section 2703 Health Homes Program allowed in the Affordable Care Act. That kind of program is a good match for Alaska for many reasons, including:

- It maintains the base Prospective Payment System (PPS) for Health Centers, but adds an amount to help cover care coordination costs. This allows Health Centers to transition away from a strictly visit-based budget for their business, and to have flexibility in funding their care coordination services and integrated behavioral and other allied health.
- The Health Home Program builds on the strengths of the Community Health Center Program – that is: patient-centered, trusting relationships, and whole-person care.
- This program, because it maintains the base reimbursement method, also affords the State Medicaid Program to adjust its method of payment, and make modifications to its MMIS, in order to recognize different payment methods.

Similar features would be welcome in a pilot or demonstration program with rural/frontier providers. An example would be a project that addresses the value of population health by financially recognizing integration of behavioral health and primary care; by rewarding improvements in population health outcomes that can be attributable to participating providers; and by incenting collaboration between hospitals and primary care providers.

Build on the strengths of frontier primary care, especially Community Health Center, providers: trusting personal relationships with patient populations, whole-person care, accountability, and connectedness to community.

Recognize that rural hospitals are challenged by the conundrum to spend money and effort to keep patients out of their facilities, and incent collaboration with innovative Community Health Centers, so that there is mutual benefit.

Attend to the limited resources many frontier providers have in their communities, and allow for creative solutions to be tried. Allow providers to transition – to experience a different way of interacting, treating and billing for patient care: from volume to value. Give them time and the tools to do it. Rural/Frontier providers are resilient and flexible.

Finally, one aspect of the Alaska healthcare system should be highlighted: as of this Monday, Alaska has only one insurance carrier participating in the federally facilitated insurance exchange here. Our Marketplace has seen premium increases for the past two consecutive years of 35-40% year-over-year. We anticipate similar rate increases this year for the remaining carrier. So, although Alaska expanded Medicaid eligibility in September 2015, a portion of Alaskans will continue to go uninsured, due to unaffordable individual health insurance premiums. This will increasingly cause a weight for our 29 Community Health Center Organizations who will continue to see a number of uninsured patients, even in light of the "Affordable" Care Act.

Thank you again for the opportunity to comment on the concept of Regional Multi-Payer Prospective Budgets. We look forward to seeing and hearing more about CMS' plans to address the unique needs and situation of rural and frontier America.

Sincere regards,

Nancy Merriman
Executive Director

RWHC
Your partner. Your source.

May 9, 2016

Center for Medicare and Medicaid Innovation
Centers for Medicare & Medicaid Services
Delivered via email: RegionalBudgetConcept@cms.hhs.gov

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

The Rural Wisconsin Health Cooperative (RWHC) appreciates the opportunity to submit our comments to the Centers for Medicare and Medicaid Services (CMS) on your Request for Information on Concepts for Regional Multi-Payer Prospective Budgets. RWHC is an active member of Wisconsin Hospital Association's Network Adequacy Council and our comments will focus on network adequacy, as we believe a prospective/global budget concept in the vain of Maryland's program might exacerbate network adequacy concerns and steerage (i.e., by using narrow networks to steer patients out of rural into urban hubs) that is being felt in rural communities.

Established in 1979, RWHC is a collaborative owned and operated by forty rural acute, general medical-surgical hospitals. Our vision that rural Wisconsin communities become the healthiest in America has led us to a twin mission of advocacy and shared services. As part of our history, we developed and ran one of the country's first rural-based health plans, HMO of Wisconsin that is now doing business as Unity Health Insurance.

RWHC supports the work of CMS to expand health insurance options available to all citizens and extend coverage to Americans who are uninsured. **A disproportionate share of Americans without health insurance lives in rural communities and could greatly benefit from efforts that protect rural access to high quality healthcare**.

Rural places and their residents have unique circumstances that must be considered and addressed in determining the network access standards to any potential new delivery model and must maintain access to local care. It is important to note that rural patients, on average, face the most daunting of health care challenges: they are older, poorer and sicker. Rural America is less healthy due to too much smoking, drinking and eating, and too little exercise, education, jobs and income. So network access standards of new models need to place specific emphasis on providing local coverage for local care so that the rural beneficiaries pursue and utilize needed care.

One of RWHC's biggest concerns in new delivery models of care is their provider network adequacy. We have already witnessed contracting practices by Qualified Health Plans (QHPs) in Wisconsin's Federally-facilitated Marketplaces (FFM) where the QHP will either fail to present local health care providers with a contract to provide health services or present terms that are so egregious that they are meant to be rejected by local providers so that the QHPs can steer service to system-owned facilities and providers outside of the community. For example, we have seen one Exclusive Provider Organization (EPO) plan fail to approach providers that the same insurer has long-standing commercial agreements with for services. This example is confusing for health care providers and consumers as they may cycle in and out of products with this insurer without fully understanding differences.

For a Maryland-like All-Payer Model to work well in rural areas, a strongly delineated, non-overlapping service area would have to be paired with sufficient funding to local providers of care that cover the costs of providing care to the beneficiary. This would also provide an adequate network of local providers that don't unnecessarily require the beneficiary to travel far outside their local area for health services. **We are concerned that most of our rural communities do not have the scale to take on the total risk of such a program**. We are more comfortable thinking about how we incent the behaviors locally that the larger risk pool needs, which very well might include some element of risk proportional to the scale of the enterprise.

RWHC believes that CMS should require payers to develop specialties and standards that reflect the historical "normal practices and standards in the geographic area." Further, we believe CMS should promulgate rules that cover third-party payers to attest that they meet access standards as part of the certification/recertification process. We believe that self-reporting shouldn't be the only process and there is a need to allow for challenging of network adequacy by both enrollees and providers. **Only strong enforcement of community access standards will prevent steerage of enrollees and inordinate leverage by health plans against rural safety net providers. Because if all payers are paying the same rates, as has been laid out in the example of Maryland's All-Payer Model, the potential to steer beneficiaries of provider-owned plans to provider-owned facilities so that resources (providers) are being maximized is the only way to maximize profit**. This seems to be an anathema to moving from volume to value, as it would seem to encourage pursuit of volume up to capacity.

Without appropriate oversight, the net effect is an undermining of local access and the financial integrity of rural safety net providers. Third-party payers have the potential to create a bias against rural providers if local access is not considered a system goal. By caring for one's neighbor, community health and infrastructure will improve. These outcomes for individuals and population health for rural communities can be measured through the use of the Community Health Needs Assessment process that has already started to survey and address population health needs.

We appreciate CMS' continued commitment to the needs of rural patients. We are excited about the opportunity for us to see some experiments that truly encourage a focus on population health out in the community versus just within the panel of patients, and we look forward to continuing our work together to mutual goals of improving access and quality of health care for all rural Americans.

Sincerely,

Tim Size

Tim Size
Executive Director
Rural Wisconsin Health Cooperative

Jeremy P. Levin

Jeremy Levin
Director of Advocacy
Rural Wisconsin Health Cooperative

From: Vickey Simonson [mailto:vickey.simonson@mtha.org]
Sent: Monday, May 9, 2016 2:53 PM
To: CMS Regional Budget Concept <RegionalBudgetConcept@cms.hhs.gov>
Subject: RFI
Importance: High

Response to Request for Information for Regional Multi-Payer Prospective Budgets

CMS seeks " input on a concept that improves the delivery of patient-centered care and population health, reduces expenditures, and includes a global budget." In 2012, in response to Section 123 of the Medicare Improvements to Patients and Providers Act (MIPPA) of 2008, the Montana Health Research and Education Foundation (MHREF) submitted a proposal on just such a concept for rural and frontier (fewer than 6 people per square mile) areas. The concept submitted at that time had taken 18 months and $750,000 to produce, under a Cooperative Agreement with the Office of Rural Health Policy (H2GRH199966.)

The model submitted, called FCHIP (Frontier Community Health Integration Project) proposed to improve care and access through the integration of essential health care services for Medicare beneficiaries in frontier communities. Because of the proposed integrated nature of the proposal, it was fairly lengthy: the six white papers which were submitted at that time are attached to this e- mail.

The model submitted was very similar in nature to that currently being implemented by the National Rural ACO; however, the FCHIP demonstration project itself was, after two years of review and deliberation, modified considerably from the original. Rather than offering reimbursement for a suite of integrated services, and a shared-savings model for a partnership of frontier CAHs (again, rather like the ACO model now being implemented in Montana and Idaho), CMS revised the project to offer four separate potential waivers of current reimbursement regulations. Interested frontier CAHs could apply for any or all of these waivers, and were required to demonstrate the probability of budget neutrality for each and/or all of the waivers requested. The applications received then underwent scrutiny and consideration by CMS and OMB for roughly two years following the application deadline. This significantly diminished project is now scheduled for an August, 2016, start date.

The model as submitted four years ago could be updated in several positive ways:

- Inclusion of the services of community health workers (CHWs) in frontier communities. A recently-concluded (August of 2015) demonstration project funded by ORHP under the FCHIP CFDA number tested the use of CHWs in frontier communities. The results were extremely promising in terms of improved patient outcomes and lowered costs, and as the demonstration progressed, the CHWs functioned much as the navigators in the currently-open CMMI "Accountable Health Communities" initiative are envisioned to do. They connected patients with community resources and addressed problems such as lack of water, electricity, or safe housing; contacted community church groups and social service organizations to provide assistance, and had a major impact on health and independence. Adding CHWs to the Visiting Nurse Services proposed in the attached white papers would yield benefits and savings well beyond any added reimbursement costs.

- Expansion of telemedicine, as proposed in the attached papers, with an added focus on telemental health. Montana is a mental health professional shortage area, and entire regions of the state are unserved. There is one psychiatrist practicing east of Billings: this is an area of roughly 49,000 square miles (out of the state's total 147,500 square miles.) Montana has the nation's highest suicide rate, the highest per capita number of veterans, and is projected to be the fourth-oldest state in the nation by 2020. Mental health is an issue we must address; telemental health is a way to begin delivering services to unserved areas. Recent studies conducted in Montana by Dr. David Schmitz and Dr. Edward Baker of Boise State University's Center for Health Policy determined that lack of support in mental health services is one of the two biggest factors affecting recruitment and retention of rural primary care providers.

In devising ways for rural and frontier providers to participate in alternative payment models, and to work on population health (which implies value rather than volume,) we urge consideration of evaluation methods that can provide valid results with much smaller data sets. States like Montana (population estimated to have reached 1,000,000 in 2012, and which is resisting addition of a second telephone area code in the state,) or Wyoming, (which has roughly 580,000 people,) Alaska (736,000 people occupying 663,000 very rugged square miles) or North Dakota, population 740,000, face different definitions of "rural" and "remote" and different corresponding economic realities than states such as Iowa or Vermont. This is part of the reasoning behind the original FCHIP's Vision Statement, which reads,

The overall vision of the Frontier Community Health Integration Project (F-CHIP) is to establish a new health care entity—a Frontier Health System—that aligns all frontier health care service delivery by means of a single set of frontier health care service delivery regulations and an integrated (not fragmented) payment and reimbursement system.

For the Medicare beneficiary, the new Frontier Health System would serve as a single point of contact and patient-centered medical home for the coordination and delivery of preventive and primary care, extended care (including Visiting Nurse Services (VNS) with therapies), long term care and specialty care. Beneficiaries would benefit from the new model through reduced unnecessary admissions and readmissions to inpatient, ER and long term care settings. Homebound frontier Medicare beneficiaries who are unable to travel to obtain medical service would receive access to expanded VNS home care, including monitoring and treatment of chronic conditions.

In essence, the local Frontier Health System would aggregate all health care service volume within its service area under one integrated organizational, regulatory and cost-based payment umbrella, spreading fixed cost and producing lower-cost care. In addition, budget-neutral, pay-for-quality incentives would be implemented by the local Frontier Health System to demonstrate high quality care provided to frontier patients at lower cost, with savings shared with the Medicare Program.

A new Frontier Health System provider type and Conditions of Participation (COP) would be created. Health care services aggregated into the new Frontier Health System include: hospital ER, inpatient and outpatient; ambulance; swing bed; and an expanded rural health clinic which includes a VNS component that may provide physical, occupational or speech therapy in the frontier patient's home as well as preventive and hospice services.

Each frontier-eligible state—Montana (MT), North Dakota (ND), Wyoming (WY) and Alaska (AK)—would propose forming one or more networks of up to 10 Frontier Health Systems to provide statewide care coordination for frontier patients, assistance in the implementation and measurement of Pay for Performance (P4P) incentives as well as distribution of shared savings from CMS to network members.

For a second time, we urge consideration of this model, with appropriate additions and changes to reflect lessons learned and new challenges appreciated.

Thank you for the opportunity to provide comment on this topic critical to the health of our rural citizens.

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From: Edward Sayer [mailto:edward.sayer@chcfc.org]
Sent: Monday, May 9, 2016 4:52 PM
To: CMS Regional Budget Concept <RegionalBudgetConcept@cms.hhs.gov>
Subject: comments/questions

It seems that giving a block of money to a hospital that then would presumably dole it out to individual practitioners or primary care entities seems logistically complex and cumbersome. I also wonder how this approach might impact the FQHC PPS reimbursement methodology. It seems that the money would be better spent in giving it to consortia of primary care folks, or maybe even a primary care association in a state.

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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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Response to Request for Information

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11, 2016

General Comments

This Request for Information from CMS reflects a significant step forward for the agency in considering major payment changes that align with improved health of the public and lower costs. CMS is making major progress through a series of innovative payment models, including Accountable Care Organizations, patient-centered medical homes, and bundled payments. The Secretary of Health and Human Services has set ambitious goals for shifting payment from value to volume. Expanding the use of global budgeting models will accelerate this progress and create tremendous momentum for improvement of health in the United States.

What makes global budgeting different from other payment models is its ability to align incentives for provider organizations across most, if not all, of the patients they serve. This allows for true healthcare delivery reform, with substantial benefits for patients. It means that practices can hire community health workers, hospitals can invest in partnerships for home care, and new protocols for appropriate care can be drafted that put health first. It also means that Boards can measure progress by health indicators, not just charts of admissions, MRIs, and other measures of fee-for-service medicine. Global budgeting can make clinical transformation possible.

Moreover, global budgeting could serve as an important catalytic tool to accelerate achievement of the ambitious goals of the Medicare Access and CHIP Reauthorization Act of 2015 and encourage physician participation in the process.

There are two important concepts, discussed in more detail below, related to global budgeting that differentiate it from other payment reform concepts. These include:

- *Separation of the overall cost goal from the specific budgets for providers.* As discussed in the answer to 1 below, a global budgeting model may work best when there is a responsible entity that, on behalf of the state, manages to an overall goal by setting individual provider budgets.

- *Separation of how the budgets are set for providers from how contributions to those budgets are collected from payers.* As discussed in the answer to 2 below, the responsible entity should set and adjust the budgets based on clear principles that reward quality care and effective prevention. The responsible entity should assign contributions to payers based on actual utilization.

CMS should use information from this RFI to develop specific pathways for global budgets that will demystify the use of this tool and make it a viable option for health systems, physicians and others across the country.

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.**

Similar to its work in Maryland, CMS should consider separating the overall cost goals of global budgeting from the setting of specific budgets for providers. This can be accomplished in two steps.

Step one: Agreement between CMS and the states involved. CMS and the states should agree to a cap for covered expenditures for all participating payers, with an option for a specific limit to expenditures for Medicare underneath.

Step two: Establishing a responsibility entity to set specific budgets. The states should designate a responsible entity with the authority to set specific institutional or organizational budgets and engage in other initiatives designed to improve outcomes and lower costs.

This two-step approach permits taking into account all expenditures among a defined group of individuals, accounting for those who do not seek care from participating providers.

For example, in Maryland, the state negotiated an all-payer overall budget cap that pertains to Maryland residents for inpatient and outpatient hospital facility expenditures, regardless of where those expenses are accrued (Step one).. At the same time, state assigned to the independent Health Services Cost Review Commission the responsibility of setting institution-specific global budgets for Maryland hospitals (Step two). It is incumbent on the Commission to set specific hospital global budgets so that the overall budget cap is not exceeded, even accounting for care outside Maryland hospitals.

WIth this two-step framework in mind, global budgeting can, in theory, be applied to any defined geography or group of people. There are two considerations that will come into play to see if such budgeting is viable:

- Do the individuals covered represent a sufficiently high percentage of the patient population of the participating providers? If not, there is the likelihood that the incentives created will not be great enough to support clinical transformation. (In Maryland,

Maryland patients represent such a high percentage of Maryland hospitals patient base that this was not a significant concern.)

- Do the individuals covered frequently seek care outside of the participating providers? If yes, then the system may not be achieve the cost goals, even if the covered institutions and organizations perform very well. (In Maryland, a relatively small percentage of state residents seek care outside the state, so this was not a significant concern.)

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;

To determine the overall prospective budget goal for the group of covered providers (step one in Question 1 above), CMS should identify an attributable population and track trends in expenditures from participating providers for that population. The simplest attributable population is a geographic population, so in Maryland the overall budget goals were set to provide savings over time, based on tracking trends in inpatient and outpatient hospital expenditures for Maryland residents. Setting cost goals for a geographic population provides the most clear methodology for assuring that overall cost and quality improvements are being made. Alternatives would include stable populations of patients who use particular services, with an assurance that these patients can be tracked over time.

This step of creating an overall budget goal does not yet assign responsibility to specific payers. In fact, it is not necessary to assign responsibility for the overall budget goals to particular payers. Payers need only contribute as directed to specific global budgets for providers, created by the responsible entity (step two in Question 1 above).

To determine how payers contribute to those budgets, the best approach is to assign the percentage based on actual utilization by payer. This is not fee-for-service reimbursement, because the percentage paid by each payer does not affect the budget for the provider (which is set by the responsible entity). But basing the contribution methodology on actual utilization, which is handled in Maryland by rate-setting, has several advantages, including: (1) recognizing that small payers may see fluctuations in patient populations; (2) aligning the incentive of payers with reducing preventable utilization where possible.

With respect to individual provider budgets, it is essential to separate the setting and adjusting of budgets by the responsible entity from the determination of how individual payers contribute to those budgets. The setting and adjusting of budgets is essential to aligning provider incentives for health; the contribution methodology is about fairness and aligning payer incentives.

To set individual provider budgets, the responsible entity generally will start with historic trends in expenditures by participating payers and then adjust (as discussed further in the answer to Question 6 below) based on such factors as market share and population growth.

The adjustments should reward the provider organizations that make investments and partnerships that reduce preventable hospital utilization and improve community health.

The responsible entity could direct that payers make quarterly or monthly payments to providers, based on estimates of previous year's utilization, with adjustments by the end of the year to align with actual utilization.

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),

The types of payments included should correspond to the participating providers. For example, since Maryland's initiative related to setting individual hospital budgets, it made sense for the costs to include Medicare Part A. Initiatives that cover physician and drug costs should include Medicare Parts B and D.

and whether all or only selected Medicare beneficiaries in a defined geographic area should be included.

Either approach could work. The considerations involved with a subset of Medicare beneficiaries are those identified at the end of the response to Question 1.

3. **Additionally, how could participating providers be held accountable for total cost of care?**

If the states involved negotiate a global budget for all patient care across multiple payers, then the responsible entity can create budgets for providers with matched incentives. For example, a responsible entity can set capitated rates to local Accountable Care Organizations for all care.

It is not as simple when the state negotiates a global cap on a subset of services, such as inpatient and outpatient hospital services. In that case, CMS should set a total cost of care guardrail for the model, and should ask either the responsible entity or the state to take other steps, which may not involve global budgets, in order to assure no increase in total cost of care.

For example, CMS could agree to model of hospital global budgets, and at the same time ask the state for a series of initiatives, such as reference pricing or medical homes, that would maximize the chance of reductions in total cost of care.

In such a situation, individual providers would be accountable for meeting their own global budgets. In addition, these providers would be aware of the threat to the model of rising

total cost of care. To make real this threat, the responsible entity could establish additional incentives (such as global budget adjustments) to assure there is no spillover into other areas of cost. For example, if hospital costs are controlled under a global budgeting model for hospitals, but long-term care costs are increasing, the responsible entity could penalize hospitals for inappropriate utilization of long-term care facilities or for patient churn with long-term care facilities.

How participating payers could be held accountable to the requirements of a prospective budget concept?

This can be handled by contracting between the responsible entity and individual payers, as well as by authority provided to the responsible entity.

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.**

As noted in the response to Question 1, it is far preferable for a responsible entity to negotiate the global budgets underneath a cap set by the state in discussion with CMS. Advantages include:

- Local ownership of a fair process
- Insulation of CMS from details of budget-setting, allowing the agency to assure overall alignment with model goals
- A local responsible party for overall model goals

Generally speaking, it may be most feasible for the initial budget to be set based on previous year's budgets, with adjustments from there (see below).

What would be the roles and responsibilities of this organization?

In tandem with the affected states, the responsible entity could help negotiate with CMS to set the basic terms of the model. The entity would then:

- Set individual global budgets
- Assign payment responsibilities to payers and assure payment
- Adjust global budgets as appropriate
- Assess gaming by providers and payers and take countervailing steps
- Investigate complaints and take appropriate corrective action for both payers and providers
- Publish reports on progress of the model
- Promote engagement and confidence by healthcare providers and payers

What resources and expertise would be necessary for this organization to set prospective global budgets across multiple payers?

The responsible entity would need:

- A professional staff free from conflict of interest.
- A board with credibility for affected parties. In theory, this role could also be played by a governmental entity. In practice, some degree of independence may be needed to avoid concerns of politicization.
- Public representation on the board
- Public deliberations of the board, except where considering information appropriately considered confidential
- Authority to perform the roles
- Authority for receiving data
- Authority to audit
- Authority to investigate complaints and take action promptly

The board could include representatives from key provider and payer groups, or independent members with credibility from these groups. An intermediate approach would permit nominations of independent people from different groups.

Sufficient resources would need to be provided to this organization. These resources could, eventually, be counted against the global budget cap set by CMS.

Would this organization need to be able to set rates for services?

No. Rate-setting is not necessary for global budgeting. For example, if there is an agreement for hospital global budgeting, the responsible entity could look at utilization data and assign the proportion of global budgets to individual payers, without worrying about the individual unit rates. Of note, this concept does not require that all payers must pay the same rates. For example, the responsible entity could set a conversion factor for different payers based on historic payment rates or based on other criteria. This would translate the utilization percentage into a percentage of the global budget.

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 responsible entity needs the authority to handle the responsibilities mentioned above. State legislation is the most straightforward way to provide this authority. It may be an option to design model agreements to provide this authority via contracting alone.

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 answer to this question depends in part on the model. If providers are individually taking full responsibility for health care costs, regardless of where those costs are incurred, then the data requirements for the responsible entity are less intense.

If, as is more likely, the model depends on attribution and market share analyses by the responsible entity, then it is vital for the entity to have timely access to data on service utilization and payer. This will allow the agency to assure that the promise of a global budget is realized. A robust Health Information Exchange is a vital tool for providing this real time insight (as well as for helping providers cooperate and manage to the overall goals of the effort). In Maryland, the state's designated health information exchange works closely with the Health Services Cost Review Commission to provider real-time insight on trends in hospital utilization.

Population health metrics are an essential component of the three-part aim. Unfortunately, many such metrics are not available frequently or in a timely fashion. One solution is to use aggregated clinical data through health information exchange.[1] Metrics such as asthma-related visits to the Emergency Department, when aggregated across all institutions serving a population, can be tracked frequently, quickly, and reliably.

Risk adjustment through a mechanism such as Adjusted Clinical Groups (ACGs) is also an important capability for both responsible entities and CMS. It is inevitable that certain providers will ask to be paid more based on the needs of their patient population; risk adjustment can allow for this issue to be handled fairly.

Another promising source of data are all-payer claims databases. The strengths of these datasets are the inclusion of all covered services, including pharmacy and outpatient care. However, the recent Supreme Court decision in *Gobeille vs. Liberty Mutual* has undermined the ability of states to establish these databases with data from self-insured employers. The federal government could undertake the activities set out by the report to establish basic standards nationally.

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.**

[1] Horrocks D, Kinzer D, Afzal S, Alpern J, Sharfstein JM. The Adequacy of Individual Hospital Data to Identify High Utilizers and Assess Community Health. JAMA Intern Med. 2016 Apr 25.

Based on the two-step model outlined in the response to question 1, this question needs to be answered twice.

For the agreement between CMS on the one hand and the states involved and responsible entity on the other, there should be a periodic negotiation of the overall cost trends based on changes in the market nationally, secular trends in healthcare, and population changes.

Within the overall goal of the model, the responsible entity will need to develop a methodology for adjusting budgets with credibility, in order to avoid gaming. This is best handled at the local level, where key parties can agree on a fair process and where potential risks to the model will be better appreciated. In Maryland, the Health Services Cost Review Commission adjusts budgets based on market share and other factors, and a key element is hospital's confidence in the fairness of these decisions.

This is perhaps the most difficult technical aspect of making global budgets work. For example, a hospital that reduces preventable asthma admissions through an innovative partnership program with community organizations may see its market share decline. The responsible entity, however, will want to recognize that preventable utilization declined and not penalize the hospital under a global budget arrangement. Conversely, a hospital that reduces orthopedic services will see market share shift to others. The responsible entity will need to recognize this shift and adjust the global budgets accordingly.

CMS should consider creating a technical assistance center to help responsible entities with the challenging process of assessing market share and preventable utilization and making appropriate budget adjustments.

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?

Measures should include measures of care quality, patient experience, and population- based health outcomes. These are necessary to assure that the global budgets are accomplishing the intended aim: permitting clinical transformation that improves health, helps patients, and lowers costs. The Institute of Medicine's report *Vital Signs* contains a set of core health and social measures that should be widely adopted.[2] Communities should be allowed to add a couple health or social measures of specific local value.

How could CMS obtain multi-payer alignment on these measures?

[2] Institute of Medicine. Vital Signs: Core Metrics for Health and Healthcare Progress. 2015; see also Sharfstein JM. Accountability for Health. Milbank Q. 2015 Dec;93(4):675-8.

Multipayer adoption of a consistent set of metrics should be part of the agreement between CMS and the involved states. States then would have the responsibility for organizing payers and bringing them to CMS; the successful State Innovation Model states have shown this to be possible.

How could CMS encourage the reporting of performance measures on the most important priorities while minimizing duplication and excess burden?

CMS should require that a limited set of metrics be adopted as part of model agreements. This would promote consistency among entities subject to global budgets in different places across the country. The Institute of Medicine Vital Signs report is a great place to start in considering these metrics.

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?**

The responsible entity should be the front line of hearing complaints, investigating and responding. Providers should be made aware of how to submit complaints. The concerns, investigation, and resolution should be available to CMS. The responsible entity should be required to refer credible allegations of illegal behavior to the Inspector General of the Department of Health and Human Services for investigation.

The concern over patient transfers can also be monitored via market share analyses and use of such tools as Admission Discharge Transfer feeds. If provider market share is declining, and it is clear that this is independent of purposeful and appropriate reductions in preventable utilization, then the provider's budget should be appropriately reduced. This consequence should be manifestly clear to participating providers from the outset.

The concern over cost shifting should also be handled by monitoring population-based cost measures. CMS and the responsible entity should have access to timely cost data related to different categories of services and cost of care for the targeted population of patients.

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.**

Hospitals are a natural provider type for global budgeting, especially since a large percentage of physicians are now employed, many by hospitals. Participation of all providers in a region is not necessary for the model in theory, because the responsible entity can track volume that moves to non-participatory providers. In practice, the concern could be that

providers still paid based on volume could aggressively market potentially unnecessary services to attributed individuals, subverting the purpose of the model.

Other types of services may also be appropriate for global budgeting. The key is for the states involved to explain to CMS why global budgeting for the class of providers makes sense in terms of lower cost, improved outcomes, and better patient experience. Generally, this means understanding which services can be reimbursed under global budgets that might otherwise be inaccessible. For example, a global budget for obstetrics services might come accompanied by a plan for significant expansions in outreach to provide access to family planning to reduce unintended pregnancies, as well as a plan to provide substantial community-based support for high-risk pregnancies.

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?

A major advantage to global budgeting is alignment of payment incentives with health of the population. It is the most prevention friendly form of payment -- with the prevention involved happening at multiple levels.

Some population health activities are well within the traditional work of covered providers, but others may not be. This means that the responsible entity as well as participating providers should be able to invest funds under the global budget in nontraditional services.

For example, with respect to hospitals, the identification of and medical case management of high utilizers is a service that is within the providers' usual span of activities.

Yet community-based prevention activities may be more appropriately handled by partners. In Maryland, the Health Services Cost Review Commission provides support for community partnerships that range far outside hospital walls and allow for engagement with organizations that provide housing, nutrition services, and other key programs.

It is not necessary nor advisable for all of these population health activities to be specified in the agreement between CMS and the responsible entity and involved states. But it is a good idea for the agreement to spell out the core population health metrics, define a set a minimum for resources to be devoted to population health activities, and establish a process to be used to identify critical initiatives. It should also be expressly clear how nontraditional providers will be able to be included in such efforts, based on evidence of their effectiveness.

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?

There are many ways to encourage this collaboration. The agreement should define a process for determining key population health activities and could encourage that a certain percentage of resources, at a minimum, be spent on nontraditional partnerships with community agencies.

At the same time, CMS should be wary spelling out too many details in the initial agreement. If the agreement specifies too much, the effect might be to distance the community activities from the urgency of meeting key model metrics. A more promising approach may be to leave to the state and to the responsible entity the design of specific efforts. The responsible entity should be empowered and expected to stop activities that are not producing results under the model and shift to more promising efforts. Indeed, accountability for the success of these efforts is as important as accountability for the more traditional services covered by the model.

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?

In addition to the ideas noted above, and apart from the specific issues raised by this RFI, CMS should consider ways to overcome the traditional reluctance of clinical providers to invest in collaborations with community organizations. Such steps might include: (1) maintaining a database of examples of successful collaborations between participating providers and community organizations; (2) providing a competitive pool of funding to match clinical investments in nontraditional partnerships; and (3) giving awards, and other recognition to innovative partnerships.

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 ability to share savings to Medicare is a major draw to a state or locality in designing multi-payer initiatives. However, at the start of the model, these savings are theoretical, and may be insufficient to attract interest by providers and payers. CMS could address this issue by creating a pathway to share a percentage of anticipated Medicare savings up front with the states and responsible entities. These savings could be used to invest in key initiatives needed for success as well as to demonstrate to key local participants the value of coming together.

CMS has a major opportunity to align Medicaid with the model, by encouraging 1115 waivers and DSRIP programs to invest in the resources needed for clinical transformation and to support supplementary needs of high risk and low income patients.

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.

Yes. Life expectancy in rural America is several years lower than elsewhere in our country, and global budgeting offers an unmatched opportunity to align the incentives of the hospitals with the health of their communities. Rural areas are also ideally suited for global budgeting, because hospitals often are associated with defined geographies. Maryland's global budget program began with a successful pilot in 10 rural hospitals.

One option would be for CMS to work with the National Rural Health Association and the Health Services and Resources Administration to develop a model pathway for global budgeting for rural hospitals. This pathway might include an assessment of population health data, an identification of key priority populations and activities, and the development of a plan to transform care and using resulting savings to invest in prevention.

Of note, CMS could approve a global budgeting pilot and allow individual hospitals in a state to opt in, since these hospitals are generally not directly competitive with one another.

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?**

Small hospitals typically do not have the staff or information technology infrastructure to handle complex payment arrangements. CMS, together with the Health Services and Resources Administration, should consider investing in a technical support center for global budgeting and rural hospitals. This might be analogous to agricultural extension centers, with which rural communities are already familiar. The agencies could also support a strong, third- party organization that could serve as the responsible party on behalf of states in multiple communities. It should be required that such an organization have staff on the ground in every area where a global budget is in effect.

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 major risk in global budgeting is that rural hospitals remain in search of volume, despite a set amount of expenditures determined in advance. To mitigate this risk, CMS must assure that hospitals have transformation plans ready to go prior to accepting a global budget. In addition, CMS should not look for extensive savings in the early years of the model, and should consider allowing systems to access anticipated savings in advance to promote transformation.

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?

CMS can identify areas of clinical care that may be inappropriate for small, rural hospitals to provide because of quality concerns. Hospitals can then be encouraged to identify partners for provision of these services.

However, CMS should not assume that rural hospitals need larger hospitals for the key purpose of prevention and community health. In fact, the smaller hospitals may be ideally suited to identifying successful programs needed in their communities. In Maryland, one hospital took over the local school health program, in order to reduce preventable asthma admissions.
Another hospital partnered to open a mental health crisis response center, and a third opened a clinic with multi-disciplinary care for asthma, diabetes, and heart failure.

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?**

Effective population-based measurement may be easier to achieve in rural areas, where CMS can measure health, costs, and quality for those in particular zip codes or counties. A national technical assistance center should be able to provide these metrics to participating rural hospitals, along with benchmarking of performance and trends.

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?**

It is to be expected -- and even desired -- that global budgeting will lead to greater numbers of transfers of complex patients to referral centers. Appropriate transfers should not be held against small hospitals, as the outcome will be greater quality and improved outcomes for patients. In some cases, CMS may wish to encourage the development of formal referral relationships with regional referral centers in the context of global budgets, which may include alternative mechanisms for paying the referral hospital.

Inappropriate transfers should be handled both by complaints (see above) as well as a benchmark set of analyses that CMS develops. Shifts in volume that are outliers should prompt further investigation. The technical assistance center should be able to provide specific guidance on distinguishing appropriate versus inappropriate transfers and referrals.

How could this concept improve access to services not readily available in these rural areas?

Small hospitals that require volume to survive may be reluctant to transfer patients for care elsewhere, even when referral centers may provide greater access and higher quality.

Undoing this perverse incentive and creating stronger referral relationships may allow more patients to receive timely care.

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President

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May 10, 2016

Centers for Medicare & Medicaid Services US.
Department of Health & Human Services7500
Security Boulevard
Baltimore, MD 21244 Dear

Sir/Madame:

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

I am pleased to provide comments on the Center for Medicare and Medicaid Innovation Request for Information on Concepts for Regional Multi-payer Prospective Budgets.

The Milbank Memorial Fund's mission is to improve population health by connecting leaders and decision makers with the best evidence and experience. One of the Fund's major goals is to facilitate information sharing among peer networks of state officials and other stakeholders with the goal of developing or applying evidence to address emerging policy challenges.

Thank you for the chance to comment on the regional multi-payer prospective budgetconcept as discussed in the RFI. Total costs of care measurement has been an areaof considerable Milbank work with selected states. The concept presents a significant opportunity for payers and communities alike who are struggling with effective transitions for socially valuable institutions that are not currently constructed to meet the trends toward more community-based health care delivery. Properly constructed, multi- payer prospective budgets offer the opportunity for such entities to change their servicemix, preserve their community presence in a new role, and meet accountable milestonesrelating to cost and quality.

A recent Milbank Fund report, "State Models for Health Care Cost Measurement: A Policy and Operational Framework," addresses many of the questions posed in the RFI, particularly the more operational and technical aspects. While we cannot speak for thestates represented in the report, we can highlight specific examples from theirexperience that should benefit CMS's review of the issues. I have attached a copy ofthe report for your detailed consideration; a brief recap and summary follows. In addition, this letter will draw on our experiences with multi-payer alignment for primary care transformation through two Medicare-sponsored projects, providing important lessons that bear on the RFI's questions.

States Included in Milbank Cost Measurement Study

The Fund launched this project at the request of four states that have advanced models for health care cost measurement and establish limits on the rate of health care cost growth – the states featured in the report included Maryland (cited as a model for the RFI), Massachusetts, Oregon, and Vermont.

- Two of these states – Maryland and Vermont – had implemented all payer models for hospital budgets; they have now obtained waiver approval (MD) or are developing new waiver proposals (VT) to include additional categories of spending such as physician services in their all payer models.
- Massachusetts enacted statutory provisions to measure and publish data on costs across all payers, and to establish a spending growth cap formula based on a percentage of the gross state product. In future years, the Health Policy Commission is vested with statutory authority to set the target at a lower rate of growth.
- Oregon has set global budgets for Medicaid spending through the rate setting process for its Collaborative Care Organizations (CCOs). The CCOs are charged with managing almost all Medicaid services for the enrolled populations (defined by regions) and the CCOs are at risk to control spending growth for many (but not all) categories of those covered services.

Broad Strategies and Complementary Goals: Our comments in this section primarily address Q. 2 relating to financial arrangements as the policy context for the global budget concept.

The states have developed health care cost measures and limits on spending growth in the context of two broad strategies to advance health care transformation: payment reforms that are aligned with total cost measures for defined populations and/or services; and transparency in health care performance, including but not limited to total cost measures.

- Three of the four states (MD, OR, VT) are using rate setting as the primary policy vehicle to set and enforce spending limits. These three states have also developed methodologies to share savings with providers and invest in new capacity to better manage cost and population health, and to improve quality.
- The total cost measures may also assist states to monitor and regulate cost shifting between payers by creating a more transparent or regulated system to monitor the effect of various cost savings and quality improvement initiatives.

The efforts described here are the service of goals that involve limiting the rate of increase of costs of care for the states. In the type of project envisioned by the RFI, the work on total costs of care measurement and budgeting would be in the service of broader policy goals yet to be defined, but presumably involving the preservation of important community institutions in a geographic region while redefining the services they offer. The complexities of such a planning process, it should be noted, may dwarf the measurement and budgeting steps analyzed in this letter.

Governance and Authority: Our comments in this section primarily address Q.4 relating to the scope of payer involvement and the role of states or other organizations, as well as 0. 11 relating to multi-payer participation and alignment.

The four states included in Milbank's study have implemented different governance models to carry out their new responsibilities. Two states expanded existing state policy organizations (MD, OR), one state consolidated existing and new authorities (VT), and one state created new entities (MA) to develop and implement their cost measures and spending targets.

CMS should give careful consideration to this element of regional prospective budget model, particularly as it relates to the role of states.

- States have an important stake in health care cost growth trends that have exceeded the rate of economic and state revenue growth, and consume a growing portion of state revenues compared to other categories of spending.
- States have strong policy levers to implement global health care cost measures – they can provide leadership to bring all stakeholders to the table in the public's interest; they can establish and enforce requirements for the system through a public process; they already have policies and operational capabilities that address many elements of the global budget concept (e.g., developing payment methodologies, implementing hospital budget controls, collecting and publishing health care performance data); they pay for services to Medicaid enrollees and public employees; they license providers and health care insurers.
- With these activities, states can establish the conditions for the public and stakeholders to initiate or participate in collective actions to address cost growth in pursuit of population-based benefits.

We recognize that CMS is considering regional models, given the size and diversity of many states' health care markets. While challenging to coordinate, these models make much economic sense. Our experience with primary care is that for providers to transform themselves, they must be sent consistent economic signals for the majority of their patients/revenues. This requires multi-payer alignment in geographic markets that are often smaller than entire states.

Medicare participation in these regional projects is extremely important, if not essential, and much can be learned from the Medicare Advanced Primary Care Practice and Comprehensive Primary Care Initiative Projects about how this alignment can be successfully achieved. Typically it involves well-facilitated local dialogue, a process to establish consensus on goals and policies and an active public sector role to address antitrust concerns and insure Medicaid participation. ERISA is problematic: often the participation of self-insured purchasers is necessary for sufficient revenue share in the affected providers, and to address free-rider concerns.

One of the key considerations for the success of a regional budget concept will be the ability of a lead organization to obtain and maintain the participation, and enforce the rules of the road, among the critical mass of providers and payers. Whether such a project is voluntary or compulsory, a very robust governance model and commitment of the stakeholders will need to be demonstrated up front for this concept to succeed. It is possible this new governance structure would require some sort of statutory authority – how it would relate to existing state, regional and local structures and regulatory authorities are important considerations

Whether the public sector leads, facilitates, or merely participates, this development process will depend significantly on local culture or leadership. In our experience, however, the government levers for this work are significant and must be coordinated. Thus to be successful, the project must be a priority for state officials.

Key Policy and Operational Activities: Our comments in this section primarily address Q. 4 relating to financial arrangements and the scope of services included as well as Q. 5 relating to data sources and infrastructure.

Establishing total cost measure or global budgets requires a significant amount of expertise and operational capacity.

- The first consideration is the scope of services to be included under the global budget. States have collected and published data for all types of services, but their policy focus for new delivery and payment models has generally started with acute and primary care services. Except for OR's Medicaid waiver, the states have not yet included behavioral health, long-term care, or substance abuse services as part of an enforceable cap (although MD and VT plan to address these components in the future).
- The states have generally focused on aggregate cost information for services (e.g., hospitals) or systems (e.g., an AGO), but they have not set provider specific measures or limits. Provider specific measures or limits would require enough data for patient attribution, and some type of risk adjustment, which further increases data and analytics requirements.
- The states have actively promoted the use of alternative payment methodologies by health plans and payers to strengthen the policy alignment with cost measures. However, the states generally have not explicitly factored their cost measures and growth limits into the review and approval of insurance premiums.

As noted in the RFI, the global budget concept would require robust data systems and analytics.

- Many states (including the four study states) have developed all payer claims databases (APCD) that can serve as a foundation for the global budget data requirements. However, APCD data alone are not sufficient. States generally do not have complete Medicare claims data. The question of states' authority to mandate data submissions from ERISA plans needs to be addressed. Some states rely on voluntary data submission. As a result, the four study states have supplemented their claims data with other data collected from providers and plans.
- The current model for state data collection systems is very costly and has many redundancies. In addition, states have invested considerable effort to define their cost measurement specifications. CMS leadership for the global budget concept could lay the groundwork to identify potential solutions including standardized specifications for data and measures.
- Traditional claims data will be supplanted in part with the advent of alternative payment methodologies. Encounter data or other proxies for claims data will need to be developed, and considerable resources are required to develop these new systems and validate them compared to claims data.
- These functions would need to be performed on a regular basis by some neutral party, with the authority and resources to collect and analyze the data.

Federal-State Policy Alignment: Our comments in this section primarily address Q.4 relating to federal and state roles to implement a global budget model.

The four study states have been engaged in complex and lengthy negotiations with CMS regarding the alignment of Medicare and/or Medicaid participation in their cost measurement models. In particular, we would note that the amount of time to obtain Federal program approvals would need to be factored into the design of a specific program solicitation for a regional global budget should CMS choose to proceed.

- CMS approval would be required for states to implement new models to control total cost growth rates as they could affect important Medicaid program features required by law, including potential impacts on mandated benefits, adequacy of provider and health plan rates, and quality and access measures. CMS would also need to approve a regional global budget model by definition because it would vary from Medicaid's "statewideness" requirement.
- CMS has primary responsibility for the Medicare program, unlike Medicaid, which is overseen by both CMS and individual states; therefore, if states or regional entities want to include Medicare in their total cost strategies, additional federal approvals will be needed. This would include access to Medicare enrollment and claims data as well as participation in any new payment models.

Accountability: Our comments in this section touch on Q. 3. 6. and 8addressing payment issues and potential unintended consequences.

Although outside the experience of our study a key concern for those payers participating in a global budget exercise will be avoiding extra and double payments for services that "leak" from the accountable provider to others in the community. Significant thought needs to put into preventing this occurrence including the investigation of reconciliations or "clawbacks" from payments, and patient attribution and incentive measures.

Concluding Observations: Our comments in this section primarily address Q. 4 in regard to characteristics of a governing model. Q. 11 in regard to payer participation (Leadership). Q. 2 in regard to general methodology. and Q. 5 in regard to data sources (Total Cost Measures and Standardization).

Leadership: The attached Fund's report highlights many of the challenges associated with health care transformation in general and with establishing measures and limits on health care costs in particular. The state's experience to date shows it is essential to establish a political consensus, obtain buy-in from key stakeholders, and lay out a clear regulatory or legislative framework in order to successfully launch and sustain cost control measures. Again, to be successful this effort must be prioritized.

Getting to Total Cost Measures: In general, the states have focused on collecting and reporting data on expenditures (payer perspective) and/or revenues (provider perspective). Total cost is a more complicated concept and measurement challenge, and it requires the capacity to link population demographics, service utilization, and claims across a variety of data sources-a process that is complex and costly.

In addition, the current methods of measuring cost do not capture the full spectrum of costs from a consumer perspective. There are some data on health plan cost sharing, but such data will not reflect costs for uninsured populations and many out-of-pocket services. This could be an important innovative feature of a regional global budget model, but iiwould take additional time and resources to design and implement.

Standardizing Cost Models: Today, each state is developing its own model for cost measurement, generally looking at cost from a statewide population perspective. Manyother stakeholders are pursuing similar initiatives at a grass roots level (e.g., physician practice level measures for total cost). As more states and stakeholders pursue these initiatives, it may be timely to consider the need for a national set of standards. The useof standard models would facilitate broader comparisons of performance and reduce measurement burden; it would also support more robust methodologies for public reporting at a system or provider level. A regional global budget initiative could providea national platform for these policy and technical discussions.

Based on the Fund's experience with the activities described above, I would summarize our suggestions as follows:

- Clear policy goals. A regional budgeting model needs clear policy goals regarding its delivery system goals.
- A robust multi-payer model is necessary including Medicare and Medicaid to achieve the necessary scale of provider and population impact, and justify the time and resources needed to advance a global budget concept. Voluntary participation is politically attractive, but may not provide the economic stability, regulatory authority and consensus development mechanisms needed to accomplish the policy goals intended.
- There should a comprehensive set of accountability measures for the providers and services included in the models, but there should be careful consideration of administrative complexity and burden.
- Ideally, the global budget concept would be designed to have a broad and measurable impact on population health, not just delivery system structure, in the region. However, many of the non-health providers that would be included in this ideal model will require additional lime and resources to take financial risk. An incremental model (in terms of scale and timing) may be needed.

I commend CMS for advancing these important policy questions, and I would be pleased to answer any questions arising from this response.

Sincerely
President
Milbank Memorial Fund

Attachment: Milbank Fund Report

American Hospital Association

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May 12, 2016

Patrick Conway, M.D.
Deputy Administrator for Innovation & Quality, Chief Medical Officer
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: Centers for Medicare & Medicaid Services' Request for Information on Concepts for Regional Multi-Payer Prospective Budgets

Dear Dr. Conway:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Request for Information (RFI) on Concepts for Regional Multi-Payer Prospective Budgets.

Our members are working to redesign the delivery system to provide better, more efficient, coordinated and seamless care for patients. **The AHA supports accelerating the development and use of alternative payment and delivery models that allow hospitals and health systems to achieve those goals. We appreciate CMS's efforts to examine an array of alternative payment models and we support the agency's efforts in exploring the feasibility of global budget payment programs in geographically defined communities. However, designing a global payment program to address the unique needs of various hospitals and health systems, including rural hospitals, is a challenging undertaking and we urge CMS to proceed in a thoughtful and deliberate manner.**

The AHA is currently exploring such a model as part of its Task Force on Ensuring Access in Vulnerable Communities, which is examining ways to ensure access to essential health care services in vulnerable rural and urban communities. The task force believes that global budget payment models, if appropriately structured, may provide the flexibility needed for hospitals in vulnerable communities to provide care in a manner that best fits a community's needs and circumstances. Global budgets also may provide financial certainty, potentially fair payments and incentives to contain health care cost growth and improve quality. The work of the task force is ongoing, and we look forward to sharing additional insights with CMS in the coming months. In the interim, we offer several overarching recommendations on global budgets.

The AHA's 2015 Committees on Research and Performance Improvement explored the redesign of a new care delivery system and identified seven key principles. The AHA supports the inclusion of these principles in any new delivery system, including the global budget payment model being examined by CMS. They are as follows:

1. *Design the care delivery system with the whole person at the center.* System design must start with the whole person, putting each patient's needs and ease of access to care before the needs and convenience of the system and its clinicians.
2. *Empower people and the care delivery system itself with information, technology and transparency to promote health*. Use technology and information to activate patients in their own care and to promote life-long health. For transformational health care delivery, patients who are highly "activated" will have better health outcomes.
3. *Build care management and coordination systems.* Develop effective care teams that provide quality care to patients through teamwork and delineated roles.
4. *Integrate behavioral health and social determinants of health with physical health*. The design of the health care system must include resources and services to provide support for behavioral health care, particularly diagnosis, treatment and prevention.
5. Develop collaborative leadership. A new care delivery system should include collaborative leadership structures with clinicians and administrators, and also focus on leadership diversity.
6. *Integrate care delivery into the community*. Participation with other organizations that offer vital community services and resources is essential if optimal health outcomes are to be achieved.
7. *Create safe and highly reliable health care organizations*. By creating a culture of high reliability, hospitals improve quality and patient safety.

In addition, to optimize the effectiveness of a global budget model, CMS should provide hospitals with the necessary tools to be successful under the program. We have several recommendations to help accomplish these goals:

- **Participation in the global budget should be voluntary and determined at a regional level.** CMS also should consider expanding the global budget model to include participation by additional health care providers (e.g., physicians). This could further align health care providers and increase accountability for the health care services offered within a community. In addition, any region choosing to participate must have population density necessary to sustain a global budget and, to the extent possible, should be permitted to select the types of services that will be included in the global budget.

- **The global budget model should be designed to account for different sizes and types of hospitals that are at very different points in the transformation process.** Hospitals and health systems have built care processes and policies around the current regulatory payment structures, and these systems will have to be changed if they are to achieve success in a global budget program. This is no small task. It will require significant investments of time, effort and finances. For example, hospitals and health systems will need to build upon their current infrastructure for health information technology, patient

and family education, care management and discharge planning. They also will need to align with other providers, both physicians and post-acute facilities, to achieve efficiencies under the model. This will entail forming new and different contractual relationships that build valuable partnerships and incentivize successful strategies.

- **The global budget model should include policies dedicated to critical access hospitals and small/rural hospitals.** While this RFI seeks general feedback on global budgets, CMS also has asked for specific feedback on the feasibility of rural hospital participation in global budgets. As indicated above, some hospitals already have taken significant steps toward achieving delivery system reform; however, rural hospitals may not be as far down this path. Specifically, due to small volumes, critical access hospitals and many small/rural hospitals have been unable to meaningfully participate in value- based payment programs or develop and sustain alternative payment models. While these hospitals would like to be part of a global budget conversation, they lack experience participating in alternative payment models and feel as though a global budget would likely be "too much, too soon." As a result, the AHA urges CMS to consider payment policies that may bridge the gap between current fee-for-service or cost-based reimbursement models and a global budget model. For example, CMS could consider a transitional hybrid payment system that includes a fixed payment that continues to cover fixed costs, but also includes incentives to achieve better health and healthier communities.

- **Payments should promote predictability and stability.** The methodology that CMS uses to set global budget payment amounts should balance savings to the Medicare program with provider financial stability and patient access to care. Payments should be predictable, stable and sufficient to allow providers to build the infrastructure and capability to redesign care delivery. This includes payments that take into account the administrative costs or capital expenditures associated with participation in a global budget model, as well as risk adjustment and high-cost/high-risk utilizers. In addition, CMS should balance the risk versus reward equation in a way that encourages hospitals and health systems to take on additional risk but does not penalize them for the additional time and experience they must gather in order to fully participate in a global budget model. Doing this would help facilitate hospitals' success under the program with regard to providing quality care to Medicare beneficiaries, achieving savings for the Medicare program, and also having an opportunity for reward that is commensurate with the risk they are assuming.

- **Providers need access to timely data and information.** Access to actionable information related to care, payment and cost will be essential to the success of a global budget model. For example, access to real-time data on patient utilization and spending for services across an episode of care will be necessary to actively manage care offered to patients. CMS will need to ensure open access to information from public and private payers to allow hospitals and health systems to make more informed decisions regarding their care delivery in the global budget model.

- **Waiver of fraud and abuse laws, as well as certain Medicare payment rules, is essential**. To allow hospitals to form the financial relationships necessary to succeed in a global budget model, it will be critical for CMS to issue waivers of the applicable fraud and abuse laws that inhibit care coordination. Specifically, CMS should waive the Physician Self-Referral Law and the Anti-kickback Statute with respect to financial arrangements formed by hospitals participating in a global budget model. These laws were designed for a different world of care delivery and payment and are not compatible with a global budget model.

  Waivers of many existing Medicare payment rules also would be necessary to provide participating hospitals with maximum flexibility to identify and place beneficiaries in the clinical setting that best service their short- and long-term recovery goals. This includes, but is not limited to, the waiver of discharge planning requirements that prohibit hospitals from specifying or otherwise limiting the information provided on post-hospital services, the skilled nursing facility "three-day rule," and the inpatient rehabilitation facility "60% Rule." These waivers are essential so that hospitals and health systems may coordinate care and ensure that it is provided in the right place at the right time.

- **CMS must address the interaction between the global budget model and existing alternative payment models.** The agency should ensure appropriate blending of different payment models to build upon the work that many hospitals and health systems have already taken to improve health care delivery. Hospitals and health systems have already invested resources to participate in existing Medicare alternative payment programs (e.g., the Medicare Shared Savings Program, Bundled Payments for Care Improvement Initiative and Comprehensive Care for Joint Replacement Model), and CMS should ensure that development of metrics for the global budget model will not work against those efforts. In addition, CMS should use its best efforts to streamline the metrics and quality measurement efforts in the global budget model with those already in existence for other alternative payment models.

Thank you for the opportunity to comment. If you have any questions, please feel free to contact me or Priya Bathija, senior associate director, policy development, at (202) 626-2678 or pbathija@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development

Reply to RFI - Concepts for Regional Multi-Payer Prospective Budgets

Due May 13, 2016

Joanne Lynn, MD, MA, MS, Director, Center for Elder Care and Advanced Illness

INTRODUCTION AND CONTEXT

I am very pleased to see CMS investigating this strategy for reforms of health care delivery. I have worked with multiple hospitals and regions in Maryland, as well as cities and counties elsewhere in the U.S., aiming to improve the care of elderly persons living with frailty, disabilities, and advanced illnesses. I have become quite convinced that, at least for this population, a substantial component of geographically-based management of the delivery system is key to reliable, efficient, high-quality care. Some of the more successful states working on the various demonstrations involving persons who are eligible for Medicare and Medicaid have implemented the work regionally (e.g., Colorado, Oregon, Michigan). Even Maryland is working toward regional collaborations and is giving grants on that basis.

The RFI is written as if regional budgets would be implemented "all at once" for all people and all payers; but, more likely, a reform this substantial would have to be implemented in stages, since many adjustments would be taking place. Good reasons support a decision for the early stages to focus on care of the frail and disabled elderly population. This population is quite dependent upon its community and the environment and services that are readily at hand. They can't travel for second opinions or bed baths! The workforce for personal care is tied to geography, as are the disability-adapted housing options, the availability of assisted transportation, and even the flexibility of employers regarding employees engaged in family caregiving. Long-term services and supports affect both health and health care, but are funded, provided, and regulated quite separately from medical care. Integrating the service array and managing it for a geographic population enables major efficiencies, e.g., by providing in-home services on a geographically concentrated basis and thereby cutting down travel time and reducing the need to charge for minimum stays. Furthermore, care of the frail and disabled elderly is a locus of exceedingly inappropriate medical care, so early successes in improving medical care while reducing costs are likely. Independence at Home demonstration sites have shown the early potential. Indeed, for most Americans, the period of ADL dependence in the last years of life is the period when they spend around half of their life-time health-related costs. And this population will double in the next twenty years, making it the most substantial predictable demographic challenge for CMS.

As a start on practical implementation, willing and appealing communities could nominate themselves to pioneer this concept. Providers could continue being paid as they have been, while population-based

measures of access and quality are put in place and a Community Board becomes established. That Community Board could be, for example, an arm of government, a coalition of providers and representatives of communities, an offshoot of the Area Agency on Aging, or a function of the public health office. It would need to monitor performance and costs (to Medicare, Medicaid, the Veterans Health System, and patients/families) and to have authority to set priorities and implement improvements. As the work saves money through improvement, most of the savings should be invested in community priorities for this population, rather than presumed to be counted as savings to the payers or income to the providers. Community investment priorities might include, for example, workforce training or recruitment, removing waiting lists for critical supportive services, or providing after-hours medical care or caregiver respite.

A very quick way to test this approach is to use the new authority to expand PACE programs. Some PACE programs have a combination of community rootedness, community coalescence, management capabilities, an existing community advisory board, and expansion possibilities that would enable them to set up the Community Board for the whole community. They already have something very close to prospective budgets for their enrolled population, coming from dual capitation from Medicare and Medicaid. They would need to test how best to market a fair price to Medicare-only beneficiaries who would pay for their long-term supports and services (LTSS) privately. We are working with PACE providers to spell out the details of a tiered set of services and the associated pricing, so that Medicare-only private payments function like Medicaid payments in the revenue stream, coming in monthly and being mostly predictable.

Regional management of eldercare has the advantage of having the main payer be CMS –through Medicare and Medicaid. The Veterans Health System also serves this population, and it would be a welcome feature to include Veterans Health System payment and services from the start. However, working with this population does not require soliciting the cooperation of the myriad other "commercial" payers. Intermediate payers, mostly capitated Medicare Advantage plans, are important in some areas and the interface with them will need to be spelled out in those communities. However, the participation of the usual commercial plans will be mostly irrelevant for this population.

Thus, CMS should try out regional authority, and CMS should try this reform out first for its prime population of frail and disabled elders. CMS should allow regions to go forward on the basis of a regional coalition that can be accountable for coordinating the services and taking responsibility for the overall financing. The remainder of my comments reflects this orientation.

<u>SECTION I: Information regarding regional multi-payer prospective budget concept</u>

- The concept requires building a strong sense of community across the region, so it probably needs to be implemented mostly in areas smaller than states (other than RI and DC).

- The prospective budgeting needs to avoid the well-known problems of block grants, which have been particularly difficult to monitor, prone to diversion to political ends, and challenging to explain to the public. This would be possible by using a capitation or shared savings model, at least until standards are better established.
- Having a constant pressure for savings from investor-owned companies will make it very difficult to establish broad standards. Early work should be limited to government-sponsored or potentially non-profit entities doing the management of funds and the setting of priorities. If private investment is needed to get underway, it should be with financing that establishes limited investor returns, such as social impact bonds, pay-for-success, and other creative financing plans.
- Performance and financing must be open to public scrutiny. This will require development of new quality metrics that reflect the priorities of elders and their families. Elements like living where one prefers (e.g., in the family home), avoiding impoverishment, maintaining relationships, avoiding severe caregiver burdens, and living comfortably will need to be developed. Most fundamentally, having a comprehensive, practical, elder-driven care plan and monitoring its implementation and performance will be a largely new and important element of performance. As an aside, once most elders in a region have a high-performance care plan, the aggregation of these plans will provide a remarkable new tool for community planning and priority setting.
- For frail and disabled elders, the appropriate care plan runs to the end of life, the provider system needs to be able to "make promises" as to performance through the last years or months of life, and thus the provider system has to be integrated across settings and time in important ways.
- The fact that the category's members leave the system by death creates challenges for quality and cost measures, and those interactions have largely been underdeveloped.
- Simultaneous with implementation of a regional plan to finance eldercare, CMS will need to develop the quality measures and dashboards and the templates for business plans and revenue flow, so that these are appropriate to this population.

SECTION II: Questions on prospective budget methodology

1. The geographic area for which CMS would set budgets needs to comport with allegiances of elders to the community, so that people generally are willing to consider this to be a shared community responsibility. This means that it will generally be geo-political boundaries – counties or cities. I would recommend starting out with regions defined for other reasons that are working well – regions for dually eligible persons innovations might be an example. Either from the start or after some programs are working well, the state will need to ensure that all

geographic areas are included in some plan. So, if a state allowed a handful of communities to undertake this work, it would be with the understanding that a future realignment would alter the boundaries so that no one is left out. Instead, a state could define the boundaries at the start so that all will be covered. There will be boundary issues, as there are now, and they will need to be ironed out in a fair way, with quality measures and finances being implemented to limit unfair allocation.

The budget would start out being set by historic spending. As standards become clear, budgets would be set by those standards, and the variations that afflict historic spending would gradually be eliminated. The standards would iteratively adjust for socio-economic and disability factors affecting the population, not just medical diagnoses.

2. Attribution would be from residence in the geographic area, and CMS would include costs for all payments, including Medicare, Medicaid, and Veterans Health System at least. One could count personal spending as an element of quality, including a measure of the tendency of the care system to incur spend-down to Medicaid (and foregone savings for the family caregivers).

3. Providers would initially be paid as they are now, but the savings would accrue to the community and would serve its priorities. Over time, preferred networks or narrow networks of providers that are efficient and high-quality would be more highly utilized. As more elders joined an expanded PACE program (or some arrangement that is functionally similar in being globally budgeted and regionally anchored), the capitation budget would come to substitute for the fee-for-service payments. As capitation is brought in line with other areas, the system would evolve to function as a global budget.

   If the aim were to move to a global budget more directly, then preserving choice in Medicare would seem to require marketing aggressively to the affected elders and families and moving to a capitated system (as in expanded PACE) or a global budget very quickly.

4. The Community Board would initially participate in setting the rates and negotiating the details of the savings calculation, but that would quickly become standardized and predictable as evidence grew and deliberate efforts were made to assure standardization. States could take this on if they initially established regions and provided the coordination and infrastructure for the work.

Eldercare entities would need support in working with claims and surveillance data, since they are not generally powerful entities now and usually do not have access to technical expertise in creating dashboards and process control charts.

5. Data would need to come from claims and care plans, so that the data included supportive services, both in the community and in facilities. One very important new source of data would be aggregation of care plans, designed to support community planning for the well-being and efficient care of the region's frail elders.

6. A major threat to this plan is the remarkable rise in the costs of new medications, devices, and diagnostic approaches. Either the budget has to rise to accommodate these, or the community has to come together to judge some as being too expensive for their merits. This is a pervasive challenge, of course, and one that is actually probably rather less pressing for frail and disabled elders than for younger populations. Nevertheless, this initiative would be somewhat affected by the escalation of costly medical interventions and of prices. Perhaps that is another reason to start with this population where these effects are somewhat muted.

7. The quality measures applied to this population at present are so inadequate as to be harmful. The key quality measure has to be whether the care plan is designed to support the elder's priorities, not whether the person has had cancer screening or has someone else's definition of optimal blood pressure management. Metrics like caregiver burden, family impoverishment, isolation, and comfort also count. One would need to aggressively develop and then set new quality metrics in place. The professional organizations of clinicians serving this population have been too weak to take on measure development at the NQF standard, so CMS needs to address not only metric development but also how to have some organizations that can provide the stewardship of metrics over time.

8. CMS could obviously monitor unintended consequences such as stinting on services, weakening community and regional government, and shifting costs to families. CMS would need to do some deliberate development of methods for understanding the interaction of survival time with quality measures and costs.

<u>SECTION III: Questions of potential participants and population health activities</u>

9. The high-quality providers of geriatric and palliative care services to this population include mostly team-based clinical care, community services, and long-term services and supports (including home-delivered and congregate meals, transportation, adapted housing, caregiver supports, and personal care). These are seriously underdeveloped in the U.S., having been

underfunded and excluded from infrastructure developments such as interoperable information technology. Leadership communities would be those that happen to have leadership providers, and other communities would need technical assistance to bring their performance up to standards.

10. Population health activities for this population build on age-friendly community strategies, such as requiring universal design in buildings and streets, providing community security for persons with mild cognitive impairment, engendering friendly visiting and chores on a "villages" or neighborly basis, and prevention of falls, delirium, and depression. These are all eminently practical and usually not costly, but frail and disabled elders have been left out of most endeavors to improve population health in this country. We don't even have population-based metrics on well-being or adverse events.

11. Payer participation beyond Medicare and Medicaid actually involves mostly accounting for elder and family costs. Other payers are trivial additions at this time. Long-term care insurance covers only part of the costs for less than 10% of the population. The Veterans Health System can be a sizable contributor, but that source is even more important for their pioneering work in how to provide high-quality care efficiently. They have pioneered medical foster homes, home-based primary care, team care, continuity charts, advance care planning, and workforce development. Many elders do have Medicare co-pays and deductibles insured in MediGap plans, but those are readily estimated and their influence on service delivery is modest. In some areas, existing Medicare Advantage plans (including SNPs) are important to engage. But generally, for this population, the participation of CMS and the state is enough.

So – bottom line recommendation – move ahead on this, starting with frail and disabled elderly Medicare beneficiaries in willing and able communities.

(I did not comment on Section IV, the potential rural specific option.)

Request for Information (RFI) on Concepts for Regional Multi-Payer Prospective Budgets Comments from the Pennsylvania Office of Rural Health

To: Centers for Medicare and Medicaid Innovation

Since 1999, Pennsylvania has participated in the Medicare Rural Hospital Flexibility Program and at present, 14 of the State's hospitals have been designated as Critical Access Hospitals. Due to this designation, these hospitals continue to provide outstanding medical care to their communities. Five of these hospitals have built replacement facilities. It is expected that as of July 1, 2016, 15 hospitals in Pennsylvania will be designated as Critical Access Hospitals. The Pennsylvania Department of Health has recently begun exploring options for a Multi-Payer Prospective Budget for rural hospitals and their communities within the Commonwealth. The Pennsylvania Office of Rural Health (PORH), as the grantee for the Medicare Rural Hospital Flexibility Program, has been consulted on this initiative.

While the Medicare Rural Hospital Flexibility Program has been largely successful, there is a recognition that a move to some form of value-based payment system is in the best interests of all concerned. Cost-based payment systems for Medicare (and Medicaid in Pennsylvania) have their limitations when the primary aim is to improve the health and health outcomes of the population while also lowering costs.

PORH has limited the comments for the RFI to Section IV Potential Rural Specific Option. The large health systems in Pennsylvania (i.e., University of Pittsburgh Medical Center (UPMC), Geisinger Health System, and Highmark Blue Cross and their Allegheny Health Network) make the Commonwealth an interesting market for a concept like a Regional Multi-Payer Prospective Budget. The comments below address how the concept could work given the large payers in Pennsylvania.

PORH is a member of the National Organization of State Offices of Rural Health (NOSORH) which also will be providing comments to the RFI. PORH has reviewed the comments being made by NOSORH and is largely in agreement of those proposed. Most certainly, PORH agrees with the need for flexibility for rural health networks in service area definition and what constitutes a provider network. The need for Care Coordination Services and a funding system for these services is strongly seconded by PORH.

Any questions regarding the attached response to the RFI can be made to:

Larry Baronner
Rural Health Systems Manager and Deputy Director
Pennsylvania Office of Rural Health
310 Nursing Sciences Building
University Park, PA 16802
814-863-8214

Section IV Potential Rural Specific Option

12. Critical Access Hospitals (CAHs) must be prepared to participate in value-based payment systems. Decisions made in the past to exclude CAHs from quality reporting were not in the long-term best interest of the hospitals. In Pennsylvania, 50% of the CAHs are affiliated with a health care system. These CAHs bring value to the system by way of the rural populations and referrals they bring to the system for higher end services. Incorporation into a Regional Multi-Payer System for these CAHs should be relatively uncomplicated. Certainly a question within the health system would be how to attribute patients to their rural hospitals and how to share in the reward and downside risk for providing for the total cost of care for patients attributed to the CAH.

Independent CAHs with a defined geographic and market areas could also benefit in a Regional Multi-Payer Prospective Budget Payment System. The model described below could be an option for this group of CAHs and larger rural hospitals.

The most vulnerable CAHs are those that share a market with a larger health system. In these markets, where patients can more easily travel for services and are not tied to any defined health system, the CAH could be vulnerable to being carved out of a market due to its lack of breadth of services and lack of market power to contract out for those services.

What is needed for the health care-affiliated and independent CAHs is a patient attribution model whereby patients select a health care system as their coordinating health care home. This system could be a large system. Examples in Pennsylvania are the UPMC Health System and the Geisinger Health System. It could be a mid-sized system such as Susquehanna Health, located in Williamsport, PA or DLP Conemaugh Health System in Johnstown, PA. Independent CAHs that are geographically and market defined are Cole Memorial, Coudersport, PA or Fulton County Medical Center, McConnelburg, PA.

The mid-sized and the small systems would have multi-payer contractual arrangements for transfer and referral services. Largely it would be a make vs buy decision. Patients in these geographic areas would not be limited in their options for health care. Ideally, they would select their local health care home, could opt for a larger system, and then have limited access to the local provider. The health care consulting firm Stoudwater Associates, located in Portland, ME has created a "Health System ACO Value Matrix" that could easily be adapted to this "Patient Attribution Health Home" model. Patients would be incentivized to use the In-In-Network for health services, accessing services at the right time with the right provider. The In-Network, where certain services are contracted, would be the next best option with payment for services negotiated by the system. Patients would have the option to seek "Out-of-Network services but would assume more of the cost for these services as they would be "retail" priced.

13. No matter what sized health system, there needs to be an upfront investment in an infrastructure to be able to operate in a Multi-Payer Prospective Budget system. Both health information technology and care coordination processes must be put in place. With respect to HIT, not only are Electronic Health Records needed but almost importantly, data analytics systems must be available that can deliver to health care providers immediate patient information

on both clinical and claims as a key to decision making. Health Information Exchanges will be necessary an information conduit. Cost and quality data for referral purposes will be a necessary transparency for providers and patient decision making.

Those rural hospitals that a part of a larger system that has data analysis and care coordination will be the rural hospitals most likely to be able to manage the downside risk. For rural hospitals to be viewed as successful in such a system, there needs to be a way in which the patients (covered lives) will be attributed to the rural hospital as the medical home of these patients and receive credit for providing high quality, low cost care.

14. Many rural hospitals, including CAHs, have already affiliated with larger health care systems and many more are evaluating affiliation options. For those that are already part of a larger system, the basic support systems are largely in place. Specialty care, HIT, and QI activities have, for the most part, been instituted. Many mid-sized and hospitals continue to need better data analytics and care coordination processes. For independent rural hospitals, the question remains as to whether these support systems can be obtained through contractual arrangements. For patients selecting the rural provider as their medical home, will the rural provider be able to manage the cost/quality outcomes to attain the desired savings through multiple payer contracts? With data analytics being necessary to any health care system management across multi-payers, this will be difficult at best for rural providers.

15. In a geographically defined rural region, patients would be encouraged to select the local health care provider as their In-Network with health care being provided and the risk accepted by the local system. The aggregate potential costs of the patients attributed to the system would be determined by using an algorithmic formula based upon multifactorial information including demographic, clinical history, etc. Currently available population health data could be included as secondary data. The evaluation of quality outcomes would be derived by analysis through the use of EHR systems. Clinical care could be compared against Evidenced Based Practice. Rural-relevant measures would be key to analyzing the care provided in rural settings.

16. For system-affiliated rural hospitals, it will be in the best interest of the system to manage transfers and referrals for the best cost/quality outcomes. For non-affiliated rural hospitals, including CAHs, can this be accomplished by contracting for services? Can these rural hospitals "purchase" the needed referral services based upon value metrics?

Larger health systems seeking to broaden their market and expand services could provide improved access to services not available in these rural areas. The best scenario for rural providers and their patients would be to have market options for these transfers and referral services, thereby obtaining the best value for attributed patients of the local system.

THREE RIVERS HOSPITAL

415 Hospital Way, PO Box 577 Brewster, WA 98812 (509) 689-2517

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: Centers for Medicare and Medicaid Innovation, Request for Information on Concepts for Regional Multi-Payer Prospective Budgets

Dear Mr. Slavitt,

As Chief Executive Officer of Three Rivers Hospital, I appreciate the opportunity to provide comments on the Centers for Medicare & Medicaid Innovation Request for Information on Concepts for Regional Multi-Payer Prospective Budgets. As a small critical access hospital, Three Rivers Hospital is committed to innovating to meet the challenge of delivering high-value care to our local community. Nearly 90% of our patients are seen in an outpatient setting, whether it is through primary care, obstetrics or therapy services. We believe that a prospective budget model that is thoughtfully designed to reflect the unique needs of small rural hospitals can sustain the crucial services we provide in the local community and we look forward to this opportunity.

As part of the Washington's State Innovation Model work, our hospital and other small hospitals like us have partnered with the Washington State Hospital Association, our state Medicaid agency and Department of Health to develop and pilot a new payment and care delivery model for the communities served by Washington's most vulnerable critical access hospitals. Known as the Washington Rural Health Access Preservation (WRHAP), a dozen of Washington's smallest CAHs have been meeting over the last year to design a model that will sustain access to essential health services in rural communities.

We believe the work undertaken by this group can provide a foundation for the development of a multi-payer prospective global budget model that could be implemented successfully in communities like ours. We urge that you work collaboratively with us and the rural providers in other states to craft a sustainable

and effective solution to the healthcare needs of rural communities.

Sincerely,

J. Scott Graham
Chief Executive Officer
Three Rivers Hospital

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

A prospective budget could be determined for individual rural communities based initially on the total amount of current spending on all of the healthcare services the residents of those communities are receiving, regardless of the site of service (e.g. hospital, clinic, home health, nursing home) or the community in which these services are delivered. The budget amount should be adjusted to take into account changes in the residential population of the community, changes in the health status of the population, and temporary circumstances (e.g., an influenza outbreak or an increase in tourism).

In Washington State, we are working with about a dozen small, remote, rural Critical Access Hospitals on a project referred to as Washington Rural Hospital Access Preservation (WRHAP). Each of the participating hospitals is organized as a public hospital district and are well suited to prospective budget implementation. As statutorily-created entities, the geographic area of a public hospital district is well defined, allowing for relatively easy identification of an attributable population. Additionally, public hospital districts are governed by locally elected boards and function as municipal governments, thereby providing a mechanism for public input and accountability.

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.

As previously stated, the existence of public hospital districts in Washington State allows clear identification of the relevant patient population without the need for complex attribution models. All Part A and B spending for services delivered by the districts should be included in the budget. Spending for other health care services that occurs inside the community should also be included in the budget, but all spending that occurs outside of the community should *only be included in accountability measures, not the payment itself, and those measures must be adjusted* to reflect the portion of the spending that can feasibly be controlled based on the actions of the hospital and physicians in the community. For example, many rural hospitals also serve as rural health clinics, nursing homes and home health agencies, and therefore manage both hospital services and post-acute services in the

community. Others do not have or operate a rural health clinic, and those hospitals should not be held responsible for services delivered by physicians in the community who do not work for the hospital or the public hospital district.

In addition to adjustments designed to address differences in the health status of the community and unpredictable events (such as a contagious disease outbreak), there should be adjustments to focus local accountability on the *utilization* of services delivered by other providers rather than the total *cost* of those services. For example, the community should be responsible for how often patients are hospitalized in other communities for ambulatory care-sensitive conditions, but not for what happens to them once they are admitted to a hospital in another community, since they cannot control what happens inside the distant hospital or the immediate post-acute care services.

The attached working document "Delivering and Paying for High-Value Healthcare Services in Small Rural Communities in Washington State" outlines the continuum of care that our hospitals and communities have determined must be available in rural areas and for which they could be responsible. In Washington's smallest communities, a prospective budget should be structured in a way that would provide the flexibility needed to sustain access to essential services and to build robust partnerships with specialists, telehealth, and larger tertiary facilities to ensure the full range of services.

Physicians and hospitals cannot successfully manage the quality and cost of healthcare services if they cannot assure their patients have affordable access to the appropriate medications. However, it is inappropriate to include Part D services in a global budget unless the providers managing the budget have the ability to control or influence the policies used to pay for drugs under Part D.

12. Should Critical Access Hospitals be included in a prospective budget? 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.

Critical Access Hospitals are ideally suited for a properly-designed prospective budget for local hospital services because of the higher-than-average portion of their costs that are fixed and not dependent on the actual volume of services. However, unless the budget and the accountability for the budget are properly designed, Critical Access Hospitals could be *more harmed* by a budget based on the total cost of care than other hospitals because a smaller-than-average share of total hospital and other services will be delivered by the CAH.

Consequently, we recommend that hospitals be paid on a prospective basis for the services they deliver, and then performance-based adjustments should be made using appropriate measures of total service utilization and spending, including services delivered in other communities.

Any prospective payment model for small Critical Access Hospitals must have provisions for adjusting payments/budgets for necessary increases in volume and for limiting the risk for spending variations. For example, many rural hospitals are located near tourist attractions or interstate highways and so the "population" they serve goes beyond the full-time residents of the community and can vary dramatically over time and from month to month. In addition, because CAHs are small, there is inherently large year-to-year variation in services. Since the hospitals have been paid based on costs, they do not have the kinds of financial reserves needed to adapt to short-term changes in volume if payments do not match the changes in cost. Few small rural hospitals have the staff or reserves to accept or manage any significant downside risk, and resources (both technical and financial) will be needed to support transformation to a new CAH payment model.

For these hospitals, a new payment model must allow for sufficient predictability to sustain local delivery system infrastructure for essential health services. This could begin with a per-resident fee from each payer, both public and private, with each payer paying for the residents who are members or beneficiaries of that payer. This fee would support standby services that are needed by all residents of the community. A second per-member/beneficiary fee would be risk stratified by payer according to the chronic disease burden of the local population and designed to support effective chronic disease management. A third payment would be paid for each individual acute service that is delivered, but the amount of the payment would be based on marginal costs rather than average costs, since essential fixed costs would already be covered by the per-resident payments. This means that the per service payments would be much lower than the current payments or reimbursements made today for those services, which in turn eliminates any incentive to overuse acute care services. At the same time, this approach would also encourage greater use of local services rather than distant services where appropriate, and the higher utilization of those services would enable them to be delivered more efficiently and effectively.

Payment should also be tied to accountability measures that are within the purview of the local CAH. Because of the limited range of services they deliver directly, most CAHs cannot assume responsibility for the cost or quality of many services patients will receive, since those services will be delivered by other hospitals or physicians that are often located in distant communities. However, with adequate, flexible payment, CAHs can take accountability for the appropriate delivery of prevention, chronic disease management, and other key services and for controlling the utilization of avoidable services. Accountability measures that are used must adjust for the low volumes of patients seen.

These types of reforms to CAH payments would both provide more predictable revenues for hospitals and physicians, more predictable costs for Medicare and other payers, and higher-quality, more affordable care for rural community residents.

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?

We believe that a prospective payment model can work well for small Critical Access Hospitals but they need to have significant support from CMS. Resources and support include the following:

- **Medicare Data.** Data is needed to analyze the service use of residents within the local district to appropriately assess where they are receiving services and at what cost. To date, the lack of this data has been the most significant impediment to progress in our WRHAP work. We are working with our state to obtain Medicaid data and with our commercial payers to obtain their data. These rural areas have a high proportion of older, Medicare enrollees. The hospitals need to be able to obtain data for these residents as well.
- **Waiver of Medicare rules.** Payment reform cannot occur without delivery system reform. The Centers for Medicare & Medicaid Services (CMS) will need to waive or change various regulations that restrict the hospital's ability to deliver services in new ways in order to facilitate payment reform. One example would be to allow small and remote Critical Access Hospitals to operate short-term "observation-type" transition beds so that low-level acuity patients can remain at the local facility and avoid unnecessary transfers.
- **Funding and technical assistance.** Resources will be needed to support transition. One drawback of the cost- based reimbursement system is that it does not allow for sufficient margins for capital improvements and investments. Care redesign requires significant investment of time and resources from executive teams that may require temporary help to keep the hospital running under the current system while they transition to a new model.
- **Complementary payment reforms for other providers.** Payment and delivery reform for small Critical Access Hospitals cannot occur in a vacuum; appropriate physician payment reforms must be undertaken in tandem with hospital payment reform. Unless independent physicians are paid differently, any prospective budget model for hospitals or for both hospitals and physicians could simply encourage risk shifting between physician and hospitals rather than true improvements of care. Similarly, payment systems between rural hospitals and Federally Qualified Health Centers need to be aligned to facilitate active partnership in community care.

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?

Strong partnerships between small Critical Access Hospitals and tertiary care hospitals

are essential to deliver coordinated, high-value care to residents of rural communities, but these partnerships are difficult to forge and sustain under current payment models for both CAHs and PPS hospitals and for the physicians who practice at the hospitals. Rather than each hospital and physician competing to obtain the revenue for serving a particular patient, they should be able to collaborate to determine which providers can deliver the highest-quality care at the most affordable cost in a setting as close to the patient's home and family as possible. It is important that CMS not try to design one-size-fits-all solutions and apply them to every community, but it is also important that appropriate solutions be developed for all of the providers delivering care to the residents of a community, not just a subset of them.

New payment models promoted by CMS need to sustain the rural delivery system and not simply drive patients to urban settings. New payment models such as care bundles should incentivize local delivery of appropriate care and facilitate partnerships between rural hospitals and larger/quaternary centers. CMS should also increase data flow from payers to facilities that allows for better care management of local populations.

Other changes are needed as well. We are working with the small Critical Access Hospitals on programs to supplement their services via telemedicine. While we have specific telehealth services requirements in our state that delineate coverage by Medicaid and commercial payers, Medicare coverage is still not guaranteed in all cases.

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?

The September 2015 report from the National Quality Forum entitled "Performance Measurement for Rural Low-Volume Providers" is an important first step to developing rurally relevant quality care measures. This work should be expanded to ensure that measures reflect the quality of care delivered, not simply the small volume of care.

Using total cost of care measures to evaluate rural health systems can put those systems at serious financial risk because they cannot control all of the services and providers that drive the total cost of care. However, rural hospitals have an important role in ensuring that local residents are receiving appropriate, high value care and can take accountability for many aspects of costs and quality. Primary care, prevention and emergency care measures tailored to low-volume settings are an appropriate way to ensure value for providers, patients and payers.

In addition, because of their small staffs, low operating margins, and lack of capital reserves, rural hospitals are unlikely to have the technical or financial capability to take on significant downside risk for any measures, and they should instead be

allowed a facilitated transition period to accept accountability for the cost and quality of services they can provide within the community.

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?

We are working to develop clear definitions of the types of patients that should appropriately be treated in a rural hospital and those that should be transferred depending on the size and capabilities of the hospital. This will improve the ability of accountability measures to distinguish between appropriate and inappropriate transfers. However, the payment system needs to provide adequate resources to rural hospitals to deliver those services that they could appropriately deliver. For example, Medicare payment systems should support short inpatient stays that will allow low-level acuity patients to avoid transfer and be cared for in the local community. Medicare payments should also support the adoption of telehealth technologies that facilitate the rapid evaluation of such patients and connections to specialists and remote facilities when transfer is appropriate.

Tom Bell

May 12, 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: Centers for Medicare and Medicaid Innovation, Request for Information on Concepts for Regional Multi-Payer Prospective Budgets

Dear Mr. Slavitt,

On behalf of 127 hospitals in the state of Kansas, the Kansas Hospital Association (KHA) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Innovation (CMMI) Request for Information on Concepts for Regional Multi-Payer Prospective Budgets. We are responding specifically to Section IV: Questions on a Potential Rural Specific Option, as well as selected questions relevant to the implementation of prospective global budget implementation in a rural setting.

Kansas is largely a rural state with 84 CAH hospitals and a number of very small PPS hospitals. As CAHs, their payment is cost-based but not all costs are covered, leaving as many as 69% of our rural hospitals with negative Medicare margins. With sequestration, the reimbursement for covered costs was also reduced. Rural hospitals are often the center for health care services in their community. They generally employ or contract with all of the medical providers and often take on other services such as EMS, home-care and/or long-term care services which are not adequately reimbursed and can negatively impact their cost report further straining hospital resources.

Over half the hospitals in Kansas, mostly rural, must look to local tax support to fill the gap in Medicare and Medicaid payments placing a significant burden on these communities. A recent study by the National Rural Health Association identified 31 rural Kansas hospitals at risk for closure. Changing from a volume based system to one that rewards value is particularly difficult for these very small operations. Currently, value is defined in terms of quality measures that, for many our CAHs, are either not part of the services they provide or are provided in very small numbers. With an average daily censes of less than five, 1 patient's metrics will skew the numbers significantly. In addition, while these hospitals care for a significant Medicare population, the majority of costs are fixed and will show little savings to the program in comparison to larger markets.

Challenges to maintain health care services in a changing environment face all Kansas hospitals. In 2011, The Kansas Hospital Association (KHA) Board of Directors identified the need for KHA to look to the future of rural health care as smaller communities struggle to maintain local services under the current volume based payment system.

Alternatives must be available to communities to preserve access to primary health services, avoid the complete closure of existing hospitals and prevent the negative impacts on the community's health and local economy. The goal must be to align the structure for service delivery with community or service area need. Two models have emerged in KHA's visioning work as potential opportunities that provide alternatives to a CAH. The options are: 1) Primary Health Center (PHC) – a 12-hour per day facility; and 2) Primary Health Center (PHC) – a 24-hour per day facility with or without Transitional Care. Both options would:

- Serve as the center for health care in a small community, providing services to patients up to the inpatient admission criteria;
- Provide ambulatory, urgent and emergency services for the same hours each day, open to the community every day of the year to provide the service array most needed and sustainable by the community;
- Focus their efforts on the primary care needs of the community;
- Have a formal relationship with a "partner organization" to assist with operational and clinical aspects of delivering services to their community; and
- Be supported by a robust EMS plan.

We have tested the concept in five communities in Kansas and now turn to the discussion of a payment model. Our findings show that the model could provide savings that would retain access to care while providing an option for communities that cannot sustain a Critical Access Hospital. In the next months, Kansas will be working to identify a payment approach for this model and working with other states to refine value based concepts for Critical Access and small rural hospitals. The Primary Health Center model has been the center of many discussions in other states and on the national stage feeding conversations at MedPAC and other policy arenas. We would welcome the opportunity to demonstrate the Primary Health Center model with a unique payment model that recognizes the need to preserve access and improve health in the rural parts of our state.

While the model is proposed as a new option for communities, the fact remains that most Kansas communities will maintain a Critical Access Hospital. Changes that effect CAHs will need to be sensitive to the unique set of challenges rural communities face. In order to maintain access to care in low density and rural population areas, there are few economies of scale that can be realized. The failure to maintain adequate services in rural communities would result in poor outcomes and higher costs for the community residents they serve.

Kansas hospitals are committed to working with CMS to define a sustainable path forward for rural providers. We appreciate the opportunity to respond to this RFI, and have outlined our responses to several of the rural specific questions below. We hope this response leads to continued dialogue on this topic. Thank you for your consideration and opportunity to provide comments.

Sincerely,

Tom Bell

Tom Bell
President and CEO

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

Designing a global payment system in geographically defined communities is a significant undertaking and KHA hopes that CMS will proceed in a thoughtful and deliberate manner. In small rural areas the concept of a prospective budget should be based on the set of services that are provided in that community and recognizes the changes in services that would be needed to address population health, reaching beyond the current cost-based limitations. The budget amount would need to be flexible as very small changes in populations, needed services and health conditions can have a large impact on a small operation.

The Kansas Primary Health Center model suggests that a specific set of services would be the basis for an integrated budget for those services rather than a geographic area. As the majority of our rural areas are served by hospitals that are governmental entities (county or district hospitals), the ability to require participation in a larger prospective budget could be very difficult and require elections or changes to state law.

The Primary Health Center Model does require a partner organization that provides 24/7 OB and surgery. This relationship could be used as a model to demonstrate a larger prospective budget approach, if the data and analytic capacity were made available to determine actual costs and potential savings.

We believe the most difficult part of the concept that the RFI is proposing is the concept of a geographic region. Many CAHs and small PPS hospitals are owned by a county or district whose geographic service area is well defined. Other providers are owned by private interests and have service area footprints and do not have specific borders. Rural Kansans who utilize all levels of service often travel significant distances for secondary, tertiary and quaternary care, sometimes even out of state. Given the geographic distribution of health care services in Kansas, it will be difficult to divide the state and attribute all the health care of a beneficiary to the geographic subset.

Whatever the outcome or the approach to a geographically determined prospective budget, it is imperative that CMS make beneficiary level data available and support the analytic capacity to prepare for the proposed changes.

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.

Certainly Medicare Parts A and B should be included as the basis for a prospective budget based on historic expenditures. Other spending is often outside the control of a community hospital, especially those expenditures that are incurred outside the community, county or district as patients seek higher levels of care due to availability. That care is often outside a region or defined geographic area. Communities have leveraged the available resources to structure their health system. Very few are fully integrated, with some operating rural health clinics and EMS and others with those services operated by a private physician, county or other entity. Combining those into one budget may be possible, but will be extremely difficult. Incentives for providers and services to work together should be the goal. If hospitals are to be held responsible for care provided by physicians and others who may not work for the hospital; time, resources and data will be needed for the transition.

The key will be flexibility to develop relationships and partnerships to provide access to the array of services needed locally and in the region.

12. Should Critical Access Hospitals be included in a prospective budget? 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.

We would encourage participation to be voluntary for CAHs. Special considerations will be needed to assure that access to services in communities served by CAHs is not further harmed by prospective budgeting. While CAHs are positioned to be the face of population health in their community, they provide a very small piece of the total cost as their services are more primary care in nature and their volumes are so small. CAHs should certainly be included and allowed to participate especially if their communities identify a larger partner through which they can access the financial and analytic expertise to implement a more complex payment system. Payment models that offer predictability and the ability to cover fixed costs as volumes rise and fall throughout the budget period will be critical. Budgets that recognize the challenges of recruiting and retaining physicians, clinicians and others with important skills as well as costs for care management, telemedicine and the distance issues to cover outreach to a low density population will also be important.

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?

Most important, Critical Access Hospitals will need financial and resource support for any kind of transition as their limited resources are focused now on managing under cost based and current PPS rules. Grants, incentives and other resources will be necessary to allow CAHs to maintain the current system while transitioning to new methods of payment and care delivery. New staff will be needed, or current staff retrained, in new delivery and care management approaches as well as access to expertise not currently housed within the hospital to manage the change process, identify and collect new data as well as prepare and implement new reporting requirements.

Access to Medicare beneficiary data that will help them understand their part in the larger system of care will be crucial. They will need support both in accessing the data, as well as analytic support to determine the services provided to their patients in other settings and the costs of services provided both locally and in the larger system of care for their community population. Lack of access to these data have been a significant barrier to understanding and beginning the changes that will be required.

Waivers or changes to Medicare rules will also be a crucial part of success. Allowing CAHs to maintain their status with limited or no acute inpatient capacity and utilizing beds for short-term transitional beds so that low acuity patients can remain local, avoid unnecessary transfers and prevent readmissions is a key part of regulatory change that is needed. Current regulations that require a 3-day acute stay should to be waived to allow patients to be treated at the most appropriate level of care in a cost effective manner. In addition, waiver of regulations that restrict the hospitals ability to deliver services in new ways with new relationships will be an important part of payment reform. Regulations will need to allow providers to direct the care of their patients outside their walls not allowed under current rules.

Finally, it will be critical to align incentives and payment reforms for non-hospital based services. CAHs are part of a larger system of care with a variety of other provider types. CAHs will not be able to successfully implement change without all aspects of the system changing at the same time. Specifically, as many physicians are not employed by the hospital, value metrics and payment incentives will need to be aligned.

As stated earlier, providing grants through the HEN or directly to hospitals and hospital groups to support data analytics and the use of data to identify opportunities for improvements and reduced costs is an important strategy to encourage and support change.

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?

Many of our smaller hospitals are beginning to consider affiliations and alignments that support the needed services for their community. In Kansas, however, with a majority of our CAHs being government owned, alignment with larger hospitals and specialty care has been more challenging. These are very different types of relationships and consequently must be designed to meet the needs of both parties. Many rural communities are fighting to maintain all types of local services and maintain their identity in the process. Again, CMS must allow flexibility in the creation of these relationships.

The Kansas work on a non-acute model requires a relationship with a larger facility. CAH's have also historically had a relationship with a supporting hospital. These relationships could be strengthened and resources provided to support the needed specialty care, information technology and quality improvement. The Kansas Heart and Stroke Collaborative, another CMMI initiative, has had excellent results in improving care for heart and stroke patients through increased training, adoption of best practice treatment and protocols for the transfer of patients. These efforts have strengthened the care locally and improved outcomes as well as saved costs through the reduction of extended care needs. CMS should avoid "consolidation" as a goal of these relationships. Care in rural areas is not just a smaller approach to urban style health care. It will be critical to maintain services (identified by community needs assessments) locally as even larger rural hospitals need a local face to be successful in population health strategies.

Twenty-five CAH's in Kansas partner with GPHA for IT, MIS & EHR support and services. This affiliation and/or partnership does in fact provide these twenty-five CAH's with affordable support and economy of scale for IT, MIS, EHR and other services that might otherwise cost much more on their own. Hospitals in Kansas have also begun to implement relationships with telemedicine centers to provide expertise at the bedside that is not available locally. Most commonly, the services include Board Certified Emergency Physicians and other critical care resources. Other specialties are slower to take hold as volumes are so low and payments are not adequate. Traditionally, in Kansas, small hospitals have contracted with larger facilities in the region to provide monthly "clinics" served by visiting specialists from the larger community.

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?

Quality metrics should also be tied to rural relevant measures that are sensitive to the low volumes and the limited range of service they deliver directly. Focus of measures on prevention, primary care, chronic disease management along with urgent and emergency care should be the focus of quality and performance accountability measures.

The September 2015 report from the National Quality Forum entitled "Performance Measurement for Rural Low-Volume Providers" is an important first step to developing rural relevant quality care measures. This work should be expanded to ensure that measures reflect the quality of care delivered, not simply the small volume of care.

One of the most frustrating issues for small and large hospitals alike are the differing sets of measures required by payers and regulatory entities. On the surface, these quality measures my look similar, but the detailed definitions require separate collection of the metrics. EHRs are not all designed to collect these different measures. Even the requirements for EHR certification were not consistent with the Meaningful Use quality measures. Programming the EHRs for all the different measures is costly and may not be an option for many small hospital systems. Anything that can be done to make the measures consistent and reduce the costs of collection would help reduce costs overall.

Rural hospitals in Kansas do want to be partners in the effort to improve quality and reduce cost. If given access to the necessary data and analytics, many are well positioned to manage chronic disease and assist their patients and community in navigating the health system and coordinating the care they receive at home and away.

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?

Including care management in the services supported at the local level is an important part of the assessing and guiding care needs on a patient specific level. Small hospitals are not staffed to provide care management today and would need to attract and or train staff for that service. We also believe that the concept of Transitional Care as described in our Primary Health Center model is a service that will assure that care is given as close to home as possible. The current three-day acute stay requirement should be waived to allow transitional care to occur at the appropriate time in a patient's care and prevent acute stays, readmissions or unnecessary transfers when this short term care is needed. Delivery system reform is crucial to ensuring that quality care is delivered in the appropriate location. Telehealth services, such as eEmergency and eHospitalist services will also provide additional expertise and support local medical staffs a service that may make it easier to recruit and retain critical physicians and midlevel providers. These services should be incentivized. We also believe that telehealth services could be used to fulfill physician supervision requirements in some circumstances.

Another area which may not be under the purview of this RFI, but could be a benefit to Americans at large is to allow local services in rural areas to be used to serve our veterans. Current ARCH program requirements are cumbersome and hospitals are often not paid for services that are provided. As you are considering non-traditional relationships between health care providers and innovations that would meet the triple aim, we encourage CMS to work with the VA to utilize available resources, save money at the federal level and provide exceptional care to veterans locally.

National Advisory Committee On Rural Health and Human Services

Response to Request for Information (RFI) on Concepts for Regional Multi-Payer Prospective Budgets

The National Advisory Committee on Rural Health and Human Services commends the Centers for Medicare & Medicaid Services (CMS) for seeking input on potential rural specific options informing Concepts for Regional Multi-Payer Prospective Budgets issued by the Center for Medicare and Medicaid Innovation (CMMI).

The RFI sought responses on sixteen questions, five of which were specifically related to how to encourage inclusion of rural hospitals such as rural acute care hospitals and/or Critical Access Hospitals (CAHs) that have defined market areas and may benefit from a prospective budget. This response will focus on the latter.

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 Committee believes that many CAHs are able to participate in this project and that they have been preparing for the kind of public health and care coordination activities that would be vital to the success of these projects. CMMI's concern that CAHs may need special consideration is well placed. A transitional period, from the cost-based reimbursement (CBR) structure to global budget payments, may be needed.

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?

The same challenges to small rural hospital participation in Accountable Care Organizations (ACOs) as addressed by the AIM ACO model are to be expected. An upfront investment by CMS providing for technical assistance necessary for movement from a hospital-centered model to a population health management model under a fixed budget rather than cost-based reimbursement would likely be needed. CMS could consider an initial planning period where organizations would have access to data and additional analytics that would allow it to fully understand utilization, cost and quality data in its service area. This would be similar to the data made available to ACOs. Initial planning support could help

smaller providers make the adjustment from fee-for-service/administered pricing to global budgeting. In the Request for Information, CMS acknowledged the positive findings of the work in Maryland. Given that state's unique Medicare payment system, providers in Maryland had an advantage in moving to this model. We believe other providers, payers and states would have an interest in building on the Maryland model but that we need to take into account that they would be starting from a very different place.

In addition, individual hospitals should have flexibility in defining their service areas using other appropriate data such as ZIP code of hospital patients, Hospital Service Areas, Primary Care Service Areas (PCSAs), or other geographic units. Within these services areas, however they are defined, it is important that all providers of health care, including the hospital, home health providers, nursing facilities, primary care providers, and others be included under the global budget. One of the advantages that rural areas could see in this kind of project is that there are a far smaller number of players to coordinate who can gather to collaborate.

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?

Research shows the lowest hospital operating margins are found in small, rural PPS hospitals and CAHs. Due to the volatility in revenue in low-volume hospitals, strategies such as multi-year budgets and periodic interim payments (PIPs) may be needed to assure cash flow while these hospitals are transitioning from current payment to global budgeting.

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 Committee believes movement to a global budget will incentivize utilization of the most cost efficient access to specialty care, including greater use of telemedicine and other information technology to improve the flow of information and improve the quality of care. Properly structured, a global budgeting system could help encourage better utilization of existing resources, with smaller providers focusing on primary care and chronic disease and lower-acuity inpatient services allowing urban partner facilities to focus on higher-acuity and resource intensive services.

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?

The Committee recommends CMS use strategies from its other demonstrations with the realization that for both budgeting and establishing the measures used to evaluate the success of the project, local input is crucial as they should be tailored to the needs of the local population. Measurement of cost of care should focus on total cost of care for beneficiaries in the service area regardless of where the service was provided. Considering quality outcomes, there should be flexibility in determining the thresholds or metrics based on the case mix that the rural hospitals currently serve and with the corresponding scope of services provided with a robust

quality improvement plan built in that is evidenced-based and reflective of the community standards.

The Committee also recommends CMS consider the findings of the work on Performance Measurement for Rural Low-Volume Providers by the NQF Rural Health Committee (September 14, 2015) it funded through the National Quality Forum recommending strategies such as the use of longer reporting periods or composite measures to address concerns about statistical reliability.

Finally, the Committee recommends risk stratification in any measurement of cost and quality outcomes based on the socio-economic status of the rural populations served. Rural providers disproportionately serve populations of higher poverty and in particular dual-eligibles that are more likely to have worse outcomes than populations with better socio-economic status.

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?

Transfers and referrals are a frequent, appropriate component of care in rural areas. While there may be concern over using transfers to shift costs, the use of the proper measures such as criteria for transfer to other facilities, availability of resources to provide requisite stabilization services prior to transfers, and options for monitoring outcomes for such transfers should guard against this. We believe a focus on the right quality metrics would provide the relevant incentives to avoid concerns about inappropriate transfers based on cost factors.

The Committee sees promise in this concept as a way to allow rural hospitals to improve the health of the population in their community in a financially viable manner. We also recognize the "risk averse" nature of small, rural providers and realize it is much easier to just say "this won't work for rural" than it is to find solutions to make it work. We encourage CMS to recognize this fact as you weigh comments received and to strongly consider a formal demonstration of this concept that would allow those regional providers both urban and rural to work together and build systems of care that focus on improving outcomes. A demonstration in this area would also provide a pathway for meaningful participation by rural providers in HHS' broader efforts on delivery system reform. As the Secretary's advisory committee on rural hospitals, we offer CMS our support in finding those solutions to make it work.

Sincerely,
The Honorable Ronnie Musgrove, Chair

From: CMS Regional Budget Concept All
To: Payer Operations
Cc:
Subject: FW: budget proposal
Date: Friday, May 13, 2016 8:48:58 AM

From: Edfriedman
Sent: Friday, May 13, 2016 2:45 AM
To: CMS Regional Budget Concept <RegionalBudgetConcept@cms.hhs.gov>
Subject: budget proposal

Dear CMS,

Thank you for this opportunity to comment on the proposed budget payment systems. Finding a payment system that is efficient but maintains access to care is a challenging task. It is most important to consider differing health care settings, including rural.

In looking at the CMS language on regional budget payment concepts the following concerns come to mind. The concept appears to give CMS the authority to force health systems to somehow provide needed care with no guarantee that the actual cost of care is actually covered or that financial risk stratification is being appropriately utilized. It could well leave facilities and health professionals in the position of having to do more with less - when reimbursement is not sufficient to cover costs.

A healthcare delivered to the most vulnerable patient (rural patients typically have poorer health, have more access and financial challenges) needs certain guarantees such as a minimum floor from a reimbursement perspective to assure that an often fragile rural infrastructure can be maintained.

If we need an indication showing that some of the current advanced payment system models have issues such as lack of necessary data, efficient comprehensive care models still under development, simply look at the first years of many Pioneer ACOs that lost money and had to drop out of the program or shift to another ACO model.

Unfortunately, there are other serious problems with this proposed payment system. This concept is based upon the payment system used in Maryland for inpatient services. As a consequence, many hospitals will try to move services to the outpatient or physician office setting because they are not covered by the global payment system. They are simply unable to sustain services in the inpatient setting and seek to move costs out of that environment in order to survive. One crucial thing to also keep in mind is that there are no rural health clinics in Maryland nor are there any Critical Access Hospitals in Maryland. Maryland's population is

generally located in a few densely populated areas.

Maryland's population and geography may allow this type of system to work in that state but is unlikely to work in a state like Iowa where the population is more dispersed in many small and medium sized towns all around the state. Furthermore, a large percentage of the Maryland population is located in the Washington DC suburbs so to the extent services are not available in Maryland, patients can typically go to DC or Virginia hospitals or facilities that are not under the same financial constraints.

It is likely that rural areas, particularly medically underserved rural areas, would not fare well under this system long-term. Economies of scale would almost certainly dictate that clinics serving communities of a certain size would be closed to achieve greater efficiencies at clinics located in larger communities where you can have greater volume. My federally certified Rural Health Clinic has served Redfield, Iowa (pop. 835) for more than 30 years. The clinic is the only source of medical care in town. But it likely would close under this proposed system. Even clinics in towns of 2,000/3,000 people would close and their patients would have go to a larger clinic located in the town of 5,000 because it is more efficient. So patients with limited transportation, gas money or elderly driving privileges of 10 miles from home would now have to drive 20 miles to the doctor. Sometimes access to life saving care could be sacrificed for a more efficient system.

Ed Friedmann, PA Redfield Medical Clinic 1013 First St.

Minnesota Hospital Association

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May 13, 2016

Patrick Conway, M.D.
Deputy Administrator for Innovation & Quality, Chief Medical Officer
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Submitted via email to RegionalBudgetConcept@cms.hhs.gov

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

Dear Dr. Conway:

The Minnesota Hospital Association (MHA), which represents 138 hospitals and health systems located throughout Minnesota, offers the following comments and feedback regarding the Centers for Medicare & Medicaid Services' (CMS) Request for Information (RFI) on Concepts for Regional Multi-Payer Prospective Budgets.

Minnesota's hospitals and health systems are undertaking a variety of payment and delivery reform models within Medicare, including multiple Medicare Pioneer, Shared Savings and Next Generation Accountable Care Organizations (ACOs) and our multi-payer advanced primary care demonstration project; Medicaid, including our state's innovative Integrated Healthcare Partnership (IHP) demonstration project that includes both regional and virtual ACO models; and commercial contracting. MHA and our members continue to seek out new ways to redesign payment methodologies and care delivery to align incentives for higher-quality care, improved population health, and lower rates of per capita health care cost growth. Accordingly, MHA is pleased that CMS is exploring different models and their feasibility, and we are especially grateful for the opportunity to provide feedback in the early stage of this exploration.

A global payment program is an intriguing approach and the demonstration project in Maryland is watched closely by MHA and health care stakeholders in Minnesota. MHA urges CMS to pursue development of other global payment programs cautiously.

First, CMS specifically sought feedback regarding the application of global payment methodologies in rural communities. Because a large portion of Minnesota's residents live and work in rural communities, this aspect of the RFI is of particular interest to MHA. On one hand, global budget models, may be structured to provide greater flexibility for hospitals, clinics and caregivers in rural communities to tailor the care they deliver to their individual community's needs and circumstances. Global budgets also offer the prospect of greater financial certainty.

On the other hand, depending on how the global payment program is structured, it might exacerbate the challenges already faced in rural communities trying to ensure access to care with smaller volumes of patients and service lines. Medicare's critical access, sole community provider, low

volume hospital designations all reflect the public policy reality that access to care in rural communities is jeopardized without some form of subsidization. Thus, any payment model must address which services are so essential that they must be preserved with additional financial support and which are less essential and may be allowed to succeed or fail purely on market forces.

Consequently, a global payment methodology that will ensure sufficient access to essential, geographic-sensitive health care services in rural communities will need to account for the costs of emergency room and emergency transportation services, which will need to include the diagnostic imaging, laboratory, electronic health record, helipad, ambulance and other costs associated with those services. It will need to be sufficient to cover the bond/debt payments on existing facilities. It will need to provide the resources necessary to recruit and retain the workforce necessary to deliver clinical care services that range from primary and preventive care, emergency and trauma care, rehabilitation and post-acute care, and long-term care at a minimum. And, of course, the payment model should be structured to adequately reflect its own costs of administration for both payers and providers, as well as technical assistance resources necessary for providers to transition to and succeed under the new payment system.

Once these costs are totaled, it is difficult to understand what savings will be achieved relative to the below-actual-cost-of-care payments received by critical access hospitals (CAHs), the struggles of small, rural or regional prospective payment system (PPS) hospitals, and the growing provider shortages experienced in rural communities today.

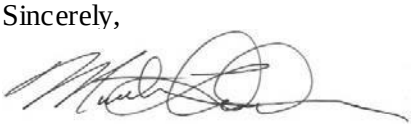
Whether exploring a global payment pilot project in a rural or urban community, MHA believes that participation should be voluntary and, at least initially, include safety valve mechanisms that will ensure continued meaningful access to a defined set of essential, geographically sensitive services.

MHA echoes the comments and recommendations offered in the American Hospital Association's May 12, 2016 letter, including the importance of avoiding one-size-fits-all approaches that fail to address the unique needs, resources and existing payment or incentive arrangements existing in a particular community or region; the need for predictability and financial sustainability, and the crucial importance of timely access to patient data for care coordination.

Global payment pilot or demonstration projects, beyond the one underway in Maryland, appear to be a worthwhile and laudable pursuit. In the context of other payment reforms already underway and the need to ensure meaningful access to geographically sensitive health care services, MHA encourages CMS to begin with voluntary demonstration projects in communities capable of both (1) managing the financial and analytical complexity to succeed and (2) aligning other state public program and commercial payment arrangements to avoid competing incentives.

Thank you for the opportunity to offer these thoughts and feedback. If you have any questions, please feel free to contact me.

Sincerely,



Matthew L. Anderson, J.D.
Senior Vice President, Policy & Strategy

THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

May 13, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services Attention:
CMS-5516-P
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G Washington,
DC 20201

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

Dear Mr. Slavitt:

On behalf of The Hospital & Healthsystem Association of Pennsylvania (HAP), which represents approximately 240 member institutions, we appreciate the opportunity to provide comments regarding the Request for Information on concepts for regional multi-payer prospective budgets. This promising program model could serve to support better management of cost and quality for a community's population by providing clear revenue expectations and connecting care across outpatient and inpatient services.

This topic is especially timely in Pennsylvania, as the Commonwealth, under the leadership of Secretary of Health Dr. Karen Murphy, is proposing to develop and implement a multi-payer global budget initiative in rural Pennsylvania. HAP member hospitals are interested in exploring the state's proposal, as well as providing guidance to the Centers for Medicare & Medicaid Services (CMS) as these program designs move forward.

As CMS explores these models, it is important to note that Pennsylvania hospitals—like many rural hospitals across the nation—are struggling financially. Thirty-four percent of rural Pennsylvania hospitals are currently operating with negative total margins and many more have dangerously narrow margins. Any changes to the reimbursement system must take into account the tenuous nature of these providers' operating models to protect access to health care in rural parts of the state.

HAP commends CMS for requesting input into the design and implementation of a multi-payer prospective budget approach. The attached document provides comments for CMS to consider while developing the details of these programs.

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Thank you for your consideration of HAP's comments. Sincerely,

Jeffrey W. Bechtel, JD
Senior Vice President, Health Economics and Policy Attachment

HAP Comments—Centers for Medicare & Medicaid Services
Request for Information on Concepts for Regional Multi-Payer Prospective Budgets

Early this year, the Commonwealth of Pennsylvania announced a proposal to develop and implement a multi-payer global budget initiative in rural Pennsylvania. Many early discussions have occurred across the provider and payer communities, and it is anticipated that a small number of pilot hospitals will be selected to move forward to test this program design.

The release of this Request for Information (RFI) signals CMS' interest and general support to explore this promising model, and HAP is supportive of efforts to test reimbursement models that align incentives, promote wellness and preventive medicine, and offer rural hospitals a stable and predictable revenue stream.

That said, it is important to note the differences in the health care marketplace between Maryland—which is often identified as a "model state" for global budgeting—and Pennsylvania. Maryland currently runs the country's only all-payer hospital rate-setting system, under which facilities in the state are paid the same amount by all government and private health insurers. Since the Maryland state legislature established the all-payer model, the Maryland Health Services Cost Review Commission, the state agency tasked with setting hospital rates, has directed hospital reimbursement.

While there are lessons to be learned from the early successes in Maryland, this model is not one that lends itself to being simply copied and started anew in a different state. For example, Pennsylvania also has a unique payer market that includes, for example, "Blues-on-Blues" competition and statewide Medicaid managed care. Obtaining payer buy-in to this model will likely be a challenge in this state.

While it is difficult to provide detailed feedback without a comprehensive understanding of the proposed model, HAP has identified a number of general observations and questions for CMS' consideration as it develops this program model. Our comments:

- Provide general observations relating to the prospective budget methodology
- Identify ways to encourage the participation of providers, private payers, and states in a regional prospective budget model
- Discuss specific thoughts about how to encourage the inclusion of rural and critical care hospitals in a proposed program
- Identify a number of other general observations, questions, and concerns that should be addressed in the final program design

PROSPECTIVE BUDGET METHODOLOGY

The RFI requested information about how to define and calculate prospective budgets, which components of Medicare and/or Medicaid will be included, and the type of geographic areas where a prospective budget could be applied.

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Calculating prospective budgets at a regional level is important to account for cost differentials across areas of a state and provide some level of protection for participating providers. For example, there are vast differences in costs across the state of Pennsylvania. Specifically, the 2014 Medicare Shared Savings Program (MSSP) results show that Delaware Valley Accountable Care Organization (ACO), located in Philadelphia, spent $11,449 per member per year (PMPM). In contrast, RiverHealth ACO, located in Harrisburg, spent $8,529. Defining how a budget will be set will be a crucial step in developing this program.

Other considerations for developing the prospective budget methodology include:

- **Inclusion of Costly Medications.** Under current CMS programs, such as the MSSP ACO program, Part D costs are excluded from the program, as beneficiaries have alternative options for medication payment (e.g., low-cost medications at large retailers, private insurance, Medicare). Additionally, Medicare Part A and Part B include payments for injectable medications and office-administered medications. The majority of these medications are very costly and used to treat cancer, vision loss, rheumatoid arthritis, and other complex diseases. CMS should consider how the global payment structure accounts for these costly medications and evaluate any potential restrictions or exceptions for their use.

- **Transition Period and Risk.** While holding participating providers accountable for the total cost of care is the general goal of the program, it is essential that the program be flexible enough to adapt to unexpected cost drivers during any given year. The intent of this model should not risk the viability of the participants, but rather strengthen their ability to provide high-quality, accessible care to the Medicare beneficiaries they serve. To this end, any model should include a transition period of no downside risk before slowly phasing it in over time. This is particularly important in rural communities where financial sustainability of facilities has been challenging.

- **Access to Payer Claim Information.** In order to be successful in managing total cost, participating providers must have access to timely information, including a list of the patients attributed to them, real-time claims information, and the tools to manage such information.

- **Payer Contract Terms.** Participating payers should be required to execute contracts related to their responsibilities in a global budget program. The contract should stipulate how their portion of the global budget will be developed each year, including a reasonable initial term with a decision point that allows approximately two years to unwind the contract so that a transition to a different model can be accomplished, in the event that a payer/provider participant chooses to terminate its participation. The contract should also set clear expectations related to data and information exchange.

- **Identification of Accountable Third Party.** In order to implement a global payment model, it is necessary for a third party to be accountable for setting the budget.

There is also a need to provide a clearly defined public comment process and appeal rights for providers.

- **Ongoing Program Flexibility.** The ability to make adjustments to the prospective budget in a timely fashion is crucial to the success of this model. As the health care market is in a state of unprecedented change, the global payment program would need the flexibility to adjust for market share shifts, population size changes, consolidations, and other changes outside the control of providers.

- **Accommodation of Beneficiary Choice.** While commercial payers have some flexibility in the design of their products and can institute products that limit choice, freedom of choice is a central tenet of the Medicare program. The model will need to accommodate Medicare beneficiaries that seek care outside of the global payment participating providers, as CMS has historically been unwilling to limit choice for the Medicare population.

- **Aligned Quality and Performance Measures.** CMS and America's Health Insurance Plans (AHIP), as part of a broad Core Quality Measures Collaborative of health care system participants, recently released seven sets of clinical quality measures. These measure sets were created in an effort to streamline the proliferation of quality metrics developed by payers related to value-based programs, and will likely evolve to be included in the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APM). CMS should encourage the utilization of aligned measures in any future multi-payer prospective budget model.

- **Monitoring Access and Utilization.** Monitoring access and delays in services will be difficult. As providers become increasing efficient with care coordination, it is reasonable to expect that lower volumes of procedures will occur. As a result, CMS should be cautious as it seeks to differentiate reductions in duplication through better care coordination versus reductions in services that could be seen as limiting access to needed health care.

POTENTIAL PARTICIPANTS AND POPULATION HEALTH ACTIVITIES

The RFI requested information about ways to encourage the participation of providers, private payers, and states in a regional prospective budget. Below are some general observations relating to this topic:

- **Likely Hospital Participants.** From the provider perspective, in the state of Pennsylvania, small, rural hospitals are the most likely to be interested in moving towards a global payment system. This interest exists because the majority of rural hospitals are experiencing funding challenges as the cost to provide care outpaces payment from federal, state, and some commercial payers. As health care is transforming, and more care is shifting from the inpatient to the outpatient setting, many

rural hospitals now are investigating how to alleviate the expense of facilities that were built for an inpatient demand that no longer exists.

- **Voluntary Participation.** While it is most desirable to have most if not all providers participating in a given region, if the prospective budget methodology is set appropriately, the level of participation for any given region should be able to be accommodated. As provider participants are at varying levels of readiness, it is critically important for participation in this program to be voluntary in nature.

- **Administrative Burden and Up-front Costs.** As in all payment models, CMS could encourage participation by minimizing the administrative burden associated with participating in this model. This would include streamlining performance measures and reducing/eliminating authorizations. Likewise, during discussions with providers in Pennsylvania who are interested in the state pilot, providers have expressed concern about the infrastructure investment (e.g., electronic health records, disease registries, population management tools, data sharing, and reporting requirements) necessary to be successful under such model. CMS needs to consider how these upfront costs will be recognized and supported.

- **Waiver of fraud and abuse laws, as well as certain Medicare payment rules.** In order to be successful in a global budget model, hospitals will need to form collaborative financial relationships across the care continuum. CMS should waive the applicable fraud and abuse laws that inhibit these relationships. These laws include the Physician Self-Referral Law and the Anti-kickback Statute

  Other waivers necessary specific to Medicare payment rules include, but are not limited to, the waiver of discharge planning requirements that prohibit hospitals from specifying or otherwise limiting the information provided on post-hospital services, the skilled nursing facility "three-day rule," and the inpatient rehabilitation facility "60% Rule." CMS has acknowledged the need to waive these rules in other value programs.

- **State Participation.** Global budget models will pose significant challenges for Medicaid agencies that are operating fee-for-service claims processing for a portion of their business which rely fully on managed care strategies. Supplemental payments (for disproportionate share and medical/health professional training) by the Medicaid agency or Medicaid managed care plans also will need to be accommodated in any new model. In order to encourage state participation, CMS will have to provide appropriate flexibility to state Medicaid agencies to implement necessary changes under their State Plan.

POTENTIAL RURAL SPECIFIC OPTION

The RFI requested information about how to encourage inclusion of rural and critical care hospitals in a prospective budget program. Below are a series of observations relating to the program design, which could promote the participation of rural and critical care hospitals.

- **Critical Access Hospital (CAH) Issues.** With the appropriate structuring, CAHs could and should be included in the prospective budgeting concept. However, there are unique questions that would need to be addressed for CAH inclusions. For example, will the global budget include all the special CAH payment arrangements that currently exist in Medicare and Medicaid programs? In addition, will the global budget include funding for capital expenditures and medical education? Will it incorporate necessary regulatory relief (e.g., 96-hour rule)? Any model associated with CAHs must also ensure that future funding will not be less than it is today.

- **Downside Risk.** Thirty-four percent of rural Pennsylvania hospitals currently are operating with negative total margins and many more have dangerously narrow margins. Regardless of their classification, these hospitals would not be candidates for managing downside risk at the onset of this model. Medicare savings should be measured by the reduction in the overall trend in health care expenditures, not by an absolute decrease in cost over the prior year.

- **Availability of Payment for Telehealth.** One "low-hanging" opportunity for rural acute care hospitals and CAHs to partner with larger institutions is through telehealth. Pennsylvania currently is considering telehealth payment parity legislation that would require payment across payers for telehealth services. The passage of this legislation is critical in ensuring that Pennsylvania providers can invest in the technology and relationships to provide access to specialty care remotely, while reducing the costs to both CMS as well as the patients by assuring proper treatment and greater efficiency. Likewise, Medicare's payment policies related to telehealth should be expanded and enhanced. This initiative can be an important driver for CMS to advance the adoption of telehealth.

- **Appropriate Quality Measures.** Measuring the cost of care and quality outcomes for rural acute care hospitals and CAHs becomes more difficult in the absence of a critical mass of beneficiaries. Each measure should be considered independently and excluded if there are too few individuals, as determined by CMS, in the denominator of the measure. Additionally, CMS should give appropriate consideration for socio-economic adjustments.

OBSERVATIONS/OUTSTANDING QUESTIONS

After evaluating Pennsylvania's rural global budget initiative and responding to CMS about this related RFI, HAP has a number of outstanding questions and/or observations.

Observations

- Pennsylvania hospitals' main goal is to provide the right care, at the right time, in the right setting. While the concern of ensuring appropriate transfers and services is indeed a safety precaution the prospective budget program will need to address, the resolution

should include collaboration among the provider community and both private and public payers.

- Provider participants must be assured that there is a "safety valve" that allows them to return to serving their community in the manner they were accustomed to prior to their participation in the model.

- Specific detail relating to the patient population, services, geographic area, rate setting (e.g., acuity and socio-economic adjustments), trend development, and other issues are necessary to fully evaluate a rural global budget proposal.

- Existing state and federal hospital licensing regulations must be revised to permit the innovative reforms necessary to ensure that this model is a success.

- Updating the regulatory/legislative structure governing the assumption of risk will be necessary. It is important to note that the level of downside risk that some/most rural providers may be able to assume is minimal at best.

- The issue of physician recruitment and retention (especially related to primary care providers) will require additional discussions and support.

- It will be important to evaluate the necessity and feasibility of a state or independent organization to negotiate and set the global budgets for participating providers. This will need to include how public and stakeholder comments will be addressed.

- Securing hospital board approval for a move like this likely will require significant time, communications, and education.

Questions

- What are the long-term implications for hospitals agreeing to this model?

- Will the prospective budget program replace all other value-based programs, e.g., MIPS, APMs, for a given provider participant?

- Are there unintended implications for the continued trend toward hospital mergers and acquisitions in regards to rural hospitals participating in these programs?

- What is the oversight or public accountability model that CMS envisions for global budgets—regulatory or waivers?

HAP is supportive of continuing to investigate the feasibly of implementing global payment in the state of Pennsylvania, but strongly urges both states and CMS to fully vet the intricacies related to such programs as the implications for a failed initiative could be catastrophic, particularly for rural communities in the state.

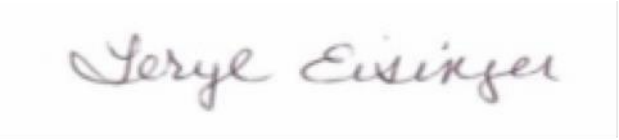
National Organization of
State Offices of Rural Health

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 or call for assistance.

Sincerely,



Teryl E. Eisinger, MA
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: TheMaryland 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.

May 13, 2016

Patrick Conway
Deputy Administrator for Innovation & Quality,
Chief Medical Officer
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, M.D. 21244

VIA ELECTRONIC DELIVERY

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

Dear Deputy Administrator Conway:

The Biotechnology Innovation Organization (BIO) is pleased to submit the following comments regarding the Request for Information (RFI) on Concepts for Regional Multi-Payer Prospective Budgets, released by the Centers for Medicare and Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI) on April 14, 2016.[1]

BIO is the world's largest trade association representing biotechnology companies, academic institutions, state biotechnology centers and related organizations across the United States and in more than 30 other nations. BIO's members develop medical products and technologies to treat patients afflicted with serious diseases, to delay the onset of these diseases, or to prevent them in the first place. In that way, our members' novel therapeutics, vaccines, and diagnostics not only have improved health outcomes, but also have reduced healthcare expenditures due to fewer physician office visits, hospitalizations, and surgical interventions.

BIO represents an industry that is devoted to discovering new treatments and ensuring patient access to them. Accordingly, we closely monitor changes to Medicare's reimbursement rates and payment policies for their potential impact on innovation and patient access to drugs and biologicals. BIO applauds CMMI's interest in obtaining broad stakeholder input through the RFI process on the issue of regional multi-payer prospective budgets. We support the Agency's broader goals to improve quality of care and reduce overall Medicare expenditures, and believe appropriate access to, and utilization of, medicines can contribute to both goals. Innovative therapies have the potential to dramatically improve patient health in the short- and long-term, and in so doing, decrease spending on other healthcare services (e.g., hospitalizations)—outcomes which should be considered in the calculation of a demonstration's impact. Thus, a prominent theme throughout BIO's feedback on the RFI is that any demonstration(s) that stems from this activity should not only maintain, but improve, patient access to needed therapies.

[1] Centers for Medicare and Medicaid Services (CMS) Center for Medicare and Medicaid Innovation. 2016 (April 14). Concepts for Regional Multi-Payer Prospective Budgets, Available at: https://innovation.cms.gov/initiatives/regional-budget-payment/.

In particular, in considering the potential application of this type of model, we encourage CMMI to ensure that:

- Any prospective budget methodology does not hinder patient access to new-to-market therapies;
- Providers share financial risk only for those outcomes which are directly tied to the quality of care they render;
- The structure of any demonstration stemming from RFI is evidence-based, and includes a sufficiently robust evaluation mechanism to broadly monitor the demonstration's impact on patients and providers; and
- Adequate patient-specific and population measures are incorporated to specifically assess the impact of any demonstration on quality of care and patient access to care.

Each of these issues is discussed in more detail in the balance of this letter.

BIO also appreciates CMMI's attention to the potential differences between implementing such a demonstration in a rural versus an urban setting. BIO urges CMMI to take these differences into account with regard to establishing any measures and benchmarks used to assess rural providers' performance and to ensure that patient access to appropriate providers and needed treatments in rural settings is maintained. We addresses this, and other issues related to including rural providers in the type of demonstration contemplated by the RFI, throughout this letter rather than as an independent section.

I. <u>Prospective Budget Methodology (RFI Section II, Q1-2)</u>: CMMI should ensure that the prospective budget methodology: (1) facilitates the achievement of the Agency's goals to improve quality of care and decrease overall expenditures; (2) does not discourage the clinically-appropriate use of new-to-market innovative technologies; and (3) does not penalize providers who treat the sickest patients.

Among CMMI's initial questions in the RFI is whether and how a prospective budget can be determined for a geographic area. As an initial matter, we encourage CMMI to ensure that budgets set under any potential demonstration are predictable and the methodology clearly communicated to participants. This will help to ensure that any expenditure goals set are feasible from the point of view of participants. Similarly, in order to achieve the quality-of care goals that would be set under such a demonstration, the prospective budget would need to account for the many facets of disease management that currently go uncompensated or undercompensated, including, but not limited to: medication and symptom management, care coordination, extended office hours, and the use of telemedicine and other electronically-driven care support mechanisms (e.g., use of IT-based communication platforms like email).

In further considering the RFI's questions, BIO identifies two potential hurdles introduced by a global, prospective budget. First, prospective budgets are often constructed based on historical costs, and thus, inherently do not take into account the evolving standard of care. This is of particular concern for patients who utilize innovative therapies as part of their overall treatment regimen. Specifically, BIO is concerned that, unless prospective budgets incorporate a mechanism to account for new technologies that come to market during the middle of a budget year, patient access to these technologies may be delayed, to the detriment of patient health outcomes and potentially overall expenditures

(e.g., in the event that the new technology replaces the need for additional hospitalizations, surgical interventions, and physician office visits).

One mechanism CMMI should consider to account for new technologies in the context of a prospective budget is to carve out payment for these technologies for the first year (or several years) that the product is on the market.[2] This type of mechanism would ensure that providers are not disadvantaged if they decide, based on the clinical circumstances of an individual patient, to prescribe the new product. It also would allow the rating-setting body—whether at the state or regional level—time to collect and analyze information about the benefits, costs, and cost-offsets of the new therapy before taking it into account in the context of the prospective budget for subsequent years. No matter how CMMI accounts for new technologies in the context of demonstrations that stem from the RFI, the Agency must develop a transparent and predictable process for doing so.

Second, prospective budgets are often based on an estimation of the "average" costs for treating a patient population, which may not sufficiently account for the true costs of providing high-quality care, especially for a heterogeneous patient population. Basing the budget on "average" costs runs the risk of penalizing clinicians for using the most clinically appropriate therapy for a beneficiary—which may depend on, for example, underlying differences in disease state or severity, co-morbidities, and tolerance of, and adherence to, specific therapies—even though that therapy may have a higher-than-average cost. If the prospective budget is not able to accommodate these higher-cost interventions, providers who treat patients likely to need these therapies will be disadvantaged or less inclined to participate in a demonstration project if their existing patient population utilizes these therapies. To address this concern, CMMI should consider the potential to establish outlier payments, such that providers who furnish high-quality, clinically appropriate care to patients whose individual circumstances require higher-than-average spending are able to recoup the baseline costs of this care.

This concern also highlights the need for CMMI to utilize robust risk-adjustment methodologies that are based on a patient's previous and current health status. Risk-adjustment methodologies also should be able to appropriately reflect the resource use and characteristics of the patient population in the demonstration, and the changes to both resource use and patient population characteristics that may occur during the course of the demonstration. Moreover, the importance of mitigating "outlier" costs and robust risk adjustment is exacerbated for providers practicing in rural settings. For these providers/provider practices, a single patient requiring particularly intensive care could overwhelm the prospective budget. In the absence of safeguards that allow providers to recoup baseline costs required to furnish high-quality care, rural practices are likely to find it difficult to participate in the type of demonstration envisioned by the RFI.

On the issue of heterogeneity, BIO also asks CMMI to take into account the characteristics of the patient population and their healthcare needs in defining the geographic scope of a "region" for purposes of a demonstration. The patient population treated as part of the Maryland All-Payer Model may serve as an instructive example with regard to the extent that patient heterogeneity may affect the feasibility and impact of the type of model described by the RFI (see section III for additional discussion on this issue).

[2] Note: Carving out payment for new technologies is a mechanism already utilized in Medicare under the Outpatient Prospective Payment System transition pass-through payment process.

II. Provider Attribution (RFI Section II, Q3): CMMI should ensure that providers are held responsible only for the aspects of patient care over which they have influence.

In the RFI, CMMI asks stakeholders to comment on how participating providers should be held accountable for total cost of care. As an initial matter, we urge the Agency to prioritize patient access to appropriate providers as it considers how to structure provider attribution in a broad payment-concept demonstration. Patient access to an adequate provider network is a prerequisite for obtaining high-quality, efficient care, and also can help to improve patient adherence to treatment regimens, which, in turn, is linked to better health outcomes and lower overall expenditures. Prior to the start of any demonstration, CMMI should assess the healthcare needs of the patient population carefully to establish a baseline with regard to access to appropriate providers; the demonstration should then be structured to improve, or at the very least maintain, the adequacy of the provider network to which a patient currently has access. In establishing this baseline, CMMI should identify and take into account the inherent differences in access to appropriate providers that patients living in rural settings face as compared to those living in more urban areas.

While there are a number of attribution methodologies that CMMI could consider, we urge the Agency to ensure that, no matter how cost and quality metrics are attributed, providers are only held accountable for those patient health outcomes and costs-of-care that they can affect. In order to do this, CMMI will need to rely on robust quality and resource use measures that are risk adjusted, discussed in more detailed below (see section IV).

Additionally, provider attribution must be sensitive to the significant differences between the role of specialists and primary care providers as well as how these providers share responsibility for the care of patients. Since primary care providers and specialists are likely to be included under a global prospective payment demonstration, as envisioned by the RFI, we are concerned that not accounting for these differences may incentivize fragmented care. Any such demonstration should not inappropriately assign responsibility to a specialist for aspects of a patient's care that the specialist is unable to influence nor negate the role of a primary care physician (e.g., a pulmonologist may not have ultimate effect on how well-controlled a patient's underlying asthma is, despite this having a dramatic impact on any specialty care provided for acute or chronic conditions). As one avenue for further exploration of this issue, BIO recommends that CMMI consider whether there are lessons to be learned from the medical home model—as implemented in both the public- and private-payor context—with regard to identifying and accounting for the different roles of primary care and specialty providers in treating patients, especially those with complex, chronic conditions.

III. Appropriate Data, Data Sources, and Tools (RFI Section II, Q5): CMMI should ensure that the development of any demonstration stemming from the RFI is evidence-based, and employs a comprehensive evaluation framework.

BIO continues to advocate that CMMI utilize data-driven simulations and other evidence-based mechanisms to guide the development and implementation of demonstrations. As CMMI recognizes in the RFI, the Maryland All-Payer Model is an instructive example of how the type of pilot envisioned by the RFI can be implemented. Thus, BIO recommends that the Agency rigorously analyze the information that is currently available with regard to the impact of the Maryland model on providers and patients. For

example, the Maryland model's performance on certain metrics was publicly disclosed at the conclusion of the first implementation year. However, these metrics tended to be broad in nature and did not stratify performance by provider type, disease state, health status, quality of individual patient care, and patient access to care—all of which are critical details that CMMI must assess before attempting to replicate this model in other regions. Recognizing an interest in expanding this type of model to other regions, the Agency also should consider including additional metrics—especially with regard to quality of care for specific patient populations (e.g., those in more rural settings)—in future years of the Maryland model, to collect and analyze data from this existing program to benefit both its refinement and the development of future demonstrations.

The Agency also should analyze the impact of Maryland's historical hospital payment program on the state's ability to participate in the current demonstration program. For example, CMMI should identify the data infrastructure the state had in place in advance of participating in the current model, and the data collection capacity of participating providers since the model began. This information is critical since the ability to collect data is the cornerstone of any functioning demonstration. In this way, Maryland providers may be able to serve, at least in part, as a comparator to judge the likely capabilities of other states or regions.

In addition to generating a strong evidence base on which to found a demonstration, CMMI also must ensure that robust monitoring and evaluation capabilities exist so that demonstrations can be continually refined to the benefit of the patients and providers participating in them. As one element of these broader capabilities, BIO strongly encourages CMMI to establish mechanisms to collect provider and patient experience data. While potentially resource-intense, this source of information is critical since quality-of-care measures may not be specific enough to identify issues that arise only for certain provider and/or patient subpopulations. BIO also recommends that CMMI analyze data collected more frequently than just annually, as patient access issues that arise unexpectedly could have serious and acute implications. CMMI also should consider making this de-identified evaluation data public at specific intervals to allow stakeholders an opportunity to perform independent analyses and allow the data to be utilized to develop and refine additional pilot programs.

IV. <u>Quality measures (RFI Section II, Q7):</u> CMMI should utilize robust quality measures to ensure that any demonstration maintains or improves individual patient care.

BIO continues to advocate that CMMI implement robust quality measures—including patient-centered outcomes measures (e.g., patient-reported outcomes measures, functional measures)—to serve as a bulwark against a sole focus on cutting costs. BIO has identified six specific elements of a "robust" quality measures set, and we urge the Agency to ensure that all of the quality measures utilized in any demonstration stemming from the RFI incorporate these elements.

<u>Quality measures should be meaningful to patients and evidence-based</u>: Measures should not only be meaningful to patients, but also: actionable by providers; represent relevant metrics of care for the disease and patient population included in the demonstration; and be able to capture the full extent of benefits and side-effects of treatment options available to the population. Moreover, such measures must be rooted in scientific evidence, and capture the standard of care for relevant patient subpopulations to ensure that the metrics do not result in the provision of inefficient or ineffective care. The selected quality measures also

should be used to highlight health disparities so that quality improvement efforts can be focused on these areas.

Quality measures should employ a comprehensive risk-adjustment methodology: The need for risk adjustment was discussed earlier in this letter (see section I). However, we ask CMMI to further specify what examples of robust risk adjustment the Agency intends to reference for such a demonstration. CMMI also should identify the efforts that are underway to improve upon existing methodologies, given the evidence that they are insufficient to comprehensively account for the underlying differences in a provider's patient population.[3] We also note that additional concerns remain about the predictive capability of existing risk-adjustment methodologies with regard to patients who suffer from diseases such as cancer, multiple sclerosis, and Alzheimer's disease.

Quality measures should promote access to evidence-based care: Demonstration programs have the opportunity to improve the quality and efficiency of the care patients receive. A key component of doing so is ensuring that quality measures promote access to the most appropriate therapy for an individual patient, based on existing evidence and considering the standard of care. CMMI should ensure that such access is inclusive of new-to-market therapies, which may not yet be incorporated into the type of prospective budget the RFI envisions at the time the therapy reaches the market (discussed in greater detail in section I). BIO considers this to be a critical safeguard to ensure that quality measures improve appropriate care. The exact mechanism through which CMMI implements this safeguard depends on the structure of the demonstration. Additionally, CMMI should consider including mechanisms in any demonstration that provide care continuity for patients who transition into or out of the demonstration.

Quality measures should establish a performance period that is meaningful in the context of the diseases/conditions from which patients included in the program suffer: The period of time over which a measure assesses the quality of care delivered should be established based on well-characterized clinical features of the targeted disease. This will allow for accurate comparisons between patients treated by different providers.

In particular, BIO urges CMMI to identify and include measures to assess, among other factors, patient access to appropriate therapies both before, and during, the implementation of a demonstration that stems from the RFI. Such an assessment must be multi-faceted, including whether patients have timely access to the most appropriate therapy at the beginning of their treatment—including new-to-market therapies—and whether patients are able to remain on a therapy that works for them throughout the course of their treatment (i.e., in consultation with their provider). Not only does access to the most appropriate therapy have the greatest potential to help patients achieve their desired health outcomes, but it can promote adherence to therapy, which can result in decreased overall health expenditures (e.g., as a result of decreased hospitalizations, physician office visits, and surgical interventions).

[3] For example, a 2016 Avalere study found that the current risk-adjustment methodology employed by CMS has resulted in underpayments to Medicare Advantage plans for the costs of treating patients with multiple chronic conditions. See Avalere Health. 2016 (January). *Federal Government Underpays Medicare Advantage Plans for Enrollees with Multiple Diseases*, available at: http://avalere.com/expertise/life-sciences/insights/federal-government-underpays-medicare-advantage-plans-for-enrollees-with-mu; also see Avalere Health. 2016 (January). *Analysis of the Accuracy of the CMS-Hierarchical Condition Category Model*, available at: http://go.avalere.com/acton/attachment/12909/f-028f/1/-/-/-/-/012016_Avalere_HCC_WhitePaper_LP_Final.pdf.

Additionally, we would like to highlight that, where possible, CMMI should aim to employ quality measures that are outcomes-focused—including patient-centered outcomes measures—instead of those that are solely process-focused. This is because, while process-related outcomes are an important start to understand how a standard of care is implemented, outcomes-measures more directly link the care provided with a specific health outcome. Since the ultimate aim of any demonstration program should be to maintain or improve quality of care, it is preferable to measure actual changes in health outcomes rather than interpret the likelihood that changes in process directly result in changes in outcomes. This is particularly true in the case of complex and chronic diseases, in which many different factors, beyond the process of care, can influence longer-term health outcomes.

In considering additional quality measures, CMMI references the potential to identify population health metrics to measure provider performance. BIO generally supports the use of population health measures insofar as they create efficiencies in collecting and analyzing data on quality and effectiveness of care and limit providers' reporting burden. However, we note that the ability of a global and/or population-based measure to accurately reflect the care an individual is receiving will vary significantly depending on the type of care, the expected homogeneity of the impact of that care on a patient population, and the condition/disease the care is meant to prevent, diagnose, and/or treat. While this may be more appropriate for certain aspects of primary care (e.g., the provision of vaccines), using global measures to assess the performance of specialty providers may obscure important information about the care individual patients, or subpopulations of patients, are receiving. Thus, we caution CMMI against an overreliance on these measures unless there is evidence to suggest such measures can appropriately capture the quality and effectiveness of care individual Medicare beneficiaries receive.

The quality measures included in a demonstration should be reassessed frequently. In order to keep pace with the evolution in the standard of care, quality measures must be reassessed and updated at least annually. In the event that a substantial change to the standard of care for a given condition occurs mid-year, CMMI should identify a mechanism that can be utilized to update quality measures soon thereafter, if needed. Routinely updating the quality measures utilized in a demonstration also has the advantage of providing multiple opportunities to, and a continued focus on the, drive toward outcomes-based measurement, including with regard to specialty care over time. BIO also recommends that CMMI establish a process to allow interested stakeholders to provide input on proposed changes to the quality measures included in a demonstration that results from this RFI. Stakeholders that work at the point of care—in particular, patients and providers—are well situated to identify changes in the standard of care that may impact existing quality measurement. Thus, allowing their input into the update process can improve the utility of the final quality measures set.

Quality measurement requirements should minimize burden on providers. BIO recommends that CMMI pay particular attention, and work with provider groups directly, to minimize the burden that quality measures reporting requirements may place on providers participating in a demonstration. The Agency should strive to strike a balance between ensuring the delivery of high-quality care, through diligently tracking care delivery, and not overwhelming already time-strapped providers, for whom Medicare may be only one of several payors with which they interact. Also, to the extent possible, BIO recommends that CMMI align—and streamline—quality measures across services and providers within the same demonstration. We caution CMMI, however, that this should only be done after

thoroughly evaluating whether a specific measure is appropriate, accurate, and reliable across different services and provider types, which is not always the case.

V. Conclusion

BIO appreciates the opportunity to provide feedback in response to the RFI, and we look forward to working with the CMMI as the Agency continues to consider this type of demonstration program in the future. Please feel free to contact me at (202) 962-9200 if you have any questions or if we can be of further assistance. Thank you for your attention to this very important matter.

Sincerely,

/s/

Laurel L. Todd
Vice President
Healthcare Policy & Research

From: CMS Regional Budget Concept
To: All Payer Operations
Cc:
Subject: FW: Comments from an Indiana CAH Hospital Administrator
Date: Friday, May 13, 2016 2:30:41 PM

-----Original Message-----
From: Tim Putnam
Sent: Friday, May 13, 2016 12:05 PM
To: CMS Regional Budget Concept <RegionalBudgetConcept@cms.hhs.gov>
Subject: Comments from an Indiana CAH Hospital Administrator

Hello Please let me know if you need any clarity on these comments:

1. Assigned patients - there should be an incentive for the patient to use local health services. There also should be an incentive for hospitals to capture the patient's business to avoid restrictions to care. This should not mandated but incentivized. In our experience with the ACO, it is clear that annual wellness visits are very beneficial to reduce the overall costs of care and quality of life. However, patients seem reluctant to go to their doctor when they are not Ill. They need to be incentivized to receive their wellness visit.

2. I am very concerned that the global budget will be set and then continue to decrease as the years go by. It will be important to address how the program could be sustainable.

3. For our hospital and community the focus of the program should be on basic services like EMS, primary health services, imaging and lab diagnostics, emergent, screenings, OB. Carve out work that can only be done at tertiary and quaternary hospitals.

4. It needs to be clear that funding for a global budget should allow the healthcare providers and hospitals to have the ability to identify and fund the patients' social needs (transportation, dietary needs, socialization, etc) if they are necessary to improve health outcomes.

5. Hospitals and providers that excel in quality and outcomes should have some type of additional funding from a separate fund. However, to receive the funding they must be required to formally share their work process with the other hospitals.

Please let me know if you need anything further. Thank you for your attention.

Regards,

Tim Putnam, DHA, FACHE
CEO, Margaret Mary Health
Batesville, IN

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:

McKenzie Health System, located in Sandusky, Michigan, 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. As background, McKenzie Health System is a 25-bed Critical Access Hospital and is a member of the Greater Michigan Rural ACO; funded through AIM and supported with Caravan Health resources.

I believe CAH's should be included in a prospective budget concept. I believe a range above and below the CAH's cost can be negotiated and the prospective budget would reflect that same range. The CAH is responsible for costs that exceed the range payment and benefits from efficiencies that fall below the range payment. Special considerations would include access to data that allows the CAH to monitor assigned beneficiary spend; access to data would need to include warehousing the data and performing analytics on that data.

Resource support would include the above mentioned data warehouse and analytics on claims data from each payer. I don't think any rural hospital handles down side risk well because most do not have deep financial pockets. If the mid-point of the range I've described is cost, then any facility is appropriately motivated to perform more efficiently, the current cost-based program does not encourage efficiency.

I believe that CMS facilitating all payers to attribute beneficiaries to the rural hospital they seek primary care from is the first step; primary care needs to include physicians, physician assistants, and advanced nurse practitioners. The rural hospital best understands which larger healthcare institution provides the best health care and develops a respectful relationship with the rural hospital. The rural hospital knows what needs in specialty care, IT and so on it requires and the relationship will most likely support the inter-relationship.

I think measuring cost of care and quality is already available to CMS. Population health however is different and may be a function of cost, quality, risk assessment and risk behaviors. This may be difficult because not all people have a relationship with a primary care provider or access care in any other way.

I believe transferred and/or referred services will be appropriately achieved because the financial resources are aligned with managing the best care for the patient. Once again the readily available services in the rural area will be determined by and between the rural facility and urban facility that is interested in the same quality and cost issues.

Sincerely,

Steve Barnett
President & CEO
McKenzie Health System

From: CMS Regional Budget Concept
To: All Payer Operations
Cc:
Subject: FW: RFI
Date: Friday, May 13, 2016 2:30:57 PM
Attachments: image001.jpg

From: Brian Whitlock
Sent: Friday, May 13, 2016 12:56 PM
To: CMS Regional Budget Concept <RegionalBudgetConcept@cms.hhs.gov>
Cc: Sayegh, Stephanie A. - CO 4th **Subject:** RFI

May 13, 2016

Center for Medicare and Medicaid Services

Innovation Center

RE: RFI on Concepts for Regional Multi-Payer Prospective Budgets

To Whom It May Concern:

The Idaho Hospital Association (IHA) appreciates the opportunity to provide input to the Centers for Medicare and Medicaid Innovation (CMMI) on the subject of rural hospital payment methodologies and the prospect of global budgets for care. The IHA supports efforts to better serve our communities and make the healthcare delivery system more efficient.

The IHA's membership is disproportionately represented by Critical Access Hospital (CAH) and rural hospitals. This is a very complex issue and requires consideration of a number of factors. CAH and rural hospitals are in varying states of preparedness with regard to their ability to manage the health of populations – or, take direct risk with regard to payment methodologies. Rural hospitals are in differing states of capitalization, ranging from existing in aged facilities to having just rebuilt or replaced original physical plants constructed with Hill-Burton funds. Any innovation plan should consider the individual circumstances of each participating hospital.

While regional global budgets will include large PPS hospitals, specific protections and policies that protect CAH and smaller, rural PPS hospitals must be part of any effective strategy to better serve rural communities. Policies such as these are necessary to preserve the existence of hospitals in rural communities and to acknowledge that the value proposition of CAH and small rural hospitals is oftentimes more about access to critical healthcare services than financial efficiency. As such, patients should not be financially penalized for receiving healthcare services locally. Driving patients to urban centers for locally available services further lessens the efficiency of rural hospitals.

Regional risk-bearing organizations may need specific protections from self-referral, anti-kickback,

and anti-trust laws while organizing access and services in a manner that best serve the region's communities while providing better outcomes and efficiency of care. The waiving of regulations that regulate length of stay at certain facilities, or qualifying lengths of stay (3 days for nursing facilities) needs to be "in play" as the most appropriate clinical settings are selected to provide efficiency and local access to clinical services.

Finally, whenever possible, innovation should build upon models that are already being contemplated or are currently in existence. The broadening of existing Medicare ACOs or Medicaid provider-based organizations formed to provide population health management services will make the delivery system more efficient by reducing the need for additional organization costs and governance structures. It would also provide opportunities to better serve dually eligible populations that are receiving both Medicare and Medicaid services coverage. Requirements to form individual organizations to serve distinct populations will only detract from efficiencies gained through innovation efforts. As providers progress down the path of accepting risk and taking direct responsibilities for population health management, the additional layering of insurance companies should be avoided to reduce layering of administrative services and their related costs. As much funding as possible needs to remain in the direct patient care arena.

Thank you for the opportunity to comment on the future innovation of our healthcare delivery system. If you have any questions about the comments provided, please contact Larry Tisdale at the Idaho Hospital Association.

Brian Whitlock

President & CEO
208.489.1400 (office)
208.850.3301 (cell)

Washington State Hospital Association

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: Centers for Medicare and Medicaid Innovation's Request for Information on Concepts for Regional Multi-Payer Prospective Budgets

Dear Mr. Slavitt,

On behalf of 101 hospitals and health systems in Washington State, the Washington State Hospital Association (WSHA) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Innovation Request for Information on Concepts for Regional Multi- Payer Prospective Budgets. We are responding specifically to Section IV: Questions on a Potential Rural Specific Option, as well as selected questions relevant to the implementation of prospective global budget payment in a rural setting. Based upon our considerable work to date, we believe that we can offer a template for successful care delivery and payment reform for small and rural hospitals.

As part of the Washington's State Innovation Model work, WSHA has partnered with the state Medicaid agency and Department of Health to develop and pilot a new payment and care delivery model for the communities served by Washington's most vulnerable critical access hospitals (CAHs). Known as the Washington Rural Health Access Preservation (WRHAP), a dozen of Washington's smallest CAHs have been meeting over the last year to design a model that will sustain access to essential health services in rural communities.

We believe the work undertaken by this group can provide a foundation for the development of a multi-payer prospective budget model that could be implemented successfully in other states. Rural communities face a unique set of challenges and any new model needs to reflect the challenge of delivering high value care in low volume settings. Rural care is not simply urban health care in miniature. All hospitals face the challenge of supporting their fixed costs and standby services within a payment system that rewards volume rather than value, but this challenge is greater for rural hospitals. In these communities, volumes are inherently low and failure to maintain adequate service delivery capacity will result in poor outcomes and higher costs for community residents.

A 2014 survey of our 10 smallest hospitals found they average 1.1 inpatients per day, but treat over 75 patients per day when their outpatient and community-based care programs are included. As is the case nationally, rural Washingtonians are older, sicker, and have lower incomes than their urban counterparts. Without access to services, some patients might die and others would need to be transported at significant cost to distant hospitals where the costs of care could be even higher. These rural areas are especially challenged in providing primary care services. Not only is it difficult to recruit physicians in remote areas, but the physicians are called upon to provide sole coverage for emergencies as well as delivering primary care.

While the payment systems for CAHs and Rural Health Clinics were intended to address their unique challenges, our smallest hospitals are finding it difficult to sustain their infrastructure and to provide effective primary care and population health services. While CAH payment is cost-based in principle, not all costs are covered and, under sequestration, reimbursements are less than the costs that are eligible for payment. In addition, there is limited ability to support community care outside the hospital walls or services that avoid hospitalization or institutionalization in expensive settings. Together, these challenges result in extremely low margins in our state's CAHs and threaten their future viability, a trend we have seen echoed in

the recent closures nationwide.

We have attached our curren t working document. It provides additional details on the alternative model we are developing for small rural hospitals and their ru ral health clinics. Briefly,we are designing a prospective budget system that combines a per-resident payment (to support essential standby services), a risk-stratified per-patient payment (to support effective population health services),a per-service payment (designed to cover marginal costs of acute care services), and performance-based payment adjustments using quality and utilization measures appropriate for rural communities.This system would provide rural hospitals with increased financial stability and increased capacity to deliver high-value services to the communities they serve. Such a payment system could be implemented in most rural hospital districts,with the state or another entity providing the facilitation and regulatory oversight needed to support multi-payer participation. However, with Medicare the largest payer for these hospitals, these changes will only be successful if Medicare participates as well.

Throughout the summer, we will work with our hospitals and the State of Washington to refine and quantify the parameters for this approach so that it can be successfully implemented. We would appreciate the opportunity to discuss how Medicare could participate. Over the course of the past year, other states have told us Washington's rural CAH reform efforts are leading the nation. We would welcome the opportunity to participate in a multi-state demonstration. The abllity to pllot Medicaid *and* Medicare reform .would be of high interest to many seeking change and sustainability in their own communities.

We hope our responsesto the rural-specific questions are helpful to you. We urge that you work collaboratively with us and the rural providers in other statesto craft a sustainable and effective solution to the healthcare needs of ru ral communities.

Sincerely,

Claudia Sanders
Senior Vice President, Policy Development
Washington State Hospital Association

Jueline Barton True Director, Rural Health Programs
Washington State Hospital Association

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

A prospective budget could be determined for individual rural communities based initially on the total amount of current spending on all of the healthcare services the residents of those communities are receiving, regardless of the site of service (e.g. hospital, clinic, home health, nursing home) or the community in which these services are delivered. The budget amount should be adjusted to take into account changes in the residential population of the community, changes in the health status of the population, and temporary circumstances (e.g., an influenza outbreak or an increase in tourism).

In Washington State, we are working with about a dozen small, remote, rural Critical Access Hospitals on a project referred to as Washington Rural Hospital Access Preservation (WRHAP). Each of the participating hospitals is organized as a public hospital district and are well suited to prospective budget implementation. As statutorily-created entities, the geographic area of a public hospital district is well defined, allowing for relatively easy identification of an attributable population. Additionally, public hospital districts are governed by locally elected boards and function as municipal governments, thereby providing a mechanism for public input and accountability.

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.

As previously stated, the existence of public hospital districts in Washington State allows clear identification of the relevant patient population without the need for complex attribution models. All Part A and B spending for services delivered by the districts should be included in the budget. Spending for other health care services that occurs inside the community should also be included in the budget, but all spending that occurs outside of the community should *only be included in accountability measures, not the payment itself, and those measures must be adjusted* to reflect the portion of the spending that can feasibly be controlled based on the actions of the hospital and physicians in the community. For example, many rural hospitals also serve as rural health clinics, nursing homes and home health agencies, and therefore manage both hospital services and post-acute services in the community. Others do not have or operate a rural health clinic, and those hospitals should not be held responsible for services delivered by physicians in the community who do not work for the hospital or the public hospital district.

In addition to adjustments designed to address differences in the health status of the community and unpredictable events (such as a contagious disease outbreak), there should be adjustments to focus local accountability on the *utilization* of services delivered by other

providers rather than the total *cost* of those services. For example, the community should be responsible for how often patients are hospitalized in other communities for ambulatory care- sensitive conditions, but not for what happens to them once they are admitted to a hospital in another community, since they cannot control what happens inside the distant hospital or the immediate post-acute care services.

The attached working document "Delivering and Paying for High-Value Healthcare Services in Small Rural Communities in Washington State" outlines the continuum of care that our hospitals and communities have determined must be available in rural areas and for which they could be responsible. In Washington's smallest communities, a prospective budget should be structured in a way that would provide the flexibility needed to sustain access to essential services and to build robust partnerships with specialists, telehealth, and larger tertiary facilities to ensure the full range of services.

Physicians and hospitals cannot successfully manage the quality and cost of healthcare services if they cannot assure their patients have affordable access to the appropriate medications.
However, it is inappropriate to include Part D services in a global budget unless the providers managing the budget have the ability to control or influence the policies used to pay for drugs under Part D. Should Critical Access Hospitals be included in a prospective budget? 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.

Critical Access Hospitals are ideally suited for a properly-designed prospective budget for local hospital services because of the higher-than-average portion of their costs that are fixed and not dependent on the actual volume of services. However, unless the budget and the accountability for the budget are properly designed, Critical Access Hospitals could be ***more harmed*** by a budget based on the total cost of care than other hospitals because a smaller- than-average share of total hospital and other services will be delivered by the CAH.

Consequently, we recommend that hospitals be paid on a prospective basis for the services they deliver, and then performance-based adjustments should be made using appropriate measures of total service utilization and spending, including services delivered in other communities.

Any prospective payment model for small Critical Access Hospitals must have provisions for adjusting payments/budgets for necessary increases in volume and for limiting the risk for spending variations. For example, many rural hospitals are located near tourist attractions or interstate highways and so the "population" they serve goes beyond the full-time residents of the community and can vary dramatically over time and from month to month. In addition, because CAHs are small, there is inherently large year-to-year variation in services. Since the hospitals have been paid based on costs, they do not have the kinds of financial reserves needed to adapt to short-term changes in volume if payments do not match the changes in

cost. Few small rural hospitais have the staff or reserves to accept or manage any significant downside risk, and resources (both technical and financial) will be needed to support transformation to a new CAH payment model.

For these hospitals, a new payment model must allow for sufficient predictability to sustain local delivery system infrastructure for essential health services. This could begin with a per- resident fee from each payer, both public and private, with each payer paying for the residents who are members or beneficiaries of that payer. This fee would support standby services that are needed by all residents of the community. A second per-member/benefici ary fee would be risk stratified by payer according to the chronic disease burden of the local population and designed to support effective chronic disease management. A third payment would be paid for each individual acute service that is delivered, but the amount of the payment would be based on marginal costs rather than average costs, since essential fixed costs would already be covered by the per-resident payments. This means that the per service payments would be much lower than the current payments or reimbursements made today for those services, which in turn eliminates any incentive to overuse acute care services. At the same time, this approach would also encourage greater use of local services rather than distant services where appropriate, and the higher utilization of those services would enable them to be delivered more efficiently and effectively.

Payment should also be tied to accountability measures that are within the purview of the local CAH. Because of the limited range of services they deliver directly, most CAHs cannot assume responsibility for the cost or quality of many services patients will receive, since those services will be delivered by other hospitals or physicians that are often located in distant communities. However, with adequate, flexible payment, CAHs can take accountability for the appropriate delivery of prevention, chronic disease management, and other key services and for controlling the utilization of avoidable services. Accountability measures that are used must adjust for the low volumes of patients seen.

These types of reforms to CAH payments would both provide more predictable revenues for hospitals and physicians, more predictable costs for Medicare and other payers, and higher- quality, more affordable care for rural community residents.

1. 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 dawn-side risk than others? How could risk be structured ta ensure Medicare savings, but also allow the rural acute care hospitals or Critical Access Hospitals to be successful?

We believe that a prospective payment model can work well for small Critical Access Hospitals but they need to have significant support from CMS. Resources and support include the following:

- **Medicare Data.** Data is needed to analyze the service use of residents within the local district to appropriately assess where they are receiving services and at what cost. To date, the lack of this data has been the most significant impediment to progress in our

WR HAP work. We are working with our state to obtain Medicaid data and with our commercial payers to obtain their data. These rural areas have a high proportion of older, Medicare enrollees. The hospitals need to be able to obtain data for these residents as well.

- **Waiver of Medicare rules.** Payment reform cannot occur without delivery system reform. The Centers for Medicare & Medicaid Services (CMS) will need to waive or change various regulations that restrict the hospital's ability to deliver services in new ways in order to facilitate payment reform. One example would be to allow small and remote Critical Access Hospitals to operate short-term "observation-type" transition beds so that low-level acuity patients can remain at the local facility and avoid unnecessary transfers.
- **Funding and technical assistance.** Resources will be needed to support transition. One drawback of the cost-based reimbursement system is that it does not allow for sufficient margins for capital improvements and investments. Care redesign requires significant investment of time and resources from executive teams that may require temporary help to keep the hospital running under the current system while they transition to a new model.
- **Complementary payment reforms for other providers.** Payment and delivery reform for sma!I Critical Access Hospitals cannot occur in a vacuum; appropriate physician payment reforms must be undertaken in tandem with hospital payment reform. Unless independent physicians are paid differently, any prospective budget model for hospitals or for both hospitals and physicians could simply encourage risk shifting between physician and hospitals rather than true improvements of care. Similarly, payment systems between rural hospitals and Federally Qualified Health Centers need to be aligned to facilitate active partnership in community care.

- What are ways for CMS, the rural acute care hospitals, or the Critical Access Hospitals ta align partnerships with larger health care institutions ta pro11ide support such as specialty care, information technology and quality improvement tools?

Strong partnerships between small Critical Access Hospitals and tertiary care hospitals are essential to deliver coordinated, high-value care to residents of rural communities, but these partnerships are difficult to forge and sustain under current payment models for both CAHs and PPS hospitals and for the physicians who practice at the hospitals. Rather than each hospital and physician competing to obtain the revenue for serving a particular patient, they should be able to collaborate to determine which providers can deliver the highest-quality care at the most affordable cost in a setting as close to the patient's home and family as possible. It is important that CMS not try to design one-size-fits-all solutions and apply them to every community, but it is also important that appropriate solutions be developed for all of the providers delivering care to the residents of a community, not just a subset of them.

New payment models promoted by CMS need to sustain the rural delivery system and not simply drive patients to urban settings. New payment models such as care bundles should incentivize local delivery of appropriate care and facilitate partnerships between rural hospitals and larger/quaternary centers. CMS should also increase data flow from payers to facilities that allows for better care management of local populations.

Other changes are needed as well. We are working with the small Critical Access Hospitals on programs to supplement their services via telemedicine. While we have specific telehealth services requirements in our state that delineate coverage by Medicaid and commercial payers, Medicare coverage is still not guaranteed in all cases.

- 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?

The September 2015 report from the National Quality Forum entitled "Performance Measurement for Rural Low-Volume Providers" is an important first step to developing rurally relevant quality care measures. This work should be expanded to ensure that measures reflect the quality of care delivered, not simply the small volume of care.

Using total cost of care measures to evaluate rural health systems can put those systems at serious financial risk because they cannot control all of the services and providers that drive the total cost of care. However, rural hospitals have an important role in ensuring that local residents are receiving appropriate, high value care and can take accountability for many aspects of costs and quality. Primary care, prevention and emergency care measures tailored to low-volume settings are an appropriate way to ensure value for providers, patients and payers.

In addition, because of their small staffs, low operating margins, and lack of capital reserves, rural hospitals are unlikely to have the technical or financial capability to take on significant downside risk for any measures, and they should instead be allowe a facilitated transition period to accept accountability for the cost and quality of services they can provide within the community.

- 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?

We are working to develop clear definitions of the types of patients that should appropriately be treated in a rural hospital and those that should be transferred depending on the size and capabilities of the hospital. This will improve the ability of accountability measures to distinguish between appropriate and inappropriate transfers. However, the payment system needs to provide adequate resources to rural hospitals to deliver those services that they could appropriately deliver. For example, Medicare payment systems should support short inpatient stays that will allow low-level acuity patients to avoid transfer and be cared for in the local community. Medicare payments should also support the adoption of telehealth technologies that facilitate the rapid evaluation of such patients and connections to specialists and remote facilities when transfer is appropriate.

Response to the RFI on Concepts for Regional Multi-Payor Prospective Budgets

Respondent, Western Healthcare Alliance: Background

The Western Healthcare Alliance (WHA) is a Colorado non-profit health network comprised of 29 rural healthcare provider members, including: 12 Critical Access Hospitals, 10 tax-exempt PPS hospitals under 75 beds, one 250-bed tertiary hospital and six ancillary providers. WHA provides smart business solutions to help members succeed by aggregating their volume to create economies of scale.

WHA and its members have spent over three (3) years proactively preparing for movement from volume- to value-based reimbursement programs. In the course of our work, WHA members collaborated to:

- Work jointly with our "sister" rural health network, the 34-CAH-member California Critical Access Hospital Network to jointly fund the substantial consulting resources, education, and market assessments necessary to analyze the best courses of action;
- Form the Community Care Alliance, LLC (CCA) to house all infrastructure (i.e., staff, medical direction, IT systems, and data analytics) necessary to participate in value-based programs and CMS alternative payment models;
- Form the Rocky Mountain Accountable Care Organization, LLC -- a Medicare Shared Savings Program (MSSP) Track 1 ACO with more than 13,000 rural Medicare Beneficiaries in Colorado and Washington;
- Form the San Juan Accountable Care Organization, LLC -- a MSSP Track 1 ACO with more than 7,000 rural Medicare beneficiaries in Colorado;
- Develop population health management programs to increase the quality and reduce the cost of healthcare for members' own employees and dependents, as well as those of local employers in their communities, and commercial payors; and
- Establish practice transformation services to assist primary care and specialty practices with adopting the principals of patient-centered medical homes.

WHA is pleased to provide the following comments and observations in response to the questions posed regarding the potential for rural hospital participation in a regional budget payment concept.

Section IV of the RFI: Questions on Potential Rural Specific Option

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

WHA believes that rural communities, and CAHs in particular, are ill-suited to a regional budget payment approach for inpatient and outpatient hospital services. Rural communities lack population scale and the most expensive hospital services are provided by regional and tertiary providers that are outside of the rural hospitals' direct control. In order to preserve the rural safety net CAHs represent in their communities, special accommodations to minimize risk must be made.

However, there is a realistic alternative to a regional budget payment for rural hospitals. CAHs, and their affiliated primary care practices (rural health clinics, RHCs), could be incentivized to *manage the total cost and quality of care* (not just hospital-based services), with a combination of shared savings reimbursement models and PMPM reimbursement tied to performance targets.

In this way, CAHs would have the opportunity to utilize their local systems of care to manage overall population health, and avoid being at-risk for the cost of acute services provided at tertiary and regional facilities. This model could then consider episodic (bundled) reimbursement to be paid to the regional and tertiary systems that receive rural referrals. As a result, this model would potentially create networks of rural communities that afford scale and access to infrastructure, and that incentivize tertiary and regional providers to partner with rural networks to receive episodic payments for rural patients' hospital services at their locations.

In order for this approach to be successful, there are several accommodations that would need to be considered, including:

- Proper funding for network development activities that are necessary to increase economies of scale and aggregate limited resources among small and rural providers. These activities include the use of consulting services, actuarial analysis, IT requirements, establishment of empowered governance, legal review, and importantly, practice transformation and learning opportunities for participants ; and
- Adequate two to three-year ramp up period for formation of infrastructure and implementation of the model. Example: WHA members spent one and a half years meeting with each other and engaging legal, IT and managed care consultants to develop the CCA as a member-owned and governed centralized infrastructure, in addition to a full year to hire staff and implement the programs. Additional time would be needed for rural providers to organize in areas that do not already participate in a network such as WHA.

In addition, there must be a full commitment to a comprehensive, primary care strategy that includes:

- A formal legal framework (such as a clinically integrated network) for CAHs to partner with regional and tertiary referral providers;
- Use of patient centered medical home models and advanced care coordination;
- A framework for developing and implementing evidenced-based protocols;
- Access to information technologies that include data analytics, predictive modeling, care planning, and quality monitoring and reporting;
- Adoption of plan designs necessary to promote patient steerage and maintain utilization within established networks;
- Scale and tools necessary to determine actuarial risk adjustment (a *critical* success factor); and
- Risk corridors that reflect the small scale and actuarial risk associated with small and dispersed populations.

The rural healthcare delivery environment is well-positioned to develop these strategies. CAHs' emphasis on primary care, along with a small network of referral hospitals, skilled nursing facilities (SNFs), and home health agencies, will serve them well in the development of such a model.

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 CAHs 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 CAHs to be successful?**

As discussed, rural hospitals lack the scale necessary for the actuarial risk associated with regional budget payments for hospital services. Rather, our recommendation is that CAH and rural hospitals can play an important role in reducing costs through programs that reward the effective management of total costs and quality of care through primary care delivery systems.

However, larger rural regional facilities, with certain specialty capabilities, could participate in bundled reimbursement for defined episodes of care for those procedures that have the adequate volumes and low cost variation as necessary to manage risk. As mentioned above, tertiary and regional systems could be also be reimbursed (and included in the care continuum) through an episodic reimbursement model. These episodic payments could then be included in the total cost of care for patients being managed by the rural systems.

As previously discussed, rural communities can develop the infrastructure necessary to manage total cost of care through primary care systems and the formation of networks that aggregate resources and increase economies of scale. The creation of these capabilities requires up-front funding and ramp-up time. Funding from CMS could be reimbursed through future shared savings (similar to the Center for Medicare and Medicaid Innovation's ACO Investment Model) to enable infrastructure expenditures to cover the cost of:

- Forming a rural health network infrastructure to enable the providers in a larger geographic region to aggregate their rural populations into an actuarially feasible population;
- Conducting market feasibility, risk and actuarial analyses, hospital and physician readiness assessment, and any other necessary evaluations to identify where to focus initial care coordination and practice transformation efforts;
- Developing a legal framework (such as a clinically integrated network) for CAHs to partner with all regional and referral providers;
- Hiring an Executive Director, Medical Director, Data Analyst, Administrative Assistant, Care Coordination Manager, Practice Transformation Leader, etc.;
- Developing a patient-centered medical home and a primary care-based care coordination model;
- Purchasing or evolving an IT analytics system(s) for care plan management;
- Engaging plan design consultants to assist with the creation of narrow provider networks and plans that encourage use of those networks; and
- Performing analytics for performance monitoring and actuarial risk adjustment.

A lack of start-up funding, guidance and ramp-up period might produce the same problems rural hospitals faced after the DRG-based prospective payment system was introduced in 1983. Moving from cost-based reimbursement that paid hospitals in relation to their actual costs to fixed-amount DRG payments proved detrimental to many rural facilities: over 400 rural hospitals closed in the roughly 15-year period that followed DRG implementation (HHS Office of the Inspector General, 1998).

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

If, as we propose, the rural hospitals and medical communities are responsible for the total cost and quality of care for the patients that are included in their defined populations, they would need to identify the regional and tertiary systems that can provide the greatest value for these patients. This will lead to rural provider negotiations with regional and tertiary systems to identify the best referral relationships based on value. These discussions can include considerations such as clinical integration capabilities, IT interfaces, remote specialty coverage, telemedicine offerings, and transitions of care

processes. This model would put the rural systems that have shared responsibility for the patients, along with the payors, in the position of being able to choose among alignment options, based on the ability of regional and tertiary partners, to deliver value through bundled and other episodic payment methodologies (where feasible). In this way, the urban and tertiary providers would have similar responsibilities for the effective management of rural patients as they do for the defined regional populations for which they would be accountable to in a budget payment concept.

A network of rural CAHs, PPS hospitals, and other rural healthcare organizations would provide the aggregate population and bargaining power needed to approach this type of value-based arrangement. This is why the WHA chose to utilize its robust network to develop the CCA for the express purpose of developing population health solutions for the rural members and their communities. However, this process was time and resource intensive, and must be accommodated.

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 CAHs?

Rural communities can participate in alternative payment models that focus on improving quality and reducing total cost of care, such as with the MSSP, so long as catastrophic and actuarial risk is managed. Migration to some risk assumption can be realized over time, as long as risk corridors are properly established and normal variation is taken into account given the small populations.

The current MSSP model can be replicated and improved in order to provide claims and other data necessary for analytics, risk stratification, and quality monitoring and reporting. In addition to the longitudinal (CQM and MIPS) measures, the rural hospitals could also continue to report meaningful core measure data for the acute services provided. In this way, rural communities would continue to be accountable for quality of care both at the population and episodic levels. And as referenced above, the regional and tertiary specialty providers would likewise be responsible to report demonstrate value.

16. For rural acute care hospitals and for CAHs, 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?

As noted above, if the CAHs and rural hospitals are responsible for total costs of care instead of just hospital care, and clustered into a network of rural communities in order to increase scale and reduce variability, they will have the means and the incentive to carefully control unnecessary referrals and direct services to the systems that provide the greatest value. Regional and tertiary centers would compete for the rural services, to the extent that geographical factors are neutral, and would be held accountable by these arrangements for having adequate access, transitions, and reporting. This will also foster greater access to care as the relationships and referral processes become better defined within the expanded networks, and with the more limited number of providers involved.

Evaluating the Maryland Regional Budget Payment Program

Success in a regional budget payment concept depends, in part, on having a large population in the risk pool. According to the U.S. Census Bureau (2015), Maryland is the fifth most densely populated state in the country with **681.7** people per square mile of land area, with Medicare beneficiaries representing 16% of the total population (Kaiser Family Foundation, 2016).

WHA's Medicare populations, like most rural communities, are less densely populated and fewer in number. Colorado ranks as the **37th** most densely populated state with **52.6** people per square mile of land area (Maryland is almost 13 times more densely populated) and Medicare beneficiaries

represent 14% of the total population (US Census Bureau, 2015; Kaiser Family Foundation, 2016). WHA's sister network, the California Critical Access Hospital Network's members are likely wise more rural and younger than Maryland. California ranks **11th**, with **251.8** people per square mile and 14% of the total population are Medicare beneficiaries (US Census Bureau, 2015; Kaiser Family Foundation, 2016). Although the Maryland Regional Budget Payment program is finding success in Maryland; larger, more rural states may lack the population size to find similar success in a regional budget payment program.

Summary

WHA believes that rural communities, and CAHs in particular, are ill-suited to a regional budget payment approach for inpatient and outpatient hospital services. Rural communities lack population scale and the most expensive hospital services are provided by regional and tertiary providers that are outside of rural hospitals and CAHs' direct control.

However, rural communities, with the right accommodations, are ideally suited to manage the cost and quality of a defined population through a *properly established primary care network*. The involvement of rural communities in the MSSP demonstrates this capability. When multiple medical communities create a larger network with greater economies of scale and aggregated resources, the necessary tools and capabilities can be acquired, and meaningful conversations can take place with tertiary providers. But these efforts require funding and time to build, as has been demonstrated by the Western Health Alliance and its formation of the Community Care Alliance.

WHA and CCA appreciate the opportunity to respond to the request for information on the regional budget payment concept. Carolyn Bruce, CEO of WHA, and David Ressler, Executive Director of CCA, would gladly provide additional information on rural-specific regional budget payment concepts, as well as, WHA and CCA's network-approach to developing rural value-based payment capabilities. The Western Healthcare Alliance is located at 715 Horizon Drive, Suite 401, Grand Junction, Colorado 81506.

Best regards,

Carolyn Bruce
Chief Executive Officer
Western Healthcare Alliance
d.

David Ressler
Executive Director
Community Care Alliance
d.

References

Kaiser Family Foundation. (2015). [Table illustration] *Total Number of Medicare Beneficiaries*. Retrieved from http://kff.org/medicare/state-indicator/total-medicare-beneficiaries/.

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United States Department of Health and Human Services Office of Inspector General. (1998). *Hospital closure: 1998*. Washington, DC: Graham Rawsthorn. Retrieved from: http://oig.hhs.gov/oei/reports/oei-04-99-00330.pdf.

From: CMS Regional Budget Concept
To: All Payer Operations
Cc:
Subject: FW: RFI
Date: Friday, May 13, 2016 2:31:29 PM

From: clif croan
Sent: Friday, May 13, 2016 1:50 PM
To: CMS Regional Budget Concept <RegionalBudgetConcept@cms.hhs.gov>
Cc: Clif Croan
Subject: RFI

Hello Center for Medicare and Medicaid Innovation,

Please include these comments in the **"Request for Information on Concepts for Regional Multi-Payer Prospective Budgets"**. The service approach described herein, for fiscal review (UM/UR) and Quality Assessment (QA), is currently available to interested parties. Per the USPTO the service is a unique product.

1. Enigami Systems, Inc. holds a number of healthcare data and display patents, both pending and awarded, which may be utilized to approach fiscal review (UM/UR) and Quality Assessment in a new and novel manner.

2. Enigami Systems, Inc. has the "shovel ready" software currently available as a Beta now introduced in Behavioral Health, however, patents and pending patents encompass ALL medicine.

3. "SymptomTracksm", or "TreatmentGuidesm" as the service is known, utilizes a basic (online) telehealth application to track symptom status (Likert scale) and medication regimens (if desired) - using diagnostic criteria.

4. Treatment modality is not a consideration as the focus is to document the (actual) treatment performance. Was it successful in eliminating symptoms ? In the case of chronic conditions - are the symptoms contained ? The evidence based outcomes reflect not "performance" in the sense of merely "working" but a measure of success/failure, of treatment. This aligns reimbursement with actual treatment performance.

5. De-identified aggregate data can provide not only condition ranking/rating (for caregivers) but can drill down to peer profiled ranking/rating of performance of symptoms (status) treatment. Thus a ranking/rating of caregivers is possible to be used for UM planning according to skill set (performance) of the caregiver.

6. Marrying the evidence based outcomes data, for caregiver rankings/ratings, to a policy driven

cost weighting provides a new approach to fiscal review (UM/UR) and QA.

7. Per the Colorado Medicaid authority the CPT code reimbursement for this service is available and 100x less expensive than the current CMS reimbursement rates.

Thank you for including these comments in your dialogue.

Clif Croan

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"Mandatory measurement and reporting of results is perhaps the most important step in reforming the health care system." - Redefining Health Care, Porter & Tiesberg

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: Centers for Medicare and Medicaid Innovation, Request for Information on Concepts for Regional Multi-Payer Prospective Budgets

Dear Mr. Slavitt,

As Chief Executive Officer of Odessa Memorial Healthcare Center, I appreciate the opportunity to provide comments on the Centers for Medicare & Medicaid Innovation Request for Information on Concepts for Regional Multi-Payer Prospective Budgets. As a small critical access hospital, OMHC is committed to innovating to meet the challenge of delivering high-value care to our local community. In addition to providing life-saving emergency care and to operating a primary care clinic, we offer a comprehensive set of services including long-term care, outpatient services, therapy services and ambulance. We are the only local provider of most health services in one of the lowest density areas of our state and as such we offer a variety of community benefit programs including health screenings, immunizations and care coordination.

We believe that a prospective budget model that is thoughtfully designed to reflect the unique needs of small rural hospitals can sustain the crucial services we provide in the local community and we look forward to this opportunity.

As part of the Washington's State Innovation Model work, our hospital and other small hospitals like us have partnered with the Washington State Hospital Association, our state Medicaid agency and Department of Health to develop and pilot a new payment and care delivery model for the communities served by Washington's most vulnerable critical access hospitals. Known as the Washington Rural Health Access Preservation (WRHAP), a dozen of Washington's smallest CAHs have been meeting over the last year to design a model that will sustain access to essential health services in rural communities.

We believe the work undertaken by this group can provide a foundation for the development of a multi-payer prospective global budget model that could be implemented successfully in communities like ours. We urge that you work collaboratively with us and the rural providers in other states to craft a sustainable and effective solution to the healthcare needs of rural communities.

Sincerely,

Mo Sheldon, FACHE
Chief Executive Officer
Odessa Memorial Healthcare Center
Odessa, Washington

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

A prospective budget could be determined for individual rural communities based initially on the total amount of current spending on all of the healthcare services the residents of those communities are receiving, regardless of the site of service (e.g. hospital, clinic, home health, nursing home) or the community in which these services are delivered. The budget amount should be adjusted to take into account changes in the residential population of the community, changes in the health status of the population, and temporary circumstances (e.g., an influenza outbreak or an increase in tourism).

In Washington State, we are working with about a dozen small, remote, rural Critical Access Hospitals on a project referred to as Washington Rural Hospital Access Preservation (WRHAP). Each of the participating hospitals is organized as a public hospital district and are well suited to prospective budget implementation. As statutorily-created entities, the geographic area of a public hospital district is well defined, allowing for relatively easy identification of an attributable population. Additionally, public hospital districts are governed by locally elected boards and function as municipal governments, thereby providing a mechanism for public input and accountability.

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.

As previously stated, the existence of public hospital districts in Washington State allows clear identification of the relevant patient population without the need for complex attribution models. All Part A and B spending for services delivered by the districts should be included in the budget. Spending for other health care services that occurs inside the community should also be included in the budget, but all spending that occurs outside of the community should *only be included in accountability measures, not the payment itself, and those measures must be adjusted* to reflect the portion of the spending that can feasibly be controlled based on the actions of the hospital and physicians in the community. For example, many rural hospitals also serve as rural health clinics, nursing homes and home health agencies, and therefore manage both hospital services and post-acute services in the community. Others do not have or operate a rural health clinic, and those hospitals should not be held responsible for services delivered by physicians in the community who do not work for the hospital or the public hospital district.

In addition to adjustments designed to address differences in the health status of the community and unpredictable events (such as a contagious disease outbreak), there should be adjustments to focus local accountability on the *utilization* of services delivered by other providers rather than the total *cost* of those services. For example, the community should be responsible for how often patients are hospitalized in other communities for ambulatory care-sensitive conditions, but not for what happens to them once they are admitted to a hospital in another community, since they cannot control what happens inside the distant hospital or the immediate post-acute care services.

The attached working document "Delivering and Paying for High-Value Healthcare Services in Small Rural Communities in Washington State" outlines the continuum of care that our hospitals and communities have determined must be available in rural areas and for which they could be responsible. In Washington's smallest communities, a prospective budget should be structured in a way that would provide the flexibility needed to sustain access to essential services and to build robust partnerships with specialists, telehealth, and larger tertiary facilities to ensure the full range of services.

Physicians and hospitals cannot successfully manage the quality and cost of healthcare services if they cannot assure their patients have affordable access to the appropriate medications. However, it is inappropriate to include Part D services in a global budget unless the providers managing the budget have the ability to control or influence the policies used to pay for drugs under Part D.

Should Critical Access Hospitals be included in a prospective budget? 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.

Critical Access Hospitals are ideally suited for a properly-designed prospective budget for local hospital services because of the higher-than-average portion of their costs that are fixed and not dependent on the actual volume of services. However, unless the budget and the accountability for the budget are properly designed, Critical Access Hospitals could be *more harmed* by a budget based on the total cost of care than other hospitals because a smaller-than-average share of total hospital and other services will be delivered by the CAH.

Consequently, we recommend that hospitals be paid on a prospective basis for the services they deliver, and then performance-based adjustments should be made using appropriate measures of total service utilization and spending, including services delivered in other communities.

Any prospective payment model for small Critical Access Hospitals must have provisions for adjusting payments/budgets for necessary increases in volume and for limiting the risk for spending variations. For example, many rural hospitals are located near tourist attractions or interstate highways and so the "population" they serve goes beyond the full-time residents of the community and can vary dramatically over time and from month to month. In addition, because CAHs are small, there is inherently large year-to-year variation in services. Since the hospitals have been paid based on costs, they do not have the kinds of financial reserves needed to adapt to short-term changes in volume if payments do not match the changes in cost. Few small rural hospitals have the staff or reserves to accept or manage any significant downside risk, and resources (both technical and financial) will be needed to support transformation to a new CAH payment model.

For these hospitals, a new payment model must allow for sufficient predictability to sustain local delivery system infrastructure for essential health services. This could begin with a per-resident fee from each payer, both public and private, with each payer paying for the residents who are members or beneficiaries of that payer. This fee would support standby services that are needed by all residents of the community. A second per-member/beneficiary fee would be risk stratified by payer according to the chronic disease burden of the local population and designed to support effective chronic disease management. A third payment would be paid for each individual acute service that is delivered, but the amount of the payment would be based on marginal costs rather than average costs, since essential fixed costs would already be covered by the per-resident payments. This means that the per service payments would be much lower than the current

payments or reimbursements made today for those services, which in turn eliminates any incentive to overuse acute care services. At the same time, this approach would also encourage greater use of local services rather than distant services where appropriate, and the higher utilization of those services would enable them to be delivered more efficiently and effectively.

Payment should also be tied to accountability measures that are within the purview of the local CAH. Because of the limited range of services they deliver directly, most CAHs cannot assume responsibility for the cost or quality of many services patients will receive, since those services will be delivered by other hospitals or physicians that are often located in distant communities. However, with adequate, flexible payment, CAHs can take accountability for the appropriate delivery of prevention, chronic disease management, and other key services and for controlling the utilization of avoidable services. Accountability measures that are used must adjust for the low volumes of patients seen.

These types of reforms to CAH payments would both provide more predictable revenues for hospitals and physicians, more predictable costs for Medicare and other payers, and higher-quality, more affordable care for rural community residents.

12. 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?

We believe that a prospective payment model can work well for small Critical Access Hospitals but they need to have significant support from CMS. Resources and support include the following:

- **Medicare Data.** Data is needed to analyze the service use of residents within the local district to appropriately assess where they are receiving services and at what cost. To date, the lack of this data has been the most significant impediment to progress in our WRHAP work. We are working with our state to obtain Medicaid data and with our commercial payers to obtain their data. These rural areas have a high proportion of older, Medicare enrollees. The hospitals need to be able to obtain data for these residents as well.
- **Waiver of Medicare rules.** Payment reform cannot occur without delivery system reform. The Centers for Medicare & Medicaid Services (CMS) will need to waive or change various regulations that restrict the hospital's ability to deliver services in new ways in order to facilitate payment reform. One example would be to allow small and remote Critical Access Hospitals to operate short-term "observation-type" transition beds so that low-level acuity patients can remain at the local facility and avoid unnecessary transfers.
- **Funding and technical assistance.** Resources will be needed to support transition. One drawback of the cost- based reimbursement system is that it does not allow for sufficient margins for capital improvements and investments. Care redesign requires significant investment of time and resources from executive teams that may require temporary help to keep the hospital running under the current system while they transition to a new model.
- **Complementary payment reforms for other providers.** Payment and delivery reform for small Critical Access Hospitals cannot occur in a vacuum; appropriate physician payment reforms must be undertaken in tandem with hospital payment reform. Unless independent physicians are paid differently, any prospective budget model for hospitals or for both hospitals and physicians could simply encourage risk shifting between physician and hospitals rather than true improvements of care. Similarly, payment systems between rural hospitals and Federally Qualified Health Centers need to be aligned to facilitate active partnership in community care.

13. 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?

Strong partnerships between small Critical Access Hospitals and tertiary care hospitals are essential to deliver coordinated, high-value care to residents of rural communities, but these partnerships are difficult to forge and sustain under current payment models for both CAHs and PPS hospitals and for the physicians who practice at the hospitals. Rather than each hospital and physician competing to obtain the revenue for serving a particular patient, they should be able to collaborate to determine which providers can deliver the highest-quality care at the most affordable cost in a setting as close to the patient's home and family as possible. It is important that CMS not try to design one-size-fits-all solutions and apply them to every community, but it is also important that appropriate solutions be developed for all of the providers delivering care to the residents of a community, not just a subset of them.

New payment models promoted by CMS need to sustain the rural delivery system and not simply drive patients to urban settings. New payment models such as care bundles should incentivize local delivery of appropriate care and facilitate partnerships between rural hospitals and larger/quaternary centers. CMS should also increase data flow from payers to facilities that allows for better care management of local populations.

Other changes are needed as well. We are working with the small Critical Access Hospitals on programs to supplement their services via telemedicine. While we have specific telehealth services requirements in our state that delineate coverage by Medicaid and commercial payers, Medicare coverage is still not guaranteed in all cases.

14. 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?

The September 2015 report from the National Quality Forum entitled "Performance Measurement for Rural Low-Volume Providers" is an important first step to developing rurally relevant quality care measures. This work should be expanded to ensure that measures reflect the quality of care delivered, not simply the small volume of care.

Using total cost of care measures to evaluate rural health systems can put those systems at serious financial risk because they cannot control all of the services and providers that drive the total cost of care. However, rural hospitals have an important role in ensuring that local residents are receiving appropriate, high value care and can take accountability for many aspects of costs and quality. Primary care, prevention and emergency care measures tailored to low-volume settings are an appropriate way to ensure value for providers, patients and payers.

In addition, because of their small staffs, low operating margins, and lack of capital reserves, rural hospitals are unlikely to have the technical or financial capability to take on significant downside risk for any measures, and they should instead be allowed a facilitated transition period to accept accountability for the cost and quality of services they can provide within the community.

15. 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?

We are working to develop clear definitions of the types of patients that should appropriately be treated in a rural hospital and those that should be transferred depending on the size and capabilities of the hospital. This will improve the ability of accountability measures to distinguish between appropriate and inappropriate transfers. However, the payment system needs to provide adequate resources to rural hospitals to deliver those services that they could appropriately deliver. For example, Medicare payment systems should support short inpatient stays that will allow low-level acuity patients to avoid transfer and be cared for in the local community. Medicare payments should also support the adoption of telehealth technologies that facilitate the rapid evaluation of such patients and connections to specialists and remote facilities when transfer is appropriate.

MARYLAND RURAL HEALTH ASSOCIATION

May 13, 2016

To: CMS, Center for Medicare and Medicaid Innovation

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

To whom it may concern:

Maryland Rural Health Association (MRHA) is a non-profit member organization comprised of local health departments, hospitals, community health centers, area health education centers, health professionals, and community members in rural areas throughout Maryland. Of Maryland's 24 counties, 18 are considered rural by the state, and with a population of over 1.6 million they differ greatly from the urban areas in the state. Many of our members have been working under the Maryland All Payer Model for many years and bring years of experience with the ultimate goal to improve the health of rural Maryland.

Rural areas have a strong history of working cooperatively across systems with strong local partnerships between hospitals, clinicians, public health departments, and other stakeholders, strategically sharing and using data to improve health. This effective model of community-clinical partnerships that lead to innovative solutions is robust. Rural communities understand collaborative partnership between community and traditional clinical health is a necessity for survival – rural health care agencies have less administrative staff and even fewer clinicians to address the health of their population.

MRHA recommends the following considerations to the All-Payer Model Demonstration:

- Importance of care coordination and helping to manage chronic diseases outside the hospital walls
- Local hospitals must work hand-in-hand with the existing Local Health Improvement Coalitions already established in the communities through the Local Health Departments
- Important to review and define how this new payment structure will successfully integrate with other types of organizations besides hospitals such as community health centers, Local Health Departments and other community providers
- State should be thinking about investments in the community and their role in those investments
- Important to address the necessary guidelines regarding risk sharing and benefits from incentives bared by all providing care that share the risk in improving health outcomes and driving down costs
- Need to address the diminishing state budget but increased demand for community based initiatives
- Workforce shortages in rural areas – what are some proposals that the state can consider to address this very real rural concern

Thank you for your consideration. If you have any questions, please do not hesitate to contact me.

Sincerely,

Lara D. Wilson, M.S.
Executive Director, MRHA

South Carolina Office of Rural Health

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May 13, 2016

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Regional Budget Payment Concept RFI

To Whom It May Concern:

Please accept the following comments in response to the request for information (RFI) issued by CMS on April 14, 2016 regarding the regional budget payment concept. As a representative of rural health care providers in the state, the South Carolina Office of Rural Health is dedicated to ensuring access to quality health care in rural communities. We are encouraged by the concepts CMS has presented in this RFI and the opportunity it creates to think more creatively about how to focus on population health and the move to value-based health care in a way that allows for meaningful participation by rural providers. While it is important to ensure the historical financial protections for Critical Access Hospitals and Rural Health Clinics as well as special billing provisions such as those for Swing Beds are preserved, a regional budget payment concept provides the opportunity for more creative and flexible financing that will help to move the needle on improving health outcomes. This is especially critical in a state like South Carolina that is disproportionately challenged by poor health outcomes.

Rural health care providers exemplify the CMS goal of "better care for patients, better health for our communities, and lower costs through improvement for our health care system". In South Carolina over the past three years, rural and urban communities alike have had an opportunity to prepare for a regional budget payment concept such as that outlined in this RFI through the state's Healthy Outcomes Program. In this effort led by SC Medicaid, health care providers were paid to care for high-risk uninsured patients in their communities. In the majority of communities, the hospital received the global payment and was responsible for creating the pathways of care for the patients. Our state's rural communities excelled in the beginning stages of the program because of one simple fact: they knew the individuals in their community who could benefit from these services. However, the global payments over the long term were not sufficient in rural communities to overcome the well-known barriers to care related to cost and availability of specialty services, transportation, and other human service needs that ultimately impact our health. Some better-resourced rural communities were able to leverage other opportunities to create a more robust program to serve their patients. In other communities, especially where providers were not accustomed to working together, this was difficult.

Overall though, we learned that a global payment allows for communities to meet their unique needs in a cost-effective way, which is increasingly important in rural communities where a growing number of individuals are 65 and older. There are several benefits to patients and providers with this model such that regional budgets would allow communities and health care providers to invest in shared resources and infrastructure that might be more effective within community based organizations (such as Community Health Workers). Also, this approach would allow Critical Access Hospitals and Rural Health Clinics to have community-based or shared "team members" such as clinical pharmacists, social workers, care managers, certified diabetes educators, nutritionists, etc. that are often hard to recruit to rural areas; this could potentially drive new job opportunities into rural communities.

Other health care providers and resources in the community could also be used to fulfill multiple roles – for example, Community Paramedics are a type of specially trained paramedic that could be used to make scheduled home visits to patients with chronic disease or other needs in their down time between emergency calls. The ability to support the social service sector in rural communities is also critical; global payments would allow rural health care providers to work more intently with these organizations to solve individual and community issues before they rise to a level of health care need (for example, ensuring there is a nutrition program for isolated seniors in the community). From a more clinical perspective, global payments would open the door to accelerate adoption of tele-health technology and services, which are important tools for ensuring sustainable health care services in the community. These payments would also help break up the fee-for-service architecture that still drives and shapes the focus of rural providers. A global payment would potentially give them more time to spend with patients, promote documentation for clinical rather than billing purposes, and provide some stability in organizations with predictable revenues. Administrative time would also become value-added – contributing directly to a patient's experience and outcomes.

There are certainly potential concerns with a global payment approach. First of all, in reference to Maryland's All Payer system, it has the advantage that the HSCRC (state agency) that oversees the system has more than 30 years' experience building trusting relationships with Maryland hospitals and historical cost and utilization data on which to base their global budget. Any global budget for a state, region or community would have to be administered by a "neutral" party. This may be a state/governmental agency but could also be, for example, a Rural Health Network, which is a non-profit regional network of health care and human service providers that would be sensitive to local needs and resources. If global payments were managed exclusively by hospitals or another health care provider, CMS would need to support the development of guidelines for communities to allocate their global budget across their various "lines of business". For example, what percentage of the budget should be spent on primary care is a critical discussion, especially for a rural community where primary care is an essential resource to sustain and strengthen. Currently, on average 4-5% of most budgets go towards primary care; industry experts suggest this should be at minimum 12-15%. Regardless of the ultimate approach, rural hospitals and clinics need to have a defined role in the oversight and management structure of the system. They also need to be supported in their ability to access new partners and resources to make this transition as well as have technical assistance provided on how to retool their clinical practice related to operations and clinical management to make the most effective use of a global payment system.

The way regions are defined for the purposes of global payment is also a critical issue for rural communities. In South Carolina, there are various referral patterns to larger markets depending on the specific needs of individual patients. These patterns need to be considered, using available data to drive decisions for regions, and may include creating structures that include competitors. It is essential that rural health care providers and communities have a strong voice in these structures, regardless of the region's ultimate size. Health care is local and communities should be able to make decisions on the services their community has available based on their needs.

Again, we are encouraged by this effort and appreciate the opportunity to provide feedback. Please reach out anytime to my office as well as my colleagues in State Offices of Rural Health across the nation (there is one in every state). We are willing and able to assist you as you work with rural communities to meet CMS' payment goals. Rural communities need to be a part of the conversation as they have solutions to share as well as unique needs that require that new payment policies should be appropriate and sufficient to meet those needs.

Sincerely,

Graham L. Adams, PhD
Chief Executive Officer

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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]. 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

[1] Estimated Costs of Rural Freestanding Emergency Departments, Findings Brief, NC Rural Health Research Program, November 2015

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[i] as well as its accompanying State Innovation Model Grant[ii] that is designed to bring additional payers including -- Medicare dual eligibles[iii] 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.[iv] 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.[v] 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

[i] https://www.oregon.gov/oha/OHPB/Pages/health-reform/cms-waiver.aspx
[ii] https://www.oregon.gov/oha/OHPR/Pages/sim/index.aspx
[iii] http://www.oregon.gov/oha/healthplan/ContractorWorkgroupsMeetingMaterials/DUALS%20TA%20TOOL%20Exec%20Summ%20%20Resources.pdf
[iv] https://www.oregon.gov/oha/Metrics/Documents/2015%20Mid-Year%20Performance%20Report%20Executive%20Summary.pdf
[v] http://www.oregon.gov/oha/pages/rhri.aspx

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T

May 13, 2016

Center for Medicare and Medicaid Innovation (CMMI)
Centers for Medicare and Medicaid Services (CMS), HHS

Glens Falls Hospital, NY, Response to Request for Information (RFI)

Dear Madam/Sir:

Glens Falls Hospital (GFH) is pleased to respond to CMMl's RFI on *Conceptsfor Regional Multi-Payer Prospective Budgets.*

Background

GFH is the largest and most diverse health care provider our geographic area and provides a comprehensive safety net of health care services to a rural, economically-challenged region in upstate New York. GFH serves as the hub of a regional system of health care providers and offers a vast array of health care services including general medical/surgical and acute care, emergency care, intensive care, coronary care, obstetrics, gynecology, a comprehensive cancer center, renal center, occupational health, inpatient and outpatient rehabilitation, behavioral health care, primary care and chronic disease management, including a chronic wound healing center. In addition to the main acute care hospital campus, a 410 bed acute care hospital located in Glens Falls, NY, GFH operates 29 regional health care facilities, including 11 neighborhood primary care health centers and physician practices, 5 outpatient behavioral health clinics, several outpatient rehabilitation sites, seven specialty practices, two occupational health clinics and two rural school-based health centers.

The primary and secondary service areas for GFH include Warren, Washington and northern Saratoga counties, covering over 2,500 square miles. However, patients travel from Essex, Hamilton and sometimes as far as Clinton counties to obtain services within the health system. With a service area that stretches across six, primarily rural counties and 3,300 square miles, GFH is responsible for the well-being of an extremely diverse, broad population and region.

GFH's current inpatient payer mix is approximately: Medicare FFS: 38%; Managed Medicare: 27%; Commercial: 20%; Medicaid/Self pay: 15%. GFH has also invested in community medical clinics and ambulatory physician's practices to improve access to care in the community.

GFH has established a diverse array of community health and outreach programs, bringing our expertise and services to people in outlying portions of our service area. These programs are especially important for low-income individuals and families who may otherwise fail to seek out health care due to financial or transportation concerns. Our history, experience and proven results demonstrate strong partnerships, regional leadership and active engagement in improving community health outcomes. GFH also meets the criteria of an eligible safety net provider under NY's Delivery System Reform Incentive Payment (DSRIP) Program, as defined by the regional criteria of serving at least 30 percent of all Medicaid, uninsured and dual eligible members in the proposed county or multi-county catchment area.
For example, GFH is currently investing in population health to control costs, improve quality and increase access for the community including participating in several payment reform initiatives as well as implementing a new Cerner EMR which it plans to deploy in the acute and ambulatory settings to

improve population health. Through many of these initiatives, GFH has developed existing and furthered long-standing relationships with all critical partners. Specifically, GFH is a network partner within the Performing Provider System (PPS) lead by the Adirondack Health Institute (AHi) to implement DSRIP program, and is a member of the Adirondacks Accountable Care Organization (ACO). GFH is also an active member and co-chair of the Adirondack Rural Health Network (ARHN), a regional multi-stakeholder coalition that conducts community health assessment and planning activities. ARHN provides the forum for local public health services, community health centers, hospitals, community mental health programs, emergency medical services, and other community-based organizations to assess regional needs and the effectiveness of the rural health care delivery system. GFH has a long history of partnership and collaboration with the public health community. Health Promotion Center staff work collaboratively with partner agencies including school districts, businesses, communities, hospitals, and healthcare provider organizations to support healthy lifestyles for our patients and community members. The Community Care Coordination department at Glens Falls Hospital is recognized as a legacy provider for intensive case management, which has since transitioned into a Health Home Care Management agency. As a result, our relationships with social services, behavioral health, and supportive community-based agencies are well established. Over the past year, GFH has significantly strengthened and expanded our relationship with area skilled nursing facilities (SNFs). There are 12 facilities in the Warren, Washington and Saratoga region, and the hospital has served as a convener for various quality improvement initiatives. Examples include addressing pharmaceutical challenges at discharge for patients transferred to SNFs and implementing consistent care transitions information to each facility.

While GFH is expanding its role in population health, it is also reinvesting in its acute facility to meet community needs. GFH is investing in several acute service lines and employing several important specialists that are not available alternatively in the community.

Responses

GFH is interested in the concept of global or prospective budgeting as a transformative practice to support population health across multiple settings and payers. Global budgeting has the potential to more closely align acute and downstream providers to simplify payment reform. While GFH plans to continue to invest in payment reform programs, the existing programs lack the cohesiveness and alignment that a global budget may bring to a community.

In furtherance of CMS' inquiry, GFH is pleased to provide its perspective on several of the questions in the RFI below. If CMMI has follow-up questions or comments, please direct them to Dr. Brian McDermott, DO MBA, Senior Vice President for Clinical Integration, Glens Falls Hospital by telephone at by email at .

1. GFH believes that it could work with CMS, payers and other stakeholders to define a specific

   geographic market that is served primarily by the acute facility. Given the rural nature of the market described above, the hospital primary and tertiary service areas are well defined and stable. Further, community providers and ambulatory practices are fairly consolidated and also have defined and stable geographic areas in which patients are served.

2. b GFH would like to explore the possibility of having fixed revenue budgets and incentives for Medicare parts A & B, including IPPS, rehabilitation and the PFS. In addition, GFH would like to explore including Medicaid and commercial carriers in a multi-payer global budget for acute and non-acute services. A comprehensive approach avoids cost shifting and creates simplicity for all providers and consumers as opposed to having each payer pursuing a different value based

model. GFH is less interested in Medicare part D, as the costs are highly variable and a provider has less control over practice and utilization patterns.

As a member of the Adirondack ACO, GFH has worked with other providers and payers to have a multi-payer care management service component. While results are promising, the incentives are not strong enough to fully realize practice transformation and alignment.

3. d Given the stable market for acute and community providers in this type of geography, fixed revenue budgets based on historical costs with some modifications for growth in health care costs and an aging population should be achievable. An arrangement to limit full down side risk is also necessary to encourage provider participation, including a capped-down, side-risk arrangement or some type of stop-loss pool.

4. d The Adirondack ACO is an example of providers collaborating through a private structure with payers to achieve a limited multi-payer strategy. GFH believes that an ACO-like structure could develop and implement a multi-payer program. The ACO-like structure would have provider, payer and consumer representation. At this point, GFH is unsure if a statutory change is needed to have state Medicaid participation, however, it is likely that Medicaid could participate via contract with CMS.

5. d Existing data.sources through already deployed platforms, given the already present coordination, should meet all necessary requirements for this concept, however, the addition of a multi-payer model adding to this database would give GFH the metrics needed to deliver better value. For example, GFH has deployed an internal population health platform through the Cerner EMR, HealtheIntent™. Adirondack ACO has Health Catalyst as its population health platform.

Prospective budgets should be adjusted based on market share shifts and risk adjustments considering the needs of an aging population. In rural areas, GFH does not expect significant market shifts or changes in population, however, the aging of the local population will have a significant impact on costs over time.

7. d Having a multi-payer database and a single set of quality metrics will give GFH the opportunity to focus on achieving quality outcomes without the current burden of multiple, sometimes contradictory quality metrics. The result would increase time and efficiencies, leading to better outcomes and reduced cost.

If the global budget includes an evaluation of the Total Cost of Care ('TCC'), cost shifting should not be an issue. The incentives created in prospective budgeting lend themselves to greater investments in access and services to keep patients healthy in lower cost settings. CMS could also require and review quality and consumer satisfaction benchmarks to evaluate the program.

9. d GFH believes that all providers in the geographic region should participate and payment models aligned. The GFH market area is served by a large FQHC and a large, multisite ambulatory practice. Given this consolidation, deploying an efficient and effective population health strategy with GFH is achievable under prospective budgeting.

10. GFH, as a network partner within the Performing Provider System (PPS} lead by the Adirondack Health Institute (AHi} to implement DSRIP program, is also a member of the Adirondacks Accountable Care Organization (ACO). Meaning, there is already a culture of collaboration and

the necessary groundwork to get broad stakeholder participation. As described earlier, GFH has a long history of partnership and collaboration with the public health community. Health Promotion Center staff work collaboratively with partner agencies including school districts, businesses, communities, hospitals, and healthcare provider organizations to support healthy lifestyles for our patients and community members. The Community Care Coordination department at Glens Falls Hospital is recognized as a legacy provider for intensive case management, which has since transitioned into a Health Home Care Management agency. As a result, our relationships with social services, behavioral health, and supportive community-based agencies are well established. Over the past year, GFH has significantly strengthened and expanded our relationship with area skilled nursing facilities (SNFs).

11. GFH believes that a prospective program based on TCC concepts is attractive to all payers and is therefore likely to encourage participation. The Adirondack ACO has had several successes as a multi-payer model, particularly the broad regional participation and work toward reducing readmissions, unnecessary Emergency Department (ED) utilization, and reducing potentially preventable ED utilization. That said, it has not been without some challenges such as aligning all stakeholder incentives, seemingly addressed in this concept.

12. GFH has no comment on CAHs.

13. As a rural hospital, although not categorically defined as a "rural acute care hospital" or Critical Access Hospital," GFH believes that it can be successful in a limited geography. A limited geography fosters strong relationships among provider networks and successful interventions and investments in community needs. A rural geography that has consolidated providers is likely to be successful deploying a consistent and efficient population health platform if payers are aligned. Rural hospitals have to be cautious about accepting downside risk. CMS should consider designing the program to limit downside risk by placing limits on the risk or facilitating stop loss.

14. GFH has alignments and relationships with neighboring academic medical centers and other institutions for specialty care. A prospective budget would not disrupt those relationships. In terms of aligning with other providers, many of the previous response described above detail our desire, willingness and already achieved contractual relationships. Prospective budgeting would further incent providers to select common platforms and tools, one of the biggest stakeholder challenges today.

15. Although GFH doesn't meet the strict definitions, our geographic service area represents a large and vastly rural population, meaning GFH provides comprehensive, safety net health care services to a rural, economically-challenged region in upstate New York. However, GFH and our community partners have thoughts about measuring total cost of care, if CMMI were interested in discussing GFH in the context of a "rural hospital" or some other distinction given our described population.

16. As an example, GFH closely monitors and frankly struggles to provide services for stroke patients since retaining adequate specialized neurosurgical staff is challenging in our area. Utilizing more advanced technologies such as telemedicine to help augment services remotely would be one way to improve unnecessary transfers to tertiary care centers.

Thank you for your consideration or our responses to your Request for Information on "Concepts for Regional Multi-Payer Prospective Budgets." Again, if CMMI has follow-up questions or comments, please

direct them to Dr. Brian McDermott, DO MBA, Senior Vice President for Clinical Integration, Glens Falls Hospital

Most Sincerely,

Brian McDermott, DO MBA
Senior Vice President for Clinical Integration
Glens Falls Hospital

AHCA
AMERICAN HEALTH CARE ASSOCIATION

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May 13, 2016

Center for Medicare and Medicaid Innovation
7500 Security Boulevard
Baltimore, MD 21244

RE: Comments on The Center for Medicare and Medicaid Innovation's (CMMI) Request for Information on Concepts for Regional Multi-Payer Prospective Budgets

To Whom It May Concern:

The American Health Care Association (AHCA) represents more than 10,000 non-profit and proprietary skilled nursing facilities (SNF). By delivering solutions for quality care, AHCA aims to improve the lives of the millions of frail, elderly and individuals with disabilities who receive long term or post-acute care (LTPAC) in our member facilities each day.

As the voice in Washington for the vast majority of America's skilled nursing facilities, it is the responsibility of AHCA to ensure that our profession's position on key legislation and proposed regulations is communicated to the appropriate governmental bodies. This document summarizes AHCA's comments regarding the multi-payer Request for Information. In short, the Association respects the Centers for Medicare and Medicaid Innovation's efforts to modernize Medicare and Medicaid.
However, we remain concerned about the omission of downstream providers, such as post-acute and long-term care providers, in demonstrations in pilots. Such providers provide services critical to ensure restoration of function and the on-going health and wellbeing of Medicare beneficiaries.

Embracing PAC Payment and Quality Modernization

Since 1965, the Medicare program has adapted and evolved to better serve patients and their families. A key component of these changes is how Medicare reimburses for services provided for patients. To help curb costs and cap spending, Medicare payment has evolved from a fee-for-service (FFS) approach to the current prospective payment system — a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. Now, Medicare has reached a pivotal point driven by an increasing older adult population which will be in need of more health care services. Medicare should adapt to meet the needs of Medicare beneficiaries and providers who deliver critical services, including post-acute care (PAC). New payment approaches will be implemented that reward providers for quality and value. AHCA supports the implementation of a value-based purchasing (VBP) program for skilled

nursing facilities, and we look forward to working with CMS to develop an approach that provides cost savings, ensures quality care for beneficiaries, and is fair to providers.

To ensure that value and quality go hand-in-hand under new payment approaches, AHCA has implemented a Quality Initiative for its members to raise the bar in care delivery and set measurable goals for quality improvement in key areas. This year, AHCA has broadened its Quality Initiative to further improve the quality of care in America's skilled nursing care centers. While avoiding setting a standard of care, the expansion will challenge members to apply the Baldrige Performance Excellence Framework to meet measurable targets in eight areas with a focus on three key priorities: improvements in organizational success, short-stay/post-acute care, and long-term/dementia care. These areas are aligned with the CMS Quality Assurance/Performance Improvement (QAPI) program, and other federal activities such as Five-Star and the Improving Medicare Post-Acute Care Transformation (IMPACT) Act.

Evolving SNF Statutory and Regulatory Environment

AHCA recognizes that CMMI faces unique challenges with implementing each demonstration. For any demonstration, CMMI should consider the combined efforts of new payment approaches, value-based purchasing, health information exchange and quality reporting which all impact SNFs. Although not new for other Medicare providers, this is the first time these components have been cumulatively implemented upon SNFs.

Specifically, going forward, Section 215 of the Protecting Access to Medicare Act of 2014 (PAMA) added new subsections (g) and (h) to section 1888 of the Social Security Act (Act). The new subsection 1888(h) authorizes establishing a Skilled Nursing Facility Value-Based Purchasing (SNF-VBP) Program beginning with FY 2019 under which value-based incentive payments are made to SNFs in a fiscal year based on performance. The incentive payments will be paid from a pool of dollars accrued through a 2% withhold applied to all SNFs. Based on their rehospitalization performance, SNFs may or may not earn back none, some, all or more than the 2% that was withheld.

Additionally, the Improving Medicare Post-Acute Care Transformation Act of 2014 (P.L. 113-185) (IMPACT Act), enacted on October 6, 2014, requires the implementation of an array of SNF quality reporting elements. Beginning with FY 2018, the Act requires SNFs that fail to submit required quality data to CMS under the SNF Quality Reporting Program (SNF-QRP) to have their annual updates reduced by two percentage points. AHCA supported both PAMA and the IMPACT Act and will continue to support quality efforts through the Association's Quality Initiative, collaborative work with CMS, and collaboration with Congress.

AHCA recognizes moving from volume to value is a Department of Health and Human Services priority both under the Affordable Care Act as well as under the Secretary's goals for moving from FFS to alternative payment methods as well as value-based purchasing. However, moving from volume to value payment methodologies combined with eroding fee-for-service (FFS) payments make it essential that the remaining FFS payments are as accurate as possible. Regarding eroding FFS payments, current Medicare Advantage (MA) enrollment, nation-wide now is approximately 33% of Medicare beneficiaries while an additional 17% of Medicare beneficiaries are attributed to some form of a Medicare Accountable Care Organization (ACO). And, AHCA research indicates continued growth in MA enrollment, ACO attribution, and enrollment of duals in likely state-based Medicare-Medicaid integration programs.

RFI Detailed Comments

The remainder of this transmittal provides an overview of our ideas which specifically pertain to this solicitation for information. We have a number of other questions and suggestions but, for now, offer these five high priority items.

Comment 1: CMMI should broadly expand access to historical, beneficiary-level claims data to all providers who are expected to contribute to the cost savings and quality improvement efforts of demonstration initiatives.

AHCA appreciates the CMS' recent and ongoing efforts to improve data transparency across the health care system, and in particular its advancements and improvements in providing data to participants of demonstration initiatives. Having access to comprehensive, robust claims data, both raw and aggregated, is absolutely essential to providers who wish to implement quality improvement initiatives within the time frames established by most of these programs. As such, CMS should expand, not restrict, the potential audience and recipients of comprehensive claims data and reports. AHCA strongly believes that CMS should provide access to full, beneficiary-level claims data, as well as aggregated reports, to any Medicare-certified provider who would be expected to make operational efficiencies and quality improvements related to the demonstration. At a minimum, CMS should make this data available to any post-acute care provider who operates in a region participating in the demonstration; CMS should not restrict data access to hospitals, even if they are the only defined "at-risk" entity under the model.

CMS currently provides detailed claims data and aggregated reports to participants of CMMI demonstration models, such as the Bundled Payments for Care Improvement (BPCI) initiative and the Comprehensive Care for Joint Replacement (CJR) demonstration. However, AHCA believes that, in these instances, CMS' definition of "participant" is too narrow. CMS typically has restricted access to full claims data and aggregated reports to providers or other entities who are required to bear risk under the given model. Under CJR, the acute care hospital is the only *required* at-risk entity, and therefore CMS guarantees data access only to those providers. However, AHCA believes it was CMS' intent under CJR for different provider types to collaborate in new and innovative ways, and to engage in risk-sharing arrangements if desired. CMS clearly expects non-hospital provider types, and in particular post-acute care (PAC) providers, to implement quality improvement initiatives and engage in care redesign. AHCA maintains that if CMS expects PAC providers to engage in the same level of care redesign and quality improvement as its defined "participants," it should also allow them the same access to the data necessary to implement such improvements.

In the RFI, CMS states that it "believes that data are available through a multitude of pathways (e.g., directly from hospitals, health systems, or third party payers)…" AHCA urges CMS to abandon the presumption that just because hospitals are allowed to share certain data and information with PAC providers that they do so freely. In AHCA members' experience, while there are examples of hospitals willing to share information with collaborating PAC providers, it is more often the case that hospitals withhold or restrict PAC provider access to vital claims data and information. There are likely many reasons for this behavior, not the least of which is the inherent financial value of the data, the instinct among providers to guard a valuable resource, and perhaps a misinterpretation of what types of data sharing are allowable under HIPAA regulations.

Comment #2: CMMI should provide more opportunities for skilled nursing providers to engage in risk-bearing arrangements.

AHCA encourages CMMI to explore testing non-hospital-centric models of provider risk-bearing as part of this demonstration, to allow additional opportunities for PAC providers to engage in risk-bearing activities. In the majority of the current risk-bearing models CMMI is testing, the hospital is the defined risk-bearing entity. AHCA understands that hospital providers are the most likely entity in a market to be in a position to bear risk. We also recognize that many skilled nursing centers are small or independently owned entities and would likely not succeed under a mandatory risk-bearing model. However, for those skilled nursing providers who are ready to engage in more robust risk-sharing arrangements, AHCA believes

CMMI should provide opportunities for them to do so. Such opportunities should not be left to the discretion of acute care hospitals.

Comment #3: CMMI should limit the ability of third-party organizations to bear financial risk on behalf of providers, similar to how the CJR demonstration allows for such arrangements.

AHCA has provided CMMI extensive feedback in the past on the issues and challenges associated with third-party conveners who directly bear risk on behalf of providers, particularly within the BPCI demonstration. We also appreciate that CMMI seems to have addressed many of our concerns in their publication of the CJR final rule, which limits the role third-party entities may play in risk-sharing, but still allows providers to contract for their services in other ways. AHCA believes that the fundamental problem with allowing third-party conveners to directly bear risk for total episode spending is that it invariably siphons funds away from direct patient care to fund the operation and profit of the convening organization. We strongly believe that these funds would be better used by providers to implement quality improvements and delivery system reforms necessary under a risk-bearing model. AHCA recommends that CMMI replicate the approach and policies established in the CJR final rule with regard to how third- party non-provider organizations may share in financial risk.

Comment #4: The demonstration should fully waive the SNF 3-day inpatient qualifying stay for coverage of skilled nursing care, to include the ability to directly admit beneficiaries to the SNF.

AHCA is supportive of efforts to test a waiver of the 3-day qualifying inpatient stay requirement for coverage of skilled nursing services, but we continue to have strong concerns that tying the waiver to a facility's rating on Nursing Home Compare will limit beneficiary access to skilled nursing care, particularly those with complex and chronic conditions. As CMS is aware, patients, families and caregivers must consider multiple factors when deciding where to seek post-acute care when it is needed. While we understand that CMS must create incentives for beneficiaries to seek care from efficient, high-quality providers, we also maintain that equal consideration also must be given to the non-clinical factors that go into the decision-making process, such as the availability of social supports and proximity to home and family.

AHCA understands that current demonstrations do not directly tie *participation* in the model to a facility's Five Star rating; however, we maintain that hospitals have a strong desire to utilize the waiver and will develop their skilled nursing networks only with facilities who have 3 or more stars. The following is an excerpt of our comments to CMMI on the CJR proposed rule:

> "Since the Five Star rating system is updated on a monthly basis, it is possible that a SNF's rating fluctuates every month. Analyzing data for two-year period (prior to the February 2015 rebasing of Five Star), we observe a 15% chance that a SNF who is rated 3 stars or higher will drop below 3 stars in the following 12 months. Not only does this level of fluctuation impact beneficiary choice of provider, but it also will make implementation of the program logistically challenging for hospitals as they try to establish a network of exclusive 3-star-or-higher SNFs. Although CMS states that the waiver will be honored based on the SNF's status at the time of discharge, hospitals may operate on information that is a month or more old, which could result in beneficiaries inadvertently admitted to what the referring hospital believed to be a 3-star or greater SNF to only find that it dropped to a 2-star. If the SNF does not meet the criteria, the stay would not be covered and the beneficiary could be financially liable for their stay. And finally, we suspect that hospitals will drop SNFs from their networks because of a drop in Five Star score despite the fact that nearly half could quickly regain a 3-star or greater rating. We anticipate this fluctuation will create unintended, unnecessary restrictions in beneficiary choice of provider, even if that provider becomes eligible for the waiver."

AHCA also believes that models which place the hospital as the sole risk-bearing entity inherently limit the ability of CMS to realize the cost efficiencies of reducing the number of inpatient admissions. We continually hear from providers about the challenges associated with "balancing" fee-for-service business lines with alternative payment models. Because hospitals currently testing risk-bearing models are still being paid primarily under fee-for-service, they continue to have a strong financial incentive to increase inpatient volumes and, in our members' experience, are less willing to explore models where downstream PAC providers could be used as a less-costly alternative to the hospital. Indeed, even though providers participating in the BPCI and CJR programs may waive the 3-day stay requirement, these models require an inpatient admission to trigger the episode. AHCA believes CMMI has a unique opportunity in this model to test innovative approaches to using post-acute care providers as a high-quality, low-cost alternative to an inpatient admission.

Comment #5: The demonstration must consider the downstream implications of such an arrangement particularly on labor and wage indices.

AHCA has long believed that use of a hospital wage index as a proxy for SNF wage indices without adjustment is inappropriate and inaccurate. Over the years, the Association has repeatedly highlighted this concern. In turn, the Centers for Medicare and Medicaid Services (CMS) has indicated SNF data has been unreliable for the purpose of developing a SNF-specific wage index. This year we have developed a new approach which filters hospital wage index data to make such information more applicable to actual SNF labor costs.

Illustrative of how challenging the current arrangement is, in fiscal year 2016, of the 89 counties with more than a 15% fluctuation in the SNF wage index due to hospital changes, three counties had significant decreases of 19%, 22%, and 32%, respectively. Our research on these counties revealed issues with hospital non-submission of data or serious issues with hospital data. To that end, SNFs have been actively engaged in working with the acute care sector in many of these areas across the country on this issue. This year, we greatly are concerned about emerging trends associated with hospital acquisition of outpatient clinics and physician group practices which further dilute the wage index for SNFs. In terms of SNF reimbursement, 70% is driven by labor costs making accurate wage index calculations critical in light of the myriad of changes noted above. We urge CMMI to consider hospital wage index impacts on SNFs in this potential demonstration and others.

Conclusion

We hope these comments are helpful and respectfully request a meeting with the CMMI team working on this effort. In addition to AHCA staff, we propose bringing representatives from the Maryland provider community so CMMI staff may hear directly from post-acute and long-term care providers on their experiences. Please contact Mike Cheek to schedule a time to meet. Thank you for your valuable time and consideration.

Sincerely,

[Transmitted Electronically]

Michael W. Cheek Senior
Vice President
Reimbursement Policy & Legal Affairs

North Carolina Office of Rural Health

Input Responses for CMS – RFI Regional Multi-Payer Prospective Budgeting

Overview:

The North Carolina Office of Rural Health (NC ORH) supports the efforts for consideration by the Centers for Medicare and Medicaid Services (CMS) to establish Regional Multi-Payer Prospective Budgeting demonstrations throughout the nation. With North Carolina being a predominantly rural state, our focus is narrowed to those rural service providers. Rural providers and the patients they serve have unique considerations and needs that must be part of this larger conversation. We agree establishment of these multi-payer networks for budgeting may be effective in rural areas and may provide incentives leading to:

- improved health outcomes and community wellness
- effective/efficient health service delivery
- appropriate service utilization
- cost containment
- improved access to services for rural residents.

Any payment system introduced into a rural provider setting should assure financial stability to low- volume rural health service providers and/or facilities. It is imperative that the budgeting structure support efforts to fill any gaps and/or shortages in the rural health delivery system. NC ORH urges CMS to allow flexibility and consult with state representatives when establishing the definition of "regional" within the demonstrations.

Section 4 of the RFI *Questions on Potential Rural Specific Option* specifically refers to rural but also sections 1 – 3 limits itself to exploring how **hospitals** (in some cases Critical Access Hospitals) could successfully participate and thrive in an environment of regional multi-payer prospective budgeting methodologies. This limited focus completely overlooks the backbone of the healthcare delivery system in predominantly rural areas which includes integrated safety-net networks that may include but are not limited to CMS certified Rural Health Clinics (RHCs), community health centers, home health services, private practices, behavioral health and, possibly, other provider types.

General Input by Section: **Section 1**

–

The three principles covered in this RFI include:

- Prospective budgets for specific geographic areas that may include Medicare and/or Medicaid savings. Participating providers could have options on the type of prospective budget, which could vary based on the scope of services included and the level of accountability for total cost of care.
- Population health activities funded under the prospective global budget, informed by the community
- A potential rural hospital track that targets the specific needs and challenges of rural communities and rural providers

Section 2 –

A prospective budget could be determined for specific regional/geographic areas with relative ease if determined in conjunction with state representatives.

Other items to consider:

- Community Health Centers (Federally Qualified Health Centers) and some Rural Health Clinics use PPS (or some other Alternative Payment Method [APM]) already.

- The large health systems in the state are currently positioning themselves in light of health care reform. These systems are gaining market share by mergers, acquisitions, management agreements and other means to spread their foot-print in their respective regions.

- Some particularly rural regions may require larger land mass to achieve necessary unduplicated patient numbers. It may be prudent to establish estimated overall costs and services then work backwards in partnership with state representatives to determine the appropriate regional/geographic areas.

- Determinations of risk load must be carefully constructed due to urban/metropolitan pockets that may "skew" regional/geographic area populations. The more urban/metropolitan area populations tend to be healthier than those living in the more rural parts of the state. CMS working in conjunction with state representatives may develop and implement an algorithm to mitigate risk prior to demonstration rollout.

States may, through their Medicaid programs, address financial arrangements, including patient attribution methodologies that may be feasible for consideration for this demonstration. Contractual stipulations on service provider management entities seemingly holds consensus as one potential tool to prevent larger health systems from "acquiring" patients as they are discharged from a higher level of care (such as a tertiary hospital) into that health system's physician network.

Ways to monitor contractual stipulations regarding a "feeder" system:

- Put caps on number of referred patients
- Out-of-network policies and procedures
- Shared cost and revenue sharing

All traditional Medicare coverage options should be included (A, B and D). Medicare Part C plans, commonly known as Advantage Plans, are operationally considered commercial payers and should be treated as such should this demonstration transpire.

Other comments for Section 2 (these include both wellness services as well as social determinants of health opportunities):

Services to be included (from a multi-payer perspective):

- Access to quality Primary Care and Preventive services
- Case management and Outreach – all aspects of outreach from care management to community wellness education
- Comprehensive dental for adults and children
- Comprehensive behavioral health for adults and children (including substance abuse services)
- Home Health and Hospice
- Skilled Nursing Facilities
- Comprehensive person-centered services for developmentally disabled
- Access to physical activity
- Access to spiritually-enriched care (focusing on whole-person/person-centered care)

- Access to comprehensive women's health
- Access to migrant health services
- Access to vision services
- Health education-including literacy
- Transportation to medical appointments
- Access to affordable and fresh foods
- Access to safe and affordable housing
- Appeal rights established for patients

Services to exclude:

- Non-evidence based procedures
- Elective procedures and surgeries

Shared Risk considerations:

- "Rainy day" fund for each region to cover budget shortfalls
    - Global risk pool
- Regions that inherently have higher risk factors should receive a higher/enhanced global budget.
- Two sets of regions - One for routine care and one for specialty care if none available

Participating providers may be held accountable for the total cost of care through performance based payments. Contractually stipulated performance measures with regular defined reporting periods through the life of the contract demonstrate a benchmark for quality as well as total cost of care. Other than performance measures discussed above, participating payers may be accountable to the requirements of a prospective budget concept through some type of incentive. Determining an attractive incentive package for commercial payers may prove difficult, if not impossible.

Oversight of this demonstration program as well as oversite within each state and/or regional/geographical area will influence all aspects of data including but not limited toappropriate data, sources of data, as well as how to support data aggregation and data sharing.

Specific data considerations:

- Consider possible way to use Medicaid Management Information Systems.
- How does Health Information Exchange (HIE) containing clinical data align in this potential demonstration discussion?
- Infrastructure concerns including storing data and maintenance of data collection systems, specifically construction of query capabilities, could pose a significant monetary investment

Considerations for potential adjustments to a prospective budget needed over time include accounting for shifts in market share, population size, change in risk burden and other market changes that could may occur. In addition, considerations for budgeting could handle boundary issues such as patients seeking services outside of the defined region. Other considerations may include:

- NC has many regions with ageing populations as well as staggered population growth rates in different regions of the state
- Cost of doing business rises every year
- Development and implementation of a plan to combat fraud within the capitated rate

determination process
- Adjustments to risk pools based on performance measure outcomes, regional/geographic area wellness benchmarks, etc.
- Allowances for services not included within a defined region might be made through agreements between regions. This could be predicated on the need of each patient. Might the money follow the patient or to the regionally assigned provider? What to do when completely out of region or state (e.g. on vacation)?
- Additional risk pool for out of network adjustments would need to be developed through the previously mentioned methods

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 already exist as exhibited through MIPS, PQRS, NCQA, UDS, HEDIS, etc. These benchmarks are already used for many incentive programs for many current payers including commercial payers.

CMS may monitor and address unintended consequences under this concept working in conjunction with states, such as providers limiting access to care, inappropriate transfers, delay of services, or cost shifting in the following ways:

- Contractual stipulations
- Give governance broad authority to enforce penalties
- Strict contracts (examples, Tennessee, Alabama, and Texas)
- Apply penalties for limiting access with appropriate procedures and remedies

Section 3 –
Several types of providers or provider characteristics that could be interested in participating in this prospective budget concept and would participation among all providers within a region be necessary for the concept to be successful:

- Incentivize paramedicine with payment regardless of patient destinations and explore community paramedicine programs
- Potential problematic governance issues would need strong oversight and operational authority
- Participation by all providers within a region would be necessary for the concept to be successful due to the overall administrative burden on both the individual provider practices as well regional/geographic area governance entity

Describe how to incorporate population health activities in this concept; describe population health activities that could be included and 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: Describe encouragement for participating providers to work with non-hospital providers and organizations to successfully manage the care, and the budget, for a defined population of beneficiaries:

<u>How:</u>
- Need community governance board that makes decisions, and is comprised of community partners, patients and family members
- Promulgate guidelines for community health needs assessments to ensure the broadest

population representation possible

- Provide incentives for participation in planning/oversight committees, workgroups
- Five key coverage areas include - primary, specialty, non-hospital, analytics, and technological infrastructure
- Incorporate population health within the provider contract based on provider specialty and their ability to accommodate particular aspects of population health
- Tie provider participation to incentives
- Referrals could be made to other community resources and integrate local resources and opportunities
- Incentivize providers by placing higher incentives on areas of high need and low resources (region would pay extra to have external providers come to its area and provide services where previously none existed)
- Derive the funding for population health activities based on diagnoses
    - Moreover, specific diagnoses would make a patient eligible/better fit for appropriate activities. One could use historical data and predictive models to get base rates on diagnoses and types of activities best suited for patients.
- Implementation of Local Health Improvement Coalitions based on model used in Maryland. Within these coalitions hospitals, providers, nonprofit and local governments work together to focus on population health initiatives
- Use of grant funds to encourage and start community-wide cooperation within regions/geographical areas
- Expanded use of clinical integrated networks to also include partnerships with non-healthcare entities

- Incentivize outside hospital partners to join regional network, incentives could be funds, technical assistance, sharing of non-financial resources, cost savings and use of electronic health records system

What:

- Community environmental changes
- Access to safety net and free clinics
- Case management
- Integrated behavioral health (including substance abuse services)
- Dental
- Vision
- Community screenings
- Community health workers to do community-based health education and community outreach
- Partner with housing
- Providers should work with community anchor points (parks, libraries, convention centers, etc.) to hold wellness fairs and provide programming, such as Mental Health First Aid
- Providers might also engage local school systems to have programs on healthy living
- Keep children in school as much as possible. Providers may establish telemedicine programs at school nurse offices in order to provide services remotely (as applicable)
- YMCA collaboration, other community development groups
- Encourage providers to hold regular meetings with their local Health Department

Population activities to be included:

- BMI Screenings
- Tobacco cessation screenings
- Healthy life activity coaching
- Metabolic syndrome education and coaching
- Physical activities advocacy

CMS might mandate that provider organizations have community based representation committees that provide feedback and perspective on community needs. Much like community assessments that are currently conducted, but these committees would be permanent operational oversight committees, having operational authority, that hospitals must take advice from and that can be used in evaluating the quality of services the hospital delivers.

Payer participation beyond Medicare FFS is critical in order to align incentives under a prospective budget and avoid cost shifting among payers.

Describe promotion of multi-payer participation of payment incentives and performance measurement as well as how might other payers be encouraged to participate:

- Potentially encourage the same or similar performance measures for tracking by private payers so consumers for transparency when comparing plans or choosing primary medical home providers
- Review 'conditions of participation' of federal health programs to remove barriers or disincentives. Continue "no-risk trial periods" followed by graduated levels of risk, as was done with Meaningful Use
- The governing structure of the state make clear that participation is 'mandatory'
- Incentivize shared risk to encourage participation
- Legislation dictating payer participation
- Access to risk pool funds only given to payers who participate
- Grant appropriate operational power to the state monitoring agency and the Department of Insurance
- Allow private payers to have input on performance measures. This allows private payers to have some ownership in the process.
- Mandate it. In Maryland all hospitals agreed to partner in this pilot program, giving them significant leverage over private payers. CMS should encourage and incentivize hospitals to all participate forcing private payers to the table. But CMS should be the one that ultimately sets the global budgets not the hospitals

Section 4 –

Should 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.

- Critical Access Hospitals should definitely be included in a prospective budget concept as should other members of the rural health safety-net
- For the process to work, all providers that are enrolled in the Medicare/Medicaid program should be included in the prospective budget
- Has to be cost-beneficial (ideal) or at least cost-neutral/ no financial loss for CAH
- If there is an initial financial loss for CAH, perhaps this loss could be off-set by CMS (at least initially)
- CAHs should be included because most are not financially sustainable under the current system
- Initially one could look at current utilization, then as their utility goes up, their payment could go up.
    - Then find out some of the gaps in care and look at these entities as medical facilities and reimburse them differently based on use
    - This would potentially increase revenue if they were able to utilize entire facility based on differences of need (e.g., have external providers come to help, or create new services based on space available and community need). Mental health, Substance Abuse, Inpatient, Nursing home, case management, etc.
- CAHs will need to form collaborative partnerships with larger institutions so that they have access to support services. These partnerships will need to be either assigned or required so that every CAH has a "partner" institution.
- Special considerations:
    - Cost reimbursement continued for three years, then a transition period (not cold turkey!) to the value system.

Some 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 may be:

- CAHs that are part of a larger regional hospital system may better be able to assume initial risks
- Inasmuch as these arrangements will include a "quality premium" involving financial incentives or disincentives tied to performance, risk could be managed, and mitigated, through technical assistance, consultation and training of shared network expertise. This is happening currently. One of the major barriers for rural hospital participation – and thus benefit – is the lack of available staff time needed to consistently ensure accuracy and timeliness of reporting data, analyze reports, and design, implement and evaluate quality improvement initiatives
- All but two CAHs in NC are affiliated with a system. Systems should have sophisticated cost-accounting systems in order to provide support to CAHs

Some types of rural hospitals might be better able to manage down-side risk than others; the risk might be structured to ensure Medicare savings, but also allow the rural acute care hospitals or Critical Access Hospitals to be successful:

- Hire mid-level practitioners and have them maximize their working capabilities
    - For example, instead of hiring specific specialty surgeons, have an experienced general surgeon. We could use a similar model for hiring a NP instead of a M.D. Maximizing a licensed clinician's working capabilities would improve savings.
- One could find out what kind of medical providers are needed based on community need/demographics. Staff the facility as best as you can to address needs, but also save on cost by not hiring top tier providers based on licensure and salary
- Use education as a resource, particularly with telehealth and tele psychiatry involving patients and providers
- Take an environmental scan of the population to assess the top needs
- Re-invent hospital as necessary to fill gaps and address needs
- Ability to manage down-side risk is dependent on sophistication and size of the owning system
- As for certain types of rural hospitals being better able to manage down-side risk, it depends on what partnerships they have in place and what can be built within the area. If they lack partnerships within the community, it's going to be harder to have an impact on population health. What happens when there is just a lack of overall resources in an area to support a critical access hospital under the global budget model?
- Creation of a global budget that takes into account the riskiness of patient population would help hospitals that struggle with managing risk. For example, rural areas of the state suffer from poorer health outcomes than others. It would be unfair for the metropolitan regions to be standalone regions. The risks must be shared or accounted for.

Ways that CMS, the rural acute care hospitals, or the Critical Access Hospitals might align partnerships with larger health care institutions to provide support such as specialty care, information technology and quality improvement tools may include:

- In a rural community CAHs may actually have better resources than other local partners in these areas
- CAHs may be part of a larger hospital system which can/should provide these resources
- CMS could provide extra money up-front for QI and technology set-up so CAH can hire staff in-house to develop these systems, or contract out
- Could IHI provide quality improvement tools?
- IT could be done outside of the community, however, it can be difficult to control quality done
- Specialty care may be brought in from other regions if locally available specialty care is unavailable. Space can be leased in CAH facilities to specialists
- Almost all CAHs in NC already have this in place. For the ones that do not, they should be assigned a "partner" institution to provide them with resources
- Incentivize the creation of partnerships, either through grants or penalties
- Provide resources for hospitals to clearly define and present their patient populations. The ability to define their population should provide insight on potential risk and strengths and weaknesses of handling the risk.

CAH could benefit significantly from partnerships with larger systems. Each defined region should have access to specialty care hospitals so that rural regions can have the same access as our urban centers. Even if these regions are not geographically linked they could still be part of the same network or defined "region".

CMS may best measure total cost of care and quality outcomes for individuals and population health for rural acute care hospitals, rural safety-net providers or for Critical Access Hospitals might include:

- On the 4/27 webinar, they mention that populations in local rural areas may not be large enough for statistical significance
- Other issues for measurement of population health include reaching remote areas and isolated populations (including farmworkers, immigrants, elderly, disabled, homeless, or other immobile or vulnerable)
- Promote adoption of 2016 HEDIS measures
- Obtain an average from geographic designated community
- By measuring one organization against bench marks cost savings can be derived
- Develop standard methodologies to calculate standard cost in geographically designated communities
- Continue to file Medicare Cost Reports so that CMS is aware of the total cost of care
- Continue development of Medicare Beneficiary Quality Improvement Program (MBQIP) to monitor quality outcomes

For rural acute care hospitals and for Critical Access Hospitals, many services are appropriately referred or transferred to other facilities. Development of process to promote appropriate versus inappropriate patient transfers for services provided may include and/or be monitored also addressing if this demonstration might improve access to services not already available in these rural areas:

- Could collect data by region to compare transfer rates
- Other facilities should document options provided to patient and communicate and coordinate transfers with referring CAH
- Borrowing from where hospital errors are reviewed. These errors are self-reported and non-punitive. This creates a non-hostile and more forthcoming environment for reporting errors and using this information for learning and informative purposes. This would be a good start to get hospitals to report without fear of penalty. Reports would be compiled and shared with the facilities of their own personal data and also include anonymous external data to see range of mistakes that others are making
- Track inappropriate transfers by using technology upgrades
- Defining parameters of what needs to be shared (insurance should not be shared or be a factor in determining transfers)
- Inappropriate variables/reasons for transfer– diagnoses, age, gender, insurance status, time of arrival, day of transfer, transferring in accepting physician, previous imaging studies, patient disposition (i.e., Most transfers occur during non-business hours and include a disproportionally high representation of non-insured)
- Governance needs to have and exercise operational oversight to define parameters
- MBQIP has Emergency Department Transfer Communication measures that help to measure this
- This falls under the subject of Care Transitions, which is a focus of the QIN/QIO. These networks should provide ongoing monitoring, coaching, and dissemination of best practices in Care Transitions so to prevent inappropriate transfers and discharges
- Paramedicine/EMS should have a role of preventing readmissions and gauging appropriate levels of care. Paramedicine/EMS should be empowered to provide low acuity care in the field and to provide input on care transitions
- The HIE could be a potential tool for tracking inappropriate transfers and tracking services provided
- Lack of certain services and high number of appropriate transfers outside the area should pinpoint what the organization is lacking in resources
- Transfers are a vital part of care, especially in communities served by critical access hospitals
    - CAH should be able to treat patients who have suffered the negative consequences of metabolic syndrome without being transferred i.e. stroke and heart attack patients
    - Significant investment should be made in telemedicine so strokes can be easily diagnosed and treated on site

<u>Special Considerations for Rural Areas</u>:

The backbone of the healthcare delivery system in predominantly rural areas includes the integrated safety-net networks that may include but are not limited to CMS certified Rural Health Clinics (RHCs), community health centers, home health services, private practices, behavioral health and, possibly, other provider types. With this understanding, there are a few special considerations for rural areas.

1. Define "Rural" – Generally speaking, North Carolina's 100 counties are roughly 30% urban/metropolitan and 70% rural. Understanding any CMS rule change impacting rural will have a significant impact across North Carolina.

2. Imperative Nature of Care Management/Coordination – With 70% of NC counties being rural, care coordination/management becomes imperative to patient centered care. Additional funding to support these services specifically in rural areas is necessary to assure consistency of services.

3. Limit administrative and/or operational burden of providers as much as possible. Rural providers work with very little if any resource margin, including staff. It is imperative to ensure systems are streamlined for optimal efficiencies. This will also help control overall cost.

Nevada responses to RFI on Concepts for Regional Multi-Payer Prospective Budget provided by: State of Nevada Reimbursement, Analysis and Payment Unit Comments in Green (5.13.2016)

RFI:
https://innovation.cms.gov/Files/x/regprosbudgets-rfi.pdf

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.

For Nevada we think distinguishing between rural and urban geographic areas would be a priority. It looks like in the Maryland model they have required specific cost reduction goals so one would think they apply similar concepts: Decide what was spent, select the cost savings goal and make that the budget. In Nevada we would expect to the cost savings in rural areas would be less than in urban areas due to access issues.

The Payment Transformation section of the SHSIP identifies a continuum of payment models to be phased in over the implementation period. The beginning of the continuum includes incentive payments for participation and is not suited to an all-inclusive payment model. However, some of the later reimbursement methodologies contain elements that could align with this model including bundled payments and shared savings/risks. This might make the all-inclusive payment model more attractive to rural hospitals.

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.

We think it may be very difficult to include Part B services, especially at first. Also, further consideration and analysis would impact the billing processes. Does it simplify billing processes? This could result in a major cost savings for providers.

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?

CMS is not talking about cost settling, so the provider incentive is that if a specific pool of reimbursement is available means the lower the cost of care the more reimbursement is leftover.

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?

If the State intended to move all payers/facilities into this model, likely legislation would be necessary. But if this was based on provider/payer voluntary participation legislation may not be necessary as the providers/payers would be agreeing to participate.

The Maryland model builds off a decades-old waiver that included a Health Services Cost Review Commission which sets rates for all payers in the State. Nevada currently sets Medicaid rates, but does not dictate any other reimbursement. The Multi-Payer Collaborative and Population Health Improvement Council created through the SIM process could be a resource for creating a conduit for identifying ways to set rates across payer types and create a budget for an all-inclusive model. Just as in the SIM work, care must be taken to avoid anti-trust violations. Nevada hospitals already submit financial and utilization data to the State, but a more robust system of accountability would be required – especially to ensure population health goals associated with lower costs are achieved.

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.

Data gathering and sharing are key factors in any payment transformation system. Connecting Nevada's providers, payers and recipients through a global – or at least compatible systems – is key. This is expensive infrastructure that is also a cornerstone of the SHSIP implementation.

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.

In Nevada we would likely be looking at Urban/Rural distinctions but we don't see why Nevada would limit services geographically.

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?

There are already multiple quality measure structures and sets being used by various providers.

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?

We think there would need to be a certain level of participation to track this. If only one hospital out of ten participates it might be difficult to measure any change. But if 5 out of ten hospitals participate it may be possible to measure. If a hospital participates there would have to be some type of agreement that this would not happen. But what is to stop, for example, a Private hospital that does not

participate from sending all Medicare/Medicaid recipients to another facility that is participating? Would that even be an advantage to send people away?

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.

Hospitals certainly seem like a good fit for the model, as well as Patient Centered Medical Homes. An urban Nevada concept would require a certain level of participation; otherwise it would be very hard to track success. Most rural hospital facilities in Nevada are already cost settled.

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?

Population health activities tend to lead to cost savings. There could be certain programs that have proven benefits (Diabetes, tobacco cessation, weight loss and fitness) which could have mandated participation requirements. In rural Nevada partnering with tribal associations and other health support organizations could assist with the influence needed to assist in chronic disease management and disease prevention which would likely result in improved population health.

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?

Both demonstrating cost savings and improved outcomes may help bring other payers into the program. Also in Nevada, build on the momentum created with the SIM project.

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.

Since they are already cost settled, they might be hard to include. As they are CAHs, they are likely the only facility in the area and it may not be possible to reduce costs as compared to urban areas.

Also, see question 1 regarding Nevada SIM SHSIP Implementation and the shared savings/risks part of payment transformation.

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?

As a Frontier State, Nevada faces extensive challenges in providing care to all Nevadans especially in rural areas. These hospitals often have difficulty maintaining an adequate and qualified workforce; they face infrastructure problems ranging from technology, available resources, lack of internet connectivity and are geographically isolated by large distances. The critical importance of rural hospitals in Nevada was recently evidenced by Nye Regional Hospital closing its doors in July 2015. This was the only hospital in this area and its closure now requires many Nevadans in to travel 200 - 300 miles to obtain the nearest hospital medical care.

Reducing funding to CAHS in Nevada would be considered with great caution, as they are vital to Nevadans in rural areas.

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?

Expanding access to care through the use of Community Health Workers, telemedicine, community paramedicine etc. as a part of the hospital service; rural or frontier hospitals could work with urban hospitals to create telemedicine partnerships that increase both scope of practice and access to care.

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?

Care in rural areas could be measured by some of the same standards as urban areas, with the understanding that not all of the same services are available in rural areas.

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?

As discussed in the answer to question 13, access to care in rural Nevada can be exceptionally limited. In some cases the rural facility is the only hospital within hundreds of miles. Due to these restictrictions, the only transfer that will generally take place is to move a patient from the rural hospital to hospital in an urban area based on the needs of the patient. In rural Nevada, it is unlikely that unnecessary transfers take place.
Contacts at the State of Nevada: Jan Prentice, Chief
Reimbursement, Analysis and Payment

Debra Sisco, Program Manager Reimbursement, Analysis and Payment

From:	CMS Regional Budget Concept
To:	All Payer Operations
Cc:	
Subject:	FW: RFI Regional Multi-Payer Prospective Global Budgets
Date:	Saturday, May 14, 2016 2:22:56 PM
Attachments:	image002.jpg image001.jpg

From: Pat Schou
Sent: Friday, May 13, 2016 7:15 PM
To: CMS Regional Budget Concept <RegionalBudgetConcept@cms.hhs.gov>
Subject: RFI Regional Multi-Payer Prospective Global Budgets

Illinois Rural Response to Global Budgets

I am submitting comments on behalf of the 51 Illinois critical access hospitals and 3 small rural hospitals that are members of the Illinois Critical Access Hospital Network (ICAHN), a statewide rural network and 501 (C) (3) Non-profit Corporation, as its executive director. In addition, I represent the Illinois Rural Community Care Organization LLC(IRCCO) established as a rural accountable care organization (ACO) in 2014 and was approved Medicare Shared Savings Program Track 1 in January 2015. IRCCO is a statewide rural ACO which currently has 22 critical access and rural hospital participants, more than 250 medical providers, 35 rural health clinics and 15 independent physician practices covering nearly 23,000 rural beneficiaries. I apologize in advance for the informal approach and comments, but I have been traveling and fulfilling ACO commitments. I understand there is interest in comments from the field and I have provided them in bullet point fashion. I am more than happy to submit additional formal comments and/or be available for discussion at a later date.

Premise: Rural hospitals and medical providers understand the need to evaluate new models of care delivery for better patient outcomes, overall health and at lower costs and welcome reasonable opportunities to participate and be part of the trial and solution. In 2014, Illinois rural providers moved forward creating their own a rural accountable care organization (IRCCO) without any federal grants or investment dollars because they wanted to learn and be part of the solution. It has been a culture shift for both the hospital and medical provider but a welcome one. The IRCCO providers believe we they have changed the conversation from physician and hospital discussion over equipment purchase to discussion on how to better coordinate care and improve patient outcomes simply by working together and using data analytics. For the first time, they have data and commitment to make changes in care processes and patient services. They have an opportunity to make risk decisions based on data and standardization.

So Would Global Budgets Work for Rural?

- Yes, multi-payer global budgets have the potential of working in rural communities. Rural healthcare is primary care based, and the rural hospital is the recognized healthcare leader. The hospital is the access point for residents needing emergency and treatment services, prevention, specialty care, rehab, advance care and social services support as well as the hub for delivery. The rural infrastructure is already in place. Granted, there are gaps and the integration of healthcare services is not perfect, but rural hospitals and their communities are making progress through community health needs assessments by identifying gaps and developing new programs to meet those needs or connecting to other resources. Using a 1-3 year demonstration project timeframe, rural hospitals could test this model. They are great field laboratories and the vast majority operate clinics, own physician practices, home health agencies and long term care facilities. To be successful, support funding and regulatory flexibility would be essential as rural hospitals have limited resources; however, rural hospitals have the capacity to make changes quickly and build local partnerships based on years of trust and

interdependence. It would be helpful, during the demonstration, for rural hospitals to be assured of their primary care services and be able to offer regulatory flexibility to tertiary care to encourage their collaboration. Critical access hospitals should have the option to participate in a demonstration project with the allowance of 2-3 independent critical access hospitals partnering as a small regional hub. The demonstration would provide time to determine if rural can safely manage risk with all payors.

Challenges for Rural Providers (*to name a few)*

- State Medicaid systems that do not pay timely and in full
- Disparate electronic medical records
- Fear of governing board for global budgets with little, if any, rural representation
- Attribution of beneficiaries fairly and to the benefit of the patient
- Limited access to actuarial information from non-government payors
- Dumping of high cost beneficiaries only to rural areas
- Fair distribution of medical providers
- Limited financial resources without incentives
- Patient engagement and acceptance

Respectfully submitted,
Pat Schou, Executive Director

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May 13, 2016

Dear Sir/Madam:

The purpose of this letter is to offer some thoughts around the questions posed in the Request for Information (RFI) on Concepts for Regional Multi-Payer Prospective Budgets. This RFI sets out a number of detailed questions for consideration that inter-relate to one another, and ultimately any approach that would be adopted would have to account for that interrelationship. While each topic is addressed in this letter, choices for included services, geographic area, methods for updating budgets, etc. must work as a cohesive package and not as a la cart choice. I will provide some thoughts about the questions posed in the RFI based on experience with Maryland hospitals prior to the All Payer Model implemented with CMMI and based on the experience since the new model's implementation. This document is not intended to respond to every question raised in the RFI, but to provide some insight from our experience in working with Maryland hospitals.

Included Services

Generally, the broader the number of included services, the better. The current limitation of the Maryland model is its hospital-only approach. There is much that can be done by hospitals to improve care coordination, and the strong incentives under Maryland's global budgets have moved hospitals strongly in that direction. While the HSCRC and CMMI certainly have a desire to see faster progress in cost containment, hospitals are large ships whose direction is hard to change. The hospitals in the State have made substantial progress adapting to limited revenue growth, disconnected from the volume increase that fueled profitability. However, a continuing challenge is that other providers in the State are still paid on a fee-for-service basis. While hospitals are removed from incentives to drive volume, physicians and post-acute care providers are not.

This lack of coordination limits hospital efforts to better manage care, or hospitals are forced to consider vertically integrating to assert more direct control over the spectrum of care. This consolidation can be expensive, and many hospital administrators are not ready to take on the management of these related services. Further, the policy consequences of further consolidation may be harmful to competition in the commercial sector where fees are negotiated between providers and insurers.

By including a broad spectrum of services into a model of this sort (with the necessary waivers from Federal and State law to allow coordination), the need for such formal integration is diminished. With financial incentives aligned, the path is clearer for hospitals, physicians, and post-acute care providers to work together in a coordinated fashion to reduce the cost of care and improve outcomes. While the system transformation will not be simple under these

circumstances, payment structure would be removed as a major institutional barrier to that transformation.

Data Needs

To undertake such efforts, data are crucial. Without information across the spectrum of care, providers cannot even evaluate the financial proposition they are facing under this budgeting approach. Access to Medicare data are critical for understanding care utilization patterns, but to the degree that all payers would be involved, commercial and Medicaid would be equally important to such an analysis. Historical data are the focus of the analyses mentioned above, but data are also crucial to monitoring patient's care, with appropriate clinical interventions as need present themselves.

Maryland hospitals have been dealing with this issue because the regulatory agency (the Health Services Cost Review Commission (HSCRC)) has targeted potentially avoidable utilization (PAU) for reductions. Under hospital global budgets, reductions in PAU should reduce costs and improve profitability. The State's hospitals have been assisted with information from the State's Health Information Exchange, the Chesapeake Regional Information System for our Patients (CRISP). However, confidentiality requirements and data reporting lags leave hospitals without the ability to manage to policies that require that information, even though the situation is improving.

Geographic Area

The geographic area for a model described in the RFI would work best if it is relatively self- contained, with a relative high percentage of total care provided within the defined region. Otherwise, shifting care patterns would require detailed and sensitive methodologies to measure and adjust these volumes – otherwise the potential risk faced by participants would be too great if the participating organization faced large influxes of volume, and the Medicare program could face substantial payment risk if the organization would easily shed volume to other providers. This model seems best suited, in the absence of refined adjusters, to relatively stable markets. However, the area should be large enough, when possible, to mitigate risk – or stop-loss provisions would need to be constructed to limit risk in these untested models.

Maryland began its experiment with hospital global budgets (not the more expansive total cost of care) with ten rural hospitals for that reason. This experiment began before the All Payer Model with CMMI; it was put in place when Maryland operated under its previous Medicare Waiver under 1814(b)(3) of the Social Security Act, which had focused on the State's Medicare payments per case relative to the nation's growth per case. This per case emphasis led to high volume growth in Maryland, and rural hospitals were selected as the natural starting place to look at global budgets to shift incentives from volume to value. While some of the hospitals experienced issues with changes in market share (one opened a new hospital building during the global budget period and experienced increased market share), generally they faced stable populations with predictable growth patterns.

Adjustment to Budgets over Time

While a major focus of the Triple Aim of healthcare reform is to bend the cost curve, a corollary for new payment methodologies should be to make sure that revenues follow the patient.
Because fixed revenue models tend to a snapshot of the current financial structure and service provisions of organizations, methodologies to update budgets need to include provisions for inflation, productivity improvement, population changes, aging, clinical care practice changes, new clinical technologies, and health information technology. And such adjustments need to be done in a way that doesn't incentivize volume growth, else the budget approach morphs into fee-for-service incentives.

In the Maryland model, the method for updating the hospital budget has been the source debate. Aside from annual discussions around the update factor to adjust for inflation and population growth, a major source of debate has been the method for crediting hospitals with changes in market share. Because volume changes due to population growth, aging, utilization patterns, and market shift occur simultaneously, the source of these changes must be decomposed into the component parts to properly changes in market share. The HSCRC's policy market shift policy ultimately credits a small fraction of volume increase to expanding facilities while revenue remains with declining facilities. A side effect of this approach is that per unit costs rise in declining facilities and profitability suffers at hospitals acquiring market share.

Monitoring performance: access to care, unwarranted transfers, delay of services, cost shifting

Potential negative side effects of global budgets include limited access to care, unwarranted transfers, delays of service, and in the unique case of Maryland, shift services from regulated space to unregulated space. The HSCRC has monitored hospital performance and has taken corrective action when these activities have been detected. However, longer term effects of the global budgets need to be monitored, because the effects are not immediately clear. For example, will global budgets affect access because of changes in hospital investments over time? Will access to new clinical methods or new technology be affected?

An important reason for having broad all-payer participation in this model is to mitigate the potential cost shifting. Maryland's All Payer Model has a long history of preventing cost shifting, and one of the requirements of the system is to set rates for all payers in an equitable fashion. While rates in a regional model with global budgets are unlikely to reflect the equity of Maryland's system, one could image coordination of global budgets among participating payers so that cost shifting would be limited or prohibited under the regional model.

Aside from reducing cost shifting as a model side effect, consistent incentives across all payers provide the potential for a higher return on investment from population health initiatives. Because these efforts require organizational change in culture and clinical processes, the entire patient population is likely to be affected when an organization makes this move. When

part of an organization's population operates under fee for service payments, however, fee for service payments penalize reductions in volume that would be welcomed under value based payment methods. These mixed signals are eliminated with an all payer approach.

Critical Access Hospitals (CAHs)

A specific issue of interest in the RFI is the application of this model in the context of Critical Access Hospitals. The global budget approach offers a stable revenue path for organizations undertaking population health management and health improvement efforts. Because CAHs are small and geographically isolated, they may face unique cost pressures from recruiting personnel to low volumes. For population health improvement, the hospital and its partners may need to invest in care coordination, care management, and other population health improvement activity. Larger organizations may be able to finance these activities out of anticipated reductions in potentially avoidable utilization, but the scale of CAH hospitals may be too small to yield enough savings to finance the necessary care coordination and population health related activities. To make this model feasible for these hospitals, some funding may need to be built into the process to assist in the transition to better coordinated care. Potentially, this could be done through the budget development process.

Conclusion

Global budgets in Maryland have been an important tool to beginning the process of transforming the care delivery system. The first half of the five year model has been successful in meeting the model's goals, and the system continues to develop toward total cost of care, beyond the hospital alone. The total cost of care approach that is raised in this RFI offers a solution to some of the difficulties that Maryland hospitals have faced. While the model is complex, it is a concept worth exploring as we move to reform the healthcare system.

Please note that these comments represent my opinions and not necessarily those of Berkeley Research Group, LLC or its clients.

Sincerely,

D. Patrick Redmon, Ph.D
Director
Former Executive Director of the Maryland Health Services Cost Review Commission

Oregon Association of Hospitals and Health Systems

May 13, 2016

Patrick Conway, M.D.
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244-1850

RE: Centers for Medicare and Medicaid Innovation, Request for Information on Concepts for Regional Multi-Payer Prospective Budgets

Dear Dr. Conway,

The Oregon Association of Hospitals & Health Systems (OAHHS) would like to take the opportunity to provide comments on the Centers for Medicare & Medicaid Innovation (CMMI) Request for Information (RFI) on Concepts for Regional Multi-Payer Prospective Budgets. We are not responding to a specific question within the RFI, but hope to inform CMS broadly regarding questions in Section IV related to rural options.

Oregon has a unique model for Medicaid delivery. In 2014, 16 community-based coordinated care organizations (CCOs) were created as a result of the Oregon Legislature passing House Bill (HB) 3650. Through this transformation, Oregon's Medicaid population was assigned to one of the 16 regional CCOs in the state for an integrated model of healthcare delivery covering physical, oral, and behavioral health. Today, approximately 90 percent of Medicaid members are enrolled in a CCO. Oregon's 32 small and rural hospitals have varying relationships with their CCO partners. As new funding models came about through the CCOs in a global budget from the state, another policy options needed to be considered and that was how to address cost-based reimbursement for Medicaid for the small and rural hospitals.

With the passage of HB 3650 in 2011, the Oregon Legislature directed the Oregon Health Authority (OHA) to begin transitioning rural (Type A/B as defined by Oregon statute ORS 442.470) hospitals from cost-based reimbursement (CBR) to alternative payment methodologies (APM) consistent with coordinated care. OHA was also charged with identifying and transitioning only those rural hospitals that could remain financially viable after changing their basis for payment. OAHHS developed a statewide collaborative, the Rural Health Reform Initiative (RHRI), to be innovative and responsive to this imminent change for our small and rural hospitals. It was clear that we needed to think through an approach that provided flexibility to these hospitals and their CCO partners given the demographic and geographic differences across Oregon. We needed to create a glide path that allowed for a smooth transition to an APM over time.

To determine which hospitals should transition to this APM and which should not, OAHHS worked with the OHA to convene an advisory work group with representatives from CCOs, the Oregon Office of Rural Health (ORH) and OAHHS to determine an analysis framework that would more comprehensively evaluate a hospital's ability to transition. A multi-step, decision-tree analysis and structure was a primary outcome of our RHRI work to evaluate a hospital's readiness to transition to the new payment methodology.

While Oregon's initial decision tree included categories around Medicaid relevance, financial strength, and unmet health care needs in a particular community, it should be noted that these variables should be evaluated for each rural community that might be looking at a decision-tree model. Given the variability in rural communities across the country, what works for one state may not be an effective measure in another.

As a principle, it was important to determine first who could transition and then what they could transition to. We believe that a one-size-fits-all approach to payment reform would do more harm than good in progressing health care transformation in rural Oregon. The el ements outlined above provided a 360-degree view of a rural hospital that takes into account several different components of the business. The state's advisory committee's goal was to create a decision tree that was all- encompassing and not just dependent on one aspect or metric in determining the "financial health" of a rural hospital.

The first decision-tree analysis, conducted in 2014, included a three-year average Financial Strength Index (FSI) from 2010-2012. This evaluation was re-run after one year, at the end of the first quarter of 2015, to include 2014 Medicaid expansion and CCO data for the Jan. 1, 2016 contracts between hospitals and CCOs. The analysis will now be run every two years. Because the first year, 2014, was a transition year, it was critical that the financial impacts of Medicaid expansion and CCOs were captured adequately. Running the analysis every two ye ars going forward allows a hospital to transition back to CBR if its overall environment changes. It should be noted that when the analysis was run a second time in 2015, two hospitals that were able to move back to CBR opted to remain on an APM.

The primary intent is for hospitals and CCOs to negotiate and reach an agreement on payment rates independently of state interventions. However, the OHA adopted in its Administrative Rules (OAR) (sections (10) – (12) added to OAR 410-141-3420), an APM which will be used should a hospital **not** be able to reach an agreement with its CCO. This non-contract payment rate—the APM developed as a result of this work—is calculated as a percent of billed charges (Reimbursement Rate), and is done separately for inpatient and outpatient services. The starting point for calculating a hospital's Reimbursement Rate is based on the individual hospital's Ratio of Cost to Charges (RCC) for the hospital's most recent fiscal year ending based on the filed Medicaid Cost Report. In essence, the hospital's cost from the previous year is used as the baseline and then is adjusted per the state's global budget rate increase, as defined by Oregon's Medicaid Demonstration Section 1115 waiver, using the following formula:

- Current Reimbursement Rate x (1+globabl budget allowance)/(1+hospital price increase)

This ultimately allows for predictable payments to both providers and payers which is not currently the case under CBR. Because the APM is prospective in nature, it provides incentives for hospitals to reduce their costs (including fixed costs) over time. However, the APM results in a level of financial risk for hospitals, that is manageable.

! An additional component of the APM could be implemented at the state's direction at a later date is the inclusion of a Volume Adjustment System (VAS). The VAS is calculated based on the hospital's total volumes: Inpatient as measured by Case Mix Adjusted Discharges (CMADs),

and outpatient as measured by equivalent CMADs.[1] The VAS would afford a hosp ital an adjustment (either a positive revenue adjustment or a negative revenue adjustment) that approximates a hospital's change in variable costs with changes in volume. The intent of the VAS is to curb hospital incentives to incre ase unnecessary volumes by providing variable cost adjustment that is approximately equal to the hospital's actual variable cost increases the hospital experiences when volumes increase. The dynamics of th e VAS are in alignment with the current incentives of the OHA and its CCO model. The VAS also builds in a predictable rate for rural hospitals that helps the hospital cover its fixed costs as volumes decline as a result of CCOs and hospitals presumably working to reduce unnecessary hospita l u tilization (e.g., unnecessary or marginal ER visits, reducing admissions and readmissions). As a result of the unknown vo lume impacts from Medicaid expansion, OHA has currently elected not to implement the VAS because of a potential dramatic increase in volumes, as new covered live s i n Medicaid coul d create an unintended consequence in the short term for payment[illegible]s to both the hospitals and CCOs.

As you can see, over the past five years of collaborative work through the RHRI, we have developed a two-part glide path as directed by the state Legislature. First, it was important to create a process to determine which hospitals could reasonably transition from cost-based reimbursement to an APM, and second, develop an APM that was more of a transition over time, while encouraging a payment model designed locally between providers and the Medicaid CCO, and if that wasn't achievable, providing a starting point, or floor, for an APM for Medicaid payments.

Thank you for the opportunity to comment on the Request for Information on Concepts for Regional Multi-Payer Prospective Budgets. We hope that CMMI finds the RHRI model outlined here to be illustrative and informative. While it is still early in this transition in Oregon, we look forward to evaluating the overall effectiveness of this work over time. If you have any questions, we welcome the opportunity to discuss this with you further.

Sincerely,
Andrew Van Pelt, MBA
Executive Vice President
and Health Systems

1 Equivalent Case Mix Adjusted Discharges (CMAD) is a useful measure of volume and is merely a hospital's number of inpatient CMAD, and dividing that gross revenue per CMAD fraction into total outpatient revenue. Total Case Mix Adjusted Discharges are the sum of the inpatient CMADs and outpatient ECMADs.

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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: Centersfor Medicare and Medicaid I1111ovatio11, Request /or Information on Conceptsfor Regional Multi-Payer Prospective Budgets

Dear Mr. Slavitt:

I am writing on hehalf of the Washington State Health Care Authority (HCA) to express our support of conunents submitted by the Washington State Hospital Association (WSHA) in the attached letter regarding CMMI's Request for Information on Concepts for Regional Multi-Payer Prospective Budgets.

As part of our State Innovation Model (SIM) grant, HCA, as the state's Medicaid agency, has been working in close collaboration with WSHA and our Depatiment of Health to develop a new service delivery and payment model for our most vulnerable critical access hospitals. These facilities provide essential services to both Medicaid and Medicare populations. The attached letter characterizes the need faced by these hospitals as well as opportunities presented by the RFI. In patiicular, we welcome support from CMS in providing access to Medicare data, and in providing flexibility in Medicare rules that might otherwise impede the ability of the hospitals to realize the delivery system and payment reforms we believe are possible.

We see the RFI as signaling the potential for closer aligmnent of Medicare and Medicaid approaches to transforming the delivery of services by critical access hospitals and encourage your careful consideration of the points raised in the WSHA response.

Sincerely,

Nathan Johnson
Chief Policy Officer

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May 13, 2016

Andrew M. Slavitt
Acting Administrator
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Washington, DC 20201

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

Dear Acting Administrator Slavitt:

Thank you for the opportunity to provide input to CMS as it considers how it could create payment systems to support higher quality, more affordable care for the residents of a geographic region, using lessons derived from the Maryland All-Payer Model for hospital services.

Problems in Current Hospital Payment Systems That Need to Be Solved

The payment methodologies used in the Medicare Inpatient Prospective Payment System (IPPS) and the Medicare Outpatient Prospective Payment System (OPPS) create financial rewards and penalties for hospitals that conflict with efforts to reduce avoidable admissions and readmissions, unnecessary testing and imaging, etc. Although the case rate structure in IPPS encourages hospitals to deliver care during each hospital stay as efficiently as possible, it creates large financial penalties for a hospital when admissions decline, and it can create excessive financial rewards when admissions increase. This is because the majority of costs in a hospital are fixed, at least in the short run, and even if the DRG payment amounts to the hospital match the average cost per case at the hospital's current volume of patients, the same DRG payment amounts will create a large profit for the hospital when it has more admissions and large losses when the hospital has fewer admissions, because the payments are much larger than the hospital's marginal cost for the services. Similarly, the OPPS pays for outpatient care on a partially-bundled per-service/per-visit basis, where the payment rates may be higher or lower than a hospital's costs depending on the volume of services. Clearly, these kinds of financial penalties and rewards make it difficult for hospitals to cooperate with efforts to reduce hospital admissions, readmissions, testing, and other services.

Hospitals are both required by law and expected by their communities to have certain essential services available to residents and visitors in the community. Community residents need 24/7 access to an emergency department, a cardiac catheterization center, imaging and laboratory services, a surgical suite, etc. in order to avoid preventable deaths and complications from

accidents, heart attacks, strokes, etc. However, the Medicare IPPS and OPPS do not provide direct support for the costs associated with maintaining these standby services; hospitals must support those costs using the revenue derived from payments for actual emergency room visits, cardiac catheterizations, CT scans, surgeries, and even unrelated procedures and services. Consequently, when there are fewer ED visits, tests, procedures, and admissions, Medicare will spend less, but the hospital will have a more difficult time maintaining its standby services. Under the structure of the current payment system, improving the affordability of care can decrease access to care.

Teaching hospitals are doubly penalized by the structure of the current hospital payment system, because they rely on revenues from admissions not only to pay for their standby services (the costs of which may be higher than in a community hospital because of the unique, specialized standby services delivered by an academic medical center) but also to pay for their medical education and research costs. Although Medicare pays teaching hospitals more than other hospitals to cover the costs of their teaching functions, these payments are explicitly tied to the number and types of admissions to the hospital. Most commercial payers do not explicitly support teaching costs, but they do so implicitly by making higher payments to teaching hospitals for an admission or service than they do to other hospitals, so as a practical matter, all of the teaching hospital's payments for teaching and research are tied to the number of patients it treats. These explicit and implicit ties between patient admissions and teaching/research revenues mean that admitting fewer patients to an academic medical center jeopardizes the hospital's ability to pay for teaching and research as well as its ability to sustain its standby services.

These problems are not unique to Medicare's hospital payment systems. DRG payment systems used by commercial payers create similar problems, as do payment systems that pay per diems or a percent of charges for individual services.

How Maryland Has Addressed These Problems, With CMS Support

The State of Maryland has a unique regulatory structure that has enabled it to mitigate the problematic rewards and penalties current payment systems create for hospitals. Maryland has the ability to require all payers to adjust payment rates to hospitals in order to avoid high profits when patient volumes increase and to avoid large losses when volumes decrease. This includes the ability to set Medicare payment rates, which ensures that both Medicare and other payers pay their fair shares of what is determined to be an appropriate overall level of revenue to support the hospital's services. When Maryland began aggressively encouraging efforts to reduce avoidable admissions and complications, it recognized that the average payments per service and per admission would need to *increase* for Medicare and other payers even though the payers' total spending would *decrease* because covering the hospital's essential fixed costs with fewer admissions and services would mean the average cost per admission would be higher.

However, the waiver that authorized Maryland to set Medicare payment rates was premised on its ability to hold the amounts Medicare paid *per hospital admission* below the amounts it paid in other states, not based on whether the Medicare program was spending less on *hospital care per beneficiary*. CMS wisely recognized that controlling overall spending was the true goal, and so it revised the waiver structure for Maryland accordingly.

The Need to Create Similar Outcomes as Maryland, But Using Different Approaches

Payment reforms are needed that can address the problems in current hospital payment systems in states other than Maryland. I do not believe it is either feasible or desirable to try and replicate the Maryland approach in other states, however. The payment methodology in Maryland is dependent on having a state regulatory body with the authority to dictate the amounts that all payers – Medicare, Medicaid, and private payers – will pay hospitals for services received by the insured beneficiaries of those payers. Maryland's approach is also dependent on that regulatory body having the skills and expertise to make fair and effective judgments about whether changes in the number of patients treated by a hospital justifies a change in the hospital's revenues. It is unlikely that most other states will be willing or able to implement a comparable system.

Fortunately, there are other ways to change hospital payment systems in ways that would address the problems described earlier without requiring the type of regulatory structure that Maryland uses. One approach will be described later in these comments.

Global Budgets for Hospital Services vs. Global Budgets for All Healthcare Services

Although the RFI states that it is explicitly designed to build upon lessons learned in Maryland, the questions in the RFI are all narrowly framed in the context of a "prospective global budget for a region." The "global budgets" in Maryland are global budgets for *hospital services*, not for *all healthcare services* in any community. Maryland only regulates payments for hospital services, it does not regulate payments for physician services, for nursing home services, home health services, etc.

One of the challenges that Maryland currently faces is that while payment systems for hospitals in Maryland no longer penalize hospitals for reducing hospital admissions and services, payment systems for *physicians* in Maryland still penalize physicians for delivering fewer services and do not give them adequate resources to help patients avoid the need for hospitalizations and procedures. This makes it difficult for physicians to support hospitals' efforts to reduce avoidable admissions and other services.

However, I do not believe that it is necessary, feasible, or desirable to go even farther than the Maryland payment system and try to establish a "global budget" for ALL healthcare services to address this, as the RFI suggests that CMS wants to do. Appropriate physician-focused payment reforms in the Medicare program and appropriate payment reforms for other healthcare providers could address this problem. Creating a true regional global budget is difficult and problematic for the following reasons:

- **Difficulty of forecasting total healthcare spending.** No one knows how to accurately project the healthcare needs and spending for a population of patients. Prospective risk adjustment models can only predict about 20% of the variation in healthcare spending even for large groups of patients. The accuracy is even lower for smaller populations of patients, simply because small changes in the number and types of patients can result in large changes in spending; for example, significant in-migration or out-migration during the year, a special event that attracts tourists, or a flu outbreak could result in the need for significantly higher expenditures on healthcare services in a small community than any budgeting process could ever plan for. Concurrent risk adjustment models are less

inaccurate because they take into account changes in the patient population and unexpected health problems that occur during the course of the year, but one cannot use a *concurrent* risk adjustment model to establish a *prospective* budget. (Concurrent risk adjustment *can* be used to provide adequate payments and achieve spending levels that are based on patient needs rather than unnecessary utilization, which is how CMS should define the goal of its initiative, rather than establishing budgets.)

- **Risks of inappropriate rationing of care.** If it is impossible to accurately predict how many services and how much spending will be needed to address the healthcare needs of a population of patients, then a fixed prospective budget could result in rationing of healthcare services, i.e., forcing healthcare providers to deny services to patients who need them because the "budget" has been exceeded. This can be avoided by allowing adjustments to the budget when patient needs are higher than expected, but if the budget can easily be changed, then it really is not a prospective budget. (If the budget is going to be routinely adjusted for changes in the needs of the community, it is better to simply create a predictable payment system that is based on patient needs.)
- **Challenges in allocating the budget.** Creating a single "global" budget for all healthcare services begs the question of whether, when, and how much individual healthcare providers will be paid for their services. If every healthcare provider is paid the same way they are paid today, then nothing has really changed about the healthcare payment *system*; the problem of deciding payment *amounts* for individual providers has simply been pushed from CMS to each individual community. Someone either has to receive the total budget and then pay individual providers (which is the equivalent of "single payer healthcare" at the local level) or some method has to be established for determining who should give back part of what they've already been paid when the overall budget is exceeded. (This is not necessary if each provider can be paid under an alternative payment system that enables and encourages them to deliver care in ways that will achieve lower overall spending levels.)

Instead of trying to establish a global budget for a community, it would be both desirable and feasible for CMS to create an alternative payment model for hospitals and alternative payment models for physicians and other healthcare providers in the community that can achieve the same kinds of positive impacts that one might hope to achieve through a comprehensive global budget but without the problems associated with that approach. If CMS creates payment systems in which physicians, hospitals, and other providers are paid based on patients' health conditions rather than based solely on what services were delivered and if CMS provides payments designed specifically to support essential standby services and healthcare service infrastructure in a community, it would create the benefits equivalent those envisioned by having a regional budget for Medicare spending, but with the added benefits of an automatic method of adjusting the budget for changes in patient needs and an automatic way of allocating the budget fairly among participating providers.

Addressing the Needs of Rural Communities and Rural Hospitals

The smallest hospitals in the most rural communities in the country are classified as Critical Access Hospitals and are paid by Medicare through a "cost-based reimbursement system" rather than the case rates and service payments under the Inpatient and Outpatient Prospective Payment

Systems. Although it would seem on the surface that cost-based reimbursement would avoid the problems of payments being higher or lower than costs as patient volumes change, this would only be true if a hospital were paid for *all* of its patients based on its costs. Because Medicare's cost-based payment system for Critical Access Hospitals only pays the hospital 101% of its costs for *Medicare* patients, the hospital cannot generate an adequate operating margin to cover the costs of services delivered to uninsured patients. Moreover, every *non-Medicare* patient the hospital treats *reduces* the Medicare payments the hospital receives to cover its fixed costs, because Medicare only pays for the proportion of the hospital's costs that are allocated to Medicare beneficiaries.

Even more significantly, under sequestration, Medicare only pays Critical Access Hospitals 99% of their actual costs allocated to Medicare beneficiaries, not 101% of their costs. In other words, today, if a Critical Access Hospital only treated Medicare beneficiaries, it would go bankrupt because the law requires that the hospital receive less revenue than its costs, no matter how low those costs are. This creates significant pressures for a Critical Access Hospital (CAH) to treat or admit commercially-insured patients and it creates financial penalties for a CAH if it encourages efforts to reduce avoidable admissions and readmissions for Medicare beneficiaries. However, even if sequestration were revoked for Critical Access Hospitals, a 1% margin would not be sufficient to allow the hospital to cover the costs of treating uninsured patients, to make capital investments in equipment and facilities, etc.

RECOMMENDATIONS FOR CMS ACTION

How to Establish a Hospital Payment System That Supports Regional Population Health

Goals for a Better Medicare Payment System for Hospitals

What is needed is a new payment system that could be used by both Medicare and other payers to support services delivered by both urban and rural hospitals that achieves the following goals:

- Provides adequate financial support for essential standby services, such as an emergency department, based on the size of the community and the age and health of the population;
- Provides adequate financial support for sufficient hospital medical and surgical care capacity to address the number and types of admissions and services needed based on the health problems of the community residents;
- Provides adequate financial support for any incremental costs the hospital incurs over and above the hospital's fixed costs for treating additional patients or treating more complex patients;
- Provides adequate support for medical education services based on the size of the medical education program rather than the number of patients treated or the number of services delivered in the hospital; and
- Enables and encourages the hospital to be as efficient as possible in the delivery of care to patients who do need to come to the hospital and to support community efforts to improve the health of the residents and avoid the need for hospital services, thereby controlling the total cost of care in the community.

Structure of a Better Payment System for Hospitals

These goals could be achieved through a five-part payment system structured as follows:

1. Annual Per-Resident Payments

The costs of standby services, i.e., services that must be available regardless of whether any patients are seen, such as the cost of having an emergency department or cardiac catheterization services staffed and ready to go on a round-the-clock basis, could best be supported through a fixed annual payment for each resident in the community. A Per-Resident Payment could also support general population health services, such as education about prevention and wellness and support for general wellness services in the community, and could help cover the costs of care for uninsured residents. The payment could potentially be stratified by age to reflect differences in the likely rates of utilization of standby services by different population groups.

The Per-Resident Payment would be paid directly to the hospital by Medicare and other payers (i.e., Medicaid and commercial health insurance plans) for each of the payer's covered members. For uninsured residents, the Per-Resident Payment could either be paid directly by the residents as a "membership fee" (which would in turn entitle them to receive individual services at lower rates than otherwise) and/or it could be supported through local or state government tax revenues for low-income residents (e.g., through a tax rebate for those with sufficient income to pay taxes or through direct payments to the hospital for those who are unemployed).

In communities with one hospital that delivers all of these standby services, the Per-Resident payment would be paid to that hospital for all of the residents in the community. In communities where two or more hospitals deliver these kinds of services, the payment amounts for each hospital could be determined through a two-step process. First, an aggregate payment level per resident would be determined as though there were only one hospital in the community delivering all of the standby services. Then an allocation of that payment between the hospitals would be determined based on past relative utilization of each hospital's standby services by the community (or based on other factors determined by the community, such as whether the hospitals focused their services on different parts of the community). Each hospital would receive that Per-Resident Payment amount for a year, and then the amount could be adjusted in the subsequent year based on actual utilization patterns over the course of the year.

2. Monthly Per-Patient Payments

In addition to true standby services, i.e., resources that are ready to deliver services for emergencies and similar conditions even if no services are actually delivered, hospitals need to have adequate capacity to address the medical and surgical care needs of the community at volumes that would be viewed as appropriate based on the level of health problems in the community and assuming effective, efficient ambulatory management and treatment of patient conditions is being delivered based on the best available evidence. For example, even with the most effective ambulatory care management of patients with chronic disease that has been achieved to date, some number of patients will have exacerbations that require hospitalization, and it will be important that a community hospital has adequate inpatient capacity to care for patients when those exacerbations and hospitalizations occur.

To support this capacity, Medicare and other payers (i.e., Medicaid and commercial health insurance plans) would make a monthly Per-Patient Payment to the hospital for each of the payer's covered members. The amount of the Per-Patient Payment would be based on the

expected rate of hospital services needed given the diagnosed conditions and risk factors among the payer's members. Since different hospitals might provide different types of services (for example, a small rural hospital might have an emergency room but very limited capacity to deliver inpatient services), the Per-Patient Payment to a hospital would also be based on the kinds of admissions and procedures it delivers. As with the annual Per-Resident Payments, in communities where two or more hospitals deliver the same kinds of services, the monthly Per-Patient Payment amounts for each hospital could be determined through a two-step process, starting with calculating an aggregate payment amount representing the cost of the total capacity needed in the community, and then allocating that amount between the hospitals based on the proportion of patients they actually serve or other factors determined by the community.

3. Per-Service Payments for Individual Services and Admissions

Although there are many problems with a payment system for hospitals that pays solely on the basis of the number of services delivered, the use of payments for individual services achieves a number of desirable goals: (1) it ensures that payers whose patients have more health problems pay a higher share of the total cost of healthcare services; (2) it enables revenues to better match providers' costs based on differences in the variable cost of healthcare services with different levels of patient volume; and (3) it enables patient cost-sharing to discourage overuse of services and reward preventive care.

If Per-Resident and Per-Patient Payments are being paid to cover the hospital's fixed costs and a subset of essential services, then the size of the Per-Service Payments can be reduced from current levels to better match the marginal or variable cost of services (rather than being set based on the average cost of services, as they are today). This would mean that a hospital would still receive higher or lower revenues if it admitted more or fewer patients or delivered more or fewer outpatient services, but the change in revenues would be much smaller than it is today, and more importantly, the change in revenues would be similar to the amount by which the hospital's costs would change with more or fewer patients, so that the hospital's operating margin would not be significantly affected. As a result, the hospital would have adequate resources to cover its costs if more patients needed care, but there would be no incentive to treat more patients simply because they would increase the profitability of the hospital.

The initial amounts of these Per-Service Payments might be set using the relative values currently embedded in the OPPS and IPPS, but with lower absolute levels. However, since the current relative values were intended to reflect the differences in *average* costs between different types of services or admissions, not the differences in *marginal* costs, it would be necessary to obtain data on the marginal costs as quickly as possible in order to revise the payment rates for each service so they match the actual differences in costs incurred when more or fewer services of a particular type are delivered.

4. Performance-Based Payments

A fourth component of the payment system would increase or decrease the payment amounts under the first three categories based on the quality of care, patient experience, and overall management of total healthcare spending relevant to the services supported by each of those other payment components. These performance-based payments should be based on aspects of cost and quality that the hospital can reasonably be expected to control.

Since the Per-Resident and Per-Patient Payment components of the payment model would not be tied directly to the number or costs of services delivered, it would be important to ensure that a

hospital did not try to avoid high-cost patients or otherwise "shift" costs to other hospitals or to other providers. This could be done by measuring the overall utilization and spending in the community on hospital services, and the utilization and spending on other services which could be viewed as substitutes for hospital services. If the utilization of the hospital's services by the community residents went down but the equivalent types of services delivered by other hospitals to the residents increased, then the payments to the hospital would be reduced in the current year through the performance adjustments. The baseline payment amounts could then be reduced in the following year by recalculating the formula that sets the payments based on the relative number of services delivered by each hospital.

5. Annual Medical Education Payments

Finally, teaching hospitals would receive an annual payment based on the number and types of medical residents at the hospital. The aggregate amount of the payment could be the same as the aggregate amount that Medicare had been paying the hospital for medical education under the current IPPS structure, but the payment would no longer be tied to the number and types of admissions. The amount of the payment could be updated each year based on inflation and could be adjusted based on performance factors relevant to the quality and efficiency of the medical education program rather than based on factors relevant to the quality of care for patients (which would be addressed through the performance-based payment category described above).

Setting and Maintaining the Payment Amounts Under the New Payment System

The initial payment amounts under this system for an individual payer and hospital could be established at levels which generate the same revenue for the hospital and the same spending level for the payer as the revenue and spending level under the current payment system. Then these individual payment levels could be transitioned over time to rates that are more similar across hospitals. This is the same approach that was used when the Inpatient Prospective Payment System was first created in 1983.

The payment levels would also need to be updated annually for inflation and adjusted periodically to reflect new technologies, new evidence about the best approach to care, etc., so that hospitals would have adequate resources to deliver high quality, cutting-edge care but without the kinds of perverse incentives that exist under current payment systems.

Benefits for Both Prospective Payment System Hospitals and Critical Access Hospitals

The attachment presents a simplified example of how the payment system described above could benefit both hospitals paid under the prospective payment system used by Medicare and many Medicaid and commercial payers and also Critical Access Hospitals paid under the cost-based reimbursement systems used by Medicare and some Medicaid programs. The example shows a hospital which receives part of its payments under cost-based reimbursement and part of its payments under a prospective payment or other payment system tied to services or admissions (this mixed model is how most Critical Access Hospitals are paid), and the example shows how using a combination of per resident and per service payments instead could provide stable funding for hospital services without the significant incentives and disincentives tied to volume that exist in both the prospective payment and cost-based reimbursement systems.

Comparison of the Steps Needed to Design and Implement an Improved Hospital Payment Model to the Steps Needed to Establish a "Global Budget"

The components of the payment model described above are all equivalent to the steps that would be needed in order to establish a fair global budget for a hospital. The global budget would need to adequately support standby costs, support sufficient inpatient and outpatient capacity to meet the needs of the community, increase if more acute services were needed than expected, etc., so the same types of calculations would be needed to establish a global budget as to establish the above payment amounts. However, by incorporating those amounts into a *payment model* rather than a "global budget," adjustments to the hospital's revenue that are needed because of changes in the number of residents and patients in the community and changes in their needs could be automatically made by each payer based on information about members, patients, and services that the hospital and the payer could generate.

How to Establish Physician-Focused Payment Models That Support Regional Population Health

Since the decisions made by physicians affect the number of patients admitted to and treated at a hospital, it is problematic if physicians are not paid in ways that are designed to support the same goals as the hospital payment system. Fortunately, the Medicare Access and CHIP Reauthorization Act (MACRA) encourages the creation of physician-focused Alternative Payment Models (APMs), and many medical specialty societies and physician groups have been developing APMs that are specifically designed to give physicians the resources and flexibility needed to reduce avoidable hospital services and to have physicians take accountability for doing so. However, one of the biggest barriers physicians will face in trying to succeed under such APMs will be if their local hospital is penalized financially under the hospital payment system when the physician succeeds in reducing the number of hospitalizations.

Consequently, it is important that CMS move quickly to design and implement better payment models for hospitals and that it move quickly to approve and implement proposals for physician-focused payment models, so that payment changes can be made for both physicians and hospitals in individual communities that will enable them to work together to improve care and reduce costs.

How to Establish Payment Models for Other Healthcare Providers That Support Regional Population Health

Similar approaches can be used to design better payment models for other healthcare providers, such as post-acute care providers. To the extent that a provider maintains an essential standby service (e.g., a community ambulance service), it could be paid in part based on the number of a payer's beneficiaries or members living in the community. To the extent that a community needs to ensure adequate capacity in the community for a particular service (e.g., hospice services), the provider(s) of that service could receive a Per-Patient Payment based on the number of individuals who will potentially need that service based on their health problems. When individual services are actually received by patients, the provider could then be paid an amount per service that is based on the *marginal* cost of delivering an additional service, rather than the average cost of delivering all of the services.

Organizational Mechanisms and Data Needed to Establish Spending and Quality Targets for a Geographic Region

Rather than trying to establish a "budget" for spending in a geographic region, it would be more feasible and desirable to establish a "target" for spending that everyone in the community agrees should be feasible and that they should mutually seek to achieve. That spending target can then be used to establish the payment amounts and performance-based payment adjustments for the hospitals, physicians, and other providers in the community in a coordinated way.

These targets need to be established at the regional level – since healthcare is delivered regionally – through a collaborative process involving all of the stakeholders in the community – hospitals, physicians, employers, government, patients, citizens, etc. It cannot be done by the federal government.

Complete and reliable data and accurate analysis of utilization and spending in a community will be needed in order to establish spending targets, to ensure that adequate and fair payment levels can be established under a new payment model, and to assist all stakeholders in identifying and implementing opportunities for improvement.

Successfully managing the total cost of care in a community and transitioning to new payment models will require very different kinds of relationships between payers and providers, between physicians and hospitals, between purchasers and providers, and between providers and patients than exist today. Today, the only interactions many of these stakeholders routinely have with each other are negotiations over prices or compensation which often result in hard feelings on one or both sides. As a result, in many communities, there is considerable mistrust that will have to be overcome in order for the stakeholders to collaboratively redesign payment and care delivery and find win-win-win approaches.

Since there is no individual or organization "in charge" of healthcare in any region, a growing number of communities have created non-profit Regional Health Improvement Collaboratives to bring together all of the key stakeholders – physicians, hospitals, payers, and patients – to develop a common vision of how healthcare quality and value should be improved, to design win-win strategies for achieving those improvements, and to help resolve implementation problems in ways that are fair to all stakeholders. Because Regional Health Improvement Collaboratives do not deliver care, pay for care, or regulate care, they can also serve as trusted, neutral facilitators of discussion among the various stakeholders, and they can provide objective information and analysis to help overcome the lack of trust that can prevent stakeholders from reaching agreement on significant reforms on their own. Regional Health Improvement Collaboratives also represent the majority of Qualified Entities in the country so they have a unique ability to provide the data and analyses needed to design multi-payer payment models for both Medicare and other payers.

Although state governments will be playing an increasingly more central role in healthcare reform in the future, partly as a result of the programs in the Affordable Care Act, they cannot be effective substitutes for the roles that multi-stakeholder Regional Health Improvement Collaboratives play. While the regulatory powers and financial resources of state governments give them some unique strengths, such as the ability to mandate the submission of quality and cost data by providers and payers and the ability to provide anti-trust safe harbors to help

establish multi-payer payment reforms and help independent providers coordinate their services, it is difficult for state governments to support multi-year healthcare transformation efforts when changes in state administrations and changes in fiscal priorities occur, and it is difficult for states to balance regulatory enforcement powers with programs to facilitate provider improvement. In contrast, the independence and stakeholder governance of Regional Health Improvement Collaboratives provide them with greater ability to support providers through multi-year transformation efforts and to do so in a way that can be adapted to the unique needs of individual geographic regions. Consequently, the greatest success in healthcare transformation will likely come from strong partnerships between state governments and Regional Health Improvement Collaboratives.

Although many aspects of the work done by Regional Health Improvement Collaboratives are challenging, one of the most challenging tasks Collaboratives face is obtaining adequate funding to support their work. CMS will need to provide funding support to RHICs to enable them to facilitate the transition to innovative payment models in ways that meet the needs of their communities.

Moving Quickly to Refine and Try New Payment Models at the Regional Level

There is an urgent need to develop and implement new payment models for hospitals both in rural areas and in urban areas. Many communities are struggling with how to control unaffordable healthcare costs, how to help both hospitals and physician practices avoid closing, and how to correct serious problems with the quality of healthcare services. It seems obvious that if healthcare providers cannot succeed financially when healthcare spending levels are bankrupting consumers and businesses, fundamental changes are needed in the way services are paid for and those changes are needed quickly.

There are a number of communities around the country that are already working on these issues and that could serve as R&D sites to help CMS refine and test better approaches. For example:

- In Washington State, as part of Washington's State Innovation Model work, a dozen Critical Access Hospitals are working together with support from the Washington State Hospital Association, the state Health Care Authority, the state Department of Health, and the state Department of Social and Health Services to redesign the way services could be delivered in their rural communities in order to preserve access to essential services, to improve the quality of healthcare services, and to reduce the total cost of care in the communities. However, the current payment system is a serious barrier to progress, and success will depend on having significant changes to Medicare payments. Rapid action is needed, because several of the hospitals are at risk of closing, which would leave their communities without access to essential care and increase total costs for Medicare, Medicaid, and local residents and businesses.
- In Hilo, Hawaii, the physicians, hospital, employers, health plans, citizens and other stakeholders are all working together through the East Hawaii Regional Health Improvement Collaborative to improve the quality and reduce the cost of healthcare on the eastern side of the Big Island. Although HMSA has been supporting the community's efforts through payment reforms in its commercial, Medicaid, and Medicare Advantage insurance plans, a large number of patients are still covered by traditional

Medicare. Rapid action is needed because significant financial problems at the Hilo Medical Center and growing physician shortages in the community could cause loss of access to essential services and result in higher total costs for Medicare and the employers in the community.

I would encourage you to contact these and other similar communities as soon as possible to learn about the work they are doing and explore forming a collaborative relationship with them in order to design and implement significant changes to both hospital and physician payment systems in a coordinated way.

Thank you again for the opportunity to offer these recommendations. I would be happy to answer any questions you may have about the recommendations or to provide any additional information or assistance that would be helpful to you in implementing them.

Sincerely,

Harold D. Miller
President and CEO

cc: CMS Deputy Administrator Patrick Conway, MD
CMMI Deputy Director Amy Bassano

Attachment: Hypothetical Example of an Improved Hospital Payment System

Hypothetical Example of an Improved Hospital Payment System

The following describes a hypothetical example of how an improved payment system for hospitals could provide more stable, adequate financial support for hospitals and more predictable spending for payers than both current payment systems in which payment is based either on the number of admissions or services or on costs.

- For simplicity, the example is focused on an "Emergency Department," but the same approach could be used for any other hospital service line for which standby capacity is needed.
- In order to illustrate how a revised payment system would work for Critical Access Hospitals as well as for hospitals paid through the prospective payment system, the example shows a hospital which receives its payments from public sector payers through a cost-based reimbursement system and its payments from private sector payers through a per-admission (or per-service) payment system (since most Critical Access Hospitals receive some payments under both approaches). However, the same results would be seen if the hospital were paid entirely on a per-admission (or per-service) basis.
- For simplicity, the new payment system shown uses only a per-resident payment and a per-service payment, but the same kinds of results would be seen with a payment system that included per-resident, per-patient, and per-service components.

The model is based on a hypothetical community with the following characteristics:

- 3,000 residents live in the community
  - 30% of residents are on Medicare and use the hospital Emergency Department at a rate of 450 visits/1000 each year. The hospital is reimbursed at 101% of costs for these visits.
  - 30% of residents are on Medicaid and use the ED at a rate of 300 visits/1000 per year. The hospital is reimbursed at 101% of costs for these visits.
  - 25% of residents have commercial insurance and use the ED at a rate of 100 visits/1000 per year. The average payment for an ED visit is $850.
  - 15% of residents are uninsured and use the ED at a rate of 200 visits/1000 per year. It is assumed that they can only afford to pay $200 for an ED visit.
- The Emergency Department costs $650,000 per year to operate. 75% of this cost is fixed cost, and 25% is variable (i.e., the variable costs are only incurred if patients are seen in the ED).

As shown in Figure 1, although the hospital is reimbursed at 101% of cost for Medicare and Medicaid patients, and although the average commercial payment is higher than the average cost per patient, the hospital still experiences a 6% loss on the operations of the ED because it does not receive a sufficient margin from Medicare, Medicaid or commercial patients to cover the full costs of serving the uninsured patients. Figure 1 also shows that a reduction in ED volume would exacerbate these losses.

Figure 2 shows that a 10% increase in the number of ED visits from insured patients would reduce the hospital's losses by 22%, but it would still not eliminate the deficit because the Medicare and Medicaid revenues do not increase in proportion to the increased volume.

Figure 3 shows an alternative way of paying for the ED services. All payers make a fixed annual payment for each of their insured members and then make a payment for each visit that averages $195 based on the marginal cost of the services delivered during a visit. The per member payment rates for Medicare and Medicaid beneficiaries are set at $240 and the commercial payment rates are set at $75 based in part on the differential rates of use for the two populations. This results in higher total payments from all of the payers so that the payments now cover the hospital's costs.

Figure 4 shows that under the new payment model, if the hospital is able to reduce the number of ED visits by 30%, the hospital ED would continue to operate with a positive margin, while reducing spending for the payers by 6-7% compared to the payments under current levels of utilization. (Under this hypothetical scenario, a 30% reduction in ED utilization would reduce spending levels for Medicare, Medicaid, and commercial payers below their original levels while leaving the hospital with a positive operating margin due to the reduction in costs needed to serve fewer patients.)

Figure 1

	CURRENT PAYMENT SYSTEM		
	$	# Pts	Total $
Cost Reimbursement			
Cost + 1%		675	$527,545
Total Public			$527,545
Fee Revenues			
Per Visit Commercial	$850	75	$63,750
Total Commercial			$63,750
Uninsured			
Per Visit	$200	90	$18,000
Total Revenues			$609,295
Costs			
Fixed (75%)			$487,500
Variable (25%)	$193	840	$162,500
Total Costs	$774	840	$650,000
Margin			($40,705)

	CURRENT PAYMENT SYSTEM *10% Reduced Visit Volume*			
	$	# Pts	Total $	Change
Cost Reimbursement				
Cost + 1%		608	$514,356	
Total Public			$514,356	-3%
Fee Revenues				
Per Visit Commercial	$850	68	$57,375	
Total Commercial			$57,375	-10%
Uninsured				
Per Visit	$200	81	$16,200	
Total Revenues			$587,931	-4%
Costs				
Fixed (75%)			$487,500	0%
Variable (25%)	$193	756	$146,250	-10%
Total Costs	$838	756	$633,750	-3%
Margin			($45,819)	-13%

Figure 2

	CURRENT PAYMENT		
	$	# Pts	Total $
Cost Reimbursement			
Cost + 1%		675	$527,545
Total Public			$527,545
Fee Revenues			
Per Visit Commercial	$850	75	$63,750
Total Commercial			$63,750
Uninsured			
Per Visit	$200	90	$18,000
Total Revenues			$609,295
Costs			
Fixed (75%)			$487,500
Variable (25%)	$193	840	$162,500
Total Costs	$774	840	$650,000
Margin			($40,705)

	CURRENT PAYMENT *10% Higher Visit Volume*			
	$	# Pts	Total $	Change
Cost Reimbursement				
Cost + 1%		743	$544,625	
Total Public			$544,625	3%
Fee Revenues				
Per Visit Commercial	$850	83	$70,125	
Total Commercial			$70,125	10%
Uninsured				
Per Visit	$200	90	$18,000	
Total Revenues			$632,750	4%
Costs				
Fixed (75%)			$487,500	0%
Variable (25%)	$193	915	$177,009	9%
Total Costs	$726	915	$664,509	2%
Margin			($31,759)	22%

Figure 3

	CURRENT PAYMENT SYSTEM *10% Reduced Visit Volume*				NEW PAYMENT MODEL *Same Visit Volume*			
	$	# Pts	Total $		$	# Pts	Total $	Change
Cost Reimbursement				**Public Revenues**				
Cost + 1%		608	$514,356	Per Member Public	$240	1,800	$432,000	
				Per Visit Public	$195	675	$131,625	
Total Public			$514,356	Total Public			$563,625	7%
Fee Revenues				**Private Revenues**				
Per Visit Commercial	$850	68	$57,375	Per Member Commercial	$75	750	$56,250	
				Per Visit Commercial	$195	75	$14,625	
Total Commercial			$57,375	Total Commercial			$70,875	11%
Uninsured				**Uninsured**				
Per Visit	$200	81	$16,200	Per Visit	$200	90	$18,000	
Total Revenues			$587,931	**Total Revenues**			$652,500	7%
Costs				**Costs**				
Fixed (75%)			$487,500	Fixed (75%)			$487,500	0%
Variable (25%)	$193	756	$146,250	Variable (25%)	$193	840	$162,500	0%
Total Costs	$838	756	$633,750	Total Costs	$774	840	$650,000	0%
Margin			($45,819)	**Margin**			$2,500	106%

Figure 4

	NEW PAYMENT MODEL *Same Visit Volume*				NEW PAYMENT MODEL *30% Reduced Visit Volume*			
	$	# Pts	Total $		$	# Pts	Total $	Change
Public Revenues				**Public Revenues**				
Per Member Public	$240	1,800	$432,000	Per Member Public	$240	1,800	$432,000	
Per Visit Public	$195	675	$131,625	Per Visit Public	$195	473	$92,138	
Total Public			$563,625	Total Public			$524,138	-7%
Private Revenues				**Private Revenues**				
Per Member Commercial	$75	750	$56,250	Per Member Commercial	$75	750	$56,250	
Per Visit Commercial	$195	75	$14,625	Per Visit Commercial	$195	53	$10,238	
Total Commercial			$70,875	Total Commercial			$66,488	-6%
Uninsured				**Uninsured**				
Per Visit	$200	90	$18,000	Per Visit	$200	63	$12,600	
Total Revenues			$652,500	**Total Revenues**			$603,225	-8%
Costs				**Costs**				
Fixed (75%)			$487,500	Fixed (75%)			$487,500	0%
Variable (25%)	$193	840	$162,500	Variable (25%)	$193	588	$113,750	-30%
Total Costs	$774	840	$650,000	Total Costs	$1,023	588	$601,250	-8%
Margin			$2,500	**Margin**			$1,975	-21%

Reponses to
Center for Medicare and Medicaid Innovation

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

SUMMARY

We appreciate the opportunity to weigh in and provide feedback on this RFI in the pursuit of a better rural solution.

From a Texas perspective, it is important to note that our landscape if uniquely diverse from other states. We have almost 200 rural facilities, many of which are Critical Access Hospitals.

SECTION I: INFORMATION REGARDING REGIONAL MULTI-PAYER PROSPECTIVE BUDGET CONCEPT

This concept could test prospective budget setting for a defined region. Key considerations for this concept could include:

- Prospective budgets for specific geographic areas that may include Medicare and/or Medicaid savings. Participating providers could have options on the type of prospective budget, which could vary based on the scope of services included and the level of accountability for total cost of care.
- Population health activities funded under the prospective global budget., informed by the community
- A potential rural hospital track that targets the specific needs and challenges of rural communities and rural providers.

If we were to use the Regional Health Partnership boundaries under the 1115 Waiver as the pilot geographic area in Texas, we would need to secure (network, build and contract) other rural providers and the tertiary hospital to participate.

Once providers were established, the benefit levels and scope of services and accountability for each provider would be established along with providers needed outside our geographic area.

We would want to make sure outliers and patients that fall outside the normal range or are catastrophic are not included. We would want to pilot this bundled or alternative payment with a disease group such as CHF or Diabetes. This would need to be stakeholder led by our provider teams.

Based on the current population surveillance for these disease groups as well as the current costs we would arrive at a prospective median payment for annual care. For example, this would include low acuity and high acuity patients.

There would need to be a system of triage, team and provider respect. Coordination for tests and ancillary services as well as an escalation to any advanced or specialty facility.

Rural providers are the front lines; they are the primary care and wellness providers. Chronic care coordination and other home health and care needs to be local and at home for patients to be successful. Tertiary care and specialty would be by referral and coordinated with our team and locally derived network. In our Regional Healthcare Partnership we have several rural facilities that have the similar patient patterns which could be strengthened with a secured model.

Sharing of patient information is needed through the continued development of the local HIE and claims data would be necessary to identify payment and disease groups.

SECTION II: QUESTIONS ON PROSPECTIVE BUDGET METHODOLOGY

CMS is interested in obtaining information on how to define and calculate prospective budgets, which components (or payment systems/schedules) of Medicare and/or Medicaid will be included, and the type of geographic areas where a prospective budget could be applied (e.g., Metropolitan Statistical Areas, hospital referral regions, or rural health service areas). CMS believes participation among all providers within an area would be important to align payment incentives among providers, minimize inappropriate shifting of care to other providers, and incentivize the improvement of

population health in a region. CMS nevertheless is interested in seeking information on whether participation among all providers within a region is necessary for the concept to be successful, and how to limit and account for any inappropriate shifting of care. Additionally, CMS is seeking information on potential methodologies to calculate the prospective budget for the region, such as a methodology based on a patient or geographic attribution, or a provider's historical revenue, as well as the types of services and costs to include in a prospective budget for both Medicare and other participating payers. CMS is also interested in seeking information regarding the governance structure of how to set global budgets and who would be responsible for negotiating and calculating the multi-payer global budgets. State governments could facilitate the setting of prospective budgets in a region or have other roles, similar to the way that the State of Maryland's independent Health Services Cost Review Commission sets rates and global budgets for all acute care hospitals in Maryland. Therefore, CMS seeks information on the need or feasibility of and the potential roles of a state or independent organization in negotiating or regulating the multi-payer global budgets within a region. CMS also believes availability of health spending data is critical to develop global budgets, quality and population health measures and to measure effectiveness of this concept. Based on prior experiences in other states including Maryland, CMS believes that data are available through a multitude of pathways (e.g., directly from hospitals, health systems, or third party payers), but CMS is interested in the input from potential participants, including providers, states and other payers, on access to data, generally and in light of the Supreme Court's recent decision in Gobeille v. Liberty Mutual Insurance Co., 577 U.S. (Mar. 1, 2016) No. 14-181. Lastly, as discussed later in this RFI, CMS is also interested in seeking information on the inclusion of rural hospitals in this concept and is seeking responses on the budget methodology with specific consideration for rural hospitals as well.

CMS is seeking responses to the following questions:

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.
    - *It would be very important to have the most recent cost and claims data to determine a prospective payment rate.*
    - *Costs would need to be evaluated by the local care teams across the continuum where risk would be assumed and then there would need to be agreement on the "bundled" payment.*
    - *One entity would have to take it for each patient and then manage it.*
    - *For our community, it would make sense for the local rural hospital to get the full payment and negotiate with the tertiary care providers and then provide the local care at home for the patients, wellness, rehabilitation, prevention and primary care, low acuity inpatient and care transitions.*

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.
    - *From a local perspective, provider teams can identify and pilot this for a specific disease group.*
    - *The prescription drug benefit should be excluded.*
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?
    - *There could be the allowance for shared savings arrangements with provider teams to share in funds not expended.*
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?
    - *Medicaid in Texas would require a large exclusion from the Medicaid Managed Care plans, unless they were part of the all-payer pilot independent of just Medicaid.*
    - *A pilot makes better sense for sum certain population.*

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.
    - *Claims data aggregated by participating provider in the pilot*
    - *Costs for traditional tertiary providers for like populations year over year*
    - *Claims data to identify patients that would be shared across the continuum and identify historical and projected costs for those with those diagnoses identified/targeted*
    - *HIE data sharing for patient data and coordination*
    - *HIE CCDA for health metrics and effectiveness*
    - *Risk Adjusted Potentially Preventable Events*
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.
    - *Regional wage basket inflation*
    - *Health care inflation*
    - *Risk*
    - *Administration*

- *We would propose having contracts with a hierarchy of specialists outside the area and branding the care inside the geographic area.*
    - *Concerted efforts would be implemented to educate patients on appropriate care options and referrals needed for care.*
    - *Contracts would be negotiated for providers outside the geographic area.*
    - *Outlier exclusions would need to apply.*

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?
    - *If you look at the 80/20 rule, patients with chronic conditions and high acuity needs cost the most.*
    - *Deploying chronic disease coordinators for one payer population and not others,*

fragments the office based on payer mix, instead of the best and most efficient care team.

- *Financial incentives could be derived to deploy pilots across other payer types by aligning them and allowing for competition.*

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?
    - *Monitoring utilization trends for like disease patients year over year and seeing where the better care is happening*
    - *CCDA outcomes reports*
    - *Utilization of rehab and wellness activities for CHF*
    - *Prevention services for Diabetics*

SECTION III: QUESTIONS ON POTENTIAL PARTICIPANTS AND POPULATION HEALTH ACTIVITIES

CMS is interested in information on ways to encourage the participation of providers, private payers, and states in a regional multi-payer prospective budget concept. CMS is seeking information on a concept that could provide different options for participating providers to select, where the options would differ based on the types of services included in the prospective budget and the entity accountable for total cost of care. CMS is interested in understanding whether this concept could allow flexible spending by providers (e.g. hospitals or integrated care networks) with guaranteed revenue so that providers could invest in the health of their population. CMS is interested in information on how to incorporate population health activities to improve the health of the region and how to encourage community involvement in determining those activities. These activities may vary by the needs of the communities, but examples could be activities addressing health promotion or disease prevention. CMS would be interested in working with State governments to facilitate multi-payer participation, including Medicaid. CMS believes the participation of both states and providers would be essential to the success of this concept. Because CMS is also interested in information regarding the inclusion of rural hospitals in this concept, CMS is seeking responses that may pertain to rural hospitals as well.

CMS is seeking responses to the following questions:

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.

- *Chief amongst the characteristics is patient care is central*
- *And secondary is optimism that change and alternative payment models can work across the leadership teams, clinical and administrative*
- *Rural hospitals that are sole community or critical access hospitals and their local clinics (rural health clinics).*
- *Specialty Care Groups and Tertiary Hospitals for a geographic area*
-

9. 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?

- *Bundle the Long Term (nursing facility or swing bed) funding in the rate.*
- *Wellness and fitness are key community drivers that people will rally behind if offered the opportunity*
- *If we can pilot a savings opportunity, which we can then take to our local employers for their employees like the Schools, City, Bank, and County then we can get local folks engaged in their health and they get to share in the savings with their health plan and premiums!*

10. 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?
    - *Allow a piloted success and advertise it to allow for discounted contracting with other payers.*

SECTION IV: QUESTIONS ON POTENTIAL RURAL SPECIFIC OPTION

CMS is interested in understanding how to encourage inclusion of rural hospitals (such as rural acute care hospitals and/or Critical Access Hospitals) that have defined market areas and may benefit from a prospective budget. CMS is interested in obtaining information on how to provide an option adapted to the unique needs of rural hospitals.

CMS is seeking responses to the following questions:

11. 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.
    - *Why shouldn't they be included? They face the same budget challenges.*
    - *Patients and all-payer negotiations required CAHs to engage and pilot on alternative payment models.*
12. 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?
    - *DATA, DATA and DATA*
    - *TIMELY DATA, TIMELY DATA, TIMELY DATA*
    - *To do this in the Medicaid or other payer groups, it will be of UTMOST importance in measure the down-side risk that we know EXACTLY what has been done in previous years and have a robust HIE and Claims database to dashboard each patient spend.*
13. 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?
    - *We are already launching specialty care, IT and quality improvement initiatives. This is a challenging next step which given the support and adequate funding could take to the next level.*
14. 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?
    - By patient, claims and CCDA (HIE) data and year over year spend for CMS
15. 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?

    We would partner with our tertiary hospitals to provide this care. We already have referral patterns and patient loyalty that we can build upon.

    Telemedicine is one way we would like to explore more appropriate and local care. We have found that after hours calls is a very important feature for patients, but it is hard for our local provider (of 1)

SPECIAL NOTE TO RESPONDENTS: Whenever possible, respondents are asked to draw their responses from objective, empirical, and actionable evidence and to cite this evidence within their responses.

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY. This RFI is issued solely for information and planning purposes; it does not constitute a Request for Proposal, applications, proposal abstracts, or quotations. This RFI does not commit the Government to contract for any supplies or services or make a grant award. Further, CMS is not seeking proposals through this RFI and will not accept unsolicited proposals. Responders are advised that the U.S. Government will not pay for any information or administrative costs incurred in response to this RFI; all costs associated with responding to this RFI will be solely at the interested party's expense. Not responding to this RFI does not preclude participation in any future procurement, if conducted. It is the responsibility of the potential responders to monitor this RFI announcement for additional information pertaining to this request.

Please note that CMS will not respond to questions about the policy issues raised in this RFI. CMS may or may not choose to contact individual responders. Such communications would only serve to further clarify written responses. Contractor support personnel may be used to review RFI responses.

Responses to this notice are not offers and cannot be accepted by the Government to form a binding contract or issue a grant. Information obtained as a result of this RFI may be used by the Government for program planning on a non-attribution basis. Respondents should not include any information that might be considered proprietary or confidential. This RFI should not be construed as a commitment or authorization to incur cost for which payment would be required or sought. All submissions become Government property and will not be returned. CMS may publically post the comments received, or a summary thereof.

May 13, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
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 Acting Administrator Slavitt:

Caravan Health welcomes the opportunity to comment on the Centers for Medicare and Medicaid Innovation's (CMMI) Request for Information on Concepts for Regional Multi-Payer Prospective Budgets, issued April 12, 2016. This is an important opportunity to explore transformational payment models and how they may be implemented in practice, including in rural areas.

Caravan Health (formerly National Rural ACO) over the past two years has organized more than 6,000 health care providers into 23 Accountable Care Organizations in the Medicare Shared Savings Pro- gram. These include 55 rural hospitals, 92 critical access hospitals, 168 rural health clinics, and 39 rural federally qualified health centers serving 500,000 Medicare beneficiaries in 31 states. It facilitated $46 million in ACO Investment Model (AIM) funding to support ACO operations and local care coordination programs. Caravan Health provides services to the National Rural Accountable Care Consortium, a Transforming Clinical Practice Initiative grantee that is assisting more than 500 rural practices in prepar- ing for and participating in value-based payment models. The Consortium includes more than 5,000 pro- viders in 38 states, and is rapidly expanding. We have changed our name to Caravan Health to reflect our growing mission to support independent small and safety net providers in both rural and urban settings.

We agree with CMMI that payment transformation and the transition away from fee-for-service reimbursement must ultimately occur across all payers, including commercial, to fully achieve the Triple Aim goals. 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[i] as well as its accompanying State Innovation Model Grant[ii]** that is designed to bring additional payers including -- Medicare dual eligibles[iii] 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.[iv]
- 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.[v]

The Oregon model, in place since 2012, has seen a successful start with the Medicaid, Medicare dual eligible patients, and public employee populations. In fact, 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.

The following are our responses to your specific RFI questions. Please note that our responses are specific to small rural and critical access hospitals and their communities of providers.

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 boundaries of the global budget should be determined by local health care service areas and referral patterns. Providers ought to be allowed to come together and self-organize to care for a defined population while managing a global budget, as was the practice in the Oregon model. Buy-in from payers is not enough to make this concept work. Ultimately, community buy-in from 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, and self-determination would be an important element to building local support for payment redesign. We believe this model works best in communities where there is only one acute care provider, and more than half of the primary care physicians in the community are willing to participate. It is highly appropriate for remote governmental and tax district hospitals who receive other community tax support.

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.

We would recommend that all payers be included in the prospective budget and all Part A, Part B and Part D claims.

With regard to patient attribution we suggest the following.

- All patients who live in the primary service area and have used the health system once in the prior year should be automatically attributed to the health system.
- Patients should also be able to self-assign to the local health system if desired.
- Under this model, beneficiaries should have reduced cost-sharing to encourage use of the rural health system as much as possible. This will spread the high (60-80%) fixed costs across more patients, reducing per capita costs, increasing volume and smoothing variability.
- We are supportive of the use of claims- and encounter-based data to match patients to providers when patient attestation is not available.

3. **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?**

CMS should carve out services from the budget that cannot be provided locally. We propose a fixed amount to cover local fixed costs, with fee-for-service billing for the balance, similar to what is proposed in CPC+. In addition, the participating providers should be able to share in savings from non-network provided services.

For example, a rural hospital and primary clinic with 65% fixed costs and an average cost-based reimbursement to PPS rate ratio of 1.1 would get 65% of last years total costs in quarterly payments. They would bill CMS for services at a rate of 35% times 1.1 (38.5%) of the fee schedule. The system may need to adjust their fixed cost percentage on a quarterly basis if volumes significantly increase or decrease (more than 10%, for example).

Most of our rural health systems provide 30-40% of the services for their community. The balance of services (60-70%) can be calculated for shared savings and we propose gain sharing on out-of-network utilization.

a. If the patients use the local system *proportionately* more, fixed costs will go down, the payors will save money and the health system will get shared savings on the amount not spent out of network, after increased in-network utilization is deducted from the out-of-network benchmark.

b. If the patients use the local health system less and use other providers more, PPS unit costs are typically lower than cost-based reimbursement. The payor will save money, but the system will get no shared savings.
c. If patients use out of network services less, the local health system will get shared savings.
d. If the local health system does nothing to reduce utilization, the payors will still benefit from not having the higher annual increases in cost-based reimbursed payments than is seen in PPS.

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?**

We suggest that CMMI review the methodology used to set global budget rates in Oregon: http://www.oregon.gov/oha/analytics/OHPRates/2015%20Rate%20Methodology%20Summary.pdf

The Oregon global budgeting model is driven by consideration of the key factors in setting global budgets; these principles could be adapted to fit CMMI's program needs as follows:

1) Rating Regions: Rural versus urban
2) Differences in Member Risk
3) Differences in Hospital Utilization
4) Differences in Specific Contracting with the managing body of the global budget
5) Data quality
6) Whether the state has expanded Medicaid access under the ACA

The methodology for risk adjustment in Oregon is the CDPS+Rx as the risk score tool to assess the disease risk at a global budget level. CDPS+Rx uses demographic indicators, diagnosis codes and pharmacy data (NDC codes) to assess the risk of the majority of the population. The risk score is not impacted by reimbursement differences, therefore rural hospitals would not have any impact on resulting risk score. The risk score is a measure of acuity at the member level based on diagnosis and types of scripts utilized. It should also be noted that risk score is applied in a budget neutral manner by rating cohort across each rating region.

Differences in hospital costs across various global budgets operating in the same region are captured through the adjustment called "A/B Hospital Adjustment." This adjustment quantifies the impact of various global budgets having varying mix of services between DRG and small and rural and critical access hospitals. This is necessary, as rural hospitals are generally more expensive than DRG hospitals.

Importantly, the Oregon model permits use of a volume adjustment system (VAS) under the global budget for rural hospitals. In general, use of a VAS can reduce the level of risk a hospital might be exposed to and align incentives to reduce unnecessary utilization by covering fixed costs, even as hospital volume declines.

One final note: A state may need to have rate setting authority over commercial insurers if the multi-payer model were to work. Oregon has this capacity today.

5. **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?**

   We suggest that CMMI review the rigorously tested quality metrics that are in place today to reward high-performing providers and hold all providers accountable for quality of care under global budgets in Oregon.

   - http://www.oregon.gov/oha/Metrics/Documents/2015%20Mid-Year%20Report%20-%20Jan%202016.pdf

   Additionally, we would like to offer these suggestions

   - Rural providers should be included in quality programs. Current policies that have exempted rural providers may be associated with a widening gap between rural and urban quality scores and growing disparities in life expectancies.[vi]
   - We are wary of developing a separate set of rural measures for quality, and would urge CMS to look to existing measures first, especially those in the domain of primary care. We are generally pleased with current MSSP quality and outcome

measures, and would like CMS to avoid burdening providers with new and untested measures as they transition to alternative payment methodologies.

- While certain quality measures may be "topped out" when applied to large and urban care settings, many of those same measures may still need improvement in rural communities.

6. **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?**

We believe that the providers should be penalized for these practices (E.g. Limiting access to care, inappropriate transfers, delay of services) with poorer patient satisfaction scores and quality scores and incentivized for good quality and patient satisfaction.

7. **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.**

We recommend broad inclusion of providers, which would be necessary to realize care coordination and management that improve population health and eventually reduce costs. At a minimum, the hospital and 50% of PCPs should be required to participate. Essential providers should be incented for delivering clinical quality and patient experience.

8. **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?**

Medical care, public health activities, social services, mental and behavioral health care, and possibility even 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.

The program should 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, as is the model in Oregon.

Traditional relationships within rural communities will provide an excellent opportunity for CMS to test new collaborative governance models and blended funding streams.

9. **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?**

Payer participation beyond Medicare FFS is essential. This is especially important in rural areas where low volume infrastructure costs and risk-bearing issues are relevant concerns. Standardized performance measurement and reporting standards 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.

10. **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.**

Yes, on a voluntary basis. There also needs to be protections put into place to ensure solvency, at least during the first 5 years of the model.

11. **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?**

As long as small hospitals have fixed costs covered and can bill for the remainder under fee-for-service, we do not see significant downside risk in this model, but believe this will limit the unrestrained cost increases of pure cost-based reimbursement.

12. 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?

Tertiary and specialty care providers should be incentivized to become preferred providers for rural health systems. This may include gain-sharing, add-on payments, or direct reimbursement for services provided to safety net providers.

Thank you for the opportunity to comment on this important payment design concept. Do not hesitate to contact me if you have questions or want to discuss these comments further.

Sincerely,
Lynn Barr
Chief Executive Officer
Caravan Health

[i] https://www.oregon.gov/oha/OHPB/Pages/health-reform/cms-waiver.aspx
[ii] https://www.oregon.gov/oha/OHPR/Pages/sim/index.aspx
[iii] http://www.oregon.gov/oha/healthplan/ContractorWorkgroupsMeetingMaterials/DU-ALS%20TA%20TOOL%20Exec%20Summ%20%20Resources.pdf
[iv] https://www.oregon.gov/oha/Metrics/Documents/2015%20Mid-Year%20Performance%20Report%20Executive%20Summary.pdf
[v] http://www.oregon.gov/oha/pages/rhri.aspx
[vi] 2014 National Healthcare Quality and Disparities Report chartbook on rural health care. Rockville, MD: Agency for Healthcare Research and Quality; August 2015. AHRQ Pub. No. 15-0007-9-EF.