National Rural Health Association

August 17, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

RE: CMS–5540–NC; Request for Information; Episode-Based Payment Model.

Submitted electronically via regulations.gov.

Dear Administrator Brooks-LaSure,

The National Rural Health Association (NRHA) thanks CMS for the opportunity to submit input on future episode-based payment models. We appreciate the agency's continued commitment to the needs of the more than 60 million Americans that reside in rural areas, and we look forward to our continued collaboration to improve health care access throughout rural America.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, long- term care providers, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

NRHA appreciates CMS' commitment to shifting payment to value-based care for all Medicare beneficiaries. Historically, episode-based models have been highly specialized or limited to acute care hospitals and physician group practices (PGPs). For example, the Comprehensive Care for Joint Replacement (CJR) model is limited to acute care hospitals in metropolitan statistical areas (MSAs), so rural is excluded. As such, many participants in episode-based models have been urban or suburban providers. Under the Bundled Payments for Care Improvement Advanced model NRHA was pleased to see several rural participants and hopes to see CMS structure future models in a rural inclusive manner.

NRHA asks that CMS make future episode-based payment models rural friendly. When CMS and the Innovation Center test new models, they are often created based on large or urban providers practice patterns. Thus, rural providers are implicitly excluded, or they are explicitly excluded, such as rural health clinics (RHCs) in the upcoming Making Care Primary model. In other instances, CMS creates rural-specific programs like the Community Health Access and Rural Transformation (CHART) model which is ending based on lack of hospital participation and feedback from our model stakeholders. **NRHA urges CMS to integrate rural providers into all value-based care models, including episode-based payment models, on a voluntary basis moving forward.** NRHA would appreciate any future efforts to make rural-specific programs; however, we would prefer that rural is included in universal models.

Rural participants across many value-based care models identified four major barriers to rural participation in value based models: 1) structural and eligibility barriers; 2) a predominantly fee-for-service payment system that makes it difficult to shift only part of care delivery and payment to be part of models; 3) low patient volumes; and 4) inadequate financial stability and reserves

required for risk assumption.[1] NRHA echoes these barriers and urges CMS to consider how to address them in future episode-based models.

The range of models, programs, and systems that CMMI, CMS, and other payers operate concurrently makes it difficult for many rural providers to succeed. Each program, model, or payment system has different goals or incentives that may conflict, prohibit concurrent participation, and are burdensome for rural providers. It is vital that CMS understand the capabilities of rural providers and build models that are inclusive and considerate of the challenges that they face.

A. Care Delivery and Incentive Structure Alignment.

How can CMS structure episodes of care to increase specialty and primary care integration and improve patient experience and clinical outcomes?

Value-based payment models are often designed for large and/or urban and suburban care delivery and management systems. However, subspecialty and other related care are often unavailable in rural areas. Rural health care organizations may more readily engage in interdisciplinary teams, innovative health care roles (e.g., community health workers [CHWs] or community paramedics) and community-based organizations (when available) that aid in the success of bundled care arrangements.[2] Episode of care models should recognize and incentivize joint planning among community health stakeholders across the episode of care, as well as interdisciplinary team-based care models across care settings. CMS should consider models that engage the full continuum of care and rural community.

Further, models should include innovative care options during development and implementation such as telehealth. Telehealth is a critical component in specialty and primary care integration for both provider to provider and patient to provider communications. Supporting telehealth in future models will ensure that practitioners and patients that are geographically dispersed can meet face-to-face and also allow rural patients to see specialists that are often not located in their local communities.[3]

How can CMS support providers who may be required to participate in this episode-based payment model?

NRHA strongly believes that participation in episode-based payment models must be voluntary in nature for rural providers given varying rates of value-based readiness in rural facilities. CMS must be responsive to the unique characteristics and challenges of rural providers when designing a model. These characteristics include low patient volumes due to geographic spread; cost-based reimbursement (for critical access hospitals [CAHs] and RHCs); limited human and financial resources; and reliance upon fee-for-service in the payment system. NRHA acknowledges the challenges of incorporating rural providers into programs that are built for the larger provider community; however, we urge CMS to instead create a model with rural and urban providers alike in mind.

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[1] Keith Mueller, et al., *How to Design Value-Based Care Models for Rural Participant Success: A Summit Findings Report*, 4-6, December 2021, https://ruralhealthvalue.public-health.uiowa.edu/files/Rural%20VBC%20Summit%20Report.pdf.

[2] *Id.* at 5.

[3] *See generally* Tyler Barreto, et al., *Distribution of Physician Specialties by Rurality*, 37 J. RURAL HEALTH 714 (2021) https://pubmed.ncbi.nlm.nih.gov/33274780/.

Ultimately, rural providers need incentives to participate in new models, especially those that involve two-sided risk. **The most important incentive for rural participants would be upfront infrastructure investments to cover the initial costs of participation.** These payments should not be subject to any future recoupment from rural providers and should operate like a grant rather than a loan. When incentives are higher, and the potential losses are lower, rural providers may be more incentivized to participate**.** Any new models should recognize the relative differences between costs directly attributable to patient care (variable costs), costs of infrastructures required to support patient care regardless of patient volume (fixed costs), and costs necessary for readiness to deliver care anytime (standby costs).[4] Bundled payment arrangements should not disincentivize large, upstream providers from coordinating with cost-based rural providers.

Smaller, more rural hospitals have not had the infrastructure to participate in the majority of current bundled payment arrangements. As previously noted, they may also be less able to withstand potential financial losses if they do not end up performing as well under the program as anticipated. Again, NRHA stresses the limited human and financial resources available to most rural providers. Participating in a new program often requires new staff to take on the additional responsibilities like quality or data reporting because existing staff are likely to perform multiple jobs already. Hiring and training new staff is a cost that could be covered by an upfront payment. CMS would need to provide resources and technical support in order to make it feasible rural hospitals to participate in the form of information technology, data analysis, tools to support transitional financial risk management, and population health management.[5,6]

How can CMS promote person-centered care in episodes, which includes mental health, behavioral health, and non-medical determinants of health?

Again, CMS must support telehealth to ensure that rural patients can reach specialists that are otherwise not available locally, including mental and behavioral health professionals.

CMS should also consider engaging auxiliary personnel in episodes of care, such as CHWs, which are proven effective in addressing social determinants of health (SDOH) and reducing health care costs. Future models should support CHWs and other qualified professionals that can help transition patients between care settings, connect patients with community resources, support care coordination, and otherwise attend to SDOH that may present barriers to recovery or positive health outcomes. In general, CMS should incorporate non-clinical professionals to fill in gaps, especially around social needs. As stressed in section A, engaging the full continuum of care and the whole rural community is key.

What should CMS consider in the design of this model to effectively incorporate health information technology (health IT) standards and functionality, including interoperability, to support the aims of the model?

Health IT continues to be a major pain point for rural providers. Conforming to new requirements, such as interoperability standards, is more onerous for rural providers compared to others. The

[4] Mueller, *supra* note 1.
[5] *Id.*
[6] Kim Breidenback & Tammy Moore, *Volume to Value Transition for Rural Health Systems*, NATIONAL RURAL HEALTH ASSOCIATION (2020) https://www.ruralhealth.us/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/2020-NRHA-Policy-Document-Volume-to-Value-Transition-for-Rural-Health-Systems.pdf

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financial resources, labor, and education involved in meeting health IT standards is oftentimes nearly impossible.

CMS must recognize that there are barriers to complying with health IT standards. Many rural providers are not using major EHR platforms like Epic. These vendors that dominate urban or large health systems are not as commonplace in rural facilities. Instead, rural providers are more likely to rely upon smaller EHR vendors because the cost is lower. This creates problems for rural providers when they must comply with IT standards or interoperability requirements. CMS must consider the different health IT capabilities between providers and offer technical assistance and other resources to ensure all participants have the opportunity to achieve IT standards.

For example, CMS provides advanced incentive payments (AIPs) to certain participants in the Medicare Shared Savings Program (MSSP). CMS outlined the acceptable uses of AIPs for participants. Similarly, CMS could offer payments for participants that meet certain criteria and direct them to use payments for program-related activities like improving their current health IT infrastructure in order to meet any applicable requirements. Rural providers are at a disadvantage when required to adhere to standards and CMS must consider their challenges when designing a program.

How can CMS include home and community-based interventions during episode care transitions that provide connections to primary care or behavioral health and support patient independence in home and community settings?

Including home and community-based interventions would rely upon the HCBS workforce, which is currently one of the worst positioned sectors for staffing. This issue is even worse in rural areas. A variety of factors makes recruiting an HCBS workforce in rural areas difficult, such as the effects of the pandemic, low pay and lack of comprehensive benefits, lack of childcare for workers' families, and geographic spread leading to longer travel times.

B. Clinical Episodes.

Should CMS test new clinical episode categories?

CMS must consider two points when deciding on what clinical episode categories to include. First, CMS mentions the possibility of shortening the traditional episode length from 60 or 90 days to 30 days. This would then position the specialist as the principal or anchor provider with a hand off to the primary care provider for subsequent care management. NRHA would support this episode length if CMS ensures that the clinical conditions fit within the 30-day timeframe and would not require another episode.

Second, CMS should include clinical conditions that typically fall within the purview of rural providers. The conditions chosen for a future model must be those that hospitals and physicians can treat on their own or with contracted specialists. As referenced throughout our response, this may be another space where rural providers are technically included as participants but do not participate because the model's policies are written for urban providers. CMS should make sure that the clinical conditions included in a future model are not only those that are treated in large urban or tertiary care systems.

C. Participants

Given that some entities may be better positioned to assume financial risk, what considerations should CMS take into account about different types of potential participants, such as hospitals and PGPs?

NRHA stresses that voluntary episode-based payment models should not shut out rural providers on the generalization that most cannot adhere to the model's standards. Likewise, if CMS considers designing a mandatory program it must guarantee that rural providers can successfully participate by accommodating various levels of familiarity with or ability to assume financial risk. CMS should also allow for voluntary participation until such levels of readiness as met. Familiarity or experience is one important indicator. CMS should also take into account rural-specific qualities mentioned in section A, such as limited financial resources or low operating margins.

Should CMS consider flexibilities for PGPs to participate, such as a delayed start or a glide path to full financial risk?

CMS should build in flexibilities for providers that cannot immediately take on full financial risk. For example, BCPI Advanced required downside risk for all participants. NRHA believes that this approach unintentionally cuts out providers that would otherwise participate and we advocate for an on-ramp or glide path to full financial risk. MSSP provides an example of a value-based program that has implemented flexibilities to allow historically underrepresented providers to participate. MSSP offers two tracks and a glide path to downside risk based on experience with accountable care. CMS should consider mirroring this structure for episode-based models.

D. Health Equity.

What risk adjustments should be made to financial benchmarks to account for higher costs of traditionally underserved populations and safety net hospitals?

Almost all rural safety net providers are more expensive than the benchmark because of their alternate payment methodologies and special payments. Experience to date has shown that working against individual spending has worked. It is anticipated that most rural safety net providers will be above an administrative or regional benchmark approach, as structured in the ACO REACH. Possible solutions may be to normalize safety net spend to the fee schedule. Currently, ACO cost calculations exclude indirect medical education and disproportionate share hospital payments from per-beneficiary costs. In theory they could also exclude other special payments like the sole community hospital 7.1% increase for outpatient services and the difference between critical access hospital payments per diagnosis-related group (DRG) and PPS hospital payments per DRG.

To mitigate the impact of excessive variation in the regional adjustment on the benchmark, two actions may be considered. First, the maximum weight used in calculating the regional adjustment could be reduced from 70% to 50%. Second, the dollar amount of the adjustment could be capped at +/- 5% of the national fee for service per capita expenditures.

Should episode-based payment models employ special adjustments or flexibilities for disproportionate share hospitals, providers serving a greater proportion of dually eligible beneficiaries, and/or providers in regions identified with a high ADI, SVI, or SDI?

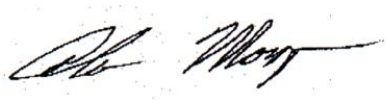
NRHA urges CMS to employ special adjustments or flexibilities that will encourage and facilitate rural provider participation. In general, the rural population is older, sicker, and poorer than their urban counterparts and that is compounded by a chronic lack of access to care. As a result, many rural

beneficiaries live in a paradox in which they are historically underserved by the health care system but need the most care. Rural communities see higher rates of food insecurity, lack of transportation, chronic diseases like diabetes and obesity, smoking, and premature death. Rural providers need a special adjustment or flexibility to participate in a future model and continue to furnish high-quality care to their more complex patients.

NRHA also encourages CMS to consider other provider types. DSH status and ADI/SVI/SDI are good indicators to pinpoint underserved populations. But rural providers that do not or cannot meet qualifications for DSH status likely still provide care for underserved populations, such as CAHs and RHCs. We also ask that CMS explore other measurements outside of ADI/SDI/SVI and also consider including providers health professional shortage areas (HPSAs).

Again, NRHA thanks CMS for the opportunity to weigh in on a future episode-based payment model. We encourage CMS to reach out to NRHA to ensure that rural providers are accounted for and represented in any new model. We are happy to partner with the agency moving forward. If you have any questions, please contact NRHA's Regulatory Affairs Manager, Alexa McKinley (amckinley@ruralhealth.us).

Sincerely,



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