NATIONAL RURAL
ACCOUNTABLE CARE CONSORTIUM

NATIONAL RURAL ACCOUNTABLE CARE CONSORTIUM COMMENTS ON THE MSSP NPRM

Background: The National Rural ACO (NRACO) was the first of its kind to bring together unaffiliated providers in multiple states to enable rural participation in the Medicare Shared Savings Program by pooling lives, expertise and financial resources. Now in its second program year, the leaders of NRACO have blazed a trail for others to follow and formed the National Rural Accountable Care Consortium as a non-profit peer learning and education organization. Today, thirty health systems in six ACOs covering nine states participate in the Consortium under a single data warehouse.

Our experience to date with the program has been very positive. Every health system has implemented data-driven care coordination and evidence-based medicine programs. Our positive impact on patient satisfaction, quality and reduced waste is evident. **We think almost all rural providers could benefit from being in this program, yet significant barriers exist that are not addressed in the proposed rule.**

Safety net providers are the only primary care systems left in the country that are not widely eligible for incentives for providing better care at a lower cost. This lack of incentives may create health disparities for rural beneficiaries, who are in significant need of Medical Homes and Care Coordination. Without the appropriate data and incentives, cash-strapped rural providers cannot redesign their delivery systems to meet the three-part aim. The MSSP is the *only* program broadly available today to create the framework for change that safety-net patients need. We urge CMS to modify the program specifically to meet the needs of safety net providers.

Executive Summary: Most of the proposed changes are welcome improvements for all providers, but still fall short of meeting the unique needs of the Safety Net. The National Rural Accountable Care Consortium recommends that ACO beneficiaries can self-assign to their rural provider, in addition to counting ED visits as primary care visits (which most of them are). In order to increase patient engagement and local volume, which lowers Medicare costs, ACO beneficiaries should be exempt from all cost-sharing when using safety net providers. They should have prospective assignment in order to facilitate their essential collaborative model to create

transparency and certainty about payments. Cost-based payments should be normalized to the PPS rate times utilization in order to avoid spurious results, and all special rural payments should be exempt. Waivers should be similar to Track 3 proposals, plus rural hospitals should be allowed to bill for primary care services in the ED.

EACH SECTION BELOW IS FOLLOWED BY COMMENTS BY THE NATIONAL RURAL ACCOUNTABLE CARE CONSORTIUM. THE NATIONAL RURAL ACCOUNTABLE CARE CONSORTIUM IS A NON-PROFIT ORGANIZATION LED BY RURAL AND FQHC ACO LEADERSHIP, INCLUDING TIM PUTNAM, CEO, MARGARET MARY HEALTH SYSTEM, STEVE BARNETT, CEO, MCKENZIE HEALTH SYSTEM, CHRIS BAUMGARDNER, EXECUTIVE DIRECTOR, ALCONA HEALTH CENTERS, JAMES SUVER, CEO, RIDGECREST REGIONAL HEALTH SYSTEM, MELANIE VAN WINKLE, CFO, MAMMOTH LAKES HEALTH SYSTEM, BROCK SLABACH, VICE PRESIDENT, NATIONAL RURAL HEALTH ASSOCIATION, TERRY HILL, EXECUTIVE DIRECTOR, NATIONAL RURAL HEALTH RESOURCE CENTER, AND LYNN BARR, CHIEF TRANSFORMATION OFFICER, NATIONAL RURAL ACCOUNTABLE CARE CONSORTIUM.

Participation Agreement Renewal and Continued Participation in Track 1

CMS Proposal: Current regulations require that ACOs participating in Track 1 (sharing savings, but not losses) may continue in the program after their initial 3-year agreement period only if they enter a performance risk-based (two-sided) track.

Proposal: We propose rules for the review and approval of participation agreement renewal requests, taking into account such things as the ACO's history of compliance with the requirements of the Shared Savings Program and the ACO's history of meeting the quality performance standard during the first 2 years of program participation. Additionally, we propose to permit ACOs to participate in one additional agreement period under Track 1, but at a lower sharing rate than the previous agreement period to encourage progression along the performance risk continuum. This policy would be available to ACOs that have met the quality performance standard in at least one of the first two years and have not generated losses that exceed the negative minimum savings rate (MSR) in both of the first two years of the previous agreement period.

NRACO CONSORTIUM: Safety net providers are **the only primary care systems left in the country that are not eligible for incentives for providing better care at a lower cost.** Without the appropriate infrastructure and incentives, cash-strapped rural providers will not redesign their delivery systems to meet the three-part aim. **The MSSP is the *only* program broadly available today to create the framework for change that safety net patients need.**

While we understand CMS's desire to move all providers into a risk-sharing arrangement, we would like to gently remind CMS that the reason we are cost-based reimbursed is that CMS cannot risk closure of safety net facilities. To think that a CAH or FQHC could close because of Shared Losses is unthinkable. **Safety Net providers should not be forced to take risk. They should be allowed to stay in**

a no-risk track indefinitely as long as they meet acceptable performance requirements.

Beneficiary Assignment

CMS Proposal: The existing methodology assigns beneficiaries to ACOs in two steps (after satisfying the statutory requirement by identifying beneficiaries who have received a primary care service from a physician in the ACO) based on the plurality of primary care services furnished by 1) primary care physicians, and 2) by specialist physicians, nurse practitioners, physician assistants, and clinical nurse specialists.

Proposal: We propose to revise Step 2 of the assignment methodology to remove certain specialty types whose services are not likely to be indicative of primary care services. Additionally, we propose to include nurse practitioner, physician assistant, and clinical nurse specialist primary care services in Step 1 in order to recognize the primary care delivered by these professionals.

NRACO CONSORTIUM: **Beneficiary attribution issues continue to plague safety net providers, who typically get about half of the number of beneficiaries attributed as their urban counterparts who provide the same amount of services.** Everyone benefits from having rural residents use their local facilities where possible and being assigned to the rural ACO participant, while preserving patient choice. Increased rural volume lowers Medicare's costs, it increases employment and revenue to the local economy and it provides more data to the local health system so they can identify patients who need additional support. **Rural ACO attribution policy should strive to assign as many patients locally as possible.**

We propose that **beneficiaries can self-assign to a Safety Net ACO**. Second, we recognize that a large number of our patients receive primary care in the ED due to the fact that many rural communities do not have the medical staff and financial resources to staff clinics outside of normal business hours. Therefore we recommend that **rural ED visits should be used for attribution purposes.** Third, we recommend that we have **prospective assignment.** Very few safety net providers have sufficient numbers of Medicare beneficiaries in order to be able to operate as a stand alone ACO. This collaborative model will only work if there is great certainty and transparency about shared savings and losses. Prospective assignment for benchmarking and reconciliation is the only method that provides certainty in a collaborative model. This will allow rural providers to estimate shared savings and have certainty on outcomes, encouraging them to invest in the interventions that will achieve the desired results.

Data Sharing

CMS Proposal: Current policy permits CMS to share claims data with ACOs that is necessary for health care operations, but only after ACOs have notified beneficiaries and provided them an opportunity to decline to have their data shared with the ACO among other requirements. ACOs can either mail notices to beneficiaries, wait 30 days before requesting data, and then follow up with the beneficiary at the next primary care office visit, or they may notify beneficiaries at the point of care and request data immediately. This process has created beneficiary confusion, delays in data sharing, and administrative complexity.

Proposal: We propose to streamline the process for ACOs to access beneficiary claims data necessary for health care operations while retaining the opportunity for beneficiaries to decline to have their claims data shared with the ACO. Specifically, we propose that ACO participants would provide written notification at the point of care through signs posted in their facilities that include template language regarding data sharing and the opportunity for beneficiaries to decline data sharing by calling 1-800-Medicare. Under this proposal, beneficiaries would express their data sharing preferences directly to CMS through 1-800 Medicare rather than passing the information through the ACO. This means that ACOs will no longer send out letters that may confuse beneficiaries, and beneficiaries will no longer have to sign and return forms to the ACO.

NRACO CONSORTIUM: **Hallelujah!**

Establishing, updating, and resetting ACO financial benchmarks:

CMS Proposal: Pursuant to section 1899(d)(1)(B)(ii) of the Act, in the November 2011 final rule, we adopted a methodology for establishing ACO financial benchmarks used for determining shared savings and losses. Under 1899(i) we have flexibility to implement alternative benchmarking approaches; however, these must not result in additional program expenditures.

Proposal: We seek comment on a number of alternative methodologies for establishing, updating, and resetting ACO financial benchmarks. For example, we are interested in hearing reactions to potentially:

- using regional FFS expenditures instead of national FFS expenditures in establishing and updating the benchmark,
- transitioning to using regional FFS cost data to make ACO benchmarks gradually more independent of the ACO's past performance and gradually more dependent on the ACO's success in being more cost efficient relative to its local market, resetting the ACO's benchmark in subsequent agreement periods such as equally weighting the three benchmark years and/or

accounting for shared savings payments received by an ACO in its prior agreement period.
- In addition, we seek comment on related changes to calculations related to the benchmark that would support these options, including changes to risk adjustment normalization and coding intensity adjustments, comparison group definitions, adjustments for ACO composition changes, the timeline for transition to regional FFS costs, and other adjustments.

NRACO CONSORTIUM: We appreciate the ideas listed above. It is not unusual for a rural patient to be seen in multiple regions for care, so regional wage adjustments will be difficult to implement for rural providers. **The average rural provider would be best served by generous benchmarking policy in addition to setting a benchmark floor equal to the state average.** We also support coding intensity adjustments as an incentive to encourage comprehensive coding, which is essential to provide necessary data for population health management. Rural providers have trended toward under-coding, given that payment is generally not affected by diagnosis. For example, National Rural ACO has 8% more patients with no HCC risk scores than other ACOs.

Encouraging ACOs to take on greater performance based risk

CMS Proposal: We seek to encourage ACOs to progress along the performance risk continuum. Based on comments from stakeholders, we believe certain aspects of the Shared Savings Program could be improved to increase interest in performance risk-based options.

CMS Proposal: We seek comment and propose a number of modifications including:

- Proposing to implement an additional performance risk-based model (Track 3) for ACOs to participate in the Shared Savings Program. Track 3 would offer a higher sharing rate than Tracks 1 and 2 and would prospectively assign beneficiaries to the ACO rather than preliminarily assigning beneficiaries to ACOs and then doing a retrospective reconciliation.
- Proposing to modify Track 2 to increase its attractiveness by making the minimum savings and loss rates variable rather than the current flat 2 percent.
- Seeking comment on what other design elements would be necessary for organizations to consider taking on greater financial risk, including options to:
- Augment the current assignment methodology by including beneficiaries on the assignment list when the beneficiary attests that a practitioner participating in the ACO is responsible for his or her care coordination.
- Waive certain FFS payment and regulations related to qualifying hospital stays for SNF admission, telehealth, qualifications for home health services, and qualifications for post-acute referrals.

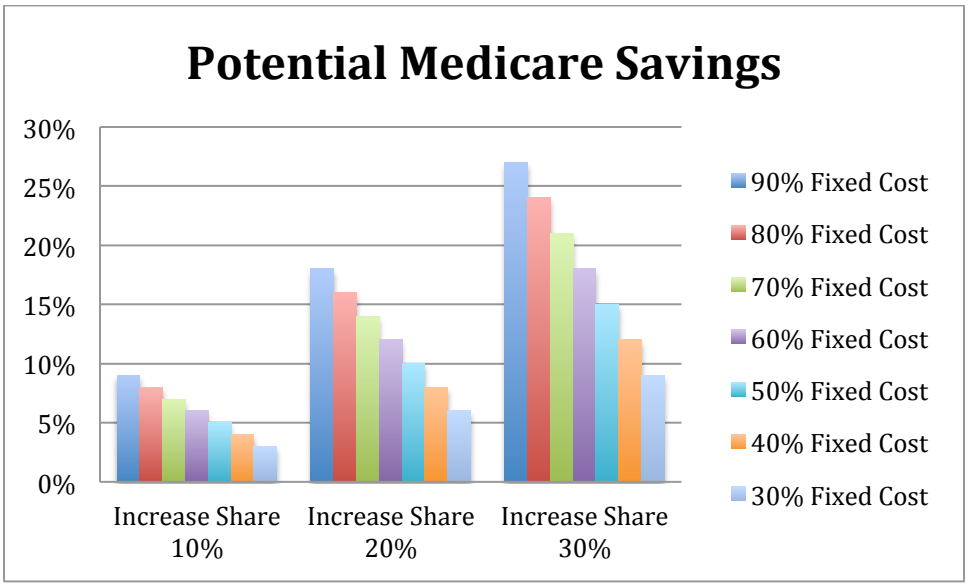
NRACO CONSORTIUM: While we understand CMS's desire to move all providers into a risk-sharing arrangement, we would like to gently remind CMS that the reason we are cost-based reimbursed is that CMS cannot risk closure of safety net facilities. **Safety Net providers should not be forced to take risk. They should be allowed to stay in a no-risk track indefinitely as long as they meet acceptable performance requirements. Therefore, we re-frame this discussion as "Encouraging Safety Net Providers to participate in ACO's."**

We agree that the above recommendations would improve the attractiveness of the program for safety net providers. In addition, there are several waivers that can have a significant impact on rural providers ability to improve care, lower costs and build market share. Specifically, waiving **the 96-hour rule, outpatient physician supervision requirement, and an ability to admit to a *swing bed* or SNF without a 3-day hospital stay** are obvious waivers against regulations that drive volume away from the rural setting and increase costs. Given the highly fractured nature of our referral patterns, safety net providers need a **clear ability to steer patients to a high-value, highly communicative referral network** while preserving beneficiary choice. As stated earlier, it is less costly and more convenient for our patients to receive primary care after hours utilizing the excess capacity in the Emergency Department. Therefore, we request the ability for our patients to use the **ED for a primary care visit** which could provide the comprehensive and preventive care they need, with providers allowed to bill as a primary care visit.

Rural Medicare PPO For ACO Beneficiaries

We request the ability to incentivize our patients to get care in our community by having **Medicare cover residual patient cost-sharing (after supplemental insurance)** if they are seen in safety net facilities. As cost-based reimbursed facilities with high fixed costs, increased local volume naturally lowers costs for Medicare while also bringing the patient closer to their medical home.

The cost of having Medicare cover in-network cost-sharing after supplemental insurance can be estimated using 2012 data from MEDPAC reports, which showed average beneficiary cost-sharing is $1550 per year, and that 10% of seniors do not have supplemental insurance that covers these costs. Currently, our cost-based facilities only have a 35% of total claims. This should yield a cost per beneficiary of ($1,550 X 10% X 35% X 50%) = $54.25 per beneficiary per year, which would be charged against total Medicare spending for the ACO. Rural providers would bear 50% of this cost by virtue of being in a shared savings program. Medicare would gain significantly due to the effect of higher volumes on per capita cost-based reimbursement. The greatest winner would be the beneficiary and the rural community, which would see increased local spending, employment and better, more comprehensive care. See Figure 1 for a model of potential savings for Medicare based on increasing volume to cost based providers.



Eligibility Requirements

CMS Proposal: We propose several minor modifications to the eligibility requirements for ACO participation including:

- requirements related to the agreements the ACOs have with Medicare enrolled entities (that is, ACO participants as defined in the program rules)
- governing body and leadership requirements - for example, currently, the ACO's medical director is required to be an ACO provider/supplier. We propose to remove this requirement to permit more flexibility.
- the process the ACO has for coordinating care, requiring ACOs to articulate how they will encourage and promote the use of enabling technologies for improving care coordination, and
- a more streamlined process to allow prior Pioneer ACOs to apply for program participation.

NRACO CONSORTIUM: We concur with these modifications.

The following table aligns our proposals with the proposals in the NPRM:

SHARED SAVINGS FINANCIAL MODEL OVERVIEW

National Rural Accountable Care Consortium Recommendations

ISSUE	Track1, Current One-Sided Risk Model	Track 1, Proposed One-Sided Risk Model	Track 2, Current Two-Sided Risk Model	Track 2, Proposed Two-Sided Risk	Track 3, Proposed Two-Sided Risk Models	TRACK 4, PROPOSED SAFETY NET MODEL
BENEFICIARY ENGAGEMENT						Medicare to cover residual out-of-pocket costs after supplemental insurance for in-network utilization. Allow beneficiary to self-assign.
TRANSITION	First agreement period under one-sided model. Subsequent agreement periods under two-sided model	Remove requirement to transition to two-sided model in a second agreement period.	ACOs may elect Track 2 without completing a prior agreement period under a one-sided model. Once elected, ACOs cannot go into Track 1 for subsequent agreement periods.	No change	Same as Track 2	Able to stay in program as long as ACO meets minimum performance standards
ASSIGNMENT	Preliminary prospective assignment	No change	Preliminary prospectiv	No change	Prospective assign	Prospective assignment for reports and

ISSUE	Track1, Current One-Sided Risk Model	Track 1, Proposed One-Sided Risk Model	Track 2, Current Two-Sided Risk Model	Track 2, Proposed Two-Sided Risk	Track 3, Proposed Two-Sided Risk Models	TRACK 4, PROPOSED SAFETY NET MODEL
	for reports; retrospective assignment for financial reconciliation		e assignment for reports; retrospective assignment for financial reconciliation		ment for reports and financial reconciliation	financial reconciliation. Allow beneficiaries to self-assign. Use rural ED visits for assignment.
BENCHMARK	Reset at the start of each agreement period	Seeking comment on alternative methodology	Same as Track 1	Seeking comment on alternative methodology	Same as Tracks 1 and 2 and seeking comment on alternative methodology	Benchmark reset at start of each period, or state average, whichever is higher
ADJUSTMENT FOR HEALTH STATUS	Historical benchmark expenditures adjusted based on CMS-HCC model. Updated historical benchmark adjusted relative to the risk	No change	Same as Track 1.	No change	Same as Tracks 1 and 2.	Historical benchmark expenditures adjusted based on CMS-HCC model. Updated historical benchmark adjusted relative to the risk profile of the performance

ISSUE	Track1, Current One-Sided Risk Model	Track 1, Proposed One-Sided Risk Model	Track 2, Current Two-Sided Risk Model	Track 2, Proposed Two-Sided Risk	Track 3, Proposed Two-Sided Risk Models	TRACK 4, PROPOSED SAFETY NET MODEL
	profile of the performance year. Performance year: newly assigned beneficiaries adjusted using CMS-HCC model; continuously assigned beneficiaries adjusted using demographic factors alone unless CMS-HCC risk scores result in a lower risk score.					year. Performance year: newly assigned beneficiaries adjusted using CMS-HCC model; continuously assigned beneficiaries adjusted using CMS-HCC model.
ADJUSTMENT FOR IME AND DSH	IME and DSH excluded from benchmark and performance year expenditures.	No change	Same as Track 1	No change	Same as Tracks 1 and 2	Also exclude rural payments: sole community hospital add-on, inpatient rehab hospital add-ons, psychiatric hospital add-ons, ESRD low volume adjustment,

ISSUE	Track1, Current One-Sided Risk Model	Track 1, Proposed One-Sided Risk Model	Track 2, Current Two-Sided Risk Model	Track 2, Proposed Two-Sided Risk	Track 3, Proposed Two-Sided Risk Models	TRACK 4, PROPOSED SAFETY NET MODEL
						frontier state hospital wage index floor, additional telehealth payments, floor on work GPCI and practice expense limits, hospital low volume adjustment, Medicare dependent hospital, home health add-on and outpatient hold harmless payments.
OTHER PAYMENT ADJUSTMENTS	Include other payment adjustments included in Part A and B claims such as, geographic payment adjustments and HVBP payments, in benchmark and performance year	Seeking comment on other technical adjustments	Same as Track 1	Seeking comment on other technical adjustments	Same as Tracks 1 and 2	Cost-based reimbursement to CAHs and Rural Health Clinics should be normalized to PPS rates (UTILIZATION X PPS RATE).

ISSUE	Track1, Current One-Sided Risk Model	Track 1, Proposed One-Sided Risk Model	Track 2, Current Two-Sided Risk Model	Track 2, Proposed Two-Sided Risk	Track 3, Proposed Two-Sided Risk Models	TRACK 4, PROPOSED SAFETY NET MODEL
	expenditures					
QUALITY SHARING RATE	Up to 50 percent based on quality performance	Up to 50 percent based on quality performance for first agreement period, reduced by 10 percentage points for each subsequent agreement period under the one-sided model	Up to 60 percent based on quality performance	No change	Up to 75 percent based on quality performance	Up to 50 percent based on quality performance
MINIMUM SAVINGS RATE	2.0 percent to 3.9 percent depending on number of assigned beneficiaries.	No change	Fixed 2.0 percent	2.0 percent to 3.9 percent depending on number of assigned beneficiaries	Fixed 2.0 percent	Fixed 2.0 percent
MINIMUM LOSS RATE	Not applicable	No change	Fixed 2.0 percent	2.0 percent	Fixed 2.0	Fixed 2.0 percent

ISSUE	Track1, Current One-Sided Risk Model	Track 1, Proposed One-Sided Risk Model	Track 2, Current Two-Sided Risk Model	Track 2, Proposed Two-Sided Risk	Track 3, Proposed Two-Sided Risk Models	TRACK 4, PROPOSED SAFETY NET MODEL
				to 3.9 percent depending on number of assigned beneficiaries	percent	
PERFORMANCE PAYMENT LIMIT	10 percent	No change	15 percent	No change	20 percent	20 percent
SHARED SAVINGS	First dollar sharing once MSR is met or exceeded.	No change	Same as Track 1.	No change	Same as Tracks 1 and 2.	First dollar sharing once MSR is met or exceeded.
SHARED LOSS RATE	Not applicable	No change	One minus final sharing rate applied to first dollar losses once minimum loss rate is met or exceeded; shared loss rate not to exceed 60 percent	No change	One minus final sharing rate applied to first dollar losses once minimum loss rate is met or exceeded; shared loss rate	Not applicable

ISSUE	Track1, Current One-Sided Risk Model	Track 1, Proposed One-Sided Risk Model	Track 2, Current Two-Sided Risk Model	Track 2, Proposed Two-Sided Risk	Track 3, Proposed Two-Sided Risk Models	TRACK 4, PROPOSED SAFETY NET MODEL
					may not be less than 40 percent or exceed 75 percent	
LOSS SHARING LIMIT	Not applicable	No change	Limit on the amount of losses to be shared in phases in over 3-years starting at 5 % in year 1; 7.5 % in year 2; and 10 % in year 3 and any subsequent year. Losses in excess of the annual limit would not be shared.	No change	15 percent. Losses in excess of the annual limit would not be shared.	Not applicable