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As leaders of the rural movement to Accountable Care, we are delighted to hear of the commitment to accelerating the movement from fee-for-service to value-based payments. We have witnessed first-hand the impact of these new systems of care on our patients and will do everything in our power to support your efforts for their benefit.

Today, rural providers lag behind, with only 10% of our providers engaged in ACO's. The ACO Investment Model (AIM) is an important first step to help us get to the 30% desired in 2016, but it must be accompanied by reforms of the MSSP that make it workable and attractive to rural providers, in addition to **ongoing support of the AIM program** until we reach the goal of 50% ACO participation in 2018. We have attached our summary of a **Safety Net Track 4 for the MSSP**, and have submitted supporting comments to CMS.

For purposes of Value-Based Modifiers, and to a lesser extent ACO's, Medicare standardizes payments to address differences in wages and practice expenses and portions of payments that serve Medicare's broader social purpose, including GPCI, HPSA, IME, DSH, and rural add-ons for Sole Community, Medicare Dependent, IRFs and IPFs. However, **Medicare ignores choice of setting differentials (hospital outpatient vs. physician office) and types of providers (physician office vs. Rural Health Clinic, FQHC or Critical Access Hospital).**

We currently run six rural ACOs. **We can see the same data seen by urban ACOs and the size of the target on our backs.** Although we are efficient in our total provision of care, with rural beneficiaries typically 3% less expensive than urban beneficiaries, our low volumes and special payments in rural settings are more expensive on a unit cost basis. We also generate 74% of our revenue from hospital outpatient services, which is typically the only location for these services available to our patients locally. Under VBM, providers will see our higher costs and drive our patients away from us. **The unintended consequence of not shielding and standardizing *all* of our special payments (including outpatient services) may be the diversion of most of our patients and the ultimate destruction of safety net providers.** We urge you to standardize all rural payments for the purposes of these two programs in order to preserve the rural medical home for 20% of Medicare fee-for-service beneficiaries.

Rural Health Clinics and FQHCs are exempt from value-based payments, including PQRS, Value-Based Modifiers and Medicare Meaningful Use. **If rural providers are not held accountable for cost and quality, our patients will suffer the consequences and our institutions will become *personas non grata* to the rest of the medical community.** We implore you to address these disparities immediately before irreparable damage to the safety net has occurred.

ISSUE	PROPOSED SAFETY NET TRACK 4 FOR THE MSSP
TRANSITION	Able to stay in program as long as ACO meets minimum performance standards. Enable collaborative ACOs to rearrange participants among them. Extend ACO terms to five years. NEVER REQUIRE RISK.
ASSIGNMENT	Prospective assignment for reports and financial reconciliation. Allow beneficiaries to self-assign. Use rural ED visits for assignment. **Remove physician visit requirement.**
BENCHMARK	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 profile of the performance year. • Performance year: newly assigned beneficiaries adjusted using CMS-HCC model; continuously assigned beneficiaries adjusted using CMS-HCC model.
ADJUSTMENT FOR IME AND DSH	Also exclude rural payments: sole community hospital add-on, inpatient rehab hospital add-ons, psychiatric hospital add-ons, ESRD low volume adjustment, 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	Cost-based reimbursement to CAHs and Rural Health Clinics should be STANDARDIZED to PPS rates (UTILIZATION X AVERAGE PPS RATE).
QUALITY SHARING RATE	Up to 50 percent based on quality performance
MINIMUM SAVINGS RATE	Fixed 2.0 percent
MINIMUM LOSS RATE	NO RISK REQUIRED
PERFORMANCE PAYMENT LIMIT	20 percent
SHARED SAVINGS	First dollar sharing once MSR is met or exceeded.
WAIVERS	Waive the CAH 96-hour rule, outpatient supervision rule, provide an ability to admit to a swing bed or SNF without a 3-day hospital stay, allow a clear ability to steer patients to a high-value, highly communicative referral network while preserving beneficiary choice, allow patients to use the ED for a primary care visit, with providers allowed to bill as a primary care visit, and waive residual cost-sharing for Medicare Beneficiaries.
BENEFICIARY ENGAGEMENT	Medicare to cover residual out-of-pocket costs after supplemental insurance for in-network utilization. Allow beneficiaries to opt in to the ACO.