NATIONAL RURAL ACCOUNTABLE CARE CONSORTIUM COMMENTS ON THE MSSP PROPOSED RULE

Executive Summary: 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 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 framework.

The NRACO experience to date has been very positive. Every health system in the consortium has implemented data-driven care coordination and evidence-based medicine programs. Improved patient satisfaction, better quality, and reduced waste are demonstrable. We believe that many rural providers and patients could benefit from this program. Most of the CMS-proposed changes to the MSSP are welcome improvements but still do not fully meet the unique needs of rural safety net providers.

Safety net providers are the only primary care systems that are **not eligible for incentives for providing better care at a lower cost**, including Value-Based Purchasing, PQRS, Value-Based Modifiers, and Medicare Meaningful Use payments. The MSSP is the *only* program broadly available today to create the framework for change that safety-net patients and providers need.

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, safety net rural providers cannot redesign their delivery systems to meet the needs of their patients. We urge CMS to modify the program specifically to meet the needs of safety net providers and to encourage broad participation. Therefore **we propose a unique version of the MSSP for the safety net -- The Safety Net Track 4.**

The National Rural Accountable Care Consortium recommends the following:

- Rural ACOs should be able to participate without risk indefinitely as long as they meet minimum standards.
- Beneficiaries should be afforded the opportunity to “opt-in” to their rural ACO.
- Rural ACOs should have prospective assignment to create payment transparency and certainty and to facilitate collaborative governance models
- We recommend that ED visits count as primary care visits for assignment and that participants are encouraged to modify delivery of care in the ED to provide 24-hour

access to care, but with a re-designed payment and delivery system that promotes primary care, meets the needs of rural communities and keeps cost down.
- We request the ability to move participants from one ACO to another so that high-performing participants are not penalized by low-performing participants, giving low performers more time to implement the program.
- The benchmark should be the higher of historic costs or the state average.
- Cost-based payments go up when unnecessary admissions are avoided, or volume declines for any reason. Therefore, cost-based payments should be normalized to the PPS rate for calculations in *all* value programs, and all special rural payments should be exempt similar to IME and DSH.
- In order to encourage rural participation, patient engagement in their medical home, and to lower Medicare costs, ACO beneficiaries should be exempt from all cost-sharing when using safety net ACO providers.
- Waivers should be similar to Track 3 proposals, plus rural hospitals should be allowed to bill for primary care services in the ED, and waivers should include the CAH-specific 96 hour rule, outpatient supervision rule and include swing beds in the SNF waiver.

BACKGROUND: Since the creation of the Critical Access Hospital (CAH) Program, more than 1300 CAHs have been created across the country. Mission-driven and frequently supported by local taxes, most of these CAHs have either acquired or contract with the majority of practices and other ambulatory services in their communities in order to preserve access. **Unlike urban hospitals that derive the majority of their revenue from inpatient services, CAH revenue is almost three-quarters outpatient.** They are highly dependent on federal, state and local funding and operate on very small profit margins. Many are facing closure due to the effects of sequestration and lack of Medicaid expansion in predominantly rural states. **By re-organizing themselves around population health, they can improve health, improve care and create a sustainable margin by reducing costs and sharing in that savings.**

2012 Pre-Sequestration Financial Indicators for CAHs – FLEX Monitoring Team

Indicator	Median Value	Indicator	Median Value
Total Margin	2.61%	**Medicare Inpatient Payer Mix**	73.59%
Operating Margin	1.13%	**Medicare Revenue/Day**	$2193
Outpatient Revenues to Total Revenues	74.14%	**Average Daily Census Acute Beds**	3.38

The cost of care at Critical Access Hospitals is highly volume-dependent. CAHs are paid on a basis of *Medicare share of acute patient days x allowable costs x 101%* (less sequestration). According to the FLEX monitoring team, in 2012, CAHs had a median 73.59% Medicare

inpatient payer mix and an average daily census of 3.38 acute beds, or 1,234 days per year. In the table below, we model the impact of increasing and decreasing volume 50% from the median in facilities that are 90% fixed cost and 50% fixed cost. There is no published data on fixed costs for CAHs, but our cost accountants estimate it ranges from 70-90%. One of our CAHs with volumes near the median calculated their fixed costs, which came to 81%, as an example. For detailed calculations, please see Appendix A.

Impact of Volume on CAH Payments (modeled with 90% and 50% fixed costs)

	Baseline	Increase Days 100%, 90% Fixed Cost	Increase Days 100%, 50% Fixed Cost	Decrease Days 100%, 90% Fixed Cost	Decrease Days 100%,50% Fixed Cost
Acute Days	1,234	2,468	2,468	617	617
Medicare Costs	$3,711,245	$4,299,623	$5,687,573	$3,308,432	$2,662,741
Cost/Day	**$3,007.49**	**$1,742.15**	**$2,304.53**	**$5,362.13**	**$4,315.63**

Regular CMS payment adjustments for CAHs, while needed to support the safety net, are creating barriers to success for rural providers in the MSSP and make us unwanted partners to our referral networks, who are increasingly paid on cost and quality. **CMS must address these issues quickly or risk further decline of the safety net due to provider steering of patients away from their community health system to avoid penalties under value-based payments.**

CMS currently protects academic medical centers and urban safety net hospitals from a similar situation by excluding IME and DSH payments in their calculations. **We strongly recommend that *for value-based calculations, such as MSSP calculations and value-based modifiers* that all claims from safety net facilities are normalized to the corresponding PPS rates. Furthermore, all special rural payments should be excluded from these calculations.**

Participation Agreement Renewal and Continued Participation in Track 1

While we understand CMS's desire to move all providers into a risk-sharing arrangement, we would like to remind CMS the reason many rural providers are cost-based reimbursed is *CMS cannot risk closure of safety net facilities*. To think that a CAH or FQHC could close due to shared losses is unthinkable, yet the average number of days cash-on-hand for CAHs, pre-sequestration was only 69 days. **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.**

In order for rural providers to achieve the minimum number of beneficiaries to participate, they have to collaborate with others, frequently with providers they don't have a relationship with or who are often not even in the same state. As the ACOs progress through the program, it will be helpful to **be able to rearrange the providers among the ACOs based on their performance annually,** so that high performing providers are not foregoing shared savings due to low performing partners, and low performing providers can be put in a remedial learning consortium instead of removed from the program. The alternative is to remove low performing providers quickly from the ACO, which does not encourage them to improve their performance and take better care of their patients. Current rules appear to allow this to happen, but we want to make CMS aware that this arrangement is needed and desired. A longer term for safety net ACOs would further facilitate this aim.

Beneficiary Assignment

Beneficiary assignment issues continue to be problematic for safety net providers, who are disadvantaged because of their use of Nurse Practitioners and Physician's Assistants for Primary Care. The requirement for a physician visit before assigning a patient to us causes many of our patients to not be assigned, and we typically get about 35% of our beneficiaries attributed to our PCPs, compared to about 60% for rural PCPs. Everyone benefits from having rural residents use their local facilities where possible and being assigned to the rural ACO participant, unless the beneficiary consciously chooses otherwise. 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, **while preserving patient choice.** Therefore, we propose that **beneficiaries can "opt-in" 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.** We also recommend a waiver that will allow us to deliver comprehensive primary care with 24-hour access using the physician-staffed, under-used rural Emergency Department. This is discussed further later in the document.

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.

Finally, we continue to advocate for a legislative fix that will remove the requirement for a physician visit in order for patients to be assigned to the rural ACO. Many rural communities have significantly more NPs and PAs than they have physicians and it is a burden to the beneficiary to impose an unwanted physician visit in order to achieve assignment.

Establishing, updating, and resetting ACO financial benchmarks:

We support CMS' recommended changes with one exception. It is not unusual for a rural patient to be seen in multiple regions for care, so regional wage adjustments will be erroneous for many rural ACOs. **We propose 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 the 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.

Special Safety Net Payments: Rural providers have many special payments that are included in cost calculations, including 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. CMS currently exempts IME and DSH payments from cost calculations in order to protect urban institutions, but does not exempt similar rural payments to protect the safety net. The same is true for all value-based payments.

In addition, safety net providers get higher payments for RHC and FQHC visits, and receive cost-based reimbursement for provider-based RHCs and Critical Access Hospitals**. By not excluding the additional payments that subsidize the safety net, CMS risks driving patients away from the providers that are there to serve them.** As volume decreases, Medicare and beneficiary costs increase, creating a vicious cycle that may break the system.

Cost-based payments should be normalized to the PPS rate for calculations in all value programs, and all special rural payments should be exempt from all value calculations, similar to IME and DSH.

Encouraging ACOs to take on greater performance based risk

While we understand CMS's desire to move all providers into a risk-sharing arrangement, we would like to 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. In 2012, median CAHs averaged 69 days cash on-hand. A shared loss might result in closure, or at the very least will take away important funds needed for capital investment. **Safety net providers should be allowed to stay in a no-risk track indefinitely as long as they meet acceptable performance requirements.**

We agree that the Track 3 recommendations would improve the attractiveness of the program for all 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, the physician supervision rule, 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. According to an AHRQ 2011 study by Hines, et al, CAH EDs see an average of 8.6 patients per day. Our EDs are required to be staffed by physicians 24/7, yet our patients can't get advice or a primary care appointment after hours, and struggle to get appointments during working hours. Our ACO beneficiaries visit the ED 20% more than the FFS national average, and 50% of these visits are primary care. Therefore, **we request the ability for ACO participants to modify our ED system so our patients can use the ED for primary care visits** and allow our ED providers to bill this as a primary care visit, with accompanying minimum standards. This will require some additional discussion and potentially a specific waiver to EMTALA.

Waiver of Residual Cost-Sharing for Medicare Beneficiaries

Finally, as discussed earlier, the cost of care we deliver is highly sensitive to volume. In order to increase volume and engagement of rural beneficiaries in their highly subsidized local health system, 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 that are cost-based reimbursed. As cost-based reimbursed facilities with high fixed costs, increased local volume naturally lowers costs for Medicare while also engaging the patient in 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, although it would probably be somewhat higher based on adverse selection and other factors. Conversely, at least 50% of the additional cost would be absorbed by rural providers through the shared savings program.

Appendix A: Theoretical Effects of Volume on Critical Access Hospital Reimbursement

A hypothetical CAH with $5 Million annual costs, a 20% market share, 73.49% share of days and 90% fixed cost and **1,234** Medicare acute days:
((($4.5 million fixed cost + $500,000 variable costs) x 73.49%) x 101%) = $3,711,245.00 Medicare Cost/1234 patients = $3,007.49 per patient day including $300.75 in variable costs: ((($500,000/1234) x 73.49%) x 101%) = $300.75.

If fixed costs are only 50%: ((($2.5 million fixed cost + $2.5 million variable costs) x 73.49%) x 101%) = total Medicare cost of $3,711,245.00. Variable costs = (($2,500,000/1234) x 73.49%) x 101%) = $1,503.75.

If the CAH doubles volume to **2468** Medicare days:
(78.27% x $4.5 million) x 101% + ($300.75 x 2468) = $4,299,622.50. Medicare Cost/2468 patients = $1,742.15/day including $300.75/day in variable costs. This includes a 4.78% increase in Medicare share, assuming other payers stay flat.

If the CAH doubles volume to **2468** Medicare days and fixed costs are 50%:
(78.27% x $2.5 million) x 101% + ($1,503.75 x 2468) = $5,687,572.50. Medicare Cost/2468 patients = $2,304.53/day including $1,503.75/day in variable costs. This includes a 4.78% increase in Medicare share, assuming other payers stay flat.

If the CAH halves volume to **617** Medicare days:
(68.71% x $4.5 million) x 101% + ($300.75 x 617) = $3,308,432.25. Medicare Cost/617 patients = $5,362.13/day including $300.75/day in variable costs. This includes a 4.78% decrease in Medicare share, assuming other payers stay flat.

If the CAH halves volume to **617** Medicare days and fixed costs are 50%:
(68.71% x $2.5 million) x 101% + ($1,503.75 x 617) = $2,662,741.25. Medicare Cost/617 patients = $4,315.63/day including $1,503.75/day in variable costs. This includes a 4.78% decrease in Medicare share, assuming other payers stay flat.

	Baseline	Increase Days 100%, 90% Fixed Cost	Increase Days 100%, 50% Fixed Cost	Decrease Days 100%, 90% Fixed Cost	Decrease Days 100%,50% Fixed Cost
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Medicare Costs	$3,711,245	$4,299,623	$5,687,573	$3,308,432	$2,662,741
Cost/Day	**$3,007.49**	**$1,742.15**	**$2,304.53**	**$5,362.13**	**$4,315.63**

Appendix B: Summary of Proposed Safety Net Track 4

ISSUE	TRACK 4, PROPOSED SAFETY NET MODEL
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.
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 normalized 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	Fixed 2.0 percent
PERFORMANCE PAYMENT LIMIT	20 percent
SHARED SAVINGS	First dollar sharing once MSR is met or exceeded.
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.
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.