



## RUPRI Rural Health Panel

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Administrator

Centers for Medicare and Medicaid Services

Hubert H. Humphrey Building

200 Independence Avenue, SW, Room 445-G

Washington, DC 20201

RE: CMS-1345-P, Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations

Dear Dr. Berwick:

The Rural Policy Research Institute Health Panel (Panel) has a 20-year tradition of providing unbiased rural health policy analyses to Congress, Administrations, and other key stakeholders. The Panel includes experts in public policy, health economics, clinical care, health law, quality improvement, and long term care. We are pleased to offer comments regarding the Centers for Medicare and Medicaid Services' (CMS) Notice of Proposed Rulemaking for implementation of the Medicare Shared Savings Program (MSSP) and new Accountable Care Organizations (ACOs). The Panel understands that CMS will receive comprehensive comments from a wide variety of sources. Thus, we will limit our comments to rural-specific issues.

### Attribution to Physicians

Rural America's health care is predominantly provided by primary care physicians. The Panel understands that CMS is limited by statute to assign Medicare beneficiaries to an ACO based on a plurality of primary care *physician* services. Yet, physician assistants (PAs) and nurse practitioners (NPs) also provide primary care in rural areas. Thus, the inability to attribute rural beneficiary encounters to PAs and NPs for ACO assignment is of significant concern. CMS might interpret the statute as referring to "physician directed care" which would allow beneficiary attribution to PAs, and to some NPs. But in absence of this interpretation, this issue would require legislative, not regulatory, action.

### Primary Care

The MSSP is a primary care-focused program. This focus resonates with the importance of primary care to rural beneficiaries. We believe that CMS is correct in attributing patients to a primary care physician (with the PA and NP

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caveats noted above) and that for administrative purposes a primary care physicians can only align with one ACO. The exclusive assignment of a primary care physician to one ACO, in combination with the non-exclusivity of all other ACO participants (including specialty physicians, hospitals, etc.), balances the need for consistent care processes along the care continuum with a desire to maintain freedom of choice for both beneficiaries and non-primary care providers.

### RHCs/FQHCs

Beneficiary attribution to a primary care physician requires encounter claims data that includes provider, provider type, and HCPCS code. As noted above, the requirement of attribution to a primary care physician rather than to a PA or an NP creates challenges for participation by certain rural providers. Furthermore, it creates particular problems for Rural Health Clinics (RHCs) and Federally Qualified Health Clinics (FQHCs) which have not been required to provide claims data in that detail. (FQHCs began supplying these data to CMS January 1, 2011). Despite absence of data required for beneficiary attribution to a primary care physician (and thus assignment to an ACO), the Panel notes that RHCs and FQHCs provide a substantial proportion of primary care to rural beneficiaries.

For those RHCs and FQHCs that are interested in becoming an eligible entity for ACO implementation and/or beneficiary attribution, we recommend that CMS work with those RHCs/FQHCs that are willing and able to begin submitting encounter claim forms in such a way that CMS can attribute primary care services to primary care physicians. For RHCs/FQHCs/ that wish to participate immediately in an ACO, we suggest that CMS establish a RHC/FQHC specific formula to establish a cost benchmark in lieu of the three years of encounter data generally needed to establish cost benchmarks. RHCs/FQHCs that wish to use their actual encounter data to establish cost benchmarks can delay participation until they have submitted three years of encounter data. We feel that Medicare claim submissions (with encounter level provider and HCPCS data) will substantiate that an ACO is currently engaging either an RHC or an FQHC, and therefore would be eligible for the RHC/FQHC shared savings bonus. This method would obviate the need for the 1-visit RHC/FQHC rule for bonus eligibility.

### 1-Visit RHC/FQHC rule for bonus eligibility

The method we suggested in the last section for attributing patients to RHC/FQHC primary care physicians would obviate the need for the 1-visit RHC/FQHC rule for bonus eligibility.

We appreciate that CMS suggested the bonus rule to create an incentive for RHC/FQHC participation in ACOs because of unavailable encounter data to attribute patients to an RHC/FQHC primary care physician. However, we are concerned that the 1-visit RHC/FQHC rule may result in primary care discontinuities. Thus, we suggest that CMS work with RHCs/FQHCs that wish to become full ACO participants (thus employing physicians to whom primary care patients can be attributed) rather than use a 1-visit rule for awarding bonus eligibility.

### Net Savings Threshold

The Panel agrees that the four conditions required to waive the net savings threshold are appropriate and will encourage MSSP participation that otherwise might not occur. Those conditions include: 1) ACO comprised only of group practice or practice network professionals, 2)  $\geq 75\%$  of assigned beneficiaries residing in non-metropolitan

statistical areas, and 3)  $\geq 50\%$  beneficiaries assigned on basis of care provided by a critical access hospital (CAH) using Method II billing, or 4)  $\geq 50\%$  of assigned beneficiaries have claim(s) originating from RHCs or FQHCs in the most recent year. Note that we have modified #4 to reflect our recommendation above.

#### Minimum Savings Rate

The Panel recognizes the statutory requirement for CMS to statistically adjust a minimum savings rate (MSR) “in a way that gives us [CMS] some assurance that the ACO’s performance is a result of its interventions, not normal variation.” CMS designed a statistical system of MSR determination based on sliding scale confidence intervals that differ based on ACO beneficiary panel size. The result is that ACOs with smaller numbers of assigned beneficiaries would have a MSR of no greater than 3.9% and large ACOs would have a MSR of 2.0 %. Although the Panel understands the requirement for methodological adjustment, the statute does not mandate *how* the adjustment must be made. Furthermore, we believe that the 3.9% MSR threshold may be a significant barrier to small ACO entry. Thus to minimize disincentives to program entry, the Panel recommends that CMS use sliding scale confidence intervals that decrease the MSR spread from 2.0% to 3.0%.

#### Denial for Under-Performance

The Panel disagrees with the CMS proposal to deny MSSP participation (reapplication) to an ACO that did not lower Medicare expenditures in the first three years of activity. Experience in the Physician Group Practice (PGP) demonstration suggests that cost savings are often not immediate and that inability to achieve cost savings immediately, or even after three years, does not necessarily mean that cost savings cannot be achieved later. Furthermore, infrastructure investment for an ACO is significant. Prospective ACOs will be reluctant to make those investments if at the end of three years they would be denied the opportunity to continue if the venture had not yet resulted in savings. As opposed to an ACO, Medicare’s down-side financial risk (compared to no ACO at all) is minimal during the first three years. Thus, the Panel recommends deleting this proposal. Instead we are confident that a detailed quality indicators performance review is sufficient to determine readiness to continue an ACO for a second three-year period.

#### Option 3

Because of the PGP demonstration experience in which few practices realized savings initially, the Panel believes that CMS should offer an “Option 3” for shared savings calculation. Option 3 would entail no down-side financial risk for the ACO in the third year (as does Option 2), yet would offer only 40% shared savings (compared to 50% for Option 2 and 60% for Option 1). Option 3 would only be available to initial ACO applicants and could not be renewed beyond year 3. This option would reduce ACO risk somewhat (requisite ACO infrastructure investment remains significant and thus risk-producing), and thus would reduce disincentives for MSSP participation.

Thank you for your consideration of these comments. Please do not hesitate to contact us with questions.

Sincerely,

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