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October 16th, 2018

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1701-P
P.O. Box 8013
Baltimore, MD 21244-8013
By electronic submission at http://www.regulations.gov

RE: 42 CFR Part 414 and 425: Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations – Pathways to Success

To Whom It May Concern:

The Rural Policy Research Institute Health Panel (Panel) was established in 1993 to provide science-based, objective policy analysis to federal policy makers. The Panel is pleased to offer comments in response to this particular proposed rule. Our comments are limited to rural-specific issues and are structured to parallel questions posed, or issues stated, by CMS (not technical comments regarding specific sections of the proposed rule).

Overall, the Panel supports efforts to improve the Medicare Shared Savings Program, and other issues highlighted in this proposed rule. Medicare represents a higher proportion of patients for most rural health care organizations and clinicians than in urban areas, so Medicare policies may have a disproportionate impact on rural providers, hospitals, and beneficiaries. Therefore, we hope our comments below serve as valuable input during the proposed rule finalization.

The Panel supports the recommendation described on page 41863, to extend the 3-day rule waver to services provided by a hospital or CAH under the swing bed arrangement. Doing so will facilitate better serving the needs of rural beneficiaries by providing covered services in their communities because the local provider is a CAH (in the absence of a skilled nursing facility).

The Panel's perspective on ACOs accepting downside risk is informed by studies of the spread of ACOs in rural regions of the country. For the past several years there has been a focused push to grow the number of participating ACOs including targeting rural providers (the AIM program being the leading illustration; also changes in attributing beneficiaries based on visits to FQHCs and RHCs). We believe this focus should remain, given that the ACO model is the primary vehicle to leverage Medicare policies that meet the congressional intent to reshape delivery of services. Compelling acceptance of downside risk after only two years of ACO

participation is likely to discourage participation by rural providers operating on very thin margins (e.g., Critical Access Hospitals and rural physician alliances). We recommend CMS consider a third-year at no downside risk for a defined group of providers (some characteristics or types – maybe CAH, FQHC, low revenue ACOs), in effect two years in level B prior to moving to C, D, and E in the BASIC track. We also recommend considering lowering the minimum savings ratio for those ACOs, and considering a downward adjustment to the maximum level of downside risk as a percent of the ACO participant revenue and/or benchmark. These changes retain the program's objective of accountability for total cost, but at a risk level more suitable for low revenue rural ACOs.

Recognizing the challenges of applying the ACO model to multiple circumstances (provider types, size of healthcare organizations, number of beneficiaries in the market, capitalization of healthcare organizations), the Panel suggests creating new demonstration projects to achieve objectives of lowering costs while achieving high quality. Those demonstrations could include: (1) innovative payment models for rural providers (e.g., global budgeting); and (2) innovative delivery system reform models that bring clinical and non-clinical together in one organization model, with companion payment redesign.

The Panel commends CMS' continued work on these critical issues and we thank you for the opportunity to submit comments prior to the finalization of this proposed rule.

Sincerely,

The Rural Policy Research Institute Health Panel

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