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February 6, 2015
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2367-P
P.O. Box 8012
Baltimore, MD 21244-8016
By electronic submission at http://www.regulations.gov

RE: 42 CFR Part 425 [CMS-1461-P], Proposed Rule: Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations.

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 offer comments regarding the Proposed Rule to implement reductions to state Medicaid Disproportionate Share Hospital (DSH) allotments, as required by the Affordable Care Act.

The Panel understands that CMS will receive comprehensive comments from a wide variety of sources. Thus we will limit our comment to rural-specific issues.

PROPOSED RULE: §425.112 would require ACO applicants to describe how they will encourage and promote use of enabling technologies. These may include electronic health records and health IT tools, telehealth services, health information exchange services, or other electronic tools. The section also requires ACO applicants to describe how they intend to partner with long-term and post-acute care providers

COMMENT #1: The Panel applauds CMS interest in establishing a record of how technology, including telehealth, is being used to improve patient care. We encourage CMS to develop a particular understanding of how the technologies are helpful in caring for patients in rural, remote locations; and how they are used to extend services (including clinical care, care coordination, and health improvement) to areas in which supporting certain local practitioners is not feasible but from which patients cannot be expected to travel to nearest provider for essential services (primary care, chronic care management). The inclusion of

requirements for long-term and post-acute partnering signal the importance of health information exchange and interoperability across the continuum of care are, especially in rural areas which disproportionately serve the elderly and those with chronic conditions and are heavy users of long term supports and services. We encourage CMS to share the data received through the application and monitoring process with researchers and others to advance our understanding of how technologies are used and under what circumstances organizations who benefit from total cost savings are viewing that use as a preferred approach to providing services. Implementation of the requirement to show how performance metrics are met will be especially important in determining further use of technology by ACOs and other provider organizations.

PROPOSED RULE: §425.402 would now include non-physician practitioners in step 1 of the beneficiary assignment process.

COMMENT #2: We are pleased to see that CMS understands the role of non-physician practitioners in providing primary care. These professionals are an integral component of the primary care system in rural places, and including them in Step 1 is a substantial improvement in the assignment process. CMS asks for comments on the extent to which these practitioners provide non-primary care services and if there ways to distinguish between primary care services and non-primary care services billed by them. While we leave the technical comments regarding payment codes to others, the Panel suggests that there be a presumption of providing primary care for these practitioners located in rural places, particularly remote rural places. Geocoding the location of the practice could provide the data for doing so.

PROPOSED RULE: §425.402: CMS calls for comment on proposals to all beneficiary self-attestation into ACOs, including which beneficiaries should have that option and what types of patient-provider relationships should be considered (*Federal Register* December 8, 2014, p 72829).

COMMENT #3: The Panel supports allowing beneficiary self-attestation under all Tracks (not limited to Track 2). We recommend that all beneficiaries be eligible to attest into an ACO, including those currently or previously aligned, and that the attestation be based on where the beneficiary reports receiving primary care services. Our recommendation is based on the reality of rural patterns of care in which patients may receive services coded as primary care during a prolonged episode of care that requires treatment in a distant facility (during which time the services may include some coded as primary care), but their primary care medical home remains with a rural primary care provider.

PROPOSED RULE: §425.404 would use claims for primary care services provided by all ACO professionals submitted by an FQHC or RHC to determine where a beneficiary received a plurality of primary care services under Step 1 of beneficiary assignment.

COMMENT #4: We concur with CMS that the revenue center codes used by FQHCs and RHCs represent primary care services, which means this change in assignment process will more accurately reflect primary care utilization by rural beneficiaries.

PROPOSED RULE: §425.600 allows ACOs operating under a one-sided model in the previous period to continue under the one-sided model if they did not generate losses in excess of the negative MSR in both of

the first 2 performance years and they meet criteria to renew their agreements. The shared savings rate would be reduced from 50% to 40%.

COMMENT #5: CMS seeks comment on whether to consider the performance trend of ACOs in determining whether or not to renew participation agreements. ACOs that formed in rural places are more likely to be among the smallest organizations (both in number of beneficiaries assigned and in resources available for investment) and therefore need more time to fully implement strategies in care management that consistently yield savings. Further, the small scale of those of organizations creates greater challenges to develop collaborations external to the participant providers to manage care across the continuum, which again requires time and experience. Therefore, the question of how long to remain in a one-sided risk model is particularly relevant to rural ACO success. Given the intent to allow organizations more time to achieve the goals of ACOs (savings and quality improvement) and the still steep learning curve and need for investment of capital and human resources to succeed as an ACO, we recommend not using trends from the first 2+ years to deny allowing an ACO to continue. If trends are used, CMS could consider a "probationary" status for one or two years to allow time to demonstrate a change in trends, although we recommend a three-year renewal without such a condition. Similarly we recommend retaining the 50% shared savings rate as an incentive for provider organizations to participate in the ACO program. In answering CMS's question we believe more time is needed to take on the two-sided risk model and that the maximum number of organizations should be encouraged to enter into the one-sided model, which argues for retaining the current percentage shavings.

Sincerely,

The Rural Policy Research Institute Health Panel

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