

Rural Health Panel

Keith J. Mueller, Ph.D., Chair
Alana Knudson, Ph.D.
Jennifer P. Lundblad, Ph.D., M.B.A.
A. Clinton MacKinney, M.D., M.S.
Timothy D. McBride, Ph.D.
Alva Ferdinand, Ph.D.
Nancy Schoenberg, Ph.D.

College of Public Health – N232A
145 River Street
Iowa City, IA 52242
319)-384-3832
Keith-mueller@uiowa.edu

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Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1770-P
P.O. Box 8012
Baltimore, MD 21244-1850
By electronic submission at <http://www.regulations.gov>

RE: CMS-1770-P: Medicare and Medicaid Programs; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements

The Rural Policy Research Institute Health Panel was established in 1993 to provide science-based, objective policy analysis to federal lawmakers. The Panel is pleased to offer comments in response to proposals regarding Medicare Shared Savings Program Requirements.

The Panel commends CMS for proposing significant changes to the Medicare Shared Savings Program (SSP) that promise to facilitate more widespread health care organization participation in Accountable Care Organizations (ACOs). Rural Medicare beneficiaries will benefit from adjustments intended to address two inequities, one based on residing in low-density and often underserved areas, and another as part of an underserved population (see page 46093 of the *Federal Register* proposed rule for delineation). The comprehensive approach CMS takes in this proposed rule will strengthen the viability of ACOs in rural areas. We would caution though, that much like it is very difficult and costly to reach the “last mile” with services such as high-speed broadband, achieving ACO extension to all rural counties will be extraordinarily challenging and may require steps beyond those suggested in the proposed rule. A discussion of rural innovative organizations offers suggestions for helping conversions to value-based payment: “How to Design Value-Based Care Models for Rural Participant Success: A Summit Findings Report” [Microsoft Word - Rural VBC Summit Report - RHV 12-2020.docx \(uiowa.edu\)](#). The Panel’s additional comments are organized by the principal changes made in this proposed rule.

Advanced Investment Payments

We concur with CMS eligibility criteria for advance investment payments (AIPs), §425/630b. CMS solicits comments on additional categories of expenses (page 46102). We suggest considering a reinstatement of

AIP eligibility for a second three-year time period in the BASIC track. Doing so may be the necessary investment to fully realize the potential of low-revenue ACOs. We also concur with the requirement for a plan for use of the advanced payment, but suggest that CMS consider technical assistance, either provided by CMS or another source, to assist the applicant health care organization with preparation of the plan. We are pleased to see that increased staffing is considered an appropriate use of AIP funds. Social determinants of health (SDOH) related strategies are notably appropriate in rural settings, particularly for services such as transportation and telemonitoring (*Federal Register* page 46191). We are especially pleased to see that advanced payments may be used to cover costs associated with building new local networks that involve community-based-organizations (*Federal Register* page 46102). We recommend employing a broad definition of allowable costs devoted to building those networks, including the transactions costs inherent in building new partnerships. The calculation of the quarterly AIP payment is based, in part, on the area deprivation index (ADI) scores that are calculated at the census blocks group levels served by ACOs. While these scores reflect socioeconomic circumstances of beneficiaries, they do not necessarily address the special circumstances of beneficiaries living in noncore rural areas. CMS rightly considered health professional shortage area (HPSA) designation, but recognizes challenges in using that designation as a measure of disadvantage comparable to the dimensions captured by the ADI measures. However, the Panel recommends CMS continue to explore measures to account for the special challenges ACOs face in providing care coordination and other services to beneficiaries in rural areas where the required personnel and facilities are not present.

Extended time in one-sided risk

Consistent with our comments on previous proposed rules and requests for information, we support the CMS decision to allow an ACO entering the BASIC track at Level A to remain in that level throughout the initial agreement period. We also support allowing those ACOs to remain in Level A for an additional enrollment period. Doing so is consistent with research reported by the RUPRI Center for Rural Health Policy Analysis, as well as studies referenced by CMS. One of the most critical variables explaining the success of rural ACOs is experience in risk-sharing arrangements, along with care management and developing networks with other providers in their service areas (including rehabilitation and long-term services and supports).

Changes to calculating benchmarks

The Panel commends CMS for addressing the need to adjust benchmarks given the impact of ACO actions on the total spending in their regions, particularly the impact of successfully generating savings for the Medicare program. While we do not have comments on the specifics of steps in calculating benchmarks, we endorse adjusting the benchmarks to account for prior savings.

Low Revenue ACOs sharing savings at lower minimums

The Panel strongly endorses CMS proposed changes to allow ACOs in the BASIC track not meeting the minimum savings rate MSR requirement to qualify for shared savings if they meet the quality performance standard or the proposed quality alternative quality performance standard under §425.512. Responding to the CMS call for comment (p 46198), we offer two observations. First, allowing low revenue ACOs to realize shared savings, particularly if their ability to invest AIP payments has expired, will help continuous investment in care management strategies and personnel, resulting in further savings and higher quality.

Second, the amount of shared savings may not be sufficient to, on its own, sustain ACO participation. This will be especially true for smaller ACOs, although the threshold of 5,000 may mitigate this observation somewhat. The Panel's earlier recommendation to consider renewing AIP during a second cycle of BASIC Level A participation is another way to facilitate building ACO capabilities.

Implementing a health equity adjustment

We support the development of the health equity adjustment to quality scores based on the proportion of underserved beneficiaries and the proportion of dually eligible beneficiaries (page 46136). We recommend that CMS consider a further adjustment to account for serving beneficiaries in noncore rural areas, where costs may be inherently higher due to scarcity of health personnel resources. This might be done through an additional modest adjustment to be applied only after the initial threshold based on population characteristics is met.

Use of social determinants of health (SDOH) measures

CMS seeks comment on using measures screening for social determinants of health (SDOH) as an eCQM/MIPS CQM measure, specifically the rate of screening, and the Screen Positive Rate (pp 46154-5). The Panel endorses required reporting on the use of screening for SDOH. Data generated by screening would be useful to ACOs as they focus on meeting the needs of underserved populations. We recommend that, in tandem with using this measure, CMS consider investments in programs such as Accountable Health Communities, which would provide resources and guidance for hospitals' actions when considering screening results. We do not endorse using changes in screening rates as a quality measure. The screening results do not measure actions taken by ACO health care providers, but are instead reflections of total community (and state) efforts to address the five domains of the social drivers of health.

Respectfully submitted,



Keith J. Mueller, Ph.D.
Chair, RURPI Health Panel