NOSORH
national organization of state offices of rural health

June 5, 2011

Donald Berwick, MD
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD

RE: Docket # CMS – 2010 – 0259

Dear Dr. Berwick

The following comments are submitted in response to the Accountable Care Organization (ACO) Notice of Proposed Rulemaking (NPRM) issued on March 31st. On behalf of the National Organization of State Offices of Rural Health, which represents the country's fifty State Offices of Rural Health as they work to improve health and health care in rural America, we are pleased to submit these comments and recommendations.

General Observations

Moving to a more integrated healthcare delivery system has the potential for tremendous clinical value for patients and healthcare providers living and practicing in rural communities. Establishing a payment system that supports the integration of care and views care delivery in an integrated environment can lead to better patient outcomes and reduced overall costs for care.

Unfortunately, NOSORH is skeptical that the ACO model, as outlined in the proposed rule, will work in most rural areas. However, we have heard from some rural providers (RHCs, CAHs, FQHCs, small rural hospitals) that they would like to be able to consider participation in an ACO and we agree that the ACO standards and requirements should not discriminate against providers and patients. If an RHC or CAH or small rural hospital believes that participation in an ACO is in the best interests of the facility and the patients, then we do not believe arbitrary barriers should be put in place to restrict or prohibit that participation.

Many of the providers serving rural underserved populations are reimbursed by Medicare on a cost basis – federally certified rural health clinics (RHCs), critical access hospitals (CAHs) and federally qualified health centers (FQHCs). Because of the unique payment methodologies used to compensate these providers for the care they provide, the challenge of successfully integrating them into an ACO model are significant.

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In addition, we believe that some of the ACO statutory requirements enacted as part of the Patient Protection and Affordable Care Act (PPACA) create particularly high barriers for full participation by some providers (i.e. RHCs and FQHCs) in the ACO initiative.

It is generally acknowledged that the current fee-for-service system has few financial incentives to encourage providers to work together. However, it should be noted that nearly 50 percent of RHCs are operated as a provider-based entity of a hospital and most of the hospitals affiliated with RHCs have fewer than 50 beds.

We believe that the increased collaboration between RHCs and CAHs and small rural hospitals gives clear evidence that if properly incentivized, rural providers will collaborate and work together.

Unfortunately, the ACO proposed rule, which attempts to establish the clinical and financial environment for a successful integrated care model fails on both counts. Despite proposals to encourage ACOs to include RHCs in their networks, we believe few ACOs will specifically include RHCs in their delivery model because of other, more damaging disincentives included in the proposed rule.

On several occasions throughout the NPRM, CMS implies that those policies that appear to discourage participation by RHCs and others in the ACO initiative are due to the way Congress wrote the law. While there is no question that some of the underlying statutory provisions of the PPACA create difficult challenges for the CMS staff, we do not believe the Agency did as much as they could to mitigate the negative policies.

Primary care physicians, Physician Assistants (PAs) and Nurse Practitioner (NPs) are central to the clinical and financial success of the ACO model set out in the proposed rule. Primary care is defined to include internal medicine, general practice, family practice and geriatric medicine. As you know, primary care is the cornerstone for RHCs and FQHCs and thus including these providers in the ACO initiative is not only consistent with the goal of ACOs, but also the goal of both RHCs and FQHCs.

We recognize that CMS is in the process of developing alternative models of ACOs which may be more attractive and reflective of the unique circumstances surrounding the delivery of healthcare in sparsely populated rural areas with a heavy reliance on PAs and NPs to deliver a majority of the primary care. We look forward to reviewing these alternative models.

Unless CMS makes dramatic changes in the ACO rules when it issues the final rule later this year, few, if any rural organizations will seek ACO status and individuals residing in rural and rural underserved areas will be denied the clinical and financial benefits that might be achieved through greater integration and accountability.

Specific Concerns:

Patient Assignment/Attribution:

As you know, rural communities are highly dependent upon PAs and NPs to deliver a large percentage of primary care in rural areas. While we recognize that the PPACA specifies that, for purposes of patient attribution/assignment, the patient must have been cared by an ACO-affiliated primary care physician during the previous 12 months, the failure to recognize the appropriate role and contributions of PAs and NPs is a serious barrier to RHC participation.

In addition, an ACO must have a minimum of 5,000 Medicare patients "assigned" to the ACO as a condition for approval as an ACO. The rules require a minimum of at least 5,000 participating Medicare beneficiaries to be part of an ACO. NOSORH believes this minimum for each ACO presents a challenge to smaller scale rural shared savings initiatives.

CMS has chosen to use the CMS claims data as a basis for patient attribution/assignment. More specifically, the CMS 1500 claim form will be used as a proxy test to determine compliance with this requirement. As you know, RHCs do not bill Medicare using the 1500 and instead, file claims using a UB-04 form. More importantly, when RHCs bill for services, they bill for a Rural Health Clinic service rather than for discrete services using CPT codes and the physician fee schedule. Finally, when a clinic submits the UB-04 claim form, they are not required to identify the specific provider who rendered the service. The service could have been provided by a physician, a PA or an NP (and in some circumstances, a nurse midwife).

Because the RHC claim form does not distinguish or identify the "rendering" provider, CMS maintains it has no way of knowing whether the patient was seen by an ACO affiliated physician and thus meets the statutory requirement.

Again, we recognize that this situation is created by the way the ACO law was written but nevertheless, we do not think this is an insurmountable barrier problem.

Recommendation 1:

We believe there are at least two alternatives that CMS should consider with respect to allowing patients seen in the RHC to be assigned to the ACO with which it is affiliated:

Require RHCs that are part of an ACO to identify the rendering provider on the UB-04 claim form using the NPI of the rendering provider.

Clearly the UB-04 Claim form can accommodate the insertion of the NPI of the rendering provider. Many clinics already include the name and NPI of the rendering provider (or in some cases, the RHC Medical Director) as a means of facilitating payment on claims for which a commercial insurer is the secondary payer to Medicare.

However, because this is not required for the processing of the RHC claim, this information is not currently being captured by the CMS contractors.

While we would strongly oppose any requirement that all RHCs report this information, we think it is a reasonable requirement for those RHCs who wish to be a part of an ACO. In turn, the Medicare contractors would be asked to capture this information and feed it into whatever database CMS will maintain to make all of the necessary ACO benchmarking assessments.

Use a patient attestation method for attributing/assigning RHC patients to the ACO.

The ACO affiliated RHC can provide CMS with a roster of Medicare patients who receive care in the RHC and the RHC should be able to also identify those RHC patients who were seen by a primary care physician during the 12 month period covered by the ACO contract. We would note that CMS is allowing a modified form of patient attestation under the Pioneer Model ACO and is allowing for attestation to be used in other areas of this NPRM.

While the rendering provider information is not currently required on the RHC claim form, the information is captured in the patient record. Should CMS have concerns that a clinic has improperly sought to attribute a patient to the ACO who was not seen by an RHC physician, CMS could ask the clinic to provide patient record documentation to substantiate the attestation. We want to reiterate that we believe these options should only be used for those RHCs seeking to participate in an ACO. This record keeping burden should not be imposed on the vast majority of RHCs who will not be participating in an ACO.

Consider allowing rural ACOs with fewer than 5,000 Medicare patients.

CMS should consider allowing smaller scale ACOs in those areas where securing 5,000 Medicare patients may be difficult or impossible. Also, CMS should consider allowing the organization to include Medicaid patients in their count and include these patients in the clinical and financial analysis. This may allow some rural organizations to become an ACO that might not otherwise be able to attain this status.

Clinical Records and CPT codes

The proposed rule indicates that the exclusion of RHCs, FQHCs and CAHs is also partly due to the limits of claims data currently submitted by FQHCs, RHCs and CAHs. This being the case, it would be possible for FQHCs, RHCs and CAHs to submit supplemental data that would meet the needs of the ACO demonstration. However, the proposed rules further indicate that there is no statutory basis for such supplemental data collection from these providers, and therefore these arrangements are not permissible.

We disagree. We believe that asking RHCs, FQHCs or CAHs that wish to voluntarily participate in an ACO to do additional reporting is well within CMS' statutory authority.

For example, the proposed rule requires substantial supplemental data reporting by all eligible providers of ACOs. The *Preventive Health* and *Frail Elderly/At-Risk Population* performance data measures, which comprise 40 of the 65 performance data measures, are all to be based upon a Group Practice Reporting Option [GPRO] data tool. This supplemental reporting mechanism is based upon sampled assessments of patient records. This is a fairly complex process of supplemental data collection and reporting. If this type of supplemental data collection is to be permitted, it seems contradictory to exclude supplemental data collection that would allow FQHCs, RHCs and CAHs to participate as eligible providers in ACOs.

Many FQHCs, RHCs and CAHs have effective electronic billing systems and, in addition, have implemented or are in the process of implementing Electronic Health Record [EHR] systems. These systems can be modified to meet the claims information reporting requirements of an ACO, including identification of services provided to a patient and the specific staff provider providing the service. The proposed ACO rules correctly emphasize the importance of EHR systems to the ACO, yet fail to recognize that such systems, currently in place in many FQHCs, RHCs, and CAHs, can be used to generate the supplemental data that would allow them to participate effectively as eligible providers in ACOs.

Recommendation 2:

As with the listing of the rendering provider's name and NPI for those RHCs wishing to participate an ACO, RHCs that are part of an ACO could also be required to identify on the UB-04 claim form or through other means, the specific services provided during the RHC encounter. The Medicare contractor could capture this data and share this information with the appropriate personnel at CMS who will oversee ACO compliance and financial assessments.

CMS could also modify the proposed rule to permit participation of FQHCs, RHCs and CAHs as eligible providers in ACOs. In lieu of the claims-based data submitted by other providers, CMS could define a supplemental set of data elements to be reported by these providers

Again, this requirement only be for those RHCs, FQHCs or CAHs choosing to participate in an ACO.

Balancing Quality and Cost-savings

Although the proposed rule speaks eloquently about the importance of paying for quality and identifies dozens of quality markers an ACO must meet as a condition for obtaining "shared savings," the fact is that the ACO proposed rule places more emphasis on reducing costs than it does on improving quality.

In fact, under the proposed rule, before an organization even gets assessed on itsits ability to meet the various quality measures, it must first demonstrate that it has reduced costs relative to the organization's benchmark. ACOs (with some exception) must meet a minimum savings rate

(MSR) of 2 percent below their benchmark as a precondition for determining whether the organization has met the quality measures.

Once an ACO has met the 2 percent MSR, it will then be evaluated on its ability to meet the quality measures. Then, if the organization can demonstrate compliance with the quality measures, it can obtain "shared savings" to the extent it reduces costs beyond the 2 percent MSR.

In others words, under the proposed rule, cost savings are more important than improving quality.

Also, the proposed rules do little to address the circumstances of physicians in rural areas. The proposed rules permit a waiver of the 2% Minimum Savings Requirement when at least 75% of the assigned beneficiaries reside in a non-MSA [Metropolitan Statistical Area]. This is a very high threshold, particularly when patients of rural health clinics cannot be counted in meeting the minimum threshold requirements of an ACO.

NOSORH believes that quality should be the principle driver behind the desire to move to a more integrated delivery system, not cost. We believe that improving the quality of care (both individually and organizationally) will lead to lower costs. It is not necessarily true that lowering costs will lead to higher quality. Unless the ACO quality and cost-savings incentives are at a minimum in balance – or to the extent there is an imbalance, it is in favor of quality, CMS runs the risk of seeing ACOs viewed as merely a cost-cutting approach by both providers and patients.

Recommendation 3:

A. Eliminate the 2 percent MSR for all ACOs, not just those including RHCs or FQHCs or in situations where 75% of patients reside in non-MSAs.
B. CMS should first determine if the ACO meets the quality standards as a precondition for the ACO's obtaining "shared savings";
C. Once the ACO has demonstrated it has met the quality standards, allow the ACO to retain a percentage of any shared savings on a sliding scale basis. The initial percentage of shared savings retained by the organization would be higher for the first dollars of savings with the percentage retained savings diminishing as the amount below the benchmark increases.

Shared Savings				
Percent Below ACO specific Benchmark	**One - Three Percent**	**Three – Five Percent**	**Five – Ten Percent**	**Above Ten Percent**
Percent of savings retained by ACO	80%	60%	30%	10%

Under this formula, the ACO has the greatest incentive to achieve early savings and diminishing value in squeezing savings out of the system that may prove to be harmful to patients.

We strongly support the bonuses CMS has proposed for ACOs that include RHCs and FQHCs and strongly recommend these be retained in the final rule.

Timing of Shared Savings Distribution

Based upon the retrospective attribution and the auditing/compliance process that will be required to determine the value of any "shared savings" we estimate that it will take between 18 months and 2 years after the close of a fiscal year before the ACO will actually receive any "shared savings" from Medicare.

In addition, it is also apparent that many organizations seeking ACO status will have to make significant up-front investments in technology and manpower. These represent real costs to the organization.

As a business decision, organizations contemplating ACO status must ask themselves if they have access to the up-front cash resources they will need to purchase and use the technology that will be required to meet the ACO quality and financial requirements. In addition, many organizations contemplating ACO status will likely have to hire additional personnel to undertake the aggressive case management services that will likely be necessary to achieve some of the clinical outcomes and improvements contemplated for ACOs.

If our assessment that it could take as much as two years before the organization actually receives any "shared savings" is correct, one has to wonder just how many organizations have access to the type of cash required to sustain the system for those two years? This type of cash-flow problem will only further discourage organizations from seeking ACO status.

We believe it will be necessary to provide more in the way of "up front" resources to ACOs to encourage greater participation in this initiative. CMS alludes to the need for infrastructure investment as part of a move to "population-based" payment but does not allow for such resources under the transition period from fee-for-service payments to population-based payments.

Recommendation 4:

Organizations obtaining ACO status should be able to obtain an advance payment from Medicare on expected savings in order to have the resources necessary to make the capital and human resource investments necessary to achieve improved healthcare and long-term Medicare savings.

Each participating ACO would be required to submit a proposed 3-year budget as part of the ACO application identifying the ACO's expected savings as a result of obtaining ACO status. The ACO would be eligible to request an advance payment (payment to occur at the beginning of

year 1) equivalent to the amount of shared savings it expects to achieve during the first year of their ACO agreement.

The amount of the advance ACO payment would be deducted from the actual shared savings based upon the following percentage basis:

Year 1, 25 percent of total advance ACO payment retained by Medicare from actual ACO's Shared Savings
Year 2, 25 percent of total advance ACO payment retained by Medicare from actual ACO's Shared Savings
Year 3, 50 percent of total advance ACO payment retained by Medicare from actual ACO's Shared Savings

Retrospective Attribution

In the NPRM, CMS proposes to establish a process for retrospective patient attribution to the ACO. In other words, the organization will not know until the end of the Fiscal Year the actual patients for whom the organization is going to be held accountable both clinically and financially.

Presumably retrospective attribution was selected (as opposed to prospective attribution) in order to ensure that the ACO seeks to improve quality and cost outcomes for all Medicare patients who obtain care from the ACO, not just those for whom the organization is deemed "accountable".

This is a very attractive proposition for the Medicare program if CMS' assumptions (i.e. ACOs will improve quality and cost-savings for all Medicare patients, not just those attributed to the ACO).

Let's assume, for example that an ACO has 8,000 Medicare patients for whom it is potentially accountable and through a variety of means, the organizations is able to substantially improve the quality of care for all 8,000 and achieve significant financial savings across all 8,000 lives. For purposes of discussion, let's assume that the organization achieves a 7 percent reduction in costs for all 8,000 Medicare patients and again, for purposes of discussion, this 7 percent reduction translates into $150 per patient on average for a total savings reduction of $1.2 Million (8,000 X $150.00).

But, if CMS does not attribute all of the 8,000 patients to the ACO and instead, only attributes 6,000, right off the bat, CMS retains a savings of $300,000 from this ACO because the savings are completely retained by Medicare through improved processes of care.

Then, CMS reduces the "shared savings" by taking the initial 2 percent of the 7 percent meaning the shared savings is only based on the difference: 5 percent. So the remaining $900,000 in savings ($1.2 Million minus $300,000) is reduced by approximately $260,000 leaving a "sharable savings of approximately $640,000. For simplicity sake, we are going to assume the straight up 50-50 shared savings meaning that the ACO gets 50 percent of $640,000 or $320,000.

In this example, the ACO modified the processes of care such that Medicare's cost were reduced by $1.2 Million but the ACO only realized $320,000 of those savings (about 27 percent).

Based upon how CMS does the patient attribution, it is possible that CMS would realize as much – if not more – in savings just on the attribution process as the ACO will realize by actually making the improvements.

NOSORH believes it is essential that the organization know up front the patients for whom it will be held accountable both clinically and financially. We do not share the concern that the organization will modify or change clinical practices only for those patients. This has not been the experience at rural providers such as Critical Access Hospitals, which continue to improve quality for both Medicare and non-Medicare patients on an ongoing basis. Instead, we believe that any process improvements the organization can make will accrue to the benefit of all patients cared for by ACO participating providers.

We notice in the Pioneer Model ACO, for which CMS is currently seeking proposals, prospective attribution is permitted and even encouraged.

Recommendation 5:

CMS should change the ACO final rule to allow for prospective attribution of Medicare patients so that ACOs can appropriately plan and allocate resources.

Shared Savings Calculation

As noted in the previous section of our comments, we believe there are serious flaws in the way CMS intends to calculate the savings that will be shared between Medicare and the ACO. While the narrative in the NPRM suggests a balanced partnership between Medicare and the ACO with the suggestion that the ACO will actually be able to obtain more than 50 percent of the shared savings, the way CMS proposes to calculate the shared savings means the principal beneficiary of reduced cost will be Medicare with little of the savings being retained by the ACO.

We believe the ACO should be able to share in the total savings achieved by the ACO for Medicare, not just for those savings attributable to the "assigned" patients. In the event CMS determines that retaining the retrospective assignment is preferable, a mechanism should be developed to allow the organization – and not just Medicare – to share in the total Medicare savings.

We believe it would be technically feasible to calculate a benchmark for ALL Medicare patients seen within the ACO, not just one for the Medicare patients attributed. CMS could calculate an average cost per beneficiary as well as an average savings per beneficiary for the ACO and base the shared savings on that average. CMS already uses an average cost per beneficiary model for determining Critical Access Hospital, Rural Health Clinic and Federally Qualified Health Center

reimbursement, and we believe these principles could be applied for determining an average cost per Medicare beneficiary for the ACOs.

As it stands, we estimate that Medicare will be the beneficiary of between 60 percent and 75 percent of the shared savings achieved by the ACO and the ACO will only retain between 25 percent and 40 percent of the shared savings.

Recommendation 6.

CMS should develop a shared savings formula that provides for a more equitable distribution of the shared savings between Medicare and the ACO.

Impact of ACOs on healthcare availability

Finally, it seems quite apparent that the greatest savings that will be achievable by an ACO will come in the form of reduced hospitalization of Medicare patients and reduced Emergency Department utilization by Medicare patients. This has serious implications for the long-term viability of many hospitals and EDs throughout the United States.

Hospitals and EDs have very high fixed costs for operation. Hospitals must sufficiently use their inpatient capacity simply to cover the fixed costs of the institution. Failure to maintain a minimum level of occupancy threatens the economic viability of the institution. This is particularly true for small rural hospitals. In addition, EDs are increasingly becoming a source of "profit" within the hospital system and the excess revenue generated in an ED is often used to subsidize less profitable services within the hospital.

Recently, we heard a CMS official state that there was a lot of waste in the healthcare delivery system and the goal of the ACO was to get rid of that waste. We certainly concur with that assessment. But it cannot go without saying that one person's "waste" is another person's "extra revenue to pay for services not adequately compensated by Medicare, " especially in small facilities needed to maintain access even though their low volumes produce relatively high fixed costs..

In other words, most healthcare providers do not retain these "wasteful" dollars but rather use these revenues to help sustain the availability of "unprofitable" services or to sustain the entire organization.

If, as expected, Medicare hospital admissions and ED utilization by Medicare patients goes down, many hospitals will be hard pressed to meet their fixed operational cost requirements. Certainly, small rural hospitals threatened by this prospect would be incentivized to want to join an ACO as a defensive position against reduced revenues. In this scenario, the hospital joins or forms an ACO in hopes that the "shared savings" realized by the organization will be sufficient to offset the lost revenue from reduced utilization. But as noted above, given the way the formula will work, the organization may be losing 75 cents of ever dollar it can "save." Eventually, this is an economically losing proposition.

As with HMOs in the '80s and '90s that did not want to pay for Graduate Medical Education costs but only costs associated with the actual care delivered to "their" patients, CMS appears headed down a similar path. If something is generating revenue above what the actual cost for the care of a patient – no matter how laudable the use to which that revenue is being put – it must be taken out of the system. But we would ask, at what larger systemic costs?

Will ACOs feel financial pressure to close "unprofitable" facilities that improve access and availability of care? Will ACOs feel financial pressure to close unprofitable services causing patients to drive many miles to obtain specialized services or simply go without?

We suspect that the answer to both questions will be yes. The move towards more "accountable" care will result in the closure of many outpatient facilities deemed "unprofitable" and the discontinuation of specialized services deemed "unprofitable."

NOSORH recommends that CMS adopt its recommendations in this submission to provide the best chance for safety net providers to remain viable in an ACO environment.

ACOs and CAHs

Finally, we must point out the unique disincentive that may exist for an ACO to include Critical Access Hospitals in their ACO network. As was previously noted, Critical Access Hospitals are reimbursed on a cost basis. Specifically, CAHs receive Medicare payments equivalent to 101 percent of their costs.

If, as expected, the ACO institutes initiatives that result in fewer inpatient hospital stays or fewer trips to the CAH's ED, there is no financial benefit to Medicare if the "unnecessary" hospital stay or ED visit would have been in a CAH. Whether a CAH is at 80 percent occupancy, 60 percent occupancy or 30 percent occupancy, there is little change in the cost (other than some marginal costs associated with some patient specific services while in the CAH). A similar situation exists with the CAHs ED.

The cost per beneficiary may go up but for the most part, the total costs remain largely the same. Therefore, unlike a PPS hospital where an unnecessary admission can result in a savings to Medicare, that is not the case in a cost-based institution such as a CAH. The CAH will still get 101 percent of costs at the end of the year. Similarly, eliminating an unnecessary ED visit in a tradition, fee-for-service ED can save Medicare money, but in a cost-based ED, that's not the case.

General Rural Physician Comments:

Physicians working in rural and/or underserved areas face different issues than their counterparts in well-served communities when trying to improve health services.

For example, if a community needs four physicians to adequately serve its patients and there are only two physicians available in local practice, that practice will likely be at full capacity. It will likely emphasize the provision of basic acute care services to as many patients as it can. In this shortage environment, it would be difficult to free up physician time to handle the duties associated with health improvement. Efforts directed toward chronic care management, preventive medicine and health promotion, as necessitated by outcome-oriented programs, would likely require the use of non-physician staff, working in a re-engineered practice operation.

Re-engineered practice operations emphasizing the use of non-provider staff will be particularly important for Rural Health Clinics and Federally Qualified Health Centers, which operate in designated underserved areas with limited resources.

However, this enhanced use of non-physician staff will become increasingly important in *all* communities in the near future. Projections of physician supply through 2020 show significant shortages in the nation, with primary care physicians being in particularly short supply. In light of this nationwide shortage, it will be particularly important to have demonstrations showing how physicians in underserved areas can successfully improve coordinated care and improve patient health. Demonstrations of ACOs *designed* to work in underserved areas could be important models for the entire nation.

Recommendation 7:

1. CMS, though its Center for Medicare and Medicaid Innovation, should continue to work with providers and patients practicing and living in rural underserved areas to develop ACO models specifically designed to meet the unique healthcare delivery challenges facing rural underserved areas.

   We encourage CMS to adopt changes related to Rural Health Clinics earlier in these comments. These comments address issues related to physician and RHC participation in ACOs. Because of the ACA statutory exclusion of non-physician providers as a locus of patient assignment in the Shared savings program, we encourage CMS to develop other models that allow assignment based on non-physician provider, where consistent with state occupational licensing laws. These providers are essential and often the central patient point of contact in Rural Health Clinics, Critical Access Hospitals and other facilities.

2. CMS should modify the proposed rules to create better ACO participation and incentive arrangements for rural physicians and physicians practicing in underserved areas. These arrangements should include:

   Rural and Underserved Area Physician Inclusion Incentives: additional incentives, including bonuses and higher shared savings rates, for ACOs which include significant numbers of rural residents and rural physicians or significant number of underserved areas or physicians who serve underserved areas.

Rural and Underserved Areas Physician Participation Incentives: additional incentives, including bonuses, to provide financial incentives for rural physicians and physicians in underserved areas to affiliate and participate with regional ACOs.

Adjusted Performance Incentives for Rural Physicians or Underserved Area Physicians: modified performance measures to be applied to rural physician practices and underserved area physician practices with specific performance improvement incentives tied to these measures.

Conclusion

We want to reiterate our belief that moving to a more integrated delivery model has great potential benefit for patients and payers. But it comes with certain risks.

We want to encourage CMS to develop, through its existing demonstration/innovation authority, some rural-specific ACO models that have clinical and financial incentives that reflect the unique challenges of delivering high quality, low-cost care in rural communities.

If the ACO initiative is going to be successful, we must be vigilant to ensure that:

1. Quality is more important than cost-savings
2. Payers and providers are equal partners in improving quality outcomes and reducing costs
3. Access to care is not sacrificed to cost savings.

Your consideration of these comments and recommendations is greatly appreciated.

If you have any questions, please do not hesitate to contact us.

Sincerely,

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