NOSORH

National Organization of
State Offices of Rural Health

October 16, 2018

TO: Centers for Medicare & Medicaid Services

SUBJECT: CMS 1701-P Proposed Pathways to Success for the Medicare Shared Savings Program

The National Organization of State Offices of Rural Health (NOSORH) is the membership association of the fifty State Offices of Rural Health (SORH). Our mission is to work with the fifty State Offices of Rural Health to improve health in rural America. State Offices of Rural Health are anchors of information and neutral observers and conveners for rural health. SORH are dedicated to addressing the issues that impact access to care and ensuring the vitality of hospitals, clinics and providers who serve nearly sixty million rural Americans. SORH support collaboration, information dissemination and technical assistance to rural health care providers across the nation including accountable care organizations, critical access hospitals, certified rural health clinics, and other providers.

NOSORH submits these comments are to ensure issues that the unique issues which impact rural ACOs continue to be able in their essential work to reduce costs and increase quality of care. Thank you for the opportunity to comment. If we can provide additional information on the impact of proposed regulations for rural and underserved communities and the providers who serve them please feel free to email teryle@nosorh.org or call for assistance.

Sincerely,

Teryl Eisinger

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NOSORH Comments on CMS Revisions for the Medicare Shared Savings Program – Accountable Care Organizations

Overview

On August 17, 2018 the Centers for Medicare and Medicaid Services (CMS) published proposed rules entitled Medicare Shared Savings Program (MSSP) - Accountable Care Organizations (ACOs) - Pathways to Success (CMS–1701–P). In this communication, the National Organization of State Offices of Rural Health (NOSORH) makes comment and recommendation related to these proposed rules.

NOSORH's comments are specific to the sections of the proposed rules which would reduce the permitted term of ACO participation in the Track 1 – upside only category. The comments also pertain to the proposed changes to Medicare payments for ACOs in an upside-only category. The comments will explore how the proposed rules will affect rural ACO participation in the ACO. The comments are followed by specific recommendations about how CMS might modify its proposals to assure continued participation of rural health care providers in the MSSP.

General Comments

NOSORH has assessed the current status of rural health care providers in MSSP ACOs. Based upon this assessment NOSORH has identified the likely implications of the proposed changes on rural ACOs. This analysis is summarized in the following comments.

Rural ACOs - Description

A substantial number of Accountable Care Organizations currently in operation include rural health care providers. An August 2018 report from the Rural Policy Research Institute (RUPRI) indicates that in 2017 53 ACOs include a provider group that is either exclusively or largely located in non-metro locations. This represents 10.2% of the 520 total ACOs in the enumeration. An additional 144 ACOs include a mixed metro/nonmetro provider group. This means that an additional 27.7% of the total number of ACOs are having some rural impact.

A January 2018 CMS estimate, cited by Caravan Health, indicated that 66 of 561 MSSP ACOs (11.8%) had participation by some rural providers. This estimate is consistent with the 2017 RUPRI enumeration for ACOs with health providers either exclusively or largely located in non-metro areas.

Almost all the rural ACOs are currently in Track 1. The RUPRI report indicates that almost all ACOs that include rural providers are in the Track 1 - upside only category. 50 of the 53 ACOs (94%) with health providers largely or exclusively from rural locations are in Track 1. 124 of the 144 ACOs (86.1%) with mixed rural/urban health providers are in Track 1. Both percentages are higher than the 84.8% of *all* ACOs in Track 1.

Rural ACOs – Cost of Operation

The costs of participating in the MSSP are substantial. A survey of all ACOs conducted by the National Association of Accountable Care Organizations (NAACO) indicated that, on average, each MSSP ACO is spending over $1.6 million on marginal costs associated with being an ACO. Costs include infrastructure costs

such as training and modifications to data systems. While this average figure covers a range of different individual ACO levels of expenditure, the same survey showed that 87% of all ACO respondents replied that their investments in ACO startup and operation were either significant or very significant.

These additional costs are an important factor affecting the potential return on investment of participating in the MSSP. If shared savings cannot offset these additional costs, an ACO will be facing a net loss. Despite this reality, CMS does not fully consider the additional costs associated with ACO operation in its calculations for the program.

Rural ACOS face greater cost challenges than do many urban ACOs.
Rural ACOs generally have lower patient volumes than do urban ACOs. As a result, the implementation cost per patient in rural ACOs is higher. It may be prohibitive. Many rural ACOs need support to be able to cover these costs.

The importance of upfront costs for rural ACOs is indicated by the significant number of rural ACOs supported under the ACO Investment Model (AIM) initiative - a one-time program which supports infrastructure development for rural or underserved area ACOs established in or before performance year 2016. According to a RUPRI study, in 2017 75% of ACOs with health providers exclusively in rural locations were AIM participants. 35.6% of ACOs with health providers largely in rural locations were AIM participants. 11.1% of ACOs with mixed rural/urban health providers were AIM participants. These numbers point to the disparate challenges faced by rural ACOs in managing the costs of running an effective ACO.

It should be noted that ACO ***costs*** are not limited to ACO patients. ACOs will generally implement system-wide infrastructure changes for all patients, not just ACO enrolled patients. For example, data processing improvements will often be system-wide for participating providers. In this way, ACO ***benefits*** will not be limited to ACO enrolled patients. The changes in infrastructure and systems will likely lead to improvements for all patients of participating providers. These benefits, including quality and cost improvements, are not part of the measurement and assessment of the MSSP.

<u>Rural ACOs – Resulting Savings</u>
'Savings', as calculated for ACOs are the difference between actual patient cost and the historically benchmarked patient cost for ACO enrolled patients. With smaller enrolled patient populations such as those in rural ACOs, the historical costs of an enrolled population may be volatile. If a relatively small number of patients develop serious new health problems, the service costs for the enrolled population could quickly surpass the benchmark. This will likely put smaller rural ACOs at greater risk than larger, urban ACOs for failing to reduce estimated costs.

Despite this challenge, several studies indicate that rural ACOs can achieve substantial Medicare savings for their enrolled patient population. These savings are achieved by ACOs that are largely Track 1, upside only organizations:

In a key study, a CMS evaluation of the AIM Program showed that in their first performance year AIM ACOs showed lowered Medicare spending with no sign of decrements in quality of care. The study showed that ACOs with upside-only financial risk in rural areas can, with up-front funding and management company support, achieve MSSP aims. In 2016, 41 AIM ACOs demonstrated $105.4 million in reduced total Medicare spending relative to similar traditional Medicare beneficiaries in the same geographic area. 30 of the 41 ACOs had lower total Medicare spending than the baseline for their enrolled patients. The AIM ACOs showed $82.8 million in net savings to the Medicare Program after subtracting earned shared savings.

A follow-up study of AIM ACOs showed similar savings performance for 2017. In that year 45 AIM ACOs – including several new first year ACOs – demonstrated a total of $81 million in lower Medicare spending. The AIM ACOs had a lower per capita spending of $172 per year, a figure which surpassed the $138 per year savings of Track 3 ACOs in the MSSP for the same period. This indicates that the downside risk assumption is not a predictive factor in the savings performance of ACOs, and that the performance of rural ACOs in Track 1 is significant even without downside risk assumption.

Several other studies point to key factors for rural ACO success. Some studies point to year-to-year improvement in ACO performance, demonstrating an operational learning curve. Other studies show differences between physician-only ACO organizations and hospital-inclusive ACOs. A few studies have suggested that ACOs supported by professional management companies fare better than do others which do not. What seems clear is that understanding of ACO savings performance is just beginning to emerge. It may be premature to make major MSSP changes, particularly if rural ACO participation in the program is to be maintained.

As mentioned previously, the Medicare savings gained from ACO operation is not limited to ACO enrolled patients. As discussed in the MSSP Pathways to Success proposed rule, CMS estimates that the overall impact of ACOs, including "spillover effects" on Medicare spending outside of the ACO program, lowered spending by $1.8 – $4.2 billion (0.5 – 1.2 percent) in 2016 alone. These analyses provide important evidence that ACOs save *more* money for Medicare than what is reflected in the basic evaluations of performance.

It should be noted that those ACOs which fail to achieve savings over their enrolled patients' benchmarks do not actually '*lose*' money. These ACOs only fail to achieve targeted savings. Services to ACO enrolled patients are paid on the same fee for service payment schedule that is used for non-enrolled patients. Should ACOs leave the MSSP these patients would continue to cost Medicare the same. The exit of ACOs from the program would simply eliminate incentives for reducing cost and improving quality in the future.

Readiness of Rural ACOs for Risk Assumption

A survey conducted by NAACO of all MSSP ACOs indicated that most of the ACOs in Track 1 would likely leave the MSSP if they were to prematurely lose the 5% APM incentive for participation. This survey showed that only 33% of respondents in Track 1 would be somewhat likely or very likely to continue their participation. The potential drop in Track 1 ACO participation in the MSSP would be even greater if these ACOs were further forced to assume downside risk. A 2018 NAACO survey indicated that 71% of all Track 1 ACOs would likely leave the MSSP if forced to assume downside risk. Given that 86% of rural ACOs are in Track 1, elimination of upside-only risk arrangements would likely lead to an exodus of most rural ACOs from the program.

Being accountable for health care does not necessarily require the inappropriate assumption of risk. While rural ACOs, as a cohort, have demonstrated the ability to generate Medicare spending reductions, in any given year some rural ACOs may not be able to achieve savings. If they were to be forced into inappropriate assumption of losses, they might face financial challenges in those years. Inappropriate assumption of risk by fragile rural provider organizations could threaten rural health system sustainability and runs counter to the purpose of the ACA – improving access to affordable, quality health care.

Summary

NOSORH believes that the aim of the MSSP in rural areas should be to permit ***widespread participation of rural health care providers in accountable care payment mechanisms***. This does not necessarily involve the assumption of inappropriate risk. While some rural ACOs are ready to assume a level of downside risk, a larger number may not be immediately able to make this transition. In addition, required assumption of inappropriate risk may create disincentives for other rural health care providers from joining into new ACO arrangements.

NOSORH believes that incentive mechanisms should be maintained to permit rural ACOs to generate Medicare savings on a discontinuous basis – allowing shared savings in some years while not putting rural health services at risk in years when no savings are forthcoming. This would require continuation and enhancement of the Track 1 type payment arrangements. NOSORH believes that these arrangements are a net benefit to Medicare. They would permit patient payment savings in some years and would cost no more than patient payments on the current fee for service schedule in others. In line with this perspective NOSORH makes the following recommendations to CMS.

Recommendations

In line with the analysis discussed previously, NOSORH makes the following recommendations to CMS.

Recommendation 1 - Maintain Current Track 1 Incentive Structure: NOSORH believes that the current multi-year participation arrangements give rural ACOs realistic term for implementation of accountable care systems. **NOSORH recommends that CMS maintain the existing track 1 structure and incentives for both continuing and new rural ACOs.**

Recommendation 2 - Maintain Eligibility of Track 1 ACOs for APM Incentives: NOSORH believes that participation in a Track 1 ACO shows a commitment of a health care organization to accountable care. Track 1 ACOs have been shown to generate savings for Medicare with no loss of quality. **NOSORH recommends that CMS maintain the eligibility of Track 1 ACOs for Alternative Payment Model (APM) incentives and MIPS exclusions.**

Recommendation 3 - Permanent Extension of Track 1 ACO Arrangements: NOSORH believes that assumption of downside risk is not essential for successful accountable care. NOSORH feels that rural ACOs can contribute to accountable care and to Medicare savings on a continuing basis while operating as Track 1 ACOs. **NOSORH recommends that CMS consider allowing ACOs to operate with Track 1 – upside only - arrangements on a permanent basis.**

Recommendation 4 - Additional Support for Costs of ACO Participation: NOSORH recognizes that all ACOs face substantial implementation and operational costs. These costs can make ACO participation prohibitive for many rural ACOs, particularly those in underserved areas. NOSORH recommends that CMS use the lessons of the AIM program to develop new support mechanisms for ACOs in rural and underserved areas.