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Dr. Donald Berwick
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
P.O. Box 8013
Baltimore, MD 21244-8013
Submitted via: **http://www.regulations.gov**

Subject: CMS-1345-P Accountable Care Organizations & Medicare Shared Savings Program

Dear Dr. Berwick:

The Rural Wisconsin Health Cooperative (RWHC) appreciates the opportunity to offer our comments regarding Accountable Care Organizations (ACOs) and the Medicare Shared Savings Program (MSSP). We are directing our comments to the proposed rule with the overall view that it is fundamentally incompatible with rural health care's need to maintain critical access to vital health services for a local populace. RWHC believes that Centers for Medicare & Medicaid Services (CMS) should rethink the concept of ACOs in rural communities and at the very least, test the proposed structure for an ACO, with potential changes that we address below, through a demonstration project.

Established in 1979, RWHC is owned and operated by thirty-five, rural acute, general medical-surgical hospitals. Our vision that rural Wisconsin communities become the healthiest in America has led us to a twin mission of advocacy and shared services. We are proud to be part of the Wisconsin health care tradition that has long promoted and embodied lower-cost and high-quality health care.
The underlying goals for ACOs are important for our country's health care system, rural and urban alike.

We understand that if ACOs are successfully implemented, they will fundamentally change how beneficiaries, providers, private health insurance plans and CMS relate to and work with each other. We agree with CMS that "providers can work together to better coordinate care for patients, which can help improve health, improve the quality of care, and lower costs." **These are important goals that all health care providers should want to attain, but as these relationships change, there is also significant risk to beneficiaries' access to local care and to the ability of rural hospitals and doctors to provide local services.**

RWHC has more experience with ACO-like entities than most rural provider coalitions given Wisconsin health care's strong history of integrated and coordinated care. Of our thirty-five members, fourteen are members of a health care system and twenty-one remain independent; to various degrees they all work with multiple payers and medical groups. We also started a rural-based HMO in the 1980s and subsequently merged it with an urban based health plan.

Provider Assignment

First and foremost, we believe CMS must assure that ACOs recognize the uniqueness of health care in rural communities when it comes to primary care providers. Unlike most urban communities, there are usually not enough providers in rural areas to support multiple ACOs having closed provider networks competing with each other. Many rural communities are located in areas that will have the potential for overlapping ACOs with multiple urban-based networks. **To retain local access, rural communities need local providers to be able to offer their services to multiple ACOs.**

RWHC believes that the proposed rule has a significant defect in terms of physician assignment exclusivity in the ACO model. Many providers cover large geographic areas and coordinate the care of their patients with multiple facilities based on the convenience of the patients they serve. Allowing physicians in these rural areas to participate in multiple ACOs provides the needed flexibility for rural environments and ensures meaningful access for Medicare beneficiaries residing in rural Wisconsin.

We recognize that the initial attribution model is retrospective in nature. However, we are concerned that forcing rural primary care physicians to align with a single ACO will have the long term effect of splintering rural health into various subparts, each dominated by a single ACO.

We believe CMS could develop a two-step attribution model for rural primary care physicians: first, costs are divided amongst primary care physicians; and then second, you attribute the costs between two or three ACOs depending on which ACO's specialist predominated with that primary care physician's patients. This would require specialists to declare a principle ACO affiliation as primary care physicians are asked to do. You would also have primary care physicians declare a primary ACO affiliation in case of patients with no specialty care rendered.

CMS should develop and test a rural model in addition to the proposed urban-centric model. The current lack of a rural ACO model reminds us of when CMS introduced the wage index and every MSA got its own index and the rest of the state was thrown into one pot of leftovers.

ACOs Effect on Rural Health Care

It must be recognized that ACOs have the potential to destabilize the existing rural safety net. Once we are beyond the initial gain-sharing pilots, it is not known whether or not ACOs will be required to honor existing Medicare rural add-on payments for safety net providers such as Critical Access Hospitals (CAH) and Rural Health Clinics (RHC). CMS needs to be very thoughtful (concerned) how the model will evolve in commercial insurance markets and/or future iterations under Medicare.

In the future, some regional ACOs could be able to negotiate payment rates with local rural providers that are at levels below the rates the providers currently receive under Medicare. This is a process that presents more risk to rural areas where providers may have little managed care type contracting experience and little or no negotiating power. It would probably be most evident in those areas where ACOs may be able to steer patients to other contracted providers. Under traditional Medicare, many rural providers receive special payment rates to reflect the various financial challenges of providing health care in rural areas. There is a concern that future iterations of the ACO model will not recognize these targeted rural special payments that have been part of stabilizing the rural safety net and provided quality health care to Wisconsin residents.

The enforcement of Community Access Standards is absolutely critical to prevent steerage of Medicare beneficiaries and inordinate leverage by Medicare ACO plans against rural providers. While the first generation of Medicare ACOs proposes to use a retrospective attribution model, it is reasonable to expect CMS to evolve the model over time to a prospective attribution model, requiring closed provider networks. To that end, it is important that the first generation of ACOs meet strong access standards. CMS and Wisconsin have previously dealt with this issue in the context of managed health care regulation. Wisconsin Statute 609.22. requires health plans (with closed provider networks) to respect "...normal practices and standards in the geographic area," and Wisconsin Insurance Code 934 (2) (a) requires, with respect to managed care plans, "geographical availability shall reflect the usual medical travel times within the community." The current CMS language for Medicare Advantage plans is similar.

There is much uncertainty in our country and the health care field (maybe too acutely felt in Wisconsin given our own much reported political conflict and uncertainty). While we understand some of the general direction, we just don't know what exact forms reform will or will not take. So we need to encourage all of us in rural health to look to strengthen the core competencies of doing more, better for less—and that the only way that can happen is through significantly greater care coordination and population health focused prevention, using a full range of corporate integrated and virtual collaboration models.

Wisconsin's health care model has worked well, according to the Dartmouth Atlas; Wisconsin was more than 15 percent below the national average in total Medicare reimbursements per enrollee in 2006. In addition to Wisconsin hospitals being a leader in lowering costs, they have been ranked in the top two for quality by the Agency for Health care Research and Quality in each of the last three years.

Organization of ACOs

It is important to make sure that all rural hospitals are allowed to fully participate in ACOs. Under the Patient Protection and Affordable Care Act (ACA), CAHs were not included in the CMS ACO demonstrations for purposes of sharing in the cost savings, and presumably governance. We appreciate that in the proposed rule that CMS allows for CAHs, billing under method II, would have the opportunity to form ACOs independently. However, why exclude CAHs that use standard billing or other Medicare enrolled entities such as FQHCs and RHCs?

If all rural hospitals and health care facilities cannot become full participants in ACOs, the ACO model may quickly evolve into a mechanism of exclusion for local rural health care. Rural beneficiaries might end up in ACOs, which do not allow them to receive care available in their home community. Protecting access to local care must be a high priority. We do not want to see a similar occurrence to what happened with the start of the Prospective Payment System (PPS), where the PPS model simply didn't work for many rural providers and 20 years of making technical fixes showed it was either not doable or administratively too complex to create a relevant rural model. The result was the creation of the CAH and Frontier programs, but only after many rural communities lost their hospitals and their local health care access.

The current Medicare Advantage program statutes and regulations have required CMS to ensure that plan enrollees have reasonable local access to covered services. It is hoped that CMS will use a similar standard for any ACOs with closed networks. If so, we would place emphasis on how CMS and ACOs interpret what is "reasonable," as being critically important to rural beneficiaries and providers, as well as to the acceptance of Medicare plans in rural communities. As stated in the CMS Medicare Managed Care Manual: "Plans must…ensure that services are geographically accessible and consistent with local community patterns of care." It is critical that CMS be clear and transparent about how it intends to apply this principle to Medicare's initial and subsequent generation of ACOs.

Further, the startup costs for the ACO model also seem prohibitive when assessed from a cost-to-benefit rationale because rural facilities may not be able to take on the additional risk involved with ACOs. RWHC recognizes CMS's need to offset payments for savings and incentivize better processes, care, and efficiency; however, rural facilities operate on a smaller budget and a smaller margin than their urban counterparts. Such large startup costs, whether due to legal services, enhancing data collection or any other number of necessary activities, coupled with the prospect of losing money, is enough to discourage participation by the majority of rural facilities and all but guarantees that they will not initiate the establishment of a purely rural ACO.

Benchmarking

It is important to improve the benchmark formula used in the ACA to measure ACOs progress. RWHC believes it is crucial to recognize that different regions of the country have placed a greater degree of emphasis on improving health care quality while slowing the growth of health care costs; Wisconsin has made such an effort and should not become penalized by being compared to itself, especially in establishing a baseline as Wisconsin health systems seek continued improvements.

We believe benchmarking should not only measure improvement relative to an ACO's own claims data, but also improvement relative to national average expenditures. Weighted equally, this will reward those ACOs that lead the nation in delivery of high-quality care, and provide a stronger incentive for those ACOs with higher costs and lower quality to compete for a greater share of savings.

Further Program Redesign

In looking at further program redesign features of an ACO, RWHC reviewed the National Committee for Quality Assurance's (NCQA) development of a private ACO model. RWHC supports the five guiding principles that the NCQA ACO Task Force set forth, that **ACOs must: have a strong foundation of primary care; report reliable measures to support quality improvement and eliminate waste and inefficiencies to reduce cost; committed to improving quality, improving patient experience and reducing per capita costs; work cooperatively towards these goals with stakeholders in a community or region; and, create and support a sustainable workforce.**

We would strongly echo the need to strengthen the country's primary care workforce and make sure that primary care workforce is adequately stocked in rural America. RWHC has been a leader both at the state and federal level on the need to improve the health care workforce in rural areas. Without a strong rural health care workforce, residents will not be able to receive care in a timely and convenient manner (a preference that has been well-documented), and the ACO model will not be successful.

As previously noted, RWHC would encourage CMS to pursue a rural demonstration project of the ACO model first. Some have referenced the CMS Physicians Group Practice (PGP) Demonstration, as sharing design elements that are consistent with the MSSP. The PGP demonstration was conducted by CMS from 2005 to 2010, using a hybrid payment model that consisted of routine Medicare fee-for-service payments plus the opportunity to earn bonus payments known as shared savings. In Wisconsin, Marshfield Clinic was a PGP participant, and while they are widely respected in the Wisconsin health care sector, participating in the PGP they spent millions and were one of a few to see shared savings throughout the demonstration. It is even more telling that they are currently looking to continue in the PGP instead of becoming an ACO early adopter.

CMS is proposing 65 measures to measure quality performance; measures fall under five domains: patient/caregiver experience, care coordination, patient safety, preventive health, and at-risk population/frail elderly health. ACOs that do not meet the quality performance thresholds will not be eligible for shared savings regardless of cost reductions. Quality reporting is the way health care is moving, and should move, but in the previously mentioned PGP demonstration, many less measures were first required and then increased, but still not reaching 65 measures by the end of the PGP project. Consideration of ramping up reporting measures over a period of time might be advisable and not as cost-prohibitive for a fledging ACO.

Finally, according to the widely respected Deloitte Analytics Institute they believe the attribution of 5,000 Medicare beneficiaries for a qualifying ACO may not be a workable threshold and argue, for scalability, it is likely ACOs will need to manage at least 20,000 Medicare lives. It is unlikely that a non-urban anchored ACO could ever attain that many lives in a workable coverage area.

CAHs are a valuable safety-net provider for almost 60 communities in Wisconsin and for more than 1300 communities across the county. If you add in the number of smaller PPS rural hospitals, the number of affected communities grow even larger that will not have the ACO's required 5,000 Medicare beneficiaries, let alone the actuarial sound lower limit of 20,000. Might there be alternative grouping or attribution of patient models that could better conform to providing quality rural health care?

The Rural Wisconsin Health Cooperative is pleased to have an opportunity to enhance this critical piece of policy that will help to strengthen strong health care services within Wisconsin and the nation as a whole. CMS has stated that it only intends for 5-10% of the hospitals in America to participate initially in the program and still faces considerable challenges in the formulation of ACOs; we would argue that rural facilities face a number of challenges with meaningful participation in the program as currently structured. CMS needs to create positive, workable rural solutions that reward better care at a more reasonable cost. ACOs are an important part of health reform in America, but as currently defined by CMS; RWHC believes they are largely impractical for most of rural America.

Sincerely,

Tim Size

Tim Size
Executive Director