Community Care Alliance

October 2, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: The Medicare Shared Savings Program Proposed Rule (CMS-1701-P), "Pathways to Success"

Dear Administrator Verma,

I am writing to share a rural perspective on the Medicare Shared Savings Program Proposed Rule (CMS-1701-P), "Pathways to Success." I represent the Community Care Alliance (CCA) and the multiple rural healthcare provider networks the CCA supports. Our members currently participate in two Track 1 MSSP ACOs. While we applaud the effort to update the MSSP, we feel the current proposal fails to support the new CMS Rural Health Strategy. Rural participants are risk adverse and need more time in a shared savings-only model.

The CCA is a rural population health services organization that manages accountable care organizations, clinically integrated networks and practice transformation initiatives. The CCA assists rural hospital networks and their community practice providers in transitioning to value-based reimbursement. We currently work with over 500 practitioners and represent over 150 rural hospitals, independent practices, federally qualified health centers and rural health clinics located in seven states.

The MSSP is one of the few Medicare alternative payment models focused on transforming an entire medical community and not just a single practice or hospital. This approach is ideal for rural communities where the hospital is usually one of the largest employers in the county and many of the local primary care practices remain independent. The MSSP makes rural collaboration on decreasing cost and improving care while maintaining independence a real possibility for rural primary care providers and facilities.

As the MSSP continues to evolve and advance, it is imperative the Administration consider the impact of proposed changes on the likelihood of rural participation. The MSSP may be the only Medicare alternative payment model option that is reasonably financially feasible for rural providers to currently participate in. It allows integration and collaboration across specialty and facility types, but for rural providers to continue, they must be able to participate at a level that doesn't threaten their bottom line. Many rural hospitals operate with near negative net patient revenue margins and simply have no reserves to cover any risk. What little they have is being invested in infrastructure. Being forced to assume risk will result in discontinuation in the program for these rural providers.

The rural communities the CCA works with have sizable Medicare populations that are sicker and more costly than comparable Medicare population sizes in urban areas. Rural providers and facilities are asked by Medicare to do more with less and still achieve a high quality of care. Luckily, the rural providers working with CCA are performing well on the MSSP quality metrics. Our ACOs demonstrate an average quality score of 95 percent after just two performance years. These two ACOs have managed to save CMS over $6 million since 2016 and have yet to achieve shared savings. With this much savings to date and no shared savings, the Administration should understand why decreasing the share of savings from 50% each year to 25% for two years disincentivizes rural participation. To be moving in the right direction and be so close, imagine how these providers and facilities felt after learning shared savings was cut in half in the Proposed Rule.

The Proposed Rule predicts a decrease of only 20 ACOs in 2019. This prediction is incredibly low. There are currently 45 ACO Investment Model ACOs, all comprised of almost entirely rural participants. Many of these ACOs are averse to risk and will be unable to continue in the MSSP, as proposed. A recent National Association of ACOs (NAACOS) survey found 72 percent of respondents reported they were likely or highly likely to leave the program if required to take two-sided risk. ACOs have been shown to generate sizeable savings for CMS, the Proposed Rule should ensure continued participation in the MSSP, not incentivize leaving the program.

A decrease in rural participation in alternative payment models could inadvertently create an urban-rural gap in preparation for value-based reimbursement models, but more importantly, it could stifle the progress CMS has already made in reducing the cost of care and saving millions of dollars in rural markets. Rural providers are meeting the quality metrics and bending the cost curve, but they lack the cash reserves to enter risk arrangements. The MSSP should reward rural providers for being intrinsically value-driven in their work by creating a track or glide path that allows for a special consideration in a non-risk environment.

I look forward to submitting more detailed comments to the agency in response to the proposed MSSP "Pathways to Success" Proposed Rule. The networks I represent agree with many of the guiding principles of the Proposed Rule; however, our hope is that the Administration can adequately alter the Proposed Rule to make rural participation feasible. Our ACOs are among the highest performing ACOs in the country in terms of the quality of care provided to Medicare beneficiaries. Please support this progress by ensuring the updated MSSP includes options for high performing rural ACOs that are unable to assume the proposed levels of risk.

Sincerely,

Connie Mack
Executive Director
Community Care Alliance