December 3, 2010

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1345-NC
PO Boc 8013
Baltimore, MD 21244

Re: CFR Chapter IV (CMS–1345–NC) Medicare Program; Request for Information Regarding Accountable Care Organizations and the Medicare Shared Savings Program

The National Organization of State Offices of Rural Health (NOSORH) is the membership organization for the country's 50 State Offices of Rural Health (SORHs). Each state maintains a State Office of Rural Health that focuses on improving access to, and quality of, health care for its rural population. NOSORH appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services' (CMS) request for comments on its initial rulemaking efforts related to the establishment of the Medicare Shared Savings Program and the testing of payment and service delivery models through the newly established Center for Medicare and Medicaid Innovation.

NOSORH believes the recently enacted Affordable Care Act holds great promise for improving the delivery and quality of health care for America's 60 million rural citizens. This rule making is truly the key to ensuring the intent of health reform legislation. NOSORH believes that the shared savings program and CMMI can support and enhance patient centered, data rich, proactive health care for the 60 million Americans who live in rural areas. CMS must be deliberate in its rule making to consider the unique needs of delivering care in rural America.

Health professional shortages, scant provider networks, lack of adequate/affordable health coverage, and other uniquely rural barriers contribute to poorer health conditions among rural populations. Rural areas continue to suffer from a lack of diverse providers to adequately address their communities' healthcare needs (USDHHS, 2009). Rural areas have half the number of physicians per 100,000 residents than those in urban areas (Fordyce *et al.*, 2007). For persons of all ages visiting their usual care provider, travel time was longer for rural than for urban patients; 14 percent of rural patients traveled more than 30 minutes (AHRQ, 2006). Rural citizens also have a greater reliance on – and thus, vulnerability to – government programs such as Medicare and Medicaid (Hospital and Healthsystem Association of Pennsylvania, 2009). Throughout rural America, more than 50 million people face challenges accessing health care (U.S. Department of Health and Human Services, 2009). Forty percent of rural citizens pay more of their healthcare costs out of their own pocket compared with their urban counterparts paying one-third of their healthcare costs out of pocket.

Hospitals in rural counties also contend with substantially more fluctuation and instability in demand for inpatient services from year to year than their larger urban/suburban counterparts. Average variability over time for the smallest facilities is nearly 60 percent higher than the average for all hospitals. This fluctuating demand can substantially affect hospital unit costs and operating margins, especially under fixed payment systems such as Medicare's PPS (Dalton, Holmes and Slifkin, 2003). Higher unit costs and slimmer operating margins make it even more challenging for rural hospitals to maintain/upgrade their physical and technology infrastructure.

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It must be said that, in general, rural providers across the nation have some level of skepticism regarding the ACO model. They have experienced network development efforts that have left their patient mix "cherry picked" and may have the general impression that most rural areas are too isolated, have too low patient volume, or poor access to reimbursement to make the development of meaningful networks of providers feasible. In answer to that concern and the questions posed by CMS in the call for comments NOSORH has relied upon the Commonwealth Fund's May 2010, Vermont Accountable Care Organization Pilot study as a frame of factual reference. Given the uniqueness of rural America's health care needs, NOSORH submits the following five general recommendations and considerations for review by CMS in development of its rulemaking.

A broad range of rural healthcare providers must be given the opportunity to participate. Rural America's health care system is dependent upon key safety net providers which are unique to rural America. There are over 1,200 critical access hospitals (CAH) and more than 4,500 rural health clinics (RHC) which rural Americans depend on for primary care. If these providers are not included in the shared savings program, the basic premise of what an ACO should do – provide patient centered care and easy handoffs among providers - are at the least compromised. Regulations must take in to account what will happen if these critical safety net providers are not included and what will happen if they are part of a network that is included in an ACO.

CMS should consider the ramifications and uncertainty which may result if uniquely rural providers are not part of an ACO. For example, if a CAH is not part of an ACO and patients that once received some of their care from that CAH then go to the ACO's affiliated hospital for all of their care, what impact does this have on the continued viability of the CAH? If an RHC and CAH join an ACO but are ineligible for shared savings, will they receive some sort of blended payment instead? Any proposed regulations must take in to account what happens if these critical rural safety-net providers are not part of an organization that chooses to become an ACO.

Multi-payer mix is critical to reducing and controlling costs in rural areas. Many providers in rural areas provide services in areas where there are simply not the 5,000 Medicare beneficiaries within the service area. The ACO model must ultimately include more that the Medicare population in order to obtain the necessary critical mass of patients in rural areas. While current ACO language authorizes the Secretary to use various payment models (including capitation), requiring a multi-payer mix is a critical requirement for reducing and controlling costs in rural areas. CMS should consider regulations that provide incentives to states that mandate Medicaid participation in ACO pilots through a state waiver.

Patient assignments/alignment must ensure patient centeredness. The Vermont pilot study concludes that in order to be successful, 60 – 70 percent of a provider's patients should be part of the ACO– particularly in rural communities. Achieving the necessary critical mass of patients needed to support shared savings and statistically meaningful performance measures is challenging in rural communities. The development of an ACO which serves rural communities may require the inclusion of multiple hospitals and larger health systems. Developing clusters of ACOs within states selected for demonstration programs could encourage the statewide infrastructure development that ACOs require. CMS should take into account that people traveling greater distances for their health care may live equidistantly from multiple hospitals, and that rural residents may have less of an "allegiance" with larger "centers of excellence." The degree to which individuals are assigned or aligned to specific ACO regions must also be carefully considered.

It is unclear how changes in payment methodology will affect the maintenance of networks– especially those with facilities located on the outer fringes of their networks. How will that affect the financial viability of these facilities – will they face the risk of losing patient revenue? And will payment services rendered by rural safety-net providers be treated as "out of network" payments similar to what currently occurs with HMOs? These issues must be carefully addressed. Policy development must take care to minimize disruptions that could actually reduce access in rural areas.

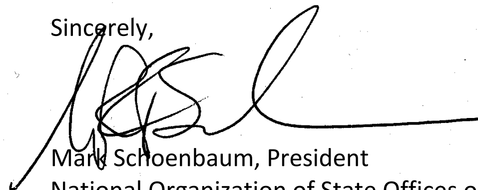
Quality measure sets must include rural-relevant appropriate measures CMS must recognize that quality measures applied in rural areas must be able to accommodate low patient volumes. Any efforts to benchmark should also reward improvement relative to a national measure and improvement relative to the ACO's own baseline. Different payment models should be applied to reflect different levels of ACO achievement of quality measures. For example, new ACOs would get paid similar to current models with some type of shared savings and then move to more sophisticated payment models as the organization evolves. Achieving the necessary critical mass of patients needed to support statistically meaningful measures of performance may require consolidated performance pool supports involving multiple payers and providers.

Limited access to capital. As stated in the Notice, the maintenance of financial management systems and robust data sharing capacities are major investments. CMS should foster financing models that take into account the disproportionately higher investments required by smaller practices to establish basic infrastructure that has a floor cost independent of scale. Funding should not be determined exclusively on a per capita basis; rather, it should be provided in a manner that enables rural providers to provide services, exchange information, measure performance and develop clinical/administrative leadership that ensures rural residents receive the same quality of care as their urban counterparts. CMS should consider encouraging shared savings models that in part attribute funds inversely based on practice size for both capital and operating needs. The cost-based and similar reimbursement systems available to some small or rural providers do have the benefit of compensating for the core infrastructure that are independent of scale; creative work is needed to blend these approaches with the performance-based models getting the most current attention.

Patient and caregiver experience. HCAHPS and other commonly used patient and caregiver satisfaction approaches are appropriate for small and rural providers across the continuum. The major issue, as noted above, is supporting payment models that will allow such providers to invest in the measurement capacity required to capture patient experience information.

On behalf of all 50 State Offices of Rural Health, thank you again for the opportunity to comment on these proposed policies and standards. Please know that NOSORH stands ready to work with CMS, policymakers and other rural healthcare advocates as a conduit of information to collect and disseminate information regarding rulemaking or in any other way to improve the delivery and quality of healthcare services for rural Americans. Do not hesitate to contact me, NOSORH Director, Teryl Eisinger teryle@nosorh.org, NOSORH Policy Committee Chair Lisa Davis (Pennsylvania Office of Rural Health, lad3@psu.edu) if you have any questions or require additional information.

Sincerely,



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