

The following are key findings from the CMS roundtable on accountable care in rural areas to explore how to integrate rural provider participation into the Medicare Shared Savings Program. Many of the recommendations identified are based on lessons learned from the [ACO Investment Model](#), authorized by Section 3021 of the Affordable Care Act. NRHA looks forward to continuing to work with CMS on the development of future rulemaking on this matter.

Element 1. Inclusion of upfront payments to enable rural providers to access capital to get started in ACO, especially with new starts/participants. The AIM ACO model was successful in bringing accountable care to new parts of the country by providing initial fund that gave them the ability to participate in the ACO model.

Element 2. Address the challenge of double-sided risk through longer lead time at one sided risk. Simply put, rural providers don't have the capital to afford down-side risk, nor frequently the capacity to analyze what the exposure would be. When you look at the lack of social infrastructure in rural areas, rural hospitals must be accountable for much more than their urban counterparts. Rural areas face generations of systemic underfunding, tying back to issues of health equity, combined with the dearth of social service infrastructure. This will likely mean that initial costs may increase, if not maintained at the same level, given increases in access to better care to a population that has been long deprived. However, over time the costs will decline which generates savings if reasonable timelines are established. For example, in the Pennsylvania Rural Health Model, more significant transformation is starting to develop in year four of the demonstration. Based on rural experience, a full contract period of at least 5 years before downside risk is important.

The AIM ACOs that took on only one-sided financial risk were consistently able to decrease spending and maintain quality for three straight years. Those that left the AIM demonstration tied to their perceived lack of readiness for financial risk-taking, which might have been addressed by a longer lead time. Research indicates that rural providers may have a higher risk tolerance if the following considerations are taken: inclusions of rural relevant measures and stop-loss or outlier protections, as well as opportunities to receive technical assistance, education, and to learn from peers. Lastly, greater flexibility to the model may be required as financial risk is increased.

Element 3. Considerations need to be made around how benchmarks are set in rural areas.

Almost all rural safety net providers are more expensive than the benchmark because their alternate payment methodologies and special payments. Experience to date has shown that working against individual spending has worked. It is anticipated that most rural safety net providers will be above an administrative or regional benchmark approach, as structured in the REACH ACO. Possible solutions may be to normalize safety net spend to the fee schedule. Currently, ACO cost calculations exclude IME and DSH from per-beneficiary costs. In theory they could also exclude/back out other special payments like the SCH 7.1% increase for outpatient services and the difference between CAH payments per DRG and PPS hospital payments per DRG.

To mitigate the impact of excessive variation in the regional adjustment on the benchmark, two actions may be considered. First, the maximum weight used in calculating the regional adjustment could be reduced from 70% to 50%. Second, the dollar amount of the adjustment could be capped at +/- 5% of the national fee for service per capita expenditures.

Beneficiaries who were assigned to the same AIM ACO over multiple years were associated with greater reductions in total Medicare spending compared to beneficiaries assigned non-continuously, though the

evaluation could not disentangle whether AIM ACOs were able reduce Medicare spending to a greater extent for continuously assigned beneficiaries or whether lower-cost beneficiaries were more likely to be attributed to the ACO over multiple years.

Other Considerations

- Lifting the cap on the 10,000-life limit that was in AIM. Studies show that for an ACO to work, there needs to be closer to 60,000 lives included to appropriately spread risk.
- Rural hospitals need to have a better understanding of waivers available to them as participants in the ACO. AIM participants could apply for waivers to Medicare rules and regulations that impedes their ability to coordinate care on behalf of the beneficiary they're serving. An example would be a hospital applied for, and received, a waiver from the inducement of referral rule to build a wheelchair ramp using hospital maintenance for a patient discharged home.
- Timeframes are critical to model success. Past efforts recommend: Reductions in time from model creation to model implementation and establishing model durations that are reasonably sufficient to achieve desired outcomes.
- Flexibility should be allowed to adjust the model based on new information. Further, transition to programs that continue successful parts of the model or allow a smooth transition to model substitution is critical.

Additional Questions for CMS consideration

- How will the AIM ACO be different under CMS from under CMMI?
- How will the forgivable loan amounts available be determined?
- Will there be options for variable risk (e.g., from no downside risk to full capitation) that would be appropriately linked to a variable shared saving/loss percentage?
- Will there be TA funding available to help new entrants determine risk level and assist with other start-up needs?

Resources

- Rural Health Value Initiative <https://ruralhealthvalue.public-health.uiowa.edu/files/Rural%20VBC%20Summit%20Report.pdf>
- Ensuring Health Across Rural MN 2030 Report. <https://www.ruralcenter.org/sites/default/files/Ensuring%20Health%20Across%20Rural%20MN%202030%20Report.pdf>
- Final AIM ACO Report <https://innovation.cms.gov/data-and-reports/2020/aim-final-annrpt>

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