NATIONAL RURAL
ACCOUNTABLE CARE CONSORTIUM

National Rural Accountable Care Consortium's Response to the Proposed Rule for the Medicare Shared Savings Program

What is at stake? CMS has introduced a proposed rule to improve the integrity and attractiveness of the Medicare Shared Savings Program. Many of the changes are welcome improvements for all providers, but they fall short of meeting the unique needs of rural providers. For a brief summary of the proposed rule please see our comments, which follow.

Who is the National Rural Accountable Care Consortium? The National Rural ACO (NRACO) was the first of its kind to bring together unaffiliated providers in multiple states to enable rural participation in the Medicare Shared Savings Program by pooling lives, expertise and financial resources. Now in its second program year, the leaders of NRACO have blazed a trail for others to follow and formed the National Rural Accountable Care Consortium as a non-profit peer learning and education organization that can disseminate knowledge learned from our data. Today, thirty health systems in six ACOs covering nine states participate in the Consortium under a single data warehouse.

Why do we care so much about the MSSP? Safety net providers are the only primary care systems left in the country that are not eligible for incentives for providing better care at a lower cost. This lack of incentives may create health disparities for rural beneficiaries, who are in desperate need of Medical Homes and Care Coordination. Without the appropriate data and incentives, cash-strapped rural providers cannot redesign their delivery systems to meet the three-part aim. The MSSP is the *only* program broadly available today to create the framework for change that safety-net patients need.

"We count our cash on hand in minutes. Every day we open the checks to see who we can pay." Lee Barron, CEO, Southern Inyo Hospital

What are the rural issues? The key economic issues that affect rural providers are that they are low volume with high fixed costs and little or no operating margin and are almost wholly dependent on Federal payments. They constantly struggle to survive, have very limited cash reserves and are totally dependent on Federal payments, which provide no margin for error or "rainy days." The effect of small cuts to

their payments in the past few years has resulted in a record number of closures. According to the Flex Monitoring Team, the average days of cash on hand for CAHs is a paltry 69 days.

The following chart illustrates key economic considerations of CAH-based health systems.

Table 1

Selected Median Financial Indicator Values for United States CAH[1]

Indicator	Median Value	Indicator	Median Value
Total Margin	2.61%	**Medicare Inpatient Payer Mix**	73.59%
Operating Margin	1.13%	**Medicare Revenue per Day**	$2193
Equity Financing	60.71%	**Median Net Revenue per Discharge (All Payers)*[2]**	$7190
Outpatient Revenues to Total Revenues	74.14%	**Average Daily Census Acute Beds**	3.38

NOTE: 2012 Data – Effects of sequestration on operating margin not shown!

Could volume be the answer to saving the rural safety net? Rural cost accountants postulate that CAHs have very high fixed costs; therefore incremental volume is essentially free. To illustrate that point, if CAH discharges are 75% Medicare, the CAH's allowable costs are $5,000,000, and there are 1000 patient days, Medicare pays the CAH 75% x $5,000,000 x 101% = $3,787,500 or $3,786 per patient day. If the CAH doubled it's average daily census from 3 to 6, and the incremental cost was only 15%, Medicare would pay the CAH $4,365,625, or $2,178 per patient day. The same is true for outpatient services, which account for almost 75% of CAH revenue. It is no coincidence that the CAH in our ACO that has the highest market share (62%) also has a very low cost per beneficiary. Different facilities have different fixed costs and different abilities to increase share, but increasing volume is a clear way to reduce the cost of rural healthcare. The following chart illustrates the potential savings by driving increased volume to cost-based reimbursed providers.

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[1] "CAH Financial Indicators Report: Summary of Indicator Medians by State." *Flex Monitoring Team Data Summary Report No. 16.* October 2014. [Data from 2012.]

[2] Data from Advisory Board Critical Access Hospital Benchmark Generator.

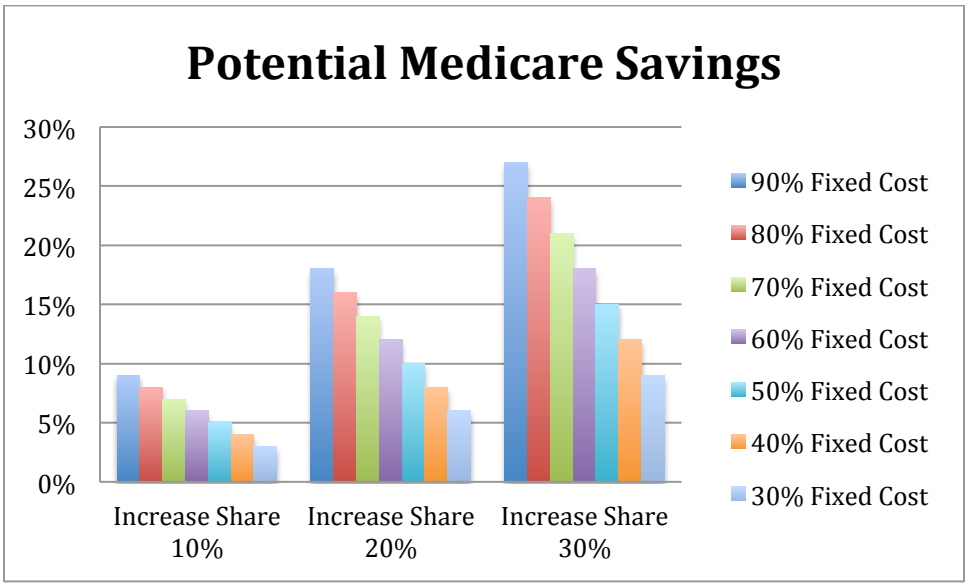

Figure 1: Volume Effects on Cost-Based Reimbursement

Can rural health systems increase market share? From the claims data we see, they certainly can. Our ACO's only get claims data on the patients who use their primary care more than anyone else, so these are presumably our most loyal customers, yet the claims data shows that they on average only capture 35% of the claims for their attributed lives. Reviewing that claims data shows they would be capable of providing an additional 35% of the services if the patient chose to get their health care locally.

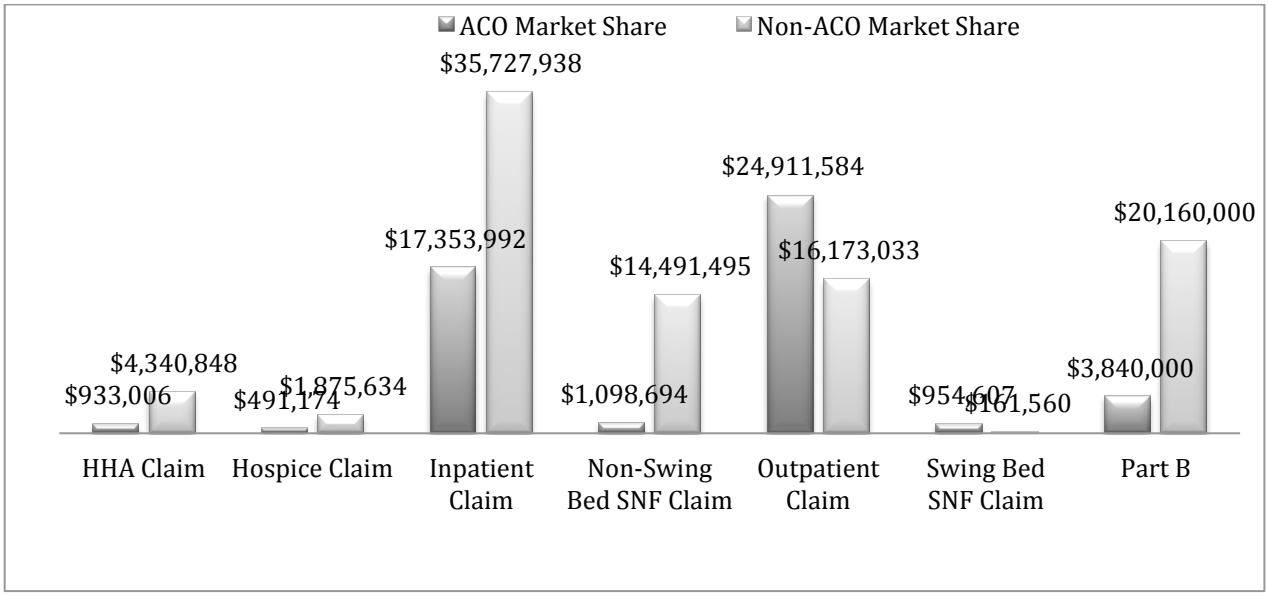

Figure 2: National Rural ACO Share of All Claims Data

Why aren't people using the local health system, even when their PCP works for the CAH? We can only speculate here, but our Community Needs Assessments show some interesting data. Unlike the national average of 70%, only 50% of our patients can name their PCP. Similarly, only 30% of ED visits nationally are for primary care, yet our data shows that 50% of our rural ED visits are for primary care. Our patients use the ED, the internet, or get in their car and drive when they can't get an appointment. There is no urgent care center in town to take care of their needs and it is very expensive to keep the clinic open after hours, in addition to creating yet another barrier to recruiting rural physicians.

How can we increase volume for Medicare Beneficiaries? Essentially by creating a rural Medicare PPO. We could increase local volume considerably if we had the ability to incentivize our patients to get care in our community by having Medicare cover residual patient cost-sharing (after supplemental insurance_. As cost-based reimbursed facilities with high fixed costs, increased local volume naturally lowers costs for Medicare while also bringing the patient closer to their medical home.

The cost of having Medicare cover in-network cost-sharing after supplemental insurance can be estimated using 2012 data from MEDPAC reports, which showed average beneficiary cost-sharing is $1550 per year, and that 10% of seniors do not have supplemental insurance that covers these costs. Currently, our cost-based facilities only have a 35% of total claims. This should yield a cost per beneficiary of ($1,550 X 10% X 35% X 50%) = $54.25 per beneficiary per year, which would be charged against total Medicare spending for the ACO. Rural providers would bear 50% of this cost by virtue of being in a shared savings program. Medicare would gain significantly due to the effect of higher volumes on per capita cost-based reimbursement. The greatest winner would be the beneficiary and the rural community, which would see increased local spending, employment and better, more comprehensive care. See Figure 1 for a model of potential savings for Medicare based on increasing volume to cost based providers.

What does the data say about rural care coordination? Our patients are literally scattered to the wind. Our members range from 182-3200 patients attributed to them who are using from 75-300 different Part A facilities and thousands of different doctors.

Meet Linda. She is 74 rural resident and was in fair health. In the last two years she has broken her hand, broken her arm, sprained her ankle and suffered a head injury from a series of falls. She has been seen in 10 different Part A facilities and 43 Part B facilities with total claims exceeding $250,000 in the past two years. Without a regular PCP, Linda used the internet to find a doctor who would help her with her back pain. The botched spinal surgery resulted in her $163,000 admission to a renowned tertiary hospital to remove the implant and help her recover. Linda deserves a medical home and a care coordinator to "watch her back."

A good example is Mammoth Lakes Hospital and Rural Health Clinics. Mammoth has 520 attributed lives that have been seen in 259 different Part A facilities and 3,294 unique Part B providers in the past two years. Review of their patients data is a "trail of tears" with patients bouncing from one provider to the next, one hospital to the next, without communication, coordination or forethought. Given the opportunity and the data, rural providers can do much better.

How can rural providers increase market share? Any business that is the sole proprietor of services in a service area that has the ability to increase its market share can do so by focusing on business fundamentals. Customers want value – high quality, great service and a low price. If a patient is ill and cannot get care in their community, the evidence suggests that he will either use the ED or get in his car and drive to the nearest available provider. They will not simply wait for the next appointment. Rural communities must create capacity for primary care to be successful in the future.

In addition, focusing on the 25% of Medicare patients that comprise 82% of total Medicare spending and giving them the help and support they need can increase market share the most with the least amount of effort. If implemented well, primary care frequently determines how and where patients get more advanced care. Rural health systems should actively recruit these patients into their rural health systems, providing them care coordination services to help them navigate their disease and the byzantine healthcare system, identifying high value providers for them and ensuring their data and history follow them wherever they go. Losing these highly coveted patients to competing health systems can devastate a rural health system.

How can rural providers increase their *margin*? Increasing market share is good for our patients and good for Medicare, but cost-based reimbursement still leaves the rural provider without an operating margin, always teetering on the brink of insolvency. We think this can be solved by the Medicare Shared Savings Program, where rural providers can earn a margin by delivering high-quality care and lower cost through care coordination of the chronically ill and by building market share. In order for it to work, however, we need specific changes to the MSSP that recognizes our unique needs and payment system.

Conclusion

The Medicare Shared Savings Program provides the necessary framework for improving care, improving health and lowering costs for rural beneficiaries. Unlike urban providers, there are no other programs for the safety net that enable these new systems of care proven to improve cost and quality. Our proposed creation of a Safety Net Track 4 will make the program extremely attractive to safety net providers and encourage their participation. Cost-based reimbursement can be effective if coupled with the right incentives to provide the right care at the right

time for the beneficiaries, while allowing rural providers to earn more for delivering better care. Please comment today at regulations.gov, CMS-1461-P.