Rural Hospital Participation in the Medicare Shared Savings Program

Executive Summary

Rural networks across the nation have been working with rural providers to assist them in applying for and participating in the Medicare Shared Savings Programs (MSSP). While these networks were successful in applying for the MSSP for a few physician-only networks and as part of a few Urban/Rural Accountable Care Organizations (ACOs) they were unsuccessful in applying on behalf of the more common rural Physician Hospital Organizations (PHOs). This is not due to a lack of significant interest, but due to beneficiary assignment issues and limitations on the Advanced Payment program.

Subsequent to conversations with CMS and CMMI on the issues preventing participation in the MSSP and Advanced Payment Program it was determined that a combination of statutory and rule-making issues and rural health care practices are causing only 10-20% of Medicare beneficiaries to be assigned to all-rural ACOs, with the majority of rural beneficiaries being assigned to urban specialists. This is a uniquely rural issue, with no reports of urban ACOs complaining about beneficiary under or mis-assignment.

As of January 2013, three years after the passing of the Affordable Care Act, nineteen different programs have been announced to provide incentives to physicians and hospitals to achieve the triple aim of better care, better health and lower costs. Most Critical Access Hospitals and their affiliated providers are not eligible for any of these programs, and most are inappropriate for small volume rural communities. The MSSP is the only program to date, in conjunction with the Advanced Payment Program, with minor modifications of both programs, that gives rural communities the opportunity and impetus to transform their delivery systems and survive and thrive under health care reform.

The following proposal is not a panacea for all rural providers, but addresses its largest segment – rural hospital anchored healthcare delivery systems which include 1,337[1] hospital service areas and 27% of the 4,985 community hospitals in the United States who are now unable to participate in the MSSP.[2]

The specific proposed modification of the MSSP and the Advanced Payment Program is as follows:

1. Assign all Medicare beneficiaries to rural communities that provide a plurality of primary care within the community, not by a single PCP, to a Community Care Organization (CCO), with shared savings payments made for patients who receive care within the CCO.
2. Provide Advanced Payments to all CCOs to support infrastructure development and chronic disease management, including a Per Member Per Month stipend.
3. Follow the remaining principles of the MSSP, while being more prescriptive in the implementation to suit the needs of rural providers.

It is estimated that 500 rural communities would participate in this program. Based on the assumptions above, the expected cost of Advanced Payments for 500 rural communities is $278 million. If these reforms were successful for 500 rural communities, CMS and CMMI could expect approximately $2.7 billion in reduced per beneficiary spending over the life of the project. Of this, CMS could expect to save

[1] http://www.tricare.mil/hospitalclassification/
[2] http://www.aha.org/research/rc/stat-studies/fast-facts.shtml

$1.2 billion and rural communities can expect to net an additional $766 million. It would also strengthen the rural safety net, promote jobs and local economies and assist rural providers in achieving the triple aim. This will fund the redesign of roughly one third of the rural-hospital anchored healthcare delivery systems to achieve the three part aim of better health, better care and lower costs.

Background

The rural healthcare delivery system takes many different forms. Given its diversity, it is difficult to describe a single program that would be applicable to all types of rural providers and systems. While some states have minimal geographic distance and barriers between urban, suburban and rural providers, many states have isolated communities that are served by a single rural hospital and a tightly knit group of primary care providers who typically work in hospital owned rural health clinics. Of the 4,985 acute care hospitals in the United States, 1,987 are rural -- of which 1,331 are Critical Access Hospitals (CAHs).[3] In 2000, almost half of CAHs were public district hospitals, often supported by local taxes.[4] This ratio is expected to be fairly stable as hospital district formation is fairly complex and static.

CAHs must be located in a rural area (or an area treated as rural); be more than 35 miles from another hospital (or 15 miles in areas with mountainous terrain or only secondary roads available) or be certified before January 1, 2006 by the State as being a necessary provider of health care services. CAHs are required to make available 24-hour emergency care services that a State determines are necessary. CAHs may have a maximum of 25 acute care and swing beds, and must maintain an annual average length of stay of 96 hours or less for their acute care patients. CAHs are reimbursed by Medicare on a cost basis (i.e., for the reasonable costs of providing inpatient, outpatient and swing bed services X Medicare Share X 101%).[5]

Rural hospitals are typically tightly integrated with their community physicians, with 20.4% having fewer than 5 admitting providers, 50.4% with 5-10 admitting providers and 29.3% with more than 10 admitting providers.[6] The hospital is often the largest employer in town and a driver of the local economy. Less than 10% are for-profit. Mid-levels (Nurse Practitioners and Physicians Assistants) frequently account for 25-75% of primary care provided in each community. Across the US, 73% of CAH inpatient days and 36% of outpatient visits are covered by Medicare. Unlike typical urban hospitals, median outpatient revenue for CAHs is 69% of total revenue.[7]

Rural hospitals are important contributors to local economies and often the community's largest employer. Estimates range from $700,000 to $1,000,000 per year in direct contribution to local economies. When retail sales and tax collections are included estimates increase and range from $18,549 to $54,739 local contribution per bed.[8]

The "rural hospital based community healthcare delivery system" is the subject of this proposed CMMI Demonstration Project. We have identified 1,371 of these types of communities including 1,118 CAHs more than 15 miles away from the nearest hospital[9] and 253 Rural Hospitals that are Sole Community

[3] http://www.aha.org/research/rc/stat-studies/fast-facts.shtml

[4] Hospitals in Rural America. Ricketts and Heaphy. Western Journal of Medicine.2000. December; 173(6): 418–422.

[5] CAH Financial Indicators Report: Summary of Indicator Medians by State Flex Monitoring Team Data Summary Report No. 7. August 2010.

[6] Report to the Congress: Medicare and the Health Care Delivery System. June 2012. MEDPAC. Chapter 5.

[7] CAH Financial Indicators Report: Summary of Indicator Medians by State Flex Monitoring Team Data Summary Report No. 7. August 2010.

[8] The Economic Impact of Hospitals in Rural Communities. Richard E. McDermott, Gary C. Cornia, Robert J. Parsons. The Journal of Rural Health. Volume 7, Issue 2, pages 117–133, March 1991

[9] Report to the Congress: Medicare and the Health Care Delivery System. June 2012. MEDPAC. Chapter 5.

Providers.[10] Rural Medicare beneficiaries represent 23% of all fee-for-service (FFS) beneficiaries and receive roughly 70% of their care from rural providers.[11]

Issues with the Existing MSSP for Rural Hospitals

In addition to requiring a minimum of 5,000 Medicare Beneficiaries, which is difficult for most rural communities to achieve on their own, rural providers are only getting a fraction of their beneficiaries assigned under the MSSP. For example, in the April 2012 MSSP application cycle, New Light Rural Health Networks applied for three ACOs with the Advanced Payment Program. Claims data revealed more than 5,000 unique Medicare Beneficiaries in each community. When CMS alerted New Light that they would not achieve the minimum number of beneficiaries to qualify, two of the applications were merged. The actual number of beneficiaries assigned is detailed in the table below:

Applications	# Rural Hospitals	# CAHs	# RHCs	# Providers	Total Net Revenue	New Light Estimate	Final Assignment	Max Shared Savings/$1
A1320 & 1321	1	5	6	12 MDs, 4 NPs/PAs	$75M	10,000	1,715	$0.08575
A1324	1	0	3	1 MDs, 5 NPs/PAs	$68M	6,100	470	$0.03852

Not only can rural communities not reach the 5,000 minimum under the current rules, if they did aggregate enough communities to qualify they would only get paid less than ten cents on the dollar of shared savings instead of the fifty cents being paid to urban providers.
The reasons for this disparity are diverse. The statute requires beneficiary assignment based on the plurality of care (most charges) provided by a single primary care physician.

a. Rural Health Clinics and Federally Qualified Health Centers are required to use Physician Assistants and Nurse Practitioners to provide primary care. These visits do not qualify for beneficiary assignment unless the patients are also seen by a primary care physician each year and the visit is documented in such a way that is not the current standard.
b. Rural physicians are required to take call to cover rural hospitals. Therefore patients are typically seen by any one of the physicians or mid-levels in the rural clinic, making it harder to achieve plurality of care with any single physician.
c. Most specialty care is not delivered within a rural community, making it more likely that the chronically ill patients that are being managed in their community will be assigned to an urban ACO because of the likelihood it is a single provider.
d. Rural physicians and mid-levels charge less than specialists, making it harder to achieve a plurality of care.
e. Due to provider shortages in rural communities, patients are frequently seen in the emergency room after hours. According to MedPac, 50% of ED visits in rural communities are for primary care, compared to 30% in urban communities. These visits do not count for beneficiary assignment.

Strengths of Rural Hospital Healthcare Delivery Systems

A common misperception is that rural care is more expensive than urban care[12,13]. While costs are higher on a unit basis due to lack of economies of scale, in 2010 rural Medicare per beneficiary spending was 3.52% lower than in urban counties, including all costs incurred by rural beneficiaries in urban markets.

[10] http://www.tricare.mil/hospitalclassification/
[11] Report to the Congress: Medicare and the Health Care Delivery System. June 2012. MEDPAC. Chapter 5.
[12] Modernizing Rural Healthcare. Coverage, Quality and Innovation. Working Paper #6. July 2011. United Health Group.
[13] http://www.healthreform.gov/reports/hardtimes/ruralreport.pdf

Inpatient spending was 1.87% lower and physician spending was 18.39% lower, offset by 14.07% higher spending in outpatient services.[14]

The natural strengths of these delivery systems are the tight integration between providers and the hospital, whether or not the providers are employed or contracted in hospital-based clinics, and the passion and support from the community for their healthcare institutions. Strong personal relationships exist between providers and patients. Providers operate at the top of their licenses and treat locally wherever possible. Skilled nursing facilities are often part of the system supporting continuity of care. Taxpayer support and cost-based reimbursements provide much needed operating funds.

Weaknesses of Rural Hospital Healthcare Delivery Systems

Although total per beneficiary spending is lower for rural residents, rural providers have higher unit costs and beneficiaries pay more than twice as much for outpatient services. In 1995, Congress passed a law that protected Medicare Beneficiaries by mandating they only pay 20% of the Medicare allowed charges, not the amount charged by the hospital which is highly variable. This benefit was not passed on to Medicare Beneficiaries seen in CAHs, a program that was started in 1996. As a result, Medicare Beneficiaries getting outpatient services in CAHs pay 47% of costs instead of the 20% paid in all other settings, although many have co-insurance.[15] Medigap insurance covers 28-36% of patients, 19-24% are covered by Medicaid, 31-41% have commercial insurance and 9-16% have no secondary insurance.[16] Some commercial plans do not cover more than 20% of the PPS rate, leaving the beneficiary with the balance of the bill, so as many as 50% of patients have a strong financial incentive to get their care elsewhere, or delay care.

Many rural areas have difficulty recruiting physicians and cannot support specialists in rural settings due to volume limitations. Rural providers have limited opportunities to control costs at distant tertiary care centers. Communication between tertiary care and rural providers is poor or non-existent. In a recent survey of 28 California CAH CEOs, not one rural community received communication when a patient was discharged from a tertiary care center. A disproportionate share of patients seek primary care in the emergency department (ED), with 50% primary care in the rural ED vs. 30% in urban.[17] Information technology infrastructure and managed care experience is sparse to non-existent. Transportation is an issue for communities covering a large geographic area or with mountainous terrain.

Opportunities for Reducing Costs in Rural Hospital Healthcare Delivery Systems

One area offering significant improvement is to reduce utilization of the rural emergency room for primary care. Unlike urban centers that see less than 30% Level 1 visits, rural residents frequently don't have after-hours access to primary care; thus more than 50% of rural ED visits are for primary care.[18]

Lack of communication and coordination of care between tertiary care settings and rural settings plagues the rural safety net. Rural providers typically received no notification or information when patients were returned to the community following tertiary care hospitalizations, and frequently first learned about the hospitalization when the patient presents to the ED. Establishing these linkages should reduce readmissions, ED utilization and ambulatory sensitive admissions.

Similar to urban areas, the greatest potential for improvement in rural health care costs are the 5-10% of the patients who make up 40-60%[19] of the health care budget. By focusing efforts to support these

[14] Rural Relevance Under Healthcare Reform. Version 3.0.June, 2012 I-Vantage Health Analytics.
[15] Report to the Congress: Medicare and the Health Care Delivery System. June 2012. MEDPAC.C hapter 5.
[16] Ibid.
[17] Ibid.
[18] Rural Relevance Under Healthcare Reform. Version 3.0.June, 2012 I-Vantage Health Analytics.
[19] High Cost Medicare Beneficiaries, May, 2005.Congress of the United States. Congressional Budget Office.

patients, better care, better health and lower costs can be achieved in rural settings. Patient Centered Medical Homes and Community Case Managers are widely recognized to achieve these goals, including reducing the aforementioned high rates of ED use for primary care, but currently no reimbursement systems exist to support those programs. Rural providers do not have the resources to fund these initiatives without assistance.[20]

Recommendation for Rural Hospital Shared Savings Demonstration Project

The strength of rural healthcare delivery systems is the integration of the physician and the hospital providers and the support and engagement of the community. Modeled after the Medicare Shared Savings Program (MSSP), the Community Care Organization (CCO) Demonstration Project would lower the barriers to participation for rural providers and reward patients for better health behaviors. The rules for quality reporting and calculation of shared savings would be identical to the MSSP, while the beneficiary assignment rules and the Advanced Payment program would be modified to fit rural providers:

- Eligibility: Rural communities that contain a rural hospital more than 15 miles from the next nearest hospital would be eligible to apply to become CCO's. Applicants would be encouraged to also enlist commercial insurers and Medicaid in the ACO.
- Beneficiary Assignment: Beneficiaries would be assigned based on the plurality of primary care services delivered by the entire CCO against any individual provider outside the CCO.[21] All RHC, FQHC, and hospital-based clinic claims would be considered primary care unless specified otherwise.
- Minimum Number of Beneficiaries per Applicant is 5,000. Multiple CCOs may need to aggregate to achieve this number.
- The Advanced Payment Program would be applied to support these communities in their transformation except they would not be subject to the income cap. Under the Advance Payment CCO Model, participating CCOs receive three types of payments:
    - An upfront, fixed payment for IT infrastructure: Each CCO will receive a $250,000 payment in the first month of the Shared Savings Program. If multiple CCOs need to aggregate into a CCO Network to achieve 5,000 beneficiaries, this amount would be translated into an upfront variable payment of $50 per beneficiary instead of a fixed payment.
    - An upfront, variable payment to create a care coordination network: Each CCO will receive a payment in the first month of the Shared Savings Program equivalent to the number of its preliminary, prospectively assigned beneficiaries times $36.
    - A monthly payment of varying amount depending on the size of the CCO to support ongoing care coordination: Each CCO will receive a monthly payment equal to the number of its preliminary, prospectively assigned beneficiaries times $8.
- Preference would be given to applicants that join a CCO network of at least 5 CCOs that would provide policies, procedures, training and informatics support. This would lower the cost of the delivery system redesign and improve odds for success.[22] In addition, networks can more easily gain participation from commercial payers, while stand alone communities would find it harder to get their attention.
- Preference would be given to applicants that include multiple payers.

[20] California's Critical Access Hospitals: The Financial Landscape. California Healthcare Foundation. 2010.

[21] NOTE: This may result in CMS paying for one beneficiary's savings to two ACOs in order to foster rural participation, however, CMS is unlikely to pay more than an aggregate of 100% of the savings to the two ACOs.

[22] When the CAReHIN Network developed a model for network support for rural ACOs, the analysis indicated that the cost of setting up a separate IT and quality reporting infrastructure for each community was 13-25% of total Medicare spending. By aggregating 10 communities into a support network, the cost of the IT, analytics, quality reporting and chronic disease management could be reduced to 2.4% of total spending for each community. (Innovation Challenge Grant, unpublished data).

- Payment methodologies and quality reporting would follow the MSSP program. CCOs will not be forced to take risk and will only participate in a one-sided model even after the initial period. CCOs that have less than 5,000 beneficiaries will have to aggregate with other CCOs to meet the 5,000 beneficiary minimum to maintain actuarial integrity.
- Shared Savings would be split 50% for CMS, 25% for Physicians and 25% for the Hospital after costs.
    - **Hospitals** as single entities would receive 25% to offset lost revenues.
    - **Physicians** would split shared savings based on performance on the quality metrics and total Medicare and Medicaid visits. Each Physician would receive a total quality score based on individual performance compared to the average for the CCO for a quality performance score. The percentage of visits would be multiplied by the quality performance score for each physician.

For example:

	Number of Visits	% of Visits	Total Quality Score	% Quality	Payment/$100,000 of Shared Savings
Dr. A	2500	20%	20	0.714	$ 14,285.71
Dr. B	3000	24%	34	1.214	$ 29,142.86
Dr. C	4000	32%	25	0.893	$ 28,571.43
Dr. D	1000	8%	30	1.071	$ 8,571.43
Dr. E	2000	16%	30	1.071	$ 17,142.86
Total	12500	100%	139	4.964	$ 97,714.29

- Quality Measures: All CCOs would report on the 33 MSSP Quality Measures and would be paid by the same rules as other MSSP participants. CCO Physician payments would be divided according to volume and quality measure performance with the ability to get up to 1 point for each quality score except meaningful use, which is two points. Measures 8, 9 and 10, which measure numbers of readmissions and ambulatory sensitive admission per 1,000 beneficiaries would be judged by the percentage of CHF, COPD, Asthma and recently hospitalized patients enrolled in the Community Case Management program due to limitations of analyzing low volume admission data. For more detail on the quality measures please see Appendix A.
- All CCOs would be exempt from antitrust review. By definition, they are health care monopolies and clinically integrated in their regions. All other fraud and abuse waivers of the MSSP would apply.
- Governance: According to the MSSP model.
- Disparities: All CCOs would be required to attest they provide services in accordance with The Joint Commission: *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*. [23]

Network Support and Data Sharing

Fundamental to the assumptions in this proposal is the existence of networks to support CCOs that have access to Medicare and Medicaid claims data. Funding provided up front by the Advanced Payment program, in addition to gain sharing arrangements, would be sufficient to support the networks involvement in each community. We also recommend that a National Learning Network is funded so that legal agreements, processes, procedures, success stories and failures can be rapidly shared between the

[23] The Joint Commission: Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals. Oakbrook Terrace, IL: The Joint Commission, 2010.

networks to increase efficiency, which would need to be funded separately, and would have a strong advisory role.

Expected Costs and Impact

On the average, previous demonstration projects have shown a cost reduction of 13% by implementing chronic disease case management and medical homes, prior to accounting for costs.[24] Medicare per beneficiary spending in rural was $8,470 in 2010,[25,26] which would yield $1,101,000 in savings per 1,000 beneficiaries before costs. We expect only 50% of that target in the first year due to start up time.

Depending on whether communities collaborated with a support network, we estimate that the cost of key interventions can range from 2.4% to 29%.[27] Assuming network support to minimize annual costs of care coordination and informatics to 2.4%, the average community could expect a net shared savings of $766,410 per 1,000 patients. Assuming 5 providers per 1,000 beneficiaries,[28] we would expect total payments of $383,205 per hospital per 1000 beneficiaries and $76,641 per physician. The primary benefit to the rural community would be seen in the form of increased utilization of services by the community, capturing more of the primary care business that might be going elsewhere, increasing economies of scale and lowering unit costs. They would also benefit from the advanced payment funding, which would partially cover the costs of implementing health care reforms and position them well for future success.

Per 1,000	Year 1	Year 2	Year 3	Total
Expected Savings	$550,500	$1,101,000	$1,101,000	$2,752,500
Adv. Payment	**($182,000)**	**($96,000)**	**$0**	**($278,000)**
Cost	**$203,280**	**$203,280**	**$203,280**	**$609,840**
Cost + Advance	**($21,280)**	**($107,280)**	**($203,280)**	**($331,840)**
To CMS	$275,250	$502,500	$550,500	$1,237,250
To Hospital	$35,985	$173,610	$173,610	$383,205
To Doctors	$35,985	$173,610	$173,610	$383,205
Per Physician	$7,197	$34,722	$34,722	$76,641

After an initial pilot group of 10 networks in ten states, each with an average of 10,000 beneficiaries, we estimate this program would be adopted in at least 500 rural communities throughout the nation. If the average rural CCO has 2,000 beneficiaries this would affect 1 million rural Medicare FFS beneficiaries. Based on the assumptions above, the expected cost of Advanced Payments for 500 rural communities is $278 million. If these reforms were successful for 500 rural communities, CMS and CMMI could expect approximately $2.7 billion in reduced per beneficiary spending over the life of the project. Of this, CMS could expect to save $1.2 billion and rural communities can expect to net an additional $766 million. It would also strengthen the rural safety net, promote jobs and local economies and assist rural providers in achieving the triple aim.

[24] Congressional Budget Office Issue Brief. Lessons from Medicare's Demonstration Projects on Disease Management,Care Coordination, and Value-Based Payment. January 2012

[25] Rural Relevance Under Healthcare Reform. Version 3.0.June, 2012 I-Vantage Health Analytics.

[26] Medicare Chartbook. Volume 4. 2010. Henry J. Kaiser Family Foundation.

[27] CAReHIN MSO Innovation Challenge Grant. Unpublished.

[28] Report to the Congress: Medicare and the Health Care Delivery System. June 2012. MEDPAC.Chapter 5.

Alternative Approach

In 2011, CMMI introduce a demonstration project , the Comprehensive Primary Care Initiative (CPCI), that paid physicians an average of $20 per beneficiary per month to provide the services listed above for the first two years, transitioning to $15 per beneficiary per month with a shared savings component in the second two years. Medicaid and commercial payers were also encouraged to participate. Because of the primary care focus of rural communities, this model is also well positioned to align rural providers if hospitals are allowed to participate. The following adjustments to CPCI are needed to make this program work for rural healthcare delivery systems:

- Eligibility: Allow 100-200 rural hospital-based communities to participate. Require that 60% of primary care visits delivered within a community are accounted for by the participant Tax ID numbers and that hospitals participate.
- Assignment: Base assignment of beneficiaries on the plurality of primary care services delivered within the community vs. outside the community regardless of provider type.
- Waive the requirement for Medical Home certification while still requiring the program elements. Although the principles of continuity of care are nearly identical, these services for rural communities are most efficiently centrally located to support all community physicians.

Appendix A
Crosswalk of CCO Demonstration Project Proposal with MSSP

• Eligibility: Rural communities that contain a rural hospital more than 15 miles from the next nearest hospital would be eligible to apply to become CCO's. CMS would analyze hospital discharge data to determine the 75th percentile service area zip codes. Claims data for these zip codes would be analyzed for primary care services. All RHC, FQHC, and hospital-based clinic claims would be considered primary care unless specified otherwise. Zip codes with a plurality of primary care claims would be assigned to the Community Care Organization (CCO). All community-hospital credentialed providers are allowed to participate in the CCO, but at least 75% of primary care visits delivered in the zip code must be accounted for by the participating providers in order for the community to be eligible. Referring providers and clinics that are not in the primary service area can join the CCO, provided that they provide more than 50% of primary care for the zip code and 75% of all primary care visits are accounted for by these providers. These zip codes would also be assigned to the CCO.	• A community is eligible based on providing the plurality of primary care services in the community by all providers in the community, including primary care delivered in the emergency room. This meets the spirit of the MSSP but does not conform to the legislation in the Affordable Care Act.
• Beneficiary Assignment: 100% of Medicare and Medicaid beneficiaries in eligible zip codes would be prospectively assigned to the CCO (with full retention of beneficiary rights to choose care providers). Medicare and Medicaid beneficiaries from non-eligible zip codes would be allowed to elect to join the CCO if desired. In some state Medicaid participation may not be possible.	• Similar to the MSSP, payments are only made on beneficiaries when they are seen by a CCO provider. • Similar to the Comprehensive Primary Care Initiative, all payors are encouraged to participate.

Applicants would be encouraged to also enlist commercial insurers in the ACO. Payments would only be made retrospectively on patients that were seen by CCO providers in the payment year.	
• Minimum Number of Beneficiaries per Applicant is 5,000	• Same as MSSP
• The Advanced Payment Program would be applied to support these communities in their transformation except they would not be subject to the income cap. Under the Advance Payment CCO Model, participating CCOs receive three types of payments: ○ An upfront, fixed payment: Each CCO (or CCO Network if multiple CCOs need to aggregate to achieve 5,000 beneficiaries) will receive a $250,000 payment in the first month of the Shared Savings Program. Networks would get an upfront variable payment of $50 per beneficiary instead of the fixed amount. ○ An upfront, variable payment: Each CCO will receive a payment in the first month of the Shared Savings Program equivalent to the number of its preliminary, prospectively assigned beneficiaries times $36. ○ A monthly payment of varying amount depending on the size of the CCO: Each CCO will receive a monthly payment equal to the number of its preliminary, prospectively assigned beneficiaries times $8.	• Same as Advanced Payment Program except qualification is based on qualification for the CCO Demonstration Project regardless of total income.
• Preference would be given to applicants that join a CCO network of at least 5 CCOs that would provide policies, procedures, training and informatics support. This would lower	• Same as HRSA/ORHP policy of supporting networks for safety net providers and the Comprehensive Primary Care Initiative.

the cost of the delivery system redesign and improve odds for success.[29] In addition, networks can more easily gain participation from commercial payers, while stand alone communities would find it harder to get their attention.	
• Payment methodologies and quality reporting would follow the MSSP program. CCOs will not be forced to take risk and will only participate in a one-sided model even after the initial period. CCOs that have less than 5,000 beneficiaries will have to aggregate with other CCOs to meet the 5,000 beneficiary minimum to maintain actuarial integrity.	• Same as MSSP
• All beneficiaries will be excluded from other ACOs.	• Avoid duplication of payments, same as MSSP, but based on beneficiary, not provider.
• Shared Savings would be split 50% for CMS before costs, 25% for Physicians and 25% for the Hospital after costs. ○ **Hospitals** as single entities would receive the 25% ○ **Physicians** would split shared savings based on performance on the quality metrics and total Medicare and Medicaid visits. Each Physician would receive a total quality score based on individual performance compared to the average for the CCO for a quality performance score. The percentage of visits would be multiplied by the quality performance score for each physician.	• Same as MSSP but is more prescriptive than MSSP for physician/hospital sharing.
• Quality Measures: All CCOs would report on the 33 MSSP Quality	• Same as MSSP but more prescriptive with description of how each physician

[29] When the CAReHIN Network developed a model for network support for rural ACOs, the analysis indicated that the cost of setting up a separate IT and quality reporting infrastructure for each community was 13-25% of total Medicare spending. By aggregating 10 communities into a support network, the cost of the IT, analytics, quality reporting and chronic disease management could be reduced to 2.4% of total spending for each community. (Innovation Challenge Grant, unpublished data)

Measures. Physician payments would be divided according to volume and quality measure performance with the ability to get up to 1 point for each quality score except meaningful use, which is two points. Measures 8, 9 and 10, which measure numbers of readmissions and ambulatory sensitive admission per 1,000 beneficiaries would be judged by the percentage of CHF, COPD, Asthma and recently hospitalized patients enrolled in the Community Case Management program due to limitations of analyzing low volume admission data. Payments to the CCOs would be adjusted based on performance. CCO costs for informatics and coordinating care are deducted from total prior to calculating Physician and Hospital payments.	payment would be calculated.
• All CCOs would be exempt from antitrust review. By definition, they are health care monopolies and clinically integrated in their regions. This would apply for commercial insurers as well. All other fraud and abuse waivers of the MSSP would apply.	• Same as MSSP
• Governance: Each CCO would have an advisory board that has equal representation of the Hospital, Physicians and Beneficiaries without a conflict of interest. Hospitals would act as the fiscal entity to reduce administrative costs and burden, but payments would be prescribed by the program.	• Same as MSSP but more prescriptive.
• Three year term	• Same as MSSP

Appendix B: List of CMMI and CMS Payment Reform programs in which >1,000 unaffiliated Critical Access Hospitals cannot participate

Program	Rationale
1. MSSP	Only get <10% of beneficiaries assigned
2. Pioneer Model	Only rural with Tertiary Care qualified
3. Advance Payment	Only physician practices qualified
4. Bundled Payments	Insufficient incidence of any one disease, similar to DRGs
5. Comprehensive Primary Care Initiative	Doesn't apply to hospital care, divides rural integrated delivery network and incentivizes physicians to send care to urban centers.
6. Financial Alignment Initiative	State program
7. FQHC Advanced Primary Practice Demonstration	FQHC program. Rural Health Clinics are ineligible, divides rural integrated delivery network and incentivizes physicians to send care to urban centers.
8. Graduate Nurse Education Demonstration	Not academic medical center
9. Health Care Innovation Awards	Program closed, very small percentage awarded to rural, primarily academic medical centers
10. Independence At Home Demonstration	Insufficient numbers to qualify for program
11. Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents	Insufficient numbers to qualify for program
12. Innovation Advisors Program	No rural program. Doesn't apply to most hospitals. Does not incentivize transformation.
13. Medicaid Emergency Psychiatric Demonstration	Don't have psychiatric hospitals in rural.
14. Medicaid Incentives for the Prevention of Chronic Diseases	State Program
15. Million Hearts	No incentives for rural hospitals.
16. Partnership for Patients	Don't qualify for incentives because not PPS.
17. Community-based Care Transitions Program	Insufficient numbers to qualify for program
18. State Innovation Models Initiative	State Program
19. Strong Start for Mothers and Newborns	Insufficient volume to qualify for program.

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Approved by the Rural Health Congress in February 2013.
Authored by Lynn Barr.