June 27, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & 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: Increasing Participation in Alternative Payment Models in Rural Communities

Dear Administrator Brooks-LaSure:

On behalf of the undersigned organizations, we appreciate recent efforts by the Centers for Medicare & Medicaid Services (CMS) to advance its value-based care strategy in rural communities, which unfortunately continue to lag behind their urban counterparts. As a result, rural populations often miss the opportunity to benefit from care furnished through these models. While to its credit, CMS has granted safety net and rural providers certain increased flexibilities in recently announced Alternative Payment Models (APMs), unfortunately, these do not go far enough. The exclusionary rules, financial methodologies, and risk arrangements that remain will continue to keep participation out of reach for many small and rural providers.

While the recently announced ACO Primary Care Flex Model is intended to target participation of safety net providers, such as federally qualified health clinics and rural health clinics, it does not address some of the fundamental challenges to rural provider participation – most notably their ability to take on significant risk or put in place the infrastructure necessary to administer capitated payments. Additionally, many rural accountable care organizations (ACOs) are excluded from this model because they include critical access hospitals and, as a result, are identified as high-revenue ACOs. We ask CMS to reconsider this unnecessary restriction, which disproportionately excludes rural ACOs from participating in the model.

The proposed mandatory Transforming Episode Accountability Model (TEAM) – which would target inclusion of safety net and rural providers as part of its own separate track – also raises significant concerns as it will force many of these rural providers into two-sided risk that could be financially unviable for many rural hospitals (even with the additional guardrails), further threatening access in these communities. We urge CMS to reconsider mandating rural provider participation in this model, and to consider additional changes to the model based on feedback from stakeholders.

Addressing these barriers and giving rural providers the appropriate resources is the key to improving rural provider and beneficiary participation in APMs, which is critical to accomplishing CMS' strategic visions for advancing equity and high-quality, person-centered value-based care

and achieving its 2030 goal of aligning all Original Medicare beneficiaries with an accountable care relationship. To that end, we also urge CMS to consider the following two strategic pillars in addressing future rural provider participation in APMs:

Redefining Success for Rural APMs to Focus on Quality. One of the main challenges rural providers faces when participating in APMs is the ability to absorb discounts or other payment cuts under the models. Rural providers tend to operate on tighter budgets and are more vulnerable to closure, in addition to having a patient base that often has higher prevalence of chronic conditions and requires more resources to be cared for. Rural providers also often face additional barriers to care coordination in rural communities, as patients may face challenges accessing care due to distance and service availability, particularly for specialty or behavioral health care.

Given these challenges, we urge CMS when defining success for rural participants in APMs to refocus on reaching improved quality of care, rather than simply achieving Medicare savings. This could tie into the CMS Innovation Center's recently announced Quality Pathway. In defining quality for rural participants, CMS should include rural-specific metrics such as maintaining access to care in rural communities and improving sustainability of rural providers. The closure or reduction of care by a rural provider could mean a total loss of access to care for that community, ultimately leading to poorer health outcomes for rural patients. When access to care and quality of care is improved, health is better managed and improved outcomes follow, which does equate to savings. However, this takes time. Requiring rural providers to absorb immediate "discounts" like those in TEAM is a short-sighted approach that could do lasting damage to access to care in rural communities.

Avoiding One-Size-Fit-All Designs. Rural communities across the United States are incredibly diverse and need innovative and varying solutions to address the unique barriers they can face to providing quality care in a sustainable way. To encourage transitions to APMs and maintain participation in models, we need to increase targeted support and uniquely designed options for model participation.

As part of this, CMS should invest in opportunities for providers to engage with beneficiaries, their advocates, and local communities to design targeted interventions or policies that best meet the unique needs of their rural communities. CMS should also explore additional waivers and flexibilities with rural providers uniquely in mind that allow them to better meet these needs and improve care for their patients. This could include flexibilities to reduce administrative burden, support workforce development, or reduce cost-sharing for underserved populations. These types of additional resources and increased flexibilities will help rural providers better engage their patients and serve their community with quality and equity at the forefront of their minds.

With these principles in mind, we encourage CMS to adopt a two-prong approach to designing models to increase rural provider and beneficiary participation:

1. ***Voluntary rural-specific models*** with appropriate resources to address the unique facets of rural communities, where models would be limited to and designed specifically for rural providers and the beneficiaries they serve. This would allow opportunities to focus on areas of critical need in rural communities, such as improving access to maternal health care and addressing mental health/substance use disorders and other chronic conditions. Additionally, offering flexibility in the design of models would allow APM participants to engage with beneficiaries and community-based organizations to identify and design care transformation opportunities and other interventions that best meet the needs of the rural community.
2. ***Rural-specific tracks*** under existing voluntary models, which would allow CMS to modify broader models to more adequately meet the needs of rural providers and beneficiaries, such as offering longer glide paths to risk, lowering discounts or including rural-specific waivers. This is not only focused on modifying methodologies or requirements for existing or new models but also creating meaningful opportunities for rural provider participation with more targeted adjustments in model design, such as up-front infrastructure funding opportunities. This will ensure rural populations have access to the benefits of these models.

We urge CMS to consider these recommendations in the context of its ACO Primary Care Flex model and TEAM, as well as its design of future models, and welcome the opportunity to meet to further discuss these principles for improving access to care in rural communities and rural provider and beneficiary participation in APMs. We are committed to working with CMS to build a future where rural communities are encouraged to and benefit from taking part in APMs and look forward to discussions that bring together our diverse range of stakeholders and CMS to focus on improving quality of care in rural communities.

Sincerely,

American Heart Association
AMGA
Avera Health
Billings Clinic
Health Care Transformation Task Force
National Association of ACOs
National Partnership for Women & Families
National Rural Health Association
Prairie Health Ventures
Premier Inc.
Tanner Health System
United States of Care