

February 6, 2015

Marilyn B. Tavenner, MHA, RN
Administrator
Center for Medicare and 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: CMS-1461-P Medicare Program; Medicare Shared Savings Program;
Accountable Care Organizations**

Dear Administrator Tavenner:

The undersigned organizations submit the following comments and recommendations to the Centers for Medicare & Medicaid Services (CMS) in response to proposed policy and payment changes set forth in CMS-1461-P Medicare Program: Medicare Shared Savings Program: Accountable Care Organizations (ACO) notice of proposed rulemaking (NPRM). The signatories to this letter represent the largest and most preeminent healthcare organizations in the country whose members include physicians, hospitals, medical group practices and nearly all existing Medicare Shared Savings Program (MSSP) ACOs. Our recommendations reflect our unified expectation and desire to see the MSSP achieve the long-term sustainability necessary to reduce healthcare costs and improve quality in the Medicare program.

While the MSSP program has generated strong interest, sustained and increased participation hinges on the potential financial opportunities being adequate to support the investments needed to improve care and, ultimately, create a program that is sustainable for the long term. First-year MSSP performance data from November 2014 showed that slightly more than half of participating ACOs (118/220) reduced costs enough to generate savings to the Medicare program. However, only about half of these (58) were able to meet the minimum savings threshold required to actually share in the savings. Thus, overall, only 26% of MSSP ACOs received a shared savings payment from Medicare. As currently designed, the MSSP program places too much risk and burden on providers with too little opportunity for reward in the form of shared savings.

The U. S. Department of Health and Human Services (HHS) recently stated a goal of tying 30% of fee-for-service (FFS) Medicare payments to alternative payment models, such as ACOs, by the end of 2016 and tying 50% of such payments to alternative payment models by 2018. *If HHS is to meet these goals and ensure continued and enhanced participation in the MSSP, it needs to: strengthen the assignment of Medicare beneficiaries; establish a more appropriate balance between risk and reward; adopt payment waivers to eliminate barriers to care coordination; modify the current benchmark methodology; and provide better and timelier data.*

Currently, 99% of MSSP ACOs participate in Track 1. While we support CMS's stated desire to move participants along to take on risk in Track 2 (and in Track 3), we urge CMS also to make necessary changes to Track 1 to ensure current and future participation in the ACO program.

Track 1 participants also will need the appropriate tools to adequately coordinate and manage care and a sufficient opportunity to share in savings so that they can support continued investment in the program and provide a pool of successful organizations willing to assume greater risk in Tracks 2 and 3.

ASSIGNMENT OF MEDICARE FFS BENEFICIARIES

We support the codification of the proposal for beneficiary eligibility determination criteria for assignment to include that the beneficiary:

- Has at least 1 month of Part A **and** Part B enrollment and does not have any months of Part A only or Part B only enrollment;
- Does not have any months of Medicare group (private) health plan enrollment (e.g. Medicare Advantage or PACE program);
- Is not assigned to any other Medicare shared savings initiative; and,
- Lives in the U.S. or U.S. territories and possessions.

We agree that these beneficiary eligibility criteria are consistent with the statute, and their explicit inclusion within the regulations helps to promote a clearer understanding of the assignment process. We also suggest that CMS consider a mechanism for removing beneficiaries who live out of the ACO service region from attribution as well.

Definition of Primary Care Services

We support the proposed rule's expansion of the definition of "primary care services" used in the attribution process to include the Transitional Care Management (TCM) and Chronic Care Management (CCM) Current Procedural Terminology® (CPT®) codes. The care coordination and care management services included under these codes are consistent with the delivery of primary care and will assist ACOs in lessening fragmentation and improving care coordination.

Consideration of Physician Specialties and Non-Physician Practitioners in the Assignment Process

We are conceptually supportive of proposed revisions to the current two-step assignment methodology. CMS proposes to revise Step 1 of the assignment process to include primary care services provided by non-physician ACO professionals, which account for the preponderance of assignments, and Step 2 of the process to remove a list of non-primary physician specialty designations. If these changes are implemented correctly, we believe that it will improve the accuracy of the assignment process to attribute beneficiaries based on the delivery of primary care and may assist ACOs in meeting required minimum attributed beneficiary requirements.

Below, we detail our concerns regarding the proposed revisions and corresponding recommendations to address these concerns.

NPs, PAs and CNSs in Assignment Process

The proposed revision calls for the inclusion of defined primary care services provided by nurse practitioners (NPs), physician assistants (PAs) and clinical nurse specialists (CNSs) who are participants within an ACO within Step 1 of the assignment process contingent on satisfying the statutory requirement that assignment is based on “utilization of primary care services” furnished by a physician. *While we agree that many of these mid-level professionals are engaged in the delivery of primary care and their inclusion within Step 1 can provide for a more accurate primary care-based assignment, we strongly contend that this positive effect requires additional assurance that the NPs, PAs, and CNSs considered under Step 1 are truly primary care providers.* As mentioned within the proposed rule, the “self-reported specialty codes reported on claims for NPs, PAs, and CNSs are not further broken down by specific specialty areas and therefore do not allow practitioners to indicate whether they are typically functioning as primary care providers or as specialists.”

Additional information may be required to provide some assurance of the primary care nature of these professionals. *CMS could potentially modify the information that is maintained in the CMS enrollment database to better reflect specialty designation for these providers or do it through an attestation process.* This approach would be similar to that used for ACO assignment within federally qualified health centers (FQHCs) and similar settings, and it is aligned with the methodology employed within the Medicaid-Medicare Pay Parity program. We would be happy to work with CMS on the operational details for this approach. Thus, CMS should require NPs, PAs and CNSs to attest or provide assurances in some other manner that they are primary care providers in order to be eligible for Step 1 of the assignment methodology.

Physician Specialties in Assignment Process

Exclusions

We agree with the proposal to remove from the assignment process those physician specialties (e.g. surgeons) that, despite using the general purpose CPT and Healthcare Common Procedural Coding System (HCPCS) codes defined as “primary care” under current regulations, do not actually perform primary care services. This approach will help address concerns expressed by a number of specialties regarding the need to be exclusive to one ACO if their services are considered in the attribution process, and it is aligned with the Agency’s overall emphasis on “primary care-centric” assignment. *We encourage CMS to be receptive to comments received from physician organizations representing specialty designations, both currently included and excluded from Table 3, to ensure the appropriateness of removing a given specialty designation from the assignment process.*

Inclusions

The proposed rule continues to include services provided by a number of physicians with non-primary care specialty/subspecialty designations as part of the beneficiary assignment process under step 2, predominately internal medicine subspecialty designations. The stated basis for

this decision is the general expectation that physicians within these specialty/ subspecialty categories frequently provide primary care to their patients. *We contend that the degree of primary care service delivery by these physicians varies significantly among the different specialty/subspecialty designations and among different practices within a given specialty /subspecialty.* Certain specialty/subspecialty practices that predominately limit their services solely to their area of specialty are thus inappropriately included within the primary care oriented attribution process.

Furthermore, this restricts specialists to active participation in only one ACO unless they bill under a second tax identification number (TIN), which can be administratively cumbersome for tax and other purposes. *We believe this inappropriate inclusion within the assignment process and its resulting limitation on ACO involvement can have a number of adverse effects including:*

- Promoting inaccurate assignment of beneficiaries to an ACO;
- Significantly affecting long-established referral channels to the practice and its financial viability; and
- Impacting access to needed specialists because of their engagement with a single ACO.

This issue was recently addressed in a June 16, 2014, comment letter from the Medicare Payment Advisory Commission (MedPAC) to the Agency regarding changes to the Medicare ACO programs (<http://medpac.gov/documents/comment-letters/comment-letter-to-cms-on-accountable-care-organizations-%28june-16-2014%29.pdf?sfvrsn=0>) in which the Commission recommended essentially that all non-primary care specialty/subspecialty physicians (based upon TIN and National Provider Identifier (NPI)) be excluded from the beneficiary assignment process and related restrictions unless specifically identified by an ACO as a 'primary care' provider.

An alternative approach to address this concern would be to continue the current Step 2 assignment based upon defined primary care services provided by non-primary care specialty/subspecialty physicians but allow designated non-primary care ACO participating physicians (based on TIN and NPI) who attest that they do not provide primary care to request exclusion from the attribution process and its resulting limitations. *We recommend that CMS further address this issue of appropriate inclusion of specialty/subspecialty physicians within the attribution process in a manner that both increases the accuracy of attribution and allows increased physician (and ACO) choice and input into the decision.*

Beneficiary Attestation

We urge CMS to offer a beneficiary attestation process for all MSSP ACOs, regardless of track. This process would allow beneficiaries to attest that they consider a particular provider responsible for coordinating their overall care. An attesting beneficiary would be attributed to the ACO with whom that provider is affiliated. Although CMS would retain its current stepwise attribution process (with modifications as discussed elsewhere in this letter), beneficiary attestation would take precedence over that process when considering to which ACO a beneficiary should be attributed. Furthermore, the beneficiary would remain attributed to that

ACO until the beneficiary enrolled in Medicare Advantage, moved out of the ACO's service area, attested to a provider affiliated with another ACO, or the beneficiary otherwise indicates that they receive their care elsewhere.

Providing beneficiaries with the opportunity to voluntarily align with an ACO would balance the important considerations of beneficiaries' freedom to choose their providers, with ACOs' interest in reducing churn, which would help provide a more defined and stable beneficiary population up front. This, in turn, would allow ACOs to better target their efforts to manage and coordinate care for beneficiaries for whose care they will ultimately be held accountable. In addition, allowing beneficiaries to attest to the provider they want to manage their care may help increase beneficiary engagement in that care.

Assignment of Beneficiaries to ACOs that Include FQHCs/RHCs

We agree with CMS's proposed changes to beneficiary assignment related to FQHCs and Rural Health Clinics (RHCs). In assigning ACO beneficiaries via a FQHC or RHC, CMS will continue to require these providers to identify via attestation their primary care physicians. As noted in the 2011 ACO final rule, CMS appropriately recognized all FQHC/RHC care provided by PAs, NPs and CNSs as primary care. CMS proposes to use only FQHC/RHC primary care physician attestation to determine if a beneficiary is assignable to an ACO. That is, actual FQHC/RHC staff utilization would have to be determined or identified before assigning a beneficiary to an ACO led by, or partnered with, a FQHC/RHC. We agree with CMS that if this condition is met then assignment to that ACO would proceed per CMS's proposed beneficiary assignment changes, i.e., FQHC/RHC care provided by an NP, PA or CNS would be recognized under Step 1 assignment.

SHARED SAVINGS AND LOSSES

As of January 1, 2015, of the 405 ACOs participating in MSSP, less than two percent have chosen Track 2. About half of the ACOs participating in the program prior to January 1 are small, provider-based, or rural ACOs, each having less than 10,000 assigned beneficiaries. We share CMS's concern that the current required transition from one- to two-sided risk may be too steep for these organizations, resulting in a situation where the ACO must choose between taking on more risk than it can manage or dropping out of the program altogether. We concur with CMS's concern that the existing features of Track 2 may not be sufficiently attractive to ACOs contemplating entering a risk-based arrangement.

To maximize the MSSP's impact on quality and costs, CMS must balance its efforts to promote the assumption of greater risk with additional policy to keep current ACOs in the program and attract new participants. This will ultimately generate the most savings in comparison to the status quo under traditional FFS and is more likely to improve the quality of care. With this balance in mind, we support CMS's stated desire to move participants along to take on risk in Track 2 (and in Track 3) and, toward that aim, express support for enhanced savings rates as well as a regional benchmarking option and a new global payment option in Track 3. At the same time, we support an additional contract period under Track 1 as detailed below.

Financial Barriers to ACO Development

One of the major barriers both to ACO participation and gradual progression towards acceptance of increased risk is access to the capital required to develop the necessary administrative, analytic and clinical infrastructure to be successful. In addition, ACOs incur ongoing costs for care management, consultation between different physicians, and other services that are not covered by Medicare FFS payments. They also forego FFS revenue when they successfully reduce hospital admissions and readmissions. It is clear that both start-up and maintenance costs for ACO development are substantial. CMS has already recognized, through establishment of the Advanced Payment Model, that access to this capital is particularly problematic within rural settings and for ACOs initiated through a collaboration of relatively small primary care/multi-specialty care practices. More recently, CMS released the ACO Investment Model to provide needed capital to allow new ACOs to form in rural and underserved areas and current MSSP ACOs to transition to arrangements with greater financial risk. We commend CMS's efforts to date to address the financial barriers to ACO development. *In the future, we recommend that CMS consider additional steps to remove barriers to needed capital and other financial resources. These could include providing monthly care management payments as is done in the Comprehensive Primary Care Initiative; partial capitation payments as authorized in the MSSP statute; and establishment of low-cost and/or federally guaranteed loan programs.*

Agreement Period Considerations Entering 2016

We are concerned that some ACOs at the end of their first agreement period will not have sufficient time to understand the implications of the final program regulations prior to having to commit for the 2016 performance year. In particular, if ACOs are required to move to two-sided risk, they will need to analyze the latest data, present options to their boards, make their final decision, prepare the appropriate renewal application, arrange for their line of credit, and alter their participation agreements, among other needed changes. We believe this will be difficult given that CMS will need additional time to review comments, conduct data analyses, prepare and issue a final regulation following the February 6 comment deadline. In addition, with only one year of fully reconciled data, it will be challenging for the ACOs to make a truly informed decision as to whether they are ready to move to a two-sided risk track and a reset benchmark.

At the same time, the current program rules—including and especially those related to shared savings and losses, waivers, and the benchmark resetting methodology—must evolve in the near future to improve the attractiveness of the MSSP and sustain and grow provider participation. More than 75% of early ACO participants either did not generate savings or did not exceed their minimum savings rate (MSR) in year one, leading to significant financial losses from start-up and ongoing operating costs associated with running an ACO. Moreover, as we discuss in the benchmark section of this letter, we believe resetting the ACO's benchmark by recalculating a purely historical benchmark is not prudent. Those ACOs who were successful would find their new targets reduced. Furthermore, a pure historical resetting would do nothing to improve the

chances of retaining those efficient and disadvantaged ACOs located in low-spending regions.¹ As a consequence, based on discussions with ACOs, we believe that many will forego participation in the MSSP altogether and return to FFS payment. A return to fee-for-service for these providers would not be in the interest of providers, Medicare and most importantly beneficiaries. If CMS is serious about moving 50% of its providers to alternative payment methods by 2018, we believe CMS will need multiple concurrent tracks for the near term.

Therefore, we recommend that CMS allow current ACOs the option to extend their current contracts by two years. This would allow certain ACOs more time to determine their readiness to change tracks and assume risk, while those that are prepared to accept new contract terms and shift to greater risk at this time could do so. This is not, however, to suggest that CMS could not make changes to the extended contract, such as adding payment waivers, but rather would not reset benchmarks or require a new track.

We further recommend that CMS change in general from a three-year to a five-year agreement period. This would provide the ACOs with the necessary time to “learn the business” of providing population-based accountable care, provide more long-term stability for ACOs, and account for the fact that avoidable incremental cost percentage is higher in the long run--all factors that would make the program more attractive.²

TRACK ONE

Track 1 Beneficiary Assignment

CMS proposes to maintain retrospective assignment under Track 1. *As we discuss in more detail under Track 3, we believe that prospective assignment should be available under all three tracks.*

Track 1 Financial Model

Track 1 MSR/MLR

Deferred Reconciliation

In the first year of the program, a quarter of the participants generated savings but did not share in them as they did not meet their MSR. For small ACOs, the MSR is unrealistically high at 3.9% savings. An alternative that stakeholders have suggested in prior years is allowing organizations that save but do not meet the MSR to defer reconciliation. The idea is to accumulate cost experience (and savings) over time, giving them an effectively larger beneficiary base, which would reduce the size of the MSR accordingly. For example a 5,000-

¹ Unpacking The MSSP Proposed Rule: Geography and Policy. *Health Affairs*. <http://healthaffairs.org/blog/2015/01/22/unpacking-the-medicare-shared-savings-proposed-rule-geography-and-policy/> (accessed 1/24/15).

² Chernew, M. McGuire, T. and McWilliams, J.M., *Refining the ACO Program: Issues and Options*, November 7, 2014.

member ACO would have the MSR of a 15,000-member ACO over three years so that its confidence interval boundary would drop from 3.9% to 2.7%. That way a small ACO that consistently saves over three years (say, 3% each year) will ultimately be eligible for a share of that savings, even though in each year separately it did not exceed the single-year threshold of 3.9%. *CMS should allow ACOs that are saving but not meeting their MSR the option to defer reconciliation across multiple years to reduce their MSR.*

Quality Performance

According to Section 3022 of the Affordable Care Act, quality improvement is a primary goal for the ACO program. However, under the current rules, the quality of care takes a back seat to generating financial savings for Medicare. Although CMS is setting performance levels for quality measures that demand higher performance on quality, achieving those higher performance levels merely prevents an ACO from having to forfeit the shared savings payments it has earned. There is no direct financial reward for improving quality of care, and there is no penalty for poor quality unless the ACO has generated savings.

This lack of reward for performance improvement can be a strong disincentive for ACOs to invest in quality improvement. Many efforts to improve the quality of care will consume ACO resources and increase spending relative to the ACO's financial benchmark in the short term, even if they decrease Medicare spending over the long term. Medicare-covered preventive services are a good example. An ACO that does extensive patient outreach for cancer screening tests, such as colonoscopies, could expend considerable resources delivering these services. Better screening, in turn, would avoid the need for expensive late-stage cancer treatments for some percentage of the patients who are screened, but those savings will not be realized until after the performance year in which the screening is provided and in many cases not until after the ACO contract period has ended. The same is true of tobacco use interventions, management of hypertension and diabetes, and other ACO quality measures.

The more an ACO strives to improve quality performance, the more it will need to spend. If the services used to improve quality are billable services, they will increase the ACO's spending level and reduce the probability of achieving the minimum threshold for shared savings. If the services are not billable, such as in areas where the FFS system fails to pay for high-value services (e.g., chronic disease management), they will create losses for the ACO in the short run, but they may not reduce any billable services, meaning that the quality improvement efforts will not result in any savings to cover the losses. In some cases, quality improvement will also reduce the number of billable services and thereby reduce providers' revenue (e.g., fewer avoidable admissions and readmissions) as well as increasing their costs, and the shared savings may not offset the costs that the providers will continue to incur in caring for other patients.

In addition to increasing the share of savings provided to top performers as discussed in the sharing/loss rate sections, good performance on quality standards or improvement in quality scores from one performance year to the next should allow ACOs that have achieved savings to more readily be able to meet their MSR and get some of those savings back. Thus, to further recognize these quality efforts, *we recommend that ACOs in any of the tracks that are above*

average in their quality performance or in improvement in their quality performance from one year to the next be rewarded by having their MSR reduced.

The purpose of the MSR is to prevent ACOs from earning savings that might be due to random variation in spending on their patient population. ACOs that are making large investments in improving performance on quality measures, and succeeding, may be less able to exceed their MSR, not due to random fluctuations in spending but precisely because they are investing more in high quality performance. An MSR reduction is a logical and positive way of acknowledging the importance of these investments. It will allow ACOs that are delivering better quality care to have a better chance of getting at least a small amount of savings, which will help them to recoup their investments in improving quality.

Track 1 Sharing Rate

CMS proposes that Track 1 ACOs that have completed a 3-year agreement may elect to continue participation under Track 1 for one subsequent agreement period, albeit with a lower sharing rate (40% instead of 50%). *We support ACOs being able to remain in Track 1 for more than one agreement period but do not support the reduction in the sharing rate.*

While there is no formal program risk in Track 1, there are certainly financial risks associated with pursuing ACO status such as the opportunity costs of tying up capital, difficulty maintaining bond covenants, shifting services to a model that would be less profitable if the organization returns to standard FFS, reputational ramifications of a possible failed venture, and ongoing investments in care management changes. According to a survey by the National Association of ACOs (NAACOS), the average first year start-up costs of an ACO are \$2.0 million, while the ongoing operating costs are \$1.5 million. CMS estimates the first year costs to be \$1.8 million. Organizations that have taken the leap into the program do not want to exit as it is difficult to unwind the structural and financial investments. At the same time, there must be sufficient reward for continuing participation. We believe that the existing Track 1 conditions are insufficient in their current form, let alone with a reduced sharing rate that CMS is proposing for the second contract term.

The existing sharing rate of 50% is a starting point under the current model; however, once the quality provisions are layered on, the sharing rate actually decreases. According to an analysis by NAACOS, had the actual quality performance scores (as opposed to reporting alone) applied to the payments in the first program year, sharing would have been reduced by 25%, creating an effective sharing rate of 37.5%. This return on investment is not sustainable for ACOs and could encourage exit from the MSSP.

Given this level of investments, and the fact that the ACOs are unlikely to get their entire share of savings, we do not believe it is realistic to drop below 50%. If anything, 50% is too low to incentivize the care change that will lead to success.³ Certainly, ACOs will not remain in the

³ Chernew, M. McGuire, T. and McWilliams, J.M., *Refining the ACO Program: Issues and Options*, November 7, 2014.

program if future contracts are lowered to 30 or 20%. CMS should recognize that as long as the ACOs are not continually losing money, it is in the interest of Medicare to keep organizations in the program even if they do not proceed to a risk-bearing model. As long as basic quality standards are met, as discussed below, ACOs in Track I should be eligible for continued participation in the MSSP at the current sharing rate of 50%.

In addition, we believe CMS should further recognize high-quality providers under not only Track 1, but also Track 2 and the proposed Track 3. Within the Medicare Advantage (MA) program, plans are rewarded with higher benchmarks for higher quality, while under MSSP Track 1, a perfect quality score can only enable you to keep up to half of the savings you earned. This leads to an asymmetry between MA plans and ACOs that would remain even if CMS brings the benchmark methodologies closer together.⁴ As a result, quality is only a punishment, not a reward, for ACOs. We believe high quality attainment or significant quality improvement over an ACO's base quality should be rewarded financially. *To emphasize and reward top quartile quality performance or improvement, CMS should provide on a sliding scale up to 10 percentage points of additional shared savings for a total of 60%. As we discuss below, we also recommend an additional 10 percentage points be shared under Track 2 and proposed Track 3.*

Track 1 Criteria for Continuation

CMS proposes the option to continue in Track 1 to be only available for ACOs that: (1) meet the criteria established for ACOs seeking to renew their agreements, including demonstrating to CMS that they satisfied the quality performance requirements such that they were eligible to share in savings in at least one of the first two performance years of the previous agreement period; and (2) did not generate losses in excess of the negative minimum loss rate (MLR) in more than one of the first two performance years of the previous agreement period.

Quality Performance

It is reasonable for CMS to assess the performance of the ACO before determining if the ACO should be allowed to continue in the program. However, the criteria laid out by CMS in the rule are somewhat vague. We believe that CMS intends the quality requirement to mean that the ACO must be in at least the 30th percentile (or 30% on flat benchmarks) for at least 70% of the measures in each domain. We do not believe that higher standards should be applied at this time as there are more incentives built into the MSSP program to improve quality than traditional FFS. For instance, when an ACO scores below the thresholds mentioned, a corrective action plan (CAP) is developed to assist the ACO in improving. Under FFS, no such plans or monitoring exist. Thus, we believe it will ultimately benefit more beneficiaries to keep as many ACOs in the program as possible. Moreover, to date, the first year of quality measurement has been pay-for-reporting. And, moving forward, the first two years will be pay-for-reporting for each new measure. During this time, ACOs are learning the measures, determining what care model

⁴ Medicare Payment Advisory Commission, *Report to Congress: Medicare and the Health Care Delivery System, June 2014.*

changes need to be made, struggling with the Group Practice Reporting Option (GPRO) web interface process, etc. Thus, the initial results may not be truly reflective of their performance.

In addition to allowing those that surpass the performance threshold to continue, we believe CMS should allow those that do not meet the threshold to proceed on a case-by-case basis depending on improvement in their scores or adherence to the required CAP. As CMS notes in the proposed rule, toward the end of the first agreement the ACO may have made great strides toward improving the care provided to the Medicare beneficiaries and thus should be allowed to continue their forward momentum. *ACOs that surpass the minimum quality standards should be allowed to proceed in Track 1, while those that do not should be allowed to appeal to CMS based on recent improvements in care and adherence to any corrective action plan.*

Financial Performance

In terms of the requirement that the ACO did not generate losses in excess of the minimum loss rate (MLR) in more than one of the first two performance years of the previous agreement period, again, CMS should consider the direction the ACO's performance is trending. Perhaps the first year the ACO lost well beyond the MLR, but in the second year the ACO came very close to the MLR. In addition, other conditions might be positive indicators such as if an ACO dramatically increased the number of tentatively assigned beneficiaries in the third performance period. In cases such as these, it may be that by analyzing more recent data CMS would determine the ACO to be performing adequately. *CMS should consider on a case-by-case basis whether an ACO that lost more than the MLR in both years and appeals its status should be allowed to continue in the program by analyzing data available from the third performance year.*

Reconsideration Process

Rather than automatically eliminating the ACOs from continuing on Track 1, we urge CMS to implement a reconsideration process for ACOs that have a compelling reason why they were unable to meet the criteria and that can document that continuation in Track 1 would not be a risk for the Medicare program. There are administrative or technical reasons why an ACO might have losses that are not associated with performance. Examples include ACOs that mistakenly did not provide historic TINs in the first months of the program or ACOs that have beneficiaries incorrectly categorized in the risk adjustment methodology. These issues can affect the accuracy of the benchmark and reconciliation calculations. If CMS intends to limit ongoing participation in Track 1 based on financial performance, which we discourage, the Agency should at least create a process for ACOs to request a reconsideration of the decision. Similarly, we believe ACOs that do not meet the quality thresholds should be allowed to engage CMS based on recent improvements in care and adherence to any corrective action plan.

TRACK TWO

Track 2 Beneficiary Assignment

CMS proposes to maintain retrospective assignment under Track 2. *As we discuss in more detail under Track 3, we believe that prospective assignment should be available under all three tracks.*

Track 2 Financial Model

Track 2 MSR/MLR

CMS proposes replacing the current flat 2% MSR/MLR under Track 2 with a variable MSR and MLR using the same methodology as is currently used under Track 1, which varies the ACO's MSR/MLR based on the number of assigned beneficiaries.

While it is true that the variable MSR/MLR can minimize the down-side risk for some ACOs compared to the current flat 2%, it can also reduce the shared savings for those that are successful. Each organization is in the best place to determine the level of risk for which it is prepared, and thus should be given a few options to choose from. For instance, new organizations that are small might be willing to take on risk but want the protection of the variable methodology, while a renewing ACO that has been saving for two years may want no MSR/MLR. This is similar to the ability of organizations within the Bundled Payment for Care Improvement (BPCI) initiative to choose from three risk tracks.

We note that under a two-sided model, an MSR/MLR is not necessary as normal variation will result in inaccuracies both up and down that balance each other out. CMS chose to apply an MSR/MLR, and now a higher one, because of apprehension that it and the providers would incur losses as more ACOs move to a two-sided risk model. However, the providers in a down-sided risk model must demonstrate their ability to repay, and they should be the final decision makers rather than CMS imposing its preference. *Thus we suggest that CMS provide Track 2 ACOs the option of choosing to have no MSR/MLR, a flat 2% MSR/MLR or a variable MSR/MLR associated with the size of the beneficiary population.*

Track 2 Sharing/Loss Rate

Under MSSP Track 2, a perfect quality score can only earn you 60% of the savings you generate. As we have noted under the other payment tracks, we believe CMS should recognize high-quality providers under all MSSP Tracks. *To emphasize and reward top quartile quality performance or improvement for Track 2 ACOs, CMS should provide on a sliding scale up to 10 percentage points of additional shared savings for a total of 70%.*

TRACK THREE

CMS proposes to create an additional risk-based option, referred to as Track 3, for ACOs ready to take on increased performance-based risk in exchange for the possibility of greater reward. The CMS proposal to develop a new risk-based Track 3 would be based on the current payment methodology under Track 2, but it would also incorporate some different elements that CMS states would make it more attractive for entities to accept increased performance-based risk. Specifically, CMS proposes to make modifications to the beneficiary assignment methodology, sharing rate, MSR and MLR, and performance payment and loss sharing limits.

We appreciate CMS developing additional options within the MSSP program that allow ACOs to increase their risk and reward. We see Track 3 as the next frontier in accountable care and population-based payment models. Particularly, given that only a handful of ACOs have entered Track 2, many ACOs may not be ready to take on additional risk for at least another agreement period. Nevertheless, we support CMS developing this model, to allow for adequate stakeholder input and so that ACOs know what expectations lie ahead. Moreover, this track could be useful for moving ACOs in more mature markets that are already low-cost, low-growth to a new benchmarking system as we illustrate below.

Track 3 Beneficiary Assignment

CMS proposes to implement a prospective assignment methodology for Track 3 ACOs that relies on the same stepwise assignment methodology used for Tracks 1 and 2. The major difference would be that beneficiaries would be assigned to Track 3 ACOs prospectively at the start of the performance year, and there would be no retrospective reconciliation resulting in the addition of new beneficiaries at the end of the performance year.

A retrospective assignment model can be beneficial for some ACOs. For example, a small ACO may be worried about dropping below the 5,000 beneficiary minimum and thus prefer a model where it could add beneficiaries throughout the year. Under a prospective model, the ACO will only lose beneficiaries. However, we concur that by the time an ACO selects Track 3, a prospective model would be preferred. With substantial risk required under this track, an ACO will want a very stable beneficiary population to avoid unexpected changes in its benchmark. Moreover, these more advanced ACOs will want to employ data analysis and beneficiary engagement techniques from the start of the performance period on a population for whom they know they are responsible. *Thus, we support prospective beneficiary assignment in Track 3.*

CMS also seeks comment on whether it should consider implementing the prospective assignment approach proposed for Track 3 under Track 2. Based on discussions with participating ACOs, *we believe that prospective assignment can be valuable across all tracks to stabilize the beneficiary population, which also aids in establishing stable benchmarks.* As we note above, there are different reasons an ACO might prefer retrospective or prospective assignment that may not relate to level of risk. Moreover, some ACOs may prefer having the ability to get accustomed to prospective assignment under a one-sided risk model before moving to a two-sided risk model. Adding the prospective assignment to other models may also give CMS more confidence in providing broader payment waivers as the population to which the waivers would apply would be easier to define. *Thus, CMS should also offer ACOs in Tracks 1 and 2 the option of choosing between prospective assignment and retrospective assignment.*

Furthermore, we believe CMS should allow ACOs to move up tracks at each annual recertification but remain within their five-year contract window. Under this arrangement, an ACO that feels comfortable assuming more risk based on its performance does not have to wait until a new contracting cycle to change tracks. ACOs would be able to more quickly transition toward models with greater risk. Similarly, ACOs should be allowed to move from retrospective assignment to prospective assignment at each recertification.

Exclusion Criteria

CMS proposes to perform a limited reconciliation for prospectively assigned beneficiaries whereby beneficiaries would only be removed from the prospective assignment list at the end of the year if they were not eligible for assignment at that time. For example, if a prospectively assigned beneficiary chose to enroll in MMA at the beginning of the performance year, that beneficiary would be removed from the beneficiary assignment list at the end of the year and the beneficiary's expenditures would not be used in determining the ACO's financial performance for that year.

CMS notes that beneficiaries would only be removed from the prospective list, but would not be added. We agree that beneficiaries should be removed under the limited circumstances proposed by CMS. We concur that beneficiaries should not be removed from the prospective beneficiary assignment list even if the beneficiary received a plurality of his or her primary care services from another ACO. This is a fundamental tenet of prospective assignment. If CMS follows our recommendations to allow ACOs to choose between prospective and retrospective assignment in both Tracks 1 and 2, then those that are concerned about having beneficiaries attributed who did not engage with the ACO during the year could continue to choose retrospective assignment under one of those tracks. It would be helpful to the ACOs, however, to get any information available from CMS during the performance period about beneficiaries who will be excluded so that they can most efficiently target their efforts. Another situation that would leave the ACO accountable for a beneficiary for whom it cannot provide care is a beneficiary moving a significant distance from the ACO mid-year. This could be especially detrimental if the beneficiary moves to a much higher spending area. *While we support CMS's exclusion of beneficiaries who are later determined to be ineligible for assignment, we also suggest that CMS consider a mechanism for removing beneficiaries who have moved out of the ACO service region.*

Timing of Prospective Assignment

CMS proposes to base prospective assignment on a 12-month assignment window (offset from the calendar year) prior to the start of the performance year. CMS further proposes to define an "assignment window" as the 12-month period used to assign beneficiaries to an ACO. The assignment window for Tracks 1 and 2 would be based on a calendar year while the assignment window for Track 3 would be based on the most recent 12 months for which data are available, and which would be offset from the calendar year.

We appreciate CMS's efforts to provide ACOs with their prospectively assigned beneficiaries as close to the start of each performance year as possible as this will allow them to begin their important work expeditiously. We recognize that CMS cannot generate all the ACO's beneficiary lists on January 1 reflecting care on December 31 or the prior year. The Agency must begin the process in advance to allow for a reasonable processing time frame that allows for verification of the assignment lists and other steps to ensure the veracity of the data. However, it does concern us that CMS did not specify an exact timeline, which we hope will appear in the final rule. *We support CMS's plan to use slightly older claims data for prospective assignment in exchange for getting the assignment lists earlier in the performance period.*

Interactions between Prospective and Retrospective Assignment Models

CMS proposes that once a beneficiary is prospectively assigned to a Track 3 ACO, the beneficiary will not be eligible for assignment to a different ACO, even if the beneficiary received a plurality of his or her primary care services from ACO professionals in that ACO during the relevant performance year. *We agree that Track 3 prospectively assigned beneficiaries should remain as such unless they are later determined to ineligible or, as we suggested, move mid-year.*

However, we recommend CMS consider additional scenarios. Specifically, now that CMS is considering allowing beneficiary attestation, it is unclear if that was meant to occur during the year or only once in advance of the performance period. In addition, we have recommended that ACOs in Tracks 1 and 2 also be able to choose prospective assignment. We recommend the following order of precedence:

- Beneficiary choice through attestation at any time during the year;
- Prospective assignment regardless of which track;
- Retrospective assignment in Tracks 1 and 2.

We believe this creates the most stable population for the ACOs, while first honoring beneficiary choice.

Track 3 Financial Model

Track 3 Benchmark and Performance Year Expenditures

CMS proposes using the same general methodology for determining benchmark and performance year expenditures under Track 3 as is currently used for Tracks 1 and 2. Despite the fact that CMS proposes to offset the prospective beneficiary assignment from the calendar year, CMS proposes to continue determining the Parts A and B FFS expenditures for each calendar year, whether it is a benchmark year or a performance year, using a 3-month claims run out with a completion factor.

Continuing to base the benchmarks on the calendar year aligns it with the actuarial analyses that calculate the risk scores and the data inputs based on national FFS expenditures (e.g. national FFS trend factors). Moreover, we agree with CMS that this allows the Agency to maintain consistent timing for the generation of historical benchmark reports for Track 3 as would be followed for Tracks 1 and 2. *Thus, we support the use of the calendar year to calculate the benchmarks and performance year expenditures.*

Track 3 Risk Adjustment

CMS proposes using the same general risk adjustment methodology for Track 3 as is currently used for Tracks 1 and 2 but proposes certain minor modifications to the existing definitions of newly and continuously assigned beneficiaries to accommodate the prospective assignment

approach proposed for Track 3. Both definitions refer to determining whether the beneficiary was assigned to the ACO or received primary care services from an ACO participant in the “prior calendar year.” However, the CMS proposal for Track 3 assignment does not correspond to the 12 months in a calendar year. Instead, CMS would use an off-set 12-month period prior to the relevant performance or benchmark year to prospectively assign beneficiaries. If CMS continues to use a calendar year as the basis for determining continuously and newly assigned beneficiaries, very few beneficiaries would be designated as newly assigned for each performance year. As a consequence, the major risk adjustment applied under Track 3 would be based on demographic factors only instead of the CMS Hierarchical Condition Categories (HCC) prospective risk scores. *While we continue to believe the current methodology inadequately captures the risk and cost associated with ACO beneficiaries, we support CMS aligning the definition of newly and continuously assigned beneficiaries to be consistent with its proposed prospective assignment approach for Track 3.*

For all three tracks, we urge CMS to consider additional changes to increase the accuracy of the risk adjustment methodology. For the continuously enrolled population, the HCC scores are capped at the ACO’s baseline risk. CMS only allows an increase in the risk adjustment based on demographic changes (e.g., the aging of the population), not on changes in the acuity of the population. On the other hand, CMS allows reductions in the risk adjustment based on demographic factors or HCC scores for the continuously enrolled. We are concerned that by only counting HCC scores that work against the ACO for the continuously enrolled population, the current policy actually disadvantages ACOs that take on the management of the sickest populations with greater medical need.

This policy stems from a concern that the ACOs will receive higher payments due to improved documentation and coding. However, ACOs do not have the same tools at their disposal as MA plans to improve coding. MA plans are able to use a separate process to submit the “one best medical record” that supports each beneficiary’s HCCs identified for validation from a hospital inpatient, hospital outpatient, or physician medical record when more than one option is available. To the contrary, ACOs can be single-setting entities with no access to other facilities or settings’ coding practices. Without this process, correct ACO coding merely serves to ensure that providers are paid appropriately and be willing to take the sickest patients. In addition, this artificial cap applies a perverse incentive in which those ACOs that meet the goal of improved patient health, reduced costs through coordinated care management, and other long-term strategies will be penalized. These organizations will see a decrease in acuity for well-managed patients that will count against them, while they will not receive credit for caring for patients whose acuity intensifies. CMS should at least allow ACOs to get full credit for any increase in HCC risk scores for the first year the beneficiary is in the ACO. This will give the ACO some time to ensure that all of the beneficiaries’ diagnoses have been captured on claims before the score is frozen. *While we believe CMS should incorporate the full growth in HCC risk scores across all contract years, at a minimum we urge CMS to recognize the full growth for beneficiaries in their first year of assignment to the ACO. In addition, CMS should continue researching alternative risk adjustment models.*

Track 3 MSR/MLR

CMS proposes to apply a fixed 2% MSR/MLR to ACOs that elect to participate in proposed Track 3, which currently applies to ACOs participating under Track 2. CMS notes that it selected 2% because this is the lowest MSR under the one-sided model and was also the MSR that was used in the Physician Group Practice demonstration. CMS believes that setting the MSR/MLR at this level would offer greater predictability, which may attract more ACOs to participate in Track 3 while also distinguishing it from Track 2.

While it is true that an MSR/MLR can minimize the down-side risk, it can also reduce the shared savings for those who are successful. Each organization is in the best place to determine the level of risk for which they are prepared, and thus should be given a few options from which to choose. For instance, new organizations that are small might be willing to take on risk but want the protection of the variable methodology. However, a renewing ACO that has been saving for two years may want no MSR/MLR. This is similar to the ability of organizations within the Bundled Payment for Care Improvement (BPCI) initiative to choose from three risk tracks. From an actuarial standpoint, we note that under a two-sided model, an MSR/MLR is not necessary as normal variation will result in inaccuracies both up and down that balance each other out, meaning chance would result in both overpayments and underpayments that would be expected to offset each other. CMS chose to apply an MSR/MLR, and now a higher one, because of apprehension that it and the providers would incur losses as more ACOs move to a two-sided risk model. However, the providers in a down-side risk model must demonstrate their ability to repay, and they should be the final decision makers rather than CMS imposing its preference. We see no value in setting different MSR/MLRs under Track 2 versus Track 3, and do not think such a difference would drive an ACO's decision to change tracks. Moreover, we do not believe that the flat 2% provides much additional stability. Even with retrospectively assigned beneficiaries, the ACOs have an estimate of their size in advance of the performance year. *Thus we suggest that CMS provide the option of choosing to have no MSR/MLR, a flat 2% MSR/MLR or a variable MSR/MLR associated with the size of the beneficiary population for Tracks 2 and 3.*

Track 3 Sharing/Loss Rate

CMS proposes to increase the sharing rate for Track 3 ACOs so that they may qualify for up to 75% of all savings under their updated benchmark in conjunction with accepting risk for up to 75% of all losses, depending on the quality performance of the organization. The increased sharing rate will benefit those mature ACOs who are able to take on significant risk, and differentiates the proposed Track 3 from Track 2. *We support the proposed sharing/loss rate of 75% for the proposed Track 3.*

CMS further proposes that ACOs with high quality performance would not be permitted to reduce the percentage of shared losses for which they would be responsible for each year of the agreement period below 40%. CMS seeks comments on whether the quality score should only allow ACOs to reduce their shared losses to something higher such as 50%. *Paying 40% of losses is a sufficient deterrent to incentivize providers to avoid losses if at all possible. Setting the percentage higher could deter participation in two-sided risk models.*

Quality Performance

We believe there are two equally important ways to measure quality performance: attainment against pre-established benchmarks and improvement over an ACO's previous performance. Within the Medicare Advantage program quality scores dictate bonuses rather than cuts. CMS explores how best to take into account an ACO's quality score when calculating the ACO's final sharing rate to further encourage ACOs to assume greater responsibility for the quality and cost of the care furnished to their assigned beneficiaries. Under Track 2, for example, an ACO with poor quality performance may be responsible for repaying Medicare up to 60% of losses while an ACO with very high quality performance may be responsible for repaying Medicare only 40% of the losses incurred. CMS proposes that Track 3 ACOs be held responsible for the same amount of downside risk as Track 2 ACOs (40%) with a maximum shared loss percentage of 75%. Track 3 ACOs can receive a shared savings payment of up to 75% of all savings under its updated benchmark.

As we have noted under the other payment tracks, we believe CMS should recognize high-quality providers under all MSSP Tracks. *To emphasize and reward top quartile quality performance or improvement in Track 3, CMS should provide on a sliding scale up to 10 percentage points of additional shared savings for a total of 85%.*

Track 3 Performance Payment and Loss Recoupment Limit

Under CMS proposals, Track 3 ACOs would receive a shared savings payment of up to 75% of all savings under its updated benchmark, not to exceed 20% of its updated benchmark. Track 3 ACOs would be accountable for between 40 to 75% of all losses under its updated benchmark, not to exceed 15% of its updated benchmark.

While we believe no transition to risk is necessary for ACOs moving from Track 2 to the proposed Track 3 given there is only a five percentage point difference in risk. We are concerned about the ACOs that may move from Track 1 to the proposed Track 3. *Under this scenario, we believe that ACOs should have their losses to be phased in over five years if going straight from Track 1 to 3: 2% for Performance Year (PY)1; 5% for PY2; 7.5% for PY3; 10% for PY4; and 15% for PY5.*

Track 3 Global Payment Model

At several points in the proposed rule, CMS seeks comment on ways to encourage ACO participation in performance-based risk arrangements. A major barrier to ACO willingness to participate in the Track 2 model to date is the level of uncertainty involved as to whether the ACO will receive a shared savings payment or be responsible for payments to CMS. Current proposals to allow beneficiaries to voluntarily choose to participate in an ACO through attestation and to provide a prospective model for patient attribution are positive steps forward in reducing the degree of uncertainty that ACOs will face, and we believe they will be helpful in promoting more interest in two-sided risk models. However, there would still be significant

financial uncertainty for ACOs because the target spending level is only determined after spending has already occurred.

To address this, CMS could offer an option under Track 3 that enabled ACOs to assume a greater degree of performance risk without assuming full insurance risk. Under this option, Track 3 ACOs could receive a risk-adjusted prospectively determined budget or benchmark as an alternative to the shared savings/losses model. By knowing its patient population ahead of time through prospective attribution and also knowing its budget ahead of time, participants in an ACO can develop a detailed business plan for how to keep spending within the budget. The ACO would then keep any savings below an agreed upon discount, and would have to absorb the cost of services above the global payment or budget. Similar approaches have been successful in the private sector. For example, the Alternative Quality Contract developed by Massachusetts Blue Cross Blue Shield defines a global budget for all of the care that a group of patients need, with annual spending levels over a five-year period defined in advance. If the provider group responsible for a set of patients keeps total FFS spending below the budget, it receives a supplemental payment based on the difference between spending and the payment. This approach has yielded strong savings while improving quality.

The statute allows CMS to use partial capitation approaches, not just shared savings. These concepts—prospectively set benchmarks, partial capitation, or per patient per month payments as in the Comprehensive Primary Care Initiative—would not only provide more predictability for the ACO, but also it would also make it much more attractive for the ACO to move up the risk/return continuum that Track 3 provides. ACOs could plan specific compensation changes for the individual physicians, practices and other providers participating in the group and determine how to distribute surpluses or allocate overages based on the extent to which these providers achieved their specific responsibilities under the ACO's business plan. *We recommend that CMS consider a prospective benchmark under Track 3.*

SUMMARY OF SHARED SAVINGS AND LOSSES RECOMMENDATIONS

To summarize our comments across the three tracks we prepared the Table 1 below. It assumes CMS adopts our suggestion to lengthen the contract period to 5 years. We believe that for most ACOs, Track 1 will be considered the “on ramp,” but some ACOs, perhaps smaller ones, may need to remain in that track for multiple contracts. Track 2 introduces “gradual risk” along with enhanced rewards, while Track 3 is for those that are able to take advanced risk and are likely ready to move to a regional benchmarking system that will recognize their efforts to keep their costs and cost growth low.

Table 1.

Issue	Track 1 "on ramp"	Track 2 "gradual risk"	Track 3 "advanced risk"
Contract length	5 year contract (2-year extension)	Same as Track 1	Same as Track 1 and 2
Risk model	One-sided upside only risk	Two-sided risk	Two-sided risk, with global payment option
Shared savings rate for ACO	Up to 50%, with an opportunity for 60% for ACOs in top quartile of quality performance	Up to 60%, with an opportunity for 70% for ACOs in top quartile of quality performance	Up to 75%, with an opportunity for 85% for ACOs in top quartile of quality performance
Minimum Savings Rate (MSR)	Variable 2.0 - 3.9%	ACOs are able to select their MSR: 1. No MSR 2. Fixed MSR of 2.0%, or 3. Variable 2.0 - to 3.9%	ACOs are able to select their MSR: 1. No MSR 2. Fixed MSR of 2.0%, or 3. Variable 2.0 - 3.9%
Minimum Loss Rate (MLR)	Not applicable	Selection must be aligned with the ACO's selection of MSR option	Selection must be aligned with the ACO's selection of MSR option
Loss Cap	10%	15%	20%
Loss sharing limit	Not applicable	Limit on losses to be phased in over 5 years starting at 0% for PY1; 2% for PY2; 5% for PY3; 7.5% for PY4; and 10% for PY5	Limit on losses to be phased in over 5 years if going straight from Track 1 to 3: 2% for PY1; 5% for PY2; 7.5% for PY3; 10% for PY4; and 15% for PY5.
Benchmark Update	Option for National or Regional	Option for National or Regional	Option for National or Regional
Benchmark Reset	Historical spending (33% weighting and savings added back)	Option of using historical spending (33% weighting and savings added back) or regional blend	Option of using regionally based prospectively set or historic benchmark
Beneficiary Assignment methodology	Beneficiary attestation and choice of retrospective/prospective assignment	Beneficiary attestation and choice of retrospective/prospective assignment	Beneficiary attestation and prospective assignment

PAYMENT WAIVERS

CMS is proposing to utilize payment waivers exclusively as incentives to move ACOs to higher-risk tracks or have prospective ACO providers initially agree to at-risk contracts. Payment waivers ought to be made policy based solely upon whether and when they can help improve clinical care and outcomes. That means any and all payment waivers that can improve care delivery should be available to all MSSP participants such that in turn all assigned beneficiary participants can benefit equally. (This is particularly true here since it is highly unlikely, as MedPAC has demonstrated, that the beneficiary knows that he/she is in an ACO and/or what that means.) For the ACO, since CMS does not propose to grant payments waiver unconditionally, an ACO ought to at minimum have the opportunity to apply and attempt to meet whatever qualifying criteria. Only after first experiencing the benefit of the waiver(s) will an ACO be able to calculate to what extent the waiver(s) helps them responsibly assume more financial risk.

Skilled Nursing Facility (SNF) Waiver

CMS proposes to allow for patients in a two-sided performance-based risk ACO to receive skilled nursing care or skilled rehabilitation services provided by a SNF without a prior inpatient hospitalization or with an inpatient hospital length of stay of less than three days. CMS believes this waiver would allow for “medically appropriate and more efficient” care and “allow ACOs to realize cost savings and improve care coordination.” *For this reason and others, we support granting waivers for Track 2 and the proposed Track 3 ACOs as well as for Track 1 ACOs.*

We support the waiver proposal for several reasons. CMS notes that granting this waiver for at-risk ACOs is, or would be consistent with, current Medicare policy that affords a similar waiver to MA plans, Pioneer ACO plans, Special Needs Plans (SNPs) and PACE (Program for All-Inclusive Care of the Elderly) plans. We understand CMS's willingness to extend this waiver to at-risk tracks since, as CMS notes, these tracks share financial “incentives that currently exist for MA plans and Pioneer ACOs.” More specifically CMS states the Agency would “likely initially limit this waiver to ACO participants and ACO providers/suppliers under proposed Track 3” because CMS argues that Track 3 providers are exposed to up to 75% of shared losses while Track 2 providers are liable for up to 60% of shared losses. We do not believe this difference (between 75% and 60% in shared savings or losses) is sufficient reason or reason enough to deny Track 2 ACOs the waiver. The assumption that Track 2 providers would somehow be less committed to “medically appropriate and more efficient” care because they would be exposed to marginally less downside risk is not evidence-based.

We also oppose CMS's proposal to “likely initially limit” the waiver to SNFs that are ACO participants and ACO providers/suppliers. This policy is inconsistent with Pioneer ACO policy, as SNFs are not formally required to be a Pioneer ACO provider/supplier. Limiting the waiver to some subset of SNFs could limit patient access, particularly in rural areas, and override patient preference or choice.

We recommend that CMS extend the SNF waiver (and additional waivers, see below) to Track 1 ACOs as well. That is, per the proposed rule, the waiver should “be made available to all

organizations . . . that have successfully participated in the Shared Savings Program or another ACO model previously.” As the proposed rule notes, the SNF three-day hospital stay rule is fifty years old this year. In a recent MedPAC meeting, MedPAC Chair Glenn Hackbarth termed the rule “archaic.” The rule made sense in the 1960s because 50 years ago it took longer to medically assess a patient and because there were few post-acute beds. However, neither of these reasons is true today. Nowadays, unnecessary or prolonged hospital stays can subject patients to infections, adverse drug reactions, delirium, expose the acute provider to possible Medicare fraud and drive up substantial unnecessary Medicare costs. The argument the rule prevents SNF overuse is not compelling since the evidence is, at best, mixed. It does appear more certain the current rule incents unnecessary SNF-driven hospital admissions. In 2010 MedPAC concluded that 40 to 60% of hospital admissions via SNFs were avoidable. Some are purely to re-establish benefits.

For these reasons and others, congressional legislation has been proposed to eliminate the prerequisite, and the waiver was the first recommendation made by the 2013 Congressional Commission on Long Term Care, that CMS should waive the three-day rule. If a SNF waiver is “medically appropriate and more efficient” and would “allow ACOs to realize cost savings and improve care coordination” for Track 2 and Track 3 ACOs, the same can be said for allowing a SNF waiver for Track 1 ACOs.

Leaving aside the fact that Track 1 ACOs are “intrinsically incented” (CMS's phrase) to limit utilization (and therefore spending) where possible, we understand CMS fears that Track 1 ACOs, absent substantial downside risk, might initially over use SNF services. Therefore, we are willing to support initial measures to ensure appropriate use among Track 1 ACOs. *Beyond the criteria CMS requires for a Pioneer ACO SNF waiver, we propose all Track 1 SNF referrals using the waiver require an ACO physician's signature, that CMS monitor waiver use and have the authority to rescind the waiver for cause and CMS could initially limit the waiver for certain prevalent, high cost chronic conditions.*

Post-Acute Care (PAC) Waiver

As CMS notes in the proposed rule, it is not clear to hospital providers that they have the authority to make post-acute referrals. Under current rules, during the discharge process the hospital, as CMS notes, “must inform the patient of his or her freedom to choose among Medicare-participating post-hospital providers and must not direct the patient to specific provider(s) or otherwise limit which qualified providers the patient may choose among.” Because certain post-acute providers “deliver higher-quality and lower-cost than others” CMS recognizes the value of allowing hospitals “the ability to recommend high-quality SNF and HHA [home health agency] providers with whom they have established relationships, rather than presenting all options equally.” More pointedly, ACOs “have the ability to clearly state to beneficiaries which providers they believe are best and why.” Therefore, CMS proposes to waive the requirement that an ACO present all options equally and avoid specifying or limiting the qualified providers of post-acute care.

CMS proposes limiting the waiver to Track 3 ACOs because beneficiaries are prospectively assigned, making it clear which beneficiaries are covered by the waiver. We recommend that CMS make the waiver available to ACOs in all three tracks. If the rationale for the waiver is providing greater assurance of quality care at a lower cost, it is irrational not to offer the PAC waiver to all Shared Savings ACOs.

As is well known, the quality of post-acute care varies widely. For example, the March 2013 MedPAC report concluded that SNFs vary considerable in the performance of quality measures, noting that “One quarter of facilities had rates 60% higher than facilities in the lowest quartile.” Concerning hospice care, last fall *The Washington Post*, using unpublished Medicare hospice reporting data, detailed at length the wide variation in quality performance between for-profit and not-for-profit hospices. We believe that the variation in PAC quality is sufficient reason to provide the waiver to all ACOs.

Concerning the administration of a PAC waiver, we agree the ACO would still be required to inform the patient or their family “of their freedom to choose among participating Medicare providers” and “respect patient and family preferences when they are expressed.” The ACO would still present a complete list of PAC providers to the patient or their family. We agree the waiver should not apply when a PAC provider pays the ACO to be included as a recommended provider. We further believe that the waiver should be limited to hospitals that are ACO participants or ACO providers/suppliers, that the recommended PAC provider meet certain quality criteria and that the ACO provide a brief written description in its waiver application describing how the waiver would meet the clinical needs of its assigned patients.

Primary Care Co-Pay Waiver

In the proposed rule, CMS asks for recommendations on other FFS payment rules that the Agency should waive to increase quality and reduce costs. We believe there is opportunity for several additional waivers that would both help MSSP ACOs improve care delivery and encourage beneficiary health-seeking behavior. Our strongest recommendation is waiving certain primary care co-pays for all ACO tracks. We offer this proposal for four reasons.

First, by waiving the copays for primary care services, the ACO can encourage patients to get the most appropriate and time-sensitive care. The waiver offers the possibility of further engaging beneficiaries in their health and their healthcare by helping ensure necessary preventative screenings are provided, chronic conditions are kept from unduly progressing, and preventing new conditions or exacerbations of existing conditions.

Second, unstable beneficiary assignment is a well-recognized MSSP problem. Michael McWilliams and his colleagues found in a 2014 *JAMA Internal Medicine* study that unstable assignment was as high as 33% and that “much of the outpatient specialty care for patients assigned to ACOs, particularly higher-cost patients with more office visits and chronic conditions, was provided by specialists outside of patients' assigned organizations, even among more specialty-oriented ACOs.” CMS notes in the proposed rule that unstable assignment or “churn rate” is 24% on average. We believe a copay waiver would reduce unstable assignment

and “leakage,” or where ACO-assigned patients’ office visits occur outside their ACO.

Third, because we propose to limit the copay waiver to five specific primary care (CPT) Evaluation and Management codes (99211-99215) and the Chronic Care Management (CCM), CPT code 99490, we believe this will produce the greatest benefit for the least amount cost to the ACO. Without an out-of-pocket (OOP) cost, the ACO patient can seek care without having to decide presumptively whether care is essential or not. For the ACO provider, the waiver will, again, help reduce year-over-year assignment instability and leakage. The copay waiver would also serve the ACO provider and patient equally well since more timely appointments and greater adherence to care would minimize the possibility of greater downstream costs due to higher intensity care. The waiver would both motivate and reinforce beneficiary-provider attestation (offered in the Pioneer ACO demonstration and discussed in the proposed rule). Voluntary alignment of a patient with his/her primary care provider is recognized by CMS as inherent in improving the goal of patient-centeredness.

Lastly, we recognize the concern that waiving OOP costs can drive over- or unnecessary utilization, i.e., the concern over the “offset effect.” Here again we are limiting the waiver to a discrete number of primary care codes delivered by primary care physicians. The waiver would also only benefit a discrete number of ACO patients since about 25% of Medicare beneficiaries have Medigap insurance and a much larger percentage have supplemental coverage via employer-sponsored plans and other policies that typically provide first dollar coverage. We also know beneficiaries without secondary coverage are poorer in health, lower in income, have higher out-of-pocket costs and stint on care. Finally, we know that waiving the primary copays will result in lower revenue for the ACO physicians and are recommending that the waiver be optional to an ACO, and in order to implement it, the ACO would need to have advanced consent of all primary care providers through their ACO participant agreements. We further recommend that the ACO be able to reimburse the physicians for the forgone revenue associated with waiver of the copays.

In sum, we believe waiving a discrete list of primary care service co-pays for all three ACO tracks would encourage the use of primary care services, improve patient outcomes over time and further patient centered care. This recommendation is consistent with MedPAC’s 2010 technical panel’s finding that lowering cost sharing services for preventive services is a way to encourage the use of high-value, high-quality health care.

Telehealth Waiver

CMS proposes to waive the limitation on “telehealth payment to services furnished within specific types of geographic areas” for Track 3 ACOs. This would allow ACO providers not in designated health professional shortage areas, i.e., urban and suburban area ACO providers, to bill for telehealth services. CMS states this waiver “could allow ACOs to realize cost savings and improve care coordination. . . .” We strongly support waiving the Medicare telehealth geographic requirements for Track 3 ACOs and further recommend they be waived for all ACOs, including Track 2 and Track 1. In addition, we strongly support waiving originating site restrictions for all three tracks. Studies have shown certain medical services delivered using

telecommunication technologies can be substitutable, cost effective, quality improving and preferred by beneficiaries. More importantly, given the ACO care coordination and infrastructure that facilitates team-based communication, there are important patient protections inherent in this health care delivery model that may not be in place outside of the ACO model.

We believe all ACOs, regardless of track, should be eligible for the telehealth waiver, removing the geographic restriction and originating site requirement. To ensure the appropriate use of telehealth services, an ACO should be required to: outline a plan on how it will use telehealth services particularly to improve chronic care management; have a mechanism in place to electronically transmit a record of the telehealth encounter to the patient's primary care provider if the eligible telehealth provider is not the patient's primary care provider; and, publicly post their use/approval of the waiver. We also recommend allowing CMS to deny or revoke a waiver as well as monitor an ACO's billing under the payment waiver to reduce possible abuse.

Like the three-day hospital stay for SNF admissions, the statutorily-imposed limitations on the use of telehealth services in the Medicare program should be modernized. (In 2011 it is estimated the Medicare program reimbursed less than \$6 million in telehealth services.) There is a well-established evidence base for certain services and technology combinations demonstrating that certain telehealth services can and do fundamentally change or disrupt the way healthcare is delivered in positive ways by expanding care delivery capacity/efficiency and improving health care outcomes particularly in under-served and rural areas. Telehealth, whether it be synchronous or asynchronous, offers the ability to enhance consultations between patients and providers, enable remote monitoring, improve the transmission of medical information, help support patients' self-management and generally improve communication and education between providers and patients when appropriate infrastructure is in place to ensure care is coordinated and enhances communications between and among the patient and the medical team members. In an ACO primary care delivery model, telehealth applications have a myriad of uses in preventing or managing numerous leading causes of illness, disability and death. In sum, telehealth services facilitate prevention, coordination and cure and deserve to be available to all beneficiaries in all ACOs.

Studies of certain medical services and technology combinations used in primary care show, for example, it is cost effective in reducing hospital admissions and re-admissions as well as reducing both emergency visits and transfers between emergency departments.⁵ Studies with a focus on chronic disease management have shown that certain telehealth services improve access, quality, and cost.⁶ Concerning quality of care, systematic reviews show telehealth has had a significant positive effect for several predominant diseases, for example, heart disease and

⁵ For example, *Effect of telehealth on use of secondary care and mortality: findings from the Whole System Demonstrator cluster randomized trial*. Steventon A1, Bardsley M, Billings J, Dixon J, Doll H, Hirani S, Cartwright M, Rixon L, Knapp M, Henderson C, Rogers A, Fitzpatrick R, Hendy J, Newman S; Whole System Demonstrator Evaluation Team. *BMJ*. 2012 Jun 21;344:e3874. doi: 10.1136/bmj.e3874.

⁶ For example, *the Empirical Foundations of Telemedicine Interventions for Chronic Disease Management*. Rashid L. Bashshur, PhD, Gary W. Shannon, PhD, and Brian R. Smith, MS. *TELEMEDICINE and e-HEALTH* SEPTEMBER 2014

psychiatric conditions.⁷ Patient satisfaction via the use of telehealth, more specifically, interactive video, telephone consultations and remote monitoring, has, on balance, been high.⁸

Similar to ACOs, the infrastructure to support care coordination and medical team communication has translated into successful deployment of telemedicine in the Veterans Administration (VA). As is well recognized, the VA and its patients continue to benefit substantially from its telehealth program. As of 2013, approximately one million veterans used some type of VA telehealth offering. The VA expects this number to increase to over four million, or two-thirds of all veterans receiving some form of VA health care, in the near future. VA use of telehealth includes a host of counseling services, prosthetic and other check-ups and the sharing of electronic medical record access for veterans' family caregivers. Another essential use of telehealth is remote patient monitoring (RPM) as a way of providing secondary prevention for patients with chronic illness. RPM use to monitor VA patients with chronic obstructive pulmonary disease, congestive heart failure, diabetes and other chronic conditions showed a reduction in hospital bed days of care in excess of 40% on pre-enrollment figures. RPM use by the VA has also led to an 81% decrease in nursing home admissions and a 66% reduction in emergency department visits. The VA reports its telehealth programming generally has among other things reduced overall bed days for veterans by 58% and hospital admissions by 38%.

Similar results have been achieved in health systems offering telemedicine services. Cardiovascular disease patients in Boston's Partners Healthcare receiving RPM services experienced a 50 % reduction in related hospital re-admissions. Similar results were achieved for Colorado patients enrolled in Centura's Health At Home program. In sum, in October 2014, the Office of the National Coordinator for Health Information Technology (ONCHIT) noted in a paper titled "Health Information Technology Infrastructure to Support Accountable Care Arrangements" that remote monitoring would produce as much as \$200 billion in cost savings over the next quarter century if properly deployed with patient protections that ensure care coordination, support communication among the patient's medical team and the patient. If properly deployed with patient protections that ensure care coordination, support communication among the patient's medical team and the patient, telehealth will lead to substantial savings to the healthcare system.

As suggested above, the use of telehealth may be particularly beneficial in rural communities. For example, the Indian Health Service (IHS) has used both live video conferencing and asynchronous technologies to improve Native American health in particularly remote locations. The IHS has been successful in improving diabetes control by significantly lowering low-density lipoprotein cholesterol and hemoglobin A1c levels through the use of telehealth technologies.

⁷ For example, *Telephone Psychotherapy and Telephone Care Management for Primary Care Patients Starting Antidepressant Treatment A Randomized Controlled Trial*. Gregory E. Simon, MD, MPH, Evette J. Ludman, PhD, Steve Tutty, MA, Belinda Operskalski, MPH, Michael Von Korff, ScD. JAMA, August 25, 2004— Vol 292, No. 8

⁸ For example, *Attitudes Toward Medical and Mental Health Care Delivered Via Telehealth Applications Among Rural and Urban Primary Care Patients*. Anouk L. Grubaugh, PhD, Gregory D. Cain, MS, Jon D. Elhai, PhD, Sarah L. Patrick, PhD, and B. Christopher Frueh, PhD. The Journal of Nervous and Mental Disease, Volume 196, Number 2, February 2008.

The IHS has also used the technology to consult with specialists throughout the country to improve its delivery of specialty care.

Despite considerable favorable evidence for certain medical service and technology combinations, telehealth remains largely a promise more so than a reality in the Medicare program. Expanding Medicare coverage for telehealth for all MSSP ACOs is urgently needed to help scale the services and patient-centered care. ACOs are particularly well-suited to the deployment of telehealth services given the structural patient protections of this health care delivery model.

Home Health Prospective Payment System-Related Waiver Requests

CMS proposes a waiver of the home-bound requirement to receive home health services. *While we support the home-bound waiver, we further suggest that CMS permit waivers of the amount, frequency and duration of skilled therapy rules, allow a pre-admission home evaluation, and provide discretion to directly assign patients to Low Utilization Payment Adjustment (LUPA) status for home health services.* Similar to the SNF 3-day stay waiver, we understand CMS has reservations with extending the waivers to Track 1 ACOs. Therefore, we are willing to support initial measures to ensure the appropriate use of the waivers by Track 1 ACOs including ensuring the orders/certifications are by ACO physicians and that CMS monitor waiver use and have the authority to rescind the waivers for cause.

Home-Bound Requirement

CMS is considering waiving the “home-bound” or the “confined to the home” requirement such that Medicare would pay for non-home-bound ACO beneficiaries to receive home health services. CMS is proposing to limit the waiver to Track 3 ACOs or to ACOs participating in a two-sided risk track only. CMS is also proposing to limit the waiver to home health agencies that are ACO participants or ACO providers/suppliers and that the home health agency have, at the time of the ACO’s application submission, a three or more star quality rating. Again, we believe strongly all ACOs are incented to wisely use medical resources. Therefore, we support the use and benefit of this waiver for all ACO tracks for several reasons.

Leaving aside the argument that health care decision-making ought to be made solely on the basis of medical care needs not payment rules, CMS cites its Independence at Home (IAH) demonstration that provides non-home-bound Medicare beneficiaries home-based primary care services. Since the IAH demonstration substantially mimics the VA's Home-Based Primary Care program (HBPC), it is worth noting that the HBPC program has been an unqualified success. The HBPC program has reduced the patient overall cost of care by 24% (\$38,000 v. \$29,000). It has reduced hospital cost of care by 63% (\$18,000 v. \$7,000) and nursing home care by 87% (\$10,000 v. \$1,400). Given the substantial evidence that home-based care independent of requiring “home confinement” has already been proven to be cost-effective, further requiring the Medicare beneficiary’s health to deteriorate to the extent he/she is home-bound before eligibility for home-based Medicare services is indefensible.

We contend further the Medicare home health home-bound requirement is inconsistent with the Medicaid program, which does not require states to have a home-bound requirement in providing home health services. There are no eligibility restrictions whatsoever for Medicaid home health services. This double standard is made worse by the fact that the Medicare home-bound requirement has caused numerous states to erroneously require their Medicaid beneficiaries be home-bound before qualifying for Medicaid home health. In a July 1, 2013, memo to CMS Administrator Marilyn Tavenner, the HHS Office of the Inspector General concluded that eleven states "have improper eligibility restrictions on the mandatory home health," in part because they, wrongly, require the Medicaid beneficiary be home-bound. This is problematic because these misinformed policies adversely affect the Medicare-Medicaid dually eligible. Though we are not making formally a legal argument, we are forced to so ask rhetorically: how is the Medicare home-bound requirement consistent with the Olmstead decision that the ADA's prohibition against discrimination in the administration of public programs disallows unnecessarily institutionalizing persons, for example via a nursing home admission, as a condition of receipt of publicly assisted medical care?

Concerning the administration of a home health home-bound waiver, we agree that ACOs should describe the staff and procedures involved in the clinical management of beneficiaries under this waiver. We also agree that there is benefit to the home health agency being an ACO participant or provider/supplier and that the home health agency has a three or more star quality rating. However, *we continue to emphasize that the home-bound waiver should be available to ACOs in all three tracks, and, given that some ACOs may not have an HHA within their organization, we recommend that CMS permit ACOs to refer to any HHA with a three or more star quality rating under the waiver when there is not one within the ACO.*

Amount, Frequency and Duration of Skilled Therapy

Additionally, under the home health benefit, the "amount, frequency, and duration" of skilled therapy services must be "reasonable," among other requirements. Strict adherence to such limits without a waiver may constrain efficiencies and deny access to limited or more intensive services that patients in ACOs may require. Limiting these home health services could also lead to unnecessary readmissions and even more costly post-acute care services. Thus, waiving the "amount, frequency, and duration" that governs current FFS home health system standards, will provide beneficiaries with increased flexibility in their care plan, reduce readmissions, and improve quality and outcomes.

Pre-Admission Home Evaluation Services

HHAs are prohibited from performing free pre-operative home safety assessments for patients scheduled to undergo surgery. A waiver of this policy would result in more informed post-acute care plans, a decreased likelihood of falls and readmissions, and a more patient-centered care plan. HHAs are especially adept at working with clinicians to assess the patient's care needs, including his or her ambulatory limits or other functional impairments, and should not be prevented, under the MSSP rules, from working collaboratively to generate a care plan at the pre-

admission stage that helps transition the beneficiary to the more patient preferred, lower cost community-based setting.

Discretionary Assignment of LUPA Status for Home Health Services

When HHAs fail to complete more than five visits in a 60-day episode of home health services, such services are paid a LUPA, reflecting the reduced amount of services provided compared with the national 60-day episode rate. We believe MSSP participants should be allowed to make extensive use of home health services as a front-line strategy for achieving adherence to care plans, compliance with medication plans and avoidance of unnecessary re-hospitalizations, regardless of their duration of need. The ability to assign beneficiaries LUPA status on a discretionary basis should be available following transition from any care setting since denying access to home health services simply because the beneficiary fails to require a full 60-day episode, or, more likely, improves in advance of that time frame, is counterproductive to the MSSP's goals of efficient use of services. This waiver request would enable pre-assignment of LUPA status to selected patients that MSSP participants and clinicians assess as needing home health services but not necessarily for the standard duration of a 60-day episode and impose no limit on visit frequency for such assigned patients.

ESTABLISHING, UPDATING AND RESETTING THE BENCHMARK

CMS proposes no specific changes to its financial benchmarking methodology in the proposed rule but does discuss five alternatives to present policy in establishing, updating and resetting an ACO's financial benchmark. CMS seeks comments on these five "suggestions regarding alternative approaches" and feedback on technical adjustments to the benchmark. It is widely recognized throughout the Medicare provider community that MSSP financial benchmarking needs to be substantially improved. Predictability, accuracy and stability over time are the major goals for improvement. Benchmarking is *the* most critical component to the success of the MSSP going forward.

There are several well-recognized problems with the current way CMS establishes, updates and resets an ACO's financial benchmark. Resetting the benchmark based on ACO-specific historical spending penalizes certain ACOs for past good performance and forces the ACOs to chase diminishing returns in subsequent contract periods when the benchmark is reset. This also reduces the incentive for ACOs to invest in efforts that will reduce future spending.⁹ Here achievement or success is punished because the reset benchmark is lower based on the lower spending reflected in the prior contract performance period. With benchmark years weighted at 10-30-60, ACOs that have significant success in their third year of performance will find their new benchmark disproportionately reduced because of that success. Furthermore, calculating the trend for the three years of historical benchmark and the annual benchmark update uses a

⁹ Chernew, M. McGuire, T. and McWilliams, J.M., *Refining the ACO Program: Issues and Options*, November 7, 2014.

national growth rate that disadvantages ACOs in many regions. There is significant variation in year to year cost trends by market that are not accounted for by using a single national dollar amount.

For these reasons and others the undersigned organizations recommend the following:

Per CMS's first option, we support changing the weighting from 10-30-60 to 33-33-33 in second and subsequent contract terms. We recognize that evenly weighting the benchmark years is not advantageous to all ACOs and may actually disadvantage ACOs that are struggling to achieve savings. But conversely, disproportionately punishing an ACO for their success is not good national policy.

We agree with CMS's second option that earned shared savings be added to future benchmark calculations. However, we would go further and urge that all savings, not just the ACO's portion, be added to subsequent contract benchmarks. Adding only the ACOs portion of shared savings is as arbitrary as allowing ACOs only half the savings they achieved.

With respect to trending adjustments, CMS suggests several alternatives to the single national dollar amount. The Agency discusses the physician group practice (PGP) comparison group as well as using county, hospital referral region (HRR) and State trends as the basis for updating. *We support a change to the benchmark trending that moves away from a single national amount toward a regional amount reflective of the actual market in which the ACO operates. We also recommend that CMS give each ACO the option to choose for their contract term whether they want to be trended with national or regional adjustment. This allows an ACO to assess whether their system of care is more reflective of the local market behavior or the national market.*

As proposed, it will be important to calculate the trend excluding the ACO to avoid creating another methodology that requires an ACO—particularly an efficient ACO—to beat its own best performance. Expanding the geographic area to get a larger reference trend when the ACO is dominant is feasible, as long as that expanded area includes some of the ACO's patients and has the same historical trend profile as the original region. We do not have sufficient data to model whether the HRR, PGP county comparison group, or pure weighted-county or State is the appropriate definition of region and request CMS to work with us in analyzing the appropriateness of each in further rulemaking before adopting these changes.

The remainder of CMS's NPRM discussion concerns using regional costs to the resetting and/or setting of the benchmark. Per CMS's discussion, this can be done by replicating the PGP methodology using a reference population, by establishing a benchmark under current rules but updating and resetting the benchmark using regional costs, or by resetting the benchmark in subsequent contract periods using a weighted average (that would use either the established benchmark formula or some alternative approach) and risk-adjusted regional costs.

While the historical benchmark captures unobserved clinical risk in the ACO base-year population, the unstable assignment within a contract period causes the constant influx of new ACO members that are assigned from the community and may not be reflective of the historical

risk. CMS states in the proposed rule that MSSP ACOs will experience a churn of beneficiaries of from 58% to 88% from the first year are assigned to the ACO in the third year. Replacing 12-42% of ACO beneficiaries results in the ACO's population becoming less reflective of its historical population and more reflective of its regional or community population. Important to note, this annual population change will occur under both retrospective and the newly proposed prospective assignment methodologies, in which CMS will provide the Track 3 ACO with a new PPR (based on a retrospective look back) each new performance year. CMS could mitigate this by using two years of historical data or maintaining the assignment of those beneficiaries who receive no primary care anywhere during the year with the given ACO for an additional year.

As stated above, we support moving toward regional costs in updating the benchmark. Due to the inherent instability of ACOs' assigned beneficiary population during the contract period, we support *in concept* using regional costs in the setting and resetting the benchmark, although we do have concerns about how regional benchmarks might affect ACOs, such as those with academic medical centers, with an attributed population that might be more complex than the community. One potential approach that accounts for the influx of new beneficiaries is blending the historical and community rates based on the level of roster turnover during the contract period. Since it is unclear at this time what is the best measure of regional (i.e., community) costs or the best method to factor into the benchmark, *we recommend that any changes in this area be an option limited to the two-sided risk ACOs in Tracks 2 and 3 ACOs that have experience in the program. For those tracks, we also recommend that CMS grant the same flexibility as applied to trending and allow ACOs the option to choose for their contract period a historical-based or regionally blended benchmark. We further recommend that CMS in the future provide more data-supported specific approaches that factor in regional costs upon which the ACO provider community can evaluate and comment more informatively.*

Lastly, we urge CMS to explore new policy options to address the inherent disadvantage facing ACOs participating in low-spending regions. A recent analysis using Dartmouth HRRs shows that ACOs in low-spending regions face a disadvantage due to the historical benchmark calculation methodology.¹⁰ The ACOs in low-spending regions produced significantly less shared savings than ACOs in high spending regions in performance year one. Unfortunately, the current MSSP policy does not provide adequate incentives for continued participation by these ACOs, and further, resetting the benchmark by blending the ACO historical and, in this case, low regional rates may not lift the ACO's benchmark sufficiently to sustain its participation on the program. As CMS stated in the proposed rule, the MSSP is best served by increasing the total number of ACO participants and moving participants into two-sided models. *We urge CMS to consider implementing new policies to address the disadvantages currently faced by low-benchmark ACOs in low-spending regions.*

¹⁰ Unpacking The MSSP Proposed Rule: Geography and Policy. Health Affairs. <http://healthaffairs.org/blog/2015/01/22/unpacking-the-medicare-shared-savings-proposed-rule-geography-and-policy/> (accessed 1/24/15).

Technical Adjustments to the Benchmark

CMS asked for feedback on technical adjustments to the benchmark. *We support the continued exclusion of policy payments, such as indirect medical education (IME) and disproportionate share (DSH), from the MSSP ACO's benchmark and reconciliation calculations under all tracks.* Inclusion of these policy add-on payments creates a financial incentive to achieve savings by simply steering patients away from teaching hospitals or safety net hospitals. Continuing to exclude these payments from the MSSP calculations means ACOs will be rewarded for true savings through care redesign rather than artificial savings from reductions in add-on payments.

REQUIRED PROCESS TO COORDINATE CARE

Health Information Technology (HIT)

We share CMS' belief that all patients, their families and their health care providers should have consistent and timely access to their health information in a meaningful format that can be securely exchanged. CMS noted in the proposed rule that HHS is committed to accelerating health information exchange through a number of initiatives including: 1) incentives and penalties for HIT and HIT adoption; 2) use of common standards and certification requirements for interoperable HIT; 3) support for privacy and security for patient information exchanged via health information exchange; and 4) the governance of health information networks.

Health information exchange is critical to the success of ACOs, as it will facilitate the data exchange needed to coordinate care and help facilitate higher quality of care. We are concerned, however, that the current data exchange environment largely facilitates the movement of data but lacks the necessary robustness to meet the needs of physicians and clinical staff. Although there has been an increase in the exchange of patient information, the act of two computers sending and receiving data does not constitute functional interoperability—the ability for information to be exchanged, incorporated, and presented to a physician or other health care provider in a contextual and meaningful manner. It is the exchange, consumption, and use of medical information that is at the heart of interoperability. Additionally, other barriers persist including cost-effective data exchange.

CMS proposes to require an ACO to describe in its application how it will encourage and promote the use of enabling technologies for improving care coordination for beneficiaries, including EHR and other HIT tools (such as population health management and data aggregation and analytic tools), telehealth services (including remote patient monitoring), health information exchange services, or other electronic tools to engage patients in their care. CMS also proposes to require that an ACO define and submit major milestones or performance targets it will use in each performance year to assess the progress of its ACO participants in implementing electronic quality reporting, connections to HIE services, or elements of their care coordination approach. The undersigned organizations oppose these new requirements, not because we do not want to improve care coordination, but we are concerned the administrative burden will hurt, not help ACOs expand coordination. ACOs need the flexibility to redesign care in ways that will promote the best care for their patients while achieving quality and shared savings targets. CMS efforts to micromanage the way ACOs utilize information technology are more likely to hinder

these efforts than support them. Instead of complying with overly restrictive mandates, ACOs should be given the flexibility to work with their participating physicians and other health professionals on how best to deploy technology in a manner that drives efficiency and quality improvement.

PROVISION OF AGGREGATE DATA REPORTS AND LIMITED IDENTIFIABLE DATA

Claims Data-Sharing and Beneficiary Opt-Out

CMS proposes to streamline the process for MSSP participants to access the beneficiary claims data that is necessary for healthcare operations. MSSP participants would provide written notification at the point of care to their patients through signs posted in the facility that would include template language regarding the sharing of their data. Patients would then call CMS directly at 1-800-MEDICARE rather than going through their healthcare provider to decline the sharing of their claims data. The signs would likewise include instructions on how beneficiaries can reverse their opt-out decision through the 800 number. Moreover, ACOs would no longer have to send mass mailings to beneficiaries with opt-out notices. *We support this more streamlined approach that will effectively provide greater access to beneficiary data with less confusion by beneficiaries and administrative burden on ACOs.*

However, if a beneficiary opts-out of data sharing, an ACO will be unable to effectively coordinate the care. Under these circumstances, we do not believe it is fair to then hold the ACO financially accountable for these beneficiaries. *Beneficiaries who opt out of sharing their data should be removed from the financial reconciliation process.*

Expansion of Beneficiary Identifiable Data Provided

CMS has proposed expanding the number of beneficiaries for whom data is made available to include those who had a primary care visit with an ACO provider during the assignment period, even if they were not preliminarily assigned to the ACO; however, this would only apply to Tracks 1 and 2. *We recommend that the expanded availability of beneficiary data also be made available for the proposed Track 3 model since this would encourage Track 3 ACOs to influence care management for all of its beneficiaries.*

Furthermore, we appreciate CMS's proposal to include health status and utilization rates in aggregate data reports, as it will make the data more meaningful and actionable. To further enhance this meaningfulness, *we offer our recommendations for additional beneficiary identifiable data elements to include in the quarterly reports:*

- Date of the beneficiary's original Medicare eligibility for Part A and Part B;
- Date of change in the beneficiary's eligibility status;
- An indicator identifying the change of an individual beneficiary's Health Insurance Claim Number (HICN), with the date of the change;

- HCC score for each beneficiary (we note that providing the information with the quarterly assignment report would eliminate the need to produce Table 2-6, “Count of Beneficiaries” by HCC);
- Opt-out information to the beneficiary attribution file to create a check-and-balance process which will ensure members are not lost in the data reporting process (this may be more important if CMS assumes the role of data opt-out via 1-800-MEDICARE);
- For each beneficiary included on each attribution report, an indicator of a beneficiary’s institutional/hospice status, which will help ACOs identify domiciled patients for which the ACO is unaware;
- Expand the information subsections for outpatient Part A services and physician services on the quarterly reports to help ACOs manage costs, access, quality, and care coordination if physician services were divided into primary care physicians and non-primary care physicians; and
- Provide de-identified claims data in the Claims and Claims Line Feed (CCLF), or, as a less preferred alternative, provide aggregated data on substance abuse claims expenditures.

An ACO’s success is dependent on the timely transfer of patient information and coordination of patient care. Since Medicare patients have the right to seek care from any provider who accepts Medicare, it can be a challenge for ACOs to monitor the services received by their assigned patients. While CMS provides each ACO with a retrospective administrative claims dataset for analysis of healthcare services to their ACO population, the data represent services that have already been provided by an ACO or non-ACO. These datasets are valuable for evaluating subpopulations of patients with chronic conditions, multiple chronic conditions, and their utilization rates, but they do not provide the ACO with a point-of-care opportunity to provide the right care at the right time while avoiding unnecessary services and optimizing the opportunities for quality improvement.

With respect to applicable laws governing patient privacy and the disclosure of PHI, and since CMS currently receives all eligibility checks from hospitals, emergency departments, and post-acute providers and maintains a real-time file of these eligibility checks, CMS could make this data available to ACOs. Doing so would offer ACOs a point-of-service notification system that would allow them to know when a beneficiary’s eligibility is being checked by a provider and a near real-time opportunity to intervene appropriately to coordinate their care, redirect the patient to an appropriate setting, or engage with healthcare providers who may not be participating with the ACO. *We believe that daily edits data feeds could be leveraged to improve care processes within an ACO and CMS should either provide these data directly to the ACOs or make the files available to security-approved organizations for dissemination to ACOs.*

Substance Use Data

CMS currently does not provide data related to substance use diagnoses and services in the monthly CCLF files. While we understand the sensitivity of such services and CMS’s exclusion of them in the files, we think there are options that would provide ACOs with more information, but not risk beneficiary privacy by suppressing identifiable elements. *We therefore urge CMS to*

Marilyn B. Tavenner, MHA, RN

February 6, 2015

Page 35 of 35

provide the de-identified cost and claim data for these services. If this is not possible, at minimum, CMS should provide the aggregate payment amount of these services in the monthly CCLF files.

CONCLUSION

On behalf of the undersigned organizations, we thank you for the opportunity to comment on the MSSP NPRM. We are hopeful that our constructive comments on improvements to the program are helpful and welcome any questions you may have.

Sincerely,

AMDA – The Society for Post-Acute and Long-Term Care Medicine
American Academy of Allergy, Asthma & Immunology
American Academy of Family Physicians
American Academy of Home Care Medicine
American College of Osteopathic Internists
American College of Physicians
American Medical Association
American Medical Group Association
American Psychiatric Association
Association of American Medical Colleges
Collaborative Health Systems, a subsidiary of Universal American
Heart Rhythm Society
Medical Group Management Association
National Coalition on Health Care
Premier healthcare alliance
Society of General Internal Medicine
Trinity Health