February 6, 2015

Marilynn B. Tavenner
Administrator
Center for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-1416-P, Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations; Proposed Rule

Dear Administrator Tavenner:

On behalf of the undersigned organizations, we appreciate the opportunity to jointly comment on key aspects of the Centers for Medicare & Medicaid Services' (CMS) Medicare Shared Savings Program (MSSP) proposed rule published Dec. 8, 2014. Our organizations represent some the largest and most pre-eminent healthcare organizations in the country, whose members include physicians, hospitals, medical group practices, and nearly all existing MSSP ACOs. Our shared 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 percent 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 Department of Health and Human Services (HHS) recently stated a goal of tying 30 percent of fee-for-service Medicare payments to alternative payment models, such as ACOs, by the end of 2016, and tying 50 percent of such payments to alternative payment models by 2018. **In order for HHS to meet its goals and ensure continued and enhanced participation in the MSSP, we urge CMS 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 percent 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 BENEFICIARIES

We generally support CMS's proposal to revise the two-step assignment methodology, which would include primary care services provided by non-physician practitioners (NPPs) – specifically, nurse practitioners, physician assistants and clinical nurse specialists– under Step 1 of the assignment process, and remove a list of physician specialty designations from Step 2 of the assignment process. To ensure that these NPPs considered under step one are truly primary care providers, however, we recommend that CMS:

- modify the information maintained in its enrollment database to better reflect specialty designation for these providers; and/or
- implement an attestation process under which services for NPPs only would be considered under Step 1 if the providers offer an attestation that they are primary care providers.

Moreover, we believe that the ACO and its providers are best able to make the determination of whether a physician provides sufficient primary care such that their provision of services should be considered in beneficiary assignment. We, therefore, suggest that CMS create a similar process by which ACOs could specifically identify or attest the specialty/subspecialty physicians to exclude from their beneficiary assignment.

Finally, we strongly believe that specialists should not be restricted to active participation in one ACO, and that there needs to be flexibility in the assignment process to prevent non-primary care physicians from being inappropriately made exclusive to one ACO. CMS's current methodology artificially restricts these 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 encourage CMS to examine the possibility of using a combination of TIN and National Provider Identifier, as currently used in the Pioneer ACO program, to address the issue of appropriate inclusion of specialty/subspecialty physicians within the attribution process.

SHARED SAVINGS AND LOSSES

We recognize that CMS has attempted to achieve a balance between offering incentives for providers to participate in the ACO program and fulfilling its obligation to protect taxpayers and the Medicare Trust Fund. However, we share CMS's concern that the current required transition from one- to two-sided risk may be too soon and too steep for many ACOs, requiring organizations to choose between taking on more risk or exiting the program. Our key recommended changes to the three tracks follow:

We applaud CMS's proposal to allow Track 1 ACOs to continue to participate in Track 1 for more than one agreement period. Track 1 allows ACOs to engage in "one-sided" risk where they share in the savings but not in the losses. We have learned that it can take several years to develop the clinical and financial infrastructure necessary to transform care delivery and create an effective ACO structure. We share CMS's concern the current required transition from one- to two-sided risk may be too steep for many Track 1 ACOs, resulting in a situation whether the ACO must choose to take on more risk than it can manage or drop out of the program.

- **We strongly oppose CMS's proposal to reduce the sharing rate for continuing Track 1 participants.** While there is no formal program risk in Track 1, there are financial risks associated with pursuing ACO status. Given the ACOs' levels of investment, and the fact that only a quarter have experienced shared savings, it is unnecessarily punitive to decrease the savings rate from 50 percent to 40 percent in their second agreement period. If fact, we recommend that CMS allow a higher savings rate for those ACOs that attain high quality or show significant quality improvement. Specifically, for all tracks, we urge CMS to adopt a sliding scale of up to 10 percentage points in additional shared savings for strong quality performance. The continued lowering of an already unattractive shared savings rate will result in an even lower return on investment that would not be attractive or sustainable for many ACOs.

- **We urge CMS to allow Track 2 and Track 3 ACOs *the choice* of a variable minimum savings rate (MSR) and minimum loss rate (MLR), a fixed MSR/ MLR of 2.0 percent, or no MSR/MLR.** Each organization is in the best place to determine the level of risk for which it is prepared, and thus should be given options to choose from, rather than being required to have a specific fixed or variable MSR and MLR, as CMS proposes. Many small and rural ACOs feel they are disadvantaged by being held to a MSR of 3.9 percent when their larger colleagues have a MSR of 2.0 percent. CMS's proposal may provide strong disincentive for small and rural entities to move into Track 2, as they would need to achieve almost twice the amount of savings as their larger colleagues in order to receive a shared savings bonus.

- **We support CMS's proposal to develop an alternative "Track 3" two-sided risk model that would offer ACOs the potential to realize more savings, but also more losses.** In general, we encourage CMS to allow for multiple "paths" toward more accountable care. For those willing to take on significant risk, there should be significant opportunity for shared savings. We also encourage CMS to explore alternative payment scenarios for Track 3 participants, such as a global payment option or other mechanisms to help transition to population-based payments.

- **We support CMS's proposal to prospectively assign Medicare beneficiaries to Track 3 ACOs, but strongly encourage the agency to allow ACOs the option to choose prospective beneficiary assignment for Track 1 and 2 ACOs.** Prospective assignment would increase certainty for the ACO and provide a more narrowly defined, stable, target

population and help minimize unexpected changes in its benchmark. These outcomes are valuable to ACOs in all tracks – not just those that take on increased risk.

WAIVERS TO ENCOURAGE ACOs TO ACCEPT RISK

CMS proposes to utilize payment waivers exclusively as incentives to move ACOs to higher-risk tracks or to have prospective ACO providers initially agree to at-risk contracts. We believe that any and all payment waivers that can improve care delivery should be equally available to all MSSP participants, and all assigned beneficiaries. Specifically, we urge CMS to finalize the following waivers for all ACOs:

- Hospital discharge planning requirements that prohibit hospitals from specifying or otherwise limiting the information provided on post-hospital services;
- The skilled-nursing facility (SNF) three-day stay rule, which requires Medicare beneficiaries to have a prior inpatient stay of no fewer than three consecutive days in order to be eligible for Medicare coverage of inpatient SNF care;
- Medicare requirements for payment of telehealth services, such as limitations on the geographic area and provider setting in which these services may be received; and
- The homebound requirement for home health, which requires that a Medicare beneficiary be confined to the home to receive coverage for home health services.

In addition, we urge CMS to move forward with the option it discusses in the proposed rule to offer a beneficiary attestation process for all MSSP ACOs, regardless of track. 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 beneficiary turnover, which would help provide a more defined and stable beneficiary population up front. To maximize these benefits, CMS should not implement beneficiary attestation in a way that overly restricts which Medicare beneficiaries may attest.

ESTABLISHING, UPDATING AND RESETTING THE BENCHMARK

We appreciate CMS's interest in modifying its current benchmark methodology to mitigate the impact on ACOs that lower expenses and achieve savings, and in better accounting for regional and local cost trends. We believe that the financial benchmarking methodology needs to be improved to ensure predictability, accuracy and stability over time. CMS should not require an ACO to continually beat its own best performance. Therefore, we encourage CMS to finalize the option to equally weight the three benchmark years, as well as the option to account for shared savings payments when resetting the benchmark. Additionally, we continue to support standardizing both the MSSP benchmark and performance year expenditures to remove all policy adjustments, such as indirect medical education and disproportionate share hospital payments, so that they reflect only actual resource utilization. Financial calculations that reward ACOs for simply changing the setting of care out of hospitals receiving policy payments would undermine these critical community missions and place patients at risk of being steered away from appropriate, high-quality care.

Further, we support allowing each ACO the option to choose for their contract term whether they want to be trended with national or regional adjustment. Transition to a regional adjustment could occur by use of a blend of national/regional trend over a contract term and would allow an ACO to assess whether its system of care is more reflective of the local market behavior or the national market. Similarly, we support in concept using regional costs to give ACOs a second option for setting and resetting the benchmark for two-sided risk tracks. This option has the potential to support the broader participation in the ACO program and increase the number of ACO choosing two-sided risk tracks. Each ACO would be able to select either the regional or their historical benchmark preference. However, we urge CMS to provide more detailed information about how it would define "regional," including what data and methodology it would use to set and update the regional rate.

PROVISION OF DATA

ACOs need more and timelier data on their patients. While we appreciate CMS's proposals to expand the data it makes available to ACOs, the agency could and should go further. An ACO's success is dependent on the timely transfer of patient information and coordination of patient care. Since Medicare beneficiaries have the right to seek care from any provider that accepts Medicare, it can be a challenge for ACOs to monitor the services received by their aligned patients. For example, CMS currently provides each ACO with a retrospective administrative claims dataset. These data are valuable, but represent services that have already been provided and do not provide ACOs with a point-of-care opportunity to provide the right care at the right time while avoiding unnecessary services. The agency should consider ways to 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.

While we support CMS's proposal to expand the number of beneficiaries for whom data is made available to include those that had a primary care visit with an ACO provider during the assignment period for Track 1 and 2 ACOs, we recommend that the agency also provide this expanded availability to its proposed Track 3 model. This would encourage Track 3 ACOs to influence care management for all of their beneficiaries. Moreover, 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. However, to further enhance this meaningfulness, it would be very helpful for the agency to include additional beneficiary identifiable data elements in the quarterly reports. For example, CMS should include the date of the beneficiary's original Medicare eligibility for Parts A and B, the Hierarchal Condition Category (HCC) score for each beneficiary and expanded information for outpatient Part A services and physician services, including behavioral health services.

Finally, we support CMS's proposal to streamline the process by which Medicare beneficiaries may opt-out of sharing their claims-level data with an ACO. However, we recommend that, if an ACO is assigned a beneficiary who opts out of sharing their data, these beneficiaries be removed

during the financial reconciliation process since an ACO will be unable to effectively coordinate the care of these patients and should not be held financially accountable for them.

On behalf of the undersigned organizations, we thank you for the opportunity to comment on this important regulation. We believe that adopting the above recommendations will help sustain and increase participation in the MSSP, as well as improve quality and decrease the cost of health care in America.

Sincerely,

American Medical Association
AMDA – The Society for Post-Acute and Long-Term Care Medicine
American Academy of Allergy, Asthma & Immunology
American Academy of Dermatology Association
American Academy of Family Physicians
American Academy of Home Care Medicine
American Academy of Pediatrics
American Association of Clinical Endocrinologists
American College of Emergency Physicians
American College of Osteopathic Internists
American College of Osteopathic Surgeons
American College of Physicians
American College of Radiology
American Gastroenterological Association
American Geriatrics Society
American Medical Group Association
American Society for Clinical Pathology
American Society of Hematology
American Society of Nephrology
America's Essential Hospitals
Association of American Medical Colleges
Catholic Health Association of the United States
Collaborative Health Systems, a subsidiary of Universal American
Federation of American Hospitals
Heart Rhythm Society
Infectious Diseases Society of America
Medical Group Management Association
National Association of ACOs,
National Rural Health Association
Premier healthcare alliance
Society for Vascular Surgery
Society of General Internal Medicine
Trinity Health