



Working Together for an Affordable Future

March 28, 2016

Mr. Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: (CMS-1644-P) Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations—Revised Benchmark Rebased Methodology, Facilitating Transition to Performance-Based Risk, and Administrative Finality of Financial Calculations; Proposed Rule

Dear Acting Administrator Slavitt:

I write today to offer the comments of the National Coalition on Health Care (NCHC) on the proposed MSSP Rule.

NCHC is the nation's largest, most broadly representative nonpartisan alliance of organizations focused on health care. The Coalition is committed to advancing—through research and analysis, education, outreach, and informed advocacy—an affordable, high-value health care system for patients and consumers, for employers and other payers, and for taxpayers. Our members and supporters include nearly 90 of America's largest and leading associations of health care providers; businesses and unions; consumer and patient advocacy groups; pension and health funds; religious denominations; and health plans. Our member organizations represent—as employees, members, congregants, or volunteers—more than 150 million Americans.

The still-dominant fee-for-service (FFS) payment model in health care unnecessarily encourages volume and drives up health care costs in the United States. Worse, it provides little incentive for the care coordination and quality care that patients, especially the most vulnerable, need. The transition to new

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models of care and payment is vital to building a high-quality health system we all can afford, and the Medicare Shared Savings Program (MSSP) can and must play a leading part in that transition.

With clear evidence that the MSSP substantially improves quality, while constraining growth in spending, CMS's immediate policy objective should be to increase the proportion of traditional Medicare enrollees who can benefit from the program, by retaining the participation of existing ACOs and expanding participation to new ACOs. We stress that this objective can and should be pursued even as CMS assists participating ACOs with moving to more advanced performance-based risk models.

By proposing a path to incorporating regional data in establishing benchmarks, offering track one ACOs an additional year before transitioning to tracks 2 or 3, and improving the process for reopening savings and losses determinations, the NPRM takes some steps toward that goal. But we are concerned that without adjustment, those steps may be inadequate to successfully sustain and grow the MSSP. Therefore, we offer specific comments that build on the NPRM's proposals.

Incorporating Regional Cost Data

CMS proposes to use a blend of 35 percent regional expenditure data and 65 percent historical ACO expenditure data for the second agreement period for ACOs that began the MSSP in 2014 or later and for the third agreement periods for 2012/2013 ACOs. CMS proposes to use a blend of 70 percent regional cost data and 30 percent ACO historical cost data in third and subsequent agreement periods for ACOs that began the MSSP in 2014 or later, and for fourth and subsequent agreement periods for ACOs that began the MSSP in 2012/2013.

Recommendation: NCHC supports the NPRM's proposal to incorporate 35 percent and 70 percent regional cost data in second and subsequent agreement periods, respectively. However, as noted below, under the heading **Transitioning to Benchmarks with Regional Cost Data**, we urge CMS take care to provide more options and greater flexibility to MSSP ACOs as they transition to benchmarks containing regional cost data.

Rationale: If continued over multiple contract periods, sole reliance on historical data in benchmarking would disadvantage providers who already have a strong record of delivering value and efficiency, relative to higher cost providers with higher initial benchmarks. We are concerned that retaining pure historical benchmarking would discourage participation in the MSSP, and increase the share of providers reliant on FFS payment, with its substantial incentives for volume.

At the same time, we recognize that some ACOs fare better under historical benchmarks. To sustain participation among this group, additional options and flexibility will be necessary to facilitate a smooth transition to the new blended benchmarking approach



Defining an ACO's Region and Weighting the Regional Population by County

CMS proposes to define regional costs based on each ACO's "regional service area," which includes all counties where one or more Medicare beneficiaries assigned to the ACO reside.

Recommendation: NCHC supports basing the region on counties rather than on other geographic units of measurement.

Rationale: Within any substantial geographic area, there can be differences between the counties served by different ACOs. Defining an ACO regional service area by counties allows for a customized regional definition for each ACO, resulting in more accurate projections of beneficiaries' costs for that ACO.

The NPRM proposes accounting for the geographic spread of an ACO's assigned population by weighting an ACO's regional expenditures relative to the proportion of the ACO's assigned beneficiaries in each county.

Recommendation: NCHC supports this approach

Rationale: Weighting the ACO's regional expenditures allows the regional service area to accurately reflect the ACO's market by recognizing the ACO's market penetration in various surrounding counties. Absent this weighting, CMS could overstate or understate the influence of the expenditures for a county where relatively few or many of an ACO's assigned beneficiaries reside. Weighting ACO expenditures relative to the proportion of the ACO's assigned beneficiaries in each county mitigates the impact of counties with a very small number of ACO-assigned beneficiaries.

CMS proposes to include counties where only one ACO-assigned beneficiary resides in the regional service area.

Recommendation: CMS should increase the threshold to one percent of the ACO's assigned beneficiary population. Should the agency finalize use of one beneficiary, we urge CMS to release the full data on all counties with one or more assigned beneficiaries.

Rationale: Setting the threshold at one beneficiary is unnecessary and adds program complexity. We note that CMS used a definition based on one percent of a participating organization's population in the Physician Group Practice demonstration, a precursor to the MSSP, and that CMS did not release ACO assignment data for counties with less than 1 percent of the ACO's overall assigned beneficiary population in the given year.

Defining the Applicable Beneficiary Population



Within the regional service area, the agency proposes to calculate costs for all “assignable beneficiaries,” including ACO-assigned beneficiaries, when determining the population used to calculate regional FFS costs for the reset benchmark. According to the NPRM, CMS intends to use these expenditures in an effort to ensure sufficiently stable regional expenditures. CMS defines an assignable beneficiary as a Medicare FFS beneficiary who receives at least one primary care service during a specified 12-month assignment window from a Medicare-enrolled physician who is a primary care physician or who has one of the specialty designations included in [§425.402\(c\)](#). Therefore, if a FFS beneficiary gets at least one primary care service from any Medicare-enrolled physician who is a primary care physician or who has one of the primary specialty designations used for purposes of MSSP assignment, the beneficiary would be included in the population used to calculate expenditures for the ACO’s regional service area.

Recommendation: NCHC supports limiting the beneficiary population to those that received at least one primary care service from a primary care physician or a physician with a specialty designation used for MSSP assignment.

Rationale: Using an “assignable” population allows for a more accurate apples-to-apples comparison by preventing beneficiaries who do not receive any primary care services during the time period from artificially lowering the expenditures against which the ACO will be compared. Similarly, it will prevent an artificially low trend from being applied to ACO benchmarks, thereby discouraging ACO retention and participation.

Risk Adjustment and Coding Intensity Adjustment

CMS proposes to limit upward risk adjustment for the continuously assigned to demographic factors in order to prevent upcoding.

Recommendation: CMS should allow risk scores to increase year-over-year within an agreement period for the continuously assigned.

Rationale: CMS has presented no real world evidence that such upcoding would occur. Its argument is based on analogy with the very different Medicare Advantage program. In fact, ACOs lack incentives to upcode, given the substantial fluctuation in assigned beneficiary population. In the absence of actual evidence of upcoding among ACOs, CMS should proceed to do all it can to improve risk adjustment in MSSP, by allowing year-over-year risk scores to increase.

Recommendation: If CMS rejects the previous recommendation, at a minimum, CMS should consider allowing risk scores to increase year-over-year for participants in two sided risk models like Track 2 and Track 3.



Rationale: The added assurance provided by such a policy could encourage progression toward higher levels of risk. Should an upcoding effect appear, CMS would be free to adjust the policy in future rulemaking, without impacting the majority of MSSP ACOs. Should an upcoding effect not appear, CMS would then be justified in allowing risk scores to increase year-over-year for all ACOs.

No Longer Accounting for Savings in Rebased Benchmarks

In the NPRM, CMS proposes to no longer account for savings in the previous agreement period when calculating the rebased benchmark for a new three-year agreement period. The agency argues that transitioning to a benchmark methodology that incorporates regional expenditures would mitigate the impact of no longer accounting for savings in subsequent agreement periods.

Recommendation: NCHC opposes this proposed change.

Rationale: We are concerned that implementing this proposal will negatively impact the very ACOs that have been successful in the program thus far, making it more difficult to sustain robust participation in the program.

CMS has not adequately explained how the proposed rebasing methodology would make up for reversing their policy on accounting for previous savings. There would certainly be situations in which this could not occur. For example, an ACO in an area with regional spending lower than the ACO's historical spending would have its rebased benchmark reduced as a result of incorporating regional spending. In this instance, the ACO is harmed by incorporating regional cost data, and CMS would exacerbate this by no longer accounting for previous savings.

Transitioning to Benchmarks with Regional Cost Data

CMS proposes to phase in the use of regional cost data over multiple agreement periods with ACO benchmarks increasingly reflecting expenditures in their regions rather than exclusively relying on ACO historical expenditures. The agency would maintain the current approach for establishing an ACO's initial benchmark based on the historical expenditures for beneficiaries who would have been assigned to the ACO during the benchmark years. Beginning with the subsequent three-year agreement period, CMS proposes to implement the regional adjustment amount by blending 35 percent of the ACO's regional service area expenditures with 65 percent of the ACO's historical benchmark expenditures. For ACOs entering their third or subsequent agreement periods, the percentage would increase to 70 percent based on regional FFS expenditures for assignable beneficiaries.

Recommendation: We support transitioning over time to ACO benchmarks that blend historical and regional expenditure data, but we believe maximizing the impact of the MSSP will require additional steps. They are detailed below:



- ***Allow 2012/2013 ACOs to begin new agreement periods with rebased benchmarks sooner.*** Under CMS’s proposal, 2012/2013 ACOs would have two full agreement periods under the current methodology, as these ACOs began new agreement periods in 2016. Requiring these ACOs to wait until 2019 while allowing ACOs that started the program later unfairly advantages those who were late adopters of accountable care over early adopters. CMS should allow interested 2012/2013 ACOs to begin new agreement periods in 2017 using the revised methodology.
- ***Provide a glide path for ACOs in initial agreement periods to gradually incorporate regional cost data.*** CMS considered, but did not propose, incorporating some regional cost data into benchmarks for ACOs that begin initial agreement periods on or after January 1, 2017. While we appreciate the need to base initial benchmarks on historical ACO expenditures, we urge CMS to provide an option for ACOs to elect a gradual phase-in of regional cost data in their first agreement period, with 10 percent regional cost data in PY1, 20 percent in PY2 and 30 percent in PY3. ACOs would then start their second agreement period with a 35 percent regionally-based benchmark. This approach would allow ACOs to ease into regionally based benchmarks and would smooth the transition between agreement periods.

Rationale: These options would allow ACOs to identify the best way to transition to the new benchmark methodology, thus maximizing their ability to handle the transition and increasing their likelihood of remaining in the MSSP. Additionally, given the range of options for establishing and resetting their benchmarks, new ACOs may be convinced to join the MSSP. We emphasize that these options would be voluntary and ACOs could still follow the proposed transition that includes no regional cost data in the first agreement period, then 35 percent and 70 percent in second and third agreement periods, respectively.

Facilitating Transition to Performance-Based Risk

CMS proposes allowing first agreement period Track 1 ACOs, beginning with ACOs with 2014 start dates, the option to extend their agreement period for a fourth year without having their financial benchmark reset. This means that a Track 1 ACO would first apply for a second agreement as Track 2 or Track 3 ACO. If CMS approves an application, the ACO could exercise the option to remain as a Track 1 for a fourth year. The ACO's fifth year would begin its three year agreement as a Track 2 or 3.

Recommendation: NCHC supports this proposal.

Rationale: This proposal would provide ACOs that are committed to two-sided risk models an additional year to prepare and plan for assuming two-sided risk – which should be conducive to their success under these new models. Additionally, providing an additional year could increase ACOs’ comfort level with making the commitment to two-sided risk.



CMS is considering allowing Track 1 ACOs to remain in Track 1 in the first year of their second agreement period and transition to Track 2 or 3 in the second and third year of their second agreement period. Again, the ACO would have to apply for the second agreement as a Track 2 or 3.

Recommendation: NCHC supports allowing Track 1 ACOs to remain in Track 1 in the first year of their second contract and transition to higher tracks beginning in year two of their second contract.

Rationale: Moving ACOs to two-side risk models is a stated policy goal of CMS. Providing an additional year of one-sided risk before proceeding to two sided risk may increase ACOs' comfort level with making the commitment to two-sided risk

NCHC further recommends that CMS reopen consideration of and adopt proposals allowing track 1 ACOs in any agreement period to advance to the higher risk track 2 or 3 following any performance year. Requiring any track 1 ACOs that are ready to assume two-sided risk to complete an additional year or two under track one only reduces participation in two-sided risk.

Administrative Finality: Reopening Determinations of ACO Savings or Losses to Correct Financial Reconciliation Calculation

CMS proposes to reopen a payment determination with respect to the amount of shared savings due to the ACO or the amount of shared losses owed by the ACO if calculated in error. CMS may reopen a determination under two scenarios: (1) at any time in the case of fraud or similar fault; or (2) for good cause, not later than four years after the date of notification to the ACO of the initial determination of shared savings/losses.

Under the NPRM, "good cause" may be established in two situations: first, when the evidence that was considered in making the payment determination clearly shows that an obvious error was made at the time of the payment determination; and second, when there is new and material evidence that was not available or known at the time of the payment determination and may result in a different conclusion. CMS has proposed a threshold to determine whether new evidence is "material." Under this proposed threshold, only errors that equate to three percent of the total amount of net shared savings and shared losses for all ACOs for the applicable performance year would be considered to have a material effect on the ultimate payment determination. In this scenario, CMS would re-compute the financial results for all ACOs affected by the error(s). CMS does not propose to apply a materiality threshold to individual ACOs. CMS would retain full discretion to determine whether good cause exists for reopening a payment determination. Changes in legal interpretation or policy would not be a permissible basis for a reopening.

Recommendation: We support CMS's decision to provide for a reopening of payment determinations when they are calculated in error.



Rationale: The assurance that an ACO will not be negatively impacted in the case of fraud, obvious errors, or new material evidence could make providers more comfortable with taking on the operational and financial challenges associated with the accountable care models, thereby facilitating greater MSSP participation.

ADDITIONAL RECOMMENDATIONS:

Allow Prospective Beneficiary Assignment for All ACOs

Current Policy: For Tracks 1 and 2, CMS uses preliminary prospective beneficiary assignment with final retrospective beneficiary assignment. For Track 3, CMS uses prospective beneficiary assignment, which relies on the same stepwise assignment methodology used for Tracks 1 and 2 but assigns beneficiaries to Track 3 ACOs prospectively at the start of the performance year.

Recommendation: CMS should consider and adopt proposals to allow ACOs participating in all tracks to choose prospective assignment of beneficiaries

Rationale: Beneficiary assignment has a significant effect on benchmarks. Under prospective assignment, there is no retrospective reconciliation resulting in the addition of new beneficiaries at the end of the performance year. This approach provides a more predictable benchmark, thereby encouraging greater ACO retention and participation in MSSP. Additionally, providing a choice between retrospective and prospective assignment would benefit Track 1 and 2 ACOs that may prefer to become accustomed to prospective assignment, enabling them to better prepare for successful participation in Track 3.

Reward High-Quality Performance and Improvement

Current Policy: An ACO that achieves CMS's established quality performance levels is not rewarded and is merely prevented from forfeiting 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.

Recommendation: We urge CMS to provide, on a sliding scale, up to 10 percentage points of additional shared savings for MSSP ACOs that demonstrate superior performance or improvement on quality measures.

Rationale: The MSSP's failure to provide a more robust reward for quality can be a strong disincentive for ACOs to invest in those quality improvement activities that do not have a direct impact on performance year expenditures.



Many efforts to improve the quality of care consume an ACO's 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 of the screened patients, but those savings would 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.

Often, the more an ACO strives to improve quality performance, the more it needs to spend. If the services used to improve quality are billable services, they will increase the ACO's spending and reduce the probability of beating its benchmark. 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 over the performance year. ACOs that make large investments to improve quality performance may be less able to keep spending below their benchmarks as a direct result of their increased investment in quality.

Our recommendation would remedy this persistent misalignment between the financial incentives for ACOs and the Medicare program's interest in sustained quality improvement.

The National Coalition on Health Care greatly appreciates CMS's efforts to improve the Medicare Shared Savings Program. Please do not hesitate to contact either myself at jrother@nchc.org or NCHC's Policy Director Larry McNeely at lmcneely@nchc.org with questions about these comments or other issues.

Sincerely,

John Rother
President and CEO

