October 16, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1701-P
PO Box 8013
Baltimore, MD 21244-8016

Submitted electronically to www.regulations.gov
RE: CMS-1701-P

Dear Administrator Verma:

The National Coalition on Health Care appreciates the opportunity to comment on the proposed changes to the Medicare Shared Savings Program; Accountable Care Organizations--Pathways to Success (CMS-1701-P). The National Coalition on Health Care (NCHC) is the largest, most broadly representative nonpartisan alliance of organizations focused on health care. The Coalition is committed to advancing—through research and analysis, public education, outreach, and informed advocacy—an affordable, high-value health care system for all stakeholders. Our members and supporters include more than 80 of America’s leading associations of health care providers, employers and unions, consumer and patient advocacy organizations, pension and health funds, religious denominations, and health plans.

The Medicare Shared Savings Program is Advancing the Health Care Value Agenda
The National Coalition is pleased to see CMS reaffirm its commitment to transitioning Medicare from a volume-driven fee-for-service-based payment system to a value-based payment system that rewards quality outcomes, innovation in care delivery, and affordability. After Medicare Advantage, MSSP is now the largest total cost-of-care (Parts A and B) value-based payment program in Medicare, with 10.5 million beneficiaries currently served by the program. The National Coalition is encouraged by the steady annual improvement in MSSP results, as measured by the number of ACOs who generate shared savings relative to their benchmarks, and the aggregate amount of
ACO spending that has been below aggregate benchmarks since the MSSP’s inception.\(^1\) The 2017 MSSP results, like previous annual results, indicate that ACOs with longer experience in MSSP are more likely to generate shared savings. Performance year 2017 saw the highest share of ACOs (34%) generate shared savings, and the lowest percentage of ACOs with shared losses. Over 50% of the ACOs that have been in MSSP since 2012 earned shared savings in 2017, according to CMS.\(^2\)

In addition to generating year-over-year savings relative to CMS-determined benchmarks, evidence suggests MSSP ACOs are also slowing the rate of per capita cost growth when compared to beneficiaries enrolled in traditional Medicare who are not served by a MSSP ACO.\(^3\) It is likely that MSSP is causing positive spillover effects on the cost trajectory of unattributed beneficiaries in traditional Medicare who also receive care from ACO-affiliated clinicians. Table 16 in the proposed rule highlights the correlation between markets with experienced ACOs, and markets experiencing the lowest cumulative per capita cost trends (which have been lower than the national average) since 2012. Moreover, since benchmarks for Medicare Advantage premiums and annual updates are based on per capita costs and trends in fee-for-service Medicare, MSSP may be moderating cost growth in Medicare Advantage as well.

**High-level Comments on Pathway to Success**

In light of the accumulating evidence that MSSP is spurring quality improvement and moderating Medicare’s per capita cost trajectory, we request that CMS modify certain proposed model design changes to retain participation by ACOs who are demonstrating progress, and to attract new entrants to the program. We agree that the “end state” for ACOs should be two-sided risk payment models. However, we recommend a steeper slope for shared savings as ACOs move through BASIC model and to ENHANCED model, with flatter, asymmetric shared loss slopes, and a broader set of model end states to support a range of ACOs serving diverse and competitive markets, while also producing better value for Medicare and beneficiaries.

The National Coalition recommends the eventual convergence of Medicare ACOs with Medicare Advantage on key model design features and parameters, such as the setting of benchmarks, capitation, annual updates, risk adjustment, quality metrics, and quality incentives. We recognize that this convergence would take time, and the feature of beneficiary choice in the ACO model may limit full convergence. Convergence of major program elements would minimize administrative complexity for Medicare, providers and plans. It would also reduce beneficiary confusion, and allow more accurate comparison of performance of the two models.

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In Table 1 below we highlight the proposed changes we believe will motivate continued improvement and broad participation in MSSP. We believe these changes are directionally correct, but defer to experts and modelers on the specific parameters, or whether alternative approaches could produce similar incentives while providing similar or better fiscal protection for Medicare. In Table 2 we identify proposed changes that we are concerned would deter continued growth in MSSP.

Table 1

<table>
<thead>
<tr>
<th>Net Positive Proposed Changes to MSSP Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benchmarks incorporating regional and ACO historic spending; phase-in of weights for regional adjustment; blended national and regional trend factors with flat dollar caps of +/−5% of national per capita Parts A&amp;B spend by type; §425.601-425.603</td>
</tr>
<tr>
<td>Risk-adjustment using prospective HCC scores for all assigned beneficiaries §425.605</td>
</tr>
<tr>
<td>Annual participation elections for beneficiary assignment options, MSR/MLR; criteria for assignment §425.226, §425.400-425.402</td>
</tr>
<tr>
<td>Telehealth and SNF 3-day hospital stay waivers for two-sided risk models §425.612-425.613</td>
</tr>
<tr>
<td>Five year agreement length, with option to move faster to risk §425.20</td>
</tr>
<tr>
<td>Beneficiary incentive options, protections §425.304-425.315</td>
</tr>
<tr>
<td>Monitoring of ACOs to protect Trust Fund dollars §425.316</td>
</tr>
<tr>
<td>Potential ACO collaboration with Part D plans</td>
</tr>
<tr>
<td>Calculating ACO quality performance score in event of extreme and uncontrollable circumstances §425.502</td>
</tr>
</tbody>
</table>
Table 2

<table>
<thead>
<tr>
<th>Proposed Changes to MSSP that Present Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in shared savings rates in both one-sided A&amp;B models, and two-sided C&amp;D BASIC models §425.605</td>
</tr>
<tr>
<td>Two-year limit in one-sided model under BASIC path for new ACOs (automatic transition schedule) §425.605</td>
</tr>
<tr>
<td>Cap of +3% risk score increase/decrease over 5 year agreement §425.605</td>
</tr>
<tr>
<td>Definition of “high-revenue” ACO §425.20; related participation terms</td>
</tr>
<tr>
<td>Mandatory ENHANCED model endpoint</td>
</tr>
</tbody>
</table>

1. Positive Steps Forward

More Flexible Options
We are encouraged by many of the proposed changes in Pathways to Success, including providing more flexibility in care delivery and beneficiary engagement to ACOs in two-sided risk models, and more beneficiary assignment options for all ACOs, including a beneficiary “opt-in” mechanism. Proposed five-year agreements would provide more stability and predictability for ACOs, and lower program administrative costs. Incorporating regional costs in setting new benchmarks as proposed is an improvement over using the ACO’s actual cost experience to set and trend benchmarks. Applying risk adjustment uniformly to all assigned beneficiaries should improve payment accuracy and encourage ACOs to serve beneficiaries with more complex conditions.

The waivers available to ACO providers in two-sided risk models are important opportunities for innovation, and we recommend that CMS consider waiving or modifying other rules under its authority. CMS has written many coverage rules to deter inappropriate over-utilization of services. Other rules were written before advanced HIT solutions became available and which now allow physicians to supervise care and care teams remotely (i.e. indirectly), and to safely delegate more care. The incentives in two-sided MSSP models support appropriate utilization and more efficient care delivery processes while promoting quality and better beneficiary experience and engagement. Many coverage rules prescribing how covered benefits are ordered (i.e. face-to-face) and delivered create barriers to more efficient delivery of safe, effective, team-based care.

Setting Benchmarks and Annual Trend Factors
In general, pegging benchmarks to average regional costs is a better approach than using ACO historical costs. However, this should be phased more slowly for ACOs that are high-spending relative to their regional average. As a program, MSSP should both incentivize high-cost and low-cost providers to participate in good faith and become more efficient. For calculating annual trend factors, we recommend that CMS explore statistical approaches to remove the cost experience of the ACO’s attributed beneficiaries from its regional trend factor calculation.

2. Concerns with Other Proposed Changes

Lower Savings Rates in BASIC Models A-D Do Not Acknowledge ACO Start-up Costs
We are concerned that both the proposed change to lower the savings rate for ACOs BASIC A-D models, and to shorten the length of time that new ACOs are permitted to remain in one-side risk arrangements, would be counterproductive. ACOs incur organizational start-up costs, which are especially challenging for smaller ACOs. In addition, ACOs have ongoing costs associated with IT, data analytics, quality measurement, care management support, and other core functions foundational to ACO success. A higher shared savings rate in BASIC A and B would provide a higher return for new ACOs who make smart start-up investments and leverage them to deliver more reliable, timely, and efficient care.

We recommend that CMS continue asymmetric models in the BASIC pathway to encourage the movement to two-sided risk. Earlier this year, in its June 2018 Report to Congress, Medpac discussed the merits of continuing asymmetric payment models in MSSP where the shared savings rate is higher than the shared loss rate, and the cap on total savings is higher than the cap on total losses. In the context of reviewing the asymmetric two-sided Track 1+ model, Medpac noted that the important question is whether “ACOs are modifying their behavior from what they would have done if not in ACOs and are reducing spending,” and further stated that it “will continue to monitor Track 1+ model to determine whether aspects of it should be extended to other ACO models to encourage uptake of two-sided risk.”

Two-Year Time Limit for New ACOs in One-Sided Model May Discourage New Entrants
The overarching program goal of motivating as many providers, in as many parts of the U.S. as possible, to join, learn, and succeed in value-based arrangements could be undermined by the proposed required pace to assume two-sided risk. This is especially a concern for new ACOs with no experience in MSSP. A recent blog post in Health Affairs, after reviewing MSSP results since 2012, suggests that three years in one-side risk models may be needed “before the ACO surpasses the learning curve.” Repayment mechanisms that are required of ACOs participating in two-sided models may be burdensome for smaller ACOs and be an added barrier for new MSSP ACO entrants.

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5 https://www.healthaffairs.org/do/10.1377/hblog20180920.604462/full/
Risk Adjustment Caps May Not Adequately Account for More Complex Beneficiaries

By capping the maximum allowable increase in average beneficiary risk scores to 3% in either direction (as calculated within four beneficiary subgroups) over a five-year agreement period, we are concerned that there may instances where ACO benchmarks are not adequately adjusted for high-cost care episodes related to diagnoses and factors outside of the ACO's control. At the same time, the cap on downward adjustments in risk scores could encourage ACOs to favor healthier beneficiaries. The incentive to code aggressively is present in both Medicare Advantage and the ACO programs, and we encourage CMS to use some of the same tools used in MA to monitor and adjust for overly-aggressive coding practices in ACOs. Over time, we urge CMS to explore changes to the risk adjustment model to lower the influence of provider-reported risk factors and rely more on demographic factors and beneficiary-reported diagnoses, functional status, and other factors that can provide equal or greater explanatory statistical power than the current model.

Challenging Participation Terms for Newly-Defined “High Revenue” ACOs

Rigorous evaluation of ACO performance in MSSP to date indicates that smaller, physician-centered ACOs are more likely to generate savings than hospital-centered ACOs in the current MSSP model. However, as noted by Dr. Michael McWilliams and coauthors in their comment letter to CMS, these results are to be expected given more aligned financial incentives for physician-based ACOs relative to hospital-based ACOs.6 Physician-based ACOs can make improvements in care that reduce avoidable hospital and post-acute utilization without worrying that such reductions will affect their revenue. In contrast, when hospital-based ACOs make similar improvements, their revenue is directly impacted. Medpac made similar observations in Chapter 8 of its June 2018 Report to Congress: Medicare and the Health Care Delivery System. As proposed, the definition of a high-revenue ACO creates a cliff that could discourage ACO growth in size and composition that would otherwise make sense for designing an optimal care delivery system.

Steep Risk Slope, Risk Exposure

The proposed new category of “high revenue” ACO, which includes a disproportionate share of ACOs that have not performed as well relative to their benchmarks as “low revenue” ACOs, would be required to assume more risk at a faster pace, with the ENHANCED model as the end point. We are concerned that this approach amounts to too much “stick” and not enough “carrot.” The exposure to downside risk jumps dramatically between Level E and the ENHANCED track, and we question whether the transition to ENHANCED track must be made by all experienced ACOs—whether high or low revenue-- for MSSP to be successful in lowering per capita cost trends. “High-revenue” ACOs may also have cost benchmarks above their regional average, and as regional costs

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take on a greater share of benchmarks, such ACOs may be further discouraged from participating in MSSP.

We believe it is premature and too limiting to declare the ENHANCED model as proposed the “final” MSSP model. As the ACO program matures, the end state could look different in different markets and among ACOs. For example, we would expect to see more ACOs partner with Medicare Advantage plans in shared risk arrangements as they become more proficient at managing risk. Such ACOs might seek to have greater alignment between models they enter with MA or other commercial plans, and MSSP. Shared risk arrangements in the commercial market vary to meet the needs of both parties, and MSSP models should be similarly flexible. At the same time, we may see Medicare Advantage risk contracting begin to adopt standard features of the MSSP models, especially if a range of shared risk models are offered.

Interaction with MACRA Advanced Payment Model Bonus Differs by ACO Type
While the possibility of receiving a 5% bonus for participating in an Alternative Payment Model (APM) is an added incentive for physicians and other clinicians to join a two-sided ACO payment model, it is a weaker incentive for hospital-based ACOs. Even for physician-based ACOs, it is extremely difficult for a clinician to know in advance if his or her revenue earned in the APM will meet or exceed the required threshold to qualify for MACRA’s APM bonus. We also recommend that the nominal risk definition in MACRA for qualifying APM status (3% ) be aligned with the E Model’s lost sharing limit.

Monitor for Gaming, Excessive Losses
We support close CMS monitoring of ACOs with shared losses or expenditures outside their corridor for two consecutive years, and termination if other behavior or organizational issues support termination. We also recognize the opportunity for ACOs to reorganize or otherwise terminate and re-enter to secure participation in MSSP under better terms as program rules or market conditions change. We support close CMS monitoring of “gaming” behavior and taking action when specific gaming behavior is identified. The proposed designations for experienced, inexperienced, and re-entering ACOs appear reasonable.

Monitor for Signs of Beneficiary Selection in ACOs
We support giving greater weight to regional costs in setting benchmarks, as well as steps to provide greater flexibility on such program parameters as beneficiary assignment and beneficiary incentives. However, we recommend close monitoring by CMS of the impact of these and other factors, including limiting decreases in risk scores, on beneficiary “selection” to ensure that ACOs are providing equitable access to both high and low-need beneficiaries, whether assigned to the ACO or not. CMS should approve, monitor, and evaluate the design of incentives that ACOs provide, as well as how incentives are actually deployed by ACOs, and whether they are focused on beneficiaries with multiple chronic conditions and unmet social needs, or on services used more frequently by relatively healthy beneficiaries.
Other Comments

Collaboration with Part D Sponsors
Integrating the Medicare Part D drug benefit with the Parts A and B care and services delivered and coordinated by ACOs has the potential to improve care and avoid costs. Data sharing by Part D plans could provide ACOs with insights for targeting and improving care. Pathways for generic substitutions and less burdensome preauthorization processes could be jointly developed to streamline workflows. By collaborating, Part D sponsors and ACOs may identify novel approaches to increase medication adherence, for example. We support creation of demonstrations that would incorporate Part D plans formally as ACO suppliers. We also see a role for beneficiary incentives or enhanced benefits that could be financed through savings generated by such partnerships.

Meaningful Quality Measures that Differentiate ACO Performance
It is encouraging to see the high performance of MSSP ACOs on the current set of quality metrics. We recommend that CMS consult with stakeholder and have a plan for “raising the bar” over time so that quality measures continue to spur improvement and differentiate among ACOs. We support scoring performance on fewer, more clinically meaningful outcomes measures and believe the role of CAHPS and other beneficiary-reported measures of access, functional status, and care experience should be given greater weight in MSSP over time. We recommend the inclusion of behavioral health quality metrics, particularly screening and referral metrics. Creation of a Medicare Advantage “stars”-like component to two-sided MSSP models, that would adjust ACO benchmarks upward based on quality scores, would add additional incentives for ACOs to participate in two-sided models.

Continue to Support Learning and Collaboration
We urge CMS and CMMI to continue to provide educational resources to ACOs, their member providers, and other ACO stakeholders. The Payment and Learning Action Network, along with technical assistance contracts that have been funded to assist providers and inform and engage stakeholders and multiple payers, help to align stakeholders around the value agenda and disseminate learning across the health care system. For inexperienced providers or those more interested in a different practice model, the path to two-sided risk in MSSP may begin first with participation in payment models such as CPC+. As CMS re-defines the pace to two-sided risk in the MSSP model, the continued availability of other alternative models for providers to test and gain experience remains important.

At the National Coalition on Health Care, we appreciate the challenges associated with designing a national, permanent component of the Medicare program that can accommodate the varied cost structures, historic care patterns, subpopulations, and geographies that have both been shaped by,
and continue to shape Medicare payment and care for beneficiaries. *Pathways to Success* proposes important steps forward in moving Medicare from volume-driven to value-driven care. In the interest of keeping all parts of the country and all types of providers engaged in the effort, we recommend that CMS make select changes to *Pathways to Success* while also building fiscal safeguards to protect Medicare and sustain lower rates of per capita cost growth while improving quality into the future. If you have any questions, please contact Ann Kempski at AKempski@nchc.org or John Rother at JOther@nchc.org

Sincerely,

John Rother  
President and CEO