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March 28, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-1644-P, Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations – Revised Benchmark Rebasing Methodology, Facilitating Transition to Performance-based Risk, and Administrative Finality of Financial Calculations; Proposed Rule (Vol. 81, No. 22), Feb. 3, 2016.

Dear Mr. Slavitt:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Medicare Shared Savings Program (MSSP) proposed rule published on Feb. 8.

Our members are committed to transforming the health care system by providing more accountable, coordinated care. Consequently, hospitals have been on the forefront of exploring and implementing alternative payment models such as accountable care organizations (ACOs). ACOs – and particularly the MSSP – are crucial to the achievement of the Department of Health and Human Services' goals to tie a greater percentage of Medicare payments to value and alternative payment models. It is encouraging that CMS has sought to solicit and incorporate stakeholder feedback on program improvements intended to sustain ACO participation and attract new organizations, both through its 2015 rulemaking process and this proposed rule.

CMS also has made a number of changes since implementation of the MSSP to encourage ACOs to move to performance-based risk. While we acknowledge the agency's interest in moving ACOs to two-sided risk models, we remain skeptical that the MSSP as currently structured sufficiently incentivizes ACOs to accept greater risk. Even after the changes made by CMS in last year's rulemaking, the vast majority of the nearly 250 ACOs that began or renewed participation in the MSSP in 2016 chose Track 1, the one-sided risk model. Further, the fact that nearly 70 of the original MSSP ACOs decided not to renew participation in 2016 may indicate that the program continues to place too much risk and burden on providers, with too little

opportunity for reward in the form of shared savings. Providers have invested significant time, energy and resources to develop the clinical and operational infrastructures necessary to better manage patient care.

Therefore, the AHA continues to urge CMS to modify the shared savings determination so that more ACOs can share in more of the savings they generate. This will allow them to continue to invest in the program and give ACOs adequate tools to coordinate and manage care. In addition, while we are pleased that CMS continues to pursue improvements to the MSSP, it is unclear whether the proposals included in this rule will offer more than an incremental improvement in the program's ability to attract new and renewing ACOs. We provide detailed comments on certain of those proposals below.

INCORPORATING REGIONAL EXPENDITURES INTO THE BENCHMARK

CMS does not propose changes to how it calculates ACOs' financial benchmarks for their first agreement period under the MSSP. That calculation would continue to be based solely on an ACO's historical expenditures. However, CMS does propose changes to the methodology it uses to rebase the benchmark between three-year agreement periods. Specifically, CMS proposes to eliminate the current upward adjustment to the benchmark to account for an ACO's prior savings, and instead to calculate and apply a regional fee-for-service (FFS) adjustment to the rebased historical benchmark. The regional adjustment would be phased in over two agreement periods for ACOs that renew participation in the MSSP, as follows: In an ACO's second agreement period, CMS would apply a weight of 35 percent to the difference between the ACO's regional average expenditures and its rebased historical benchmark expenditures. In an ACO's third and subsequent agreement periods, the percentage would increase to 70 percent of the difference between the ACO's regional average expenditures and its rebased historical benchmark expenditures. An ACO with expenditures below the regional average would see an increase to its benchmark; conversely, an ACO with expenditures above the regional average would see a decrease, making savings harder for that ACO to achieve.

The AHA appreciates that CMS recognizes the need to decrease the reliance on historical financial performance so that ACOs that renew their participation are not penalized for their achievements. At the same time, however, we oppose CMS's additional proposal to eliminate the upward adjustment to the benchmark for ACOs that received shared savings payments in the prior agreement period. ACOs that generate savings or demonstrate financial improvement should not be penalized in subsequent agreement periods by having their previous success make future savings more difficult to achieve. Under CMS's proposal, an ACO's historical performance will continue to contribute to its benchmark, and the historical portion should not be unduly depressed by including the ACO's prior savings. This approach would be particularly punitive to ACOs with expenditures higher than their regional average but that demonstrated savings nonetheless. Though, presumably, this is the exact type of ACO CMS would like to encourage, the agency's proposal could discourage such progress since in subsequent agreement periods the ACO would experience two downward forces on its benchmark (one from its prior savings and another from the regional adjustment).

Further, while we generally support CMS's phased-in approach to incorporating regional data, we urge some flexibility for current ACOs. The agency should allow ACOs that began their second agreement period on Jan. 1, 2016, to transition to the new methodology beginning with their next performance year, if they so choose, rather than wait until the start of their third agreement period. Similarly, ACOs that renew for 2017 should be allowed to decide whether to use the current or proposed methodologies for their second agreement period, since those ACOs must decide over the next few months whether to apply for renewal, and may not have the benefit of a final rule before making that decision.

ENCOURAGING TRANSITION TO RISK-BASED MODELS

CMS proposes an additional renewal option to encourage renewing ACOs to move more quickly to two-sided risk. The option would be available to Track 1 ACOs that are renewing for the first time, and thus eligible to renew for a second agreement period under Track 1. If the renewing Track 1 ACO instead selected a two-sided risk model (Tracks 2 or 3), that ACO would be able to extend its first agreement period under Track 1 to a fourth year and defer movement to Track 2 or 3 by one year. After the fourth performance year, the ACO would transition to Track 2 or 3 for a three-year agreement period. **The AHA supports this proposal, which would provide another option for ACOs seeking a glide path to two-sided risk.** However, we remain concerned that this option would provide sufficient incentive to entice ACOs to forgo the additional two years of experience with upside-only risk in Track 1, for which they otherwise would be eligible.

REOPENING DETERMINATIONS

CMS proposes to define the circumstances in which it would reopen a determination of ACO savings and losses to make corrections after the financial calculations have been performed. Specifically, CMS proposes that it would have discretion to open a repayment determination at any time in the case of fraud or "similar fault" (defined in current regulations at § 405.902). In addition, CMS would have discretion to reopen a payment determination within four years of the date of notification to the ACO of the initial determination of shared savings or shared losses if there is good cause. CMS would have the sole discretion to determine if good cause exists. It also would have sole discretion to determine if an error was made, whether a correction would be appropriate, and the timing and manner of any correction.

We appreciate CMS's consideration of the need to balance Medicare program integrity concerns that payments be made accurately and in a timely manner with the need to minimize unnecessary operational burdens for ACOs and CMS, and to support the ACOs' ability to invest in additional improvements to care delivery. **However, we have concerns about the proposed approach, which appears one-sided. It seems to provide CMS with a blank check to reopen determinations and potentially recoup funds from an ACO, in some cases after the ACO's contract with the MSSP is complete and/or due to errors the ACO did not commit.** If this proposal is finalized, we urge the agency to be judicious in exercising its authority, as well as to

consider the potential operational burden of reopenings on affected ACOs. Further, we urge CMS to clarify that "good cause" could include ACOs' identification of their own errors, not just those made and/or identified by CMS or one of its contractors.

Once again, the AHA appreciates the opportunity to comment on the proposed rule and offers our insights to increase the success of ACOs in the MSSP. If you have any questions concerning our comments, please feel free to contact Melissa Jackson, AHA senior associate director for policy, at (202) 626-2356 or mjackson@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President