American Hospital Association

800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100 Phone
www.aha.org

February 5, 2015

Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-1461-P, Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations; Proposed Rule (Vol. 79, No. 235), Dec. 8, 2014.

Dear Ms. Tavenner:

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 Dec. 8, 2014.

Our members are enthusiastic about the MSSP as one pathway to advance their ongoing efforts to transform care delivery through improved care coordination and financial accountability. We appreciate that CMS has acknowledged the importance of encouraging continued and enhanced participation in the program and reducing administrative burden for accountable care organizations (ACOs). It is critical that CMS attract new MSSP participants and encourage ongoing participation of existing ACOs to meet Secretary Burwell's recently announced goal to tie 30 percent of fee-for-service (FFS) Medicare payments to alternative payment models, such as ACOs, by the end of 2016 and to increase that amount to 50 percent of FFS payments by 2018.

However, as currently designed, and as proposed in this rule, the MSSP applies too many "sticks" and offers too few "carrots" to participating providers and, possibly, to those entities contemplating MSSP participation. In other words, the MSSP places too much risk and burden on providers, with too little opportunity for reward in the form of shared savings. While some of CMS's proposed improvements are welcome and could be make the program more attractive to new applicants and existing ACOs, we question whether other proposals go far enough to correct misguided design elements that emphasize penalties rather than rewards.

Providers have invested significant time, energy and resources to develop the clinical and operational infrastructures necessary to better manage patient care. **Therefore, the AHA urges 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.**

Specifically, we urge CMS to:

- Balance the risk versus reward equation in a way that encourages ACOs to take on additional risk but does not penalize ACOs that need additional time and experience with the MSSP before they are able to do so;
- Modify the assignment of Medicare beneficiaries to increase focus on primary care services and provide ACOs with assignment options that would allow them to better identify and target services to those beneficiaries for whose care they will be held accountable;
- Adopt payment waivers – such as the skilled-nursing facility three-day stay rule, certain hospital discharge planning requirements related to post-acute care; the homebound requirement for home health; telehealth payment restrictions and the two-midnight rule – to eliminate barriers to care coordination;
- Modify the current benchmark methodology to help ensure that an ACO does not have to compete against its own best performance, and explore options that would help address regional cost differences; and
- Develop a "rapid response" system to provide better and timelier data to help ACOs better manage and coordinate care.

These changes would help strike a balance between better, quality care for Medicare beneficiaries; savings for the Medicare program; and sufficient opportunity for rewards to encourage ACOs to invest in the infrastructure necessary to successfully take on risk.

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. Our detailed comments are attached. If you have any questions concerning our comments, please feel free to contact me or Melissa Jackson, AHA senior associate director for policy, at (202) 626-2356 or mjackson@aha.org.

Sincerely,

/s/

Rick Pollack
Executive Vice President

AMERICAN HOSPITAL ASSOCIATION (AHA)

DETAILED COMMENTS

SHARED SAVINGS AND LOSSES

CMS proposes changes to the two existing MSSP tracks, as well as the creation of a new track, with a focus on encouraging ACOs to take on increased performance-based risk. While we understand CMS's desire to create incentives for ACOs to move along the risk continuum, we are concerned that the agency's proposed approach does not provide an adequate glide path for those who are not yet prepared to take on increased risk but are working toward doing so. CMS should do more to encourage sustained program participation among current ACOs, which have invested significant resources in the development of infrastructure and the redesign of care processes, *especially* those that need more time to gain experience in the program before moving to two-sided risk. The current and proposed structure of MSSP incentives is "upside down" in that it is more punitive than rewarding. CMS should implement more carrots and fewer sticks to encourage assumption of risk and motivate quality improvement.

For example, we strongly urge CMS to modify the shared savings methodology to make the proposed sharing rates for all MSSP tracks a minimum, which could be upwardly adjusted to reflect an ACO's high performance on quality. An ACO's quality score should be used to award additional shared savings, rather than as a means to reduce the shared savings amount. Currently, the program is structured such that an ACO's quality score can only reduce the ACO sharing rate. Given that ACOs must meet minimum quality standards and thresholds in order to receive any shared bonus, we urge CMS to reward those ACO providers that exceed certain threshold levels. The more potential there is to earn a shared savings bonus, the more attractive the program will become to prospective participants. In addition, we offer the following comments on CMS's proposed changes to the MSSP tracks.

<u>Proposed Changes to Track 1</u>. The AHA supports CMS's proposal to allow ACOs to participate in Track 1 for more than one agreement period, but opposes any reduction in the percentage of savings in which such ACOs could share (known as the sharing rate). Specifically, CMS proposes to allow Track 1 ACOs to continue to participate in Track 1 for another three-year agreement period. However, ACOs that do so would see a decrease in their sharing rate of 10 percentage points, from 50 to 40 percent, in their second agreement period. CMS states that this is intended to encourage Track 1 ACOs to move eventually to one of the two-sided risk tracks, which would potentially allow them to realize greater savings but also introduce greater risk. However, this is another example of "upside down" incentives that are more oriented toward punishment than reward. We share CMS's concern that the current required transition from one- to two-sided risk may be too steep for many Track 1 ACOs, 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. To avoid that choice, it makes sense to allow

Track 1 ACOs to re-enroll in Track 1 while they continue to build the needed expertise to make participating in a two-sided risk track viable.

The minimum savings rate (MSR) already provides a major hurdle for ACOs to cross before they may share in the savings they generate; in the first MSSP performance year, around 25 percent of Track 1 ACOs generated savings but did not share in those savings since they did not meet their MSR. Even once the MSR is met, the 50 percent savings rate is a maximum – and as such, is already paltry at best. Given the significant investment that ACOs make to participate in the MSSP – an AHA analysis performed by McManis Consulting estimated start-up costs of $11.6 million for a small ACO and $26.1 million for a medium ACO – an even lower sharing rate than currently exists represents a reduced return on investment that would not be sustainable for many ACOs.

We also oppose CMS's proposal to grant renewal in Track 1 only to those ACOs that did not generate losses in excess of the negative MSR in at least one of the first two performance years that the ACO participated in the MSSP, in addition to meeting the other criteria for renewal. ACOs started in different places in terms of their ability to manage risk, and some may have faced a steeper learning curve than others. It may, therefore, be premature to judge an ACO's ability to perform on data from only two years of participation in the MSSP. We instead urge the agency to decide on a case-by-case basis whether an ACO that meets all other relevant criteria should be able to renew participation in Track 1. In making this determination, CMS should consider mitigating factors such as improved financial performance or evidence of a compelling reason that the ACO was not able to meet the financial criteria.

Finally, we strongly urge CMS to hold all Track 1 ACOs accountable to a standard MSR of no more than 2 percent, regardless of the number of attributed beneficiaries. This is especially true for small and rural ACOs, which are disadvantaged by being held to a MSR of 3.9 percent when their larger colleagues have a MSR of 2.0 percent. This policy provides a strong disincentive for small and rural entities to participate in the ACO program, as they need to achieve almost twice the amount of savings as their larger colleagues in order to receive a shared savings bonus.

Proposed Changes to Track 2. The AHA urges CMS to allow Track 2 ACOs to choose between methodologies for calculating the MSR and minimum loss rate (MLR). Currently, the MSR and MLR for Track 2 ACOs are a fixed 2 percent. CMS proposes to vary the MSR and MLR based on the size of the beneficiary population assigned to a Track 2 ACO, as it currently does for Track 1. Under this methodology, the MSR and MLR would range from 2 percent for ACOs with assigned beneficiaries of 60,000 or more to 3.9 percent for ACOs with 5,000-5,999 assigned beneficiaries. This proposed change would mean that Track 2 ACOs could generate more losses before being required to share in the losses, but they also would have to demonstrate higher savings before being able to share in savings.

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. While it is true that a variable MSR/MLR would minimize the down-side risk for some ACOs compared to the current flat 2 percent, it also would reduce the

shared savings for those that are successful. ACOs are best able to determine the level of risk they are able to accept, and should have options that give them the greatest chance of successfully doing so. For instance, new organizations that are small might be willing to take on risk, but want the enhanced loss protection of the variable methodology even if it reduces their potential to share in savings. However, a renewing ACO that has achieved savings for two years already may want a smaller, predictable MSR/MLR.

Proposed Creation of Track 3. We appreciate that CMS has proposed a new, alternative two-sided risk model that would offer ACOs the potential to realize more savings, but also more losses. Specifically, CMS proposes that Track 3 ACOs would have a set MSR of 2 percent with a potential sharing rate of up to 75 percent (capped at 20 percent of the ACO's benchmark). Similarly, the ACO would be at risk for up to 75 percent of any losses (capped at 15 percent of the ACO's benchmark). CMS would calculate and risk-adjust the benchmark for Track 3 ACOs using methodologies similar to those used for the other two tracks. The agency would prospectively assign beneficiaries to the ACO, rather than the preliminary prospective assignment followed by retrospective reconciliation that is used for the two existing MSSP tracks.

Though we are pleased that CMS is interested in developing additional options within the MSSP program that allow ACOs to increase their risk and reward, we see Track 3 as the "next frontier." We support CMS beginning the development of this model now, to allow for adequate stakeholder input and so that ACOs know what expectations lie ahead. Given that only a handful of ACOs have entered Track 2, we do not envision many ACOs being ready to take on the additional risk in Track 3. We encourage CMS to continue to gather and incorporate stakeholder feedback into the design of a Track 3 option because as ACOs gain additional experience with the program, more may demonstrate interest in opportunities for increased risk.

In acknowledgement that there may be some ACOs that are interested in increased participation in performance-based risk arrangements – particularly as those ACOs with experience in the Pioneer program consider their next steps – we also encourage CMS to explore alternative payment scenarios for Track 3 participants to help transition to population-based payments. For example, CMS could create an option for a risk-adjusted global payment or global budget. An ACO participating in such a model would know its patient population and budget prospectively and could thus develop a detailed business plan to stay within the budget. The ACO could then keep any savings below an agreed upon discount (similar to the approach in the Bundled Payments for Care Initiative), but would have to absorb the cost of services above the global payment or budget.

ASSIGNMENT OF MEDICARE BENEFICIARIES

Prospective Assignment of Medicare Beneficiaries. We support CMS's proposal to assign Medicare beneficiaries prospectively to Track 3 ACOs, and urge the agency to offer prospective assignment at the beginning of the performance period for Tracks 1 and 2 as well. CMS has proposed prospective assignment as an alternative to the process of preliminary

prospective assignment followed by retrospective reconciliation that is used for the two existing MSSP tracks. A Track 3 ACO would be responsible for all its prospectively assigned Medicare beneficiaries, even if over the course of the year a beneficiary chooses to receive the plurality of his/her primary care services from providers outside that ACO.

We agree with CMS that prospective assignment would increase certainty for the ACO and provide a more narrowly defined target population. These outcomes, however, may be valuable to ACOs in all tracks – not just those that take on increased risk. To take responsibility for the care of a population in both the fiscal and quality arenas, it is essential for an ACO to understand for which population it is accountable. The ACO may be able to improve care management, identify and target services to high-risk individuals, develop specific outreach programs, and proactively work with patients and their families to establish care plans. In contrast, some ACOs might want to benefit from the potential to add assigned beneficiaries over the course of the performance period through retrospective attribution.

Revisions to the Two-step Assignment Process. The AHA generally supports CMS's proposals to revise the current two-step assignment process to increase focus on primary care; however, we urge the agency to modify its proposal to better ensure that the provision of primary care services truly drives assignment.

The agency currently uses a two-step process to assign Medicare beneficiaries to an ACO. In step one, beneficiaries are assigned to the ACO whose primary care physicians have provided them with the greatest amount of primary care services. If the beneficiary has not received primary care services from a primary care physician, under step two, the beneficiary is assigned to the ACO whose physicians (including specialists) have provided more primary care to that beneficiary than the primary care physicians in any other ACO.

AHA members that participate in the MSSP are concerned that, currently, a significant level of their population results from attribution based on provision of specialty services; it is particularly difficult for an ACO to manage care for these beneficiaries since the beneficiaries may not actually receive primary care from an ACO provider (or at all). CMS's proposed changes help address these concerns, but raise additional issues:

- **Inclusion of primary care services furnished by non-physician practitioners (NPPs) in step one of the beneficiary assignment methodology**. CMS proposes to consider care provided by an ACO's NPPs – specifically, nurse practitioners (NPs), physician assistants (PAs) and clinical nurse specialists (CNSs) – in step one of the assignment process. While we agree that many of these professionals provide primary care, further steps are necessary to ensure that their inclusion within step one results in a more accurate primary care-based assignment. As mentioned in 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." These codes are clearly not adequate to ensure these NPPs provide primary care. Instead, we recommend that CMS implement an attestation process under which services furnished by NPs, PAs and CNSs would be included in step one only if the

provider offers an attestation that he/she is a primary care provider. While CMS would need to develop the operational specifics for this approach, the required participation agreement between the ACO and its participants could serve as a platform.

- **Exclusion of specific physician specialties from the beneficiary assignment methodology under step two.** CMS proposes to exclude services provided by certain specialists from consideration under step two of the assignment process but to include services provided by a number of other physicians with non-primary care specialty/ subspecialty designations. By doing so, CMS recognizes that some specialists – such as cardiologists – commonly provide primary care, while some – such as surgeons – may bill what are generally considered primary care codes, such as office visits and other evaluation and management services, even though specialty care is being provided. While we agree with this general premise, the ACO and its providers are best able to make the determination of whether a physician provides sufficient primary care such that his or her provision of services should be considered in beneficiary assignment. We therefore suggest that CMS create a process by which each individual ACO could specifically identify the specialty/subspecialty physicians to include in its beneficiary assignment.

Beneficiary Attestation. We urge CMS to adopt the option in the proposed rule 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 which that provider is affiliated. Although CMS would retain its current stepwise attribution process (with modifications as discussed above), beneficiary attestation would take precedence over that process when considering to which ACO a beneficiary should be attributed. Further, the beneficiary would remain attributed to that ACO unless the beneficiary enrolled in Medicare Advantage, moved out of the ACO's service area or attested to a provider affiliated with another ACO.

Providing beneficiaries the opportunity to align voluntarily 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 target more effectively 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. To maximize these benefits, CMS should implement an attestation process that is not overly burdensome for ACOs or for beneficiaries. For example, in the Pioneer ACO beneficiary attestation pilot, participating ACOs were allowed to mail attestation forms only to certain beneficiaries attributed to the ACO in the 2013 or 2014 performance years. Further, the process the participating Pioneer ACOs were required to follow was highly intensive, requiring a number of the ACOs to contract out management of the attribution process, potentially reducing the attractiveness of participation for new ACOs.

ESTABLISHING, UPDATING AND RESETTING THE BENCHMARK

The AHA appreciates CMS's interest in modifying its current benchmark methodology to help ensure that an ACO does not have to compete against its own best performance. Specifically, although the agency does not propose any changes to the benchmark methodology, it requests comment on the following potential modified approaches to setting, updating and resetting the financial benchmark:

- Weighting equally the three benchmark years when resetting the benchmark from one MSSP agreement period to the next.
- Accounting for shared savings payments when resetting the benchmarks.
- Using regional factors to establish and update benchmarks.
- Holding an ACO's historical costs constant relative to its region when resetting the benchmark.
- Transitioning ACOs to benchmarks based only on regional fee-for-service costs.

We encourage CMS to finalize the options to weight equally the three benchmark years and to account for shared savings payments when resetting the benchmark. The current methodology places more weight on the later years of the three-year period used to calculate the benchmark. Since the later years are when an ACO is more likely to demonstrate savings, this methodology could disproportionately penalize ACOs that have demonstrated savings. Equally weighting the three benchmark years would result in a more gradual lowering of the benchmark for an ACO that has demonstrated savings. Further, CMS should make an 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 success make future savings more difficult to achieve. These diminishing returns would discourage continued program participation.

Further, though we conceptually support updating and resetting the benchmark using regional data to better reflect local and regional cost trends, we urge CMS to delay finalizing such changes until it defines "regional" in proposed rulemaking (and provides further detail on what related data it would use) and performs additional analysis on how using regional data would impact MSSP ACOs. In its discussion about benchmarking options, CMS notes that it could use methods similar to those used in the Physician Group Practice program. However, AHA members that participate in the MSSP program have expressed concern about that methodology – specifically, regarding the lack of transparency in how comparison groups were determined and applied. If CMS does move forward with use of regional data, we urge the agency to pilot the changes first by allowing ACOs to choose whether their benchmark would be updated and reset using national or regional data.

ENCOURAGING ACOS TO ACCEPT PERFORMANCE-BASED RISK

Waiver of Medicare Payment Regulations. We strongly encourage CMS to finalize the waivers of Medicare payment rules that it discusses in the proposed rule and to make the waivers available to all MSSP ACOs. CMS solicits comments on options to encourage ACOs to accept two-sided performance-based risk and is considering waiving certain Medicare requirements, including:

- **Hospital discharge planning requirements** that prohibit hospitals from specifying or otherwise limiting the providers who may provide 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

- **Homebound requirement for home health,** which requires that a Medicare beneficiary be confined to the home to receive coverage for home health services.

Waiving these payment regulations is essential so that ACOs may coordinate care and ensure that it is provided in the right place at the right time. We agree with CMS that these waivers could provide ACOs with valuable tools to increase quality and reduce unnecessary costs; however, these tools should be available to advance the success of *all* MSSP ACOs, not just those in a two-sided risk track. Before ACOs accept greater risk, they must first establish confidence that they will achieve savings based on successful delivery changes. Holding back helpful tools will not serve the program.

Further, CMS should implement the waivers in a manner that is not prohibitively burdensome to ACOs that wish to take advantage of them. For example, AHA members that participated in the Pioneer ACO program and have applied for the SNF waiver reported an overly burdensome application and reporting process. Instead, CMS should ensure that the waivers are easily accessible to ACOs and should rely on the MSSP's existing cost and quality metrics to ensure that ACOs continue to provide high-quality, appropriate care to their ACO populations.

Finally, the AHA suggests that CMS waive the two-midnight inpatient admission criteria for hospitals that participate in an MSSP ACO. Waiver of the two-midnight rule for hospitals that are ACO participants would allow those hospitals to provide care in the most appropriate setting without regard to the rule's arbitrary time-based criteria. Such a waiver would be appropriate since the ACO would ultimately bear financial responsibility for the cost of an inpatient stay that may have been reimbursed as outpatient under the two-midnight rule.

PROVISION OF DATA

We support CMS's proposal to increase the data it provides to ACOs on both their prospectively attributed beneficiaries and, for Tracks 1 and 2, on those beneficiaries who may be attributed to them through retrospective assignment. However, we continue to stress the importance of providing real-time data to help ACOs better manage and coordinate care and strongly urge CMS to develop a "rapid response" system to provide such data to ACOs. Specifically, CMS proposes to add additional beneficiary identifiable data elements to the data it provides ACOs on preliminarily prospectively assigned beneficiaries (as well as prospectively assigned beneficiaries for Track 3 ACOs). The agency would provide the "minimum data set necessary" for purposes of the ACO's population-based activities related to improving health or reducing health care costs, required process development, care management and care coordination. These data would include:

- Demographic data, such as enrollment status;
- Health status information, such as risk profile and chronic condition subgroup;
- Utilization rates of Medicare services, such as the use of evaluation and management, hospital, emergency and post-acute services, including dates and places of service; and
- Expenditure information related to utilization of services.

In addition, the agency proposes to provide Track 1 and 2 ACOs with certain identifiable data (name, date of birth, health insurance claim number and sex) for each beneficiary who has a primary care visit with an ACO physician during the beneficiary assignment period.

The timeliness and accuracy of claims data from CMS has been a major challenge to the success of the ACO program. ACO providers need to know not only which Medicare beneficiaries are attributed to them (as discussed in more detail above), but also their utilization patterns in order to improve the quality and cost of their care. Our MSSP ACO-participating hospitals have stressed that the data provided are inadequate, incomplete and often erroneous. Moreover, the data are often six to nine months delayed. It is critical for an ACO to know its aligned beneficiaries on a monthly, not quarterly, basis. This is necessary to measure and track beneficiary utilization, as well as quality and financial indicators. Coordinating patient care must occur in real time, not retrospectively. Moreover, access to timely Medicare claims data is necessary to obtain a complete picture of the care received by the beneficiary inside and outside of the ACO. Finally, the inclusion of claims data related to behavioral health services would allow for better care coordination and management of high-risk patients.

Beneficiary Opt-out Process. The AHA supports CMS's proposal to streamline the process by which Medicare beneficiaries may opt-out of sharing their claims-level data with an ACO. CMS proposes to simplify the opt-out process by requiring beneficiaries to contact Medicare directly via 1-800-MEDICARE to opt out of claims data sharing. CMS also would eliminate the waiting period for beneficiaries who do not opt out, which means ACOs would

begin receiving those beneficiaries' claims data earlier. AHA members that participate in the MSSP report that the current opt-out approach is costly to perform and is confusing to Medicare beneficiaries. The streamlined approach proposed by CMS would remove undue administrative burden on the ACO. However, we recommend that, if an ACO is assigned beneficiaries who opt out of sharing their data, the beneficiaries should be removed during the financial reconciliation process since an ACO will be unable to coordinate effectively the care of these patients and should not be held financially accountable for them.