

February 6, 2015

Marilyn Tavenner, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

Re: CMS-1461-P Medicare Program; Proposed Rulemaking for the Medicare Shared Savings Program

Dear Ms. Tavenner,

The Engelberg Center for Health Care Reform at The Brookings Institution has been involved in developing payment reform models such as accountable care organizations (ACOs) since before the Pioneer ACO and Medicare Shared Savings Program (MSSP) were established by the Patient Protection and Affordable Care Act (ACA). We believe models that align quality care and payment are critical in supporting providers in delivering the best possible care to their patients, especially in an era of increasingly personalized and prevention-oriented medicine. The goal of ACOs remains the same as it has been—enable physicians, hospitals, and other health care providers to get the support they need to deliver high quality care to patients and lower overall health care costs. The MSSP has been an important catalyst for transforming health care systems of varying sizes in all parts of the country. While early results show that these organizations have improved quality in many areas, only a quarter of the MSSP ACOs have been able to reduce spending enough to share in savings generated from their efforts.¹ Further refinements to the MSSP are necessary to ensure the long-term sustainability and success for both individual organizations as well as the program.

We believe that the Notice of Proposed Rulemaking (NPRM) released on December 1, 2014 begins to address many of the pressing challenges that have arisen in early experiences, and we appreciate the openness from the Centers for Medicare and Medicaid Services (CMS) in soliciting further reform ideas through the NPRM. The breadth of issues presented, the critical juncture at hand for the Medicare ACO program, and the other reforms taking place throughout the health care system means that the final rule will have implications not only for the MSSP but also the overall Medicare program and the US health care system. We believe that there are a number of areas in the proposed rule that need further refinement in order to ensure success going forward for the program and the wider health care system. In particular, we think CMS should use the NPRM process to strategically align the program with other payment reforms and performance measurement systems, a point we emphasize in several places throughout our comments. Our submission focuses on a number of areas addressed in the NPRM, framed in terms of the broader themes that we discuss below. Ultimately, we intend for these comments to help the MSSP achieve the important goals of improved patient care and reduced costs.

¹ McClellan et al. Early Evidence on Medicare ACOs and Next Steps for the Medicare ACO Program. Health Affairs blog. January 22, 2015

Our comments reflect the experience of ACO implementation gained through research, analysis, and communication with many current and prospective Medicare ACOs and participants in private-sector and Medicaid accountable care reforms. The Engelberg Center for Health Care Reform leads an [ACO Learning Network](#) committed to providing participating organizations—including ACOs, other non-ACO providers, payers and purchasers, medical associations and societies, consulting firms, pharmaceutical manufacturers, and other industry stakeholders—with the tools and knowledge necessary to successfully implement accountable care, and additionally deliver national guidance on practical policy steps. Over the past six years, we have gained significant knowledge from those organizations in all stages of ACO implementation and practice. We have also spoken with many of our members and others to receive feedback on how the MSSP could be further improved. These discussions and analyses inform a large part of the comments we offer below.

The work conducted through the ACO Learning Network and other related activities has demonstrated that the process of becoming and implementing an ACO can be time-intensive, cumbersome, uncertain, and slow. Successful accountable care practice requires the engagement and commitment of providers, payers, and patients. There is also not a “one size fits all” model for an ACO; organizations have both different starting points and different opportunities to transform care based on their current capabilities. ACOs have seen varying levels of success, driven by a number of different factors: size, scope, and ability to develop effective networks; previous experience with risk-bearing arrangements, experience and ability for physicians to transform care, level of physician and patient engagement, demographic and health status of the patient population, regional differences, and other organizational and market characteristics. In addition, there are a number of other factors that are harder to quantify but may be better predictors of success, such as organizational culture and leadership. Empirical research on which of these factors and combinations of factors are most likely to drive success is still in its early stages. CMS policy choices will have a significant impact on the ability of these diverse organizations to succeed. Given this uncertainty, it is imperative that the MSSP continue to support organizations of varying size, experience, and other characteristics to determine which can succeed. Payment and regulatory policy should thus provide a path with different starting points to achieve improvements in care, while also meeting the general requirements of MSSP participation. Further, because success in transforming care requires an ongoing commitment, ACOs need a clear and predictable path forward. Over time, MSSP should develop a stronger capability to help organizations implement effective improvements with more speed and certainty or transition out.

As CMS considers comments from a variety of stakeholders on the proposals set forth in the NPRM, we emphasize the following general principles to ensure the continued success and participation of the MSSP:

- 1. Creating greater certainty for program participants.**

One of the primary concerns across the broad spectrum of ACOs is the uncertainty associated with MSSP program participation. For instance, many organizations want greater predictability around their financial performance and the benchmarks used for cost assessment. The current methodology for calculating an ACO’s financial benchmark (three years of historical spending

data on attributed patients trended forward) does not adequately account for regional variation or the health status of attributed patients and creates unfair comparison metrics relative to other ACOs and providers. Including better regional adjustors over time and improving transparency on the financial benchmarks for all ACOs would allow organizations to better understand where they fall on the continuum of historical and expected future spending. Likewise, many ACOs have serious concerns about the current patient attribution process, which uses a blended prospective-retrospective assignment methodology. A transition to full prospective attribution for all ACOs assuming two-sided risk, as well as the option of patient attestation at the beginning of each performance year for all participants, would provide organizations with greater certainty about how many and which patients they are responsible for through their accountable care arrangement. Updated benchmark methodologies, prospective attribution, and patient attestation will require full and up-to-date risk adjustment to account accurately for population health status.

In addition to financial uncertainty, there are also a number of operational issues and barriers that continue to slow the progress of ACOs. Primary among them is the lack of timely, readily usable claims data as well as timely interim updates on Medicare's claims-based performance measures for attributed patients. ACOs have requested to receive data on a monthly, rather than the current quarterly schedule, in order to facilitate improvements in practice for the beneficiaries they serve. Additionally, many ACOs have struggled to adequately understand and analyze the data; further, many ACOs believe that they are not receiving the most appropriate information available for improving care. We urge CMS to build on its proposals to improve claims data and claims-based performance updates.

Finally, while CMS has worked diligently to listen to provider and ACO issues, a number of ACOs have expressed concerns about limited back-and-forth communication with CMS resulting in lack of clarity on how to meet programmatic requirements or resolve issues as they arise. Enhanced communication channels with CMS staff and clearer expectations, including programmatic deadlines, could help to ease these concerns. In addition to clear guidance from program administrators, we also urge CMS to create a clearer long-term program outlook for five or more years for program participants. While the ACO program will continue to evolve, ACOs should have a better idea or expectation about what is to come. In particular, some ACOs have expressed uncertainty about what happens in year 4 or year 5 after their existing agreements expire. To make significant investments in improving care, program participants should be able to map out a long-term plan about the consequences of steps to improve care beyond the three-year participation agreement.

We want to emphasize that while ACOs need greater certainty, and while CMS should aim to enable a range of organizations to implement accountable care, this does not mean that CMS should create a large number of tracks and program variants to accommodate each individual

organization's preferences. Such a program would be hard to administer effectively. Rather, the MSSP should include a coherent set of tracks that form a pathway for organizations continuing in the program to make meaningful shifts away from fee-for-service payment to population-based care.

2. Establishing a Clear and Achievable Transition Path to Financial Risk.

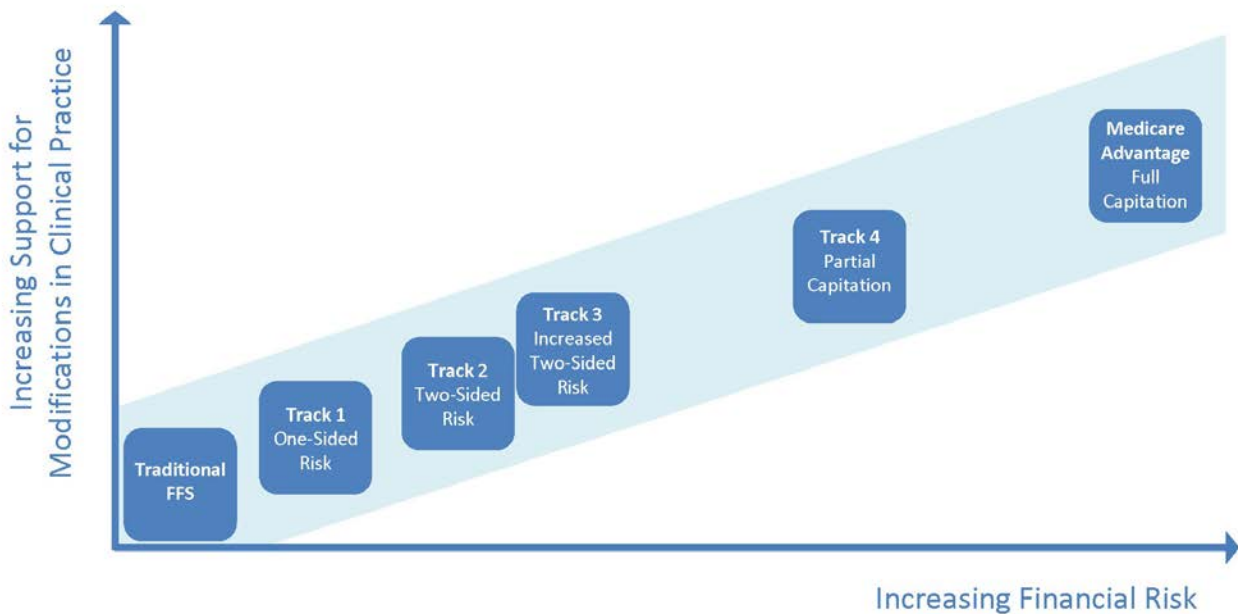
A primary goal of the MSSP is to enable improvements in care for a population that are not feasible under FFS payments. Thus, the MSSP ought to enable participating organizations to move to increasing financial risk over time in a predictable and logical way; if a significant shift away from FFS is not needed for an organization to improve care, then it does not need to be in the MSSP. To date, less than 5 percent of program participants have chosen to assume two-sided risk through Track 2. While we recognize that many organizations will require several years to build the competencies necessary to assume downside financial risk, CMS could do more to facilitate and encourage this transition beyond providing greater certainty about the program. We commend CMS for proposing a further risk track – Track 3, or perhaps more accurately, a further step toward population-based risk – for those ready to do so. We also support CMS' proposed waivers of some FFS reimbursement that are less important in this environment, and that can make it easier for organizations to succeed at a higher risk level. However, there remain too few incentives, both positive and negative, for more organizations to make this move. In principle, we support the proposal to allow program participants in the current cycle to remain in one-sided risk in Track 1 for an additional 3-year performance cycle, though all ACOs should be expected to transition to significant risk-sharing in order to remain in the program. CMS attempts to nudge organizations into two-sided risk by reducing the eligible quality sharing rate for those remaining in Track 1, but many ACOs believe there should be “carrots” accompanying this “stick.” We believe that as ACOs adopt more risk and progress along the track options [see Figure 1 below and Appendix A], this transition should be accompanied with greater “carrots” such as increased support for modifications in clinical practice via regulatory flexibility.

For instance, positive incentives that may become more available to organizations as they move further along the risk continuum include extending the waivers proposed in Track 3 to Track 2 ACOs; expanding the scope of waivers available in Track 3 ACOs; moving to a prospective attribution model for both Track 2 and 3; and enabling shared savings at a lower minimum savings rate (MSR) and shared losses at a lower minimum loss rate (MLR) for all ACOs assuming two-sided risk, perhaps at a lower sharing rate. In addition to these changes to risk tracks, we believe that an improved risk adjustment methodology, which more accurately reflects the changing health status of the patient population, is essential for reinforcing incentives for organizations that assume two-sided risk to focus on high-risk beneficiaries. We discuss all of these proposals more fully in comments that follow, along with reinforcing proposals to further improve and adjust the proposed financial risk tracks (levels). Further, we propose adding a

Track 4 with a 50% capitated payment for historical Medicare part A and part B, similar to that included in the Pioneer pilots.

Putting these proposed reforms together at a program level, we encourage CMS to move to a more integrated approach, where the tracks more clearly build upon each other and share a number of key characteristics, to create a more cohesive program in which organizations can transition to increased financial risk over a reasonable time period, including an aligned attribution process and standardized MSR and MLR process, and other programmatic requirements. This integrated, long-term program should allow a committed organization to enter at their comfort level, and progress to a point that is a significant shift from FFS where care is improving and cost growth is being slowed.

Figure 1. Proposed Transition Path to Increasing Financial Risk in MSSP



3. Engaging Patients.

ACOs increasingly realize the importance of meaningful engagement with patients in order to effectively transform care. Improving communication with and engagement of beneficiaries can create a more complete culture of accountable care, in which patients are empowered and supported to work with their providers to improve their care. More activated patients are critical for appropriate decisions about how, when, and where to seek care that is best for them, depending on their preferences and health status. There is increasing clinical evidence that informed and engaged patients can improve clinical outcomes, patient experience, and satisfaction.²

² Hibbard JH et al. 2013. Patients with lower activation associated with higher costs. Health Affairs 32(2):216-222.

We support CMMI's current pilot program for a select number of Pioneer ACOs to implement an attestation model in which previously assigned beneficiaries can positively identify their primary care provider (PCP) and thus declare their active participation in an ACO. Results regarding the extent to which patients choose to join an ACO and the potential long-term impact are not yet available, but private-sector programs have had promising results, and increased beneficiary engagement is a fundamental objective for Medicare. Consequently, we encourage CMS to adopt a similar attestation option for MSSP ACOs assuming two-sided financial risk. We believe that, unlike the Pioneer pilot, the attestation process should be available to all patients, not just those previously assigned to the ACO. To assure that this process is consistent, we propose that CMS initially administer patient attestation in conjunction with the ACO "opt-out" process, supported by greater beneficiary educational support. There are a number of streamlined processes that could be implemented to facilitate beneficiary engagement with ACOs in this combined approach to education, opt-out, and attestation. We describe this proposal more fully in our comments below. After beneficiaries are informed by mail or otherwise by CMS that one of their primary physicians is part of a Medicare ACO, and possibly that their other physicians are in an ACO, they could use a web portal and 1-800-MEDICARE to get more information about opting out or attestation. We also recommend that CMS consider additional incentives for patient participation in the ACOs, including waiving or reducing copays and deductibles for patients when they receive care from their primary care physician or other providers in the ACO. Furthermore, CMS could allow ACOs to cover additional costs that are deemed necessary for chronic care management, such as transportation, wheelchairs and other medical equipment, gym or wellness program memberships, heating or air conditioning, and improvements to the home such as railing installation or other methods to ease movement.

In conjunction with these beneficiary engagement steps, CMS should also support better patient education around the goals and features of Medicare ACOs, and how patients can work with their providers to improve care. This should include better signage and literature in physician offices, as proposed by CMS, as well as other communication methods such as text messages.

4. Aligning MSSP with Other Medicare Payment Programs.

The MSSP is just one of many innovative payment and delivery reforms occurring for Medicare patients. CMS should streamline certain MSSP processes and requirements with other payment models that support more person-focused care, such as the Bundled Payments for Care Improvement (BPCI) Initiative and the Comprehensive Primary Care (CPC) Initiative. This could include aligning the following among these alternative payment models: quality measures, risk adjustment calculations, reporting mechanisms and requirements, data collection and dissemination, and other core elements of participation.

In addition to aligning these programs, CMS should assure that ACOs can participate in multiple reform models. In our proposed reforms as well as those proposed by others (e.g., MedPAC), ACOs will be a meaningful payment alternative between a FFS system and capitated Medicare Advantage plans. In essence, ACOs are a bridge between payment models at either end of the risk-bearing spectrum. Creating a more cohesive payment reform strategy across Medicare could facilitate more innovation and allow for easier transition of individual providers and provider groups or networks to the most effective payment model for their capabilities along the risk-bearing continuum. Thus, ACOs and Medicare Advantage should have aligned features, including quality measures and quality bonuses, benchmarks, and risk adjustment mechanisms. Similarly, quality measures in the traditional FFS program should be aligned with those in the ACO program.

5. Taking Lessons from Commercial ACOs.

While MSSP has experienced success in achieving higher quality its first three years, and some Medicare ACOs have achieved significant early savings, many of our ACO Learning Network members as well as other ACOs have found that accountable care arrangements in the private sector can support greater innovation in care. A recurring theme is that data and performance indicators are supplied more frequently and completely from commercial health plans—usually on a monthly basis, rather than quarterly or annual basis with less of a lag time than CMS. Other ACOs have highlighted the ability to implement reinforcing payment reforms, such as medical home payments combined with two-sided accountability for overall costs. ACOs have also expressed better communication with their health plan partners and a sense that they can more easily resolve issues that arise during contracting and implementation. The commercial sector seems to be leading in payment and contracting innovation that can enable larger shifts away from FFS payment, and CMS should seek to align with these practices as they emerge.

For example, CMS is undertaking some efforts to align performance measures that are appropriate for both Medicare and commercial populations. We encourage CMS to continue shifting toward more outcome oriented quality measures, particularly those that are patient reported. Larger ACOs and potentially those taking on more downside risk should be required to report more sophisticated quality measures, but should also be eligible for additional payment bonuses for successful performance as in Medicare Advantage. Efforts could be undertaken to align CMS and commercial plans around data sharing, supporting indicators, and even multipayer payment reforms.

In all of the areas highlighted above, CMS has the opportunity to continue refining the MSSP with an eye toward what has and has not worked in both public and private sector ACO efforts. Throughout our comments, we highlight the lessons learned by current participants and assess how the regulations can be adjusted to ensure continued participation and success of existing ACOs, as well as new organizations that are committed to using ACO payment reforms to improve care and lower costs. ACOs can be a

critical part of greater system-wide support for needed improvements in health care delivery. Through our experience and conversations with ACOs of all sizes and sophistication across the country, we remain optimistic that CMS can set the MSSP on a more sustainable and successful path by addressing the major concerns we have raised, as reflected in the specific comments that follow. We appreciate your attention to the future of the MSSP and look forward to providing further assistance to CMS in its continued development, implementation, and ultimate success.



Mark McClellan
Senior Fellow and Director of the Initiatives on Value and Innovation in Health Care
Engelberg Center for Healthcare Reform
The Brookings Institution

COMMENTS ON PROPOSED CHANGES

A. DEFINITIONS

Establishing clear definitions and requirements to guide program participation and requirements is essential to the effective establishment and operation of an ACO. **We support all of the definitional changes proposed by CMS**, including the following:

- Definition of ACO Provider/Supplier
- Definition of Assignment
- Definition of Hospital
- Definition of Primary Care Services (*refer to “Consideration of Physician Specialties and Non-Physician Specialties in the Assignment Process, pg. 13 for additional comments*)
- Definitions of Continuously Assigned Beneficiary and Newly Assigned Beneficiary
- Definition of Agreement Period

B. ACO ELIGIBILITY REQUIREMENTS

Similarly, clear guidelines related to eligibility requirements are necessary to improve program transparency and support consistent practices. **We support the following proposals to modify the eligibility requirements, without comment:**

- Agreement Requirements
- Sufficient Number of Primary Care Providers and Beneficiaries

Identification and Required Reporting of ACO Participants and ACO Providers/Suppliers

ACOs must accurately report a list of their ACO participants and providers/suppliers. In order to improve transparency, CMS is adjusting its requirements regarding ACO participant and ACO provider/supplier lists (pg. 72769). We support the proposal to require ACOs to provide a complete and certified list of Medicare participants and ACO provider/suppliers prior to the beginning of each agreement and before each performance year thereafter. However, we also encourage CMS to consider an extension or transition of the period in which ACOs are required to updated their provider lists; many commercial arrangements currently allow up to 6 months for ACOs to report relevant changes.

Transition of Pioneer ACOs Into the Shared Savings Program

To reduce unnecessary burden on ACOs, we agree with CMS’ proposal to establish an efficient process to ease an ACO’s potential transition from the Pioneer ACO Program to the MSSP. CMS can draw on experience from transitioning the Physician Group Practice Demonstration to MSSP (pg. 72779). In particular, given the uncertainty of the Pioneer ACO Program and whether it will be extended, we believe that organizations should have a smooth transition path to MSSP if they would like to remain in a Medicare ACO arrangement. **We support all of the proposed requirements for an organization to make this transition, in particular the requirement that applicants apply to a two-sided risk model**, since we believe that CMS should not encourage any organization’s shift to a less risky financial arrangement and since the Pioneer ACOs generally have the capabilities to transition to some financial risk.

C. ESTABLISHING AND MAINTAINING THE PARTICIPATION AGREEMENT WITH THE SECRETARY

Application Deadlines

A number of ACOs have expressed concerns about the lack of clarity regarding application deadlines and when certain tasks must be completed. For example, the final rule issued in 2011 specified that all ACOs must have a publicly accessible website, which includes program participants, shared savings in each performance year, the division of shared savings, and quality scores. Many ACOs have failed to create a website that meets all of these specifications, in part due to a lack of clear guidance from CMS staff on when the website must be completed. Other ACOs have expressed concerns that CMS is reluctant to issue upfront due dates. This lack of clarity adds excess burdens to ACO administrators. We urge CMS to follow through on the proposal to revise the application process to better reflect the review procedure used for application assessment and further clarify due dates for the submission of application and other programmatic materials (pg. 72781). For these reasons, **we support the proposed changes as written.**

Renewal of Participation Agreements

In order for the MSSP to continue as a successful program, CMS must take measures to ensure that ACOs are allowed to continue to participate only if they demonstrate a clear commitment to the program's principles and have taken proactive measures to transform care. Although CMS has an interest in the program's continued to grow, ACOs must be held accountable for program requirements and should not continue if they cannot demonstrate a long-term capacity to achieve improved quality and reduced costs. At the same time, as ACOs consider whether to renew their MSSP arrangements, it is critical for organizations to clearly understand expectations and which areas may need adjustment for continued participation. In the case that an ACO is not meeting program requirements, CMS must inform the organization in a timely way with clear information about how the ACO is falling short so that it has an opportunity to take steps to enable continuation in the program. For these reasons, we support all of the proposals set forth by CMS to be used in determining eligibility for continued participation, including whether the ACO satisfies criteria for operating under selected risk model, the organization's history of compliance, whether the ACO met quality performance standards during at least 1 of the first 2 years, and whether an ACO under two-sided risk repaid losses owed during first 2 years (pg. 72781). We similarly support the proposal to have CMS clearly state what criteria an ACO is failing to meet and thereby allowing appropriate time for correction. In the case that an ACO is not meeting criteria, CMS will notify the ACO and allow time for adjustment. For these reasons, **we also support these proposed changes as written.**

D. PROVISION OF AGGREGATE AND BENEFICIARY IDENTIFIABLE DATA

The receipt of timely and accurate data is critical for ACOs to monitor their patients and improve their quality and financial performance. ACOs consistently highlight the need for improvements in this area, and we are pleased that CMS is proposing active steps to address current deficiencies (pg. 72785). In addition, ACOs would like to know how their performance compares to other participating organizations and we recommend that CMS make such information available.

Aggregate Data Reports and Limited Identifiable Data

We agree with CMS' proposal to make additional data needed for population-based activities available at the beginning of each agreement period, each performance year and quarterly thereafter. This additional data includes: demographic data such as enrollment status, health status information such as risk profile and chronic condition subgroup, utilization rates of Medicare services such as E&M and hospitals, and expenditure information related to utilization of services (pg. 72786). We recommend that CMS also include the following data in addition to what is proposed above: full population health records that include ancillary services (e.g., laboratory exams and results) and up-to-date Part D pharmacy claims, and financial determination. ACOs have reported health plan partners releasing additional data to support care delivery and monitoring of financial performance: practice patterns, member profiles on high risk attributed members, drug utilization, relative payments for facility care at hospitals and non-hospital providers, patient migrating out of the ACO, and attribution trends over time. We encourage CMS to consider all of these data elements. Most importantly, we recommend that CMS release data on a monthly rather than quarterly basis—such as in many commercial arrangements—to facilitate and accelerate improvements in the ACO.

In addition to CMS providing better data to individual ACOs, we also believe it is imperative for CMS to release more ACO-level aggregate data. We applaud CMS for releasing first year financial and quality results for all ACOs that began in 2012 and 2013, as well as the recently released public use file (PUF) and additional research files; however, additional data aggregated to relevant measures at the ACO level would be very helpful for individual organizations, researchers, and the broader public. The release of more data on individual ACOs would allow organizations to better compare their performance and progress to their peers. Such data for researchers and the public would help improve the evidence base guiding further reforms in the ACO program. Additional data elements that could be released for all ACOs include more timely and relevant financial benchmarks, quality measure scores on a quarterly basis, utilization data, updated beneficiary counts, and other metrics of each ACO's performance over time.

Recommendations

- **In addition to the proposed data elements, we recommend that CMS also share the following with ACOs: full population health records that include ancillary services (e.g., laboratory exams and results), Part D pharmacy claims, and financial determination**

- **Send data to ACOs on monthly rather than quarterly process to facilitate and accelerate ACO performance**
- **Provide more timely and detailed aggregate data on the MSSP, as well as additional data elements related to each ACO's demographics and performance over time, to enable more rapid learning about ACOs and policies that affect ACOs**

Claims Data Sharing and Beneficiary Opt-Out

Based on experiences with data sharing and to improve awareness of all the services beneficiaries receive, including those outside of the ACO, we agree with the proposed modifications of claims data intended to reduce burden on ACOs while supporting meaningful beneficiary choice about claims data sharing (pg. 72786). For instance, we agree with the change in process for beneficiary opt-out that allows beneficiaries to directly call 1-800-Medicare and removes the option for the mailed notification later. Further, we recommend that this should be coupled with the proposed patient attestation process. Given the additional challenges of improving care for patients who have chosen to opt-out of data sharing, we propose that these beneficiaries also be completely opted out of risk-bearing ACOs for attribution purposes, a proposal we discuss further in subsequent sections. The opt-out process must be accompanied by improved patient education, as many beneficiaries do not have a good understanding of the uses and restrictions on ACO data sharing. We ask CMS to also consider the opt-out process be available online through a designated secure website if the appropriate security considerations are in place. The website used for opting out of data sharing could be a valuable asset to improve information available to beneficiaries about the program and their understanding of the program. The beneficiary-focused website could provide additional information about the ACOs, its goals, and why patient would or would not want to be included. We further discuss these options in later sections. CMS, however, should provide summary data on ACOs that includes aggregated data from beneficiaries who opt-out of data sharing to enable ACOs to better track better how they are doing against their benchmarks. Moreover, CMS should be transparent in their calculation of benchmark measures for ACOs to replicate the methodology for non-opt-out beneficiaries. Finally, as stated in the previous section, we recommend that CMS release data on a monthly rather than quarterly basis—such as in commercial arrangements—to facilitate and accelerate improvements in the ACO.

If CMS does not finalize our proposal to remove patients from an ACO that choose to opt-out of data sharing, we urge CMS to provide summary data that includes aggregated data from beneficiaries who opt-out of data sharing. This would enable ACOs to better track how they are performing.

Recommendations

- **Finalize the proposal to move the opt-out process from a mailed notification letter to direct patient call to 1-800 Medicare; consider use of a website for opt-out process**
- **In the case that a beneficiary opts out of data sharing, that individual shall also be excluded from the ACO's patient assignment process**



- **If CMS does not exclude patients from assignment who have chosen to opt-out of data sharing, they should provide aggregate data on those patients who have opted out**
- **Deploy strategies to increase patient education and awareness of data use, including creating a more beneficiary-friendly website that provides additional information on the ACOs, its goals, and the value of being a part of an ACO**
- **Send data to ACOs on monthly rather than quarterly basis to facilitate and accelerate ACO performance**

E. ASSIGNMENT OF MEDICARE FFS BENEFICIARIES

The beneficiary assignment process for ACOs has an important impact on the number of patients an ACO is accountable for, the demographic and health status mix of those patients, and ultimately the thresholds that providers must attain in order to succeed financially. For these reasons, CMS must create clear attribution processes that recognize the challenges that ACO face in identifying and understanding the patients that have been assigned to their organization. Given the current assignment process for ACOs, which relies on where a patient receives a plurality of their primary care services during a given year, many patients may either not be attributed to an ACO that includes their primary care physician—because they did not seek care from their PCP—or be attributed to an ACO that does not accurately reflect their preferred primary care service provider—because they received care from another provider, including a specialist, in conjunction with an acute episode or chronic condition. ACOs have also experienced an average “churn” rate of 24 percent (ranging from 12 to 42 percent), which is a significant turnover from year-to-year and create significant uncertainty for an ACO when attempting to target care to the right patients. Most importantly, we believe that ACOs should be afforded more certainty with regard to what patients will be attributed to them, how that patient population may change over time, and what they can do to ensure that their patients remain a part of their ACO over time. Addressing these issues would also benefit Medicare by preventing ACOs from achieving more favorable selection during a performance period in order to improve their benchmark. There are a few ways that CMS could adjust the attribution process, including transitioning to a partially prospective attribution model, which we further describe in the subsequent section on attribution. We believe that ACOs that bear downside risk (i.e., Tracks 2 and 3 in the proposal) should transition to a prospective attribution model, coupled with a patient attestation process and robust risk adjustment. In the interest of patient preferences and to transition to a more active attribution process, we believe that patient attestation should trump the traditional assignment rules. The specific nature of this refined attribution process is further discussed in the subsequent section, but there are also a number of other proposed changes that we support.

Basic Criteria for Beneficiary Assignment to an ACO

For the reasons described above, specifically related to greater clarity of the assignment process, we support the proposal to further clarify the criteria used to assign a patient to an ACO, as outlined below (pg. 72792).

- Has at least 1 month of Part A and Part B enrollment and does not have any months of Part A only or Part B only enrollment.
- Does not have any months of Medicare group (private) health plan enrollment.
- Is not assigned to any other Medicare shared savings initiative.
- Lives in the U.S. or U.S. territories and possessions as determined based on the most recent available data in our beneficiary records regarding the beneficiary’s residence at the end of the assignment window.

Recommendations

- **Finalize the proposed revisions to the criteria used to assign a patient to an ACO**
- **Provide further guidance to ACOs on the attribution process and methodology upon request**

Definition of Primary Care Services

We recognize that in addition to the billing codes used for traditional in-office primary care services, there are other services provided by clinicians who are necessary for health maintenance both following discharge from a facility as well as over time for a chronic condition. In particular, we support the proposal to use both chronic care management (CCM) and transitional care management (TCM) service codes for a patient's assignment to an ACO (pg. 72793). This expanded definition would better reflect a wider scope of services that patients receive, which we believe are fundamentally primary care driven.

Recommendations

- **Finalize the proposal to include chronic care management (CCM) and transitional care management (TCM) services in the definition of primary care for the purposes of patient assignment to an ACO**

Consideration of Physician Specialties and Non-Physician Practitioners in the Assignment Process

In addition to expanding the scope of services and billing codes utilized for patient assignment, many ACOs believe the scope of providers used for attribution should be expanded. While some organizations believe that the current two-step process for attribution should be simplified to one step in order to reduce uncertainty, we believe it is necessary to continue using the second step for patients who do not receive primary care services from a primary care physician. Many patients, particularly those with major or complex chronic conditions, such as cancer, congestive heart failure, inflammatory bowel disease, or diabetes and related metabolic syndromes and disorders, receive a plurality of their services from a specialist who acts as their primary physician. CMS should consider a higher threshold for patient assignment based on specialty visits, in order to prevent a patient being attributed to an ACO as a result of a one-time acute care visit to a specialist. Given protections to prevent such attribution based on a single visit, we support the proposal that primary care services received from a PCP should remain the primary step for attribution, but CMS should continue to allow secondary attribution for those patients who receive primary care from a non-PCP provider (pg. 72795).

In order to better account for where and how patients receive their primary care, we support the principle of including Nurse Practitioners (NPs), Advanced Practice Registered Nurses (APRNs), Physician Assistants (PAs), and Clinical Nurse Specialists (CNSs) in the definition of primary care providers for the purposes of patient attribution (pg. 72795). While we support this principle, we note that an option for non-physician practitioner attribution would also benefit an AC and would account for differences in practices. For example, an ACO in a rural or underserved community with a number of participating federally qualified health centers (FQHCs) may utilize non-physician practitioners differently from a small physician practice in an urban community. While we understand that the ACO option could create

administrative challenges for CMS, allowing ACO flexibility about whether and what non-physician practitioners to include in step one of attribution will allow them to more accurately account for the characteristics of their provider participants and how patients traditionally receive their primary care services. This method using non-physician practitioners for the purposes of attribution already occurs in a number of commercial accountable care arrangements. We believe that CMS should provide the opportunity for these clinicians to be used for attribution purposes if they align with the structure, management, and operation of the ACO.

We have no comments on the proposed changes for which specialties should be used for assignment in the second step of the attribution process.

Finally, we propose that CMS consider allowing certain beneficiaries to designate up to two primary care physicians, one of which is a specialist. For example, a patient with a severe chronic condition and cancer would be allowed to designate their traditional PCP in addition to a specialist (e.g., an oncologist). We recognize that CMS would need to determine how to reconcile cases in which the two designated primary care providers are in different ACOs, such as giving the beneficiary the option of which provider they feel is more responsible for their care management.

Recommendations

- **Continue to use the current two-step patient assignment methodology**
- **Allow ACOs the option of including Nurse Practitioners (NPs), Advanced Practice Registered Nurses (APRNs), Physician Assistants (PAs), and Clinical Nurse Specialists (CNSs) in the definition of primary care providers for the purposes of patient attribution**
- **Consider allowing patients with chronic conditions or short-term intensive health needs to designate two primary care providers, including a specialist**

F. SHARED SAVINGS AND LOSSES

Creating the right payment conditions for ACOs is critical to ensure financial benefits from improving care to Medicare, as well as individual participating organizations, and for that reason is critical for achieving improvements in care for Medicare beneficiaries. CMS must set reasonable expectations for ACOs that are attainable, but also ensure that organizations remain committed to the dual aim of improving patient care and controlling costs. We appreciate that the proposed changes begin to address these issues, but believe that further reforms are needed to help facilitate a more rapid transition to increased levels of financial risk. Such larger shifts away from FFS are critical to enable bigger reforms in care and more momentum for delivery and financing reform.

As of the writing of the proposed rule, there were approximately 330 participating programs across the country (pg. 72815). With the addition of 89 additional MSSP participants in January 2015, there are now over 400 organizations participating in the program. However, very few organizations have transitioned to two-sided risk as originally intended (98% of participants remain in Track 1).

We propose that CMS create clearer incentives for ACOs to transition to increased levels of financial risk over time, in a way that is reasonable and ensures that organizations are proactively seeking to implement substantial improvements in care. We recognize that many ACOs are not willing and able to take on two-sided risk from the outset and continue to believe that these organizations should be afforded sufficient time to get off the ground under an upside only financial model. At the same time, it is imperative that organizations do not remain in one-sided risk for longer than necessary.

There is no single change that will make ACOs willing to move from Track 1 to more risk. Consequently, we have proposed a pathway approach with multiple reinforcing steps to support and encourage the transition to higher risk. We believe that those ACOs willing to take on downside financial risk should be rewarded for their efforts, through a number of incentives, including increased sharing rates, waiving an increasing number of current Medicare restrictions designed for FFS payments, and providing additional flexibility to allow them to continue delivery innovation. A number of program requirements should be streamlined across all tracks, including prospective attribution and patient attestation processes. Indeed, rather than creating multiple “tracks” which will be difficult to administer and to align with other Medicare payment reforms outside the ACO program, the current ACO “tracks” should be regarded more like a clear and predictable pathway to encourage organizations to take a stepwise approach to implementing reforms in care that may require larger shifts away from FFS payment to sustain. This does not mean that all Medicare ACOs must aim for high levels of downside risk in their payments over time, but it does mean that the MSSP should clearly encourage further progress in improving care supported by further payment reforms. We believe that the NPRM begins to address some of the opportunities to encourage continuing progress in reforming care, and hope that our comments below build upon this perspective and reinforce the importance of a coherent program pathway for organizations. We have included a table at the end of our comments that summarizes the proposed changes across all of the financial risk tracks.

Modifications to Existing Payment Tracks

To date, the vast majority of ACOs have opted to enter Track 1, in which they are eligible for shared savings without incurring any of the downside financial risk if they see an increase in total cost of care over time. As this payment shift represents an important but only limited shift away from FFS payment, and thus supports only slight changes from FFS-financed care, the MSSP program should be designed for organizations that are aiming to assume meaningful two-sided financial risk over time. However, a large portion of ACOs have indicated that they would not be willing to assume two-sided risk under the current conditions of the program. Given the existing requirement that ACOs transition into two-sided risk following the completion of their first 3-year performance period, it is reasonable to assume that many organizations would leave the program if the pathway to greater risk is not more attractive. We support the efforts of CMS to help ease this transition by allowing ACOs to gain more experience in one-sided risk, but urge CMS to increase program predictability and develop stronger incentives to encourage this transition for more organizations.

A number of our ACO Learning Network members and other ACOs we have spoken with support the proposal to allow organizations to remain in Track 1 under a one-sided financial risk model for an additional performance cycle (pg. 72804). While this proposal will create more of an “on ramp” for financial risk, we are concerned that this option will slow the adoption of two-sided risk models for these organizations, and we do not want it to remain indefinitely. In order to encourage ACOs to make this transition to two-sided risk, we support the proposal to reduce the sharing rate in the second performance cycle in Track 1, which we further discuss in the next section. These changes alone will not be enough to encourage this transition. Unless or until other changes are made to make two-sided risk more attractive, we can anticipate a large number of ACOs to leave the MSSP after their second performance cycle, despite their interest in moving beyond shared savings and, in many cases, despite the fact that they are developing arrangements with commercial health plans that allow for greater contracting flexibility. As we note below, we believe these other changes should progress along the risk assumption spectrum.

Recommendations

- **Finalize proposal to allow ACOs currently in Track 1 to remain in that financial track for an additional three-year performance cycle**
- **After completion of the second three-year performance cycle provide ACOs with the option to transition into a two-sided shared savings model in subsequent performance cycle or terminate the shared savings contract**

Proposals Related to Transition from One-sided to Two-sided Model

While we support the flexibility that CMS has afforded organizations that wish to stay in one-sided risk for another performance cycle, we also encourage CMS to continue to clarify that the program will feature a feasible pathway to two-sided risk over time. We also support the proposal to establish a set of necessary conditions for continued participation in Track 1: 1) the organization must have been eligible for shared savings in at least one of its first two performance years in the first agreement period and 2) the ACO must not have generated losses in excess of the negative MSR in at least one of the first

two performance years of the previous agreement period (pg. 72805). It is important to ensure that organizations not succeeding at shared savings are not allowed to continue “free riding” with the potential for shared savings and with the benefits of the MSSP without showing clear signs of success in improving quality and controlling health care costs. These conditions reasonably hold ACOs accountable for noticeable improvement in their first agreement period.

We also support the proposal to allow previously terminated ACOs to reapply for Track 1 (pg. 72805) beginning 2 years after their initial termination. It is important to recognize that not all ACOs are immediately able to assume the full responsibility of shared savings. Many of our ACO Learning Network members believe that the onboarding process of becoming an ACO and developing the capabilities for shared savings has taken longer than anticipated, especially given some of the uncertainties in this new program. Those ACOs that re-enroll in the program should be required to demonstrate improvement in capabilities necessary to adopt a shared savings model. As the MSSP stabilizes in the future, CMS can reconsider whether and under what conditions ACOs should be allowed to reapply.

While we recognize the intention of the proposal to reduce the sharing rate from 50 percent to 40 percent for ACOs that remain in Track 1 for an additional agreement period (pg. 72804), it is unclear how much of an impact that change will have for organizations as they make reenrollment decisions. Assuming that many of these ACOs are still transforming and may not have earned significant shared savings to date, the 10 percent decrease in shared savings may not be enough to encourage their transition to two-sided risk in which they could face losses. A number of ACOs have expressed concerns about the proposed reduction in sharing rates in the second performance cycle; however, we believe that the adjustment is both fair and appropriate. CMS notes that they recognize the potential for ACOs to be pushed to two-sided risk prematurely, but we believe that two agreement periods (6 years) should be a sufficient enough time for an organization to gain the experience required to take on increased financial risk. Those not ready to make the transition at that point are unlikely to be suitable for the program, and as a general matter CMS should not allow them to continue.

Recommendations

- **Finalize the proposal to establish a set of necessary conditions for continued participation in Track 1 for one additional three-year performance period, including demonstration of shared savings in at least one previous performance year and not having any generated losses in excess of the negative MSR in one of the previous performance years**
- **Finalize proposal to allow previously terminated ACOs to reapply for Track 1 if they can still meet the necessary eligibility requirements and to demonstrate the capability to meet program financial and quality targets.**
- **Finalize the proposal to reduce the shared savings rate for a second three-year performance cycle in Track 1 from 50 percent to 40 percent, in order to create incentives for ACOs to transition out of one-sided risk**

Proposals for Modifications to Financial Models with Downside Risk

It is important to create the adequate incentives for organizations to want to enter into Track 2 and begin to take on two-sided risk. One way to create those incentives is to adjust the MLR to make it more attractive for ACOs in two-sided risk by better accounting for differences in certainty about random variations in spending created by differences in size among organizations. Track 2 currently uses a fixed MSR and MLR of two percent, while Track 1 has variable rates (ranging from 2.0 to 3.9 percent) based on the ACO's beneficiary population size. While we acknowledge that the proposal to move Track 2 to a variable MLR would better insulate smaller ACOs from potential shared losses (pg. 72807), many smaller ACOs are more concerned about having an attainable MSR than insulation from downside risk. Consequently, we believe that the MSR and MLR should remain at a flat two percent for all ACOs assuming two-sided risk, with the exception of the potential additional change discussed in the following paragraph. CMS will generally have evidence from a shared-saving contract period on the performance of these smaller ACOs by the time they enter a risk arrangement. Assuming that there is also some empirical evidence on ACOs entering Track 3, we believe that the MSR in Track 3 should also be held at a flat two percent. If CMS is concerned about payouts from random variation, this could be addressed by transitioning from smaller to larger risk sharing rates, as we propose elsewhere. This approach would also help avoid a large step-up from no shared savings or risk payments, which would help increase predictability for ACOs.

Also, we propose that CMS explore extending the range of MSR downward to one percent for ACOs in Tracks 2 and 3 with a patient population of over 80,000 patients and possibly a broader range of ACOs that have a demonstrated track record. None of the five program participants with an attributed population of over 60,000 patients was able to attain shared savings in year one. These ACOs believe that, given the size of their patient population, a one percent reduction in total costs is unlikely to occur or persist by chance and should make them eligible for shared savings. Similarly, more extensive data over time on smaller ACOs may permit lower thresholds for them as well. Alternatively, CMS could permit a range of lower thresholds for shared savings and losses between two percent and one percent that is supported by empirical data, depending on the characteristics of the ACO.

There are a few further adjustments that we think should be implemented in parallel with the adjustments to the MSR and MLR. Some ACOs have expressed a desire for adjusting the loss rate over time so that it does not perfectly match the MSR (i.e. moving away from identical savings and loss rates). This change could be adopted as a transitional measure to encourage ACOs to move into two-sided risk. For example, an ACO that has transitioned from one-sided to two-sided risk between agreement cycles might be eligible for 60 percent of shared savings, but only 15 percent of shared losses in year one of the new performance cycle. In year two, the ACO might be responsible for 30 percent of shared losses, which then increases to 60 percent in year three.

As discussed in later sections, we believe the same MSR and MLR calculations should also occur in Track 3 of MSSP in order to create equity across all ACO assuming two-sided risk.

Recommendations

- **Reject the proposal to move to a sliding scale for MSR and instead keep the MLR at a flat two percent for all ACOs in two-sided risk**
- **Reject the proposal to move to a sliding scale for MSR and instead keep the MSR at a flat two percent for all ACOs in two-sided risk**
- **If empirical evidence supports the claim that ACOs in Tracks 2 and 3 with greater than 80,000 assigned patients are significantly less likely to meet their existing MSR threshold, extend the lower bound of the MSR range to one percent for those organizations. Alternatively, CMS could permit a range of lower thresholds for shared savings and losses between two percent and one percent that is supported by empirical data, depending on the characteristics of the ACO.**
- **Consider creating a sliding scale for the shared loss rate (15 percent to 60 percent) that changes over time to allow ACOs to assume increasing levels of downside risk as they gain more experience**

CREATING OPTIONS FOR ACOS THAT PARTICIPATE IN RISK-BASED ARRANGEMENTS

As we have emphasized throughout our comments, we believe it is critical for MSSP participants to transition to two-sided risk arrangements over time. Providing a range of on-ramps along with stronger incentives for organizations to move to two-sided risk could encourage more ACOs to transition to two-sided risk than under the existing Track 2 financial arrangements. We support the proposal to give additional incentives to ACOs that are willing to take on greater risk than currently possible in Track 2 of the program; however we believe that many of the proposals set forth for Track 3 participants should also apply to Track 2 participants, including the assignment methodology, MSR and MLR, and waivers for existing FFS payment requirements. We offer suggestions for each of the proposals set forth for Track 3, as well as whether we believe they should be extended to Track 2. Finally, we also propose a Track 4, which would allow ACOs to move to a 50% capitated payment for Medicare Part A and Part B. We model this track on the current option for population-based payments offered to Pioneer ACO program participants in year three of their contract.

In conjunction with the shift toward increasing risk-based payments, and opportunities for larger organizations to share savings at lower MSR levels, we also believe that performance measures and reporting should likewise increase along the continuum. We encourage CMS to continue moving ACOs toward more outcomes and patient reported measures, using measures that are derived from providers' own data systems, particularly for ACOs that move toward more substantial risk. As an added incentive for more advanced ACOs to report on more sophisticated and advanced measures, and to improve on those measures, we also encourage CMS to consider providing higher shared savings to organizations that have been able to produce better measures beyond the minimum. High performance on quality measures in advanced ACOs could also be a basis for bonus payments, analogous to quality bonuses in the Medicare Advantage program. In addition, very large health care organizations generally have a stated goal of providing better integrated care, and have more substantial capital for investing in population-level health reforms. They may also present more of a risk of market power with

anticompetitive effects on prices as well as quality. Greater reporting requirements for very large ACOs would help CMS develop better system-wide tracking and allow a clearer determination of their performance.

Proposals for Prospective Assignment of Beneficiaries in Downside-Risk ACOs

Many ACOs have expressed serious concerns that they often do not know how many patients have been attributed to their organization, who those patients are, and what their health status is at the beginning of a performance year. This uncertainty makes it difficult for the ACO to effectively implement practice transformation to maintain and improve the health of their patients over time. Some ACOs have described the current patient attribution process in MSSP as resulting in the organization “flying blind.” We appreciate the level of analysis and contemplation that CMS included in the proposed rule to weigh the relative benefits and drawbacks of changing the attribution methodology, and agree with their decision to use a prospective assignment process for ACOs in Track 3 (pg. 72810). As CMS notes, a prospective methodology would offer greater certainty for ACOs. At the same time, we recognize that steps are needed to discourage organizations from “gaming” the program by only focusing on a narrowly focused subset of FFS beneficiaries or seeking to exclude high-cost patients from being attributed by sending them to other non-ACO providers. While ACOs assuming two-sided risk should be given greater certainty about what patients they are accountable for, this knowledge should be accompanied by steps that encourage organizations to transform care for the overall Medicare population they might serve. Increasing evidence suggests that patients served by ACO providers, but not formally attributed, can also realize improved health status over time.³

Along with prospective attribution, CMS should undertake more rigorous risk adjustment of benchmarks based on the attributed patient populations to ensure that ACOs are being accurately assessed for genuine health and financial improvement over the performance period. We believe that CMS should do a full risk adjustment annually to account for patient status over time. If CMS is concerned about increased payments due to more complete reporting of patient health status – a desirable goal for the program – CMS could consider an across-the-board adjustment for an overall increase in risk coding for the entire program, similar to the adjustment process in Medicare Advantage. CMS should use ACO quality measures, measures of ACO participant characteristics, potentially along with other utilization-based measures and sources of evidence, to track whether and how the attribution process may be affecting the composition of ACO beneficiary populations.

In addition to supporting prospective attribution for Track 3 ACOs, we believe prospective attribution should also be extended to other downside risk ACOs (i.e., Track 2). Prospective attribution could be a significant incentive for ACOs to transition to two-sided risk and would encourage more organizations to assume downside risk sharing. Moreover, all organizations engaged in risk sharing would benefit from reduced uncertainty about the population they are serving. In fact, a number ACOs have expressed an interest in moving directly from Track 1 to Track 3 if prospective attribution is not also extended to Track

³ McWilliams, et al. 2013. “Changes in health care spending and quality for Medicare beneficiaries associated with a commercial ACO contract.” *JAMA* 310(8):829-36.

2. For this reasons, we believe Track 2 ACOs should be afforded the same benefit of prospective attribution as Track 3 ACOs have been offered.

Recommendations

- **Finalize the proposal to use a prospective patient attribution methodology for Track 3 MSSP participants**
- **Extend the prospective patient attribution methodology proposed for Track 3 to Track 2 as well**

Proposed Exclusion Criteria for Prospectively Assigned Beneficiaries

As the proposed rule noted, there will be some beneficiaries who at the end of each performance year should logically be excluded from assignment to an ACO. We support the proposal to do a limited reconciliation at the end of each performance year, which would remove patients that are no longer eligible for assignment at the time to reconciliation (pg. 72811). This reconciliation should include any patients who chose to enroll in Medicare Advantage at the beginning of the performance year, and those who moved outside of the ACO provider’s coverage region in the first six months of the performance year. We have also proposed excluding beneficiaries who opted out of data sharing for ACOs that are taking on downside risk. We agree that patients should not be removed from the prospectively assigned patient list simply because they sought care from providers in the same ACO coverage region. While there may be some prospectively assigned patients with whom the ACO’s providers have little contact over the course of the year and for which the ACO is now responsible, keeping these conditions could help to mitigate some of the concerns about an ACO attempting to avoid care to high-risk, high-cost patients.

In addition to these exclusion criteria for changes in patient status, we also encourage CMS to adopt an opt-out process for beneficiaries that do not wish to be a part of the ACO. This assignment opt-out process should coincide with the data opt-out process, and be supported by the same beneficiary education tools, in order to streamline the process for CMS and consolidate the patient decision-making process. CMS should notify ACOs of changes in their attributed patient population as a result of opt-outs following the first quarter of each year. CMS should track and report on ACO opt-out rates and consider high opt-out rates as a factor for further evaluation and consideration for continued participation in the MSSP.

To date, most ACOs have reported data sharing opt-out rates of between 2 and 3 percent. If this rate were to significantly increase following the adoption of the expanded assignment opt our process, CMS should reconsider the policy.⁴

Recommendations

- **Finalize the proposal to do a limited reconciliation at the end of each performance year to account for any patients that are no longer eligible for assignment**

⁴ MSSPs Should Jump-Start Management by Quickly Obtaining Consent to Data Sharing. ACO Business News. July 2013.

- **The exclusion should include any patient who enrolled in Medicare Advantage at the beginning of the performance year, moved outside of the ACO's coverage region in the first six months of the performance year, or opted out of data sharing**
- **Extend the same exclusion criteria for prospective patient attribution to Track 2**
- **Allow beneficiaries to opt-out of assignment to the ACO, which would coincide with the data sharing opt-out process**

Proposed Timing of Prospective Assignment

We agree with CMS that it is important to provide downside-risk ACOs (Tracks 2 and 3) with a list of prospectively assigned beneficiaries close to the start of each performance year in order to allow these organizations to implement appropriate clinical interventions and transformation (pg. 72812). Likewise, we support using a 12-month assignment window (offset by a calendar year) prior to the performance year. We recognize that this assignment window may not align with a calendar year, like it does for Tracks 1 and 2, but rather begin take the first 12 month window in which all necessary data is available.

Recommendations

- **Finalize the proposal to use a 12-month assignment window for Tracks and 3, offset by a calendar year prior to the performance year**
- **Extend the same timing for prospective patient attribution in Track 2**

Proposals for Determining Benchmark & Performance Year Expenditures Under Track 3

In conjunction with clarifying the attribution process for Track 2 and 3, it is also important for CMS to specify the process for calculating benchmark and performance year expenditures. We agree with the proposals set forth in this section, including continuing to determine Parts A and B FFS expenditures for each calendar year, whether it is a benchmark or performance year. As noted, this proposal will remove actuarial bias between benchmarking and performance years for assignment and financial calculations.

Recommendations

- **Finalize the proposed process for determining benchmark and performance year expenditures as written**

Proposals for Risk Adjusting the Updated Benchmark for ACOs in Tracks 2 and 3

As we note above in our recommendations for prospective attribution for ACOs bearing downside risk, effective risk adjustment is necessary to ensure that ACOs have a benchmark that accurately reflects the risk profile of their population. ACOs should rightfully have their benchmarks adjusted when there is a genuine change in health and risks status of their patient population. In the interest of aligning the benchmarking process with the attribution process, we agree with clarifying that benchmarking should occur during the assignment window, rather than the most recent calendar year (pg. 72813). However, we offer an additional change to the risk adjustment methodology, which we believe should be made across the entire program. The program currently adjusts an ACO's patient and population risk score upward as a result of demographic changes, but does not likewise adjust upward as a result of increase severity of patient conditions. Many ACOs feel as though the failure to adjust the risk annually based on

the health status of individual patients puts them at a disadvantage. Those ACOs that have been able to make genuine improvement to the status of patients' health over the course of the year see a downward adjustment as the patient gets healthier, but do not see a similar upward adjustment if the health status of the patient gets worse. The current risk adjustment methodology effectively creates a disincentive to improve the health status of the patient population. Especially with the changes to opt-out and the opportunities for more substantial reforms in care with more movement to downside risk, we strongly urge complete, up-to-date risk adjustment to support ACOs that are doing the most to improve care and thus attract and retain higher-risk patients. This is also a necessary step for cross-program alignment; using different risk adjustment rules in Medicare Advantage and other payment reform programs creates artificial distortions and incentives, and is administratively complex. Thus, we urge CMS to transition to a risk adjustment process that uses HCC scores on an annual basis to appropriately increase or decrease the benchmark, similar to Medicare Advantage, and to consider "rebasings" if necessary (planned and announced far in advance so as to avoid unexpected changes).

Recommendations

- **Finalize the proposal to define the benchmarking period as the assignment window, rather than the most recent year, in order to align with the process established for prospective assignment**
- **Consider ways to better account for increases in the severity of patients' conditions from year-to-year, by allowing an annual upward adjustment in the risk score**

Proposals for Final Sharing/Loss Rate and Performance Payment/Loss Recoupment Limit

We believe that those ACOs assuming larger two-sided financial risk should have a higher potential upside on the final sharing rate. The increase to a sharing rate of 75 percent for those in Track 3 appears significant enough to help encourage ACOs to transition into the highest risk track over the long term, however, it is unclear whether ACOs will agree that the increase would be enough in the short term to drive participants into Track 3. We agree that more can and should be done to help ease the transition between tracks. Thus, we ultimately support the proposal to offer upwards of a 75 percent sharing rate for Track 3 ACOs (pg. 72814). In addition, we agree that the loss rate should be the same as the sharing rate—75 percent. We also support the proposal to increase the payment limit to 20 percent of the ACO's updated benchmark and set the shared loss limit at 15 percent in each of the three performance years. We believe this mix of potential savings and losses should create incentives for those ACOs ready to assume higher levels of risk to enter Track 3, while also providing them with an appropriate level of downside risk. This transition to increasing sharing and loss rates is consistent with our ideal pathway to higher risk for organizations that show they can improve care and lower costs.

Recommendations

- **Finalize the proposal to set the final sharing and loss rate at up to 75 percent for ACOs entering Track 3, depending on their quality performance**
- **Finalize the proposal to set the payment limit at 20 percent and the loss limit at 15 percent of the ACO's benchmark**

Proposals for Minimum Savings Rate and Minimum Loss Rate in Track 3

In addition to allowing Track 3 ACOs to receive a higher final sharing rate, it is also important to establish a fair MSR and MLR that allows them to have certainty when assuming increased two-sided risk. Establishing a set MSR, regardless of an ACO's population size, increases predictability and may make the transition to Track 3 more attractive for ACOs. For this reason, we support the proposal to hold the MSR at two percent for all ACOs in Track 3 (pg. 72815). We also believe that the MLR should be set at a flat two percent for all ACOs in Track 3. This would align Track 3 with Track 2 and maintain equity across all ACOs assuming two-sided risk. As we proposed above for Track 2 ACOs, we also believe that CMS should consider adjusting the loss rate over time (i.e. moving away from identical savings and loss rates—like 50 percent in Track 1). This change could help to shift the level of shared losses over time as the ACO gains more experience at two-sided risk. For example, an ACO that has transitioned from one-sided to two-sided risk between agreement cycles might be eligible for 60 percent of shared savings, but only 15 percent of shared losses in year one of the new performance cycle. In year two, the ACO might be responsible for 30 percent of shared losses, which then increases to 60 percent in year three. This increasing loss rate over time could help facilitate the assumption of risk and create less immediate downside risk for those ACOs new to two-sided risk.

Recommendations

- **Finalize the proposal to set the MSR for all ACOs in Track 3 at a flat two percent**
- **Finalize the proposal to set the MLR for all ACOs in Track 3 at a flat two percent**
- **Create a sliding scale for the shared loss rate (15 percent to 60 percent) that changes over time to allow ACOs to assume increasing levels of downside risk as they gain more experience**

Inclusion of a Population-Based Payment Option for MSSP Participants

As we have discussed throughout our comments, we believe that the MSSP should provide those organizations willing and interested in assuming risk beyond shared savings with a clearer path to partially capitated payment arrangements. To provide a clear pathway to such partially capitated payments, we propose that CMS should also consider a Track 4 that organizations could select as they progress beyond two-sided risk. This track would allow an additional phase for organizations that intend on assuming full risk through Medicare Advantage. This option could be considered within the statutory scope of "shared savings" since, from a technical standpoint, the partial capitation program could be designed in a way that does not provide higher payments to the ACO unless overall spending falls and that provides more net revenues to the ACOs as total savings rise. Alternatively, this additional step toward increased downside risk for MSSP participants could be provided using authority granted through the Center for Medicare and Medicaid Innovation (CMMI), though the program will be more successful if it is not viewed as temporary or changeable, but as an integral part of the Medicare ACO options. Moreover, organizations at this level of risk sharing will already have a demonstrated track record of providing quality care at a low cost.

Track 4 could be structured similarly to the Pioneer ACO Model's population-based payments that are available to participants in program year 3 when the organization demonstrates an annual savings rate (averaged over the first two performance years) of at least 2%. In this model, Track 4 participants would receive a population-based payment up to 50% of the ACO's historical Part A and Part B claims expense. The organization would also share in up to 70% of the savings and losses generated for services beyond the capitated amount for those claims. Given the increased level of risk assumption, we propose that ACOs in this track be held to a flat one percent MSR and MLR. Like the Pioneers that assume a population-based payment, we propose that the performance payment and loss limit be set at 15 percent. We recognize that additional issues not covered in our comments need to be addressed in order to ensure appropriate reconciliation between the capitated payment and FFS payments. This reconciliation process is necessary to ensure that provider services and payments are accurately accounted for in the organization's financial performance.

This program would enable organizations that demonstrate effectiveness in improving care and lowering costs to have a greater ability to redesign care to support additional improvements. It would also provide more predictability as part of an overall ACO shared savings strategy than is the case with the current Pioneer program. It would also help assure that organizations who participate in this track have a proven ability to succeed with significant risk sharing. We believe that the inclusion of Track 4 would provide an important step and improved clarity for organizations interested in moving towards greater risk.

Recommendations

- **Create a population-based payment model for ACOs willing to assume partial capitation for up to 50% of their historical Medicare Part A and Part B costs, with the following financial specifications:**
 - **Up to 70% shared savings and losses for costs not included in the capitated payment**
 - **Fixed one percent MSR and MLR for savings and losses outside of the capitated payment**
 - **A 15% performance payment and loss sharing limit**
- **Extend all other programmatic requirements and conditions used for the two-sided risk models to Track 4, including prospective attribution, patient attestation, risk adjustment, waivers from FFS payment requirements, and benchmarking**

COMPLEMENTARY REGULATORY CHANGES FOR ACOS PARTICIPATING IN PERFORMANCE-BASED RISK ARRANGEMENTS

As we have noted, few Medicare ACOs have moved into risk sharing arrangements, although such arrangements are becoming increasingly common in other commercial insurance programs and are showing important benefits for care. To encourage the transition to two-sided risk—which will enable organizations to take further steps to improve quality and reduce costs—CMS has articulated a variety of regulatory modifications to be used by organizations if they accept two-sided risk. In general, these modifications involve Medicare regulations that were implemented to address risks of overuse and excess costs under FFS payment. As ACOs shift toward bearing greater financial risk, the benefits of these rules are less clear, and as we illustrate below, relaxing the rules may facilitate new types of services that can help ACOs improve outcomes and lower costs for their beneficiaries.

Payment Requirements and Program Requirements That May Need To Be Waived In Order to Carry Out the Shared Savings Program

The Secretary has waiver authority with regard to certain Medicare program rules in order to increase effective implementation of two-sided risk tracks (pg. 72816). For instance, CMS has proposed that organizations that have agreed to two-sided risk in Track 3 may use the following waivers: SNF 3-day Rule, Billing and Payment for Telehealth Services, Homebound Requirement Under the Home Health Benefit, and Referrals to Post-Acute Care Settings. Many current program participants agree that these waivers would encourage the transition to two-sided risk and should be extended to additional program participants. We agree that ACOs that shift further in the direction of risk sharing should have additional flexibility to provide such services and be provided with additional waivers, but believe that CMS should go further in providing some of these flexibilities to a broader range of ACOs that have moved away from one-sided risk.

We believe that the waivers for the SNF 3-day Rule and Referral to Post-Acute Care Settings are particularly important. The current FFS system impedes ACOs' ability to effectively coordinate care and reduce costs in these particular areas. The current 3-day SNF rule financially bars beneficiaries from using the SNF without a hospitalization, which we believe prevents ACOs from effectively preventing an unnecessary hospitalization when care could have been better delivered by a SNF. Likewise, all ACOs should be able to not only provide information to patients about which post-acute care providers are of highest quality, but also recommend facilities which are part of the ACO or for which they have an established relationship. A number of organizations have highlighted these two waivers in particular as a deterrent to effective care coordination that could significantly reduce unnecessary costs and care. These rules are intended to deter inappropriate use for providers under FFS reimbursement, but have fewer such benefits and are more likely to get in the way of well-coordinated, personalized care in organizations that have more accountability for overall costs and quality.

We also propose that CMS consider additional waivers to include co-pays for beneficiaries of the Chronic Care Management (CCM) code. Finally, CMS should provide more clarity on what additional

costs the ACO can cover that may be deemed necessary for chronic care management, such as transportation to and from appointments, wheelchairs and other medical equipment, gym or wellness program memberships, heating or air conditioning services at home, and other home improvements for physically impaired patients, such as railing installation. CMS should work with ACOs to provide flexibility and guidance on what other kinds of costs they could cover for their beneficiaries.

We encourage CMS to consider additional waivers on an ongoing basis between performance years and allow individual ACOs to submit requests through a more formal review process.

Recommendations

- **Expand the use of waivers (SNF 3-day Rule, Billing and Payment for Telehealth Services, Homebound Requirement Under the Home Health Benefit, and Referrals to Post-Acute Care Settings) to a broader range of ACOs who transition beyond one-sided risk into Tracks 2, 3, and 4**
- **Include waivers for co-pays of beneficiaries of the CCM code and provide more guidance on what additional costs ACOs can cover that are deemed necessary for chronic care management**

Beneficiary Attestation in Two-Sided Risk Arrangements

CMS has also proposed other options for improving the transition to two-sided risk arrangements, such as beneficiary attestation (pg. 72826). This program is currently a pilot in the Pioneer ACO program for beneficiaries previously assigned to a given ACO. We recommend that CMS adopt a similar attestation process for MSSP participants that are bearing downside risk and believe that, unlike the Pioneer pilot, the attestation process should be available to all patients in downside risk ACOs, not just those previously assigned to the ACO. This reform proposal complements the opt-in and opt-out changes that we have discussed previously (pg. 11) by combining the data opt-out and beneficiary attestation process. Beneficiary attestation can clarify the attribution process, which is particularly important for ACOs that are bearing financial risk to be able to identify beneficiaries that are under their care for optimal coordination and management.

To alleviate the administrative burden for ACOs, and to help assure that communications related to attestation are consistent especially in the early stages of the program, we suggest that CMS manage contact with beneficiaries and directly provide the instructions for attestation along with other information about the ACO program. The beneficiary attestation and data opt-out processes should occur through a phone call to 1-800-MEDICARE or a web-portal that includes a drop-down menu of participating providers. In order to ease the decision-making process of patients and reduce the likelihood that they select the wrong provider, we recommend that CMS inform patients about the ACO provider to whom they were assigned under prospective attribution (i.e. a list of likely providers—such as those that the patients has seen in the last 2 years—that could be used for PCP selection and subsequent election into the ACO). We believe that attestation should be based on the patient’s

selection of their PCP, rather than the name of an ACO, since most patients will not be familiar with the name of their provider's ACO. While we encourage CMS to provide the name of the relevant ACO for each provider option given to beneficiaries, we recognize that this may add additional administrative burdens. In the absence of providing both the provider and ACO name in the selection materials, we believe that selection of the patient's preferred provider is an adequate and sufficient proxy for selection of the provider's ACO.

The option of patient attestation should be extended to all two-sided risk ACOs. Even with this provision, we believe that the prospective attribution process we have proposed above will continue to be the primary process for patient assignment. Without stronger financial and other beneficiary incentives, we are likely a long way from the point where most beneficiaries will sign up through attestation. As we have also noted, reduced copays when a patient receives care from an ACO professional would be another example of a beneficiary incentive.

We have already noted some features that could be implemented by CMS as part of attestation and attribution, and we expand on those here. First, we propose that the patient attestation and beneficiary opt-out processes only occur during the first three months of each performance year. This should provide beneficiaries with adequate time to make an informed decision about whether they would like to attest to an ACO and share their data, while also building in protections against efforts to encourage or discourage a patient from participating in the ACO based on their health status. Second, CMS management of the process helps assure that beneficiary communications about opting in or opting out will be consistent and appropriate. Administration by CMS also reduces potential additional administrative duties for ACOs and their providers. Although CMS would be responsible for contacting and administering the process for attestation, we believe that other consistent means of informing beneficiaries may be appropriate, such as signage in patient waiting area.

As we also noted earlier, we recommend that CMS consider allowing certain beneficiaries to designate up to two PCPs, one of which is a specialist. For example, a patient with a severe chronic condition or cancer would be allowed to designate their traditional PCP in addition to a specialist (e.g., an oncologist). We recognize that CMS would need to determine how to reconcile cases in which the two designated PCPs are in different ACOs, such as giving the beneficiary the option of which provider they feel is more responsible for their care management. This additional attestation process would ensure that the physician most accountable for a patient's long-term care management is appropriately used for attribution.

Recommendations

- **Allow MSSP participants in two-sided risk models to attest to an ACO, as part of the new attribution and beneficiary opt-out process**
- **Pilot a program to provide additional financial incentives, including reduced copays for primary care services, to patients who choose to join an ACO**
- **Institute the following parameters for the attestation process**

- **ACOs must inform patients of the option to attest to an ACO, but CMS would administer the process and maintain information on patient choices.**
- **Allow a 3-month period at the beginning of each performance year for patients to attest to an ACO**
- **Consider allowing patients with chronic conditions or short-term intensive health needs to designate two primary care providers, including a specialist**

Seeking Comment on Methodology for Establishing, Updating, and Resetting the Benchmark

As we have emphasized, having predictable financial benchmarks is a foundational part of success for ACO participants as well as the MSSP at large. We believe that the current methodology for establishing, updating, and resetting the benchmark may be unfair to ACOs because it does not account for a number of factors that significantly influence the ACO's performance, including regional cost trends, the ACO's experience over time, and the overall risk profile of the patient population. Further, ACO benchmarks that depend only on an ACO's past costs will take ACO payments out of alignment with Medicare's other payment programs such as Medicare Advantage, with the result that the same organization could receive substantially different payments based simply on which Medicare program it uses. We appreciate the proposed rule's acknowledgement of these challenges and offer our comments on how the benchmarking process can be improved.

Factors To Consider in Resetting Benchmarks & Alternative Benchmarking Methodologies

CMS currently estimates a benchmark for each agreement period for each ACO using the most recent available 3 years of per beneficiary expenditures for Parts A and B services for Medicare FFS beneficiaries assigned to the ACO (pg. 72832). Benchmarks are reset at the start of each agreement period when CMS establishes ACO-specific benchmarks that account for national FFS trends. Since the initial rulemaking, many ACOs have consistently expressed concerns over the process used to set their benchmarks. ACOs have remarked that the existing benchmarking methodology that uses the national trend does not sufficiently account for the influence of cost trends in the surrounding region or local market on the ACO's financial performance. ACOs have also noted that, if they succeed in reducing costs, their future benchmarks will be adversely affected; and if they reduce costs less, they will have higher future payments. Thus, we are pleased that CMS seeks comment on many benchmarking methodologies in the proposed rule: equally weighting the 3 benchmark years, accounting for shared savings payments in benchmark, using regional FFS expenditures (as opposed to the national factors) to trend and update the benchmark, implementing an alternative that uses an initial historic benchmark in the beginning and then a constant regional FFS in subsequent years, and transitioning the benchmark to just use regional FFS costs over multiple periods. We recognize that there are advantages and disadvantages to each of these approaches and appreciate the thoughtful analysis by both CMS as well as other stakeholders. We support MedPAC's emphasis on considering the short-term sustainability of the current benchmarking model, as well as longer term issues such as the balance between historical and regional benchmarks. Ultimately the benchmarking process should create equity among program

participants and not perpetuate differences between benchmarks for inefficient and efficient ACOs,⁵ and should not be out of alignment with Medicare Advantage benchmarks. We provide further comments for each of the proposed updates to the benchmarking process.

While we understand the potential value of equally weighting all performance years (spreading out the benchmarking so that performance is judged over time and not disproportionately on just the third year), many ACOs have expressed reservations about whether this is truly a good marker of the most recent financial status of the organization. We likewise have concerns with the proposal to include the shared savings payment in the benchmark. Those ACOs that were able to reduce spending in the prior performance period, but not hit the MSR, would be disadvantaged and not see those real improvements factored into an increased and more favorable benchmark. The third proposal to use regional factors in establishing and updating the benchmark captures the significant variation between different regions of the country, but may be too radical an approach. With a benchmark based solely on regional costs, like was used for the Physician Group Practice (PGP) demo, the ACO could become a winner or loser based in large part on the comparison group of how other providers in the region are performing. Moreover, for a voluntary program like the ACO program, organizations may choose to participate simply because their baseline costs are lower; while such ACOs can reasonably argue that this is only fair, it could lead to significant increases in Medicare costs without improvements in quality. Likewise, option four to hold the ACO's historical cost constant relative to its region is a move in the right direction, but we have concerns there as well. While this approach realizes the importance accounting for regional costs, it also create a static benchmark based on the organization's historical performance and does not evolve to account for changing performance or patient mix of the ACO over time. Finally, none of these approaches align with methods used for updating payments in other Medicare programs, like Medicare Advantage.

We conclude that the fifth methodological change to benchmarking should be finalized—transitioning ACOs to benchmarks based on regional FFS costs over multiple agreement periods (pg. 72841). We believe that this benchmarking process best recognizes concerns about performance relative to other providers in the region, while also encouraging the ACO to continue to improve over time. Transitioning to an increasing proportion of the benchmark based on regional costs over time also helps to ease ACOs into the program, so that ACOs that may benefit from regional adjustment have already demonstrated a track record of lowering costs and improving care. It will be important for CMS to set clear guidelines on how the regional comparison groups will be established and what impact they will have on individual ACOs' benchmarks. We propose the following transition path beginning in the second and each subsequent performance period for an ACO: second contract begins a gradual transition to a regional benchmark (10 percent per year, ending at 40 percent historical benchmark/60 percent regional benchmark); third contract completes the transition by year five (80 percent historical benchmark/20 percent regional benchmark); fourth and any subsequent contracts are 100 percent regional. We believe

⁵ Medicare Payment Advisory Commission. Comment Letter RE: File code CMS-1461-P. Available at <http://www.medpac.gov/documents/comment-letters/medpac-comment-on-cms-s-medicare-shared-savings-program-accountable-care-organizations-proposed-rule.pdf?sfvrsn=0>

that a proposal like this one, which blends regional costs and historical performance while permitting adjustments ahead of the subsequent contract period if necessary, will create a more sustainable benchmarking process that accounts for regional variation and continues to reward ACOs that are performing well.

Additionally, for the reasons we have noted above, no matter which benchmark methodology is adopted by CMS, more complete and up-to-date risk adjustment should be employed to better capture the population characteristics of each ACO. Many ACOs feel as though their benchmark should be adjusted annually in a way that accounts more accurately for the current health status of ACO beneficiaries. We urge CMS to transition to a risk adjustment process that uses HCC scores to appropriately increase or decrease the benchmark, similar to Medicare Advantage.

Recommendations

- **Adopt the benchmarking methodology that transitions ACOs to benchmarks based on regional FFS costs over multiple agreement periods**
- **Adopt an improved risk adjustment methodology based on HCC scores that is used appropriately to both decrease and increase the benchmark at the beginning of each performance year**

G. ADDITIONAL PROGRAM REQUIREMENTS AND BENEFICIARY PROTECTIONS

There are specific criteria that ACOs must satisfy in order to be eligible to participate in the MSSP. These policies include how ACOs will be monitored with respect to the program requirements and what actions will be taken against ACOs that are not in compliance (pg. 72845). **We approve of all of the following modifications set forth to ensure consistent practice by all participants:** Public reporting and transparency; termination of participation agreement; reconsideration process; monitoring ACO compliance with Quality Performance Standards.

PROVIDING FINANCIAL SUPPORTS FOR ORGANIZATIONS WISHING TO BECOME ACOS

In order to effectively transform clinical practice, ACOs must create or procure significant financial and human capital, as well as transform their information technology and delivery infrastructure. An increasing number of physician groups and smaller provider networks are beginning to realize the potential value of becoming an ACO; however the financial costs can be prohibitive for many organizations. We applaud CMS' establishment of the Advance Payment Model for ACOs at the beginning of the program in 2012 and the recent announcement of a revised ACO Investment Model to help these ACOs get off the ground as an ACO. First year results suggested that the advance payments to ACOs in 2010 may have made a difference; a higher percentage of those ACOs attained shared savings relative to other program participants.⁶ We urge CMS to continue such steps to remove or reduce the financial barriers to participation.

ADDITIONAL STRATEGIES AND INCENTIVES FOR PATIENT ENGAGEMENT

One significant area that we feel was inadequately represented in the proposed rule are strategies and incentives to improve patient engagement. We believe that improved communication with patients and engagement with them across the care continuum is a critical factor for the long-term success of ACOs. These strategies have the potential to foster a culture of accountable care in which the patients become a part of the care team. We believe that ACOs bearing more downside risk should be afforded greater flexibility around what approaches they can employ to better engage and incentivize patients. As noted previously, we applaud the patient attestation pilot being tested in the Pioneer ACO program and believe a similar opportunity should be extended to ACOs and patients in the MSSP. We highlighted some of the necessary conditions that we believe can be used to help ensure a successful implementation of this process—CMS assumes administrative responsibilities for contacting patients and recording their preferences; a 3-month window during which patients can attest; and a streamlined process to attest, including a list of likely ACOs based on the patient's previous primary care services.

In order to keep these patients activated and continuously enrolled in the ACO, there are a number of additional steps, including financial incentives, which we believe should be implemented. ACOs should provide more complete and easier to understand documentation to help patients understand what an

⁶ F Mostashari and R White. The ACO Hypothesis: What We're Learning from the Medicare Shared Savings Program. *UpFront* blog. The Brookings Institution. March 10, 2014.

ACO is, why they would want to attest to an ACO, and how such attestation can lead to higher-value care and improved health status. We encourage CMS to loosen the current restrictions on marketing materials to allow ACOs to provide patients with a more comprehensive understanding of the elements of an ACO, which would benefit a patient's decision about whether to attest to the ACO. This may include better signage and literature in physician offices, as well as other communication methods such as text messages. Given that most patients will still be assigned based on the attribution process and that CMS will administer the attestation process, we do not have significant concerns about organizations inducing high-cost patients to seek care through alternative providers.

We also urge CMS to consider additional incentives for patient participation in ACOs that are bearing financial risk, including waiving or lowering copays and deductibles for patients when they receive care from their PCP or other providers included in the ACO's list of preferred providers. While the cost of these waived patients would be borne by the ACO, these ACOs have stronger incentives to limit overall costs, and we believe that the long-term benefits of this process—better care management, continuous enrollment in the ACO, more focus on low-cost primary care services—could outweigh the upfront costs. Alternatively, just as ACOs today are able to decide how to allocate their shared savings among PCPs, specialists, reinvestment, and other expenses, the ACO could be allowed to allocate a certain percentage of their shared savings directly to patients. For example, the patient's shared savings could be built directly into the savings rate established with CMS (e.g. in Track 1: 45% of savings could go the ACO, 45% kept by CMS, and 10% distributed to patients). There are obvious technical and administrative burdens of using such a model, but this would be a clear way for CMS to demonstrate the importance that they would like to place on the role of patients in accountable care success.

As noted before, CMS should provide more clarity on what additional patient costs the ACO can cover that may be deemed necessary for chronic care management, such as transportation to and from appointments, wheelchairs and other medical equipment, gym or wellness program memberships, heating or air conditioning services at home, and other home improvements for physically impaired patients, such as railing installation. CMS should work with ACOs to provide flexibility and guidance on what other kinds of costs they could cover for their beneficiaries, particularly for ACOs that are bearing substantial financial risk.

Recommendations

- **Allow MSSP participants in all downside risk tracks to attest to an ACO as a supplement to the existing attribution process.**
- **Waive or lower copays and deductibles for patients who attest to the ACO when they receive care from their primary care physician or other providers included in the ACO's list of preferred providers**
- **CMS should provide more clarity on what additional costs an ACO can cover that are deemed necessary for chronic care management, which have traditionally been assumed by individual beneficiaries**

IMPROVING COORDINATION WITH MEDICARE PART D

Another potentially effective approach to improve care for beneficiaries is to support better coordination between MSSP providers and Medicare Part D. This can provide support for more effective pharmaceutical use, which can lead to significant health improvements and lower overall Medicare costs. Part D plans currently do not have direct financial incentives to optimize the total value of drugs used in ACOs, since this spending is not accounted for in their financial benchmark. Similarly, ACOs do not have appropriate incentives to optimize use of Part D drugs since their costs are not included in the ACO financial benchmarks. There are a couple of approaches that could help to facilitate coordination with Medicare Part D, including enabling Part D plans to receive a bonus or percentage of shared savings when contracting with ACO providers, or additional financial incentives to use medication therapy management. We urge CMS to consider incentives in both the MSSP and Part D programs to encourage alignment and closer coordination of the respective programs to optimize pharmaceutical outcomes of beneficiaries in both programs.

Recommendations

- **Consider approaches to foster coordination between Part D plans and ACO providers, including providing Part D plans with a bonus or percentage of shared savings when contracting with ACO providers or additional financial incentives**
- **Consider incentives in both the MSSP and Part D programs to encourage alignment and closer coordination of the respective programs to optimize pharmaceutical outcomes of beneficiaries in both programs**

CONCLUSION

We support the extensive efforts of CMS to further refine the Medicare Shared Savings Program for continued effectiveness and sustainability. The ACO program has the potential to have substantially greater benefits for Medicare beneficiaries and for reducing the overall cost of the program, and can be a critical part of the efforts at CMS and HHS to support improvements in care throughout the entire health care system. We look forward to continuing to work with CMS to enable innovation in care that improves quality and reduces costs.

Appendix A. Financial Parameters for MSSP Risk Tracks (changes from proposals in NPRM marked in blue)

	Track 1: One-Sided Risk Starter ACO Model	Track 2: Two-Sided Risk Model	Track 3: Advanced Two-Sided Risk Model	Track 4: Population-Based Payment Model
Transition to Two-Sided Model	Allow ACOs to remain in a one-sided risk model for an additional performance period (not to exceed a total of 6 years in one-sided risk) before being required to transition into a two-sided risk model	ACOs may elect Track 2 without completing a prior agreement period under a one-sided model ACOs cannot switch into Track 1 for subsequent agreement periods	ACOs may elect Track 3 without completing a prior agreement period under a one-sided model ACOs cannot switch into Track 1 for subsequent agreement periods	ACOs may elect Track 4 without completing a prior agreement period under a one-sided model ACOs cannot switch into Tracks 1, 2, or 3 for subsequent agreement periods
Capitated Payments	N/A			Population-based payment of up to 50% of ACO's historical part A & B revenue
Quality Sharing Rate	Up to 50% based on quality performance in the first performance period Reduced by 10 percent (40%) in second performance period, if ACO remains in Track 1	Up to 60% based on quality performance	Up to 75% based on quality performance	Up to 70% of savings for services not included in the capitated payment, based on quality performance
Shared Savings	First dollar sharing once MSR is met or exceeded			First dollar sharing once MSR is met or exceeded for payments outside of capitated payment
Minimum Savings Rate (MSR)	2.0% to 3.9% depending on number of assigned beneficiaries.	Fixed 2.0% Explore extending the lower bound to one percent for organizations with over 80,000 beneficiaries, if there is evidence that these organizations are statistically less significant to reach the MSR		Fixed 1.0% for savings outside of the capitated payment
Minimum Loss Rate (MLR)	N/A	Fixed 2.0%		Fixed 1.0% for losses outside of the capitated payment
Shared Loss Rate	N/A	One minus final sharing rate applied to first dollar losses once	One minus final sharing rate applied to first dollar losses once	One minus final sharing rate applied to first dollar losses once

Appendix A. Financial Parameters for MSSP Risk Tracks (changes from proposals in NPRM marked in blue)

	Track 1: One-Sided Risk Starter ACO Model	Track 2: Two-Sided Risk Model	Track 3: Advanced Two-Sided Risk Model	Track 4: Population-Based Payment Model
		MLR is met or exceeded; Shared loss rate not to exceed 60% Consider creating a sliding scale for the shared loss rate (15 percent to 60 percent) that changes over time to allow ACOs to assume increasing levels of downside risk as they gain more experience	MLR is met or exceeded; Shared loss rate not to be less than 40% or exceed 75% Consider creating a sliding scale for the shared loss rate (15 percent to 75 percent) that changes over time to allow ACOs to assume increasing levels of downside risk as they gain more experience	MLR is met or exceeded; Shared loss rate not to be less than 40% or exceed 70%
Performance Payment Limit	10%	15%	20%	15% of savings outside of capitated payment
Loss Sharing Limit	N/A	Limit on the amount of losses increases annually over 3 years (5% in year 1, 7.5% in year 2, 10% in year 3 and subsequent years); Losses in excess of the annual limit would not be shared	15% Losses in excess of annual limit would not be shared	15% of losses outside of capitated payment Losses in excess of annual limit would not be shared
Beneficiary Assignment	Maintain existing beneficiary assignment process: preliminary prospective beneficiary assignment, followed by retrospective reconciliation at the end of each performance year based on whether the patient received a plurality of services from ACO providers	Prospective patient assignment for reports and financial reconciliation at the beginning of each performance year Limited reconciliation at the end of each performance year to remove ineligible beneficiaries, including those that joined MA plans or moved outside of the ACO provider network region		

Appendix A. Financial Parameters for MSSP Risk Tracks (changes from proposals in NPRM marked in blue)

	Track 1: One-Sided Risk Starter ACO Model	Track 2: Two-Sided Risk Model	Track 3: Advanced Two-Sided Risk Model	Track 4: Population-Based Payment Model
Patient Choice in Assignment	N/A	Allow patients to opt-in or opt-out of assignment to an ACO as a supplement to the existing patient assignment process, which occurs simultaneously with beneficiary decision about data sharing opt-out <ul style="list-style-type: none"> • Opt-in or opt-out may occur during a 3-month period at beginning of each performance year • ACOs must inform patients of the option to attest ACO via signage in patient waiting areas • CMS administers the process and collects all patient choices • Patient opting into the ACO are eligible for eliminated or reduced copays for primary care services furnished by providers in the ACO provider network 		
Benchmark	Continue to use existing historical methodology	Continue to use existing historical methodology in first agreement period Beginning in second agreement period, transition the benchmark to a blended historical-regional methodology: <ul style="list-style-type: none"> • Second contract: gradual transition to 40 percent historical benchmark/60 percent regional benchmark • Third contract: transition from 20 percent historical/80 percent regional to 100 percent regional benchmark after the first year • Fourth and any subsequent periods: 100 percent regional 		
Adjustments for health status and demographic changes	In conjunction with revised benchmark methodology transition, use CMS-HCC risk adjustment model on an annual basis to account for the risk profile and health status of the patient population. Newly assigned beneficiaries adjusted using CMS-HCC model; continuously assigned beneficiaries adjusted on an annual basis using demographic and health status factors, which can result in both a decreased and increased risk score			
Waivers for Existing FFS Payment Requirements	N/A	Allow the use of waivers (SNF 3-day Rule, Billing and Payment for Telehealth Services, Homebound Requirement, and Referrals to Post-Acute Care Settings), with greater flexibility from traditional FFS restrictions for ACOs that are bearing more substantial downside risk Consider use of waivers for co-pays of beneficiaries of the CCM code, and to allow ACOs to cover additional costs that deemed necessary for chronic care management, particularly for ACOs bearing downside risk		
Quality Measures	<ul style="list-style-type: none"> • Continue to shift toward more outcome oriented quality measures, particularly those that are patient reported • Require more sophisticated quality measures for larger ACOs and those taking on higher risk • Consider providing payment bonuses for reporting on more advanced measures and for better performance on quality measures, as in the Medicare Advantage program 			