March 28, 2016

VIA ELETRONIC MAIL

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Re: CMS-1644-P: Notice of Proposed Rulemaking on Medicare Shared Savings Program Accountable Care Organizations (81 *Fed.Reg.* 5,824 (Feb. 3, 2016))

Dear Acting Administrator Slavitt:

The Health Care Transformation Task Force ("HCTTF" or "Task Force")[1] appreciates the opportunity to provide input to the Centers for Medicare & Medicaid Services ("CMS") on CMS-1644-P Medicare Program: Medicare Shared Savings Program ("MSSP"): Accountable Care Organizations ("ACO") Notice of Proposed Rulemaking ("Proposed Rule").

The Task Force supports many of the Proposed Rule's policies, several of which we have advocated for in past comment letters. Below, we provide input, raise questions, and offer suggestions on the proposed changes, organized into the Proposed Rule's three main sections: (1) Revised Benchmarking; (2) Facilitating the Transition to Risk; and, (3) Administrative Finality of Financial Calculations.

1. Revised Benchmarking Policy

The Task Force fully supports CMS' decision to integrate regional factors into the benchmark rebasing methodology, as it will help to create greater sustainability for the MSSP and its ACOs. This proposed change represents a necessary improvement that may attract historically-

[1] The Task Force is a group of private sector stakeholders that wish to accelerate the pace of delivery system transformation. Representing a diverse set of organizations from various segments of the industry – currently including providers, health plans, employers, and consumers – we share a common commitment to transform our respective businesses and clinical models to deliver the triple aim of better health, better care, and reduced costs. Our member organizations aspire to put 75 percent of their business into value-based arrangements which focus on the triple aim by 2020. We strive to provide a critical mass of policy, operational, and technical support from the private sector that, when combined with the work being done by CMS and other public and private stakeholders, can increase the momentum of delivery system transformation.

efficient ACOs to the program while providing an incentive for current ACOs to continue their participation. Though a clear step in the right direction, the HCTTF also recognizes that the proposed approach may not always provide a material incentive for certain ACOs to join or continue participating, such as for efficient ACOs who operate in efficient regions where their historical performance is very close to the regional benchmark.

Specifically, the Task Force expresses our support for the following proposals related to the revised benchmarking:

- Adopting a blended approach to incorporating regional expenditures while leaving a portion of the benchmark historical; and,
- Applying the full HCC risk adjustment when comparing an ACO to its region.

For other proposed changes to the benchmarking methodology, the Task Force makes the following recommendations:

- **Defining the ACO's Regional Service Area**
  We support the proposal to use the county in which one assigned beneficiary resides as the geographic unit of measure. **However, we recommend that for ACOs which represent a sufficient percentage of their service area (which calls into question the validity of the comparison group), CMS consider including the adjacent counties in the regional measurements**, similar to the approach used in the Pioneer model. For this approach, CMS would determine and establish the proportion of ACO-assigned beneficiaries to non-assigned beneficiaries in the county in order to determine whether adjacent counties should be included.

- **Determining County Fee-for-Service (FFS) Expenditures**
  The Task Force agrees with the proposal to remove all non-assignment eligible beneficiaries when calculating a region's FFS expenditures. **We urge CMS to set policy that also removes an ACO's own assigned beneficiaries from the calculations**, in order to demonstrate a true comparison of the ACO to the FFS expenditures within the applicable region.

- **Timing of Applicability of Revised Rebasing and Updating Methodology**
  The underlying policy goal of the MSSP is to grow the program, expanding the practice of high-value care to more beneficiaries across the country. We suggest several modifications that will further this goal:

    - **The Task Force has long supported the principle of choice, as a one-size-fits-all approach is hardly ideal for such diverse organizations as ACOs. Moreover, we urge CMS to provide options for ACOs in the timing of their move toward regional benchmarking.** Such options should include the opportunity to select a 35 percent regionally-based benchmark in the first agreement period, incentivizing historically-efficient providers to join the program. Whatever the methodology, CMS should be transparent to the degree that ACOs are able to model/estimate their benchmarks under the various options prior to making a selection.

- **Pioneer ACOs which move into the MSSP should have the option to move directly to a regional benchmark, given they are already subject to regional benchmarking components currently.** Pioneer ACOs moving to the MSSP will have completed two contract periods and have invested in a model that includes regional components in the benchmarking methodology. Former Pioneer ACOs who may join the MSSP would be entering their third contract period and should therefore get the same benefits as those MSSP ACOs entering their third contract period. We urge CMS to clarify that Pioneers ACOs entering the MSSP are not expressly tied to the "second or subsequent agreement period" definition in the MSSP program. The same approach to policy appears appropriate for any Next Gen ACOs which may move into the MSSP program in the future.

- **At the very least, ACOs who renewed their contracts in 2016 should be given the option to move toward regional benchmarks without having to wait until their third contract period.** More than any other cohort, these early adopters deserve this option and we see no significant rationale for their exclusion. These ACOs should not be penalized simply because of unfortunate timing.

- **Accounting for Past Savings within Revised Benchmarking**
  In the June 2015 final rule, CMS established policy that adjusts the rebased historical benchmark to account for savings generated by an ACO during the prior agreement period. The Proposed Rule seeks to reverse this policy, eliminating any adjustment for past savings. **We urge CMS not to finalize this proposal, which actually provides a disincentive to widespread MSSP ACO sustainability.**

  As noted above, the move to a regional benchmark may not meaningfully benefit all ACOs, especially those in historically efficient regions. Thus, while the logic associated with eliminating any ACO-specific adjustment as part of the move to regional benchmarking model seems sound at first blush, the reality is that the proposal's impact on ACOs will differ, and those that benefit marginally if at all from the regional benchmark will be significantly disadvantaged if the adjustment for its realized savings is eliminated.

  In order to encourage ACOs to continue in the program, move closer to a regional benchmark, and ultimately toward assuming two-sided risk, the Task Force believes that an ACO's past shared savings should be incorporated into the historical component of the benchmark in the second and subsequent contracts. This would allow for the benefit of regional benchmarking, while ensuring the program remains attractive to all successful ACOs. Therefore, the HCTTF urges that current policy continue.

- **Adjusting Benchmarks for Changes in ACO (Taxpayer Identification Number) Composition**
  The necessary, and therefore common, practice of ACOs making modifications to their participant lists between performance years has become a significant burden for CMS as the program grows in size and complexity. The Task Force understands the administrative burden imposed on CMS by the current process, and supports the effort to streamline the approach**. However, given the current instability and inaccuracy of the existing benchmark on any given ACO, CMS should perform additional analysis and policy**

development on the fundamentals of benchmarking before establishing a proxy process for making adjustments.

CMS proffers that the magnitude of changes under the proposed methodology for ACOs is +/- 2 percent. While that may be an insignificant variance across the program, the potential impact on individual ACOs can be very significant. A variance that is more than the minimum shared savings rate cannot possibly be deemed acceptable. As a completely voluntary program, CMS should consider MSSP policies from the perspective of an individual ACO deciding whether to participate, or continue participating, in the program. **Thus, the Task Force urges CMS to refrain from establishing a proxy process until it can be proven to be accurate and reliable from ACO to ACO. CMS should also provide sufficient data in order to foster transparency that allows for modeling any future proposed, streamlined approach.**

- **CMS Should Make Available Interim Risk Scores Quarterly**
  As noted in other parts of this letter, transparency around data and methodology are of critical importance, both for operational planning as well as for facilitating the movement toward risk. Without knowing population risk scores until settlement, financial modeling and risk management are extremely difficult. **Though not directly related to the Proposed Rule, we fare compelled to use this opportunity to urge CMS to provide interim risk scores on both the population and region to ACOs on a quarterly basis.**

2. Facilitating the Transition to Risk

CMS believes that for the long-term sustainability and effectiveness of the program, efforts to move ACOs to two-sided, performance-based risk must be strengthened. The Task Force supports efforts that promote opportunities for ACOs to assume risk. As mentioned above and in previous communications, the Task Force promotes policies that provide choices for ACOs. **Therefore, we urge CMS to allow ACOs to move up the risk tracks between performance years without waiting for a new agreement period.** We believe early movement to risk should not only be allowed, but encouraged and even rewarded.

The Task Force supports the proposal to offer an optional one-year extension under Track 1 for ACOs who agree to assume risk in their second agreement period. However, given the upcoming APM program under MACRA, and seeing that these ACOs will have already committed to taking on risk, CMS should effectively consider the additional year as the first performance year of the second, risk-bearing contract, rather than the fourth performance year of the first contract and find that this commitment to risk satisfies the APM test under MACRA. We understand CMS would have to mitigate confusion, by providing clarity around the delay in rebasing and other logistics.

The present uncertainty around MACRA implementation gives us reason for pause. **While HCTTF supports opportunities to move to two-sided risk as ACOs are ready, we are concerned about potential negative impact depending on how CMS defines the nominal risk threshold that divides MIPS vs APM approaches to Medicare physician payment.** Without MACRA implementation policies in place, it is difficult to fully evaluate this proposal.

3. Administrative Finality

Current CMS regulations for the MSSP provide the ability for initial determinations to be reopened when the amount of shared losses has been calculated in error. (42 C.F.R §425.314(a)(4).) The Proposed Rule seeks to establish "good cause" criteria for a reopening to occur when: (1) there is new and material evidence that was not available or known initially that may result in a different conclusion; and, (2) the evidence that was considered in making the payment determination clearly shows that an error was made.

The MSSP reopening/administrative finality policy appears to be patterned after longstanding general Medicare policy applied historically in FFS programs. However, in the context of ACOs, the Task Force believes that a reopening period of four years is unnecessarily lengthy. **We urge CMS to shorten the reopening period to provide ACOs with more financial certainty, and suggest a two-year window instead.**

The HCTTF appreciate CMS' efforts to further define parameters around reopening payment determinations within the MSSP. **The HCTTF asks that CMS outline specific processes for circumstances when an ACO seeks payment reopening and is prepared to present evidence that an error has been made.**

CMS also addresses the new and material evidence standard that supports a "good cause" reopening. The Proposed Rule rejects establishing a materiality threshold for individual ACOs, and instead indicates that the materiality standard should be applied on a program-wide basis only. **The Task Force urges CMS to reconsider this position and establish policy for a materiality threshold on an individual ACO level and consider a materiality threshold of 2 percent.** This approach would recognize that though determinations may have an insignificant effect on the program as a whole, negative impacts to a particular ACO could be financially devastating. This approach would also be consistent with how CMS handles reopening in other contexts.

Please contact HCTTF Executive Director, Jeff Micklos, at jeff.micklos@leavittpartners.com or (202) 774-1415 with any questions about this communication.

Sincerely,

Lee Sacks
EVP Chief Medical Officer
Advocate Health Care

Francis Soistman
Executive Vice President and President of Government Services
Aetna

Farzad Mostashari
Founder & CEO
Aledade, Inc.

Shawn Martin
Senior Vice President, Advocacy, Practice Advancement and Policy
American Academy of Family Physicians

Peter Leibold
Chief Advocacy Officer
Ascension

Emily Brower
Vice President, Population Health
Atrius Health

Jeffrey Hulburt
President and Chief Executive Officer
Beth Israel Deaconess Care Organization

Dana Gelb Safran, Sc.D.
Chief Performance Measurement & Improvement Officer and
Senior Vice President, Enterprise Analytics
Performance Measurement & Improvement
Blue Cross Blue Shield of Massachusetts

Joseph Hohner
Executive Vice President, Health Care Value
Blue Cross Blue Shield of Michigan

Kristen Miranda
Senior Vice President, Strategic Partnerships & Innovation
Blue Shield of California

Mark McClellan
Director
Duke Margolis Center for Health Policy

Michael Rowan
President, Health System Delivery and Chief Operating Officer
Catholic Health Initiatives

Carlton Purvis
Director, Care Transformation
Centra Health

Wesley Curry
Chief Executive Officer
CEP America

Susan Sherry
Deputy Director
Community Catalyst

Robert Green
Executive Vice President, Population Health Management Officer
Dartmouth - Hitchcock

Elliot Fisher
Director for Health Policy & Clinical Practice
Dartmouth Institute for Health Policy and Clinical Practice

Shelly Schlenker
Vice President, Public Policy, Advocacy & Government Affairs
Dignity Health

Chris Dawe
Managing Director
Evolent Health

Ronald Kuerbitz
Chief Executive Officer
Fresenius Medical Care

Angelo Sinopoli, MD
Vice President, Clinical Integration & Chief Medical Officer
Greenville Health System

Stephen Ondra
Senior Vice President and Enterprise Chief Medical Officer
Health Care Service Corporation

Dr. Richard Merkin
President and Chief Executive Officer
Heritage Development Organization

Mark Wilson
Vice President, Health and Employment Policy, Chief Economist
HR Policy Association

Anne Nolon
President and Chief Executive Officer
HRHealthcare

Lynn Richmond
Executive Vice President
Montefiore

Leonardo Cuello
Director
National Health Law Program

Debra Ness
President
National Partnership for Women & Families

Martin Hickey
Chief Executive Officer
New Mexico Health Connections

Jay Cohen
Senior Vice President
Optum

Kevin Schoeplein
President and Chief Executive Officer
OSF HealthCare System

David Lansky
President and Chief Executive Officer
Pacific Business Group on Health

Timothy Ferris
Senior Vice President, Population Health Management
Partners HealthCare

Jay Desai
Founder and CEO
PatientPing

Blair Childs
Senior Vice President
Premier

Joel Gilbertson
Senior Vice President
Providence Health & Services

Steve Wiggins
Chairman
Remedy Partners

Michael Slubowski
President and Chief Executive Officer
SCL Health

Bill Thompson
President and Chief Executive Officer
SSM Health Care

Rick Gilfillan
President and Chief Executive Officer
Trinity Health

Judy Rich
President and Chief Executive Officer
Tucson Medical Center Healthcare

Dorothy Teeter
Director
Washington State Heath Care Authority