



June 27, 2016

VIA ELECTRONIC MAIL

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

Re: CMS-5517-P: Notice of Proposed Rulemaking on Merit-Based Incentive Payment System and Alternate Payment Model Incentives under the Medicare Physician Fee Schedule (81 Fed.Reg. 28,162 (May 9, 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: Merit-Based Incentive Payment System and Alternate Payment Model Incentives under the Medicare Physician Fee Schedule Notice of Proposed Rulemaking (“Proposed Rule”), which implements the Medicare Access and CHIP Reauthorization Act of 2015 (“MACRA”).

The HCTTF supports the policies of MACRA and moving Medicare payment for physician services to a value-based formula that focuses on quality, resource use, clinical practice improvement, and meaningful use of certified EHR technology under the Medicare Incentive Payment System (“MIPS”). As a major proponent of value-based care furnished through alternate payment models (“APMs”), the HCTTF also supports the opportunity for qualifying physicians to benefit from participating in “Advanced APMs” or “MIPS APMs.”

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 – 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 triple aim focused, value-based arrangements 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.

Our comments primarily focus on the proposed policies addressing advanced APMs and MIPS APMs. While MIPS represents an important policy change in the Medicare payment program, it runs the risk of hindering industry progress in coordinating care between physicians and other health care providers occurring today in existing APMs. The Medicare program is currently advancing many APMs, and understandably physicians play a critical role in all of them. We urge CMS to interpret “Advanced APMs” and “MIPS APMs” in ways that support the maturation of ongoing value-based payment models occurring in existing APMs. Conversely, we recommend avoiding promulgating policies that create significant distractions or misaligned incentives for participating physicians that challenge or harm the transformation efforts of existing APMs.

I. Advanced APMs Generally

MACRA requires Advanced APMs to meet three statutorily-defined criteria. Our comments on CMS’s proposed implementing policies addresses each of these criteria below, as well as other Advanced APM-related comments.

We appreciate and fully support the designation of the Medicare Shared Savings Program (Tracks 2 and 3), Next Generation ACO Model, Comprehensive ESRD Model, and the Oncology Care Model Two-Sided Risk Arrangement as Advanced APMs. While we also support designating the Comprehensive Primary Care Plus (CPC+) model as an Advanced APM, we believe that model would be improved by incorporating provider accountability for total cost of care in order to more fully meet the goals of the Triple Aim.

Generally, we are concerned that there are no requirements for the clinical care models used by the Advanced APMs (other than the models considered medical home models). Cost savings and the transition of health care spend to value-based payment models cannot be the lone goals of health care transformation. Meaningful transformation requires that the transition to APMs also result in improved delivery of care (*i.e.*, greater care coordination; use of shared care planning and partnership with patients at levels of care; and demonstration of improved patient care experience). We strongly recommend that as entities take on financial accountability for quality performance and value, and assume financial risk, these entities must likewise be able to demonstrate that they promote and support sustainable, effective, evidence-based, accessible and patient- and family-centered care models.

A. Certified EHR Technology Requirement

MACRA requires that Advanced APM participants use certified EHR technology (“CEHRT”). **The HCTTF supports CMS’s proposal that an Advanced APM require at least 50 percent of eligible clinicians enrolled in Medicare to use the CEHRT functions in the first year (proposed to be 2017) to document and communicate clinical care with patients and other health care professionals. We also support the increase in the qualifying percentage to 75 percent in year two.** The proposed standards afford appropriate flexibility to APM entities seeking to be recognized as Advanced APMs, and are not overly restrictive for existing APMs

with regard to their current technology interfaces. The proposal largely allows what is working today to continue to be used in the future. In addition, many eligible clinicians working in facility settings would potentially be in an Advanced APM. **CMS should make it clear that CEHRT certified to either inpatient or ambulatory standards qualifies for use in an Advanced APM.**

B. Applicable Quality Measures

MACRA requires an Advanced APM to provide for payment for covered professional services based on quality measures “comparable to those in the quality performance category under MIPS.” CMS proposes that qualifying quality measures must include at least one of the following types of measures: (1) any measure included on the proposed annual list of MIPS quality measures; (2) quality measures endorsed by a consensus-based entity; (3) quality measures developed under section 1848(s) of the Social Security Act; (4) quality measures submitted in response to the MIPS Call for Quality Measures; or, (5) any other quality measure as determined by CMS. All measures endorsed by the National Quality Forum would meet these criteria. In addition, one outcome measures must be required by the Advanced APM.

HCTTF supports the proposal for an Advanced APM to require one outcome measure and one measure from a defined set of measurement sources, and the flexibility to choose more measures from those categories as the Advanced APM sees fit. Advanced APMs already require a series of measures (including quality measures) that best fit the needs of their payment/care delivery model. Advanced APMs are free to select additional measures from the named sources or add additional outcomes measures, but should not be required to do so. The proposal supports innovation and experimentation at an individual APM level, which provides the potential for long term benefits that continually improve upon person-centered care.

Ultimately, though, the Advanced APMs quality measures will only be as strong as the underlying models’ requirements. **Currently, there is no consistency across models in obtaining stakeholder feedback on the quality measure sets. We strongly recommend this be a standard part of the process.** One way to operationalize this is to obtain feedback through the Measure Applications Partnership.

C. More than Nominal Risk

In implementing the “more than nominal risk” standard, CMS proposes to promulgate two standards: (1) a generally applicable standard; and (2) a medical home standard. **The HCTTF supports the concept of a separate, more flexible standard for medical homes, given the importance of primary care services to person-centered, value-based payment arrangements.** While the Comprehensive Primary Care model has not been certified for expansion because it has not met the necessary cost-savings requirements, the importance of primary care is worthy of special treatment here to help the new Comprehensive Primary Care Plus model qualify as an Advanced APM.

However, we are concerned that the proposed generally applicable definition of “more than nominal risk” does not go far enough to help promote and protect the current transformation taking place through physician participation in existing APMs. The HCTTF urges CMS not to adopt policies that create distractions or misalign incentives for physicians who have invested and are already participating in APMs. The broader goal of transforming payment models to promote value-based, person-centered care acknowledges there are many ways to achieve the goal, provided regulatory or marketplace dynamics do not impose a barrier to one or more approaches.

There are no statutory constraints on promulgating a more flexible definition of “more than nominal risk,” specifically one that could achieve the goal of protecting what is already in place, while also moving non-participating physicians into value-based arrangements through the MIPS program. Given that the upside of the MIPS payment formula in later years is greater than the five percent bonus for qualified practitioners (“QPs”) or partially qualified practitioners (“Partial QP”) who participate in Advanced APMs, CMS need not be concerned about the Advanced APM standard being used in a way that is detrimental to the system.

1. Financial Risk Standard

The HCTTF believes that a payment arrangement that causes an APM entity to lose the right to all or part of an otherwise guaranteed payment should be available as a qualifying financial risk standard for all types of APM entities, in addition to the other proposed elements of the generally applicable financial risk standard. (See 42 C.F.R proposed §414.1415(c)(2).) The logic underlying this behavioral economics theory should apply to physicians regardless of the type of APM they are participating in, and can be a significant incentive to realizing the desired physician behavior across all APM models.

2. Nominal Amount Standard

For the nominal amount standard, we urge CMS to allow for a “percent of the aggregate Medicare Parts A and B revenue of all eligible clinicians in the APM Entity group” to be a qualifying methodology for APM Entities other than medical homes. We suggest that this percent of aggregate APM Entity group revenue standard be offered as an alternative or option to the total cost of care risk standard (proposed at four percent). (See 42 C.F.R. proposed §414.1415(c)(3)(i)(B).) We believe a percent of Medicare Parts A and B revenue methodology should be set higher for all other types of APM Entities than the annual maximum MIPS update percentage for any given year.

D. Advanced APM Determinations

The HCTTF supports the proposed Advanced APMs determination and notification process. (See 42 C.F.R. proposed §414.1410(b).) We believe informal guidance, including website posting, is the most expedient way to accomplish this notification, and also allows for prompt updating as the need arise over time.

E. Definition of APM Entity

The Proposed Rule defines an APM Entity as an entity that participates in an APM or Other Payer APM through a direct agreement with CMS or a non-Medicare other payer, respectively. We believe this definition is restrictive and should be modified.

CMS acknowledges that the Quality Payment Program should have enough "flexibility to be applied meaningfully to physician practices and patient quality of care." We respectfully request that CMS expand the definition of an "APM Entity" to include any entity that executed a Participation Agreement requiring the entity to comply with the relevant terms of an APM as defined under the rule.

The definition of an APM Entity, in its current form, could unnecessarily limit the flexibility of the Quality Payment Program and its application to APMs involving intermediaries. In these APMs, such as the Bundled Payment Care Initiative ("BPCI") Initiative, providers enter into Participation Agreements with intermediaries, which in turn contract with CMS. The providers do not have "a direct agreement with CMS" yet obligate themselves to comply with the terms in the governing "direct agreement." We believe that the definition of an APM Entity could be expanded in this way without compromising the integrity of the Quality Payment Program. Any changes to the definition of an APM Entity would have applicability for entities in which MIPS eligible clinicians also participate in MIPS APMs.

F. Other Payer Advanced APMs

We strongly support including Medicare Advantage ("MA"), commercial, and Medicaid business (included managed care organizations ("MCOs")) as Other Payer Advanced APMs. Including other payers as Advanced APMs would help advance CMS' movement toward value-based care, which the HCTTF supports greatly.

As CMS has stated, both in this Proposed Rule and otherwise, one of the Administration's primary goals is to continue to move away from traditional volume-based Medicare fee-for-service (*i.e.*, original Medicare) and toward value-based payment incentives. We agree that the Proposed Rule's policies are a logical next step in the movement from volume to value, and we believe that payers other than original Medicare are already making significant movement toward value-based contracting arrangements.

We also recognize that given the differences in the health needs of a 65 and older population and a younger, commercial population, there are sound reasons why the commercial programs may need to vary from current federal criteria for the aged programs in areas such as quality and value measures. We, therefore, support making the Other Payer Advanced APM category as broad as possible – including MA, commercial business, Medicaid MCOs, and other appropriate entities – to help move the entire health system toward person-centered care focused on value and optimal patient outcomes. The HCTTF also welcomes the opportunity to collaborate with CMS in developing appropriate metrics for Other Payer

Advanced APMs, and encourages CMS to finalize a more flexible approach that supports continued innovation in the private sector to achieve the goals of high quality and efficient care.

II. MIPS and Advanced APM Participant Determination

A. Reporting Groups for MIPS Eligible Clinicians

CMS proposes that MIPS eligible clinicians in an APM Entity that participates in certain types of APMs be assessed under MIPS based on their collective performance as an APM Entity group. **We recommend that CMS not limit these definitions to tax ID numbers (TIN), which are governed by the IRS to meet business functions, nor the virtual group definition as defined in statute.** Instead, we encourage CMS to consider providing additional flexibility to allow clinicians to submit MIPS reporting group rosters to CMS to define a MIPS reporting group in order to acknowledge the way healthcare systems and networks are organized around quality improvement. This approach allows a large, multispecialty TIN to split into clinically-relevant reporting groups, or multiple TINs within a delivery system to report under a common group.

While we support the MIPS APM entity scoring, we believe that the activity of providers organizing into MIPS reporting groups reinforces accountability and ownership over performance and furthermore serves as a foundational precursor to Advanced APM participation. From an operational standpoint, we recognize that the submission of rosters to define groups for MIPS will be challenging for CMS. CMS should consider scaling operational infrastructure for enrolling clinicians in APMs now, especially given CMS's projected growth in APM participation. **We strongly urge CMS to leverage the APM enrollment infrastructure for identifying MIPS reporting groups.** We further believe that utilizing existing infrastructure, such as the PECOS system, will provide an incentive for eligible clinicians to regularly update their enrollment data, therefore providing CMS with more accurate data on the MIPS APM participants.

B. Groups Used for Advanced APM QP Determination

CMS proposes that members of eligible clinician groups would consist of all eligible clinicians identified (by a unique TIN/NPI combination) as participants in an Advanced APM Entity during the performance period using Participation Lists provided by the entity to CMS, except when APM participants are not eligible clinicians (*e.g.*, the participants are hospitals only). **CMS states that when no Participation List is available, a list of affiliated practitioners who have contractual relationships with the Advanced APM Entity will be used; when both lists exist, only the Participation List will be used. We urge CMS to further clarify this policy.**

The HCTTF urges CMS to allow Advanced APM Entities to submit a roster of TIN/NPI combinations to define APM Entity groups for the purposes of determining QPs. First, a Participant List may be a mix of physician groups and hospitals. Even in the case that a

Participant List is available, the NPIs associated with the Hospital TIN would still need to be identified. When a Hospital TIN is listed in an ACO's Participant List, for example, that inherently also includes all of the eligible clinician NPIs who bill underneath that TIN during the year. While the TINs are fixed for the performance period (usually at the end of September), the NPIs are not. **We urge CMS to automate the process of identifying the applicable NPIs within an MSSP ACO based on those eligible clinicians billing underneath the TINs submitted to CMS during the performance period. If CMS is unwilling, it should use the NPI list provided by the Entities in February of each year.**

For the Next Generation ACOs, however, not all NPIs within a TIN are participants. The Model also relies on prospective assignment and a fixed NPI list that is finalized in July of each year (May for new applicants this year). We are concerned that the NPI list is created more than 1.5 years in advance of the date CMS proposes to make the QP identification. Additionally, because the primary purpose of the fixed NPI list is alignment in the Model, this list is generally limited to primary care providers and fails to account for all NPIs that are added to the TIN in that performance period.

While these NPIs may not be included in the attribution process, they are caring for the patients and responsible for their spending and the quality of care. Moreover, their care in that year will directly impact the prospective attribution of the patients for the following performance period. We urge CMS to consider how to include newly added NPIs who bill under a TIN within the performance year as QPs on the Participation List. These eligible clinicians, if employed or contracted, will have a provision in their agreement assuming the responsibility for compliance with the model's associated laws and regulations that could be audited if necessary. **CMS should permit Next Generation ACOs to continue updating the NPI list throughout the performance year for MACRA purposes knowing that CMS will not use those NPIs for attribution in the model until the next year. CMS should also consider a designation that can be routinely updated in PECOS to capture participation in an Advanced APM or Other-Payer APM Model.**

If the Comprehensive Care for Joint Replacement ("CJR") program were to become an Advanced APM, inherently the hospital would be the Entity and the only participant. However, physicians are clearly furnishing the surgical procedures among other services. While we do not believe the eligible clinicians themselves should have to hold the program risk (it should be the entity), in this case we believe the affiliated physicians – the CJR collaborators – would be those with whom the hospital has an agreement regarding the program and are billing services associated with the bundle (*e.g.*, a gainsharing agreement with a physician who has a contract with the hospital). In addition, this could be a health system employed physician who has agreed to all of the associated rules and regulations related to the program, but may or may not have agreed to share risk. **Should CJR become designated as an Advanced APM, CMS should require the hospital to provide an affiliates list as proposed.**

C. Timing of Group Identification

CMS proposes that identification of Qualified Participants for each Advanced APM Entity be a single point-in-time assessment. CMS proposes December 31st of each QP performance period as the best single opportunity to comprehensively assess active participation by eligible clinicians in their Advanced APMs. Picking what appears to be a specific date each year causes us concern. In particular, we do not believe this will be reflective of all of the NPIs who bill under a TIN on the Participant List of an MSSP ACO during the year and actively contribute to attribution under the model.

This “single point-in-time” option may work for the Next Generation ACOs if CMS chooses to rely on the fixed NPI list, but the December 31st date is almost 1.5 years after the Participant List is submitted under that program. For programs that fix the NPI list, the date seems quite late. For those that do not, it seems to miss the broader set of clinicians.

Thus, CMS should reconsider its proposal to require a specific single point-in-time assessment, and should instead afford flexibility for the Advanced APM to select a date of its choosing based upon the needs and operational realities of the model. We suggest CMS automate where possible, recognizing that CMS may need to customize the determination depending on the model.

III. APM Scoring Standard for MIPS Eligible Clinicians Participating in MIPS APMs

CMS proposes to establish a scoring standard for MIPS eligible clinicians participating in certain APMs in order to reduce reporting burden by eliminating the need to report under MIPS and the APM. Accordingly, CMS proposes to assess the performance of a group of MIPS eligible clinicians in an APM Entity based on their collective performance as an APM Entity group. We appreciate that CMS has considered how to simplify reporting for MIPS eligible clinicians participating in APMs; however, as discussed in further detail below, we have concerns with the definition of MIPS APMs and the reweighting of the MIPS performance categories.

A. Criteria for MIPS APMs

MIPS APM is a new concept introduced in the Proposed Rule. Given MACRA does not define the term, CMS has discretion to establish its parameters. CMS proposes to define a MIPS APM as one that: (1) participates in the APM under an agreement with CMS; (2) includes one or more MIPS eligible clinicians on a Participation List; and, (3) bases payment incentives on performance (either at the APM Entity or eligible clinician level) on cost/utilization and quality measures. The HCTTF believes this definition is too narrow and prevents clinicians participating in APMs that are not considered MIPS APMs from reporting as an APM entity.

MIPS APMs should not be limited to those that include MIPS eligible clinicians on a Participant List. CMS should recognize the multiple avenues available for clinicians to participate in an APM, and provide maximum flexibility for APMs to group physicians in ways best suited for their operations. The HCTTF urges CMS to allow MIPS clinicians to submit a roster of TIN/NPI combinations to define clinically-relevant reporting groups for MIPS. For

organizations that operate under multiple APMs, their physicians may be grouped differently for different purposes, so MIPS APMs policies should not be set to limit how physicians can be grouped or create new requirements that impose duplicative burdens.

In sum, we believe there is enormous value in providing clinicians with the flexibility to define MIPS groups themselves and report their list of Affiliated Providers to CMS under a self-attestation process. It reinforces accountability and ownership over performance, and lays a foundation for additional APM participation. While this approach poses administrative challenges for CMS, it is consistent with current operations for APM participation. As participation in APMs increases, CMS may need to scale its operational infrastructure to support that growth anyway, so we urge CMS to strongly consider doing so at this time.

Under the APM Incentive, CMS proposes to use “affiliated practitioners,” (*i.e.*, eligible clinicians who are in a contractual relationship with an Advanced APM Entity based at least in part on supporting the Advanced APM Entity's quality or cost goals under the APM), to determine the eligible clinicians used for the QP. We believe this approach can also be applied to MIPS APMs. **We urge CMS to use a consistent and flexible approach for who is considered a participant under Advanced APMs and MIPS APMs.**

CMS also indicates that the APM scoring standard would not apply to MIPS eligible clinicians involved in APMs that include only facilities as participants (such as the CJR bundled payment model). We do not support this approach. Existing hospital-led APMs have shown promise and success to date; that should be recognized. Moreover, facility-led APMs have facilitated clinicians transitioning to APMs by providing additional resources to clinicians, such as care managers and EHR technology. Preventing facility-led APMs from being MIPS APMs will prevent clinicians employed by hospitals from utilizing the APM scoring standard and deter clinicians from participating in facility-led APM models. This would threaten the viability of facility-led APMs in mandatory models as clinicians would be reluctant to engage in contracts based on the APMs quality and cost goals. **We urge CMS to allow facility-led APM entities to qualify as APMs, and to revise the requirement so that the APM entity includes one or more MIPS eligible clinicians on either a Participation List or an Affiliated Providers List. The first criterion could be revised to read as “participates in an APM sponsored by CMS.”**

IV. Consider Allowing Specific Bundled Payment Programs to Choose either MIPS APM Scoring or Participation as an Advanced APM

How CMS finalizes the standards for MIPS APMs and Advanced APMs will determine how specific APM models will be categorized. Under the Proposed Rule's standards, many of the Medicare bundling payment models do not qualify as Advanced APMs or MIPS APMs, and for different reasons. For Advanced APM purposes, all of the BPCI models and the CJR model meet the proposed nominal risk standard. However, CJR does not meet the CEHRT requirement and the BPCI models do not meet the CERHT or quality/cost measures requirements.

In addition to the policy recommendations listed above, **the HCTTF also believes that CMS should provide opportunities for individual participants in specific bundled payment**

programs to choose to qualify for either MIPS APM status or Advanced APM status. The opportunity to choose would reward those entities that wish to push themselves forward while allowing others to remain at a level of transformation they are more comfortable with. It would also provide an opportunity to test the effectiveness of adding quality measures to the BPCI Initiative to help the consideration of potential future bundling payment models.

An example best illustrates our recommendation. As noted above, the BPCI Initiative does not qualify for MIPS APM scoring or as an Advanced APM under the Proposed Rule. If CMS were to finalize its policies as proposed, CMS could make available the opportunity for interested BPCI participants to execute an amendment to their Participation Agreement with the convener/Awardee that obligates them to meet either or both of the CEHRT requirements and quality requirements. While the implementation details make operationalizing the recommendation more complex, the concept is straightforward: allow committed entities to take on more obligations that help accelerate their transformation while they obligate themselves to additional tasks that improve upon their person-centered, value-based care delivery. The HCTTF would welcome the opportunity to work with CMS on the appropriate qualifying quality/cost measures, including patient reported outcomes and utilization-type measures, and format of such contract amendments.

The CJR model reflects a situation where the APM is very close to qualifying as an Advanced APM – missing just the CEHRT piece – but in the end does not qualify as either a MIPS APM or an Advanced APM. While we argue for its qualification as a MIPS APM entity above, CJR programs should also be given the opportunity to voluntarily assume CEHRT obligations to help qualify them for Advanced APM status. Alternatively, CMS could impose by regulation a CEHRT obligation on CJR programs similar to the EHR meaningful use program, which would then qualify all CJR programs as Advanced APMs.

As noted in our general concerns about Advanced APMs, we believe that all Advanced APMs must be founded on evidence-based patient-centered clinical care models with a strong connection or foundation in primary care. As CMS considers allowing bundled payment programs to become Advanced APMs, we urge them to ensure that bundled payment models provide for continuity of care and linkages to primary care, which are essential to the goals of health system transformation.

The common theme is that in addition to possibly modifying the proposed criteria for MIPS APMs and Advanced APMs, **CMS could provide opportunities for willing APM entities to voluntarily assume additional obligations, including demonstration of strong care coordination and primary care foundation that would help them qualify for such status, which would help them move their transformation progress forward.** Again, the HCTTF is prepared to make specific recommendations for CMS consideration to help foster this volunteer opportunity on behalf of interested and willing APM entities. For example, for those entities that choose to participate as Advanced APMs but do not meet their contractual

obligations, they should be subject to financial consequences with regard to the Advanced APM bonus payment.

V. Implement a Transition Period to Downside Risk Models

The HCTTF fully supports the adoption of two-sided risk models as a way of achieving truly person-centered, value-based care. Our principles stand on that very premise: our members aspire to have 75 percent of their business in triple-aim-focused, value-based arrangements by 2020. **Yet, we recognize that such a state is unlikely to happen overnight for all stakeholders and believe policymakers and private sector actors should effectively chart a course toward two-sided risk that sets that as the ultimate goal and incentivizes actors to invest in models that help lead them to that goal.** Similarly, the MACRA law affords flexibility for a glide path to participation in downside risk models.

The bulk of existing Medicare APMs will not qualify as Advanced APM status under the Proposed Rule. This means that physicians who participate in current APMs may become distracted or even encounter misaligned incentives when implementing MIPS while simultaneously complying with policies imposed by their existing APMs. Worst case scenario, physicians may cease participating in an existing APM due to MIPS obligations.

We urge CMS to consider implementing a transition period to downside risk for existing APMs to qualify as Advanced APMs. CMS has routinely used transition periods in past policy making to help achieve the goal of effectively moving stakeholders to new policies. We believe that broad public policy goals similarly support a transition period in this context.

For existing Medicare ACOs, the level of financial investment made in their models is viewed as significant. Based on a recent survey, the National Association of Accountable Care Organizations reported that the average investment (start up and operating costs) across all types of ACOs is \$1.6 million. This level of investment reflects a substantial commitment to the accountable care model and the goals of value-based care. Most Medicare ACOs are included in the Medicare Shared Saving Program's (MSSP) Track 1, where there is no downside risk. We urge CMS to adopt a policy that incentivizes current MSSP Track 1 ACOs to move to two-sided risk and recognizes the significant commitment they have made so far to value-based care.

Specifically, the HCTTF urges CMS to consider establishing a transition period policy that deems MSSP Track 1 ACOs as meeting the Advanced APM definition for two years, with the expectation that those ACOs will transition to a two-sided risk model by the end of the transition period. Alternatively, CMS could tie the transition period to the existing ACO contract term. This flexible approach would recognize the ongoing progress organizations are making in those models, while establishing an appropriate expectation that those organizations will move forward toward two-sided risk models on this timeline.

In the interest of fairness and accountability, we support financial consequences for those ACOs which avail themselves of the transition period, but are unable to or do not move

to a two-sided risk model at the end of the transition. The concept of the deeming an ACO as an Advanced APM is to help that ACO move forward, but the benefits of the transition should be foregone if that ACO does not reach the goal. The process for recovering the Advanced APM incentive payment in this instance could follow a process similar to that for recovering pre-paid shared savings from participants in the ACO Investment Model that do not fulfill the terms of the model agreement.

VI. Create a New Two-Sided Risk ACO Model

While many MSSP Track 1 ACOs endeavor to move to two-sided risk models, the available options through MSSP Tracks 2 and 3 or Next Generation ACOs may prove out of reach for some MSSP Track 1 ACOs. MSSP Tracks 2 and 3 and the Next Generation ACO models are sophisticated models that establish incentives to drive effective outcomes, yet may be challenging models for every Track 1 ACO to transition to as their next step on the transformation continuum.

We urge CMS to consider developing a new ACO two-sided risk model that provides an intermediate step along the continuum to the other fully mature two-sided risk models. The design of any such new model is beyond the scope of this rulemaking; the HCTTF stands ready and willing to work with CMS on this separately. However, in concept, this type of new MSSP model could be designed in a similar way to existing MSSP models or, under our proposed change to the generally applicable “more than nominal risk” standard noted above, could be designed with a payment component that withholds otherwise obligated payment to participants if certain parameters are not met.

VII. Interim Final Rule

The HCTTF recognizes that we have recommended significant changes to the Proposed Rule. In light of this, **we strongly urge CMS to adopt an interim final rule with comment period rather than a final MACRA rule at this time.** Also, we encourage CMS to continue the open dialogue with MACRA stakeholders to provide feedback and identify needed program adjustments that may not become apparent until the MIPS and APM programs begin to be implemented. The breadth of this major payment system change is very significant, and the details are important for the program and its participants to be successful. Accordingly, an interim final rule approach will provide flexibility and allow for a smoother and more successful implementation that best serves Medicare beneficiaries.

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

Sincerely,

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