June 22, 2015

Senate Finance Committee Chronic Care Working Group
Submitted via: chronic_care@finance.senate.gov

Dear Senate Finance Committee Chronic Care Working Group:

The Health Care Transformation Task Force[1] is pleased to respond to the May 22nd stakeholder request of the bipartisan, full Finance Committee chronic care working group. The suggestions below meet the three designated policy objectives: the proposed policies increase care coordination among individual providers across care settings who are treating patients living with chronic diseases; streamline Medicare's current payment systems to incentivize the appropriate level of care for patients living with chronic diseases, and facilitates the delivery of high quality care, improve care transitions, produce stronger patient outcomes, increase program efficiency and contribute to an overall effort that will reduce the growth in Medicare spending. Our recommendations focus on efforts that address the total cost, quality and care experience, and advance our collective goal of putting 75 percent of our business into value-based payment arrangements by 2020.

I. Improving Quality and Cost for Medicare Beneficiaries

We applaud the Committee's focus on chronic care. Incenting early care coordination can delay progression to costlier and debilitating diseases. However, for those at the highest utilization, additional, more-focused, efforts are needed to complement new chronic care incentives. As the Committee considers proposals to improve care for Medicare patients with chronic conditions, we ask you to consider a pilot program to not only coordinate and improve care for high cost beneficiaries but also reduce cost in Medicare fee-for-service (FFS).

To test different approaches, we ask that the Committee's chronic care working group consider the development of models in traditional Medicare that are led by Medicare Advantage plans (including chronic Special Needs Plans (SNPs)), Accountable Care

[1] The Health Care Transformation Task Force (Task Force) is a group of private sector stakeholders that came together to accelerate the pace of delivery system transformation. Representing a diverse set of organizations from various segments of the industry – currently including patients, payers, providers and purchasers – we share a common commitment to transform our respective business and clinical models to deliver the triple aim of better health, better care and reduced costs. Our organizations aspire to put 75 percent of their business into value-based arrangements that focus on the Triple Aim of better health, better care and lower costs by 2020. We hope 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.

Organizations (ACOs) and other organizations participating in Medicare's alternative payment models, such as ESRD Seamless Care Organizations (ESCOs). In testing different models, the most successful model would allow flexibility to structure payments in a variety of ways to reduce the amount of federal spending, while improving quality and addressing the unique health needs of high cost beneficiaries.

As the Committee noted in its letter to stakeholders, according to MedPAC, the costliest 10 percent of Medicare beneficiaries accounted for almost 60 percent of annual FFS spending in 2010. According to research conducted by Avalere Health (provided as Attachment 1), the top 10 percent of costliest Medicare beneficiaries had per member per month (PMPM) spending 6.5 times the average FFS PMPM cost for all beneficiaries.[2]

This population is more likely to have chronic conditions, including chronic kidney disease (CKD), heart failure, and chronic obstructive pulmonary disorder (COPD). More than half (51 percent) of these individuals have five or more comorbid conditions. This population is also more likely to be dually eligible for both Medicare and Medicaid.

Finally, spending on Part A services represents a larger share of total Medicare spending for these high cost beneficiaries (59 percent) compared to the average FFS population (43 percent), offering an opportunity to drive efficiency through coordinated care that prevents hospital admissions and readmissions.

Most importantly, the sickest and most vulnerable Medicare beneficiaries too often do not get the quality of care that they need and deserve. The highest cost beneficiaries are often in and out of facilities, seeing multiple providers and taking many medications. Yet all of these services do not necessarily translate into higher quality of care. Traditional Medicare FFS offers little comprehensive medical management infrastructure, including care management for the highest cost Medicare beneficiaries, even though they are the individuals who could benefit most from it. Unmanaged Medicare FFS utilization may not improve care; it also exposes beneficiaries and their families to potentially unlimited out of pocket costs.

Model of Care Delivered Through Medicare Advantage Plans, SNPs, ACOs and Other Alternative Payment Models

Given the significant impact this population has and will continue to have on our health care system, we believe now is the time to begin, in earnest, to foster real collaboration among payers, providers, patients and caregivers and to focus on integrated approaches that improve quality and patient outcomes and experience as well as lower costs.

[2] The Task Force is about to release a white paper on "Proactively Identifying the High-Cost Population"; we will provide that document to this Working Group as soon as it is issued.

Effective care management programs have proven results that will help improve outcomes and lower costs for beneficiaries with chronic conditions. For example, Arizona's Mercy Care Plan was able to lower the rate of hospital days by 43 percent, reduce the hospital readmission rate by 21 percent, decrease the average hospital stay length by 21 percent and had a 19 percent reduction in emergency department visits. Similarly, Maine's NovaHealth partnership was able to provide preventive care for 99 percent of patients, while achieving fewer hospital days for 50 percent of patients, fewer hospital readmissions for 45 percent of patients, and an overall reduction in medical costs ranging from 16-33 percent.[3]

Greater adoption of such programs could be driven through focused efforts led by Medicare Advantage (MA) plans, ACOs or other alternative payment models to deliver integrated, coordinated care to the costliest 10 percent of Medicare FFS beneficiaries at a cost to the federal government that is lower than the current FFS system. Programs for high-cost beneficiaries should take a patient-centered approach that includes the use of integrated case management. Our comments below describe a program that offers a new approach to improving outcomes and lowering costs. Our comments describe a range of options; generally, we recommend that the payment and benefit waivers discussed be applicable to all three approaches (MA plans, ACOs and other alternative payment models).

Program Specifics: Additional Benefits, Lower Cost Sharing, High Quality Provider Networks

The high cost beneficiary approach described here utilizes flexibility and program design features not currently available under the Medicare Advantage, Special Needs Plan, Medicare Shared Savings Program, or Pioneer ACO construct. This patient-centered approach would provide enhanced benefits not currently covered under the Medicare program, including in-home personal care, ambulatory palliative care, transportation, and meal services, while reducing or eliminating cost sharing to remove barriers and improve health outcomes.

Organizations participating in the program would establish high-quality provider networks that ensure patients are receiving integrated coordinated care, and program eligibility would be limited to those entities with experience managing the care of high cost chronic patients, as well as high-performing Medicare Advantage plans, SNPs, ACOs or entities affiliated with ESCOs. The program would consider chronic care management payment, scaled based on number of comorbid conditions that would increase with complexity and needs of the patient. This program would explore new enrollment approaches, such as

[3] Thomas F. Claffey, Joseph V. Agostini, Elizabeth N. Collet, Lonny Reisman and Randall Krakauer. Payer-Provider Collaboration In Accountable Care Reduced Use And Improved Quality In Maine Medicare Advantage Plan. Health Affairs. 2012;31 (9):2074-2083.)

requiring identification of high cost enrollees and proactive outreach on behalf of health plans, providers and CMS, along with the potential for passive and continuous enrollment. Finally, programs would be subject to enhanced performance metrics, stronger quality standards tied to the increased care coordination (such as connecting transportation to the rate of missed appointments), stronger patient engagement standards, and ongoing evaluation and monitoring by the Centers for Medicare & Medicaid Services (CMS).

Payment Models

The payment model would include the use of risk adjustment to account for the complex health needs of the population. Depending on whether the model is led by an MA plan or an ACO or an alternative payment model, such as entity affiliated with an ESCO, CMS could test different payment methodologies to determine how best to achieve savings. For models led by MA plans, CMS could guarantee savings and set a capitated payment, for example, 98 percent of the projected FFS cost for the high cost population. For ACOs and other alternative payment models, CMS could test other shared savings models and include features such as the use of a medical home or bundled payments, or options allowing ACOs to waive co-insurance in specified circumstances. The current Part D payment methodology and framework would be used to deliver drug benefits to enrolled beneficiaries.

Opportunity for Savings is Significant

Research conducted by Avalere concluded that under a capitated payment rate 5 percent less than FFS rates, the proposed program for high cost beneficiaries would decrease federal spending by over $80 billion dollars over the 2015-2024 federal budget window. Under a capitated payment rate 1 percent less than FFS rates, Avalere estimated savings to the federal government of almost $17 billion for this same period.

II. Value Based Insurance Design (VBID)

In addition to coordinating care for Medicare beneficiaries with chronic conditions, CMS should test a VBID model in the Medicare Advantage program for beneficiaries with specific chronic conditions. VBID should be implemented in conjunction with other initiatives, such as care management, provider engagement, medication adherence, and other programs that will promote patient engagement and wellness. VBID should not include cost-sharing increases intended to steer older adults or those with disabilities away from perceived low-value care. Constructed well, VBID should be transparent and accountable, so that “high-value” designations are supported by an evidence base that is publicly available to patients and providers.

Additional Medicare Care Coordination Opportunities through VBID

The current restrictions on the use of VBID in Medicare Advantage inhibit innovations that have the potential to improve Medicare beneficiary health outcomes and achieve cost savings in both the short and long term. Under current regulations, Medicare Advantage plans are not permitted to waive cost sharing for individuals with specific chronic conditions because the benefit plans must be the same for all plan members. VBID would permit the reduction or elimination of cost sharing for a subset of plan members with specific conditions, rather than having such cost sharing conditions apply to the entire benefit package.

Care management initiatives have the potential to achieve meaningful improvements in quality and reductions in cost. CMS should grant flexibility to authorize non-covered Medicare benefits (such as transportation for specific clinical purposes), or to substitute alternative benefits for specific sub-populations or individuals, when doing so is expected to result in better care or outcomes at a better cost, and is offered as an option to the beneficiary. Often these services can be instrumental in caring for the member at home, rather than an institution. Examples might be home services such as custodial care that is not otherwise covered by Medicare, other than skilled needs or “hospital at home” programs.

Allowing reduced cost-sharing for certain clinically indicated sub-populations would allow for longer term cost reduction for the Medicare Advantage population as a whole and populations served by ACOs and other alternative payment models, and improved health outcomes for sub-population benefitting from a VBID design. In some instances, the VBID aspects could be treatment or time-specific, and in others, the reduced cost sharing may continue for the duration of the illness.

CMS should also allow member and provider incentives to reward and encourage healthy behavior as a benefit cost within Minimum Medical Loss Ratio (MLR) guidelines. One example is a reward for achieving milestones in medication adherence, knowledge of their conditions and appropriate treatment, or selection of providers with demonstrated favorable outcomes. Also, allowing provider incentives specific to goal achievement should be allowed as a benefit cost within Minimum MLR guidelines.

Coordination opportunities exist in Prescription Drug Plan (PDP) and pharmacy collaboration as well. Allowing risk-sharing associated with cost and value of a drug product would incorporate more tools with potential for improving quality and cost outcomes in synergy with other endeavors. MA plans should also increase collaboration with PDP plans not part of the same enterprise to enable VBID for shared members. This would enable combined and coordinated programs involving medication adherence, education, and risk-sharing of potential benefit to all.

Program Specifics

Through VBID and other approaches such as care management, education, adherence programs, and appropriate incentives, we can alter the course of chronic illness, producing both short term impact on quality and cost, particularly in conditions such as Heart Failure, and longer term impact increasing year-by-year, in conditions such as Type II Diabetes.

A program devoted to better adherence in Diabetes Type II including eliminating copayments and deductibles for anti-hypertensive drugs and most or selected anti-diabetics, eliminating copayments and deductibles for diabetic eye and foot examinations, providing lifestyle management interventions and robust care management can prevent or substantially delay the progression of Type II Diabetes. (A visual presentation of how targeted conditions are impacted by care management, prepared by Aetna, is provided as Attachment 2 to this correspondence.)

Such innovative programs also present an opportunity to address the psycho-social axis of needs and strengthen overall care management and wellness services. Programs providing a comprehensive approach to physical and mental health, as well as support for situational challenges such as isolation, are also possible.

III. Hospice and Advanced Illness Care

Increasing Beneficiary Value and Access to Hospice

Increased Hospice election is commonly associated with higher quality care, member and family satisfaction and less unnecessary care, particularly unnecessary acute care of little or no value. However, the requirement that a member give up the ability to obtain "curative" therapy is not helpful and prevents beneficiaries from obtaining the type of palliative care available from hospice and certain levels of curative care the patient may need even though they are near end of life. As documented in several peer reviewed publications, when paired with effective care management, quality of care and cost savings can be achieved without limiting access to curative care.[4]

Program Specifics

CMS should test a Hospice model that would give participating MA and MA-Prescription Drug (MA-PD) plans the option to offer hospice benefits concurrently with curative care to plan enrollees and liberalize the eligibility requirement of a 6 months prognosis to 12 months. As part of a model, we recommend CMS monitor Hospice length of stay; impact on acute, intensive care unit and emergency room utilization; impact on medical cost; and member and family satisfaction (through FERC or similar survey instrument). We also

[4] Randall Krakauer, Claire M. Spettell, Lonny Reisman and Marcia J. Wade Opportunities To Improve The Quality Of Care For Advanced Illness. Health Affairs. 2009;28(5):1357-1359.

recommend that a model include the study of utilization of all services in the hospice population, particularly those services deemed "curative."

Approaches that would give participating MA and MA-PD plans the option to offer hospice benefits concurrently with curative care may provide more flexibility, peace of mind, and cost savings to plan enrollees. In addition, extending the eligibility requirement from a 6-month prognosis to 12-month prognosis would better represent current end-of-life care standards.

IV. Reforms to the Medicare ACO Programs

In response to your request for input on how alternative payment models, such as the MSSP ACO program, could be improved to care for chronically ill beneficiaries, we believe the ACO and similar programs are well-placed for this call to action, as participants are accountable for the cost and quality of care for beneficiaries aligned to their ACO, for all services covered under Medicare Parts A and B. This provides a powerful incentive to develop robust care management infrastructure and work to change the trajectory for patients for whom the ACO is now responsible.

Our Task Force includes numerous members that operate ACOs in both the Pioneer and MSSP models. In early June, CMS released a final rule concerning the MSSP, which included many promising changes to the model, including: allowing ACOs to re-sign another 3-year agreement in one-sided risk at the same sharing rate (50%); rebasing the benchmark in a second agreement more generously with equal weighting of benchmark years, and inclusive of any savings generated, even amounts below the minimum savings rate necessary to trigger bonuses; a new Track 3 that offers ACOs up to 75% sharing rate, prospective attribution, and a payment waiver of the 3-day prior hospitalization rule for skilled nursing facility admission; and a refinement of the attribution methodology to include non-physician providers such as Nurse Practitioners and Physician Assistants. In addition, CMS suggests it will move forward this summer with rulemaking process that proposes an alternative methodology for rebasing benchmarks in second agreement periods.

In response to the MSSP Proposed Rule, the Task Force made detailed comments to CMS regarding an alternative approach that would transition the benchmark methodology to use a regional comparison over several agreement periods. In line with a key principle of payment reform highlighted by MedPAC Executive Director Mark Miller at the May hearing, a regional benchmark can enable “flexibility” for ACOs to direct resources appropriately by creating a tangible, prospective target. Task Force members strongly believe the best approach is one that gives ACOs a menu of options that allow both more experienced ACOs and less experienced ACOs to see opportunities in the model. It is important to incorporate historical spending at the beginning of the transition to entice less efficient providers, while

gradually moving to a regionally derived target to attract more efficient providers. We view there to be several elements of this potential approach important to consider:

1. Defining the region: Task Force members define "region" as every county where at least 10% of the attested, preliminarily and/or prospectively attributed beneficiaries reside
2. Defining the comparison group: Task Force members consider a relevant comparison group to be *all* Medicare FFS beneficiaries (including those assigned to other ACOs), who *are not* preliminarily or prospectively assigned to that ACO within the region (as defined above)
3. Dealing with small numbers: to derive a valid comparison, some ACOs may need to have their region enlarged to incorporate *any* county with a preliminarily assigned beneficiary, and still further, to contiguous counties
4. Risk adjustment: Task Force members believe CMS should adjust both the assigned population and the comparison group using a risk adjustment model that shifts up and down as health status declines or improves.
5. Transitioning from ACO historical costs to a regional benchmark: CMS should provide options for ACOs to transition to a regional benchmark. These might reflect performance at the end of first contract period, gradually blending historical and regional benchmarks over several agreement periods, but more aggressively for ACOs below regional average in first period and less so for those above.

We believe these changes are amenable to inclusion in the changes CMS indicates it is likely to pursue in the summer of 2015 proposed rulemaking. It would be important to simulate the effects of these changes prior to implementation as Task Force members recognize that our recommendations are based on hypotheses and the specific experiences of members.

In addition to our comments above, Attachment 3 to this communication is our response to the MSSP proposed rule. This correspondence provides relevant recommendations to strengthen the program such as improving attribution (including beneficiary attestation), expanding program access to waivers, improving risk adjustment and strengthening content of and access to data sets.

Recently, CMS through its test lab, the Centers for Medicare and Medicaid Innovation (CMMI), announced a new ACO model, the Next Generation ACO. This model is intended for advanced ACOs attracted to a higher level of risk/reward (up to 100% full risk). CMMI will offer Next Generation ACOs a range of different payment options including capitation along with several new tools to enhance beneficiary alignment with their ACO, such as a small beneficiary reward for seeking care within an ACO, allowing beneficiaries to "attest" their alignment with the ACO, and new payment waivers. The Task Force applauds this announcement and expects several of its members will apply to become a part of this new model. However, in a recent communication to CMS, the Task Force also highlighted several changes it believes may be important to advance the model.

- Changes to the financial model
    - Moving to a regionally-derived benchmark over time
    - Re-institute an MSR/MLR for the 80% risk sharing track
    - Improve the financial rewards for quality performance via the "discount methodology"
    - Expand population-based payments to preferred providers and SNF affiliates
- Improved patient alignment
    - Proposed beneficiary reward may not be calibrated to induce behavior change - recommend cost structures to promote access to care or remove barriers
    - Improving beneficiary to ACO communication and approval process

In advancing the ACO models in the Medicare program, CMS has made significant strides in working to improve the outcomes for beneficiaries. Yet more work is still to be done. We encourage the Committee to work collaboratively with CMS to ensure ACOs have both financial and non-financial incentives as tools to improve care.

V. Risk Adjustment

Another issue that was a key theme of the May Finance Committee hearing was the topic of risk adjustment, and how it is applied through Medicare payment programs. It is particularly salient for populations of chronically ill beneficiaries, who have disproportionate health expenditures and thus are susceptible to adverse selection problems, especially in enrollment-based models. Robust risk adjustment that properly compensates for these outsized expected costs can work to mitigate these incentives greatly. How well these models are calibrated to predict the level of spending associated with a patient's health status is of paramount importance; too generous and spending will overcompensate for actual risks incurred in the course of care, but not generous enough, and these patients may be avoided entirely or their care may be compromised via intentionally restrictive network design. On the other hand, risk adjustment models can be effectively gamed, which can result in overpayments that persist over many years.

This has broad implications for Medicare payments. The dominant risk adjustment model in Medicare is the Hierarchical Condition Category (HCC) model, which is derived from ICD-9 diagnoses and demographic information to prospectively predict costs for a given beneficiary. CMS uses HCC models in the two most dominant alternatives to traditional Medicare, the Medicare Advantage program and in its ACO programs. MA plans are paid a capitated rate adjusted for the HCC risk for the population enrolled, which can increase from year to year, while ACO benchmarks are also adjusted via the HCC model, the risk adjusted payments can only go down. The introduction of the HCC model into private MA plans in 2006 resulted in significant narrowing in gaps in access for sick patients; prior to the

HCC introduction, risk adjustment was done on solely on a demographic basis, and plans had incentives to avoid high cost patients.[5]

Yet there has been emerging evidence that the HCC model may need fundamental improvements. MedPAC has found that the HCC model overestimates costs for relatively low cost beneficiaries, while underestimating costs for relatively high cost beneficiaries, such that MA plans with disproportionate numbers of high cost beneficiaries are at a financial disadvantage, and thus the selection problems may continue to persist.[6] Welch, et. al. found two-fold variation in the frequency of select chronic diagnoses across hospital referral regions, but no relationship to underlying mortality, and a stepwise decrease in mortality among subpopulations with the same chronic illness burden as diagnostic frequency increased).[7] This reflects a bias in favor of more observationally intensive medical practice.[8] Song, et. al. found beneficiaries that moved from the least intensive regions, to the highest, saw their risk scores double, which suggests again that much of the difference in risk scores across regions are most likely unrelated to patient disease burden . [9]

Currently, CMS factors in a legislatively proscribed "Coding intensity adjustment," but this may not recoup all overpayments.

MedPAC has made suggestions about improving the risk adjustment model that are worth evaluating: 1) blending the prospective HCC model to use concurrent adjustment for conditions that are "chronic, costly and easy to verify" 2) using base-year costs as a variable in HCC modeling 3) truncating costs at a given threshold .[10] The Commission notes that of these three options, the second option is best, but the trade-off among all options is that it reduces incentives to try to control costs. Additional reforms to the HCC model are plausible, but they may all suffer from a fundamental issue – the reliance on claims-based methodology subjective to the incentive to "upcode" and increase the number or state of conditions apparent on a particular patient.

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[5] Newhouse JP, Price M, Huang J, McWilliams JM, Hsu J. Steps To Reduce Favorable Risk Selection In Medicare Advantage Largely Succeeded, Boding Well For Health Insurance Exchanges. Health Affairs. 2012;31(12):2618-2628.

[6] Medicare Payment Advisory Commission. Report to the Congress: Medicare and the health care delivery system. MedPAC; 2014

[7] Welch H, Sharp SM, Gottlieb DJ, Skinner JS, Wennberg JE. Geographic variation in diagnosis frequency and risk of death among medicare beneficiaries. JAMA. 2011;305(11):1113-1118.

[8] Wennberg DE, Sharp SM, Bevan G, Skinner JS, Gottlieb DJ, Wennberg JE. A population health approach to reducing observational intensity bias in health risk adjustment: cross sectional analysis of insurance claims. BMJ: British Medical Journal. 2014;348.

[9] Song Y, Skinner J, Bynum J, Sutherland J, Wennberg JE, Fisher ES. Regional Variations in Diagnostic Practices. New England Journal of Medicine. 2010;363(1):45-53.

[10] Medicare Payment Advisory Commission. Report to the Congress: Medicare and the health care delivery system. MedPAC; 2014

A recent study shows a promising alternative avenue. Wennberg, et al. demonstrate that an exogenous measure of population health (self-reported measures of obesity, smoking status, and general health status derived from the CDC's Behavioral Risk Factor Surveillance Survey, as well as two "low variation" conditions – stroke and hip fracture - derived from FFS claims) is a better predictor of mortality than either the standard HCC, a visit-corrected HCC, or a measure of poverty.[11] Prior to adjustment, the standard HCC index explained the most variation in spending, but after adjustment for physician visits, both alternatives were more powerful. Using exogenous measures that are not easily – or ideally, impossible, to game – may be a fruitful alternative. The key limitation of the Wennberg model was that it was based on geographically defined measures of health (zip-code or county) that would limit its usefulness within markets. A model that used individual risks and function, ascertained from annual wellness surveys, might be an alternative worth testing for future implementation.

For this reason, Congress should work together with CMS to identify such alternatives. In addition to using exogenous factors, MedPAC's suggestion of using "verifiable" conditions is likely key. Congress can make an enormous difference in this work by adequately funding the development of a new risk adjustment algorithm less susceptible to gaming. Pursuing exogenous factors highly correlated with patient illness burden, collected by patient-reported measures and perhaps verified using biometric data is promising. If successful, the alternative methodology will recoup Congress' investment many times over, if the overpayments in Medicare Advantage are any indication. The Task Force encourages Congress to aggressively pursue this strategy in partnership with CMS.

Thank you for the opportunity to provide this comment. Please contact Susan Winckler (susan@leavittpartners.com) with any questions.

Sincerely,

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[11] Wennberg DE, Sharp SM, Bevan G, Skinner JS, Gottlieb DJ, Wennberg JE. A population health approach to reducing observational intensity bias in health risk adjustment: cross sectional analysis of insurance claims. BMJ: British Medical Journal. 2014;348.

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Characteristics of High-Cost Medicare Beneficiaries

Identifying High-Cost Medicare Beneficiaries

- Identify Medicare beneficiaries covered by Parts A and B, not enrolled in Medicare Advantage, and alive for all of 2010
- Find all paid claims for each beneficiary in each year, and aggregate the payment amounts
- Among eligible beneficiaries, determine whether their payments are in the top 10% on a PMPM basis
- Follow for two years (through 2012) or until death

Highest Cost Beneficiaries Sicker, More Likely Dual Eligible

CHARACTERISTICS OF HIGHEST-COST (2012 PMPM TOP 10%) AND AVERAGE MEDICARE FFS BENEFICIARIES IN 2012

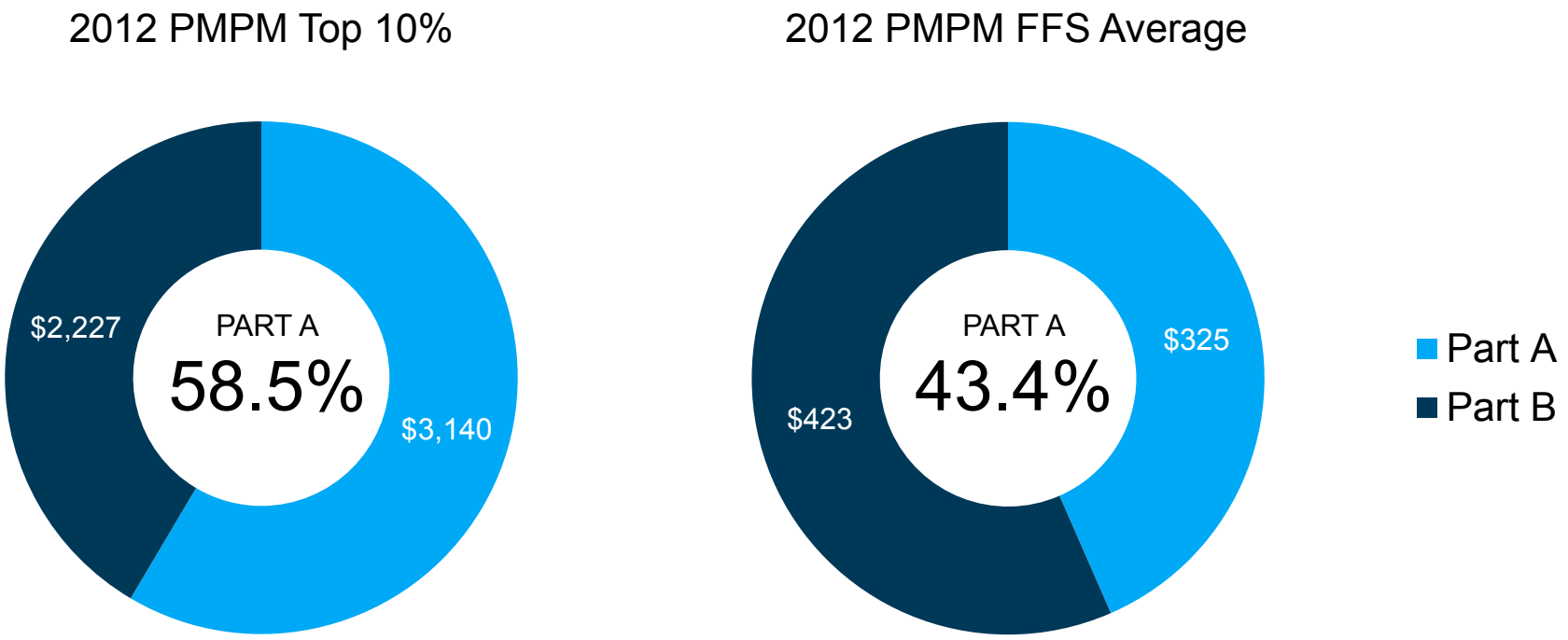
Characteristic	2012 PMPM Top 10%*	2012 PMPM FFS Average
Average PMPM Costs	$5,366	$824
Dual Eligible Percent	30.7%	19.8%
End Stage Renal Disease Percent	11.7%	1.1%
Hospitalizations per 100 Beneficiaries	1.9	0.3
Average # of Chronic Conditions†	4.6	2.1
Selected Chronic Conditions		
Chronic Kidney Disease (CKD)	38.7%	5.6%
Heart Failure	34.2%	6.3%
Chronic Obstructive Pulmonary Disorder (COPD)	26.9%	8.7%
Stroke/Transient Ischemic Attack	8.3%	2.3%

* Threshold for the top 10% of PMPM ($2,541 per month) based on beneficiaries alive for at least one month in 2012, enrolled in both Parts A and B while alive, and not enrolled in any MA plan

† Chronic conditions included are: Alzheimer's; asthma; atrial fibrillation; CKD; COPD; depression; diabetes; CHF; hyperlipidemia; hypertension; ischemic heart disease; osteoporosis; rheumatoid arthritis and osteoarthritis; stroke/TIA; and cancer (breast, prostate, lung, colorectal, or endometrial)

Part A Is a Larger Share of Total Medicare Spending for High-Cost Beneficiaries versus for the National Average

MEDICARE SPENDING BY PART A VERSUS PART B, TOP PMPM 10%* VERSUS FFS AVERAGE

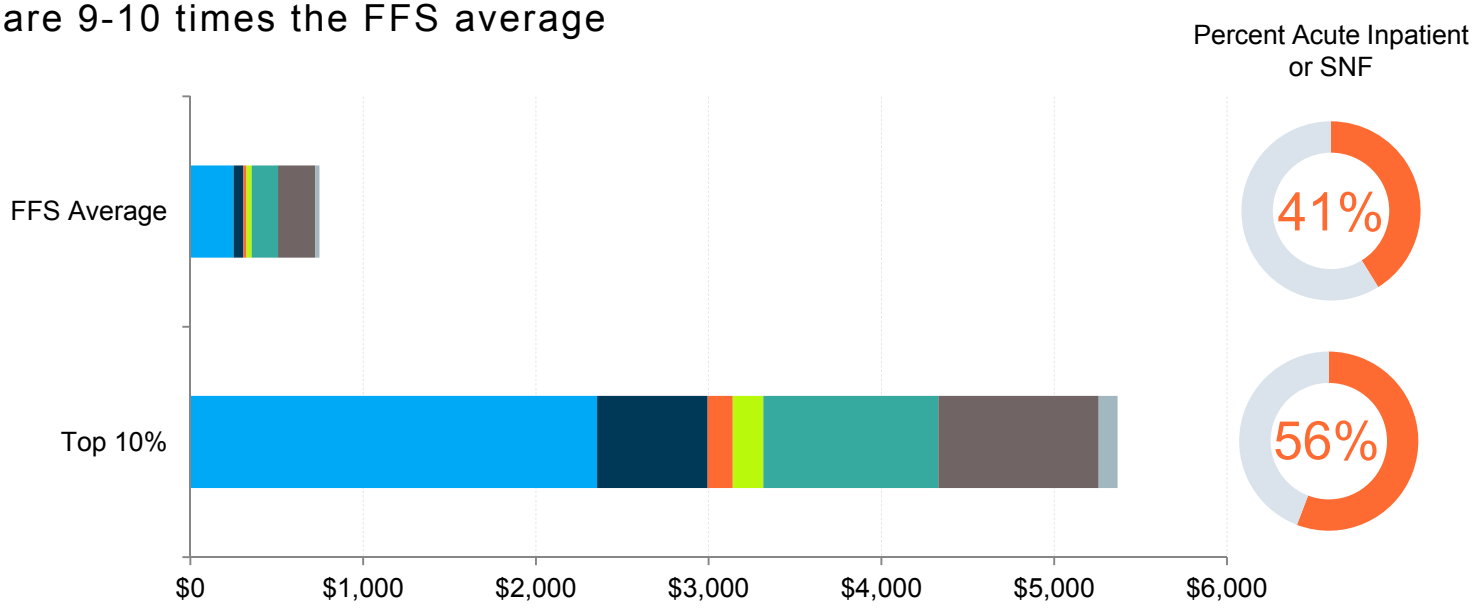


* Threshold for the top 10% of PMPM ($2,541 per month) based on beneficiaries alive for at least one month in 2012, enrolled in both Parts A and B while alive, and not enrolled in any MA plan

Medicare Spending on High-Cost Beneficiaries Driven by Disproportionate Increases in Acute Inpatient and SNF Use

PMPM MEDICARE SPENDING BY TYPE OF SERVICE, TOP PMPM 10%* VERSUS FFS AVERAGE

Medicare payments for the top 10% most costly beneficiaries (on a PMPM basis) are 6.5 times the FFS average; however, payments on acute inpatient and SNF services for the top 10% of beneficiaries are 9-10 times the FFS average



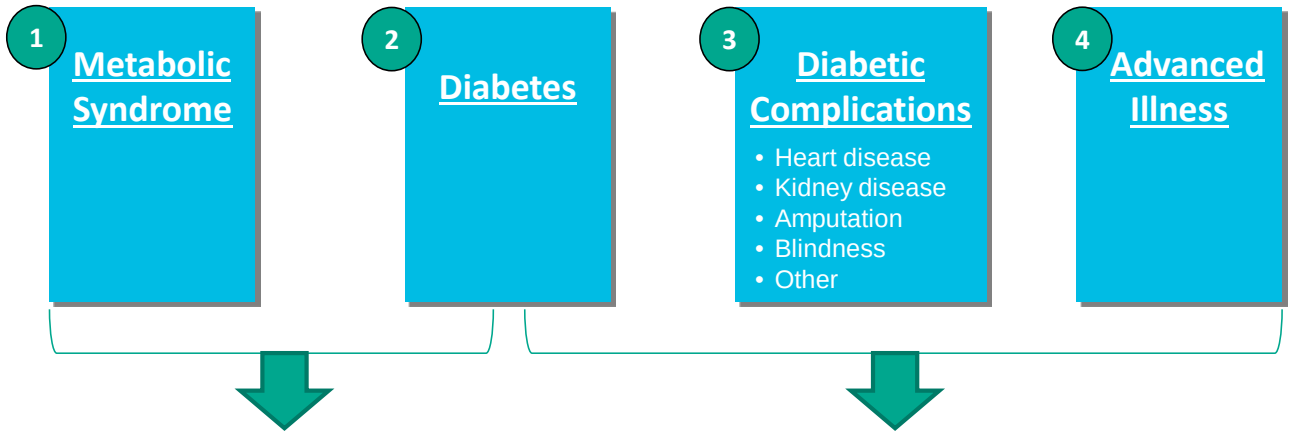
	Top 10%	FFS Average
Inpatient	$2,354	$250
SNF	$640	$58
Part A Home Health	$146	$17
Part B Home Health	$176	$30
Hospital Outpatient	$1,014	$153
Physician	$928	$216
DME	$109	$24

* Threshold for the top 10% of PMPM ($2,541 per month) based on beneficiaries alive for at least one month in 2012, enrolled in both Parts A and B while alive, and not enrolled in any MA plan

The targeted conditions are *impactable*

The example of diabetes

Unmanaged progression →



- New care management model begins intervention here.
- *Aggressive lifestyle changes delay or prevent the progression of disease.*

- Current care management model begins intervention here.
- *Lifestyle changes, medication management and/or surgical interventions delay the worsening of complications.*
- *Education on treatment options assists members to make choices for end of life care.*

February 6, 2015

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Washington, DC 20201

Re: **CMS-1461-P Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations**

Dear Administrator Tavenner:

The Health Care Transformation Task Force (Task Force) is pleased to provide input on the Centers for Medicare & Medicaid Services (CMS) in response to proposed policy and payment changes set forth in CMS-1461-P Medicare Program: Medicare Shared Savings Program: Accountable Care Organizations (ACO) notice of proposed rulemaking (NPRM).

As we described in previous communications, the Task Force is an emerging group of private sector stakeholders that is coming together 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, consumers and academic institutions – we share a common commitment to transform our respective business and clinical models to deliver the triple aim of better health, better care and reduced costs. Our organizations aspire to put 75 percent of their business into value-based arrangements that focus on the Triple Aim of better health, better care and lower costs by 2020. We hope 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.

The Task Force's shared principles reflect our commitment to a specific timeline for the migration from fee-for-service toward payment models that promote patient-centered care, improved population health, and lower total cost of care. Our outputs reflect agreement on common private and public approaches that will best facilitate transformation.

Current ACO Environment

In considering revisions to the MSSP regulations, it is essential for CMS to consider the current reality of the ACO marketplace. The initial program approach has generated great interest and participation. CMS has made significant efforts to be an effective payer partner and has made remarkable progress in providing information, data and claims to the participants. Participants

have tried many new approaches to improving and coordinating care. Beneficiaries have experienced better care and better outcomes and we have all learned a great deal as a result.

However, as ACO participants, consultants and industry experts gain greater experience with ACO Shared Savings Models in general, it has become increasingly clear that to be sustainable, the financial opportunity must provide sufficient reward to support the investments needed to improve care and yield a meaningful return. Unfortunately, many are coming to the conclusion that the MSSP does not meet that test.

Many aspects of the current regulations make it more difficult for the ACOs to obtain a positive financial return. The minimum savings rate, the beneficiary data-sharing opt-out process, delay in receiving claims, inability to communicate with beneficiaries, uncertainty of the benchmark, expected rebasing that would decrease savings opportunities in future years, and the inability to use more advanced approaches with skilled nursing facilities, home healthcare, and telemedicine, all limit ACOs' ability to generate sufficient savings. These factors, as well as the newness of attempting to manage a population's experience in the "fee-for-service open network, no referral" world creates great uncertainty about ACOs' ability to deliver sufficient savings to obtain a return on their investment. Furthermore, the program's retroactive beneficiary assignment causes instability in the ACOs' benchmarks[1] and creates a moving target in terms of identifying the patients for whom the ACO would be held accountable.

The right strategy for CMS to get maximum impact on improving quality and decreasing costs is to better help ACOs be successful in every Track and continue in the program. We recommend structuring the program to afford more opportunity to explore alternative care approaches, with greater potential to share in more of the savings to encourage potential providers to invest more in care coordination and therefore produce meaningful improvement. Most of our comments, therefore, take positions that increase the likelihood of wider provider participation in the program and further investment in infrastructure that support improved, patient-centered care delivery and enable transition to full risk. While there is much in the NPRM that suggests that CMS understands the need for this approach, there are several areas in the NPRM that we believe should be revised. These are:

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[1] We understand CMS' stated policy position to not identify a fixed population for practices so that ACOs would make an investment in improving care for their total population. We agree that some investments in practice improvements can be made that will affect all patients without regard to scale, such as an open appointment system. But some direct investments in care management, such as hiring registered nurse care managers, are driven by the volume of patients to be managed. Given that there is an estimated 20 to 40% turnover in ACO-attributed populations, CMS was, in effect, asking ACOs to invest in care for all Medicare patients touched by their practices, even though the potential shared savings would only be available for 60-80% of the managed population. This policy created additional uncertainty about the value of making significant investments in improving care.

- Program Evolution – Encourage two-sided risk, but acknowledge the diversity of ACOs; allow a prospective attribution option; support further exploration of bundled payments, pre-payments or capitation in MSSP.
- Benchmarking – Explore regionally-based benchmark updating and resetting in addition to refinements to historically-based benchmark option; evaluate improvement in risk adjustment methodology.
- Regulatory Flexibility – Support waiver of fee-for-service payment policy, beneficiary communication restrictions and benefit design parameters.
- Attribution – Respect beneficiary choice in primary care provider; allow ACOs to identify providers on whom attribution should be based.
- Data – Support CMS run data-opt out process; Provide consist and current data including for beneficiaries who have received primary care, make public not just descriptions of MSSP formulas, but the code and formula itself; evaluate inclusion of substance-abuse claims in at least aggregate form.

Program Evolution

Encouraging 2-Sided Risk and Beyond

With so few ACOs selecting two-sided risk, CMS makes several proposals to encourage two-sided risk:

- Reducing the shared savings rate to 40/60 in Track 1 for the second contract
- Introducing a variable MSR/MLR in Track 2
- Creating a new Track 3 with a set 2 percent MSR/MLR and a shared savings rate of 75/25

Yet, the impact statement assumes little success of these proposals, indicating that 90% of ACOs will still most likely choose Track one in 2016. Half of all MSSP ACOs started in 2012 and 2013, and if 90% of those choose Track one, participation in two-sided risk would be little better than it is today.[2] The core issue is whether the benefits (increase in savings rate, changes in MSR/MLR, caps on savings and losses, waivers that make savings more likely) outweigh the risk of taking on losses. We applaud CMS for seeking to mitigate some of the downside elements, thereby modifying the current balance to incentivize two-sided risk. ACOs participating in two-sided risk will be more successful at reaching the programs goals than other ACOs. However, the market reality is that for many providers, accepting downside risk exposure at this stage in the evolution of the MSSP appears ill-advised. There are just too many uncertainties regarding benchmark methodologies, ability to coordinate care in the FFS market, data availability, as well as CMS and provider operational challenges.

[2] Rebasing in their second contract will play a significant part in ACOs decision and is addressed in the Benchmarking Section of this letter.

Changes to Track 1

While we agree that a two-sided risk arrangement provides more incentive for an ACO to reduce costs and coordinate care, we suggest CMS keep in mind that even absent downside risk, ACO participation in the upside only model has been a good investment for CMS. The incentive to create savings is still present and has led to systematic efforts to increase value for both ACOs and CMS. As discussed in changes to Track 2 and 3 below, while movement to two-sided risk is important, one-sided risk still holds short-term opportunity for CMS.

ACOs come in all sizes and forms. Some are set up by organizations with a history of taking on risk, others are created by small physician practices banding together for the first time. CMS should acknowledge those differences when offering options to increase financial risk. The organizational skills to manage financial risk are not necessarily the same ones that result in excellent care coordination or other activities that reduce costs. Moreover, for small ACOs, the variable MSR under Track 1 makes it harder to obtain shared savings compared to larger ACOs, which means they are less likely to avail themselves of the savings necessary to recover their investment and generate the reserves necessary for two-sided risk. To encourage MSSP participation and drive CMS closer to the recently announced HHS goals for value-driven care, CMS should maintain the 50/50 split into the second contract—supporting those ACOs that are skilled in generating savings, but not yet prepared for financial risk.

Furthermore, CMS should explore whether, for an ACO that generates sub-MSR savings in two or more contract years, it might pool the spending across the years and recalculate the MSR to see if the ACO meets a valid MSR over the longer time period.

Finally, we strongly urge CMS to reconsider its policy on how to account for quality in the shared savings calculation. Under current policies, the maximum shared savings rates for Tracks 1 and 2 are only achievable by a small subset of ACOs in years two and three when rates are based on quality performance rather than just quality reporting. The reduction in the shared savings rate that the majority of ACOs can expect when factoring in quality is a major deterrent to continuing participation. CMS should reward ACOs by permitting the maximum shared savings rates when they are able to achieve a quality achievement or improvement score at the median. So in Track 1, an ACO whose quality performance is above the median would get more than a 50% share, while those below median would get less than a 50% share.

Changes to Track 2

We are concerned that the proposed changes in the NPRM actually have the effect of making Track 2 *less* attractive. The primary driver of low participation in Track 2 is that the 10% increase in the shared savings rate is insufficient to encourage ACOs to take on risk. Changing the MSR/MLR does not address this fundamental problem and could make the Track less attractive by making savings harder to achieve for smaller groups otherwise willing to take on risk. CMS should explore additional opportunities to make Track 2 more attractive to providers.

CMS should continue to explore opportunities to make Track 2 (and two-sided risk in general) more attractive to providers to encourage faster movement in that direction. For example, a strategy missing from the proposed rule is making the MSSP models more viable for ACOs by increasing the number of their patients in ACO models through contracts with commercial payers. CMS should play a leadership role in creating efficiencies between Medicare and private sector ACO requirements to facilitate alignment.

Changes to Track 3

Attribution

ACOs are divided over whether prospective or retrospective attribution is ultimately more beneficial to an organization's overall efforts. Some ACOs crave the certainty that comes with an upfront identified population of patients under prospective attribution. Other ACOs emphasize the importance of accuracy in being held accountable only for the beneficiaries for whom they have provided care. Both camps seek certainty with regard to their assigned patient population and during times of transition, few things are more valuable. In a retrospective model, CMS is certain that the beneficiaries for whom they pay out savings received services from the ACO and it is on the basis of those services that the savings were generated and not due to beneficiary selection by the ACO. Similarly, the ACO is certain that the beneficiaries on whom savings are based received services from the ACO.

matches

However, this presents a false dilemma. The closer the prospectively attributed population the retrospectively attributed population; issues of uncertainty and inaccuracy are diminished.

Therefore, we suggest that CMS not only institute a prospective option, but also find ways to improve prospective attribution such that the need for retrospective reconciliation and the retrospective attribution model as a separate option is less necessary. Currently, CMS reports a 24 percent difference between prospectively assigned populations and those assigned retrospectively. However, that discrepancy decreases to 17 percent after accounting for eligibility. It is in that 17 percent where the uncertainty for most ACOs lies.

While not clear in the data, one source of difference is a beneficiary moving to another geographic area. These beneficiaries should be excluded from the prospective list (just like eligibility exclusion) if they move in the first half of the year. There is no way for an ACO to game this situation, and there is no way for an ACO to maintain care coordination of these patients.

Another situation that should trigger a potential change in eligibility is when a patient starts a long-term care arrangement. CMS could exclude those patients who do not have a visit to an ACO provider after the admit date.

CMS should continue to conduct detailed data analysis (such as that reported in the proposed rule) and continue to solicit stakeholder feedback on how to reduce the difference between prospective and retrospective lists. The less variation between prospective and retrospective lists the more certainty there is that beneficiaries are linked with their chosen primary care provider.

CMS should continue its monitoring for gaming through quality measures and consideration of overall population risk.

While prospective attribution is being refined, CMS should allow ACOs to elect which attribution method they prefer. We are not aware of any circumstance where the preliminary attribution list for a retrospective ACO cannot serve the same purpose as a prospective attribution list for a prospective ACO in determining waiver applications and other such decisions that benefit from knowing who the beneficiaries are at the start of the performance year.

Benchmark Adjustments for Prospective Attribution

We agree with CMS that timeframe adjustments are needed to operationalize prospective attribution and concur with the proposed adjustments.

Shared Savings/Losses

simply

CMS should improve the savings opportunities in both Tracks. Decreasing Track one to 40% makes an uncertain opportunity almost definitely unattractive. Lacking adequate return, ACOs are likely to underinvest and therefore not be successful which creates a self-fulfilling prophecy rather than an effective pathway for risk. We agree that an increase in the sharing rate is necessary to incentivize increased participation in two-sided risk. The Track 3 approach is sufficiently different from our proposed Track 1 savings rates. The variation in the shared savings cap is also an incentive to move ACOs to two-sided risk. Along with CMS, we place great value on the move to two-sided risk as an accelerator to reaching the program's goals; something that more than compensates for the reduced savings to CMS.

MSR/MLR

all

Similar to the attribution challenge, it is not really possible to determine the "best" MSR/MLR for ACOs. As CMS points out, setting the variability corridor at 2% was somewhat arbitrary. The scaling by number of beneficiaries in the ACO only accounts for one consideration in a multifactorial situation. The MSR/MLR that is appropriate for a given ACO is best determined by a combination of factors which include an ACO's ability to handle risk, its number of beneficiaries and its local market. While the number of beneficiaries in the ACO is a known quantity to both CMS and the ACO, the local market and an ACO's individual ability to handle risk are more difficult to discern. In other comments, we have attempted to address the geographic aspect by supporting (see section on Benchmarking) an option of moving to a regional benchmark, which makes the local market more of a known quantity.

The remaining aspect unaccounted for is an ACO's willingness to absorb financial risk. CMS should not attempt to substitute its judgment for that of the ACO on their ability and willingness to bear risk. An MSR/MLR of zero may be seen as heightened risk to some ACOs, but others will view it as more likely to result in shared savings. As discussed under Track 2, there is no evidence that moving the MSR/MLR slightly in one direction or the other will make a dramatic difference. This means the choice of the individual ACO remains one of the most critical factors in the

appropriateness of the MSR/MLR. Rather than attempt a guess, CMS should allow an ACO to select from a few MSR/MLR options in the range of 0 to the size based MSR/MLR available if they were under Track 1. However, the preservation of the symmetry in the MSR/MLR creates protection for CMS.

Beyond Two-Sided Risk

Shared savings is an excellent transition to a value based payment model, but its very construction means it cannot be the end point of value based payment. Changes to the underlying payment system such as full capitation, risk-adjusted capitation, bundled payments and prepayment are the logical evolution of the shared savings model. We encourage CMS to use the final rule to begin a public discussion about where its vision for underlying payment system reform is going and to begin to put out details about what is next and when. Just as with ACOs, some providers are more ready than others.

Benchmarking and Rebasing

While a transition to regional benchmark is the best option presented by CMS in the rule and we discuss it at length, the Task Force believes there is an even better option that takes into account the variability between ACOs. Because CMS cannot predict the best pace of the transition for each ACO, it should provide a set of options for moving to a regionally-based benchmark. These options would be more influenced at the beginning of the transformation process by historical spending, but blend in regional spending over time. Providing such a menu of options (including maintaining a historically-based benchmark methodology for another contract period, one or two transition glide paths, and a complete conversion to a regional benchmark) would allow more advanced ACOs to move more quickly to beating a regional target, while at the same time providing a pathway to success for less experienced ACOs.

Although CMS lays out several options, which we discuss in great detail below, we are concerned about a lack of data and detail regarding those options. We urge CMS to consider issuing a proposed rule to propose one or a combination of options. At a minimum, CMS should issue a final rule with comment to allow stakeholders to weigh in on the details of the finalized option.

Taskforce Support for Option 5 MSSP Transition to Regional Benchmarks

We support option 5 as most aligned with the principles of the Task Force. There are core elements to making this option successful: defining the region, managing changes in patient acuity and adjusting the pace of the transition. CMS should flesh out these proposals and model them to receive the best input from the stakeholder community. We offer these preliminary thoughts on the three domains.

1. Defining the Region: Every county where at least 10% of the self-attested patients or the preliminarily or prospectively assigned beneficiaries to the ACO have their primary residence is in the region.

2. Defining the Comparison Group: All Medicare FFS beneficiaries (including those assigned to other ACOs) not preliminarily or prospectively assigned to the ACO in the region's counties that make up the comparison group.
3. Dealing with small numbers: For a few ACOs, the region might not contain enough beneficiaries in the comparator group for a valid comparison. While the inclusion of beneficiaries assigned to other ACOs should go a long way to preventing small number problems, CMS should expand the included counties to any county with a preliminarily assigned beneficiary. If a valid minimum of beneficiaries in the comparison group is still not attainable, then the group can be expanded to contiguous counties.
4. Risk adjustment: Use HCC coding comparison between the ACO assigned beneficiaries [DL1] and the comparison group to create a risk adjustment factor. This factor should be adjusted in both directions when health status changes. CMS should study whether the MA adjustment is valid or whether an ACO specific adjustment is needed. CMS should also explore the feasibility of concurrent risk adjustment which could be superior to the current prospective model.
5. Transitioning from ACO historical costs to regional benchmark: Offer at least three paths for those organizations that choose to transition-
    a. Below regional benchmark at the end of the first contract
        i. 2nd contract: 50% (Historical Benchmark) / 50% (Regional Benchmark)
        ii. 3rd contract: 20% (Historical Benchmark) / 80% (Regional Benchmark)
        iii. 4th contract: 100% (Region)
    b. Above the regional benchmark at the end of the first contract
        i. 2nd contract: 80% (Historical Benchmark) / 20% (Regional Benchmark)
        ii. 3rd contract: 50% (Historical Benchmark) / 50% (Regional Benchmark)
        iii. 4th contract: 20% (Historical Benchmark) / 80% (Regional Benchmark)
        iv. 5th contract: 100% (Regional Benchmark)
    c. Move straight to regional benchmark.
6. Achieving Budget Neutrality: We believe this benchmark is a sustainable model that will attract more ACOs to the program, generating a greater denominator from which to generate savings to offset the shift to regional benchmarks for those in transition path (a). Furthermore, we believe that those in transition path (b) will almost certainly continue with the program in the 2nd contract and likely will continue in the 3rd contract. The reduced paid out savings (but unchanged program savings) due to the inclusion of the region in the 2nd and 3rd contract will also offset the transition costs for those in path (a). We urge CMS to consider this stakeholder feedback when examining the budget neutrality of this option.

Comments on Option 4: A 6-Year ACO Specific Benchmark

We agree with CMS that this change will encourage more ACOs to remain in the program than resetting the benchmark for each contract based on ACO specific historical costs. However, we believe that the transition to a regional benchmark is an excellent option due to its greater equity, greater incentives for continual improvement by high and low cost ACOs alike and established stakeholder support. We are concerned that the existing ACOs at the end of their first agreement period will not have sufficient time to understand the implications of the final program regulations prior to having to commit for the 2016 performance year. In addition, with only one

year of fully reconciled data, it will be challenging for the ACOs to make a truly informed decision as to whether they are ready to move to a two-sided risk Track.

By extending the contract period, CMS would provide the ACOs more time to determine which Track would be the best next move. CMS would then have more data to determine which ACOs should not be allowed to continue in the program. These benefits are true even outside of rebasing. Therefore, CMS should extend the agreement period from three years to five years under all models for this and all subsequent agreement periods.

Taskforce Support for Option 3: Regional Updates to Benchmarks in All Contract Years

While unnecessary in a transition to regional benchmarking, if that approach is not chosen, CMS should consider replacing the national update factor with a regional update factor. Using regional updates increases the likelihood that savings are the result of ACO-specific improvements furthering the goals of the MSSP. If CMS moves toward regional updates, it should revisit its statistical analysis of the minimum shared savings rate for Track 1 to see if the power would be increased if it were to move to regional benchmarks and therefore a lower MSR is possible.

To define the region for the regional update factor described in the previous paragraph, we refer CMS to the definition of region described previously in our discussion under Option 5.

Comments on Option 1 and 2: Even Weight of Prior Years and Returning Earned Shared Savings to the Benchmark

We support the transition to regional benchmarks as an excellent solution to increasing the equity of and sustaining the MSSP. However, we recognize that some ACOs would prefer to reset the benchmark at the end of each contract on ACO specific costs (either as part of a blend of historical benchmark and regional benchmark or solely on a historical benchmark). Both the proposal to evenly weight the historic baseline years and add back the savings in resetting the benchmarks would increase the sustainability of the MSSP; however, we stress our commitment to more wholesale reform in the near term.

Should Option 2 be adopted, we recommend one refinement. We encourage CMS to return to the benchmark all program savings. If CMS does not do so, then with each new contract the shared savings rate for the ACOs will effectively be cut in half. This will not provide sufficient incentive for providers to remain in the program.

Risk Adjustment

We take this opportunity to highlight the absolute importance of risk adjustment for ACOs. There are two types of risk in health care. The first risk is that a person has an unavoidable accident, or that an ACO attracts a population with unusually high burden of disease. This is insurance risk, which is addressed through risk adjustment. The second risk is that a person will receive sub-optimal healthcare; this is risk the ACO can influence. Better risk adjustment of insurance risk

leads to better ACO programs. An ACO program that transfers too much insurance risk to health care providers is not sustainable. We recommend that CMS allow for risk scores to go up as well as down for continuously enrolled beneficiaries. CMS should transparently evaluate risk adjustment methodologies including concurrent models and models more aligned with Medicare Advantage.

Regulatory Flexibility

As recognized in the NPRM, there are many regulatory policies in place that make sense in a FFS marketplace but limit the ability of ACO to coordinate and improve care in the MSSP context. The waivers discussed in the proposed rule are all potential tools for an ACO to improve care coordination and reduce costs, and thus generate savings. Consistent with our earlier comments, CMS should give every ACO the maximum opportunity to be successful in the Program. We recognize, however, that CMS may have concerns about potential abuse of waivers by ACO providers still operating in a FFS environment. We suggest that CMS consider whether waiver review protocols, consumer protections, and quality criteria could be built into the waiver application process in such a way that could allow for extension of these waivers to ACOs in both one-sided and two-sided risk Tracks.

CMS asked whether the waivers should be limited to only ACOs in their second contract and whether the waivers should be limited to those beneficiaries who are preliminarily or prospectively assigned to the ACO. Subject to the additional suggestions noted in this section, we see no reason to limit the waivers to ACOs only in their second contract. Furthermore, we support making all waivers available, on a consistent basis, to all beneficiaries for whom an ACO can request data. In addition, we recommend that ACOs be able to educate beneficiaries about the waivers.

SNF 3-Day Rule

Avoiding unnecessary hospitalizations is one of the primary goals of coordinated care and therefore of an ACO. As Medicare beneficiaries are financially barred from using the SNF without a hospitalization, ACOs are unable to prevent an unnecessary hospitalization in the event that the necessary care could be provided in a SNF. We see limited likelihood for abuse of this waiver by most ACOs, with the exception of SNF-based ACOs or a health system with SNFs. CMS should simply monitor at-risk entities for evidence of excessive utilization and waive the 3-day rule for all ACOs. Thus, we support the waiver of the SNF 3-day stay rule.

Tele-Health

When setting a national policy, it is necessary to use national definitions of an originating site. However, granting the waiver and allowing the ACO to use their much more extensive knowledge of local resources aligns the service to the needs of the area. Furthermore, tele-health with originating site requirements can also generate savings because it allows for greater access to physicians. To date there has been limited adoption of tele-health services because of limited reimbursement opportunities. The MSSP program presents an opportunity for CMS to learn more

about the potential value of tele-health, such as substituting these services for more difficult to obtain specialty visits. To protect against any abuses, CMS should monitor for ACOs that are outliers for these services and do not achieve savings. Thus, we support the waiver of the originating site policy under the tele-health benefit.

Homebound Requirement for Home Health Services

Home health services can be critical to chronic care management and support the waiver of the current homebound requirement. We recommend, however, a change to which beneficiaries are eligible. Those who would most benefit from the services are those beneficiaries who need the full range of services, but do not quite meet the definition of homebound.

Referrals to Post-Acute Care Providers

The ability to develop a care coordination relationship with post-acute care providers is very valuable. However, that relationship only has real value when the patients use those providers. ACOs – regardless of Track -- should be able to not only provide information on the quality of care provided by post-acute care providers, but also recommend facilities with which the ACO has an established relationship. This should not stand in the way of beneficiaries choosing another facility if they prefer.

Reducing Barriers to Wellness and Care Coordination While not proposed by CMS, we ask CMS to consider giving ACOs the ability to offer certain financial incentives that reduce barriers to care and facilitate care coordination. (The private sector offers examples of successfully implementing such incentives.) As well documented in benefit design, people respond to even small increases and decreases in cost-sharing under their health coverage. CMS should consider how ACOs should be able to leverage this effect to provide better care coordination. An example of such services is the new Chronic Care Management code which requires ~$8 a month in co-insurance. This co-insurance may serve as a barrier to accessing care and prevent beneficiaries from using a service that would improve health outcomes and generate savings opportunities. Thus it would make financial sense for ACO participants to waive the co-insurance. Similarly with respect to encouraging beneficiaries to stay within the ACO when seeking care, an ACO may find it beneficial to waive co-insurance for primary care providers. We encourage CMS to carefully consider the possibility of this type of flexibility. We also ask the CMS articulate its reasoning for not granting such waivers, particularly as to whether the barrier to the waiver is a policy position of CMS or a legal barrier.

Securing OIG Feedback on Waivers

Nothing discourages the taking of risk more than uncertainty in policy. In terms of the willingness to take risk, the clarity of the language of the waivers only matters if it successfully reduces the anxiety of providers to utilize the waivers. The power of the waivers is proportional to the providers' willingness to use them, and that willingness is based on the perception of the clarity of the language not the clarity as determined by long legal review. Providers will be more likely,

ultimately, to accept downside risk if they understand clearly what is permitted under the waivers. To improve that clarity, we encourage CMS to work with OIG on a feedback process for ACOs that is simpler and timelier than the current OIG opinion process.

Attribution

Honoring Patient Choice

One of the central tenets of MSSP is that beneficiary choice of providers is maintained. Beneficiary choice in provider relationships should also be honored if they choose to identify a primary care provider. As CMS discussed in the preamble of the proposed rule, there are many situations where, for a particular year, the plurality of primary care services may shift away from a beneficiary's primary care provider. Simple and common examples include dealing with an acute illness or condition requiring specialized evaluation and management services, extended time away from primary residence, low health care utilizers where a single service plays a big role in determining plurality, and many other circumstances. Beneficiaries should be able to declare that despite the data from a single, peculiar year, "this physician, this nurse practitioner, this physician assistant is whom I have a special relationship with, this is who I want to coordinate my care. "

Just as all people using Medicare Part A and B are eligible to be in an ACO, they should all be eligible to make the choice of their primary care provider. Certainly honoring patient choice of their provider is a prerequisite for a truly patient-centered program. However, we acknowledge the sheer size of that base creates operational and communication challenges. We propose three congruent approaches for supporting beneficiary choice.

Step 1: Applicable to All Medicare Part A and Part B Beneficiaries

CMS should leverage the proposed data opt-out process. CMS should expand the description in Medicare and You handbook to provide this full range of options for beneficiaries:

1. Choose your Primary Care Provider: If that provider is in an ACO, the beneficiary will then be assigned to that ACO, regardless of any potentially contradictory service methodology.
2. Do nothing: Beneficiary is then assigned by the service methodology and data is made available to the ACO to which they are assigned (if they are assigned)

Further, we urge CMS to consider how to best address assignment of beneficiaries who opt-out of data sharing. Having a beneficiary opt-out of data sharing takes away many of the tools ACOs use to improve quality and coordinate patient care, thus reducing their likelihood for success. At the same time, including beneficiaries who opt-out of data will provide more comparable benefits across patients such as access to additional services under the payment waivers. Recognizing the need to balance these dynamics, we recommend CMS work with stakeholders to better understand beneficiaries' concerns and providers' uses of the data to further explore innovative solutions to improving their care.

Step 2: Applicable to Beneficiaries Who Are Preliminarily Assigned to an ACO

For beneficiaries who will be assigned to an ACO, CMS should provide an additional opportunity for the beneficiary to make an informed choice. CMS should mail a targeted letter to each beneficiary who will be preliminarily or prospectively assigned to an ACO no later than November 1 the year before the performance year. Unlike the handbook, which covers all ACO options, this letter is solely focused on making sure the beneficiary is matched to the right primary care provider to coordinate their care.

The letter should identify the primary care provider and/or ACO to whom they will be assigned and list other primary care physicians from whom they have received a primary care service. The letter should let them know that if they agree with the identified provider/ACO, they can simply do nothing and would be assigned using the service methodology. If they disagree and want either one of the other identified physicians/providers or to name another physician/provider to be their primary care provider, they should be able to call 1-800-Medicare and make the change on a form and return it to the ACO or CMS. Please note that this differs significantly from the Pioneer experiment in two respects. The beneficiary is presented with multiple options in an attempt to have them make an affirmative choice.

Step 3: Applicable to Beneficiaries Who See An ACO Professional During the Performance Year

At face-to-face office visits, ACO primary care providers should be allowed to inform beneficiaries about their ability to designate their provider as the ACO primary care provider responsible for coordinating their care. CMS should provide guidance on appropriate ways to engage in such activity. Beneficiaries would do so either in writing at the office visit or by calling 1-800-Medicare after the visit. Such an informed patient choice should be honored in all circumstances, including if the beneficiary had been prospectively assigned to an ACO.

Additional Considerations

The framework above does not constitute an additional administrative burden to ACOs. The ACO is only involved in one of the three pathways and it can choose whether or not to engage beneficiaries in this way.

In addition, we urge CMS to reconsider limiting beneficiary choice to ACOs participating in two-sided risk... We recommend that CMS allow beneficiary choice for all beneficiaries.

This approach should reduce churn in the performance year, as well as correct churn in the historical year. One cause of churn is that a beneficiary was incorrectly assigned to an ACO provider during the historical period, due to peculiarities of the historical year. Moving them out of the historically assigned ACO to another provider could be moving them back to their long-term

primary care provider (i.e. good churn). CMS data presented in the proposed rule indicates this type of correction could be as high as 13 percent.

This framework provides excellent beneficiary protection. The only opportunity for ACOs to "recruit" beneficiaries is at face-to-face office visits. The visit confirms the relationship between the ACO provider and the beneficiary, which also limits the possibility of systematic targeting that is possible in a broader marketing effort. Further protection is provided by annual risk adjustment and vigilance regarding complaints and patterns suggestive of selection.

Finding the Right Providers

We support CMS proposals to narrow the provider types included in attribution. As we discussed in our section on two-sided risk, decreasing the difference between prospective and retrospective attribution should be the goal rather than choosing between the two. To that end, CMS should allow ACOs to designate which providers should be used for purposes of attribution. Such a designation would increase the likelihood that a beneficiary is attributed to a provider who will coordinate and be responsible for their care, making both prospective and attribution more accurate. Using the CMS enrollment data, it would not be difficult for CMS to monitor these designations for any signs of gaming.

The Role of NPs, PAs and CNS in Primary Care

We applaud CMS for its elegant solution to acknowledge the critical role nurse practitioners, physician assistants and certified nurse specialists play in primary care. We encourage CMS to finalize it changes to step 1 of the attribution process. The combination of these changes and ACO provider designation should go a long way to increasing the accuracy of attribution while preserving patient choice in providers.

Continued Improvement in Attribution

As discussed in the Track 3 section of this letter, continued improvements in attribution provide greater certainty to everyone in the process. CMS should explore these following options to see if any would have reduced churn and/or created better alignment with primary care providers:

- Use plurality of events rather than costs
- Increasing the time period of attribution to a 24 month period
- Increasing the weight of annual wellness visits, transition of care management services and chronic care management services as indication of care coordination
- Using the most recent data point as a tie-breaker

With the exception of chronic care management services, all of these could be subject to analysis of past ACO attribution and their effects be considered for the final rule.

Data

Substance Abuse and Alcohol Treatment Claims

We encourage CMS to work with SAMHSA and other stakeholders, including Congress, to review the regulations governing the disclosure of substance abuse and alcohol treatment data in light of new technology and new payment models.

While those efforts are underway, we make two recommendations to the current processes employed by CMS. CMS should consider whether beneficiary privacy rights would be adequately protected if claims for other services that contain, as ancillary information, a reference to a diagnosis of alcohol or substance abuse, were scrubbed to remove such references and then provided to the ACO. Provided that such an approach adequately removed any implication of 42 CFR Part 2, it would improve an ACO's ability to provide optimal care to that patient. (As CMS already deploys technology to identify the claim, removing an already identified data element is in the realm of operational feasibility.) Second, CMS should consider whether it would be beneficial to give beneficiaries the option to consent to allow claims that have been scrubbed of all reference to a diagnosis of alcohol or substance abuse to be shared with the ACO to which they have been assigned, as is currently done under the Pioneer program. We also recommend that CMS consider providing ACOs with aggregate reports that include complete aggregate-level data.

CMS Data

CMS should use open source methods or make open source their methods and codes for all data and calculations in the MSSP. This creates greater clarity for the ACOs and fosters research and policy efforts as well. Narrative description of the calculations is not sufficient, CMS should make available the code and artifacts.

CMS should experiment with carving-in additional care components (such as Part D costs) to support efforts to move to full accountability/global budget for organizations ready to do so.

sets

CMS should improve the comparability of existing data sets and seek to provide additional data (MDS, CCW, Oasis). CMS should continue to improve its revision process for these data sets possibly considering outside certification of its process.

Global Concerns

Finally, we encourage CMS to work across payers to promote comparability of data sets and program design. Such efforts would greatly aid groups with smaller Medicare populations to increase their patient pool through contracts with commercial payers, thereby helping justify both the infrastructure investments and facilitate a transition to downside risk under Tracks two and three.

Please contact Tonya Wells at wellstk@trinity-health.org with any questions.

Sincerely,

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