



October 16, 2018

**VIA ELECTRONIC MAIL**

Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
7500 Security Blvd  
Baltimore, MD 21244

Re: Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations-Pathways to Success

Dear Administrator Verma:

The Health Care Transformation Task Force (“HCTTF” or “Task Force”) thanks the Center for Medicare and Medicaid Services (“CMS”) for the opportunity to respond to the Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations-Pathways to Success Proposed Rule (“Proposed Rule”).

The Task Force is a consortium of private sector stakeholders that support accelerating 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 affordable, high quality health care that puts patients first and improves the overall health of communities. Our member organizations aspire to have 75 percent of their business in 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.

The Proposed Rule reflects an evolution in the Medicare Shared Savings Program (“MSSP”) for Accountable Care Organizations (“ACOs”), which has been a key driver for providers to adopt value-based payment in the Medicare fee-for-service program and beyond for the past seven years. We appreciate CMS’s thoughtful consideration of how various aspects of the program could be improved to maximize overall program performance and ultimately improve the affordability and quality of care for Medicare beneficiaries. We share CMS’s goal of encouraging more rapid adoption of alternative payment models and a sustainable transition away from fee-for-service (“FFS”) health care, and our comments herein are based on our members’ deep experience with operating ACOs and shared risk arrangements in Medicare and commercial payer arrangements. We look forward to additional dialogue about how best to achieve these important objectives.

## I. Supporting sustainable delivery system transformation

Accountable care organizations are making positive changes to the delivery system and producing real savings to Medicare while improving the quality of care for beneficiaries. It is important that CMS continue support for this foundational alternative payment model that has encouraged the greatest provider participation in a Medicare value model to date, while finding ways to iterate and improve the program. **The Task Force wholeheartedly agrees that providers need a better pathway to two-sided risk in the Medicare Shared Savings Program. Yet, the incentives to start down that path should be appropriately calibrated to encourage voluntary entry and eventual transition to risk rather than unnecessary departure of high-performing ACOs.** In striking this balance, CMS should address these principles in finalized program policy:

- **Patients should be partners in the ACO.** Providers' participation in an ACO program should provide real value to patients, and ACOs should inform patients about the benefits of ACOs. Too often, restrictive marketing and communication policies present a barrier to engaging patients or modifying the outreach approach based on patient need. The ability to reach patients where they are is the first step to adopting a consumer-directed care delivery model, while ensuring sufficient protections to prevent selective marketing.
- **Providers need more predictability and a better business case for taking on performance-based risk.** All providers seek alternative payment models that offer predictability and a reasonable return on their investments in delivery system reform. ACOs require significant upfront and ongoing investment to operate successfully, but providers often lack insight as to whether those investments are generating return. Whether or not investment risk is considered program risk for Medicare payment purposes, the reality is that providers will factor investment costs against potential upside when making decisions about participating in an alternative payment model. Setting the upside shared-savings rate too low (especially in the early years) increases the business and investment risk and so reduces the program's opportunity to attract savvy providers and drive down utilization costs and improve quality of care. Providers are also looking for models with greater transparency and simplicity to incent movement to two-sided risk.
- **More ACO participation now will lead to greater long-term savings.** Annual MSSP performance data demonstrate that ACOs' performance improves over time, on average, with those ACOs participating over a longer period of time showing greater improvement in financial performance. Providers should be encouraged to join the program now and gain experience over time with graduating levels of performance-based risk to maximize long-term gains. The widespread development of high-performing ACOs will also help to drive down cost trends and increase positive spillover to the non-ACO assigned population.
- **ACO policies should encourage participation from high performers regardless of provider category.** The cumulative performance data from the MSSP program paint a picture of the average ACO. There are high performers in every track and category producing results that are drastically different from the lowest performers. Widely applicable policies that are mostly intended to modify the behavior of the lowest performers could also disallow or disincentivize high performers from continuing to produce savings. The ACO program should encourage good performers to continue apace through appropriate exceptions while putting guardrails in place to protect against consistently poor performers.

- **The measure of ACO success should incorporate a formal program evaluation.** There is much discussion about the most accurate way to measure individual MSSP participant performance and overall program impact. CMS analysis presented in the Proposed Rule also finds that MSSP ACOs produce significant net savings when considering claims data beyond the benchmark, including spillover effects on related populations and the “feedback effect” of wider ACO participation in lowering FFS trend and subsequent benchmarks. Several independent evaluations using CMS data also indicate that the relative-to-benchmark method for evaluating program performance underestimates true savings to the Medicare program. Statistical analysis by Harvard researchers used control groups to determine net savings to Medicare from the MSSP program in 2015 (\$256.4 million) was nearly 2.8 times greater than the amount reported by CMS using only benchmark comparisons (\$92.3 million).<sup>1</sup> While the ACO benchmark methodology may be appropriate for policy purposes, for purposes of evaluating impact on the Trust Fund, it is important to incorporate a broader set of measurement approaches to determine overall impact on spending for non-ACO assigned Medicare FFS beneficiaries and Medicare Advantage expenditures.

The Propose Rule seeks to improve the long-term success and sustainability of MSSP by creating a pathway for ACOs to more rapidly transition to performance-based risk. The greatest potential savings to Medicare will come from ACOs reducing claims-based medical cost. Current data shows that these medical costs are being reduced in all types of ACOs, which is a positive trend. However, the greatest potential for program savings is likely to be achieved when more ACOs move to performance-based risk. Thus, the program will only realize its maximum net savings potential if CMS finalizes policy that encourages broad participation in this voluntary program and properly aligns incentives to inspire participants to advance along the risk continuum. We offer recommendations below to advance these important objectives.

## **II. Participation options**

The Task Force has long supported the creation of new two-sided risk models that would provide an intermediate step along the continuum to fully mature two-sided risk models for both hospital and physician-led ACOs. For this reason, we supported CMS’s Track 1+ ACO model to assist MSSP Track 1 ACOs in the transition to Advanced APMs. If structured appropriately, the new participation options could provide a desirable glide path to participation in models with higher levels of performance-based risk.

### ***A. Basic track glidepath***

The real potential of the ACO program depends on both the breadth of participation as well as the financial incentives to control costs while improving quality of care. We are supportive of CMS’s intent to reduce the time allowed for ACOs to remain in upside-only payment arrangements, but we believe that upside-only payment arrangements serve an important function as a transitional state on the path to full-risk models that allow providers to become familiar with program requirements and managing risk.

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<sup>1</sup> McWilliams et al available <https://www.nejm.org/doi/full/10.1056/NEJMsa1803388>

As proposed, however, the Basic track falls short of creating an attractive path for providers to voluntarily follow given the level of investment required to stand up and operate an ACO. CMS has proposed a maximum financial upside rate of 25 percent for the first two performance levels of the Basic track, increasing to 30 percent, 40 percent, and 50 percent shared savings rates with increasing levels of risk. Our provider members strongly believe that a 25 percent shared savings rate in the first two years will be a barrier to entry for new ACOs because the investment costs alone would outweigh any potential return.

Further, the Task Force has previously shared our perspective with CMS that a 50 percent shared savings rate may not provide sufficient incentive for providers to take on higher levels of risk (*given the challenges around predictability, transparency and simplicity of the financial model as described above*) or to invest in the delivery reforms necessary to succeed in a performance-based risk model. The shared savings rates as proposed will be a major deterrent for keeping existing ACOs in the program and encouraging all participants to invest in practice transformation. **Therefore, we urge CMS to set the entry-level shared savings rate for the Basic track at 50 percent with higher shared savings rates for levels with performance-based risk.** It is critical to create a feasible business case for new entrants to transition away from fee-for-service by setting a reasonable potential upside rate, while increasing the reward as risk increases. As noted in the next subsection, this step-up approach at these levels of shared savings also has the potential to create greater consistency for ACOs to move from the Basic to the Enhanced track.

### ***B. Enhanced track glidepath***

As proposed, some ACOs would not be eligible to enter the Basic track or to renew for a second agreement period, and would instead have the option of enrolling in the Enhanced track. The difference in risk level from the Basic Level E to Enhanced track is significant. CMS should either build a glide path to the highest risk level within the Enhanced track or offer an additional track to help bridge the gap. If CMS finalizes the proposed distinct options for high-revenue versus low-revenue ACOs (*discussed further below*), we believe an Enhanced glidepath could encourage more high-revenue ACOs to join the program that would otherwise drop out. To maximize interest in moving to the Enhanced track, CMS should start the shared savings rate in line with the shared savings rate for the Next Generation ACO program's Risk Arrangement A (80 percent).

### ***C. Full track option***

In addition to MSSP Basic and Enhanced tracks, we recommend that the agency expand the CMS Innovation Center's successful Next Generation ACO program nationwide through either a voluntary "Full" risk track in MSSP or separately through the agency's Sec. 1115A authority to expand models successful in reducing spending and improving the quality of patient care. The MSSP Full Track option, or nationwide expansion of the Next Gen ACO program through separate rulemaking under Sec. 1115A authority, could offer the opportunity for provider organizations experienced in managing risk to accept 80 percent or 100 percent upside and downside risk, resulting in high-quality, coordinated care for beneficiaries and significant savings to the Medicare trust fund. CMS's first annual report on the Next Gen ACO program showed significant savings to Medicare – a 1.1 percent reduction in Medicare spending (over \$62 million net of shared savings payments) and improved utilization and quality of care across several domains for the 18 participants in performance-year one (2016). It is relevant to note that

a number of Next Gen ACOs started their journey as Track 1 MSSP ACOs, which demonstrates the importance of CMS creating a comprehensive glidepath to risk.

#### ***D. Differentiate participation options based on ACO performance***

The proposed rule offers distinct participation options for new and renewing ACOs based on the broad categories of total Part A and B FFS revenue and prior experience with performance-based risk. CMS offers justification for this differentiation that high-revenue ACOs – which typically include a hospital – are more capable of controlling the total expenditures of its assigned beneficiaries. This proposal would create unnecessary complexity and disincentive hospital-led ACO participation. **The HCTTF does not support distinct participation options for high-revenue versus low-revenue ACOs as proposed.** The objective of the Medicare Shared Savings Program is to incent all providers to work collaboratively to benefit patients. The best way to drive high quality care for patients is to create incentives that drive all the providers in a system – including hospitals – to collaborate to innovate and deliver high quality, cost effective healthcare.

**The Task Force recommends an alternate distinction based on actual ACO performance over time.** The 2017 MSSP results confirm that ACO performance improves with longer participation in the program. For ACOs inexperienced with risk, the early years of ACO participation require significant investment in system change and a steep learning curve; the returns on that investment risk are realized over the lifetime of the ACO, not necessarily the first or second year of the performance period. Providing a longer window for successful ACOs to continue in the program and achieve a reasonable return on their investment will encourage broader upfront adoption, incentivize better performance, and encourage greater long-term returns by retaining high performers.

Therefore, CMS should institute gatekeeping mechanisms to ensure that ACOs meeting set cost and quality goals can continue participation within an MSSP track. The Proposed Rule already lays out a much more aggressive policy for early termination of ACOs with expenditures exceeding the minimum loss ratio for two years. We agree that ACOs that are unable to succeed under a risk-based arrangement should not be permitted to remain in the program. However, the Task Force encourages an extended observation period to assess ACO performance for at least three years – and consider improvements over time – before limiting participation options. Under the current reporting cycle timeline, ACOs are not informed of their performance until October of the following year. A critical component of performance improvement lies in the ACO's ability to analyze the performance data being provided to the ACO and make targeted improvements based on this information. At least three performance years would be needed to collect two years of completed performance data on which to base that assessment. For current ACOs that have at least three years of participation experience, CMS could use existing performance data to make a determination.

#### ***E. Mandatory progression***

While the Task Force supports encouraging providers to move into fully-mature value-based payment arrangements with performance-based risk, we find it unnecessary to mandate movement from Basic Level E to the Enhanced Track for any ACO given that the nominal risk associated with Basic track Level E satisfies the Advanced APM threshold under the Quality Payment Program. If that threshold were to change, HCTTF would be open to revisiting this proposal at that time. As noted in a prior comment, this policy as currently proposed only impacts so called high-revenue ACOs and, given

we do not support that proposal, we similarly believe that the mandatory progression proposal should not be finalized.

### **III. Benchmarking refinements**

#### ***A. Risk adjustment***

CMS has proposed modifications to the risk adjustment methodology to account for changes in case mix and severity of assigned beneficiaries and to eliminate the distinction between continuously and newly aligned beneficiaries, which is a step in the right direction. However, CMS's proposal to cap the risk score growth at +/-3 percent seems arbitrary without supporting data. Further, by capping the growth in risk scores for a defined attributed population, risk adjustment in performance benchmarks is not reflective of the population a provider is managing year to year. This discrepancy can contribute to adverse incentives for program participants and encourage cherry-picking. Alternatively, CMS should focus on bringing more consistency to the risk scoring approaches across Medicare APMs and Medicare Advantage.

#### ***B. Regional factors***

CMS proposes to incorporate regional factors when establishing the benchmark as part of the first agreement period, as well as for updating the benchmark. We recommend that CMS maintain the cap on the regional adjustment at 70% percent. We also encourage CMS to remove ACO beneficiaries from the regional comparison group; including ACO beneficiaries in the comparison defeats the purpose of accounting for non-ACO regional expenditure trend. These changes will help create a stronger business investment case within a financial model that is often complex, opaque and unpredictable.

### **IV. Program policies**

The Task Force is generally supportive of the refined program policies as proposed, including the additional certainty and predictability provided by 5-year agreement periods; annual participation elections for retrospective or prospective beneficiary alignment; enhanced beneficiary engagement options; and expanded access for all two-sided ACOs to payment rule waivers. We recommend CMS consider modifications to the following policies as proposed.

#### ***A. Offer 12-month extension to current ACOs***

CMS should allow existing ACOs that would be qualified for the 6-month extension to instead extend for a full year. Prorating the performance period benchmark would introduce numerous complications for measuring performance. For example, Medicare expenditures demonstrate strong and well-known seasonality which would skew performance results when comparing performance from the first six months of the calendar year against a prorated benchmark which represents an annual average. Also, the change in beneficiary assignment methodology mid-year could present issues related to managing two different populations.

#### ***B. Beneficiary assignment methodology***

CMS has proposed to offer ACOs the option to elect a new hybrid approach to beneficiary assignment, in which beneficiaries could opt-in or be assigned to the ACO with seven relevant primary care claims in a year. As CMS acknowledges in the Fact Sheet description, this approach would limit

assignment to those who choose to opt-in, or those who are chronically ill. We are very concerned that the seven claims per year threshold is too low and would leave out a large portion of Medicare beneficiaries from the program. We encourage CMS focus on implementing the new voluntary alignment provisions this year and further research the implications of such a hybrid approach before implementing.

### ***C. Early termination***

As noted above, the Task Force supports the proposal to allow CMS to terminate an ACO's participation agreement immediately or with advanced notice if the ACO is negatively outside the MLR corridor, but recommend CMS extend the period of review to 3 performance years as well as consider evidence of improvement over time before making a determination to terminate an ACO.

### ***D. Overlap with other APMs including CPC+***

Various alternative payment models – including population-based payment models, episodes of care, and advanced primary care models – when deployed in coordination can have a positive synergistic impact on care for Medicare beneficiaries. The HCTTF has offered CMS recommendations for providing APM participants adequate flexibility to manage model overlap based on their unique market situation in a way that encourages greater alignment and ultimately drives better outcomes for patients.<sup>2</sup> It is therefore notable that the Proposed rule does not address the longstanding policy for Comprehensive Primary Care Plus (CPC+) practices participating in ACOs. The CPC+ model meets a critical gap in advanced primary care payment models, which incorporates care management fees and performance-based incentive payments. The new care management fees are accounted for as ACO expenditures but are not accounted for in the historical cost base for an ACO's benchmark for five years, which harms the ACOs participating in transforming primary care practices. CMS should discount the CPC+ care management fees from ACO benchmarks to encourage primary care investment and coordination with ACOs, until those costs are fully incorporated into the baseline and therefore the benchmark.

### ***E. Waiver applicability***

Through existing waivers, ACO participants have been able to better meet the needs of individual patients in a variety of innovative ways. However, providers are understandably cautious to utilize waivers when applicability is unclear. Our members report uncertainty around the availability of particular waivers due to limited commentary about CMS's intended scope or applicability for particular ACO participants. Given that waivers are currently available on an opt-in basis, this uncertainty has led some stakeholders to decline the opportunity out of fear of noncompliance if they implement a waiver incorrectly. With the expanded availability of waivers under the proposed rule, we urge CMS to expedite and regularly update Frequently Asked Questions guidance documents and/or commentaries in response to recurrent questions regarding common provider circumstances. CMS and the Office of the Inspector General should also explore mechanisms for providers to ask questions for guidance about the waivers short of a traditional Advisory Opinion.

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<sup>2</sup> 8/28/2018 Letter: <http://hcttf.org/cms-bpcia-aco-synchronization/>

If you have questions or follow up needs, please contact HCTTF Executive Director Jeff Micklos ([jeff.micklos@hcttf.org](mailto:jeff.micklos@hcttf.org)) or HCTTF Senior Director Clare Pierce-Wrobel ([clare.wrobel@hcttf.org](mailto:clare.wrobel@hcttf.org)).

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