The Voice of Accountable Physician Groups

March 28, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
US Department of Health and Human Services
Hubert Humphrey Building, Room 445-G
200 Independence Ave., SW
Washington, DC 20201

Re: CMS-1644-P Medicare Shared Savings Program: Accountable Care Organizations—Revised Benchmark Rebasing Methodology, Facilitating Transition to Performance-Based Risk, and Administrative Finality of Financial Calculations

Dear Acting Administrator Slavitt,

We appreciate the opportunity to comment on the Medicare Shared Savings Program (MSSP) Accountable Care Organization (ACO) revised benchmarking proposed rule (proposed rule). CAPG represents over 200 multispecialty physician organizations across 40 states, Washington, DC and Puerto Rico. Our members participate in value-based payment models across Medicare Advantage and traditional Medicare. CAPG members have successfully operated under risk-based payment models for decades.

Our members' preferred model of risk-based coordinated care is prepaid capitation. This model best aligns the incentives for physicians to provide high quality coordinated care. Under this model, the payment amount does not fluctuate based on the volume of services provided. Instead, the physician organization is paid a set amount per member, per month.

In this capitated model, the physician organization has the flexibility to tailor payments to its individual contracted or employed physicians (paying a salary, sub-capitation, or even fee-for-service in some cases). Our member physician organizations hold their employed and contracted

physicians to robust performance standards, with a portion of the downstream payment often depending upon performance metrics in a range of areas.

Capitated payment allows our members to deploy proven techniques and innovative approaches to improve patient care. The model incentivizes a team-based approach, whereby healthcare professionals such as care managers, nurses, social workers, care navigators, pharmacists and others are deployed as part of a team led by a primary care physician. Each member of the team is encouraged to practice at the top of his or her license. The primary care-led team improves patient outcomes.

These arrangements also incentivize physicians to provide the right care at the right time, in the most effective setting. For example, rather than trying to maximize fee-for-service payments in high cost settings, patients are treated safely in lower cost settings, including the home, when appropriate. Our experience is that this approach is better aligned with patient preferences.

Our members are participating in the Medicare Shared Savings Program, Next Generation, and Pioneer ACO programs, and have been doing so from the introduction of these initiatives. We appreciate the important role these programs play in the future of delivery system reform. We also know that accurate and fair benchmarks will be critical to a successful ACO program, and thus to the success of delivery system reform.

Summary of CAPG Comments

Below we provide detailed comments on the policies contained in the proposed rule. To summarize:

- **Medicare ACOs will serve as the foundation for successful implementation of the Medicare Access and CHIP Reauthorization Act (MACRA) and must be attractive to a large number of potential participants across the country**. Today, our members are evaluating their MACRA options, including whether they will participate in the Merit-Based Incentive Payment System (MIPS) or alternative payment models (APMs). Many of our members believe that APMs will be the preferred of the two options. At present, risk-bearing Medicare ACOs seem to be the primary way that an organization may become a bonus-eligible APM under MACRA. Given this outlook, we encourage you to design a Medicare ACO program that is as attractive to the greatest number of organizational participants as possible.

- **As written, the benchmarking proposed rule may not improve the attractiveness of the MSSP ACO program and may make this choice less attractive than MIPS for some organizations**. Our analysis of the proposals in the rule and the related data indicates that on an aggregate national basis, the benchmarks may <u>decrease</u>. If that is the effect of the final rule, the ACO program will become substantially less attractive to organizations seeking to participate in APMs. Given the lack of available options, an unattractive ACO program will push sophisticated groups, capable of taking financial

risk, back into MIPS/fee-for-service. We encourage the agency to consider this and call on your to make improvements in the final rule and continue to offer new APM options for sophisticated risk-bearing groups.

- **Beneficiary engagement remains a key sticking point**. While beneficiary engagement is not addressed in this rule, we continue to believe that it is a critical issue for ensuring the success of the ACO program. We have long called on CMS to implement more progressive approaches to beneficiary alignment – including beneficiary election, beneficiary incentives for seeking care from an ACO, and differential cost sharing for in-ACO versus out-of-ACO services. While the Next Generation ACO program represents an important first step toward an improved attribution and introduces a care coordination incentive program, we call on the agency to quickly incorporate these tools into the MSSP. Our member ACOs continue to face leakage issues in the ACO program which are a barrier to success. ACOs need to be equipped with the tools to encourage beneficiaries to seek care within the ACO.

We appreciate the opportunity to comment on these proposals and look forward to working with you to design a sustainable ACO program for the future.

MACRA and the ACO Program

When Congress enacted MACRA, it sought to transition traditional Medicare away from its reliance on a flawed, volume-driven, fee-for-service reimbursement model to risk-based alternative payment models, including capitation. This intent is evident throughout the law, which sets out a framework intended to encourage swift movement from fee-for-service to risk-based coordinated care. Rather than an APM strategy of limited experimentation, MACRA clearly contemplates systemic change.

As our members evaluate the available APM options, it is clear that the ACO program plays a central role in MACRA implementation. We note that participation in the MSSP ACO, Pioneer ACO, and Next Generation ACO programs has continued to grow in recent years. These models have improved the quality of care in traditional Medicare and have begun to bring coordinated care principles to previously unmanaged populations. But, a relatively small fraction of participants are accepting two-sided risk in these models. We believe that MACRA has the strong potential to change that picture and to incent the move to risk contracting. Along with performance-based risk, we expect to see continued quality improvement, care coordination, and patient satisfaction.

We believe that much of this move to risk-based coordinated care and the promise of better care at a lower cost rests on the shoulders of the MSSP ACO program. We call on CMS to take two actions in this regard. First, to continue to improve the ACO program to make the risk tracks as attractive to as many participants as possible. Second, CMS must continue the ACO evolution, building toward capitated payment options and incorporating care management lessons learned from programs such as Medicare Advantage.

Updating the ACO's Benchmark (changes within the three-year agreement)

We are very concerned about the proposed methodology for updating ACO benchmarks. Based on our analysis, we believe that on an aggregate national basis, ACO benchmarks will decrease. We ask that CMS reconsider this proposal and make necessary revisions in its final rule.

Under existing regulation, benchmarks are updated using the absolute amount of change in national FFS Part A and Part B expenditures for ESRD, disabled, aged dual eligible, and aged non-dual eligible separately. Under the proposed rule, benchmarks will be updated using the rate of change in regional Part A and Part B expenditures separately for the four categories.

Our analysis shows variable impact across the country, with winners and losers, but we are particularly concerned about the relatively high number of potential losers under this proposed methodology. CMS itself admits in the regulatory impact analysis section of the rule that the policy changes would have mixed effects, increasing or decreasing benchmarks for ACOs depending on the circumstances. The agency goes on to say "an overall increase in program savings would likely result from taking into account service-area trends in benchmark calculations."[1] CMS is predicting a net federal savings of $120 million more in savings as a result of this proposed rule. In the regulatory impact analysis, CMS points to different factors that contribute to this additional savings. However, we are concerned that this savings will disproportionately come from the lost savings opportunity of our members as they work to improve upon lower benchmarks. In light of the context of the ACO program described above, we encourage the agency to reconsider its proposed changes.

We also encourage CMS to make available additional resources and tools for ACOs to evaluate how the changes in the final rule will impact their benchmarks. The proposed changes are incredibly complex and difficult to model. For this program to be sustainable and successful, we believe that substantial additional support will need to be made available to stakeholders.

Rebasing Benchmarks (resetting at the end of one three-year agreement to begin a new three-year agreement)

We recommend that CMS continue to examine equitable methodologies for rebasing ACO benchmarks. Such an approach must take into account not only the factors that have contributed to ACOs leaving the program, but also factors that might be barriers to organizations in efficient, managed care heavy markets entering or continuing in the ACO program.

Under existing regulation, benchmarks are rebased using ACO expenditures in the base period and applying the rate of change in national FFS Part A and Part B expenditures for the four beneficiary categories. CMS makes an adjustment to reflect ACO savings achieved in the base period. Under the proposed rule, benchmarks would be re-based using ACO expenditures in the base period and applying the rate of change in regional Part A and B expenditures for the four

[1] 81 Fed. Reg. 5,859 (Feb. 3, 2016).

categories. CMS would make an adjustment to reflect the difference between an ACO's costs and its region's FFS costs.

One reason for the proposed change is to account for changes in factors outside of the ACO's control that affect the regional spend. One example includes changes to the region's hospital wage index. While we agree that these factors have contributed to ACO program exits, we have concerns about the proposed solution.

In regions where there is a substantial amount of managed care, or a dominant, successful ACO, the rate of spending growth per capita in the region would be limited. The "halo effect" or "spillover effect," is well-documented in other contexts and cannot be ignored in the ACO program. In such areas, the update to the benchmarks would be lowered by the success of risk-based coordinated care. This creates the wrong set of incentives for the future of the ACO program.

CMS is proposing to eliminate an adjustment that accounts for an ACO's past savings when the ACO's benchmark is rebased. CMS would replace that adjustment with an adjustment that accounts for the difference between the ACO's costs and its region's FFS costs.

In June 2015, CMS finalized a policy that would make an adjustment to reflect the average per capita amount of savings earned by the ACO in its first agreement period when resetting the benchmark for a second agreement period. Including these savings would help improve the benchmark for the subsequent agreement. This policy was intended to address stakeholder concerns that benchmark rebasing would disadvantage ACOs that had generated savings and that some ACOs may be holding back on achieving savings because it would reduce their benchmarks for future periods.

CMS should not finalize this proposal. We do not believe that the regional adjustments proposed sufficiently address the concerns about benchmark rebasing such that this adjustment for prior savings can be eliminated. We expect that ACOs in efficient, low-cost areas will be harmed by the proposed transition to this regional benchmarking methodology. The negative impact of the proposed rule would be exacerbated by eliminating an adjustment that accounts for their savings achieved in prior agreements. Therefore, we encourage you to abandon this proposal.

The proposed benchmark rebasing would change an ACO's benchmark by a percentage of the difference between the ACO's costs and costs of all beneficiaries that could be aligned in the ACO's region. The proposed percentage is 35% in an ACO's second agreement period and 70% in the third and subsequent agreement periods. If this methodology is employed, we contend that the percentages should be 100% in all agreement periods for ACOs with costs lower than their region's costs. Percentages below 100% penalize ACOs for good performance and unnecessarily increase the complexity of the shared savings calculation. Further, for ACOs with costs higher than the region's costs, the percentage should be 0%. Otherwise, an ACO with poor

past performance is penalized by having its benchmark decreased, making it even more likely their future arrangements will be unfavorable.

As we evaluated the various proposals relating to benchmark updating and rebasing in the proposed rule and modeled the impact of the changes, it became clear that this proposed rule creates winners and losers. While this proposed rule may represent an improvement for some ACOs, for many of our members in efficient areas this rule will either have little effect or a negative effect on the attractiveness of the ACO program. Given the broader context of the ACO program and its importance in MACRA implementation, we encourage CMS to consider developing benchmarking options for ACOs to pick from, including a national benchmark. We also ask that the agency continue to consider other adjustments to the benchmarks that can make the ACO program more attractive to a wide number of participants.

Coding Intensity

In the proposed rule, CMS comments that it considered several alternatives to limit the impacts of intensive coding by ACOs while still accounting for changes in health status within an ACO's assigned beneficiary population. One alternative CMS describes is applying a coding intensity adjustment similar to the methodology used in MA. Under this approach, CMS would develop a coding intensity adjustment by looking at risk score changes over time for beneficiaries assigned to the ACO for at least two consecutive prospective risk adjustment data years relative to the FFS population.

We oppose this proposal. The coding intensity adjustment in Medicare Advantage unfairly penalizes physician organizations engaged in accurate coding practices. The different incentives for accurate coding in MA as compared to the FFS population at large are well documented. We find it inappropriate to expand the penalties for accurate coding to ACOs.

Facilitating the Transition to Two-Sided Risk

CMS expresses an interest in facilitating the transition of ACOs into two-sided risk models from one-sided risk models. CMS is concerned that some ACOs completing their initial agreement period in Track One may be entering a second agreement in Track One because it is not ready to enter two-sided risk. Entering a second agreement would delay entry into risk models. CMS is proposing to allow ACOs that apply for a two-sided risk agreement an additional year in an upside only contract. This proposal would also delay the rebasing of an ACO's benchmark for an additional year.

We support additional flexibility for ACOs that encourage the transition into risk-based coordinated care. We look forward to additional information from the agency about MACRA's performance and payment periods so we can best understand how this proposal squares with eligibility for MACRA's APM bonus.

Overall, we encourage the maximum amount of flexibility for ACOs that want to move to risk-based coordinated care. Therefore, we support this flexibility to the extent it assists ACOs that need an additional year to prepare for their move to risk.

Administrative Finality: Reopening Determinations of ACO Savings or Losses to Correct Financial Reconciliation Calculations

Currently, there is no limit on the timeframe for CMS to correct errors on aspects of the MSSP ACO programs, such as historical calculations of benchmarks and ACO reconciliations. CMS is proposing a four-year period after final reconciliation for reopening historical calculations. However, CMS is proposing that there be no such limit on reopening historical calculations in the case of fraud.

We believe that this timeframe is overly long. Particularly in light of the rapid change in this program, we call for a shorter lookback period. A two-year look back period would provide greater financial certainty for ACOs.

Alignment with Commercial ACOs

There is a substantial amount of ongoing contracting work in the commercial ACO space. We believe there are multiple opportunities to achieve greater alignment between these efforts in the commercial space and the Medicare space. We would be pleased to work with CMS to begin to harmonize these efforts.

Capitated or population-based payment models/Third Option

We again call on CMS to adopt a population-based payment or capitated model option in MSSP for those ACOs that are prepared to do so. We believe that CMS must appropriately build options for ACOs at both sides of the spectrum of ability to take on financial and clinical risk. We believe that more must be done to develop the destination of the ACO evolution, to develop options for organizations willing and able to take global risk. We believe that there are a number of organizations that are ready to take on risk today and they would welcome the opportunity to design an ACO track to achieve that objective. We also believe development of subsequent tracks would serve an important purpose for organizations contemplating entering the ACO program – it would serve as an indication of where the program is intended to go over time and how the agency sees it developing into greater levels of accountability for patient care.

Attribution and Beneficiary Engagement

We have repeatedly cited the issues of beneficiary engagement and "stickiness" to the ACO network as a major barrier to success in the MSSP. CAPG member ACOs see a tremendous amount of leakage of their ACO beneficiaries – that is to say that many ACO beneficiaries are receiving care outside of the ACO network.

We understand that CMS is committed to upholding the fee-for-service nature of the program and allowing beneficiaries to maintain free choice of providers. Therefore, to balance these two

concerns, we recommend that CMS work to develop rules that allow all ACOs in two-sided risk models to use financial and/or other incentives to encourage beneficiaries to see providers affiliated with the ACO. This may include lower cost sharing for visits within the ACO as compared to visits outside of the ACO. In addition, legislation previously introduced in the House of Representatives would have allowed ACOs the additional flexibility to design incentive programs for beneficiaries, subject to the approval of the Secretary of HHS. We encourage the agency to use its regulatory authority to begin to test such a model as soon as possible.

Conclusion

The ACO program provides the opportunity to advance risk-based coordinated care in traditional Medicare. We believe that it is a critical component in the move from volume to value. Because of that, ACO policies must be carefully crafted to encourage participation in the program and simultaneously incentivize the movement to two-sided risk models. Creating a successful and sustainable program requires striking a balance between the needs of the ACO community and the needs of the federal government.

We encourage you to reconsider the benchmarking proposals in the rule to improve the attractiveness of the program, particularly for organizations in efficient markets. We also continue to call on CMS to improve beneficiary engagement and attribution.

If you have any questions, please do not hesitate to contact us.

Sincerely,

DONALD H. CRANE
President & CEO