AMERICA'S PHYSICIAN GROUPS

Taking Responsibility for America's Health

October 16, 2018

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

Re: CMS–1701–P– Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations—Pathways to Success

Dear Administrator Verma:

We appreciate the opportunity to provide comments on the Medicare Shared Savings Program (MSSP) Accountable Care Organization (ACO) Pathways to Success proposed rule (proposed rule). America's Physician Groups (APG) represents over 300 medical groups and independent practice associations (IPAs) across 43 states, the District of Columbia, and Puerto Rico. APG members participate in MSSP Tracks 1, 1 plus, and 3 in addition to the Next Generation ACO program and have been doing so since the inception of these models. We appreciate the role MSSP plays in the future of delivery system reform.

For years, APG members have pushed for accelerated movement away from our nation's antiquated fee-for-service (FFS) reimbursement system where clinicians are paid simply by the number of services they provide, rather than on the quality or outcomes of care provided. Our members are committed to moving away from FFS towards value-based alternative payment models where clinicians are held accountable for quality, efficiency, and patient outcomes.

While further improvements to MSSP can and should be made – and certain provisions in the proposed rule raise concerns for APG members – overall, the proposed rule takes important steps in advancing the movement to value and greatly enhances MSSP now and in the future. The guiding principals of accountability, competition, engagement, integrity, and quality serve as an important framework and provide context for many of the changes CMS is proposing. APG applauds the Agency's efforts to accelerate the value movement and strengthen MSSP through this proposed rule.

Summary of APG's Recommendations

- APG supports CMS redesigning participation options to facilitate transition to performance-based risk and moving from 3-year to 5-year contact periods
- APG opposes the proposed significant reduction in shared savings opportunities in the Basic Track
- APG supports the ability for ACO to have the flexibility to modify the attribution methodology. However, we would recommend that it could only be exercised once during the contract term.
- APG supports requiring experienced, high revenue ACOs to move to risk at a more accelerated rate
- APG supports the concept of terminating ACOs whose continual performance is a drain on the taxpayer or a result of gaming unless it is outside the ACO's control
- APG supports the proposed FFS benefit enactments and waiver opportunities
- APG recommends that CMS facilitate a mechanism for ACOs to address socioeconomic variables through billing for the service or allow ACOs to receive the services as in-kind donations from community agencies
- APG recommends that the ACO program adopts BPCI-A like approach to the 3-day SNF waiver to avoid undue burden and standardize the process among the models.
- APG recommends that the risk adjustment benchmark be based upon a methodology similar to the Next Generation ACO program and the cap be increased to 6 percent
- APG supports the expansion of the telehealth waiver but recommends two adjustments relating to the start date and participation
- APG recommends that CMS convene a panel of experts to improve and strengthen the risk adjustment and benchmarking aspects of the program to align these elements among models
- APG strongly supports the movement away from regional only benchmarking to a more blended approach for the trend factor, however, the methodology should be modified in areas that have a low spending growth trend
- APG supports the proposal to allow for beneficiary incentives, however, we recommend that CMS modify it them to allow any of the ACO partners to furnish the incentive since they will share in the savings or losses
- APG supports opportunities for data sharing among any clinical partnerships used in collaboration with ACO providers, not only pharmacists
- APG supports the opportunity for beneficiaries to participate in voluntary alignment by selecting their primary care clinician, but we advocate for a more streamlined selection process
- APG supports the new "opt-in" concept and believe that it will lead to enhanced integration between the ACO entity and the beneficiary, thereby helping to decrease churn
- APG believes that ACOs should be able drop poor performing clinicians from their participant list throughout the year

- APG recommends that NPI participation be allowed rather than just participation at the TIN level
- APG urges the Agency to continue to work with stakeholders to reduce unnecessary quality measurements and develop additional quality metrics

Below we have provided detailed comments on the policies contained in the proposed rule.

Redesigning Participation Options to Facilitate Transition to Performance Based Risk

Creating a BASIC Track with Glide Path to Performance-Based Risk

In order to create a new pathway to transition ACOs to performance-based risk, CMS is proposing to restructure the current MSSP program into two new tracks: (1) a BASIC track, offering a path from a one-sided model for eligible ACOs to progressively higher increments of risk and potential reward within a single agreement period, and (2) an ENHANCED track based on the existing Track 3 (two-sided model), for ACOs that take on the highest level of risk and potential reward. CMS will provide flexibility to allow ACOs that are ready to accelerate their move to higher risk within agreement periods and enable such ACOs to qualify as Advanced APM entities for purposes of the Quality Payment Program (QPP). This approach includes proposals for replacing the current 3-year agreement period structure with an agreement period of at least 5 years for improved program stability and certainty.

APG supports this redesign, including the 5-year agreement period, as we believe it better incents the movement to risk and provides an automatic pathway to do so. Of the 561 currently participating ACOs, 82 percent are in upside-only arrangements. CMS is taking necessary steps in this proposed rule to limit the time ACOs may spend in these upside-only arrangements by automatically advancing participants in the BASIC track to marginally higher levels of downside risk, ending in Level E which is equivalent to the current Track 1 plus model. We support Track 1 plus being included as a permanent part of the MSSP program.

APG has consistently asked CMS to provide a smoother and more gradual glide path along MSSP tracks towards increasing levels of risk, and we thank the Agency for addressing our concerns in this regard.

However, APG has ***significant*** concerns regarding the reduction to shared savings for participants in the BASIC track. **APG urges CMS to meaningfully increase shared savings percentages in the BASIC Track Levels A through D**. The current levels proposed are not sufficient to encourage new organizations to join the program. The costs and risks of forming and maintaining an ACO are significant; the rewards should be high enough to offset those deterrents. We recommend that shared savings remain at 50 percent beginning in level A and continuing through Level E. Such shared savings rates are necessary to ensure stability and sufficient participation in the program. APG remains concerned that a lower shavings rate will reduce participation among new and returning

ACOs and ultimately be a barrier to more physicians moving to value in traditional Medicare.

Creating an ENHANCED Track

CMS proposed to retain the old MSSP Track 3, which they are renaming the ENHANCED track. The ENHANCED track allows sophisticated ACOs the opportunity to accept higher levels of potential risk and reward to further drive significant, systematic change in our nation's health care delivery system. Participants in the ENHANCED track would also contract for a 5-year agreement period.

APG supports opportunities for physicians to participate in increasing levels of downside risk, including in the ENHANCED track of the MSSP. Our members are excited about the opportunity to access up to 75 percent of shared savings. However, we note that the shared losses of between 40 – 75 percent (not to exceed 15 percent of their benchmark) are significant, thus, we note that timely sharing of data from CMS to these ACOs with be absolutely critical and key to their success.

Length of Contract

APG supports moving from 3-year to 5-year contracts. Longer contract terms provide greater stability and predictability in the program and allow ACOs to develop longer-term strategies to achieve the program's goals and achieve sharing savings. The current 3-year contract terms were too short and created anxiety among ACOs regarding the constant need for significant systemic program decisions, deflected attention from care redesign activities, and stymied innovation on the clinical side.

Proposals for Permitting Annual Election of Beneficiary Assignment Methodology

CMS has proposed that the ACO can select on an annual basis either prospective or preliminary prospective with retrospective reconciliation attribution for their beneficiary assignment methodology. If an attribution methodology change is made, then CMS will reconfigure the benchmark for the remaining performance years in the contract.

APG supports the ability for ACO to have the flexibility to modify the attribution methodology, however we would recommend that it could only be exercised once during the contract term. This is to prevent ongoing gaming of the system by switching attribution model based upon financial arbitrage rather than focusing on care redesign.

Determining Participation Options Based on Medicare FFS Revenue and Prior Participation

CMS' results to date have shown that ACOs in two-sided models perform better over time than one-sided, low revenue ACOs (which are typically physician-led) and perform better than high revenue ACOs (which often include hospitals) and the longer ACOs are in the program the better they do at achieving the program goals of lowering growth in expenditures and improving quality. The Agency cites specific data that indicates in performance year 2016, about 68 percent of Shared Savings Program ACOs in two-sided models (15 of 22 ACOs) shared savings compared to 29 percent of Track 1 ACOs; 41

percent of low revenue ACOs shared savings compared to 23 percent of high revenue ACOs; and 42 percent of April and July 2012 starters shared savings, compared to 36 percent of 2013 and 2014 starters, 26 percent of 2015 starters, and 18 percent of 2016 starters.

CMS is proposing to allow ACOs to advance through the BASIC track and ENHANCED tracks based on their level of experience in MSSP and their type – namely high revenue or low revenue in Parts A and B FFS. CMS states that high revenue ACOs, which generally include hospitals, are more capable of controlling the total expenditures of assigned beneficiaries yet perform poorer than low revenue ACOs, which are typically physician led.

Based on this data, APG supports requiring experienced, high revenue ACOs to move to risk at a more accelerated rate. However, we caution CMS to not punish early adopters and first movers. The Track 1 plus ACO program began this year. The first ACOs eligible for Track 1 plus in 2018 included some ACO in Track 1 that opted to enter Track 1 plus in their last contract year. These ACO were in the 2016 cohort and could have remained in Track 1 for 2018. These groups took the initiative to take on risk sooner than mandated and should not be penalized for being early adopters. Under the proposed rule, these groups would be considered experienced and be required to enter the ENHANCED Track with only one year of downside risk experience. APG recommends that these groups be allowed to enter the new program at BASIC Level E.

Further, while APG certainly supports accelerating movement to risk as we know that two-sided risk models better align incentives high-quality, lower cost care, we are open to allowing high performing ACOs additional flexibility when entering and moving though MSSP tracks and levels. Those that are historically low performers should be required to either quickly demonstrate success or be terminated from the program.

ACO Involuntary Termination

CMS is proposing that if an ACO is determined to be outside the "negative corridor" then they have the right to require a corrective action plan for the first year followed by a termination from the program during the second year.

APG supports the concept of terminating ACOs whose continual performance is a drain on the taxpayer or a result of gaming. However, we want to ensure that such a termination was is not for reasons outside of the ACO's control such as an overlapping CMMI model that is negatively impacting the ACO financially. **APG recommends that CMS develop an appeal process in order for the ACO to articulate if the reason for termination was due to extenuating circumstances**. The ACO should not be held to the consequences of unexpected financial loss.

Fee-for-Service Benefit Enhancements

SNF 3-Day Rule Waiver

In the current regulations, the SNF 3-day waiver is only utilized in Tracks 1 plus and 3 where prospective attribution is employed. CMS is proposing that effective July 1, 2019, all ACOs under a two-sided risk track (that would include all except Level A and B in the BASIC track) would receive approval to utilize the SNF 3-day waiver. CMS notes that once the beneficiary is prospectively assigned to the ACO, the 3-day waiver can be used even if the beneficiary is eliminated from the attribution list in subsequent quarters. APG welcomes this change in policy, however, we maintain that the waiver continues to be underutilized due to other reasons which must be modified. These include program requirements like a signed contract between ACO and each SNF.

In order to utilize the SNF waiver, two steps must occur: (1) a contract must be signed between the SNF affiliate and (2) the ACO must confirm that the SNF has maintained a 3 Star rating or above.

The newly launched Bundled Payments for Care Improvement Advanced (BPCI-A) has streamlined the waiver process through an online XLS file that CMS maintains to verify which SNFs are eligible and the ability to easily communicate to CMS that the BPCI-A participant will be utilizing the waiver in care redesign. **APG recommends that the ACO program adopts BPCI-A approach to avoid undue burden and standardize the process among the models.**

Telehealth Services

CMS is proposing (under the direction of the Bipartisan Budget Act (BBA) of 2018, Public Law No: 115-123') that in 2020, ACOs under a two-sided risk track and utilizing prospective attribution (not preliminary prospective) be allowed to employ telehealth waivers with the patient's home as the originating site. **APG supports the expansion of the waiver but recommends two adjustments**. First, CMS should allow for a July 1, 2019, start date to avoid confusion with the SNF 3-day waiver. Second, allow preliminary prospective models to participate. We understand that the latter is based upon an interpretation of the BBA, however, since CMS is proposing to allow attribution models to change on a yearly basis from prospective to preliminary prospective with a retrospective reconciliation, it doesn't make sense from a care delivery system to not include the preliminary prospective model. For example, an ACO may be using telehealth for a beneficiary in December but once that ACO switches to preliminary prospective in January, they are unable to provide the same service.

Provisions of the Bipartisan Budget Act for Telehealth in the Shared Savings Program, Beneficiary Incentives

Beneficiary Incentive Programs

CMS is proposing to allow any ACO in a downside risk model to provide an incentive payment – no more than 20 dollars annually per service – to any beneficiary completing a specific primary care service (e.g. an Annual Wellness Visit). The benefit must be furnished by exclusively the ACO and not by any of the ACO partners including a hospital or acute care facility.

APG supports the proposal to allow for beneficiary incentives, however, we recommend that CMS modify it to allow any of the ACO partners to furnish the incentive since they will share in the savings or losses. We do support the prohibition in accepting any financial support for the beneficiary incentives from pharmaceutical or medical device companies.

Since CMS has lifted the uniformity standard for the Medicare Advantage (MA) plans to allow medical and nonmedical services to be provided to targeted populations, it has become clear that the usage of nontraditional services such as transportation and food delivery are essential to achieve high quality and low-cost goals. **APG recommends that CMS facilitate a mechanism for ACOs to be afforded the same opportunity to address socioeconomic variables through billing for the service as an additional benefit or allow ACOs to receive the services as in-kind donations from community agencies.**

Coordination of Pharmacy Care for ACO Beneficiaries

CMS has suggested that pharmacists and ACO providers can work more collaboratively through data sharing. **APG supports opportunities for data sharing among not only pharmacists but any clinical partnerships used in collaboration with ACO providers**.

Empowering Beneficiary Choice

Voluntary Alignment

The frequency of beneficiary churn among ACOs has negatively impacted the ability of ACOs to generate savings and implement long term health impact. CMS previously assigned beneficiaries to the ACOs based upon model selected (Track 1 plus had prospective while Track 2 had preliminary prospective with final retrospective assignment) using a claim tier model in which primary care providers in the first tier. This model left beneficiary choice out of the selection.

In 2018, CMS began to allow beneficiaries to voluntarily select a primary care provider which was a welcome addition. However, using the current Medicare.gov website to identify the provider has proved burdensome and confusing to the beneficiary. We believe that streamlining the process through a smart phone application, via a phone

call, or through the other modifications in eMedicare.gov would lead to greater adoption.

APG supports the opportunity for beneficiaries to participate in voluntary alignment by selecting their primary care clinician, but we advocate for a more streamlined selection process.

Opt-in

CMS is proposing to include a new "opt-in" methodology that allows the beneficiary to proactively select an ACO. This would facilitate the recognition of the value of the ACO as an entity. **APG supports this new concept and believes that it would begin to lead to an enhanced integration between the ACO and the beneficiary**. Currently, most beneficiaries are unaware of the presence of an ACO and even if they are a part of one. With the advent of an "opt in" assignment, ACOs can now begin marketing the ACO as an entity which could include quality statistics. This is similar to a selection of a network that employees enroll into on a yearly basis thus, would be familiar.

Participant List

In the current program, CMS requires the participant list to be at the TIN level and an ACO cannot add or drop throughout the year. However, if a TIN has poor quality, a group may terminate them from the ACO but then that TIN still remains on the participant list for the entire year. This greatly impacts ACO quality and also allows the poor performing TIN to have access to the five percent incentive bonus if the ACO is an Advanced APM. **APG believes that ACOs should be able drop poor performers from the participant list throughout the year. APG also recommends that ACOs be allowed to enter NPIs rather than just TINs on their participant list**. This would allow ACOs to select NPIs that are able to demonstrate high quality and efficient practice patterns thereby enhancing the ACOs performance.

Additionally, as the Qualifying APM Participant (QP) threshold increases, many ACOs participants are considering reconfiguring TINs into two separate groups for specialists and primary care providers in order to qualify as QP in the Advanced APM. Allowing NPI designation on the participant list would alleviate the additional burden of developing two TINs for multispeciality groups.

Benchmarking Methodology Refinements

Risk Adjustment

CMS is proposing to allow risk adjustment to both newly and continuously assigned beneficiaries per enrollment type – a modification from the current policy of an adjustment to only newly assigned. APG supports this change but believes that capping it at 3 percent is insufficient. **APG recommends that the cap is reconsidered and raised to at least 6 percent.** Additionally, the implementation of the cap based upon

benchmark 3 and performance year will lead to a larger percentage of participants exceeding the cap as the contract years go by. **APG recommends that the risk adjustment benchmark should be based upon a rolling methodology similar to the Next Generation ACO program**.

The change in adding regional benchmarking to the first agreement period is very beneficial for efficient providers that continue to struggle to beat historical benchmarks. **APG supports this modification but we believe that capping the regional portion at 50 percent is unnecessary and should remain at 70 percent to continue to support efficient providers**.

APG recommends that CMS convene a panel of experts to improve and strengthen the risk adjustment and benchmarking aspects of the program due to the inconsistency of the methodology between ACO models, MA, and other APM models including bundles.

Trend factors

CMS is proposing to move from a regional-only trend factor to a blend of regional and national. **APG strongly supports the movement away from regional only to a more blended approach, however, benchmark methodology should be modified in areas that have a low spending growth trend**.

The current proposed rule penalizes organizations with historically low spending growth by holding them to a higher standard than those who are in high spending growth areas. We propose that organizations that are 1) in regions with growth trends below the national average, and 2) have historical spending at or below 85 percent of the national average receive an additional three percent increase to their trend factor. This change to the benchmark would encourage organizations in California and other efficient areas to transition to a risk based APM instead of continued MIPS participation.

We understand that though the selection of risk adjustment and benchmarking methodology is crucial in the long-term sustainability of the program, CMS must balance the needs of the high/low cost and efficient areas.

APG recommends that CMS convene a panel of experts on an annual basis to improve and strengthen the risk adjustment and other benchmarking aspects of the program by exploring additional methods to adjust for variables outside the control of the ACO.

Program Data and Quality Measures

Meaningful Measures Initiative.

CMS, through the Meaningful Measures initiative, has committed to advancing measures that minimize burden on clinicians, improve outcomes for patients, and drive high-quality care. CMS is proposing eliminate quality measure 11 which assesses the ACO's level of adoption of Certified Electronic Health Record Technology (CEHRT) and rely on attestation. APG supports this; attestation is utilized and in other models

including the Next Generation ACO program and this change will help eliminated unnecessary burden.

APG urges the Agency to continue to work with stakeholders to reduce unnecessary quality measurements and better develop additional quality metrics in a way that supports support ongoing activities in the Patient over Paperwork and Meaningful Measures initiatives.

Specifically, **APG askes that CMS consider social determinants of health (SDOH) factors when risk adjusting ACO quality metrics**. Research had demonstrated that SDOH are significant driver of both cost and outcomes. It is critical that CMS consider these factors when evaluating ACO performance.

Conclusion

The Medicare Shared Saving Program provides an opportunity to advance risk-based coordinated care in traditional Medicare and is a component in moving our nation's delivery system from volume to value. Because of that, MSSP policies must be carefully crafted to not only encourage participation in the program but also incentivize the movement to two-sided risk models. Sustaining MSSP requires that CMS strike a balance between the needs of participating ACOs and the needs of the federal government.

While APG remains supportive of MSSP and we certainly hope to continue to work with CMS to strengthen and improve the program, we also recognize the advancement of other Advanced APMs and value-based models in MA. MSSP is an important program aimed at improving value in traditional Medicare, but APG also eagerly looks forward to the next iteration of value models in Part B including the forthcoming Direct Provider Contracting (DPC) model. APG has provided details based on our Third Option of how this model would work, and we are pleased to continue to provide expertise in this respect as CMS moves forward.

We thank you in advance for your consideration and appreciate the opportunity to submit these comments. Further, we offer ourselves and our members as a resource to you as you continue to work to strengthen Medicare ACOs. Please do not hesitate to contact me or my Federal Affairs staff (Valinda Rutledge, VP of Federal Affairs vrutledge@apg.org; Margaret Peterson, Director of Federal Affairs mpeterson@apg.org) with any questions you may have.

Sincerely,

Donald H. Crane
President & CEO
America's Physician Groups