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Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Verma:

On behalf of the AMGA, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) "Medicare Program: Medicare Shared Savings Program; Accountable Care Organizations – Pathways to Success," proposed rule (CMS-1701-P).

Founded in 1950, AMGA represents more than 450 multi-specialty medical groups and integrated delivery systems representing approximately 177,000 physicians who care for one-in-three Americans. Our member medical groups work diligently to provide innovative, high quality patient-centered medical care in a spending efficient manner. Many of our medical groups currently participate in the Medicare Shared Savings Program (MSSP), or the Accountable Care Organization (ACO), in the Track 1+ and Next Generation ACO demonstrations, the Comprehensive Primary Care + model, as well as other related Medicare demonstrations. AMGA, therefore, continues to have a very strong interest in improving population health, care quality and reducing Medicare spending growth.

We begin with a list of our key recommendations.

1. AMGA objects to CMS' persistence in measuring program performance against ACO benchmarks since they are not valid counterfactuals. For this reason, AMGA disagrees that spending relative to benchmarks serves as a justification for a more rapid transition into risk-bearing ACOs.
2. To allow providers a reasonable chance to succeed under the MSSP, CMS needs to improve program benchmarking to correct for current weak financial incentives. Moreover, CMS should discontinue use of historical spending in resetting subsequent agreement period benchmarks. This corrects for providers having to endlessly improve upon past performance. Instead, CMS should simply update benchmarks annually after the first performance period. The current use of a regional blend factor, however calculated, does nothing to address the underlying flaw of continuing use of historical spending.

3. Providers participating in the proposed ACO Basic track should have the option to remain in an upside-only track for three years, rather than the two years that CMS has proposed (essentially discounting PY 2019). That is, they should be given the option of a second year under Basic B. As proposed, new ACOs would receive 2.5 years of upside only; continuing Track 1 ACOs can sign a new five-year agreement on July 1, 2019 and get an additional two years of upside only, or they can sign a new agreement beginning January 2020 or January 2021 and receive an additional two years of upside only.
4. CMS' proposal of a 25 percent shared savings rate for Basic Levels A and B further weakens what are already nominal financial incentives. The shared savings rate should be no less than 50 percent for upside-only ACOs. Upside only "low revenue ACOs should receive higher earned shared savings, for example, 75 percent or 80 percent.
5. CMS' proposal to define high- versus low- revenue ACOs as those with revenue more than or less than 25 percent of their assigned beneficiaries' annual Part A and B expenditures is too restrictive. CMS should start at 30 percent and consider other metrics in distinguishing the two and/or define risk tolerance more granularly.
6. CMS' proposal to terminate an ACO from the program if it falls outside the negative Minimum Savings Rate (MSR) or Minimum Loss Rate (MLR) corridor is an unnecessary provision, as ACOs in the proposed glide path will assume financial risk. In addition, it cannot be determined that ACOs that fall outside of their negative corridor, are, in fact, losing the Medicare program money as benchmarks are not valid counterfactuals.
7. AMGA supports CMS' proposal to (more) accurately risk score the continuously enrolled by allowing scores to increase by a maximum of three percent over the five-year agreement period. We also recommend CMS work to improve Medicare risk scoring beyond use of Hierarchical Condition Category (HCC) coding via, for example, select use of Consumer Assessment of Health Plans (CAHPS) data.
8. As AMGA has argued previously, payment waivers for the Skilled Nursing Facility (SNF) 3-day rule and telehealth and Remote Patient Monitoring (RPM) should be available to all ACOs. We disagree with CMS' rationale for restricting these payment waivers to two-sided models. Whether at-risk or not, the waivers provide ACOs with the ability to ensure patients are receiving the most appropriate care in the most appropriate setting.
9. Per the Balanced Budget Act (BBA) of 2018, AMGA supports CMS' proposal to establish a voluntary beneficiary incentive program and a voluntary alignment program. AMGA believes other incentives should be added to incentivize beneficiaries to receive their care within an ACO "network."
10. AMGA supports a voluntary beneficiary opt-in based assignment methodology.
11. AMGA supports the use of additional codes in defining primary care services for the purposes of beneficiary assignment.
12. AMGA encourages the agency to issue a Notice of Proposed Rule Making (NPRM) or a Request for Information (RFI) that outlines proposed ways in which ACO providers can, within legal and regulatory restraints, actively coordinate beneficiary care with Part D providers.
13. AMGA also encourages CMS to better align quality measure reporting requirements across the Medicare program.
14. AMGA supports CMS' proposal to align certified electronic health record technology (CEHRT) across the MSSP and the Quality Payment Program (QPP). Currently set at 50 percent, this threshold would increase to 75% if CMS finalizes the increase in its pending Medicare Physician Fee Schedule rule and opts to align the programs in this MSSP proposal.

15. AMGA recommends CMS provide additional clarity before moving forward with its proposal to address quality performance, scoring, and any financial reconciliation for ACOs that were affected by “extreme and uncontrollable circumstances.”

Overview Comment

Over the past several years, AMGA has stated that the Medicare program, as well as commercial payers, should continue to move toward value-based payment arrangements. The current Fee for Service (FFS) payment model promotes volume of services provided and does not incent prevention or better patient health. AMGA members are leaders in moving to value and are heavily invested in the MSSP, in other Merit-based Incentive Payment System's Alternative Payment Models (MIPS APMs), and Advanced APMs, including the Next Generation ACO demonstration.

Concerning the MSSP, AMGA remains concerned that the program, since its inception in 2012, has suffered from weak financial incentives. Substantial evidence of this has been published in numerous [Health Affairs](#), [Journal of the American Medical Association \(JAMA\)](#), [JAMA Internal Medicine](#), and [The New England Journal of Medicine](#) articles and in other reputable publications by academic researchers. Because of weak incentives, the MSSP has produced limited financial savings to date. However, it is important to note that what savings the program has produced, including savings achieved by Track 1 ACOs, are widely under-appreciated. The belief persists that program performance can be measured against ACO benchmarks, or that they serve as valid counterfactuals. They do not. Program performance has been compromised by, among other reasons, flaws in the program's financial benchmarking formulas, both in benchmark updating and in resetting or rebasing. In addition, observers typically fail to fully account for or recognize favorable spillover effects, including those in the Medicare Advantage program.

We would also be remiss if we did not note that program quality improvement performance has markedly improved. In performance years 2016 and 2017, the mean composite quality performance scores were 93 percent and 91 percent respectively.

Because of weak financial incentives, we were not surprised to read, for example, in the Harvard Department of Health Care Policy comment letter dated September 18, “ACOs have had little incentive to ever lower spending because of the link between the spending reductions they achieve and subsequent benchmarks. One could argue that it is astonishing that the MSSP has produced any savings at all.” The current proposed rule suggests CMS believes it is time to create an MSSP 2.0. This is made evident in the proposed rule's executive summary where the agency argues the program needs to be “redesigned” or reinvented. Again, because of weak financial incentives, we do not believe the program needs redesign. The problem to date has been the lack of legitimate opportunity to succeed under MSSP 1.0.

AMGA recognizes the proposed rule offers several potential, if not real, improvements to the program. For example, the proposed rule would improve how the agency risk adjusts for the continuously assigned beneficiary. These improvements aside, the program has always been largely defined by how the agency calculates ACO benchmarks. CMS proposes to reform how the agency calculates established and reset or rebased benchmarks by revising its use of a regional blend. As we argue below, this proposed change, while well intended, cannot correct an inherently flawed benchmark formula. Incorporating a regional blend is problematic *per se*. Simply stated, we recommend the agency simply update annually an ACO's benchmark after

performance year one and not reset or rebase the ACO's benchmark using historical spending. This would obviate the need for a regional blend. Again, because the program suffers from weak incentives, commensurate with this change, we also recommend CMS substantially increase the percent of earned shared savings for those ACOs with comparatively low spending in their region. We also recommend the agency exclude an ACO's spending in calculating annual benchmark updates.

We believe that if the agency improves MSSP financial benchmarking by correcting for the perverse effects of the regional blend, and as we argue below, make improvements to risk adjustment, risk tolerance, quality performance benchmarking and beneficiary engagement, the agency can expect the provider community to continue to be enthusiastic MSSP participants.

Proposed Basic and Enhanced Tracks

Briefly summarized, CMS proposes to create two new ACO tracks: Basic and Enhanced. The Basic track would consist of five levels: A through E. Basic A and B would present no financial risk. Level C through E would pose increasing financial risk. By Level E, ACOs would face financial risk comparable to the current Track 1+. The proposed Enhanced track would be comparable to the current Track 3. Track 1, 1+ and Track 2 models would sunset. Under the proposed rule beginning July 1, 2019, newly formed ACOs that are also "low revenue" could participate under Basic A for ostensibly two performance years, or half of 2019, or July 1 through December 31, and all of calendar year 2020 and 2021. Existing or renewing Track 1 ACOs would have to begin with Basic B beginning July 1, 2019. Participating 2018 ACOs that sunset on December 31 of this year can continue in the program through June 30, 2019 without having their financial benchmark reset.

Essentially, CMS is reducing providers' current ability to participate in the MSSP at no risk from six years via two contracts of three years each. Under the proposed glide path, providers will have a maximum of two years before moving into a risk-bearing model. CMS' proposal to accelerate the transition from no risk to at risk is what the agency terms, a "pressing concern," for several reasons. The agency argues, in part, at risk or two-sided ACO models outperform no risk ACOs. Although AMGA rejects how CMS calculates savings in the MSSP, we understand CMS has concluded in 2016 that 68 percent of two-sided ACOs shared savings compared to 29 percent of Track 1 ACOs. CMS also notes 41 percent of "low revenue" ACOs' shared savings compared to 23 percent of "high revenue" ACOs. CMS is also concerned the presence of no risk or upside only ACOs may be encouraging marketplace consolidation.

We do not believe there is adequate information to conclude at risk ACOs out-compete no risk ACOs. Among other reasons, again, it has been convincingly demonstrated that ACO financial benchmarks are not legitimate counterfactuals. In addition, CMS admits that in 2016, 15 of 22 at risk Track 2 and 3 ACOs shared savings. This sample size is too small to draw a definitive conclusion.

While we support the move to risk-bearing agreements, our members have expressed concern that limiting upside agreements to two years does not take into account operational challenges in transitioning into an essentially new MSSP program. We believe CMS should offer a third, upside only year. Among other reasons, we offer seven. First, performance cannot or should not be measured relative to benchmarks. For example, up until 2017, benchmarks were updated annually using a national growth factor only, despite the fact spending growth varies

geographically. The national growth factor includes all beneficiaries, including those who had no calendar year spending. This compromises the accuracy of national updates; and, ACO spending reductions also are included in the national growth factor, further artificially lowering the update. In sum, benchmarks, specifically those of upside only ACOs, should not be used to rationalize accelerating risk agreements.

Second, assuming CMS finalizes many of the proposed changes in this rule, providers should be given adequate time to adjust to these regulatory changes. Essentially, CMS has created a new MSSP program and ACOs will need at least a year to understand how these new regulatory changes affect their operations. Additionally, while CMS has been diligent in working to ensure the timely sharing of ACO data, the fact remains that there is a year plus data lag to ACOs. Thus, ACOs will not truly understand how or whether their care management processes are working for more than a year after they enter the program.

Third, the program is reducing Medicare spending. In its September 18 letter, Harvard scholars estimate \$431 million in savings, particularly in post-acute care, over 2014 and 2015. Therefore, there is certainly no urgent need to impose downside risk. Fourth, CMS does not want to risk momentum in program participation, particularly among ACOs that are positive within their MSR corridor. Fifth, CMS should recognize upside only does not mean ACOs are at no risk of losing their investments in administrative and reporting costs. ACOs have invested in the necessary health information technology, care management processes, staffing, and related infrastructure to assume responsibility for a patient population. Logically, if Track 1 were not at risk, fewer providers would remain in the program. Instead, nearly half of the 2012-2013 Track 1 class and a third of the 2014 class have dropped out of the program. Sixth, the intended positive effect risk bearing imposes, that it will enhance savings, will be mitigated by, among other options, ACOs partnering with third-party management firms to limit their risk exposure. Finally, CMS should critically evaluate whether there is, in fact, a correlation between upside only agreements and industry consolidation, as the agency suggests there is. We see no evidence that supports this belief.

Specifically, AMGA supports the agency's proposals to:

- Extend the current agreement period from three to five years
- Allow ACOs to select their Basic level prior to the start of a performance year
- Allow ACOs in any Basic and the Enhanced track the flexibility to change their selection of beneficiary assignment methodology, either prospective or prospective with retrospective reconciliation, prior to the start of the performance year
- Allow ACOs to forgo the formal 2019 application cycle
- Allow ACOs with a participation agreement ending date of December 31, 2018, or the 2012 and 2013 ACOs and the 2016 ACOs, to extend their current agreement to June 30, 2019
- Allow existing ACOs to terminate their agreement effective June 30, 2019 and restart under a new five year agreement on July 1, 2019
- Allow existing Track 1s, defined as "inexperienced," that enter the Basic track on July 1, 2019 to remain in Basic B until January 2021
- Allow existing Track 1s that choose to complete their current agreement the choice to re-enter the program under Basic B, C, D or E

- Allow ACOs in all other current tracks to continue under their existing agreement until they expire
- integrate Track 1+ into the MSSP
- allow Track 2 ACOs the option to elect to enter the proposed Enhanced track or elect to enter the proposed Basic track at the highest level of risk or Level E
- allow low revenue ACOs the ability to transition from Basic to Enhanced after a single agreement period under Basic while retaining the opportunity to return to the Basic
- gradually increase risk thresholds at Basic Level C and Level D at two and four percent of revenue, respectively, and set Basic Level E at the current Track 1+ risk level.

AMGA recognizes providers need a glide path to succeed under the MSSP. We believe if CMS makes the appropriate improvements to the MSSP discussed below, providers will have an improved glide path to succeed under incremental financial risk as proposed in this rule.

Use of Regional Factors When Establishing and Resetting ACOs Benchmarks

Because CMS currently resets financial benchmarks using historical spending based on the ACO's immediately previous three performance years, or their just concluded agreement period, it becomes increasingly difficult for ACOs to improve upon their past performance. For this reason, CMS in 2016 introduced a regional adjustment to the reset or rebased historical benchmark beginning with the ACO's second agreement period.

CMS is now proposing to include a regional adjustment to initial ACO agreements beginning July 1, 2019 and to all subsequent agreements. CMS also proposes to revise the regional blend weights. Specifically, CMS proposes to continue to apply a first time 35 percent regional weight if the ACO's historical spending was lower than its region and a 25 percent regional weight if the ACO's historical spending was higher than its region. However, in subsequent agreement periods, CMS is proposing to reduce the regional blend weights. For second agreement periods, CMS is proposing to apply a regional weight of 50 percent if the ACO's historical spending was lower than its region and 35 percent if the ACO's historical spending was higher than its region. In third and subsequent agreement periods, the regional blend would be 50 percent for all ACOs.

CMS argues it is lowering the regional blend weights because in instances where the ACO's spending is lower than its region, "low-spending ACOs," the agency states, "may become overly inflated to the point where these organizations need to do little to maintain or change their practices to generate savings." The regional blend also presents a problem regarding ACOs with spending comparatively higher than their region. For ACOs with comparatively higher spending, a regional blend is a disincentive for them from participating in the program or continuing to participate in the program, particularly when the agency is proposing to require ACO participants to take on financial risk earlier. As Dr. J. Michael McWilliams and his Harvard colleagues reported in their September 18 letter in response to the proposed MSSP rule, "introduction of the regional adjustment in 2017 was associated with a 21 percent drop out in the 2014 ACO cohort," and these were the ACOs that "had higher spending for their region than those who remained in the program." McWilliams terms this problem, "cost-increasing selective participation" because the selective drop out of ACOs with comparatively higher spending creates perverse incentives.

The agency's proposal to mitigate the perverse effects of the regional blend is inadequate. It does nothing to solve the inherent problem: the agency's policy to reset or rebase an ACOs benchmark using their historical spending. If the agency addressed or remedied this problem

there would be no need for adding a regional blend. Not surprisingly, McWilliams and his colleagues conclude, “we recommend replacing the regional adjustment with higher shared savings rates for ACOs with lower spending for their service area.” They recommend shared savings rates rise continuously from a minimum of 50 percent for ACOs with comparatively high regional spending to shared savings rates at 80 percent for ACOs with comparatively low regional spending. They recommend also the agency use two years of data to assess an ACO's spending relative to their region. While we are not certain these shared savings percentages are perfect, they improve upon current weak financial incentives, and help level the playing field between high and low spending ACOs. They would not, as McWilliams and his colleagues argue, mean higher shared savings would decrease net savings to the Medicare program. They argue, for example, higher shared savings rates would attract more provider participation and provide additional motivation to lower spending. Eliminating a regional blend would also obviate the need, as CMS proposes, “to cap the regional adjustment amount using a flat dollar amount equal to the 5 percent of national per capita expenditures.”

We noted the impetus for adding a regional blend was to mitigate the problem of resetting benchmarks using, or still using, an ACO's historical spending. We further recommend the agency abandon the practice of benchmark resets in all subsequent ACO agreement periods. Here again, logic forces us to agree with Dr. McWilliams and his colleagues. In their September 18 letter, they recommend, “Eliminate rebasing of benchmarks that links an ACO's new benchmark to its spending changes in the prior period. This link should be completely severed. Instead, the ACO's original baseline should be updated annually according to a growth rate that is unrelated to its prior performance, adjusting for changes in the ACOs' participating providers.” Resetting or rebasing an ACO's benchmark, which would occur every five years under the proposed rule, “greatly diminishes ACOs' incentives to ever save because,” McWilliams, et al. write, “spending reductions now are penalized with lower benchmarks later.” Because of the link between spending reductions and subsequent benchmarks, they go so far as to state, “it is astonishing that the MSSP has produced any savings at all.” They note, not surprisingly, that just prior to 2016 when the 2012-2013 class would be required to have their benchmarks reset, 23 percent dropped out of the program, or nearly four times the percent the left the program in both 2013 and 2014. While we do not support the continued use of a regional blend in resetting or rebasing and now, as CMS proposes, in establishing benchmarks as well, we want to make clear AMGA continues to support the use of regional spending in calculating annual benchmark updates.

We also are obligated to note as we have in past comment letters our concern that CMS continues to include an ACO's spending on its assigned beneficiaries in calculating annual benchmark updates. This formula is increasingly problematic as ACOs account for an ever-increasing percentage of the FFS population in their region. This is the same problem or error in ACO benchmark resetting. This approach makes it difficult to determine if ACOs are reducing spending compared to a counterfactual.

In sum, via these benchmark-related changes, CMS has the opportunity to simplify the program, increase financial incentives, level the playing field, improve participation and retention, and drive greater savings.

Levels of Risk and Reward in the Basic Track's Glide Path

For Basic Levels A and B, CMS is proposing a final earned shared savings rate of 25 percent based on quality performance to first dollar shared savings for ACOs that meet or exceeded their MSR. Earned shared savings would not exceed 10 percent of the ACO's updated benchmark, consistent with current Track 1 policy. Basic Level C would be able to earn upwards of 30 percent in earned shared savings. Since Level C is at risk, shared losses would not exceed two percent of total A and B revenue. If this amount exceeds one percent of the ACO's updated benchmark the loss sharing limit is capped at one percent of the updated benchmark. Level D risk allows for upwards of 40 percent in earned shared savings with shared losses not to exceed four percent of total A and B revenue, or two percent of the updated benchmark. Level E would allow for upwards of 50 percent in earned shared savings with shared losses commensurate with the revenue-based loss-sharing limit for an Advanced APM.

As noted above, current MSSP financial incentives are weak. Beyond benchmark updating and resetting problems, current financial incentives are further diluted by the fact that ACOs bear the upfront and ongoing costs of program participation. In addition, ACO quality performance benchmarking, distinctly unlike the Medicare Advantage Star quality program, remains downside only. An ACO's quality performance benchmark multiplier cannot be better than 1.0. In effect, CMS' proposal to further weaken already inadequate financial incentives will only make matters worse. Therefore, AMGA cannot support CMS' proposal to reduce shared savings to below 50 percent. Instead, to maintain an incentive for program participation, the shared savings rate should be 50 percent for upside-only ACOs. More specifically, stronger financial incentives should be offered to "low revenue" ACOs and those ACOs taking increasing levels of risk. They should be able to earn shared savings up to 75 percent or 80 percent.

Differentiating Between Low Revenue ACOs and High Revenue ACOs

CMS proposes low and high revenue ACOs for the purposes of further defining participation options.

CMS proposes to define a low revenue ACO as one whose revenue is below 25 percent of its assigned beneficiaries' total Part A and B expenditures for the most recent calendar year. CMS defines high revenue as an ACO with revenue that is at least 25 percent of its beneficiaries' Part A and B expenditures. Low revenue ACOs tend to be, CMS' analysis found, physician-only and/or rural based ACOs. High revenue ACOs would tend to be or include a hospital. With more control over their total spending and/or being better capitalized, high revenue ACOs, CMS argues, should be more ready and capable of accepting higher financial risk. Low revenue ACOs less so. As noted above, for purposes of ACO participation, CMS is proposing to allow low revenue ACOs to participate in Basic for as long as two, five-year agreement periods.

CMS seeks comments on their proposed definition of low and high revenue, any alternatives including defining by hospital-based and physician-led based on their Tax Identification Number (TIN) composition, and differentiating low and high by the size of their assigned populations.

In theory, AMGA supports the distinction between low and high revenue ACOs. There is intuitive logic that risk tolerance be commensurate with organization size or financial wherewithal. In practice, low volume ACOs would be afforded the opportunity to participate at lower risk thresholds for a comparatively longer period. CMS notes its analysis found that 88 percent of self-reported small, physician only and rural ACOs met the 25 percent threshold. This point

aside, since self-reporting is imperfect, should the agency finalize this distinction, we recommend the agency begin with a 30 percent threshold or margin to account for physician groups with a comparatively larger number of specialists. Over time, the agency can adjust the percent threshold as their ability to discriminate improve. We also recommend CMS consider more than two revenue definitions or categories. The proposed distinction may be too stark. Concerning alternative definitions using self-reported composition, TINs, and size of an ACO's assigned beneficiary population, we similarly encourage the agency to consider using more than one metric or data point in differentiating ACOs. That is, low and high revenue could and should be defined by multiple criteria.

Minimum Savings Rate and Minimum Loss Rate

In CMS' final June 2015 MSSP rule, the agency offered at-risk ACOs the option to select a MSR/MLR that will apply for the duration of the ACO's 3-year agreement period. Under current policy, ACOs applying to participate in a two-sided model may select from three options: 0% MSR/MLR, symmetrical MSR/MLR in 0.5% increments between 0.5% and 2.0%, and an upside/downside symmetrical MSR that varies based on the ACO's number of assigned beneficiaries.

CMS is proposing to maintain the same MSR/MLR options—both for one-sided and two-sided models—as applicable to the model under which the ACO is participating in the Basic glide path. Therefore, one-sided models would have a variable MSR based on the ACO's number of assigned beneficiaries. Those in two-sided models--Basic C, D or E--would select from the options outlined above before the start of their first performance year under risk. This would also apply if an ACO elects to transition more quickly in the glide path or from Level A to Level C or beyond.

AMGA supports this proposal.

Risk Adjustment Methodology for Adjusting Historical Benchmark Each Performance Year

ACO stakeholders have criticized the agency's policy using a risk scoring methodology that differs between newly assigned and continuously assigned ACO beneficiaries. CMS uses Hierarchical Condition Category (HCC) prospective risk scores to account for changes in severity and case mix for newly assigned ACO beneficiaries between the third benchmark year and the performance year for newly assigned beneficiaries and in subsequent agreement period performance years. CMS uses demographic factors only to adjust risk scores for the continuously assigned ACO beneficiaries, or those that are assigned to the ACO year-over-year through the performance agreement. As the proposed rule reminds stakeholders, "if the CMS-HCC prospective risk scores for the continuously assigned population are lower in the performance year, we use the lower CMS-HCC prospective risk scores to adjust for changes in severity and case mix in this population."

In the proposed rule, CMS states the agency's "preferred approach would eliminate the distinction between newly and continuously assigned beneficiaries." However, the agency has been reluctant to do so because of concerns regarding coding intensity. Nevertheless, CMS admits in its examination of the continuously enrolled in 2016, 86 percent of those continuously enrolled in an ACO would have received a larger positive adjustment to their benchmark had they been coded the same as the newly enrolled. The agency's concern is that perpetuating this policy for the continuously enrolled could incent ACOs to avoid complex patients. Therefore, CMS is proposing a symmetrical cap of a positive or negative three percent for the agreement

period such that between Benchmark Year 3 (BY3) and any performance year there would never be more than a three percent adjustment in either direction. The proposed change would take effect July 1, 2019.

AMGA has argued for years that CMS more appropriately or accurately risk score the continuously enrolled. Therefore, we strongly support this proposed change. While CMS notes their study of risk score trends shows that for ACO aged/non-dual beneficiaries, the enrollment category that represents the majority of assigned ACO beneficiaries, less than 30 percent of ACOs would see limited positive risk adjustment. We appreciate CMS providing this data point, however, we encourage CMS to make fully transparent their research related to this finding, or its findings on the three other ACO assigned beneficiary categories.

In addition, we believe CMS can always do more to improve Medicare risk scoring, or move beyond HCC coding. For example, in a March 2016 *Health Affairs* article, Sherri Rose and her colleagues reported that their “findings suggest that a regional benchmark adjusted only for standard claims-based variables could unfairly penalize ACOs serving sicker patients.” As a remedy, these researchers argue, “the ACO CAHPS survey could provide valuable additional information for risk adjustment purposes” such as measures of functional status. Use of CAHPS data, the researchers argue, could also be used to detect upcoding and thus allow CMS to evolve beyond the agency's proposed three percent cap for the continuously enrolled.

Monitoring For Financial Performance

“Now that we have additional experience with monitoring ACO financial performance,” CMS states, “we believe that the current regulations are insufficient to address recurrent poor financial performance.” CMS states further, “some ACOs may not have sufficient incentive to remain accountable for the expenditures of their assigned beneficiaries.” Therefore, CMS is proposing to “monitor for whether the expenditures for the ACO's assigned beneficiary population are “negative outside corridor.” If an ACO falls outside or beyond its negative MSR or MLR corridor, CMS is proposing pre-termination actions. If the ACO falls beyond its negative MSR or MLR corridor for another year, CMS proposes to terminate the ACO's participation. CMS notes only 19 of 194 of first year Track 1 ACOs that renewed (in 2016) fell outside of their negative corridor in their first agreement period. The agency observed similar performance results for ACOs that started their first agreement period in 2014 and 2015.

AMGA certainly supports agency efforts to protect Medicare beneficiaries and Medicare trust funds. That said, since again benchmarks are not valid counterfactuals, it is impossible to determine whether ACOs that fall below or outside their negative MLR corridor are losing the Medicare program money. Even assuming ACOs falling outside their negative MLR corridor are, in fact, losing money, should the proposed rule go final, participating ACO providers will have significantly less time participating in upside only or no risk agreements or significantly less time to be “unaccountable for the expenditures of their assigned beneficiaries.” That is how the proposed Basic glide path remedies or solves for this problem. We will add, somewhat ironically, ACOs outside their negative MLR corridor are saving money in the sense that they are not earning shared savings.

Under this discussion, CMS also notes the agency “considered prohibiting ACOs from obtaining reinsurance to mitigate performance-based risk.” The agency therefore seeks comment on “ACOs' use of reinsurance, including their ability to obtain viable reinsurance products covering a

Medicare FFS population.” Considering the program's history of weak financial incentives, flawed financial benchmarking, limits on risk adjustment, and downside only quality performance benchmarking, we find it difficult to believe prohibiting at risk ACO providers from purchasing reinsurance would ultimately benefit participating ACOs and the Medicare program.

SNF 3-Day Rule and Telehealth Waiver Rules

As we argued in our February 2015 comments in response to CMS' December 2014 proposed MSSP rule, the SNF payment waiver should be made available to all ACOs. First, because the SNF 3-day waiver dates back to the inception of the Medicare program more than 50 years ago, we agree with former Medicare Payment Advisory Commission Chairman Glenn Hackbarth's assessment that the rule has become “archaic.” The SNF rule was created when mean hospital lengths of stay were substantially more than twice what they are today. Meeting the 3-day rule in the 1960s was easily accomplished. Today that is no longer the case. Second, the proposed rule recognizes ACO program participants need a glide path to risk. As we wrote in our 2015 comments, providers need the ability to reform their practice patterns before they are required to take on financial risk. The SNF and telehealth waivers enable providers an ability to do this. Intentionally denying them these tools, in effect, compromises the success of the program. Third, the benefit of prolonging a beneficiary's hospital stay such that he or she qualify for a SNF admission is far outweighed by the potential iatrogenic harm extended hospital stays present. Finally, five years of performance data demonstrate program savings have been substantially driven by reductions in SNF utilization, which lends evidence that the ACO provider community is uninterested in abusing SNF care.

CMS continues to argue in this proposed rule, risk-bearing models have more impetus “to engage in systematic change, promote accountability for a patient population and coordination of a patient medical care, and encourage investment in redesigned care processes.” Even assuming this statement were true, it is neither a reason to deny no risk providers these waivers, nor an either-or instance.

AMGA does, however, support CMS' proposal to allow preliminary prospectively assigned beneficiaries to remain eligible for the 3-day SNF rule waiver for the remainder of the performance year regardless of if their assignment status changes during the performance year. Effectively, beneficiaries would remain eligible to receive SNF services under the waiver unless they meet one of two exceptions: they enroll in a Medicare health plan or are no longer enrolled in Part A or Part B. AMGA has no objection to this proposal.

Beneficiary Incentives

The Bipartisan Budget Act (BBA) of 2018 included a provision that allows ACOs to apply to operate a beneficiary incentive program. Specifically, the provision allows an ACO to make an incentive payment of up to \$20, in the form of a cash equivalent, for each qualifying service furnished to an ACO assigned beneficiary. The incentive payment, which CMS proposed to begin July 1, 2019, would be made by the ACO, not the Medicare program, and the ACO is responsible for all costs in establishing and operating the program. A participating ACO can, however, use earned shared savings to fund these payments. Payments made are disregarded in calculating an ACO's benchmark. CMS is proposing to allow ACOs participating in two-sided risk models only to participate regardless of the ACO's beneficiary assignment choice.

AMGA supports this voluntary program but strongly believes it should be available to all ACOs. As we note in this comment, CMS needs to create a set of incentives for all ACOs to provide opportunity for success in the MSSP program. To further incent beneficiary participation and reduce leakage (discussed directly below) AMGA also supports CMS waiving ACO assigned beneficiary co-pays and deductibles if they remain within the ACO “network”.

Revisions to Policies on Voluntary Alignment

The BBA of 2018 also allows Medicare FFS beneficiaries to voluntarily identify an ACO provider as their primary care provider for the purposes of the beneficiary's assignment to the ACO. These beneficiaries would be assigned prospectively to an ACO's list of assigned beneficiaries beginning with the subsequent performance year – though the beneficiary would retain their right to change their designation at any time. The MSSP currently allows a beneficiary to select an ACO provider, however, only if the provider meets one of the MSSP primary specialty designations. To satisfy the BBA of 2018, CMS proposes to assign a beneficiary to an ACO based upon his or her selection of any ACO professional, regardless of specialty, as their primary care clinician. Under this definition of voluntary alignment, CMS is removing the requirement that the ACO professional designated by the beneficiary be a primary care physician as defined under current MSSP regulations. The BBA also allows the beneficiary to align with an ACO independent of whether the beneficiary has received any services from the ACO provider. This means CMS is removing the requirement that a beneficiary must have received at least one primary care service from the ACO professional. The beneficiary will remain assigned to the ACO in which the provider participates during the entire ACO agreement period and subsequent agreement periods even if the beneficiary no longer seeks treatment from the ACO. However, CMS is proposing an exception that would limit voluntary assignment when the beneficiary also is eligible for assignment to an entity participating in a CMS Innovation Center demonstration being tested or expanded.

AMGA has supported efforts to improve or expand methods by which a Medicare beneficiary can participate in or receive care from an ACO. At least in theory, allowing for voluntary alignment addresses two problems. First, as Lynn Barr and her colleagues noted in their May 11 [Health Affairs](#) Blog essay, an ACO with 5,000 assigned beneficiaries, the program minimum, have a 10 percent chance of randomly earning shared savings. Providing additional avenues to grow an ACO's assigned beneficiary population helps to some extent mitigate this problem. Voluntary alignment would as well, at least in theory, help reduce program leakage, whereby the assigned beneficiary receives some or all of their care outside their assigned ACO. For example, the January NORC at the University of Chicago evaluation of the Next Generation ACO (NGACO) demonstration found that 37 percent of NGACO assigned beneficiaries received their care outside the NGACO network and 47 percent received their care both in and out of the NGACO network. Leakage is particularly problematic when ACO assignment is prospective. However, we do not believe it would be counterproductive to assign voluntarily aligned beneficiaries that have not sought care via the ACO in subsequent agreement periods, particularly when agreement periods are proposed to extend to five years. It would exacerbate the leakage problem.

Beneficiary Opt-In Based Assignment Methodology

In the proposed rule CMS states, the agency is “considering implementing an opt-in based assignment methodology.” As detailed, CMS “would allow, but not require, ACOs to elect an opt-in based assignment methodology.” For those ACOs that have elected this methodology, CMS would use a hybrid assignment approach that would be based on “opt-ins, supplemented

by voluntary alignment and modified claims-based methodology.” Opt-ins would be assigned prospectively. If the beneficiary did not opt-in or voluntarily align, then the beneficiary would be assigned under this methodology to the ACO only if he or she received at least seven primary care services from one or more of the ACO’s primary care providers. Beneficiaries would not be assigned even if they simply received a plurality of their primary care services from the ACO. Currently, only approximately 25 percent of ACO beneficiaries would meet the threshold assignment of seven primary care services. CMS identifies a seven services minimum, “because it would enable such ACOs to focus their care coordination activities on beneficiaries who have either opted-in to assignment to the ACO or voluntarily aligned with the ACO or who are receiving a high number of primary care services from ACO professionals and may have complex conditions requiring coordination.” ACOs participating under this methodology would retain their ability to select prospective or prospective with retrospective reconciliation assignment. CMS is also seeking comment on whether to establish a geographic limitation on this methodology such that the beneficiary would be limited to ACOs located near the beneficiary’s residence. CMS argues this approach could be more preferable than an opt-in only and/or a voluntary alignment approach (where currently 92 percent of the voluntarily aligned were already assigned to the same ACO using the existing claims-based assignment methodology). It would likely provide stronger statistical confidence in determining financial performance and provide stronger incentives for ACOs and their participants to improve care delivery. CMS is also seeking comment on whether the agency should assign beneficiaries to all ACOs using this hybrid assignment approach.

AMGA supports the proposed opt-in based assignment methodology, as long as ACOs can voluntarily participate. Concerning a geographic limitation, while we recognize this would be difficult to formulate, we agree in principle that there be geographic limits placed in assigning ACO beneficiaries.

Revisions to the Definition of Primary Care Services Used in Beneficiary Assignment

CMS is proposing to amend the definition of primary care services for the purposes of ACO beneficiary assignment by adding an additional six Current Procedural Terminology (CPT) codes and three Healthcare Common Procedure Coding System (HCPCS) codes. The CPT codes concern advance care planning, health risk assessments, psychotherapy services, annual depression screening, alcohol misuse screening and alcohol misuse counseling. The three HCPCS codes are those created in the recent proposed Physician Fee Schedule rule: GPC1X; GCG0X; and, GPPRO1.

AMGA supports the use of these additional codes.

Program Data and Quality Measures

As part of the agency’s Meaningful Measures initiative, CMS is focused on “updating quality measures, reducing regulatory burden, and promoting innovation.” CMS also notes in the proposed rule that it is “important that the quality reporting requirements” under the MSSP “align with the reporting requirements” under other Medicare initiatives, as well as other payers, to “minimize the need for Shared Savings Program participants to develop excessive resources in understanding differences in measure specifications or engaging in duplicative reporting.” As part of this effort, CMS is requesting comments and recommendations on how to “further advance the quality measure set” for ACOs. As a related aside, we note in the CY 2019 Medicare Physician Fee Schedule (PFS) proposed rule, CMS noted its intention to reduce the

total number of quality measures in the MSSP measure set by seven in an effort to “reduce the burden on ACOs and their participating providers.”

In our response to the proposed CY 2019 PFS, we repeated our concern that the agency begin to measure for value, and correlate quality and spending or outcomes achieved relative to spending. Absent measuring for value, we wrote CMS has created a situation in which the Medicare program is “perversely awarding earned shared savings to ACOs that have comparatively worse quality than the worse performing ACOs or those falling below their negative medical savings or loss ratio.”

We are encouraged by CMS’ desire to align quality measure reporting requirements across Medicare programs. As we also noted in our PFS comments, “we see no reason why the MSSP and the Medicare Advantage program’s quality measures are different.” Among numerous others, former Center for Medicare and Medicaid Innovation (CMMI) Deputy Director Sean Cavanaugh made this same argument in his recent October 3 testimony before the Senate Aging Committee. For example, among the proposed 24 MSSP 2019 measures, less than half are also included in the Medicare Advantage Star Ratings program. We are also encouraged CMS to begin to adopt a more routine use of patient reported outcome measures.

Promoting Interoperability

CMS indicated its “desire to continue to promote and encourage” ACOs to use certified electronic health record technology (CEHRT) and align any requirements with the MACRA Quality Payment Program (QPP). To that end, CMS is proposing to add a requirement that all ACOs “demonstrate a specified level of CEHRT use in order to be eligible to participate” in the MSSP. Concurrent with this new requirement, CMS is proposing to retire the MSSP’s EHR quality measure (ACO-11) effective January 1, 2019.

For ACOs that do not meet the financial requirements to qualify as an Advanced APM, CMS is proposing to require ACOs to certify that at least 50 percent of their eligible clinicians use CEHRT to document and communicate clinical care to their patients and other providers. This requirement, CMS notes, would align the MSSP with other care delivery models, including those being tested by the Center for Medicare and Medicaid Innovation (CMMI). Of note, this requirement would not relieve MIPS eligible clinicians who are participating ACOs from their need to report in the MIPS Promoting Interoperability performance category.

CMS also is proposing that in order for an ACO to qualify as an Advanced APM, the ACO must certify that the percentage of eligible clinicians participating in the ACO meet or exceed the CEHRT thresholds as required by the QPP. Current regulations set this threshold at 50 percent. However, as proposed in the pending Physician Fee Schedule (PFS) rule for performance year 2019, CMS would require Advanced APMs under the QPP to meet a 75 percent CEHRT threshold. CMS is seeking comment on whether this higher threshold “may be warranted now or in the future” for the MSSP. The MSSP proposal would align the CEHRT requirement with the QPP regulation for those ACOs that meet the financial risk criteria to qualify as an Advanced APM. This effectively would impose the higher threshold requirements on the Basic Level E and Enhanced tracks.

Should the PFS increase the CEHRT threshold requirement to 75 percent, in finalizing this proposed rule, CMS should match the percent. CEHRT threshold percentages should be aligned across APM models.

Coordination of Pharmacy Care for ACO Beneficiaries

In the proposed rule, CMS notes briefly ACOs stakeholders continue to express interest in improving care coordination and collaboration with Medicare Part D drug plans to “reduce the risk of adverse events and improve medication adherence.” CMS provides a number of examples of how ACOs and Part D plan sponsors might collaborate. For example, CMS states ACOs and Part D plan sponsors may be able to enter business arrangements to “support improved pharmacy care coordination.” CMS is requesting comment on how MSSP ACOs and Part D plan sponsors could work together to improve coordination of pharmacy care for Medicare FFS beneficiaries. CMS also is requesting comment on what type of support Medicare ACOs would need from CMS to establish new and innovative business arrangements to promote pharmacy care coordination. CMS also is interested in existing arrangements and what current barriers to coordination exist.

AMGA is interested in exploring ways to improve coordination between ACO providers and Medicare Part D plans – while avoiding anti-kickback and related legal restrictions. As our members and the agency are well aware, Medicare spending on Part D benefits will reach \$92 billion this year, or more than 16 percent of net Medicare expenditures. As has been widely reported, this spending has been rapidly trending upward, as the average annual rate growth in Part D costs per beneficiary has increased to 4.4% annually between 2013 and 2016, as compared to 2.4% between 2007 and 2013. This growth is expected to continue, due in part to the costs associated with specialty drugs. Therefore, we encourage the agency to publish in 2019, a proposed rule or Request for Information (RFI) that outlines ways in which ACO providers can, within legal and regulatory restraints, actively coordinate and/or partner with Part D plans.

Extreme and Uncontrollable Circumstances Accommodation

In previous rule making, CMS established policies for how to address quality performance, scoring, and any financial reconciliation for ACOs that were affected by “extreme and uncontrollable circumstances” – namely the 2017 California wildfires and Hurricanes Harvey, Irma, Maria, and Nate. CMS finalized a policy that would be applied if 20 percent or more of an ACO’s beneficiaries resided in an emergency declared area as determined under the QPP or if the APM Entity is located in such an area. Now, CMS is proposing to extend this policy to performance year 2018 and subsequent years. CMS also is proposing to apply these policies to the MSSP’s quality reporting period; if an ACO is unable to submit data to CMS, the agency would not be able to measure the ACO’s quality performance. However, CMS may opt not to include the quality-reporting period under the extreme and uncontrollable circumstances policy if the quality reporting period is extended. CMS indicated this would provide the ACO with an additional opportunity to submit quality data, making additional accommodations superfluous.

Regarding the quality-reporting period, AMGA would ask that CMS provide clarification on how the agency would determine and announce whether the extreme and uncontrollable policies are governing, or if the reporting period will be extended. CMS notes the possibility of extending the reporting period in both this proposed rule and the December 2017 Interim Final Rule with a Comment Period that originally established the policies for assessing the financial and quality performance of MSSP ACOs affected by extreme and uncontrollable circumstances. However,

CMS is silent on when or why the reporting period would be extended. Before moving forward with this policy, CMS should explain its decision making process.

Should CMS make a determination that an ACO is facing extreme and uncontrollable circumstances, it is proposing the following.

- The ACO's minimum quality score would be set to equal the mean quality performance score for all Shared Savings Program ACOs for the applicable performance year.
- The higher of the ACO's quality performance score or the mean quality performance score for all Shared Savings Program ACOs would be used for ACOs that are able to "completely and accurately report all quality measures." If the ACO's quality performance score is used, the ACO also would be eligible for quality improvement points.
- If the ACO receives the mean Shared Savings Program quality performance score, the ACO would not be eligible for bonus points awarded based on quality improvement during the applicable performance year.
- If an ACO receives the mean Shared Savings Program ACO quality performance score for a performance year, in the next performance year for which the ACO reports quality data and receives a quality performance score based on its own performance, CMS would measure quality improvement based on a comparison between the ACO's performance in that year and in the most recently available prior performance year in which the ACO reported quality.

Regarding determining the benchmark of an area affected by an extreme and uncontrollable circumstance, CMS considered adjusting the benchmark to account for disasters that occur during a benchmark year. However, CMS opted instead to rely on its regional adjustment factor policy to account for any variations in expenditures. CMS is seeking comment on this proposal. We would refer CMS to our comments on the problems with the regional blend. Absent a reform that addresses the underlying issue with the regional adjustment factor, applying it to ACOs in a region recovering from an extreme or uncontrollable circumstance will perpetuate the flaws.

We thank CMS for consideration of our comments. Should you have questions please do not hesitate to contact AMGA's David Introcaso, Ph.D., Senior Director of Public Policy at (703) 842.0774 or at dintrocaso@amga.org.

Sincerely,



Jerry Penso, M.D., M.B.A.
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