

March 25, 2016

Mr. Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

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

Dear Acting Administrator Slavitt:

The undersigned organizations submit the following comments and recommendations in response to the proposed rule, *Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations—Revised Benchmark Rebasing Methodology, Facilitating Transition to Performance-Based Risk, and Administrative Finality of Financial Calculations*, as published in the *Federal Register* February 3, 2016. The signatories to this letter include organizations representing physicians, hospitals, medical group practices, academic medical centers and nearly all existing Medicare Shared Savings Program (MSSP) ACOs.

Our recommendations reflect our unified expectation and desire to see the MSSP achieve the long-term sustainability necessary to enhance care coordination for Medicare beneficiaries, lower the growth rate of healthcare spending and improve quality in the Medicare program. Specifically, our key goals for the MSSP include encouraging increased participation, enabling existing ACOs to continue in the program and creating a successful, long-term ACO model for Medicare. Although 100 new ACOs joined the MSSP in 2016, to date over 30 percent of ACOs who joined in 2012 or 2013 have chosen to leave the program. These early adopters faced significant challenges meeting program requirements, as have many ACOs that remain in the program, particularly those that have not yet earned shared savings. It is in Medicare's interest for ACOs to endure in the program and to continue providing high quality care for Medicare beneficiaries and to reduce the growth rate of Medicare spending. While we recognize and appreciate CMS's efforts in this notice of proposed rule-making (NPRM) to improve program methodologies to retain and attract ACOs, we emphasize the critical need for the agency to further modify the program to address other critical issues such as quality measurement, risk adjustment and unstable assignment to ensure a successful future for this program.

Summary of Recommendations

In general, we support the proposal to incorporate a component of regional cost data into ACO benchmarks. If executed correctly, such changes will attract new ACOs while retaining existing participants and ultimately improving the long-term viability of the program. Given that our analyses show ACOs on average spend three percent less than comparable fee-for-service (FFS) expenditures, it should remain a priority of the Secretary to refine the model in ways that will promote further program growth. In this letter we urge CMS to modify aspects of the proposed benchmarking

methodology, and we provide additional recommendations pertaining to other proposed changes. Specifically, we recommend that CMS:

1. Finalize, with modifications, the proposal to blend ACO historical and regional cost data into ACO benchmarks
2. Provide ACOs with choices related to transitioning to new benchmarks that incorporate regional cost data
3. Exclude ACO-assigned beneficiaries (for all ACOs in the region) from the regional beneficiary population
4. Finalize the use of assignable beneficiaries (as opposed to all beneficiaries) for nationally-based updates, regionally-based updates and regional cost calculations
5. Base the counties used to define an ACO's regional service area on those in which at least one percent of the ACO's assigned beneficiaries reside
6. Consider a different approach to ensure a statistically valid population for calculating regional end stage renal disease (ESRD) costs rather than using state averages, at least until CMS releases data to properly evaluate basing regional ESRD costs on state-level averages
7. Finalize the proposal to adjust for an ACO's risk relative to its region for the purposes of determining the regional adjustment to the ACO's reset historical benchmark
8. Replace the national trend factor with a regional trend factor for ACOs in second and subsequent agreement periods
9. Honor the current policy that accounts for savings in rebased benchmarks
10. Provide stakeholders with data to model the impact of adjusting benchmarks to account for ACO Participant Taxpayer Identification Numbers (TIN) changes
11. Finalize the optional fourth year in Track 1 for ACOs moving to Track 2 or 3 and allow ACOs to transition to a higher risk track at the start of any calendar year rather than solely at the end of their agreement periods
12. Modify and enhance the proposal to reopen ACO determinations by allowing providers to request a redetermination, considering the impact to a specific ACO in determining materiality and shortening the timeframe from four to two years

Incorporating Regional Cost Data

Under current policy, CMS resets ACO benchmarks based on ACO-specific historical spending. Specifically, the agency calculates the reset benchmark using risk-adjusted average per capita expenditures for Parts A and B services for original Medicare fee-for-service (FFS) beneficiaries. The benchmark includes beneficiaries who would have been assigned to the ACO in each of the three calendar years prior to the start of the agreement period. CMS trends forward each of the first two benchmark years' (BY1 and BY2) per capita risk-adjusted expenditures to third benchmark year (BY3) dollars based on the national average growth rate in Parts A and B per capita FFS expenditures verified by the CMS Office of the Actuary (OACT). The three benchmark years are weighted equally. CMS accounts for savings generated under the ACO's prior agreement period if they determine the ACO generated net savings across the three performance years under its first agreement period.

CMS's methodology for resetting benchmarks penalizes ACOs for performing well in the past and forces them to chase increasingly more challenging benchmarks in subsequent agreement periods. We are very concerned about this flawed methodology, especially as the program continues and ACOs face difficult decisions about whether to continue participating in subsequent agreement periods. Essentially, those ACOs that are successful are punished as reset benchmarks are reduced based on lower spending in prior agreement periods. This policy also reduces the incentive for ACOs to invest in efforts that will reduce future spending, a result which is detrimental to the ACO as well as the Medicare Trust Funds. CMS's February 3 Notice of Proposed Rulemaking (NPRM) addresses these concerns by proposing a new methodology for ACO benchmarking which incorporates regional cost data as benchmarks are reset in subsequent agreement periods.

We appreciate CMS' response to our February 2015 comment letter, which encouraged incorporation of regional cost data into ACO benchmarks. Overall, we support CMS's proposal to incorporate a blend of regional FFS cost data along with a portion of the ACO's historical costs in reset benchmarks. Under this proposal, CMS would use a blend of 35 percent regional expenditure data and 65 percent historical ACO expenditure data for the second agreement period for ACOs that began the MSSP in 2014 or later and for the third agreement periods for 2012/2013 ACOs. CMS proposes to use a blend of 70 percent regional cost data and 30 percent ACO historical cost data in third and subsequent agreement periods for ACOs that began the MSSP in 2014 or later, and for fourth and subsequent agreement periods for ACOs that began the MSSP in 2012/2013. This proposal builds on benchmarking changes the agency finalized in its June 2015 rule and would strengthen the MSSP by improving one of the most critical program policies.

In previous rulemaking, CMS considered, though did not formally propose, alternative approaches to resetting ACO benchmarks, such as by transitioning ACOs from benchmarks based on their historical costs toward benchmarks based *only* on regional FFS costs. Rather than exclusively relying on regional cost data, which would not take into account the patient population of a specific ACO, we support blending historical ACO and regional cost data for non-ACO beneficiaries into reset benchmarks. We do not feel it is appropriate to rely exclusively on regional cost data for reset benchmarks and are pleased CMS did not take that approach. Many ACOs, such as those with academic medical centers, may have unique patient populations which necessitate that CMS continue to use a portion of historical cost data in reset benchmarks.

We urge CMS to finalize its proposal to incorporate 35 percent and 70 percent regional cost data in the second and subsequent agreement periods, respectively. However, as detailed in the balance of this letter, we urge CMS to adopt more options and greater flexibility to MSSP ACOs as they transition to benchmarks containing regional cost data. This input is designed to ensure maximum program participation and success, which benefits ACOs, the beneficiaries they serve, and the Medicare Trust Funds which benefit from savings generated by successful ACOs.

Defining an ACO's Region and Weighting the Regional Population by County

CMS proposes to define regional costs based on each ACO's "regional service area," which includes all counties where one or more Medicare beneficiaries assigned to the ACO reside. CMS's proposed definition of an ACO regional service area allows for a customized regional definition for each ACO, and we support basing the region on counties rather than on other geographic units of measurement. The agency also proposes to account for the geographic spread of an ACO's assigned population by weighting an ACO's regional expenditures relative to the proportion of the ACO's assigned

beneficiaries in each county. We support this approach as it would accurately reflect the ACO's market by recognizing the ACO's market penetration in surrounding counties. Absent this weighting, CMS could overstate or understate the influence of the expenditures for a county in which either relatively few or many of an ACO's assigned beneficiaries reside. Weighting ACO expenditures relative to the proportion of the ACO's assigned beneficiaries in each county mitigates the impact of counties with a very small number of ACO assigned beneficiaries, and we urge CMS to finalize this policy.

While county weighting would help mitigate the impact of CMS's proposal to include counties where only one ACO-assigned beneficiary resides in the regional service area, this threshold is far too low and adds unnecessary program complexity for little (if any) meaningful gain. **In defining the region, we urge CMS to increase the population threshold and only include counties with at least one percent of the ACO's assigned beneficiary population,** as with other Medicare programs, including the Physician Group Practice demonstration, a precursor to the MSSP.

Further, the data CMS provided along with the NPRM only includes the total number of assigned beneficiaries for each county where at least one percent of an ACO's assigned beneficiaries resided for 2012, 2013, and 2014. CMS did not release ACO assignment data for counties with less than one percent of an ACO's overall assigned beneficiary population in the given year. We expect CMS limited the data to avoid complexity of extra information that has a relatively small effect, and we recommend CMS take the same approach for limiting the regional service area definition by only including counties where at least one percent of an ACO's assigned beneficiary population resides. **Should the agency finalize use of one beneficiary, we urge CMS to release the full data on all counties with one or more assigned beneficiaries.**

Defining the Applicable Beneficiary Population

Within the regional service area, the agency proposes to calculate costs for all "assignable beneficiaries," including ACO-assigned beneficiaries, in determining the population used to calculate regional FFS costs for the reset benchmark. According to the NPRM, CMS intends to use these expenditures in an effort to ensure sufficiently stable regional expenditures. CMS defines an assignable beneficiary as a Medicare FFS beneficiary who receives at least one primary care service during a specified 12-month assignment window from a Medicare-enrolled physician who is a primary care physician or a provider who has one of the specialty designations included in §425.402(c). We support limiting the beneficiary population to those that received at least one primary care service from either a primary care physician or a provider with a specialty designation used for MSSP assignment. Using an "assignable" population allows for a more "apples to apples" comparison by preventing beneficiaries who do not receive any primary care services during the time period from artificially lowering the expenditures against which the ACO will be compared. Similarly, it will also prevent an artificially low trend from being applied to ACO benchmarks.

However, we take issue with CMS's proposal to include ACO-assigned beneficiaries in the regional service area population (reference population). Rather than comparing ACOs to themselves and other ACOs, CMS should compare ACO performance relative to FFS Medicare by defining the reference population as assignable beneficiaries without ACO-assigned beneficiaries for all ACOs in the region. At the very least, CMS should exclude the ACO itself from the region to prevent an otherwise tautological comparison that essentially double counts those ACO-assigned beneficiaries. In an area where the ACO has significant market saturation, it is especially essential to remove the ACO beneficiaries from the regional population to avoid comparing the ACO to itself. Excluding all ACO-

assigned beneficiaries (those involved in MSSP ACOs and well as other CMS ACO demonstrations such as the Pioneer and Next Generation models) also allows for a cleaner comparison between ACOs and FFS. Should the agency include the ACO-assigned beneficiary population, the regional cost data would be skewed by reflecting ACOs' efforts to coordinate care and reduce expenditures for the ACO population.

In the NPRM, CMS states its concern that removing ACO-assigned beneficiaries would result in a reference population that is not large enough. However, according to our analysis based on 2014 data, if CMS removed ACO-assigned beneficiaries from the reference population, only 38 ACOs would have had a reference population smaller than 5,000 beneficiaries. Finalizing a flawed program methodology in order to address a small percentage of ACOs is nonsensical and more importantly, harmful to the majority of program participants. **We urge CMS to modify its proposal by changing the definition of the reference population to exclude all ACO-assigned beneficiaries.**

To address those ACOs whose reference population falls below 5,000 after removing the ACO-assigned beneficiaries, we recommend CMS use a modified approach to reach 5,000 beneficiaries in those instances. For example, CMS could bridge the gap by increasing the weight of the counties that have a lower proportion of resident ACO beneficiaries, and thus higher FFS population. Another option would be for CMS to expand the regional service area to include assignable beneficiaries in adjoining counties until a sufficient comparison group is reached. Yet another option, recommended by MedPAC in their March 11, 2016 comment letter to CMS on this NPRM, would increase the stability of the regional FFS spending calculations by increasing the number of years of data included in the calculation. For example, by using a five year rolling average for county level spending estimates. In cases where area expenditures are driven largely by the ACO(s), CMS could similarly pull in contiguous counties to ensure a fair comparison. Any one of these approaches would both address CMS's concern about not having an adequate reference population and would be far preferable to the approach the agency has proposed.

Calculating Regional Average Expenditures and Using State-Level ESRD Data

CMS proposes to base the regional costs for reset benchmarks by calculating Hierarchical Condition Category (HCC) risk adjusted regional per capita FFS expenditures using county level Parts A and B expenditures for the ACO's regional service area for each Medicare enrollment type (end stage renal disease [ESRD], disabled, aged/dual eligible, aged/non-dual eligible). CMS proposes to weight the expenditures by the proportion of assigned beneficiaries for the most recent benchmark year for each Medicare enrollment type (ESRD, disabled, aged/dual eligible, aged/non-dual eligible). Using an approach consistent with current policy, CMS proposes to utilize a three-month claims run out with a completion factor for regional costs, and the calculations would exclude payments related to indirect medical expenses (IME), disproportionate share hospital (DSH), and uncompensated care. We strongly support the exclusion of IME, DSH and uncompensated care payments from an ACO's benchmark and performance year calculations, and we are pleased to see in this rule CMS remains committed to its policy of excluding these add-on payments.

We support CMS's proposed general approach to calculating regional expenditures. However, we are very concerned about CMS's proposal to calculate regional ESRD expenditures using state-level data. Specifically, CMS proposes to compute state-level per capita expenditures and average risk scores for the ESRD population in each state and apply those state-level values to all counties in a state. CMS argues in the NPRM that using statewide expenditure and risk score data for the ESRD

population is appropriate given the small numbers of ESRD beneficiaries in many counties and the agency maintains that using statewide values would be more statistically stable.

We share CMS's concern about having an adequate sample size to ensure statistical reliability and validity, and we would prefer not to use national ESRD data. However, based on the NPRM and limitations of data released by CMS, it remains unclear whether using state-level ESRD data truly is the best solution. Applying state-level data for all counties within a state will likely skew results for certain ACOs, a concern which may be particularly acute for ACOs operating in certain areas of a state such as those near state borders or ACOs in areas with high ESRD costs. Though CMS cites using a similar approach for MA, the agency does not adequately demonstrate that using state-level data is the optimal solution in the case of the MSSP, nor does the agency explain in detail its consideration and analysis of alternatives to state-level data. Further, CMS did not release sufficient data for stakeholders to properly analyze alternatives to state-level ESRD data.

We urge CMS to immediately provide data to allow stakeholders to model ESRD cost data based on other geographic units of measurement such as Metropolitan Statistical Area (MSA), Hospital Referral Regions (HRRs), and Geographic Practice Cost Indices (GPCIs) localities. Specifically, we request CMS provide county-level ACO assigned data by beneficiary category, which would allow us to analyze these and other alternatives. It is essential for the agency to provide this data so we can properly evaluate and respond to CMS's proposal.

Until CMS makes data available, we recommend the agency consider a different approach and re-open this issue in future rulemaking after providing necessary data. To ensure a statistically valid regional ESRD population, we recommend CMS consider a few methods to reach a statistically valid threshold. These approaches could be similar to those used to reach a regional population of 5,000 beneficiaries after removing ACO-assigned beneficiaries. For example, CMS could ensure a valid regional ESRD population by increasing the weight of the counties that have a lower proportion of resident ACO beneficiaries, and thus higher FFS population. Another option would be for CMS to expand the regional service area to include ESRD beneficiaries in adjoining counties until a sufficient comparison group is reached. Yet another option would be to increase the number of years of data included in the calculation.

Financial Benchmark Updating Methodology

To align with CMS's proposal to use regional FFS expenditures in resetting an ACO's historical benchmark, CMS is proposing to use regional FFS expenditures to update an ACO's financial benchmark using the same weighted average of risk adjusted FFS expenditures in counties where the ACO's assigned beneficiaries reside. CMS believes doing so would "better capture the cost experience in an ACO's region, the health status and socio-economic dynamics of the regional population, and location specific Medicare payments." When updating the benchmark, CMS would again use assignable beneficiaries, exclude IME and DSH but include demonstration payments. CMS would then truncate at the 99th percent and risk adjust by the four Medicare beneficiary enrollment types. CMS also is seeking comment on using, instead, the flat dollar equivalent of the projected absolute amount in regional per capita expenditures for Parts A and B FFS services. **We agree CMS should use the same regionally-based update formula to reset and update ACO benchmarks. Therefore, we do not support the alternative proposal to use the regional service area's flat dollar equivalent.**

Risk Adjustment and Coding Intensity Adjustment

We continue to oppose CMS's use of different methods for updating risk adjustment for newly and continuously assigned beneficiaries. That is, we oppose CMS's policy, as stated in the proposed rule, to "take into account changes in severity and case mix for newly-assigned beneficiaries and demographic factors to adjust for changes for beneficiaries continuously assigned to the ACO." CMS is in effect limiting risk adjustment due to demographic factors for all continuously assigned beneficiaries. It is unreasonable to assume a provider organization, however effective, can manage a population such that patient conditions never worsen over time and it never carries a higher disease burden. **CMS should, within limits, allow risk scores to increase year-over-year within an agreement period for the continuously assigned.**

We oppose this policy also because the proposed rule states that, "as a result of normal changes to beneficiary assignment from year to year, beneficiaries whose risk scores were subject to ACO coding initiatives in one year may no longer be assigned to the ACO in the next year." If year-over-year unstable assignment, which CMS estimates at 24 percent, negates or at least mitigates CMS's coding intensity concerns, what explains the agency's insistence in persisting with its continuously assigned risk adjustment policy? CMS also notes employing regional trend calculations for resetting the benchmark "are expected to mitigate the risk of sensitivity to potential coding intensity efforts by ACO providers/suppliers." For these reasons we see no logic to CMS's "considering ultimately moving to a coding intensity adjustment similar to the methodology used in the MA program."

If CMS is in fact considering moving to a coding intensity adjustment for the MSSP, we recommend the agency consider the Sherri Rose, et al., discussion of using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey information, i.e., comparing CAHPS survey health status measures with concurrent changes in case mix as assessed by diagnoses in claims. As Rose and her colleagues note, "An increase in HCC scores without worsening in self-reported health status, for example, would suggest a change in coding without a true change in the health risks of patients attributed to an ACO." (See Rose, et al., "Variation in Accountable Care Organization Spending and Sensitivity to Risk Adjustment: Implications for Benchmarking," Health Affairs (March 2016): 440-448.)

We support CMS's proposal to "adjust for an ACO's risk relative to that of its region in determining the regional adjustment to the ACO's reset historical benchmark." The proposed rule notes, and CMS staff confirms, that the agency is proposing to comparatively risk adjust "in relation to FFS beneficiaries in the ACO's regional service area," meaning specifically risk adjusting in relation to assignable beneficiaries. This would be consistent with how CMS is proposing to account for regional expenditures in resetting and updating ACO benchmarks. As the proposed rule explains, this is because using all FFS beneficiaries would likely result in inappropriately comparing an ACO's assigned beneficiary to a healthier (FFS) population. We are however concerned that in practice ACO providers may inherit the inherent problem in FFS, that of unobserved clinical risk.

No Longer Accounting for Savings in Rebased Benchmarks

Under current policy, CMS adjusts rebased historical benchmarks to account for the average per capita amount of savings generated during an ACO's previous agreement period by adding a portion of their savings to the rebased benchmark (only for ACOs that have net per capita savings across the three performance years). This policy was finalized in a June 2015 rule, in which CMS stated:

“We agree with commenters on the importance of accounting for the financial performance of an ACO during its prior agreement period in resetting the ACO’s historical benchmark. In particular, we believe that this adjustment is important for encouraging ongoing program participation by ACOs who have achieved success in achieving the three-part aim in their first agreement, by lowering expenditures and improving both the quality of care provided to Medicare FFS beneficiaries and the overall health of those beneficiaries. Absent this adjustment, an ACO who previously achieved success in the program may elect to terminate its participation in the program rather than face a lower benchmark that reflects the lower costs for its patient population during the three most recent prior years.” (80 FR 32778)

In the NPRM, CMS proposes to reverse this policy and, if finalized, the agency would no longer account for savings in the previous agreement period when calculating the rebased benchmark for a new three-year agreement period. The agency argues that transitioning to a benchmark methodology that incorporates regional expenditures would lessen the impact of no longer accounting for savings in subsequent agreement periods. We strongly disagree with this rationale and do not believe CMS adequately explains how the proposed rebasing methodology would make up for reversing their policy to account for previous savings. For example, an ACO in an area with regional spending lower than the ACO’s historical spending would have its rebased benchmark reduced as a result of incorporating regional spending. In this instance, the ACO is harmed by incorporating regional cost data, and CMS would exacerbate this by no longer accounting for previous savings. It is highly unusual and concerning for CMS to propose abruptly reversing course on its policy to account for shared savings, which was finalized only eight months prior to publication of this NPRM.

We surmise one of the reasons CMS proposes to reverse course and exclude savings from reset benchmarks is so the agency may realize their own savings as a result of the NPRM. CMS estimates the overall budget impact of the rule is \$120 million in savings to Medicare from 2017 through 2019. We are troubled by CMS’s proposal to take savings away from ACOs, which are achieved as a result of their hard work to improve quality and lower costs, merely to improve the agency’s bottom line. In essence, under this duplicitous proposal, CMS would be giving with one hand and taking with another. We strongly believe moving to regionally-based benchmarks should be budget-neutral and not result in ACOs losing savings they worked so hard to produce.

CMS should evaluate the rationale of accounting for shared savings apart from its consideration of incorporating regional cost data into benchmarks, as they are separate issues and ACOs will be affected differently by each policy. Further, should CMS finalize our recommendation to remove an ACO’s assigned beneficiaries from the assignable population used to calculate regional cost data, this would diminish the argument that adding a regional cost component makes up for no longer accounting for shared savings in reset benchmarks. ACOs should be accountable for their performance relative to FFS Medicare in their region as well as rewarded for previous savings, thus it is important to both remove ACO-assigned beneficiaries from the reference population and to account for a portion of shared savings in reset benchmarks. These recommendations provide for a fair and accurate way to measure and reward ACO performance. **In addition, rather than finalizing CMS’s proposal to exclude shared savings from reset benchmarks, we urge CMS to not only account for the shared savings in reset benchmarks, but to also account for all savings – not just the ACO’s portion – and add that amount to reset benchmarks.** Adding only the ACOs portion of shared savings is as arbitrary as granting successful ACOs only half the savings they achieved.

Transitioning to Benchmarks with Regional Cost Data

CMS proposes to phase-in the use of regional cost data over multiple agreement periods with ACO benchmarks by increasingly reflecting expenditures in their regions, rather than continuing to exclusively rely on ACO historical expenditures. The agency would maintain the current approach for establishing an ACO's initial benchmark based on the historical expenditures for beneficiaries who would have been assigned to the ACO during the benchmark years. Beginning with the subsequent three-year agreement period, CMS proposes to implement the regional adjustment amount by blending 35 percent of the ACO's regional service area expenditures with 65 percent of the ACO's historical benchmark expenditures. For ACOs entering their third or subsequent agreement periods, the percentage would increase to 70 percent based on regional FFS expenditures for assignable beneficiaries.

ACOs that began the MSSP in 2014 would be the first affected by the revised rebasing methodology and, if finalized, their new benchmarks for the three-year agreement period beginning in 2017 would reflect the 35 percent regional expenditure data. These ACOs would also be the first to shift to a 70 percent regional adjustment, beginning with their third agreement period starting in 2020. ACOs that began the MSSP in 2012 and 2013 and started new agreement periods in 2016 would not have regional cost data incorporated until their next agreement period begins in 2019, at which point their reset benchmark would reflect 35 percent regional cost data.

We support transitioning over time to ACO benchmarks that blend historical and regional expenditure data, but believe the general approach in the NPRM can be improved with certain methodological changes. The proposed methodology to reset benchmarks will affect ACOs differently, with some seeing significant and unexpected swings in their reset benchmarks. According to our analysis on the effect of incorporating 35 percent regional cost data into reset benchmarks, an estimated 66 percent of ACOs would have their benchmarks adjusted by greater than two percent from actual spending, with 24 percent negatively affected and 42 percent positively affected. These unexpected and significant swings would present substantial challenges and would likely force ACOs harmed by the new methodology to leave the MSSP altogether.

In addition to the magnitude of the benchmark change, CMS must also consider the pace of the transition. Too rapid a transition could lead to ACOs leaving the MSSP, while too slow a transition could discourage ACOs, particularly those that have already lowered expenditures relative to their region and face challenging benchmarks. ACOs in the latter may want to move more quickly to reset benchmarks with the new methodology. To mitigate unexpected benchmark swings and to ease the transition across the MSSP, we urge CMS to provide a glide path with options for ACOs to decide for themselves how and when to move to the new benchmark methodology.

We request that CMS provide maximum flexibility and choices, which would benefit individual ACOs by providing options for how they transition to the new benchmarking methodology and would in turn best serve the MSSP overall. This approach would increase the likelihood that ACOs remain in the program, while still ensuring the MSSP gradually moves to benchmarks that reflect regional cost data. It is important to note that only 86 of the 333 MSSP ACOs received shared savings payments for 2014, representing a little more than a quarter of 2014 ACOs. These results illustrate the significant challenges ACOs face achieving success in the MSSP and underscore our concerns about the long-term sustainability of the MSSP ACO business model. **While we support the proposed transition in the NPRM, with 35 percent regional cost data in the second**

agreement period and 70 percent in the third agreement period, we urge CMS to provide the additional voluntary options outlined below to retain and attract MSSP participants.

Recommended options for ACOs to transition to new reset benchmarking methodology:

- ***Allow 2012/2013 ACOs to begin new agreement periods with rebased benchmarks sooner.*** Under CMS's proposal, 2012/2013 ACOs would have two full agreement periods under the current methodology, as these ACOs began new agreement periods in 2016. Requiring these ACOs to wait until 2019 creates an unfair position compared to ACOs that started the program later and would want to move to the revised methodology sooner. We recommend CMS allow interested 2012/2013 ACOs to begin new agreement periods in 2017 using the revised methodology. These organizations should not be deprived of such improvements to the program for another two years because CMS was not able to finalize a regulation in time.
- ***Provide a glide path for ACOs to gradually incorporate regional cost data throughout an agreement period.*** Some ACOs will face significant swings in their ACO benchmarks as a result of the revised methodology. We urge CMS to allow ACOs to elect to have their benchmark incorporate the regional cost data in a gradual manner, rather than face large increases at the start of a new agreement period. This option would allow ACOs to phase in regional cost data with 10 percent in Performance Year (PY) 1, 20 percent in PY2, and 35 percent in PY3. Similarly, in the subsequent agreement period they could choose to continue a gradual phase-in with 45 percent in PY1, 55 percent in PY2, and 70 percent in PY3. Overall, ACOs would ultimately reach the 70 percent regional benchmark, but this option would appeal to ACOs concerned about facing steep increases at the start of agreement periods.
- ***Provide a glide path for ACOs in initial agreement periods to gradually incorporate regional cost data.*** CMS considered, but did not propose, incorporating some regional cost data into benchmarks for ACOs that begin initial agreement periods on or after January 1, 2017. While we appreciate retaining a policy that bases initial benchmarks on historical ACO expenditures, we urge CMS to provide an option for ACOs to elect a gradual phase-in of regional cost data in their first agreement period, with 10 percent regional cost data in PY1, 20 percent in PY2 and 30 percent in PY3. ACOs would then start their second agreement period with a 35 percent regionally-based benchmark. This approach would allow ACOs to ease into regionally based benchmarks and would smooth the transition between agreement periods.

These options would allow ACOs to identify the best way to transition to the new benchmark methodology, thus maximizing an ACO's ability to handle the transition and increasing their likelihood of remaining in the MSSP. Additionally, given the range of options for establishing and resetting their benchmarks, new, perhaps more reluctant ACOs would be incentivized to join the MSSP. We emphasize that these options would be voluntary and ACOs could still follow the proposed transition that includes no regional cost data in the first agreement period, then 35 percent and 70 percent in second and third agreement periods, respectively.

Tax Identification Number Composition

CMS has long recognized that the addition or removal of ACO participants or ACO provider/suppliers (identified by Taxpayer Identification Numbers (TINs) and National Provider Identifiers, respectively) during the term of an ACO's participation agreement would require adjustments to the ACO's benchmark, risk scores, and other aspects of the methodology. In the most recent June 2015 final rule, CMS amended the MSSP regulations (at §425.118(b)(3)(i)) to incorporate portions of previously issued subregulatory guidance.¹ Among other things, this provision specifies how CMS annually adjusts an ACO's assignment, historical benchmark, and the quality reporting sample.

However, CMS was surprised by the high volume of change requests from ACOs, both adding and removing ACO participants, in the initial performance years. For the 2015 performance year, CMS adjusted benchmarks for 245 of 313 ACOs (78 percent) with 2012, 2013 or 2014 start dates to reflect changes in ACO participants. In the NPRM, CMS states its concern that although the current methodology is accurate, it is operationally burdensome and will become even more complex with the addition of Track 3 participants, which require additional assignment runs for each performance year. In light of the operational burden, CMS proposes an alternative approach to streamlining calculations of adjusted historical benchmarks that reduces the number of benchmark years for which assignment would need to be determined.

Under this modified approach, CMS would make adjustments to the historical 3-year benchmark from the most recent prior performance year, and would make adjustments to this benchmark using expenditures from a single reference year. CMS proposes to define the reference year as benchmark year 3 of the ACO's current agreement period for which beneficiary assignment has been performed using both the ACO Participant List for the most recent prior performance year and the new ACO Participant List for the current performance year. Calculations for the adjustment would be made in relation to three populations of beneficiaries assigned to the ACO in the reference year: stayers, joiners and leavers. CMS would first isolate the marginal difference in per capita expenditures associated with the leavers to adjust the stayer component up or down, and would then add in the per capita expenditures for the joiners.

We fundamentally believe CMS should not develop and apply such a proxy until it alters the underlying policy that an ACO is defined as a collection of TINs. As previously stated in our past comment letter, we assert that only the ACOs themselves can determine which physicians and non-physician practitioners are functioning as primary care providers and thus should be included in attribution. We believe that the inclusion of ACO suppliers should be at the National Provider Identifier level rather than the TIN level, or a combination thereof. This will ensure that only non-physician practitioners and specialists who are eager participants and willing to take on accountability for their patients are included in attribution. Such a change in the program would surely cause additional and substantial shifts in the Participant Lists and necessitate reconsideration of the proposed proxy benchmarking policy.

¹ See "Changes in ACO participants and ACO providers/suppliers during the Agreement Period" available online at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram/Updating-ACO-Participant-List.html> (last modified November 16, 2015).

We concur with CMS that the magnitude of changes in the ACO Participant Lists is causing the agency to adjust historical benchmarks more frequently than anticipated and thus understand why CMS is seeking to reduce its operational complexity. However, we are concerned that CMS neglected to propose changes to mitigate the underlying instability and inaccuracy of the *existing* benchmark methodology that can result from significant TIN composition changes before it seeks to establish a new proxy process. CMS notes that “the magnitude of the change for most ACOs was between -2 percent and +2 percent,” which is quite substantial for an individual ACO that must meet a two percent minimum savings rate. We know of a number of ACOs where the benchmarks were artificially low because of innocuous changes in TINs, such as restructurings, where CMS chose not to make any corrections or accommodations. The problem occurs when the benchmark years do not accurately reflect the acuity of the patients seen in the performance period. If, for example, an ACO introduces a new service line for complex patients within an existing TIN during the performance period for which there would be no history of treating such patients in the baseline period the benchmark would be understated. Thus, while it may be true that CMS’s proposed adjustment for Participant List changes indeed closely approximates the previous results, we are concerned that those results themselves were already fundamentally flawed. **CMS should address the instability and inaccuracies introduced in the benchmarks by Participant List changes causing a disconnect between the acuity of patients in the baseline versus those in the performance period.**

CMS states it believes this revised approach offers the right balance between approximating the accuracy of the current methodology for adjusting historical benchmarks and operational ease, and that initial modeling suggests the proxy is highly correlated with the existing approach. Setting aside the accuracy of the existing system, both of these statements may be correct, but there is no way for stakeholders to verify such an assertion. CMS did not release detailed results of this analysis, nor did it release enough information to replicate such an analysis. While ACOs may receive the claim and claim line feed files, these are not sufficient to run new attribution calculations, as it will miss the so-called “joiners.” While an analysis in the Standard Analytic File or Virtual Research Data Center might have been feasible in the comment period, the TINs are not present on these files, among other drawbacks.

Without detailed data we are concerned that while the overall model might be a good fit, the variation for a specific ACO might be quite high. For instance, organizations with beneficiaries cycling in and out of attribution more often than others may see a more volatile association with their “true” benchmark. This might point to a policy where those organizations below a threshold for enough stayers would revert to the existing policy as suggested for those organizations with no stayers (an unlikely scenario). But, we cannot uncover or investigate such issues without additional information and thus cannot adequately comment. **CMS should delay this policy until it either provides detailed, transparent analytic results or provides stakeholders an ability to replicate CMS methodologies with accessible data and additional time.**

CMS also seeks commenters’ suggestions on the anticipated interactions between the proposed approach to adjusting ACO historical benchmarks using an expenditure ratio and rebasing alternatives. While we do not support the use of the proxy in lieu of re-running the benchmarks, if CMS chooses to finalize this policy, it should provide additional details in the final rule regarding what was meant by this request for comments. It is not clear to us what interactions CMS is referring to that may have a material impact on the results of either the TIN adjustment or the regional adjustment. CMS must share its analyses on the interaction and what policy choices it made in finalizing the policy.

Facilitating Transition to Performance-Based Risk

CMS proposes to allow first agreement period Track 1 ACOs, beginning with ACOs with 2014 start dates, the option to extend their agreement period for a fourth year without having their financial benchmark reset. This means a Track 1 ACO would first apply for a second agreement as a Track 2 or Track 3 ACO, then, should CMS approve their application, the ACO could exercise the option to remain as a Track 1 for a fourth year. The ACO's fifth year would begin its new three-year agreement as a Track 2 or 3. CMS is also considering allowing Track ACOs to remain in Track 1 in the first year of their second agreement period and transition to Track 2 or 3 in the second year of their second agreement period. Again, the ACO would have to apply, and be selected for, the second agreement as a Track 2 or 3. Under either alternative CMS would update and reset the ACO's benchmark using the proposed regional/historical blend formula.

We recognize it is CMS's policy to ultimately move participants to risk-bearing agreements. Therefore, we appreciate the agency's interest in finding ways to accelerate this process. **While we support the option of a deferral, on balance we are not confident these alternatives will be measurably successful.** If a first agreement period Track 1 ACO was interested in remaining in the program, but uncertain about its ability to successfully manage financial risk, or even qualify to sign a risk-bearing agreement, why would the ACO not simply choose to continue as a Track 1 for a second agreement period, particularly when the organization still faces the same problem of unstable assignment as a Track 2 ACO would? While Track 3 addresses patient churn via prospective assignment, providers may not be willing to immediately accept 75 percent downside risk. If the proposed changes to resetting and updating ACO benchmarks are made, they alone may measurably improve provider interest and ability to participate in Tracks 2 and 3. In addition, how CMS defines APMs and the MIPS under MACRA will, as CMS recognizes, influence provider interest in accepting financial risk. That said, we believe these options are worth offering as a choice to Track 1 ACOs.

In accelerating Track 1 ACOs' ability to take on financial risk, we note CMS's December 2014 proposed rule discussion of "other possible alternatives" that would allow ACOs to annually "split their ACO participant TIN list into different risk tracks" during an agreement period. In this "segmented lists" discussion, the agency outlined seven criteria under which this could be accomplished. We note this related, previous discussion because **we still believe allowing ACOs to annually, incrementally move into risk arrangements would prove valuable.** Allowing an ACO to "accept varying degrees of risk" within an agreement period would position the ACO to best balance their exposure to and tolerance for financial risk and would create a true glide path for providers. Quality measurement could remain the same, but reported by risk track. Benchmarking could similarly remain the same if a Track 1 ACO was limited to moving to Track 2. This may be the best option for allowing ACOs to learn for themselves how to successfully transition to risk contracting.

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

CMS proposes to reopen a payment determination with respect to the amount of shared savings due to the ACO or the amount of shared losses owed by the ACO if calculated in error. CMS may reopen

a determination under two scenarios: (1) any time in the case of fraud or similar fault;² or (2) for good cause, not later than four years after the date of notification to the ACO of the initial determination of shared savings/losses. Under the NPRM, "good cause" may be established in two situations. First, when the evidence that was considered in making the payment determination clearly shows on its face that an obvious error was made at the time of the payment determination. Second, when there is new and material evidence that was not available or known at the time of the payment determination and may result in a different conclusion. CMS proposes a threshold to determine whether new evidence is "material." Under this proposed threshold, only errors that equate to three percent of the total amount of net shared savings and shared losses for all ACOs for the applicable performance year would be considered to have a "material effect" on the ultimate payment determination. In this scenario, CMS would re-compute the financial results for all ACOs affected by the error(s). CMS does not propose to apply a materiality threshold to individual ACOs. CMS would retain full discretion to determine whether good cause exists for reopening a payment determination. Changes in legal interpretation or policy would not be considered a permissible basis for a reopening.

We support CMS's decision to provide for a reopening of payment determinations when they are calculated in error. However, we strongly believe the proposal does not go nearly far enough, and we urge CMS finalize the following modifications to enhance the protections afforded by a payment determination reopening. Specifically, we urge CMS to:

- **Limit the timeframe for good cause redeterminations to two years, rather than the proposed four years.** The standard ACO agreement period is three years. A four-year look-back would pose an excessive administrative burden on both ACOs and the Medicare program. An ACO may no longer be participating in the MSSP, let alone even operating four years from a given performance year. A two-year look-back would provide greater financial security to both ACOs and CMS and would be much less administratively burdensome.
- **Reduce the three percent materiality threshold.** When applying a materiality threshold to total shared savings and losses to all ACOs, the proposed three percent is far too high. Many payment determination errors may impact a small number of ACOs with little likelihood of reaching the three percent payment threshold. As the MSSP grows in size, scope, and in the number of participating ACOs, and thus, the potential for greater total shared savings or losses, this materiality threshold becomes less likely to result from a payment determination error. A payment error of just one percent of total MSSP shared savings/losses may be the difference between an individual ACO remaining financially solvent or shutting down.
- **Allow a materiality threshold for individual ACOs.** While we understand CMS's concerns with administrative burdens, these do not outweigh the potential financial duress that could lead to an ACO's closure due to a payment determination error. An error could impact less than three percent of total MSSP shared savings or losses for a particular year, but still have a substantial impact on a particular ACO's shared savings or losses. For both program integrity purposes and for the financial solvency of MSSP ACOs, CMS should reopen a payment determination with respect to the amount of shared savings or losses when the error impacts an individual ACO by some percentage established by CMS.

² Similar fault is defined under 42 CFR § 405.902 to mean, "to obtain, retain, convert, seek, or receive Medicare funds to which a person knows or should reasonably be expected to know that he or she or another for whose benefit Medicare funds are obtained, retained, converted, sought, or received is not legally entitled. This includes, but is not limited to, a failure to demonstrate that he or she filed a proper claim as defined in part 411 of this chapter."

- **Permit individual ACOs to appeal a payment determination if they feel that the calculation was made in error.** In the proposed rule, CMS would retain full discretion to determine whether good cause exists for reopening a payment determination. This discretion is not harmed by providing ACOs with the ability to appeal a payment determination that may have been made in error. In fact, permitting individual ACO appeals would help prevent future redeterminations and reduce the administrative burden associated with such reopenings. An ACO's appeal may serve to alert CMS to a larger issue, which can be solved timely and more efficiently than one discovered years down the road. Further, we urge CMS to be transparent with its process for determining "good cause".
- **Hold ACOs harmless for errors made by CMS in the payment determination process.** ACOs should not be penalized for payment determination errors that result in the ACO receiving more money (or paying less money) than the ACO should have received (or paid) under the MSSP. These reopenings would occur years after the ACO's applicable performance year. After one or several years, the ACO will have moved forward with program participation and used any "excess" money for continued patient care improvements and ACO operations. The potential for ACOs to repay money to CMS due to CMS error creates a level of uncertainty that all ACOs would have to budget for, further adding to the annual costs of operating an ACO. Holding ACOs harmless for CMS errors would protect ACOs' liability, encourage additional investment in care coordination efforts, and enable continued and new participation in the MSSP. We note that the NPRM would permit a payment determination to be reopened in cases of fraud or similar fault, thus, eliminating any potential concerns regarding illicit ACO behavior.

Allow Prospective Beneficiary Assignment for All ACOs

Beneficiary assignment has a significant effect on benchmarks, which are established and adjusted based on where beneficiaries receive a plurality of primary care services during the benchmark and performance years. For Tracks 1 and 2, CMS uses preliminary prospective beneficiary assignment with final retrospective beneficiary assignment. For Track 3, CMS uses prospective beneficiary assignment, which relies on the same stepwise assignment methodology used for Tracks 1 and 2 but assigns beneficiaries to Track 3 ACOs prospectively at the start of the performance year. Under this method, there is no retrospective reconciliation resulting in the addition of new beneficiaries at the end of the performance year. This approach provides a more stable beneficiary population and a more predictable benchmark.

We support allowing ACOs in all tracks to have the option of choosing prospective or retrospective assignment. Certain ACOs, such as a small ACO worried about dropping below the 5,000 beneficiary minimum may prefer a model where it can add beneficiaries throughout the year, and would thus prefer the retrospective assignment model. However, other ACOs, such as those entering Track 3, would likely prefer a prospective model, which would help them stabilize their beneficiary population and thus avoid volatile benchmark changes just as they are undertaking substantial financial risk. Moreover, these more advanced ACOs typically employ data analysis and beneficiary engagement techniques from the start of the performance period on a population for whom they know they are responsible. Further, providing a choice between retrospective and prospective assignment would benefit Track 1 and 2 ACOs that may prefer to become accustomed to prospective assignment or may be eligible for payment waivers. For example, under Track 3, CMS

permits a waiver of the Skilled Nursing Facility (SNF) 3-Day Rule. This allows Track 3 ACOs to receive payment for otherwise-covered SNF services when a prospectively assigned beneficiary is admitted to a SNF without a prior 3-day inpatient stay. In the final June 2015 rule, CMS explains its rationale for limiting the waiver to Track 3:

At this time we are limiting the waiver to ACOs in Track 3 because under the prospective assignment methodology used in Track 3, beneficiaries will be assigned to the ACO for the entire performance year, and it will be clearer to the ACO as to which beneficiaries the waiver applies than it would be to an ACO in Track 1 or 2 under preliminary prospective assignment. We believe that having clarity as to whether the waiver would apply to SNF services furnished to a particular beneficiary is important to allow the ACO to comply with the conditions of the waiver and could also improve our ability to monitor waivers for misuse. (80 FR 32804)

By allowing ACOs in all tracks to select prospective assignment, CMS could provide broader use of payment waivers, as the population to which the waivers would apply would be easier to define.

We also urge CMS to offer a beneficiary attestation process for all MSSP ACOs, regardless of track. This process would allow beneficiaries to attest that they consider a particular provider responsible for coordinating their overall care. An attesting beneficiary would be attributed to the ACO with whom that provider is affiliated. Although CMS would retain its current stepwise attribution process, beneficiary attestation would take precedence over that process when considering to which ACO a beneficiary should be attributed. Furthermore, the beneficiary would remain attributed to that ACO until the beneficiary enrolled in Medicare Advantage, moved out of the ACO's service area, attested to a provider affiliated with another ACO, or the beneficiary otherwise indicates that they receive their care elsewhere.

Providing beneficiaries with the opportunity to voluntarily align with an ACO would balance the important considerations of beneficiaries' freedom to choose their providers, with ACOs' interest in reducing churn, which would help provide a more defined and stable beneficiary population up front. This, in turn, would allow ACOs to better target their efforts to manage and coordinate care for beneficiaries for whose care they will ultimately be held accountable. In addition, allowing beneficiaries to attest to the provider they want to manage their care may help increase beneficiary engagement in that care. Along those lines, MedPAC recommends allowing financial incentives for beneficiaries to be more engaged, which we also support. **In sum, given the direct link between beneficiary assignment and benchmarks, we strongly urge CMS to modify its beneficiary assignment policy to allow all ACOs to select either retrospective or prospective beneficiary assignment and to honor beneficiary choice through attestation.**

Reward High Quality Performance and Improvement

The Affordable Care Act specifies quality as a primary goal for the ACO program. Yet, an ACO that achieves CMS's established quality performance levels is not rewarded and is merely prevented from forfeiting the shared savings payments it has earned. There is no direct financial reward for improving quality of care, and there is no penalty for poor quality unless the ACO has generated savings. This lack of reward can be a strong disincentive for ACOs to invest in quality improvement. In contrast, MA plans are rewarded with higher benchmarks for higher quality, which leads to an asymmetry between MA plans and ACOs. As MedPAC noted in their Feb. 2, 2015 letter to CMS, "Otherwise, the ACO with top quality performance would end up with a lower benchmark than an

MA plan in the same market with top quality performance. That situation could be seen as inequitable for the ACO."

Many efforts to improve the quality of care consume ACO resources and increase spending relative to the ACO's financial benchmark in the short term, even if they decrease Medicare spending over the long term. Medicare-covered preventive services are a good example. An ACO that does extensive patient outreach for cancer screening tests, such as colonoscopies, could expend considerable resources delivering these services. Better screening, in turn, would avoid the need for expensive late-stage cancer treatments for some of the screened patients, but those savings would not be realized until after the performance year in which the screening is provided and in many cases not until after the ACO contract period has ended. The same is true of tobacco use interventions, management of hypertension and diabetes, and many other ACO quality measures.

The more an ACO strives to improve quality performance, the more it often needs to spend. If the services used to improve quality are billable services, they will increase the ACO's spending and reduce the probability of beating its benchmark. If the services are not billable, such as in areas where the FFS system fails to pay for high-value services (e.g., chronic disease management), they will create losses for the ACO in the short run, but they may not reduce any billable services, meaning that the quality improvement efforts will not result in any savings to cover the losses. ACOs that make large investments to improve quality performance may be less able to keep spending below their benchmarks as a direct result of their increased investment in quality.

We urge CMS to use a similar approach for MA and MSSP by properly rewarding ACOs for high quality. It is important to recognize high quality performance compared to established measure thresholds as well as to recognize – and reward – quality *improvement* relative to an ACO's previous performance. **Therefore, to emphasize and reward above average quality performance or improvement, we urge CMS to provide on a sliding scale up to 10 percentage points of additional share savings.**

All Medicare ACOs Should Be Qualified APMs under MACRA

As CMS heads into rulemaking on the Medicare Access and CHIP Reauthorization Act (MACRA) we want to take this opportunity to share our perspective on the issue of qualified Alternative Payment Models (APMs) and its interaction with the MSSP. MACRA strongly encourages physicians to participate in APMs, which are defined in MACRA as:

- (i) A model under section 1115A (other than a health care innovation award).
- (ii) The shared savings program under section 1899.
- (iii) A demonstration under section 1866C.
- (iv) A demonstration required by Federal law.

It is clear from this language that all MSSP ACOs are included within the MACRA definition of an APM.

On March 3, 2016, CMS announced that 30 percent of Medicare fee-for-service payments are now attributed to APMs, fulfilling a goal set by Secretary Burwell last year. The CMS Office of the Actuary included all MSSP ACOs in its definition of APMs. If the Secretary is counting all ACOs as APMs for purposes of meeting the Medicare payment target, then all must be counted as APMs for purposes of MACRA.

MACRA further requires that payments to physicians participating in an APM be made under arrangements in which quality measures comparable to those that will be used in the Merit-Based Incentive Payment System (MIPS) apply, certified electronic health record technology is used, and the physician participates in an entity that bears more than “nominal financial risk.” Given these qualifications, it is the view of the undersigned organizations that physicians participating in all MSSP ACOs should be able to qualify for APM incentive payments under the regulations implementing MACRA should they meet the required revenue or patient participation thresholds. The comments of CMS Deputy Administrator Patrick Conway are consistent with this view: “Setting today’s goal and achieving it early has led to additional benefits, on top of better patient care and smarter spending. Through alternative payment models, we’re spending money in a smarter way by paying for quality and better outcomes, not quantity.”

The definition of the word “nominal” is “very small in amount.” To date, CMS has typically measured the financial risk associated with an ACO using one yardstick: the total cost of care for the ACO’s patient population. Currently, an ACO that does not have to pay money to CMS if its patients’ Part A and B costs exceed a CMS-developed financial benchmark is considered by the agency to be upside only and is not recognized as being accountable for financial risk. There are many financial risks that can be far more than nominal that this approach overlooks, however, including: start-up costs to get the ACO off the ground such as data analysis and establishing procedures for coordinating care and sharing information, ongoing costs for new employees such as care managers, and foregone revenue from billable services that are reduced by the physicians participating in an ACO due to use of appropriateness guidelines and efforts to reduce exacerbations of patients’ conditions requiring emergency department visits and hospitalizations. The ACO incurs these costs with the goal of recovering them through shared savings, but if the savings are not achieved, the ACO incurs losses. With only a quarter of ACOs receiving any shared savings, all of the ACOs that incur these costs face a significant financial risk, even if they are not in a track that requires them to make a direct payment to CMS.

An ACO could be viewed as a product line. The ACO incurs costs associated with the product line and receive revenues from it. The financial risk to the ACO is that the revenue it receives may not cover the costs of participating in it. An ACO that involves physicians taking the time to jointly develop treatment plans, reducing complications, improving the appropriateness of test ordering, hiring care managers, and participating in a clinical data registry may experience reduced fee-for-service revenues because they are providing high-value services which are not payable under the Medicare fee schedule and they are providing fewer or less expensive billable services. The financial risk to the ACO is that the shared savings payments will not be enough to cover these reduced revenues. The ACO could be saving money for Medicare by reducing hospital admissions and expensive tests and procedures, but still be losing money for the participating physicians. The definition of more than nominal financial risk should not be based on the relative gain or loss to the Medicare Trust Fund, but on how much the physicians participating in the ACO gain or lose.

Under this approach, all Medicare ACOs, including those in Track 1, should qualify as APMs under MACRA. Physicians participating in Medicare ACOs, including Track 1 ACOs, at the threshold levels set by MACRA, should qualify to earn the annual 5 percent incentive payments for APM participation and be exempt from MIPS. In most cases, it seems likely that payments under an APM will be made to an entity rather than directly to an eligible physician. For example, Medicare ACO shared savings payments are paid to the ACO, not to the individual physicians or group practices participating in the ACO. In sum, **Medicare ACOs should be recognized as eligible APM Entities under MACRA.**

Conclusion

On behalf of the undersigned organizations, we thank you for the opportunity to provide feedback on this NPRM. We are hopeful that our constructive comments on improvements to the proposed rule are helpful, and we welcome any questions you may have.

Sincerely,

American Academy of Allergy, Asthma & Immunology
American Academy of Dermatology Association
American Academy of Home Care Medicine
American Academy of Neurology
American Academy of Physical Medicine and Rehabilitation
American College of Cardiology
American College of Physicians
American College of Surgeons
American Geriatrics Society
American Medical Association
AMGA
American Psychiatric Association
American Society for Clinical Pathology
American Society of Cataract and Refractive Surgery
American Society of Nephrology
Association of American Medical Colleges
Endocrine Society
Medical Group Management Association
National Association of ACOs
Premier healthcare alliance
Society of General Internal Medicine
Society for Cardiovascular Angiography and Interventions