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October 16, 2018

The Honorable Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
**Attention: CMS-1701-P**  
P.O. Box 8013  
Baltimore, MD 21244-1850

***RE: Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations – Pathways to Success, CMS-1701-P***

Dear Administrator Verma:

The Association of American Medical Colleges (“the AAMC” or “Association”) welcomes the opportunity to comment on the proposed rule entitled “Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations – Pathways to Success,” 83 *Fed. Reg.* 41756, issued by the Centers for Medicare & Medicaid Services (CMS or the Agency).

AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members are all 151 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America’s medical schools and teaching hospitals and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

The AAMC supports alternative payment model (APM) programs, such as accountable care organizations (ACOs) and bundled payment initiatives, that seek to promote high-quality, efficient care while retaining at their core the essential patient-physician relationship. Many academic medical centers (AMCs) are participating in new payment models, including the Medicare Shared Savings Program (MSSP or the program), Next Generation ACO Model, the Bundled Payments for Care Improvement (BPCI) Advanced model, the Oncology Care Model, and others.

The MSSP has the potential to reduce costs, improve quality of care, and promote collaboration and care coordination. We urge CMS to establish policies that encourage increased participation in the ACO program so that the program can achieve its long-term goals.

### **Summary of Issues on Which AAMC Provides Comments**

The following items are the AAMC’s recommendations on key proposals:

- **ACOs Should be Permitted More Years in Upside-Only Risk Arrangements:** CMS should allow all new ACOs to be in BASIC Levels A-B (shared savings only) for 4 years before requiring the ACOs to move to Level C (downside risk). ACOs that demonstrate contained cost growth relative to Medicare cost growth and perform well on quality should be allowed 5 years with no downside risk.
- **The ENHANCED Track Should Always be Optional:** All ACOs should be allowed to remain indefinitely in a BASIC Level E arrangement rather than being forced to move to the higher risk ENHANCED Track. Additionally, CMS should develop more options for gradual risk increases between BASIC Level E and ENHANCED.
- **BASIC Savings Sharing Rates Should Not be Reduced:** CMS should not finalize the reduction from the current shared savings rate of 50 percent. CMS should maintain the 50 percent sharing rate for upside-only Levels and gradually increase the sharing rates from Level C up to Level E to recognize the downside risk ACOs take on in those arrangements.
- **ACO Participants' Fee-for-Service (FFS) Revenue Should Not be Used to Create Distinctions:** CMS should not create different participation options and policies based on whether an ACO is "low revenue" or "high revenue." The proposed revenue standard is arbitrary and does not reflect an ACO's actual ability to bear greater financial risk.
- **5-Year Agreements:** CMS should finalize the proposal to move to 5-year agreement periods to promote stability and predictability for ACOs.
- **Cost Performance Alone Should Not be Cause for Involuntary Termination:** CMS should not finalize its proposal to broaden the agency's authority to terminate an ACO based on its financial performance relative to the ACO's Minimum Savings Rate/Minimum Loss Rate.
- **Partial Performance-Based Risk for Voluntary Termination Should Align with the Quality Payment Program (QPP):** ACOs taking on downside risk that wish to voluntarily terminate during a performance year should only be at risk for pro-rated reconciliation if they remain at risk through August 31, in line with the QPP performance period.
- **Cap on Risk Adjustment Should Not be Limited to 3 Percent Over 5 Years.** CMS should finalize its proposal to risk adjust for newly and continuously assigned beneficiaries and, at a minimum, should establish an annual cap of 3% on risk score growth to best ensure that year-over-year changes in patient complexity and health status are appropriately accounted for.
- **Incorporating Regional Adjustments to the Benchmark Should be Flexible to Allow for All ACOs to Succeed:** CMS should provide maximum flexibility and choice to ACOs and allow different approaches to phase-in regional blends to the benchmark.
- **Annual Written Beneficiary Notification is Unlikely to Strengthen Beneficiary Engagement:** CMS should not implement burdensome annual notification requirements for ACOs and instead should permit ACOs greater flexibility to communicate with patients about the program.
- **Additional FFS Benefit Enhancement Flexibility Should be Implemented in 2019:** CMS should expand the use of the existing Skilled Nursing Facility (SNF) 3-Day Rule Waiver and implement the broader availability of telehealth services for the 2019 performance year.
- **Specialists Should Not be Included for Voluntary Alignment:** CMS should consider protections from unintended consequences that may result from the inclusion of specialists.

## GENERAL COMMENTS

The MSSP has the potential to lower cost, promote care coordination and improve quality of care. Sustained and increased participation in the program will depend on potential financial opportunities being adequate to support the investments needed to improve quality and coordinate care. The MSSP has grown in recent years and now includes 561 ACOs covering 10.5 million beneficiaries.<sup>1</sup> ACOs have been leaders in the shift to value-based care. Recent reports have shown that ACOs have improved quality and have generated net savings to Medicare. A 2017 Health and Human Services (HHS) Office of Inspector General (OIG) report entitled “Medicare Shared Savings Accountable Care Organizations Have Shown Potential for Reducing Spending and Improving Quality” found ACOs achieved high quality performance with a score of 90.5 percent out of 100 percent for performance year 2017.<sup>2</sup> The 2017 MSSP performance year results showed net savings of \$314 million to the Medicare trust funds.<sup>3</sup> In its June 2018 report, the Medicare Payment Advisory Commission (MedPAC) also referenced several peer reviewed studies that found savings from the program.<sup>4</sup>

For the program to achieve its long-term goals, CMS should set forth policies that encourage participation by establishing incentives for ACOs to increase quality and reduce costs. One of our chief concerns with this proposed rule is that the combination of requiring downside risk for spending in excess of benchmarks after year one or two of the program, earlier blending of historic benchmarks with regional benchmarks, and reduced shared savings rates will result in many ACOs exiting the MSSP program and discourage participation by new ACOs in the future.

## REDESIGNING PARTICIPATION OPTIONS

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

CMS proposes to redesign the program’s participation options by discontinuing Track 1, Track 2 and the deferred renewal option, and instead offering two tracks that eligible ACOs would enter into for an agreement period of at least 5 years:

- (1) BASIC track, which would include an option for eligible ACOs to begin participation under a one-sided model and incrementally phase-in risk and potential reward over the course of a single agreement period, an approach referred to as a glide path; and
- (2) ENHANCED track, based on the program’s existing Track 3, for ACOs that take on the highest level of risk and potential reward.

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<sup>1</sup> Centers for Medicare & Medicaid Services, *Medicare Shared Savings Program Fast Facts* (January 2018). available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/SSP-2018-Fast-Facts.pdf>

<sup>2</sup> Department of Health and Human Services Office of the Inspector General (HHS OIG), *Medicare Shared Savings Accountable Care Organizations Have Shown Potential for Reducing Spending and Improving Quality* (2017). Available at <https://oig.hhs.gov/oei/reports/oei-02-15-00450.asp>

<sup>3</sup> National Association of ACOs, *More Medicare Accountable Care organizations (ACOs) Achieve Quality and Cost Goals in 2017* (August 30, 2018). Available at <https://www.naacos.com/press-release--more-medicare-acos-achieve-quality-and-cost-goals-in-2017>

<sup>4</sup> Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System* (June 2018). Available at: [http://www.medpac.gov/docs/default-source/reports/jun18\\_medpacreporttocongress\\_sec.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/reports/jun18_medpacreporttocongress_sec.pdf?sfvrsn=0)

Within the BASIC track, CMS proposes a glide path that includes 5 levels: a one-sided risk model available only for the first 2 consecutive performance years of a 5-year agreement period (Levels A and B), and three levels of progressively higher risk and potential reward in performance years 3 through 5 of the agreement period (Levels C, D, and E). ACOs would be automatically advanced at the start of each participation year until they reach the track's maximum level of risk/reward (designed to be the same as Track 1+ Model).

With respect to participation options within the BASIC track, ACOs new to the program would have the flexibility to enter the glide path at any one of the five levels. ACOs that previously participated in Track 1 (or a new ACO in which a specified percentage of its ACO participants have recent prior experience in Track 1) would be ineligible to enter the glide path at Level A (thereby limiting their participation in one-sided risk). For ACO participants with recent prior experience in a Track 1 ACO, Level E must be entered into no later than the fourth performance year. Special rules apply for so-called "low revenue" ACOs that have experience in ACO initiatives and would otherwise be required to be at Level E of the BASIC track.

***CMS Should Allow ACOs to Participate in BASIC, in an Upside-Only Level, for at Least 4 Years Before Transitioning to Downside-Risk***

The AAMC has major concerns with CMS's proposal to require risk for spending in excess of benchmarks (downside risk) after 2 years (and in some cases, after 1 year) in the BASIC Track. **We urge CMS to not finalize this proposal. Instead, we recommend that CMS allow all new ACOs to be in Levels A-B (shared savings only) for 4 years before requiring the ACOs to move to Level C (downside risk).** Additionally, ACOs that demonstrate contained cost growth relative to Medicare cost growth and perform well on quality should be allowed 5 years with no downside risk. These ACOs are demonstrating progress and movement toward assuming risk in the future. The reasons that shared savings only models should be allowed for a longer period of time are enumerated below.

- *Aggressive Push to Downside Risk Could Slow Movement from Volume to Value-Based Payment Due to Insufficient Time to Prepare for Risk.*

MSSP Track 1 is the most popular option for ACOs, representing 82 percent of MSSP ACOs in 2018. Currently, many ACOs remain in Track 1 after the first agreement period because they are unprepared to assume downside risk yet. To assume risk, ACOs need predictability and positive performance results. The ability to assume downside risk depends on a variety of factors, such as local market, leadership, financial status, resources required to address social determinants of health, and number of patients with complex conditions.

To prepare for changes, the ACOs also need to have a sufficient amount of performance data from prior years. Under CMS's proposal ACOs would have only one year of performance data before shifting to downside risk. This does not allow time for taking steps to improve performance to ensure success in the program in future years.

It takes time for ACOs to gain experience with the program and to start to produce consistent savings. Research shows that ACOs improve over time in the program. It takes the average ACO that earned savings in 2017 three years to initially generate savings. Of the 142 ACOs that earned shared savings payments in 2017 and had prior program experience 36 percent had losses in one of their first two years in the program. Two years is not sufficient time to prepare for downside risk. ACOs need to be able to commit to a risk path on a timeline that they can achieve.

Surveys suggest that an aggressive push to “two-sided risk” arrangements in the MSSP could cause many of the current Track 1 ACO participants to drop out of the MSSP and would discourage other providers from participating in the future. This could slow the movement of providers from volume to value-based payments. CMS needs to balance the goals of transitioning providers to payment models with more financial risk while also retaining participation of those willing to work on value-based models.

- *ACOs Incur Significant Risk to Participate in ACO Models, Including in One-Sided Risk Arrangements*

It is important to recognize that there is financial “risk” involved in one-sided ACO models, such as Track 1. ACOs incur significant costs to participate in the MSSP, including costs for clinical and care management, health IT, population analytics and tracking, redesign of care processes, and management. ACOs will lose money if they do not earn enough shared savings to offset the costs of participation.

- *ACOs Have Demonstrated Success in Reducing Medicare Spending Without Accepting Downside Risk*

The majority of Track 1 ACOs have reduced Medicare spending relative to CMS benchmarks even though they are not subject to downside risk. The MSSP performance year 2017 results show net savings to the Medicare Trust Fund of \$314 million after accounting for shared savings payments made to ACOs. It is important to note that many ACOs generate savings by having expenditures lower than their benchmark even though they do not surpass the Minimum Savings Rate and thus do not qualify for earned savings. While they do not earn shared savings, these ACOs are still saving money for the Medicare Trust Fund and are demonstrating an increasing likelihood of achieving shared savings over time. This is likely due to experience in the program and investments in care coordination, quality and analytics. CMS should encourage their continued participation in the program.

- *ACOs Have Demonstrated that They Outperform Fee-for-Service (FFS) Providers on Quality*

Another important factor to consider is that shared savings only ACOs have improved quality of care. The HHS OIG Report<sup>5</sup> from August 2017 found that ACOs outperformed Medicare FFS providers on 81 percent (22 of 27) of the individual quality measures and performed better than 90 percent of all FFS providers when looking at hospital readmissions. These findings confirm that ACOs are providing high quality care to the Medicare beneficiaries they treat and continue to improve quality over time. Therefore, it is critical for CMS to continue to support these efforts and not force ACOs that perform well on quality to assume downside risk when they are not ready.

ACOs that score at or above the 50<sup>th</sup> percentile in quality in 2 years of participation in the program have clearly invested significantly in data analytics software, clinical improvements, staff training, and operational changes to achieve high-performance on ACO quality metrics. Though these ACOs may not have earned sufficient shared savings relative to their benchmarks to allow them the financial readiness to assume risk, they have demonstrated high quality care and should be given additional time (at least 4 years) prior to being forced into taking on downside risk.

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<sup>5</sup> HHS OIG, *Medicare Shared Savings Accountable Care Organizations Have Shown Potential for Reducing Spending and Improving Quality* (2017) Available at <https://oig.hhs.gov/oei/reports/oei-02-15-00450.asp>

***CMS Should Reduce Risk Associated with Moving from BASIC to ENHANCED***

CMS proposes a gradual glidepath for risk under the BASIC track but does not propose a similar glide from BASIC Level E to ENHANCED. There is a significant increase in financial risk an ACO must assume when it must transition from BASIC Level E to the ENHANCED track. The ENHANCED track requires maximum losses based on total cost of care and it is capped at almost 4 times the amount in the BASIC Level E. CMS acknowledges this significant increase and requests feedback.

**We urge CMS to create a revenue-based loss sharing limit for the ENHANCED Track and to create more options for gradual risk increases between BASIC Level E and ENHANCED.** It is important that CMS not force ACOs into a model with levels of risk that they are unable to assume. ACOs that are not ready for such high levels of risk will exit the program. Many ACOs have generated savings to the Medicare program while improving the quality of patient care. We urge CMS to continue to enable them to participate in the program. We recommend that CMS allow all ACOs to remain indefinitely in BASIC Level E rather than being forced to the ENHANCED Track.

***CMS Should Maintain a 50 Percent Shared Rate for Levels A-B and Increase the Rate for Levels C-D***

In the BASIC track, CMS proposes to set the rate at which an ACO can share in savings to a maximum of 25 percent for Levels A and B, 30 percent for Level C, 40 percent for Level D, and 50 percent for Level E. This represents a significant reduction in the sharing rate for Levels A-D compared the current sharing rate of 50 percent for Track 1. The ENHANCED track would have a sharing rate of up to 75 percent (unchanged from the current rate for Track 3).

The **AAMC strongly opposes the reduction** from the current shared savings rate of 50 percent. Instead, we recommend that CMS maintain a 50 percent sharing rate for Levels A-B and increase the savings rate for Levels C-D to 55 percent and the rate for Level E to 60 percent, in recognition of the level of downside risk.

To incentivize ACOs to lower spending, it is important to enable ACOs to share in the savings. Establishing a shared savings rate that is too low (e.g. 25 percent) limits the opportunities for the ACO to benefit relative to the status quo because, as has been described above, the ACOs incur substantial costs simply for participating in the program. This includes the costs of governance and operations, quality reporting, and efforts to redesign care. The proposal to reduce the shared savings rate in all levels of the BASIC track except Level E is likely to eliminate opportunities for ACOs to save, might reduce ACO investments in the program, and would ultimately discourage participation in the program.

Instead of attempting to set policies that would make savings-only models less appealing, **we recommend CMS focus on making models with downside risk more attractive while also supporting shared savings only models.**

**Determining Participation Options Based on Medicare Fee-for-Service (FFS) Revenue**

***Differentiating ACOs on the Basis of FFS Revenue of ACO Participants is Arbitrary and Will Likely Lead to Less Participation by Hospitals***

CMS proposes to create a new distinction to define ACOs as either high or low revenue, with that determination creating separate and distinct options for how that ACO may participate in the

program going forward. CMS proposes to define revenue determinations by the Parts A and B FFS revenue of the ACO's participants (FFS billing by tax identification numbers, or TINs) for the most recent calendar year for which data is available as compared to the expenditures of the ACO's aligned beneficiaries for the same calendar year. If the FFS revenue of its participants is at least 25 percent of that of the total expenditures for its beneficiaries, the ACO would be considered high revenue. If less than 25 percent, it is low revenue. In calculating ACO revenue, CMS proposes to include hospital add-on payments such as Indirect Medical Education (IME), Disproportionate Share Hospital (DSH) adjustment, and uncompensated care costs (UCC), but not include those same payments when calculating beneficiary expenditures.

ACOs determined to be high revenue under the proposal would be limited in their ability to participate in the BASIC track of the program (if at all) and be pushed to take on two-sided risk sooner. CMS claims that this approach is intended to evaluate an ACO's ability to control expenditures, and thus be able to take on greater levels of performance-based risk. In general, CMS notes that "low revenue" ACOs tend to be smaller, physician-led, and less likely to have access to capital necessary to assume risk.

**The AAMC opposes categorizing ACOs by FFS revenue and urges CMS to not finalize the proposed revenue distinctions.** The reasons that there should be no distinction based on revenue are enumerated below:

- *Revenue Does Not Equal Control or Ability to Bear Risk*

Medicare revenue is **not** synonymous with an ACO's ability to control beneficiary expenditures. CMS's proposed approach does not measure how much of the beneficiary expenditures flows through the ACO's Participants (i.e., that 25 percent or more of the beneficiary's expenditures were billed by ACO Participants). Furthermore, Medicare revenue does not capture ownership or external private investment in the formation and management of an ACO. Research shows that insurers and venture capital funds are investing millions of dollars in certain ACOs, which are often physician-led, and CMS's proposed approach would not capture such private investment when determining the revenue of ACO's Participants.

- *Inclusion of Add-On Payments in Revenue Calculation Unfairly Penalizes Teaching Hospitals and Academic Medical Centers*

Including IME, DSH, and UCC payments in the calculation of ACO revenue, but not in the expenditures calculation unfairly penalizes the teaching hospitals that receive such add-on payments. It is also inconsistent with program's policy to exclude these add-on payments from both the benchmarks and performance year expenditures calculations because the agency does "not wish to incentivize ACOs to avoid these types of providers that receive these payments."<sup>6</sup> This policy alone will make it less likely that ACOs engage teaching hospitals as ACO Participants. The Medicare program has long recognized the higher costs associated with the important societal roles of teaching hospitals and has provided IME and DSH payments to help offset these costs. In addition to training future physicians and other health care professionals, teaching hospitals treat the sickest and most complex Medicare patients. They have higher case mix indices and treat a disproportionate share of outlier cases. These institutions also receive the majority of transfers from other hospitals when

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<sup>6</sup>Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations – Pathways to Success, 83 Fed. Reg. 41786, 41809 (August 17, 2018)

patients need more sophisticated diagnostic and treatment services than other providers can deliver.

Finalizing the inclusion of these hospital add-on payments in the revenue calculation will give ACOs a strong incentive not to include teaching hospitals in their networks. This will not only affect teaching hospitals but also the vulnerable beneficiaries treated by these hospitals because they will have limited access to the care coordination efforts, enhanced services like the skilled nursing facility (SNF) 3-day rule waiver and telehealth, and additional future beneficiary incentive programs available through ACOs to the vulnerable populations disproportionately treated by teaching hospitals and academic medical centers.

- *CMS Policies Should Drive All Providers to Collaborate*

The best way to drive high quality care for patients is to create incentives that drive all the providers in a system to collaborate to innovate and deliver high quality, cost effective health care. MedPAC addressed this in its June 2018 report<sup>7</sup> noting that while hospitals may have certain conflicting interests that create challenges for ACO participation, the Commission recommends hospitals should continue to be part of ACOs. Rather than finalize unnecessary and arbitrary distinctions for ACOs, CMS should work to support all ACOs as they progress on the value-based care continuum, and the agency should create meaningful incentives for ACOs to assume risk. The goal of ACOs is to incent all providers to work collaboratively to benefit patients. CMS should adopt policies that continue to engage hospitals as key players rather than create incentives to exclude hospitals as ACO Participants.

## **5-Year Agreement Periods**

### ***Transitioning to 5-Year Agreement Periods Promotes Stability and Predictability for ACOs***

In an effort to provide stability and certainty for ACOs, CMS proposes to move to longer agreement periods by revising the definition of “agreement period.” CMS proposes to modify the definition at 42 C.F.R. § 425.200 that agreements beginning in 2020 and subsequent years will have a term of participation of 5 years, instead of 3 years. CMS proposes agreement periods of 5 years and 6 months for agreements beginning July 1, 2019 to balance the transition to longer agreements with adequate time for ACOs to apply to participate in the program under the proposed modified terms. We support this proposal.

One motivation for this proposal is that longer agreement periods could improve program incentives and support ACOs by providing greater stability and certainty over benchmarks. This is in part because benchmarks are set at the beginning of the agreement period, and then adjusted annually based upon changes to the ACO’s certified ACO participant list, changes to the assignment of beneficiaries, annual risk adjustment, and annual benchmark updates. Additionally, extended agreement periods would delay the effects of benchmark rebasing by 2 years (relative to a 3-year agreement).

While not expressly noted by CMS, another benefit of a longer agreement term would be the longer periods of participation in the program between application cycles for ACOs. This allows more time for ACOs to focus on current participation without needing to balance future participation

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<sup>7</sup> Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System* (June 2018). Available at: [http://www.medpac.gov/docs/default-source/reports/jun18\\_medpacreporttocongress\\_sec.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/reports/jun18_medpacreporttocongress_sec.pdf?sfvrsn=0)

considerations and administrative burden related to the renewal process. **The AAMC supports longer agreement periods as it will help promote stability and predictability for ACOs participating in the program.**

### **Permitting Annual Participation Options**

#### ***Permitting ACOs to Elect its Beneficiary Assignment Methodology Annually Allows Greater Flexibility and Tailoring of Participation for ACOs***

CMS proposes to implement Section 50331 of the Bipartisan Budget Act (BBA) of 2018 by allowing all ACOs to choose the prospective beneficiary assignment methodology for an agreement period (instead of preliminary prospective assignment with retrospective reconciliation beneficiary assignment methodology). Going further, in response to stakeholder interest in allowing more flexibility for ACOs, CMS proposes to provide additional flexibility to permit ACOs to elect the beneficiary assignment methodology annually for each performance year within an agreement period. An ACO would choose its beneficiary assignment methodology at the time of its application to enter or renew its participation in the program, and then have an annual opportunity to notify CMS of its intent to change its assignment methodology in advance of the next performance year under the agreement. **The AAMC supports this additional flexibility for ACOs and recommends that CMS finalize this policy as proposed.**

#### ***CMS Should Permit an Annual Election of the Minimum Savings Rate (MSR)/Minimum Loss Rate (MLR)***

CMS also proposes to permit the election of different levels of risk within the BASIC track's glide path under a new proposed policy (42 C.F.R. § 425.601) whereby an ACO can elect to transition more quickly from a one-sided level to a two-sided level. As part of the proposal, when an ACO transitions to a downside risk taking level it will elect a symmetric MSR/MLR that will apply for the remainder of the agreement period under performance-based risk. Permitting annual elections is a critical tool that can encourage ACOs to try new approaches and transition to higher levels of risk and reward; however, without additional flexibility related to the MSR/MLR selection, ACOs will not have the full opportunity to meaningfully tailor their participation. Given the extended 5-year agreement period proposed by CMS, it is that much more important that CMS allow ACOs to select their MSR/MLR prior to the start of each performance year rather than be locked into that selection for up to 5 years. **The AAMC supports the agency's efforts to add annual elections to the program to incorporate additional flexibility for ACOs, but also recommends that CMS carry that logic further and adopt an additional election policy to permit ACOs to modify their MSR/MLR selection annually.**

### **Early Termination & Voluntary Termination**

#### ***Cost Performance Alone Should Not be Cause for Involuntary Termination***

CMS proposes to amend the program's regulations to allow the agency to monitor an ACO's financial performance and take early termination action against the ACO, in addition to current policy which allows the agency to terminate an ACO's agreement for program integrity concerns. Specifically, CMS proposed to monitor whether an ACO's expenditures for its assigned beneficiaries exceed the ACO's negative Minimum Savings Rate (MSR), under a one-sided model, or its Minimum Loss Rate (MLR), if under a two-sided model. If the ACO is negative outside the

applicable “corridor” for a performance year, CMS proposes to add to the regulations authority for the agency to take pre-termination actions, including a corrective action plan (CAP). If the ACO is negative outside the corridor for a second performance year, CMS proposes to allow the agency to immediately or with advance notice (30 days) terminate that ACO’s agreement.

The proposed MSR/MLR standard sets a low bar, especially considering that ACOs in a two-sided risk model can forgo an MSR/MLR altogether (by setting it at 0 percent). This policy would disincentivize ACOs from taking on greater risk/reward via its MSR/MLR selection, because the ACO could be kicked out of the program if it fails to achieve cost savings in a given year. Furthermore, setting the performance threshold at the MSR/MLR is redundant for ACOs in downside risk, as they are already accountable for repaying their shared losses if their expenditures exceed their benchmarks outside of the MLR.

To demonstrate that the proposed policy is far too broad, consider that ACOs participating in one-sided risk are often early in their transition to practicing value-based care, and may not be able to achieve immediate savings. In reviewing 2017 performance, of the 142 ACOs that earned shared savings payments and had prior program experience, 51 had losses in one of their first two years in the program. Had the proposed policy been in place, they would have been put under a CAP and may have been removed from the program prematurely.

Understanding that CMS is considering broader scope of its authority to terminate ACOs that are “bad actors,” the AAMC suggests that the CMS consider more appropriate standards of poor financial performance that are more tailored to the agency’s intent. One approach might consider a standard that looks at the ACO’s cost growth relative to national expenditure growth trends to demonstrate that the ACO is an outlier requiring corrective action. For example, CMS could monitor ACOs based on whether the ACO’s expenditure trend is substantially higher than the national expenditure growth trend, such as 5 percentage points higher, and take the pre-termination action in those cases, rather than based on the ACO’s selected MSR/MLR. Should the agency move forward with any type of early termination policy, at a minimum it should be used only in rare cases where the agency has documented program integrity concerns. **The AAMC does not support this policy and urges CMS not finalize it as proposed.**

***The Voluntary Termination Notice Deadline Should Be Extended to August 31 to Trigger Partial Reconciliation for a Performance Year***

CMS also proposes to change the policies governing an ACO’s voluntary termination of its agreement. CMS proposes to reduce the minimum notification period to 30 days (from 60 days) for an ACO’s voluntary early termination from the program. In addition, CMS proposes to require that ACOs in two-sided risk models that voluntarily terminate effective after June 30 share in pro-rated losses using the full 12 months of performance year expenditure data. CMS also proposes to pro-rate shared losses for any ACO that is involuntarily terminated at any point in the performance year that was participating in a two-sided risk model.

The AAMC has concerns regarding the June 30 proposed deadline for an ACO to voluntarily terminate from the program without financial risk of sharing in losses if in a two-sided risk model. ACOs do not have sufficient performance year data by June 30 to make an informed decision about continued participation in the program, as they would only have one quarter of performance year data and would not have the final reconciliation with final risk adjustment for the prior performance year (if applicable), due to the timing performance reports.

The June 30 cutoff also has an interaction with the Quality Payment Programs in regard to ACOs participating in a track/level that qualifies as an Advanced Alternative Payment Model (AAPM) because the performance period for qualifying participants (QPs) in an AAPM ends August 31 (but includes qualifying snapshots on March 31 and June 30). In setting a June 30 financial risk deadline, CMS could potentially strip an ACO subject to financial risk from appropriate QP AAPM status. Instead, CMS could align prorated financial risk with the QPP performance period, creating better synergy between popular AAPM policy and QPP policy. Considering the timing of actionable performance data and the QPP performance period, **the AAMC recommends that CMS modify its proposal to hold an ACO accountable for a portion of shared losses only if the ACO terminates effective on or after August 31.**

## BENCHMARKING METHODOLOGY REFINEMENTS

### Risk Adjustment Methodology

#### *CMS Should Risk Adjust the Benchmark to Better Reflect Patient Complexity*

CMS proposes to change the program's risk adjustment methodology to use CMS-HCC prospective risk scores to adjust the historical benchmark for changes in severity and case mix for *all* assigned beneficiaries, subject to a symmetrical cap of positive or negative 3 percent for the agreement period, for agreement periods beginning on July 1, 2019, and in subsequent years. This approach would eliminate the current distinction between newly and continuously assigned beneficiaries.

**We strongly support CMS's proposal to eliminate the distinction between newly and continuously assigned beneficiaries. However, we believe the 3 percent cap over 5 years is insufficient.** As proposed by CMS, the 3 percent cap is across a 5-year period and not a year-over-year increase. A cap of 3 percent is arbitrary and not sufficient when applied across five years, considering that many ACOs could exceed the 3 percent cap in the first performance year of an agreement period. **Instead, we recommend that CMS amend the policy to apply, at a minimum, the symmetric 3 percent risk adjustment cap annually.** This will preserve further stability and better reflect the clinical complexity and patient characteristics of an ACO's population. It is essential for an ACO's benchmarks to be adjusted annually for continuously assigned beneficiaries when there is a genuine change in health and risk status of their patient population. ACOs who have made genuine improvement in their patients should see a downward adjustment if the patients get healthier and an upward adjustment if their health status worsens.

**CMS should also apply changes to its Medicare Advantage risk adjustment methodology to the Medicare Shared Savings ACOs.** Specifically, CMS announced in its Medicare Advantage 2017 Advance Notice and Draft Call letter its plans to refine the risk adjustment model to improve the accuracy of payments to plans serving beneficiaries who are low income and dually eligible for Medicare and Medicaid. Applying a risk adjustment methodology that accounts for low income beneficiaries to ACOs would be particularly beneficial to ACOs that include teaching hospitals and academic medical centers as Participants, as they typically serve a higher number of low income patients with more complex conditions and should not risk penalty for doing so.

## **Benchmarking Methodology**

### ***CMS Should Provide Maximum Flexibility and Choices to ACOs for Incorporating Regional Adjustments to the Benchmarking Methodology***

CMS proposes to incorporate regional expenditures into benchmarks beginning with initial agreement periods, rather than beginning with an ACO's second agreement period. The Agency also proposes to cap the maximum amount of regional expenditures at 50 percent. Specifically, ACOs would have the following blended regional expenditure component incorporated:

- First agreement period - 25 or 35 percent (the higher rate would apply if ACO spending is lower than its region);
- Second agreement period – 35 or 50 percent during the second agreement period; and
- Third and subsequent agreement periods - 50 percent.

CMS also proposes to introduce a symmetric +/- 5 percent cap, implemented separately for each beneficiary category and based on national per capita expenditures.

Creating appropriate benchmarks for ACOs is a key to success and is essential for keeping those ACOs engaged in the program. The AAMC is generally supportive of CMS incorporating a portion of regional cost data in the benchmark. However, we have some concerns about the application of a 25 or 35 percent regional expenditure amount in the first agreement period. While we recognize that regional expenditure cost data in the benchmark can be beneficial, we think it is important not to rely exclusively on regional cost data as there could be ACOs that have complex patient populations that would necessitate use of a greater portion of historical costs in the benchmark. Therefore, **we support the concept of using a blend of historical and regional cost data to establish ACO benchmarks that would be phased in more gradually than the CMS proposal.**

We believe CMS should provide maximum flexibility and choices to ACOs and allow different approaches to transition to any new benchmarking methodology, primarily a more gradual phase-in of the regional blend in the first agreement period for ACOs with costs higher than their regions. For example, CMS could apply a 10 percent blend in performance years 1 and 2, 20 percent in year 2 and 3, and 30 percent in year 5 of the first agreement period. If CMS adopts its proposal to include regional blends to the benchmark in the first agreement period, CMS should monitor the impact on participation in the ACO shared savings program by provider type, including Academic Medical Centers and make refinements as needed to ensure sustained participation.

### ***Regional Service Area Should Include Counties of Residence Where More than 1 Percent of Assigned Beneficiaries Reside***

In the 2016 ACO rule, CMS defined the ACO's regional service area based on counties of residence of the ACO's assigned beneficiaries. There could be multiple counties included in the ACO's regional service area. An ACO's region would include any county where *one* or more beneficiaries assigned to that ACO reside. CMS would weight the county level FFS costs by the proportion of the ACO's assigned beneficiaries in the county. Therefore, if only one beneficiary resides in the county, the county would have a very small weight in the calculation of the benchmark. **While we support basing the regions on counties in which the ACO's beneficiaries reside, we believe that the threshold of one beneficiary is too low.**

The AAMC has heard from multiple AMCs that participate in ACOs that it is common for them to have assigned beneficiaries that reside far away from the ACO's general service area. Academic

medical centers tend to be destinations for specialized care, drawing patients from around the country and the world with specific and complex health care needs. If CMS adopts this threshold, ACOs with AMCs could have many different regions of the country included in their benchmark calculation even if they care for only one patient who resides in a particular county. **We recommend CMS increase the threshold to one percent of the ACO's assigned beneficiary population, as CMS did in the Physician Group Practice Demonstration**, for example. This will reduce complexity and result in a better reflection of the ACO's general regional service area.

***CMS Should Remove ACO-Assigned Beneficiaries from the Regional Service Area Population Calculation***

In determining the regional expenditures for resetting the benchmark, CMS calculates FFS costs for all assignable beneficiaries including those who have been assigned to the ACO. CMS states that "assignable beneficiaries, are Medicare FFS beneficiaries that received at least one primary care visit from any Medicare primary care physician or physician with a primary care specialty designation for purposes of ACO assignment during the 12-month assigned period window.

AAMC supports limiting the beneficiary population to "assignable beneficiaries." Beneficiaries who have not received a primary care service during the time frame should be excluded as they would inappropriately lower the expenditures against which the ACO would be compared. However, if the ACO-assigned beneficiary population remains in the calculation of expenditures, the regional cost data could be skewed by the ACO's efforts to coordinate care and reduce expenditures for the ACO assigned beneficiaries. Therefore, **we urge CMS to remove ACO-assigned beneficiaries from the regional service area reference population** so that an ACO's performance is compared relative to the FFS population instead of the ACO population.

***CMS should Continue Exclusion of IME, DSH, and Uncompensated Care from Benchmarks***

**The AAMC continues to strongly support the exclusion of IME, DSH and uncompensated care payments from an ACO's benchmark and performance year calculations.** We are pleased to see in this rule CMS remains committed to its policy of excluding these add-on payments. This policy is necessary to protect beneficiary access to necessary care at teaching hospitals. The Medicare program has long recognized the higher costs associated with the important societal roles of teaching hospitals and has provided DGME, IME, and DSH payments to help offset these costs. In addition to training future physicians and other health care professionals, teaching hospitals treat the sickest and most complex Medicare patients. They have higher case mix indices and treat a disproportionate share of outlier cases. These institutions also receive the majority of transfers from other hospitals when patients need more sophisticated and diagnostic and treatment services than other providers can deliver.

To include these policy add-on payments in ACO benchmarks would give ACOs a strong financial incentive to find savings by steering patients away from teaching hospitals rather than through redesigned and improved care which are the goals of the program. Continuing to exclude IME, DGME, and DSH payments from the benchmark and performance calculations will help ensure that decisions by ACOs will be based on *clinical* determinations that are in the best interests of the patient.

***CMS Should Account for Savings in Rebased Benchmarks***

We urge CMS to adjust rebased historical benchmarks to recognize savings in expenditures that a successful ACO achieves during its first agreement period. Specifically, CMS should add a portion

of the savings from the previous agreement into the rebased benchmark to encourage ongoing participating in the program. ACOs that invest in care coordination and quality improvement and lower expenditures should be rewarded.

#### PROVIDING TOOLS TO STRENGTHEN BENEFICIARY ENGAGEMENT

##### **Beneficiary Incentives**

###### ***CMS Should Consider Administrative Burden When Finalizing Incentive Program Policies***

CMS proposes to allow any ACO in Track 2, Levels C, D, or E of the Basic Track, or the Enhanced Track to establish a CMS-approved beneficiary incentive program to provide incentive payments to eligible beneficiaries who receive qualifying services. As required by the Bipartisan Budget Act of 2018 (BBA), CMS proposes a \$20 payment limit, updated annually consistent with the consumer price index and rounded to the nearest dollar, and made no later than 30 days after the service. A beneficiary would be eligible to receive an incentive payment if the beneficiary is assigned to an ACO through either preliminary prospective assignment with retrospective reconciliation or prospective assignment. CMS proposes that the ACO legal entity must furnish the incentive directly to the beneficiary, and that the payment may only be a cash equivalent (e.g., a check or rewards card) and not cash. The ACO would be responsible for funding the costs of operating an incentive program, including funding the cost of the incentive payments, and must keep records of all incentives paid out to assigned beneficiaries. ACOs would not be allowed to accept or use funds from outside entities (including but not limited to an insurance company or a pharmaceutical company) to finance its incentive program. ACOs would be required to publicly report annually the total number of incentive payments furnished, the HCPCS codes associated any qualifying payments for which an incentive was furnished, the total value of all incentive payment furnished, and the total type of each incentive payment.

**The AAMC supports CMS’s proposal to implement the BBA’s vision of a beneficiary incentive program for ACOs taking on downside risk.** Because CMS would require ACOs to fully fund the costs and administration of such a program, the AAMC asks that CMS consider reviewing initial uptake of the option to offer incentive programs and whether the result is that only ACOs in certain markets or with similar profiles are available to take advantage of the opportunity (for example, ACOs serving wealthier, suburban beneficiary populations rather than those serving urban or rural populations). In the event that CMS observes incentive programs are not widely available to beneficiaries, the AAMC recommends that CMS consider novel ways to finance programs through “pre-payments” of shared savings to ACOs or other capital-funding concepts.

##### **Empowering Beneficiary Choice**

###### ***Requiring Beneficiary Notifications is Unlikely to Strengthen Beneficiary Engagement***

CMS proposes to modify the current beneficiary notification requirements (informational signs in Participant facilities and physician offices and written notification upon request) and, in addition, would require a standard written notification be provided annually to *all* Medicare FFS beneficiaries at their first primary care visit of the performance year in the form and manner specified by CMS. Beginning July 1, 2019, the ACO would also be required to inform the patient about the beneficiary’s ability to identify, or change identification of a primary care provider, for purposes of voluntary alignment. The proposal is designed to ensure that beneficiaries have a sufficient opportunity to be

informed about the program and how it may affect their care and health data.

The agency previously required annual written notification to beneficiaries and abandoned that policy in response to confusion among beneficiaries and ACO feedback related to operational burden. The proposal for a written notification at the place of service is administratively complex and cost prohibitive. ACOs and their Participants do not have sufficient data on all Medicare FFS beneficiaries to know whether at the time and place of service the care furnished was the first primary care service that beneficiary received that year. Furthermore, that beneficiary, while seeking care from the ACO Participant, might not be assigned to the ACO in which the practitioner participates or might not reside in the market of that ACO and could be reasonably confused and scared in response to the required language relating to claims data sharing with the ACO. A CMS template for the notification does not ease operational burden, as suggested by CMS, and does not address the bigger concerns relating to beneficiary confusion and complaints.

The Next Generation ACO Model currently requires that an annual written notification be mailed to aligned beneficiaries early in the performance year. It is unclear from the proposal whether CMS conducted an analysis of 1-800-MEDICARE call data as to whether the timing of that notification resulted in a higher volume of complaints. CMS should conduct market testing and beneficiary focus groups to better understand how Medicare FFS beneficiaries engage with their health care providers and understand their role in their care.

To better support and strengthen beneficiary engagement, CMS should instead consider permitting ACOs greater flexibility to communicate with patients about the program, such as including language on the ACO websites as well as phone-recorded messages. Current program rules restrict ACO communication to beneficiaries and inhibit an ACO's ability to explain the benefits and services provided by ACOs. **The AAMC does not support the agency's proposal to require ACOs to provide written notification** to all Medicare FFS beneficiaries at the place of service.

***CMS Should Not Implement Opt-In Assignment Methodology Until the Agency has a Greater Understanding of Traditional Medicare Beneficiary Consumer Behavior***

CMS proposes to allow ACOs to elect a new "beneficiary opt-in" enrollment-based assignment methodology that would be supplemented by a modified claims-based assignment and voluntary alignment. The opt-in assignment would be based on an affirmative recognition of the relationship between the beneficiary and the ACO. The "opt-in" approach would be supplemented with a modified claims-based assignment approach that focuses on the most complex patients by assigning beneficiaries to the ACO with seven or more primary care service visits from ACO clinicians.

Altering the attribution process to require beneficiaries to actively elect an ACO would create insurmountable administrative complexities and would be confusing to beneficiaries. As noted in our comments on the proposed requirements for beneficiary notifications, Medicare FFS beneficiaries are not engaged or generally aware of the services and benefits of ACOs. Although CMS introduced the voluntary alignment process to allow beneficiaries to designate a primary clinician via the MyMedicare.gov website, the program remains underutilized. Rather than add more complexity and confusion to beneficiary engagement with ACO assignment, CMS should instead focus on improvements to increase the use of the voluntary alignment option. This would serve as an incremental improvement to the broader challenges of educating Medicare FFS beneficiaries about ACOs.

**The AAMC opposes CMS's proposed introduction of an opt-in assignment methodology to the**

**program at this time**, and instead recommends that CMS consider proposals to improve voluntary alignment before moving towards the development of an enrollment-based method.

#### FEE-FOR-SERVICE BENEFIT ENHANCEMENTS

##### **Skilled Nursing Facility (SNF) 3-Day Rule Waiver**

###### ***CMS Should Finalize the Proposal to Expand Use of SNF 3-Day Rule Waiver to All ACOs in Two-Sided Risk Regardless of Beneficiary Assignment Methodology***

CMS proposes, beginning July 1, 2019, to expand eligibility for the SNF 3-Day Rule waiver to include ACOs participating in a two-sided model regardless of the ACO's selected beneficiary assignment methodology. The AAMC fully supports this proposal, as the SNF 3-Day Rule waiver is a critical tool ACOs can use for coordinating and improving the quality of care. How a beneficiary is assigned to the ACO should not limit the ACO's access to this tool.

The AAMC recommends that CMS consider expanding use of the 3-Day Rule Waiver for ACO Participants for all Medicare FFS beneficiaries, in an effort to provide better care to all patients, and not only those that are attributed to the ACO. This would streamline care coordination for all beneficiaries and greatly minimize burden associated with the current process.

##### **Billing and Payment for Telehealth Services**

###### ***The AAMC Supports the Expansion of Telehealth Services for ACOs and Urges CMS to Implement Beginning July 1, 2019***

CMS proposes to expand the use of telehealth services for ACOs. Beginning with performance years 2020 and beyond, the agency would treat the beneficiary's home as an originating site and not apply the originating site geographic restrictions for telehealth services furnished by a physician or practitioner participating in an applicable ACO. CMS proposes to expand telehealth services only to ACOs under a two-sided risk arrangement that elect to participate under the prospective beneficiary assignment methodology. The telehealth expansion would not be available to an ACO participating in two-side risk that elects to participate under the preliminary prospective beneficiary assignment methodology.

The AAMC supports the proposal to expand options for telehealth services for ACOs, as an additional tool that can support care coordination and beneficiary engagement with the ACO. The AAMC urges CMS to implement the use of the telehealth services expansion sooner, beginning July 1, 2019, considering that the benefit enhancement is currently in use in the Next Generation ACO Model and could easily be adapted for use in the program.

#### UPDATING PROGRAM POLICIES

##### **Policies on Voluntary Alignment**

###### ***CMS Should Not Include Specialists in Voluntary Alignment***

CMS proposes to modify current policies to assign a beneficiary to an ACO based upon his or her selection of any ACO professional, regardless of specialty, as his or her primary clinician. Under this proposal, a beneficiary may select a practitioner with any specialty designation as his or her primary care provider and be eligible for voluntary alignment assignment to the ACO in which the

practitioner is an ACO professional. Currently the ACO professional designated by the beneficiary must be a primary care physician as defined at § 425.20, a physician with a specialty designation included at § 425.402(c), or a nurse practitioner, physician assistant, or clinical nurse specialist. CMS proposes to use a beneficiary's designation to align the beneficiary to the ACO in which his or her primary clinician participates even if the beneficiary does not receive primary care services from an ACO professional in that ACO.

**The AAMC is concerned about the unintended consequences that may result due to the inclusion of specialists in the voluntary alignment process.** If a beneficiary elects such a professional as his or her primary clinician, it could lead to the assignment of beneficiaries who do not actually receive their primary care from the ACO. This could be especially problematic for faculty practices that participate in ACOs, as they are more likely to include specialists within the same billing TIN, and thus could result in beneficiaries who only seek certain specialty services from the practice becoming more broadly assigned to the ACO. The AAMC recommends that at a minimum, if CMS finalizes its proposal, the Agency require that a beneficiary who elects a specialist as his/her primary clinician must have at least one qualified primary care service during the prior performance year with an ACO professional as defined under Step 1 or Step 2 of claims-based assignment.

#### **Definitions of Primary Care Services Used in Beneficiary Assignment**

##### ***CMS Should Only Incorporate Additional Codes for Primary Care Services in Step 1 of the Assignment Process***

CMS proposes to revise the definition of primary care services to include the following Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes: (1) advance care planning service codes, CPT codes 99497 and 99498; (2) administration of health risk assessment service codes, CPT codes 96160 and 96161; (3) prolonged evaluation and management or psychotherapy service(s) beyond the typical service time of the primary procedure, CPT codes 99354 and 99355; (4) annual depression screening service code, HCPCS code G0444; (5) alcohol misuse screening service code, HCPCS code G0442; and (6) alcohol misuse counseling service code, HCPCS code G0443.

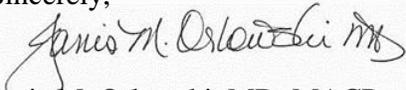
**The AAMC supports the proposal to modify the definition of primary care services to include the additional services enumerated above, but only if they are limited to Step 1 of the claims-based assignment process.** Step 1 of claims-based assignment is focused on primary care services furnished by primary care physicians who are ACO professionals, whereas Step 2 considers primary care services furnished by ACO professionals, including specialists. The proposed additional codes should be limited to use in for assigning beneficiaries on the basis of care furnished specifically by primary care physicians and not all ACO professionals. Furthermore, CMS should continue to refine the primary care billing codes used in beneficiary assignment to ensure that those used are consistent with current billing practices.

Administrator Verma  
October 16, 2018  
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## **Conclusion**

Thank you for your consideration of these comments. If you have any questions concerning these comments, please feel welcome to contact Gayle Lee, Director of Physician Payment Policy and Quality at 202-741-6429 or [galee@aamc.org](mailto:galee@aamc.org) or Phoebe Ramsey, Senior Regulatory Analyst at 202-448-6636 or [pramsey@aamc.org](mailto:pramsey@aamc.org).

Sincerely,

A handwritten signature in black ink that reads "Janis M. Orlowski MD". The signature is written in a cursive style and is positioned above the typed name.

Janis M. Orlowski, MD, MACP  
Chief Health Care Officer

cc: Ivy Baer, AAMC  
Gayle Lee, AAMC  
Phoebe Ramsey, AAMC