Medicare Shared Savings Program Proposed Rule
Executive Summary of NAACOS Comments
February 6, 2015

Because CMS has recognized the quality and savings accountable care organizations (ACOs) bring to Fee for Service (FFS) Medicare, the agency has recently announced by 2016 it will tie 30% of all FFS payments to alternative payment models such as ACOs and bundled payments, increasing to 50% by 2018. While the Medicare Shared Savings Program (MSSP) has generated strong provider interest, sustained and increased participation hinges on the adequacy of the program's potential financial opportunities being adequate to support provider investments needed to improve care delivery and ultimately to create a program that is sustainable long term. Improvements must be made to the program for ACOs to earned shared savings, foster innovation and achieve ever-higher quality care. NAACOS in conjunction with a broad spectrum of preeminent physicians, hospital and medical group practice stakeholders, is forwarding a lengthy list of recommendations we believe if accepted will substantially improve the ACO program's clinical and financial success.

In order to meet the above-stated goals and ensure continued and enhanced participation in the MSSP, NAACOS generally recommends that CMS:

1. **provide an option for more predictable, prospective assignment of Medicare beneficiaries in all MSSP tracks;**
2. **stronger consideration of physician specialties and non-physician practitioners in the assignment process**
3. **give Medicare beneficiaries an option to align with their primary care physician and ACO;**
4. **remove financial barriers to primary care;**
5. **establish a more appropriate balance between risk and reward;**
6. **strengthen the incentives to improve quality of care;**
7. **adopt payment waivers to eliminate barriers to care coordination;**
8. **modify the current benchmark methodology to include regional adjustments; and,**
9. **provide better and timelier data to the ACOs.**

The following provides a summary of the detailed recommendations contained in the NAACOS comment letter to the Medicare Shared Savings Program proposed rule. To read the full NAACOS comment letter, please visit www.NAACOS.com.

ASSIGNMENT

NAACOS supports the proposed codification of beneficiary eligibility determination criteria for assignment to include that the beneficiary having at least one month of Part A and Part B enrollment, and does not have any months of a Medicare private health plan enrollment, is not assigned to any other Medicare shared savings initiative, and lives in the US or US territories. NAACOS also supports the proposed expansion of primary care services to include the Transitional Care Management (TCM) and Chronic Care Management (CCM) CPT codes. Use of these codes will enhance delivery of primary care, improve care coordination, and lessen fragmentation.

Consideration of Physician Specialties and Non-Physician Practitioners in the Assignment Process

- *Inclusion of primary services furnished by NPs, PAs, and CNSs in step 1 of the beneficiary assignment methodology*. CMS should require additional assurance of the primary care nature these medical professionals provide through an attestation process.
- *Exclusion of specific physician specialties from the beneficiary assignment methodology under step 2*. We encourage CMS to be receptive to comments received from physician organizations representing specialty designations both currently included and excluded to ensure the appropriateness of removing a given specialty designation from the assignment process.
- *Continued inclusion of specific physician specialties within the beneficiary assignment methodology under step 2.* We believe this inappropriate inclusion within the assignment process and its resulting limitation on ACO involvement can have a number of adverse effects including:
    - Promoting inaccurate assignment of beneficiaries to an ACO;
    - Significantly affecting long-established referral channels to the practice and its financial viability; and,
    - Impacting access to needed specialists because of their engagement with a single ACO.

Beneficiary Choice to Align with ACO

We 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. 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.

SHARED SAVINGS AND LOSSES

Agreement Periods

NAACOS recommends that CMS extend the agreement period from three years to five years under all models and all subsequent agreement periods. For ACOs with existing contracts, they would have the option to extend for 2 years at the end of their 3rd year or sign a new 5 year contract. By extending the length of the contract period, CMS would provide ACOs with more time to determine which track would be the best next move for them. CMS would then have more data to determine which ACOs should not be allowed to continue in the program. We also believe that mandatory rebasing the ACOs at this point is premature and ACOs should be rebased depending on their choice of extending or signing a new contract.

TRACK ONE

NAACOS believes that prospective assignment should be offered under Track 1. Prospective assignment can help stabilize the beneficiary population which aids in establishing stable benchmarks. An ACO also may appreciate the ability to become accustomed to prospective assignment under a one-sided risk model before moving to a two-sided risk model.

NAACOS recommends that CMS allow ACOs who are saving but not meeting their MSR to defer reconciliation across multiple years to reduce their MSR and improve their chance of being eligible for shared savings.

NAACOS supports ACOs being able to remain in Track 1 for more than one agreement period, however, we do not support the reduction in the shared savings rate (down from 50% to 40% in second agreement period). As long as basic quality standards are met, ACOs in Track 1 should be eligible for continued participation in the MSSP at the current shared savings rate of 50%. CMS should further recognize high-quality providers under Track 1. High quality attainment or significant quality improvement over the ACO's base should be rewarded

financially. To emphasize and reward top quartile quality performance or top quartile improvement, NAACOS believes that CMS should provide an additional 10 percentage points of shared savings for a total of 60%. ACOs that surpass the minimum quality standards should be allowed to proceed in Track 1, while those who do not should be allowed to appeal to CMS based on recent improvements in care and adherence to any corrective action plan. We do not believe that higher quality standards should be applied at this time as there are more incentives built into the MSSP program to improve quality than traditional FFS.

TRACK TWO

NAACOS believes that prospective assignment should be offered under Track 2. Prospective assignment can help stabilize the beneficiary population which aids in establishing stable benchmarks.

NAACOS believes that CMS should provide the option of no MSR/MLR, a flat 2 % MSR/MLR, or a variable MSR/MLR associated with the size of the beneficiary population for Track 2. Each ACO is in the best position to determine the level of risk for which they are prepared to take and have options depending on their status. To emphasize and reward top quartile quality performance or top quartile of improvement, NAACOS believes that CMS should provide an additional 10 percentage points of shared savings for a total of 70%.

TRACK THREE

NAACOS supports prospective beneficiary assignment in Track 3. Prospective assignment can help stabilize the beneficiary population which aids in establishing stable benchmarks.

NAACOS believes that CMS should provide the option of no MSR/MLR, a flat 2 % MSR/MLR, or a variable MSR/MLR associated with the size of the beneficiary population for Tracks 2 and 3. CMS should recognize high-quality providers under all MSSP Tracks. To emphasize and reward top quartile quality performance or top quartile of improvement, CMS should provide an additional 10% percentage points of shared savings for a total of 85%.

- CMS should allow ACOs to move up tracks at each annual recertification, but remain within its five-year contract window. This way, if an ACO is prepared to accept more risk, they can move to another track without having to wait for the next contract cycle.
- We believe that ACOs should be allowed to move from retrospective assignment to prospective assignment at each recertification.
- NAACOS supports CMS's exclusion of beneficiaries who are later determined to be ineligible for assignment. CMS should consider a mechanism for removing beneficiaries who have moved out of the ACO service region so that these beneficiaries are not considered when measuring the ACO's financial performance for the year.
- NAACOS urges CMS to consider additional changes to increase the accuracy of the risk adjustment methodology as the current methodology does not capture the risk and cost associated with ACO beneficiaries.
- We believe CMS should recognize the full growth in HCC risk scores across all contract years in order for ACOs to ensure all diagnoses have been captured on claims before the score is set.
- CMS could offer an option for Track 3 ACOs to have a risk-adjusted global payment or global budget as an alternative to the shared savings/losses model to help lessen the financial uncertainty ACOs can face in Track 2 and provide more predictability in financial planning.

The Table below summarizes all the Tracks and their characteristics.

Issue	Track 1 "on ramp"	Track 2 "gradual risk"	Track 3 "advanced risk"
Contract length	5 year contract (2-year extension)	Same as Track 1	Same as Track 1 and 2
Risk model	One-sided upside only risk	Two-sided risk	Two-sided risk, with global payment option
Shared savings rate for ACO	Up to 50%, with an opportunity for 60% for ACOs in top quartile of quality performance	Up to 60%, with an opportunity for 70% for ACOs in top quartile of quality performance	Up to 75%, with an opportunity for 85% for ACOs in top quartile of quality performance
Minimum Savings Rate (MSR)	Allow ACOs who are saving but not meeting MSR to defer reconciliation across multiple years to reduce their MSR	ACOs are able to select their MSR: 1. No MSR 2. Fixed MSR of 2.0%, or 3. Variable 2.0 - to 3.9%	ACOs are able to select their MSR: 1. No MSR 2. Fixed MSR of 2.0%, or 3. Variable 2.0 - 3.9%
Minimum Loss Rate (MLR)	Not applicable	Selection must be aligned with the ACO's selection of MSR option	Selection must be aligned with the ACO's selection of MSR option
Loss Cap	10%	15%	20%
Loss sharing limit	Not applicable	Limit on losses to be phased in over 5 years starting at 0% for PY1; 2% for PY2; 5% for PY3; 7.5% for PY4; and 10% for PY5	Limit on losses to be phased in over 5 years if going straight from Track 1 to 3: 2% for PY1; 5% for PY2; 7.5% for PY3; 10% for PY4; and 15% for PY5.
Benchmark Update	Option for National or Regional	Option for National or Regional	Option for National or Regional
Benchmark Reset	Historical spending (33% weighting and savings added back)	Option of using historical spending (33% weighting and savings added back) or regional blend	Option of using regionally based prospectively set or historic benchmark
Beneficiary Assignment methodology	Beneficiary attestation and choice of retrospective/prospective assignment	Beneficiary attestation and choice of retrospective/prospective assignment	Beneficiary attestation and prospective assignment

PAYMENT WAIVERS

CMS is proposed to utilize payment waivers exclusively as incentives to move ACOs to higher-risk tracks or have prospective ACO providers initially agree to at-risk contracts. Payment waivers should be implemented as policy solely upon whether and when they can help improve clinical care and outcomes. That means any and all payment waivers that can improve care delivery should be available to all MSSP participants such that in turn all assigned beneficiary participants can benefit equally. NAACOS recommends the following waivers for all three Tracks: (1) skilled nursing facility; (2) post- acute care; (3) primary care co-pay; (4) telehealth; and, (5) home health prospective payment system-related waiver requests.

ESTABLISHING, UPDATING AND RESETTING THE BENCHMARK

We appreciate CMS's interest in modifying its current benchmark methodology to mitigate the impact on ACOs that lower expenses and achieve savings, and in better accounting for regional and local cost trends. We believe that the financial benchmarking methodology needs to be improved to ensure predictability, accuracy and stability over time. CMS should not require an ACO to continually beat its own performance. Therefore, we encourage CMS to finalize the option to equally weight the three benchmark years, as well as the option to account for shared savings payments when resetting the benchmark. Additionally, we continue to support standardizing both the MSSP benchmark and performance year expenditures to remove all policy adjustments, such as indirect medical education (IME) and disproportionate share hospital (DSH) payments, so that they reflect only actual resource utilization. Financial calculations that reward ACOs for simply changing the setting of care out of hospitals receiving IME/DSH payments would undermine these critical community missions and place patients at risk of being steered away from appropriate, high-quality care.

Further, we support allowing each ACO the option to choose for their contract term whether they want to be updated with national or regional adjustment. Transition to a regional adjustment could occur by use of a blend of national/regional trend over a contract term and would allow an ACO to assess whether its system of care is more reflective of the local market behavior or the national market. However, we urge CMS to provide more detailed information about how it would define "regional," including what data and methodology it would use to set and update the regional rate.

Finally, due to the inherent instability of ACOs' assigned beneficiary population during the contract period, we support in concept using regional costs in the setting and resetting the benchmark, although we do have concerns about how regional benchmarks might affect ACOs, such as those with academic medical centers, with an attributed population that might be more complex than the community. One potential approach that accounts for the influx of new beneficiaries is blending the historical and community rates based on the level of roster turnover during the contract period. Since it is unclear at this time what is the best measure of regional (i.e., community) costs or the best method to factor into the benchmark, we recommend that any changes in this area be an option limited to the two-sided risk ACOs in Tracks 2 and 3 ACOs that have experience in the program. For those tracks, we also recommend that CMS grant the same flexibility as applied to trending and allow ACOs the option to choose for their contract period a historical-based or regionally blended benchmark. We further recommend that CMS in the future provide more data-supported specific approaches that factor in regional costs upon which the ACO provider community can evaluate and comment more informatively.

REQUIRED PROCESS TO COORDINATE CARE

Health Information Technology

ACOs need the flexibility to determine how to deploy technology in a manner that drives efficiency and quality improvement. NAACOS opposes the proposed new requirements for ACOs to describe in their application how

they will use and support enabling technologies for improving coordinated care as well as provide milestones and performance targets throughout the year.

PROVISION OF AGGREGATE DATA REPORTS AND LIMITED IDENTIFIABLE DATA

Expansion of Beneficiary Identifiable Data Provided

CMS has proposed expanding the number of beneficiaries for whom data is made available under Tracks 1 and 2 and proposed to include health status and utilization rates in aggregate data reports.

- NAACOS believes that the expanded availability of beneficiary data should be made available for Track 3 to encourage ACOs in Track 3 to influence care management for all of its beneficiaries.
- NAACOS believes that additional beneficiary identifiable data should be included in aggregate data reports to enhance the meaningfulness of the information, including: (1) Date of the beneficiary's original Medicare eligibility; (2) Date of change in the beneficiary's eligibility status; (3) An indicator identifying the change of an individual beneficiary's Health Insurance Claim Number (HICN), with the date of the change; (4) Hierarchal Condition Category (HCC) score for each beneficiary; (5) Opt-out information to the beneficiary attribution file to create a check-and-balance process which will ensure members are not lost in the data reporting process; (6) For each beneficiary included on each attribution report an indicator of a beneficiary's institutional/hospice status which will help ACOs identify domiciled patients for which the ACO is unaware; (7) Expand the information subsections for outpatient Part A services and physician services on the quarterly reports to help ACOs manage costs, access, quality, and care coordination if physician services were divided into primary care physicians and non-primary care physicians; and, (8)Provide aggregated data on substance abuse claims expenditures.

Data for Real-time Coordinating of Care

An ACO's success is dependent on the timely transfer of patient information and coordination of patient care. Since Medicare patients have the right to seek care from any provider who accepts Medicare, it can be a challenge for ACOs to monitor the services received by their assigned patients. With respect to applicable laws governing patient privacy and the disclosure of PHI, and since CMS currently receives all eligibility checks from hospitals, emergency departments, and post-acute providers and maintains a real-time file of these eligibility checks, CMS could make this data available to ACOs. Doing so would offer ACOs a point-of-service notification system that would allow them to know when a beneficiary's eligibility is being checked by a provider and a near real-time opportunity to intervene appropriately to coordinate their care, redirect the patient to an appropriate setting, or engage with healthcare providers who may not be participating with the ACO. We believe that daily data feeds could be leveraged to improve care processes within an ACO and CMS should either provide these data directly to the ACOs or make the files available to security-approved organizations for dissemination to ACOs.

Claims Data Sharing and Beneficiary Opt Out

- NAACOS supports using 1-800-MEDICARE for beneficiaries to opt out of data sharing and we applaud CMS for this more streamlined approach to lessen confusion by beneficiaries and administrative burden on ACOs.

NAACOS recommends that beneficiaries who opt out of data sharing be removed from the financial reconciliation process as this will effectively eliminate the ability for an ACO to coordinate care. ACOs should not be held financially responsible for these beneficiaries.