March 27, 2017

Ms. Seema Verma
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: Review of three ACO issues requiring urgent CMS attention

Dear Administrator Verma:

The National Association of ACOs (NAACOS) appreciates the opportunity to alert you to key issues affecting ACOs, which require swift policy remedies by the Centers for Medicare & Medicaid Services (CMS). These issues include modifying and finalizing plans for Track 1+, addressing problematic interactions between episode payment programs and ACOs, and allowing for extended Track 1 participation. They are each detailed below and we look forward to working with you and your staff to address these and other critical issues affecting ACOs.

NAACOS is the largest association of ACOs, representing over 3.3 million beneficiary lives through 233 Medicare Shared Savings Program (MSSP) ACOs, Next Generation, and commercial ACOs. NAACOS is an ACO member-led and member-owned non-profit organization that works on behalf of ACOs across the nation to improve the quality of Medicare delivery, population health and outcomes, and health care cost efficiency. Our members, more than many other healthcare organizations, want to see an effective, coordinated patient-centric care process. Our recommendations reflect our expectation and desire to see ACOs achieve the long-term sustainability necessary to enhance care coordination and health outcomes for Medicare beneficiaries, reduce healthcare costs, and improve quality in the Medicare program.

Track 1+

We strongly support developing a new ACO model, Track 1+, which is designed to create a glide path for ACOs to take on risk and includes lower risk levels than those required in other Medicare ACO models. CMS's plans to develop Track 1+ represent an important step to ensure the long-term viability of the ACO model by introducing a new ACO track with less downside risk than what is required in existing two-sided ACO models. Track 1+ must be designed to incentivize ACOs to begin taking on risk in a manner that holds them accountable for cost and quality but does so in an appropriate way, providing an on ramp to assuming risk. We applaud CMS's efforts to develop Track 1+ and urge the agency to establish it so that it's widely available to ACOs of all sizes and structures and that participation in the model is not restricted to a specific number of agreement periods. We also greatly appreciate CMS's plans to develop Track 1+ as an Advanced Alternative Payment Model (Advanced APM) starting in 2018 under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Quality Payment Program (QPP).

Since inception of the MSSP, CMS has emphasized the need for ACOs to assume downside financial risk for their patient populations as the best way to incentivize ACOs to reduce unnecessary utilization and lower the growth rate of Medicare expenditures. However, as a portion of total 2017 Medicare ACOs, including those in the MSSP and the Next Generation Model, ACOs in two-sided risk models only represent approximately 15 percent and within the MSSP that portion is less than 9 percent. The one-sided Track 1 remains by far the most popular option and from 2012 to 2016 the rate of adoption for Track 1 has been four times the adoption rate of two-sided models.

With continued calls for ACOs to take on risk, we must recognize that ACOs remain in Track 1 in large part due to the high levels of risk required in the two-sided models. The current two-sided models (MSSP Track 2, 3 and the Next Generation ACO Model) include risk levels that are significantly higher than what the vast majority of ACOs can bear and therefore are not viable for most ACOs. The decision to take on risk is at the heart of an ACO's choice about which model to select and having to potentially pay millions of dollars to Medicare is simply not practical nor feasible for most of these organizations. This type of risk necessitates that ACOs have considerable financial backing. Many ACOs are unable to access investor capital and face many barriers to obtaining sizeable credit. Without large enough assets to secure loans, many physician owners are left having to personally guarantee debts and obligations. Basing risk on total cost of care creates situations where physicians could be responsible for repaying a substantial amount, if not all, of their Medicare income for a particular year.

The challenges of taking on risk are often exacerbated for those in rural areas and safety-net providers, which care for the most vulnerable patients. These providers tend to have even fewer resources and may struggle to come up with start-up and investment costs, let alone be in a position to assume downside risk. Even the promise of higher shared savings rates or the ability to utilize payment rule waivers afforded to two-sided ACOs is not enough to overcome the barriers to assuming considerable financial risk. Further, ACOs are in the business of delivering care and are not necessarily well equipped to take on what is essentially actuarial risk more typical of a health insurance company. Finally, while a slight majority of ACOs are physician-owned, many others share ownership and financial responsibility with hospitals, which often share the same concerns about such high risk.

Based on these realities, it is critical that CMS amend and finalize elements of Track 1+ to provide a much-needed option that enhances accountability for cost but does so in a manner appropriate for ACOs. While we strongly support Track 1+, we urge CMS to modify elements of the model, which are detailed in CMS's factsheet (last updated January 20, 2017). We also request clarification on a number of issues not addressed in the factsheet or other available information from CMS on Track 1+.

The appendix includes our detailed comments on Track 1+, and our central recommendations include that CMS:

- Finalize Track 1+ risk levels to align with those required under the QPP for an APM to be considered "advanced" and allow flexibility around ACO determination of the maximum risk level.
    - Lower the 4 percent benchmark-based standard to 3 percent for 2018
    - Allow ACOs to choose between the benchmark- and revenue-based standard
    - Maintain an 8 percent revenue-based standard for Advanced APMs and Track 1+ in future years
- Not unfairly penalize certain types of ACOs and allow all ACOs to be eligible to participate in Track 1+. Participation should not be restricted based on ACO size, composition or participation in two-sided ACO models. CMS should also refrain from excluding ACOs that are owned or operated by a health plan.
- Finalize Track 1+ designation as an Advanced APM under the QPP.

- Increase the shared savings rate from 50 to 60 percent, and allow that to further increase on a sliding scale up to 70 percent for ACOs that demonstrate high quality performance or improvement.
- Allow existing ACOs entering into Track 1+ in 2018 the option to have their benchmarks rebased using the new rebased benchmarking methodology rather than having to wait until the start of their subsequent agreement period.

Overlap of Episode Payments and ACOs

Both bundled payment and population health models, including ACOs, have increased in popularity in recent years. While these programs are often considered in isolation, beneficiaries can fall into both types of programs in the same year, which leads to complex program overlap policies that favor bundled payment programs over ACOs. Under current CMS policy, a bundled payment participant maintains financial responsibility for the bundled payment episode of care. Any gains or losses during that episode are linked to the bundled payment participant and are removed from ACO results during year-end financial reconciliation. In the case of the Bundled Payments for Care Improvement (BPCI) when CMS calculates an ACO's shared savings, the spending for ACO patients with an episode of care provided by a bundled payment participant is set to that bundler's target price, regardless of actual spending. Target prices based on higher cost baselines arbitrarily raises an ACO's performance cost and removes their saving opportunity. At the same time, certain ACOs can benefit from bundled payment program overlap if a bundle target price is lower than the ACO's actual spending. While this impact may be favorable or unfavorable for an ACO depending on their costs relative to those of the bundlers in their market, the net effect skews accountability for population-based models and in general undermines ACOs' opportunities for savings through care redesign since any savings would automatically go to the bundler.

At the same time, for the Comprehensive Care for Joint Replacement (CJR) model as well as the cardiac episode payment models (EPMs), CMS will attribute savings achieved during an EPM episode to the EPM participant, and it will include EPM reconciliation payments for ACO-assigned beneficiaries as ACO expenditures. NAACOS continues to oppose this approach as it unfairly penalizes ACOs. CMS will make an adjustment to the reconciliation amount to account for any of the applicable discount for an episode resulting in Medicare savings that is paid back through shared savings under the MSSP or any other ACO model, but only when an EPM hospital also participates in the ACO and the beneficiary in the EPM episode is also assigned to that ACO. In these cases, CMS will reclaim from the EPM participant any discount percentage paid out as shared savings for ACOs when the hospital is an ACO participant and the beneficiary is aligned with that ACO. The agency explains that this adjustment is necessary to ensure that the applicable discount under the EPM is not reduced because a portion of that discount is paid out in shared savings to the ACO and thus, indirectly, back to the hospital. This overlap policy puts ACOs at a disadvantage and unfairly penalizes the ACO that is also invested in coordinating EPM patients' care.

The problem is further exacerbated by the fact that the 60 to 90-day patient episode of care is carved out of the ACO's provider network and there are no requirements for the bundler to transition the patient or their medical records back to the ACO to which they are assigned. CMS argues that prioritizing bundled payment programs helps assure adequate sample size for bundlers. However, much of the variation in per-episode spending is a result of utilization of post-acute care or readmissions, both of which ACOs are often instrumental in managing or preventing. ACOs focus on and make considerable investments in care coordination and improving care transitions to manage post-acute care effectively. Many successful ACOs credit these efforts for allowing them to achieve shared savings. In addition, bundled payment models focus solely on per-unit costs rather than total cost, thereby leaving the very important issue of volume unaddressed.

CMS reversed its previous decision to prohibit ACOs from gainsharing arrangements with bundlers in the final EPM rule published in December of 2016. However, this policy does not apply to all CMS bundled

payment initiatives, nor does the agency properly incentivize ACOs and bundlers to partner in coordinating beneficiary care. In fact, the rules guiding shared savings in the bundled payment programs, such as the Bundled Payment for Care Improvement Initiative (BPCI), specifically preclude an ACO from receiving payments for savings achieved in the bundled payment programs. While the agency claims to encourage collaboration, it has not required nor given proper incentives for bundled payment participants to enter into agreements with ACOs. Many ACOs report significant challenges negotiating arrangements with bundled payment participants, who have little incentive to do so. Unless bundled payment participants and ACOs sign collaborative agreements, ACO patients' care should not be included in bundles. Further, when appropriate based on the bundle and care provided by the ACO, we urge CMS to allow ACOs to participate directly as bundlers in such payment models so they are afforded the opportunity to benefit from the care coordination activities they are already engaged in.

CMS policy should promote the growth of population-based payment models that take responsibility for the entirety of patients' care needs and invest in care coordination throughout the year, thus reducing costly care such as avoidable hospitalizations. We urge CMS to take immediate action to give priority to population-focused health care and exclude ACO beneficiaries from bundled payment programs unless a collaborative agreement exists between the bundler and the ACO. ACOs and bundled payment participants must coordinate care and medical information of the patients they serve. While bundled payments may be able to deliver savings over the short term, placing an emphasis on programs that do not address volume or total cost of care could undermine the success of ACOs in the long term. Importantly, these models also fail to address the issue of controlling the volume of services provided. By holding episode participants responsible only for a single episode of care, CMS leaves the Medicare Trust Fund susceptible to aggregate overspending resulting from increased volume. In contrast, ACOs are responsible for total cost of care and therefore have a large incentive to address unnecessary procedures and spending.

Due to the problems detailed above, we believe CMS should refrain from implementing any new voluntary or mandatory bundled payment programs until and unless the aforementioned issues can be resolved. For bundled payment programs currently underway, we urge CMS to exclude ACO beneficiaries from bundles. These beneficiaries could be identified in the HIPAA Eligibility Transaction System (HETS) as being prospectively or preliminarily assigned to an ACO, which would indicate to a bundler that these beneficiaries would not be participants in the bundled payment program. Additionally, we call on CMS to conduct a rigorous analysis to determine the effect of overlapping value-based programs, including the interplay between bundled payment programs and ACOs before moving forward with additional programs. CMS must refrain from implementing new voluntary or mandatory bundled payment programs unless the issues related to overlap with ACOs are addressed in a way that does not harm the ACO model.

ACOs are at a critical turning point. With the implementation of MACRA accelerating the proliferation of new and innovative payment models, CMS must take action to avoid competing priorities and problems that exist when multiple programs overlap. We urge CMS to prioritize population-based payment models like the MSSP and Next Generation ACO Models, as this is the greatest opportunity to focus on total cost of care and truly transform how health care is delivered.

Extended Track 1 Participation

As discussed previously, MSSP Track 1 remains by far the most popular option for ACOs, representing over 90 percent of MSSP ACOs in 2017 and demonstrating a growth rate four times that of two-sided ACOs from 2012 to 2016. However, ACOs may only remain in Track 1 for two agreement periods before being required to move to a two-sided risk model or drop out of the program. Many ACOs remain in Track 1 because they are unprepared to assume risk requiring them to potentially pay millions of dollars to Medicare, which is simply not practical nor feasible for most of these organizations. Providers in rural areas and safety-net providers, which care for some of the most vulnerable patient populations, often face even greater challenges than other providers when considering taking on risk. As a result of the lower risk thresholds in

Track 1+ relative to Track 2, 3 and the Next Generation Model, the introduction of Track 1+ will allow more ACOs to assume risk. However, many Track 1 ACOs are not prepared at this time to assume even the lower amount of risk in Track 1+.

ACOs that began the MSSP in 2012 or 2013 renewed their participation agreements in 2016 and are on schedule for their third agreements to begin in 2019. This is the first time ACOs will be forced to move into two-sided risk arrangements. These ACOs represent the first cohort of ACOs in the MSSP and those that remain have shown significant dedication to the ACO model. They embraced the MSSP early on and were instrumental in working collaboratively with one another and CMS to help shape the program. For nearly six years, these ACOs have faced a number of challenges, some of which have been addressed by CMS through regulatory changes such as modifications to the benchmarking methodology. Many program modifications are still needed. The MSSP and these ACOs have evolved considerably, creating a shifting landscape for these early adopters. Many of these ACOs need more time to prepare for two-sided risk. While six years may sound like enough time, given the early bumps in the road and considerable learning curve for these ACOs, this is not enough time. It's important to recognize that Track 1 ACOs that are not ready for risk will not move forward; they will quit the program altogether. This unintended consequence will significantly undermine the MSSP and result in diverting valuable investments in care coordination away from Medicare patients and towards other patients under value-based contracts. Further, the disproportionate emphasis on the goal of reducing costs often overshadows the equally important goal of quality improvement that the ACO model offers, which in the long run will benefit both patients and the Medicare program broadly.

The MSSP has gained considerable momentum in recent years, and it would be devastating for individual ACOs and for the program to see a mass exodus of 2012/2013 ACOs in the 2019 performance year if regulations are not changed to allow continued participation in Track 1. In a Spring 2016 NAACOS survey, *The ACO Cost and MACRA Implementation Survey,* when asked how likely ACOs are to participate in the MSSP if CMS requires the ACO to share losses, almost half of survey respondents said they "definitely would not" or "likely would not" participate. Therefore, we strongly urge CMS to modify regulations during 2017 to allow ACOs that meet certain criteria to continue participating in Track 1 for a third agreement period. Swift action is needed by the agency on this issue so that a revised policy is in place by the beginning of 2018 when ACOs are planning for the following year.

By the time of the 2019 application cycle in spring/summer of 2018, there will be four years of publicly available performance results for 2012/2013 ACOs: 2012/2013, 2014, 2015, and 2016. The 2017 performance results will not be available until after the close of the 2019 application cycle, assuming that cycle follows those of previous years. Based on evaluation of the four performance years for which data will be available in early 2018, we urge CMS to allow 2012/2013 Track 1 ACOs that meet at least one of the criteria below to have the option to continue in Track 1 for a third agreement period.

ACOs that generate savings in at least two of the four performance years

ACOs have demonstrated an increasing likelihood of achieving shared savings over time. This is likely the result of a combination of factors, such as their experience in the program and realization of long-term commitments and investments in priorities such as care coordination, quality improvement efforts and data analytics. This trend is promising and means more savings over time for the Medicare Trust Fund. However, it's important to note that many ACOs generate savings, as defined by having expenditures lower than their benchmark, but do not surpass their Minimum Savings Rate (MSR) and thus do not qualify for earned shared savings. The MSR in Track 1 is tied to the number of beneficiaries and can be as high as 3.9 percent for smaller ACOs, which is a considerable hurdle. While these ACOs may not earn shared savings, they are saving Medicare money and CMS should encourage their continued contributions through MSSP participation. Therefore, we urge CMS to allow ACOs that generate savings relative to their benchmark

(including those that do not surpass their MSR) in two of the four performance years to have the option of continuing in Track 1 for a third agreement period.

ACOs that score at or above the 50th percentile in quality performance in two of three pay-for-performance years

ACOs that demonstrate superior quality performance have invested significantly in data analytics software, staff training, and operational changes to result in achieving high quality performance scores. Though they may not have earned sufficient shared savings to allow them the financial readiness to take on a downside risk option, they have demonstrated superior quality and should therefore be given additional opportunities to work on processes focused on lowering costs prior to being forced into a two-sided track. Therefore, we urge CMS to allow ACOs that score at or above the 50th percentile in quality performance in two of three pay-for-performance years the option of continuing in Track 1 for a third agreement period.

ACOs that improve their overall quality score by 10 percentage points or greater over the course of pay-for-performance years

ACOs that demonstrate a significant improvement in their quality score over the course of the pay-for-performance years (2014, 2015 and 2016) have a clear investment in quality and have had an impact on the Medicare beneficiaries they serve by significantly improving their overall quality performance score in the MSSP. These ACOs should be rewarded for these efforts and given additional time to shift their focus to decreasing costs prior to being forced into a downside risk track. Therefore, we urge CMS to allow ACOs that improve their overall quality score by 10 percentage points over the course of the three pay-for-performance years the option of continuing in Track 1 for a third agreement period.

In addition to the criteria specified above, we urge CMS to consider additional criteria including for ACOs with spending that is lower than that of their region. These ACOs are savings money compared to other fee-for-service Medicare providers in their region and keeping them in the MSSP incentives them to continue focusing on lowering spending and improving quality.

Conclusion

It is our hope that we can confer with you and your staff at the earliest ability to discuss these issues and share our experiences and thoughts on strengthening and prolonging ACOs for the benefit of the 10 million seniors receiving care from ACOs and for the approximately 240,000 physicians in ACOs who treat this population. I appreciate your consideration of these important issues and will contact your office to arrange a meeting.

Sincerely,

Clif Gaus
President and CEO
National Association of ACOs

Appendix: Detailed Comments on Track 1+

The recommendations in this appendix are in response to the Track 1+ Factsheet CMS released in January 2017, which is the most up-to-date information available at the time of this letter.

Qualification of Track 1+ as an Advanced APM

CMS position: CMS states that Track 1+ includes sufficient financial and nominal risk and meets other criteria that allow it to qualify as an Advanced APM, beginning with 2018 performance.

NAACOS recommendation: In passing MACRA, Congress clearly intended to create an accelerated pathway for physicians to move from fee-for-service to APMs, with a particular emphasis on APMs that include accountability for quality and cost. Track 1+ exemplifies the type of model Congress intended and represents an important option for Track 1 ACOs to transition to a model that includes risk. Track 1+ will also incentivize new providers to form ACOs, thus bolstering the growth and success of the Medicare ACO Model. The Advanced APM bonuses will be key determinants for many ACOs to take on risk under Track 1+. ACOs are on the cusp of so much potential, and we feel that creating Track 1+ as an Advanced APM will benefit ACOs today and moving into the future. We strongly support CMS designating Track 1+ as an Advanced APM.

Track 1+ Risk Levels

CMS position: In the factsheet, CMS explains that Track 1+ will:

- Require downside risk with two possible risk arrangements that include either a revenue- or benchmark-based loss sharing limit. CMS will determine which risk arrangement applies for a particular ACO after evaluating the following criteria:
    1) The ACO includes an ACO participant (as identified by Taxpayer Identification Numbers / CMS Certification Numbers) that is or is owned or operated by, in whole or in part, an inpatient prospective payment system (IPPS) hospital, cancer center, or a rural hospital with more than 100 beds.
    2) The ACO includes an ACO participant that is owned or operated by, in whole or in part, a rural hospital with 100 or fewer beds that is not itself included as an ACO participant.
    3) The ACO includes an ACO participant rural hospital with 100 or fewer beds that is owned or operated by, in whole or part, a health system.

If at least one of these criteria are met, the ACO's loss sharing limit will be 4 percent of the ACO's updated historical benchmark.

If none of these criteria are met, the ACO's loss sharing limit would be 8 percent of ACO participant Medicare fee-for-service (FFS) revenue (which would include total Parts A and B FFS revenue for ACO participants that are rural hospitals with 100 or fewer beds) in year 1 (2018). In years 2 and 3 (2019 and 2020), if the nominal risk requirement revenue standard for Advanced APMs under QPP increases above 8 percent of APM Entity revenues, ACOs in the Track 1+ Model with a revenue-based loss sharing limit would be offered the option to accept higher risk in order to continue to be considered participants in an Advanced APM. In subsequent years of the model, the loss sharing limit will be aligned with the required nominal amount for Advanced APMs. If the loss limit, as a percentage of ACO participants' FFS revenue exceeds the amount that is 4 percent of the ACO's updated historical benchmark, then the loss limit would be capped and set at 4 percent of the updated historical benchmark.

NAACOS recommendation: For 2018, we urge CMS to finalize Track 1+ risk levels to align with those required under the MACRA QPP for an APM to be considered "advanced," thus ensuring Track 1+ qualifies an Advanced APM. Specifically, we request that CMS lower the 4 percent total cost of care threshold to 3

percent. CMS finalized a 3 percent threshold to meet the Advanced APM nominal risk criteria, and there is no reason CMS should finalize a threshold above that for Track 1+. On page 77426 of the final MACRA rule CMS explains, "Regarding the total risk portion of the proposed standard, we agree with commenters that the meaning of 'nominal' can be relative and that for many APM Entities, 4 percent of a total cost of care benchmark could represent a significant fraction of an APM Entity's revenue. We believe such amounts of risk would be more than nominal for all APM Entities, but much more substantial for some APM Entities."

Based on CMS's own rationale that 4 percent is a significant amount of risk and that the intent of Track 1+ is to provide a glide path to assuming risk, we urge the agency to lower the Track 1+ loss sharing limit from 4 to 3 percent for ACOs that are evaluated under a benchmark-based standard. In our comments to the agency in response to the MACRA final rule, we urged CMS to further reduce the nominal risk benchmark-based standard below 3 percent for all Advanced APMs. We will continue to advocate for a lower standard for future years, around 1 percent total cost of care, which is more reflective of a true on-ramp into risk and would be manageable for ACOs that want to continue in the program and begin assuming risk in a responsible manner. However, we understand that in order for Track 1+ to meet the 2018 Advanced APM criteria the 3 percent threshold is required, so we therefore recommend that CMS align Track 1+ with that threshold.

For ACOs evaluated under a revenue-based standard, we support the 8 percent threshold CMS includes in the Track 1+ Factsheet, which also aligns with the Advanced APM nominal risk criteria. CMS notes that in future years the agency may increase the Advanced APM threshold beyond 8 percent. We urge CMS not to raise this threshold beyond 8 percent and to maintain the 8 percent threshold for both the Advanced APM nominal risk criteria and for Track 1+. We also urge CMS to exclude Part A revenue from the Advanced APM nominal risk criteria and, once finalized, to use the same approach with Track 1+.

For ACOs evaluated under the revenue-based standard, the loss sharing limit will be based on both assigned beneficiaries and those not assigned to the ACO but who receive Medicare covered professional services billed under the Physician Fee Schedule from providers who are part of/reassign their Medicare billing rights to ACO participant TIN practices. Setting the threshold based on assigned and unassigned beneficiaries creates complexity for ACOs that are comprised of multiple TINs and do not have information about the Medicare FFS revenue received by their participant TINs for unassigned beneficiaries. It is essential that CMS provide ACOs with this information in a timely manner so that the ACO understands what the loss sharing limit will be. This information, or estimates based on previous year's billings, must be provided during the application process so ACOs have the necessary information available to carefully consider the risk required under Track 1+.

Aside from the decisions about the Track 1+ loss sharing limit, we are concerned about the complexity of the bifurcated approach that CMS details in the Track 1+ Factsheet. This approach is unnecessarily complicated and will be confusing for stakeholders. Rather than using a complex process to dictate whether an ACO has its maximum loss rate set based on the benchmark- or revenue-based standard, we urge CMS to remove the complexity and allow the ACO – not the government – to select either the Track 1+ benchmark- or revenue-based standard. This puts the responsibility in the ACO's hands, providing greater flexibility for ACOs that are committing to assuming risk under Track 1+.

Financial Benchmarking

CMS position: The agency will use the same rebased benchmarking methodology for Track 1+ as it does with other MSSP tracks, which was modified through a June 2016 final rule to gradually incorporate regional expenditure data into rebased benchmarks. However, in the Track 1+ Factsheet, CMS notes that because it considers a Track 1 ACO that moves into Track 1+ to be continuing in its same agreement period, the new rebasing methodology would not apply until the start of a subsequent agreement period. CMS explains that Track 1 ACOs that move into Track 1+ would have their benchmark rebased using CMS's

revised benchmarking methodology under the same timeframe detailed in the June 2016 final rule. Therefore, 2012/2013 ACOs must wait until 2019 to have their benchmark rebased using the new methodology.

NAACOS recommendations: Although we have recommendations to enhance the rebased benchmarking methodology, which we have previously expressed to CMS, we are supportive of the new overall rebasing methodology. However, many Track 1 ACOs that began the MSSP in 2012/2013 are eager to move to the new rebased benchmarking methodology and preventing them from doing so increases the likelihood they will leave the MSSP. We strongly recommend that existing ACOs entering into Track 1+ in 2018 be given the option to have their benchmarks rebased using the new methodology rather than having to wait until the start of their subsequent agreement period.

Track 1+ Availability/Eligibility

CMS policy: The agency explains that it will limit how long an ACO can participate in Track 1+ before moving to a two-sided model with greater risk. Specifically, new ACOs would be permitted to participate for one three-year agreement period, and current Track 1 ACOs that transition to Track 1+ during their existing agreement period could finish their agreement period and have the opportunity to renew for one subsequent three-year agreement period in Track 1+.

ACOs currently in MSSP Tracks 2 and 3 or the Next Generation Model would not be eligible for Track 1+. Further, according to the Track 1+ Factsheet, the same legal entity that participated in one of these tracks/models cannot participate in Track 1+. And, an ACO would not be eligible to participate in Track 1+ if 40 percent or more of its ACO participants had participant agreements with an ACO that was in one of these performance-based risk ACO initiatives in the most recent prior performance year. CMS also stipulates that in order to be eligible for Track 1+, an ACO cannot be owned or operated by a health plan (consistent with the definition of health plan under 45 CFR § 160.103).

NAACOS recommendations: The numerous restrictions for Track 1+ participation are unnecessary and counterproductive to establishing a successful new model. We strongly support Track 1+ as a voluntary model available to new ACOs and those in Track 1, but we also urge CMS to make this opportunity available to ACOs currently in MSSP Tracks 2 and 3, as well as to those currently in the Next Generation Model. ACOs in these tracks/models have demonstrated a clear commitment to value-based payment and to assuming financial accountability. However, some of these ACOs may not be successful and could face repaying losses greater than they anticipated. Should they conclude they are unable to continue in their current ACO track/model, allowing them to participate in Track 1+ would be more beneficial for the ACOs and Medicare rather than requiring them to remain in an unsustainable situation. Faced with this dilemma, many ACOs would likely drop out of the program. Therefore, allowing them to move into Track 1+ would be a better option and would not penalize them for their early commitment to a two-sided risk model. We strongly recommend that CMS allow all new and current ACOs, regardless of track/model, to participate in Track 1+.

We strongly urge CMS to allow all ACOs to be eligible to participate in Track 1+ and to not restrict participation based on ACO size, composition or ownership. Such participation limits unfairly disadvantage ACOs, such as those affiliated with a health plan. While CMS has stated its belief that certain types of ACOs (i.e., larger ACOs, those with hospital participants or those affiliated with health plans) are better equipped to take on downside risk, we disagree with this assertion. The financial position and backing of a particular ACO as well as the ability to assume risk depends on a variety of factors, such as local market dynamics, culture, leadership, financial status, and the resources required to address social determinants of health that influence care and outcomes for patients with complex needs. Therefore, we urge CMS to make Track 1+ available to all types of ACOs and not exclude any based on their size, composition or health plan affiliation or ownership.

Further, we urge CMS to establish Track 1+ as a permanent MSSP track through future rulemaking. Developing Track 1+ creates an important glide path for assuming risk, representing an option in between Track 1, which has no downside risk, and the higher risk levels included in the other two-sided ACO tracks/models. While CMS notes that the agency envisions Track 1+ as an on-ramp to other two-sided ACO models, many ACOs will likely never be able to assume the very high levels of risk in the existing two-sided models. This is demonstrated by the current low levels of participation in those ACO tracks/models relative to participation in Track 1. We urge CMS to retain the current two-sided ACO tracks/models as options for ACOs that are ready to assume those levels of risk and to establish Track 1+ as a permanent part of the MSSP.

However, it's important to note that we oppose limiting Track 1+ participation to a certain number of agreement periods and forcing ACOs to take on greater risk in other models. We see no reason that ACOs could not remain in Track 1+ indefinitely. Further, placing such a strict time limit on Track 1+ participation creates a strong disincentive for ACOs to participate. Many ACOs considering Track 1+ participation want to test the waters of two-sided risk and do not want to be forced into even greater risk in just a few years or be prohibited from returning to Track 1 should they have difficulty in Track 1+.

Limiting Track 1+ participation to a certain number of agreement periods would likely result in ACOs eventually dropping out of the program rather than assuming risk they are not prepared for. Retaining ACOs in Track 1+ would benefit ACOs and Medicare by continuing to incentivize them to enhance quality of care and generate savings for themselves and the Medicare Trust Funds. Therefore, we urge CMS not to restrict Track 1+ participation to a particular number of agreement periods.

Financial Structure

Minimum Savings Rate (MSR) and Minimum Loss Rate (MLR)

CMS position: The factsheet explains that CMS will use the same MSR/MLR as with MSSP tracks 2 and 3. Under those tracks, ACOs have a choice of a symmetrical MSR/MLR, ranging from 0 to 2 percent, in 0.5 percent increments. Or, the ACO can choose to have their MSR/MLR set based on the number of assigned beneficiaries, and CMS uses the same sliding scale as with Track 1, which ranges from 2.0 to 3.9 percent.

NAACOS recommendations: The MSR/MLR are key components of the ACO model design and represent the percentages by which an ACO's actual expenditures differ from their benchmark, after which point the ACO would be eligible to earn shared savings or would be required to repay losses. We support CMS allowing Track 1+ ACOs to have a choice of a symmetrical MSR/MLR: no MSR/MLR; symmetrical MSR/MLR in 0.5 percent increments between 0.5 percent and 2 percent; symmetrical MSR/MLR to vary based upon number of assigned beneficiaries (as in Track 1).

Shared Savings Rate

CMS position: CMS specifies first dollar savings once the MSR is met/exceeded and the agency will use a final sharing rate of up to 50 percent based on quality performance.

NAACOS recommendations: As with other MSSP tracks, we recommend that Track 1+ ACOs have first dollar savings after surpassing the ACO's MSR. However, the shared savings rate of 50 percent is not high enough. This is the same as Track 1, which does not require downside risk. ACOs that take on risk under Track 1+ should be rewarded with a higher savings rate, as they are with in other MSSP tracks and the Next Generation ACO Model. We urge CMS to revise the shared savings rate and increase it to match that of Track 2, which is set at 60 percent. Further, for all ACO tracks and models – including Track 1+ – we recommend the shared savings rate increase based on quality performance/improvement. Specifically, for Track 1+, we urge CMS to allow the shared savings rate to increase from 60 percent up to 70 percent on a sliding scale based on quality performance or improvement.

Shared loss rate

CMS position: CMS details a shared loss rate of 30 percent.

NAACOS recommendations: We support a shared loss rate of 30 percent for Track 1+. This rate is essential to defining potential losses as it determines what portion of the losses the ACO would have to pay back, should its losses meet or exceed the MLR. In the proposed MACRA rule, CMS proposed that for an APM to meet the nominal amount standard the specific level of marginal risk must be at least 30 percent of losses in excess of expected expenditures. While the agency did not finalize any required shared loss rate for an Advanced APM, their proposal illustrates that the agency considers 30 percent sufficient to meet the nominal risk criteria, and we therefore recommend a 30 percent shared loss rate for Track 1+.

Performance Payment Limit

CMS position: The Track 1+ Factsheet specifies a performance payment limit of 10 percent.

NAACOS recommendations: A higher payment performance limit is an incentive to move into Track 1+, and we request that CMS align the Track 1+ performance payment limit with Track 2 by setting it at 15 percent, rather than aligning it with Track 1.

Beneficiary assignment

CMS position: The factsheet explains that Track 1+ would utilize prospective beneficiary assignment for reports, quality reporting and financial reconciliation, which is the same approach used under MSSP Track 3.

NAACOS position: We urge CMS to provide Track 1+ ACOs, as well as ACOs in all MSSP Tracks, the option of using the Track 1 and 2 assignment methodology (preliminary prospective assignment with retrospective reconciliation) or using the method used for Track 3 (prospective assignment). We strongly support allowing ACOs 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 threshold, may favor a model where the ACO can add beneficiaries throughout the year, and would thus prefer the retrospective assignment model. However, other ACOs would likely prefer a prospective model, which would help them stabilize their beneficiary population and thus avoid volatile benchmark changes. Further, 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. For these reasons, we strongly recommend that CMS provide Track 1+ ACOs, and all MSSP ACOs, the option of choosing either retrospective or prospective assignment.

Adjustments for beneficiary health status and demographic changes

CMS position: CMS explains it will use the same method as with other MSSP tracks for Track 1+ adjustments for health status and demographic changes. Specifically, Track 1+ ACO historical benchmark expenditures will be adjusted based on CMS-Hierarchical Condition Categories (HCC) Model. Updated historical benchmark will be adjusted relative to the risk profile of the performance year assigned population. For the performance year, newly assigned beneficiaries are adjusted using CMS-HCC Model, while continuously assigned beneficiaries are adjusted using demographic factors alone unless CMS-HCC risk scores result in a lower risk score.

NAACOS recommendations: We have previously expressed concerns about CMS's use of different methods for updating risk adjustment for newly and continuously assigned beneficiaries, the latter of which are prohibited from increases to their risk adjustment scores based on health status but may have decreases to risk scores. It is unreasonable to assume an ACO, however effective, can manage a population such that patient conditions never worsen over time and it never carries a higher disease burden. For Track 1+, and all MSSP tracks, we urge CMS to allow risk scores to increase year-over-year within an agreement period for

the continuously assigned. Should CMS require limits to risk score changes, we would support a 3 percent cap on average risk score increases or decreases, which is the approach used for the Next Generation ACO Model. Therefore, we urge CMS to address the flaws with the risk adjustment methodology for Track 1+ as well as more broadly in the MSSP by allowing risk scores to increase for continuously assigned beneficiaries.

Payment Rule Waivers, including the Skilled Nursing Facility (SNF) 3-Day Rule Waiver

CMS policy: The Track 1+ Factsheet clarifies that Track 1+ ACOs may elect to apply for a SNF 3-day rule waiver. Medicare typically requires that beneficiaries have a prior inpatient hospital stay of no fewer than three consecutive days in order to be eligible for Medicare coverage of inpatient SNF care. This waiver allows ACOs, under certain circumstances, to be exempt from the requirement for the 3-day inpatient hospital stay and permits ACO beneficiaries to receive SNF services without first having the 3-day inpatient hospital stay.

NAACOS recommendations: We support allowing Track 1+ ACOs to apply for a SNF 3-day rule waiver. We also strongly encourage CMS to make available to all Medicare ACOs, including Track 1+, waivers related to the following:

- **Hospital discharge planning requirements** that prohibit hospitals from specifying or otherwise limiting the providers who may provide post-hospital services;
- **Medicare requirements for payment of telehealth services,** such as limitations on the geographic area and provider setting in which these services may be received;
- **Homebound requirements for home health,** which mandate that a Medicare beneficiary be confined to the home to receive coverage for home health services; and
- **Medicare primary care co-payments**, which would reduce or eliminate cost-sharing otherwise applicable under Medicare Part B for some or all primary care services furnished by health care professionals within the network of the ACO.

Waiving these payment regulations is essential so that ACOs can effectively coordinate care and ensure that it is provided in the right place at the right time. Payment rules such as those described above are not necessary in a population health model, which inherently in the model's design creates incentives to reduce unnecessary utilization and costs and improve quality. These payment rule waivers would provide ACOs with valuable tools to increase quality and reduce unnecessary costs and should be available to advance the success of all ACOs, including those in Track 1+. Further, CMS should implement the waivers in a manner that is not prohibitively burdensome to ACOs that utilize them. CMS should ensure that the waivers are easily accessible to ACOs and should rely on the ACOs' existing cost and quality metrics to ensure that ACOs continue to provide high-quality, appropriate care to their ACO populations.

Comments on Track 1+ Elements Not Addressed in the MACRA Final Rule with Comment Period

In addition to our comments in the previous section on Track 1+ elements included in the Track 1+ Factsheet, this section of the letter includes our recommendations for other Track 1+ program elements and requirements, which we urge CMS to incorporate into the design of Track 1+.

Financial Structure

Financial mechanisms to demonstrate ability to repay losses

If Track 1+ ACOs incur losses, they should have a variety of acceptable repayment mechanisms, including those currently permitted by CMS (placing funds in escrow, obtaining a surety bond, establishing a line of credit, or establishing a combination of the approved repayment mechanisms). We also urge CMS to restore reinsurance as a qualifying repayment mechanism. Reinsurance was a permissible repayment

mechanism for MSSP ACOs until CMS removed this option in the June 2015 final MSSP rule. The agency's rationale for doing so was that few ACOs were using this option. However, we question that logic especially considering how few two-sided ACOs there were at that time. Further, despite limited initial use of reinsurance for demonstrating ability to repay losses to CMS, reinsurance continues to be an option which some ACOs pursue separate from their CMS obligations. We see no harm in CMS reinstating reinsurance as an option, and we urge CMS to do so for all two-sided ACO tracks/models, including Track 1+.

Under the financial risk standard finalized by CMS, if actual expenditures for which an APM Entity is responsible under the APM exceed expected expenditures during a specified performance period, the agency will allow a reduction of payment rates to the APM Entity and/or the APM Entity's eligible clinicians, among other options for repaying losses. We urge CMS to develop an option for ACOs to repay losses through reduced payment rates of the ACO's eligible clinicians in future years. Through this mechanism, CMS would identify the Tax Identification Number (TIN)/National Provider Identifier (NPI) combinations that participate in the ACO for a specific performance period and, similar to downward payment adjustments under the Merit-based Incentive Payment System (MIPS), CMS would reduce the payment rates for those TIN/NPIs by a certain percent in a future payment adjustment year to recoup the ACO's losses. ACOs would include language in the agreement between the ACO and its participant TINs and their individual practitioners detailing specifics of this repayment mechanism. Allowing ACOs to choose this as one of the mechanisms to repay losses would provide a new option that some ACOs may prefer over repaying losses in a lump sum. We urge CMS to work collaboratively with us to further develop this concept and the key details that would be needed to implement it.

Beneficiaries and Alignment

Minimum number of beneficiaries

We recommend CMS implement a minimum threshold of 5,000 beneficiaries for Track 1+, which is consistent with the other MSSP tracks but is lower than the 10,000 (or 7,500 for rural ACOs) beneficiary threshold used in the Next Generation ACO Model. We also recommend that for Track 1+ CMS implement the same policy it recently finalized in the final 2017 Medicare Physician Fee Schedule for MSSP Track 2 and 3 ACOs that fall below 5,000 beneficiaries at the time of financial reconciliation. Under that policy, Track 2 and 3 ACOs that choose a non-variable MSR/MLR at the start of the agreement period but subsequently fall below 5,000 assigned beneficiaries at the time of financial reconciliation remain eligible for shared savings (or losses). Further, their MSR/MLR used for financial reconciliation remains the same as what the ACO selected at the start of the agreement period and does not change if the population falls below 5,000. If the ACO selected a variable MSR/MLR based on its number of assigned beneficiaries, CMS will use the same approach it currently uses for Track 1 ACOs in this situation, which relies on an expanded sliding scale for the MSR/MLR to match the number of assigned beneficiaries, should that population fall below 5,000.

Voluntary beneficiary alignment

In the final 2017 Medicare Physician Fee Schedule, CMS finalized a modification to the MSSP beneficiary assignment algorithm to allow beneficiaries to designate an ACO professional as responsible for their overall care. We are very pleased that CMS finalized the use of voluntary alignment which will allow beneficiary designations to result in the beneficiary being assigned to the designated provider as long as certain criteria are met. Providing beneficiaries with the opportunity to voluntarily align with an ACO balances the important considerations of beneficiaries' freedom to choose their providers with ACOs' interest in reducing patient churn and having a more defined and stable beneficiary population identified up front. This, in turn, allows 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. CMS finalized this policy for all MSSP tracks, and as such we request that this policy also be applied to Track 1+.

Quality and waivers

Quality reporting requirements

We support CMS implementing the same quality reporting requirements for Track 1+ as with ACOs in other MSSP tracks, including reporting via the CMS Web Interface, evaluation on claims-based measures and patient satisfaction. MSSP ACOs demonstrate positive results with quality, and we see no reason for using different measures or requirements for Track 1+.

However, we strongly urge CMS to allow quality performance and quality improvement to increase the percent of shared savings that a Track 1+ ACO may earn, from our recommended 60 percent shared savings to 70 percent. Under current MSSP rules, 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. In contrast, Medicare Advantage (MA) plans are rewarded with higher benchmarks for higher quality, which leads to an asymmetry between MA plans and ACOs. As noted by the Medicare Payment Advisory Commission (MedPAC) in their February 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 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. The more an ACO strives to improve quality performance, the more it often needs to spend. 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 properly reward Track 1+ ACOs, as well as all MSSP 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 shared savings to Track 1+ ACOs, from 60 to 70 percent**.**

Compliance waivers

We urge CMS to use the full scope of the combined authority granted by Congress under the Affordable Care Act to issue waivers of the applicable fraud and abuse laws similar to those it has issued for ACOs in the Pioneer, MSSP, and Next Generation Programs. Specifically, CMS should issue:

- An ACO "pre-participation" waiver of the Stark and Anti-kickback statutes to protect ACO-related start-up arrangements in anticipation of participating in Track 1+;
- An ACO participation waiver of the Stark and Anti-kickback statutes that applies broadly to ACO-related arrangements during the term of the participation agreement;
- A shared savings distributions waiver of the Stark and Anti-kickback statutes that applies to distributions and uses of any earned shared savings payments or internal costs savings;
- A waiver of the Anti-kickback statute for ACO arrangements that implicate the Stark law and satisfy the requirements of an existing exception; and
- A waiver of the Beneficiary Inducements civil monetary penalty and the Anti-kickback statute for medically related incentives offered by ACOs, ACO participants, or ACO providers/suppliers to assigned beneficiaries to encourage preventive care and compliance with treatment regimes.

These waivers are critical to removing legal and regulatory barriers that inhibit providers from working together to provide better-coordinated, high quality care.