



October 16, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: (CMS–1701–P) Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations—Pathways to Success

Dear Administrator Verma:

The National Association of ACOs (NAACOS) is pleased to submit comments in response to the proposed rule, *Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations—Pathways to Success*, as published in the August 17, 2018 Federal Register. We express appreciation for efforts to update the Medicare Shared Savings Program (MSSP) and request the agency move forward to modernize the MSSP and ensure its long-term success, while incorporating our recommended policy changes in a final regulation. These recommendations reflect our desire to see the MSSP achieve the long-term sustainability necessary to enhance care coordination for millions of Medicare beneficiaries, lower the growth rate of healthcare spending and improve quality in the Medicare program.

NAACOS is the largest association of ACOs, representing more than 6 million beneficiary lives through 370 MSSP, 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, population health and outcomes, and healthcare cost efficiency. Our members, more than many other healthcare organizations, want to see an effective, coordinated patient-centric care process.

The ACO model is a market-based solution to fragmented and costly care that empowers local physicians, hospitals and other providers to work together and take responsibility for improving quality, enhancing patient experience and reducing waste. Importantly, the ACO model also maintains patient choice of clinicians and other providers. While the origins of Medicare ACOs date back to the George W. Bush Administration, the MSSP has grown considerably in recent years and now includes 561 ACOs, covering 10.5 million beneficiaries. ACOs have been instrumental in the shift to value-based care and a central part of the ACO concept is to transform healthcare through meaningful clinical and operational changes to put patients first by improving their care and reducing unnecessary expenditures.

This fall NAACOS conducted a poll of to collect feedback in response the Pathways to Success rule to solicit input about the rule to help inform our comments. The survey, conducted by NAACOS through a web-based questionnaire sent to all MSSP ACOs, drew 153 responses from 127 unique ACOs, representing 23 percent of MSSP ACOs. NAACOS released a report on the findings from the poll, which is available [here](#). There are a number of notable results detailed in the report which we hope CMS will consider as it evaluates comments. For example, when asked about their ACO's overall level of support for the proposed rule, 27 percent of respondents report favoring the rule while more than 60 percent report opposing the proposed rule.

The levels of support and opposition were informed by what ACO respondents identified as the top opportunities and challenges in the proposed rule. Specifically, 57 percent of respondents reported concern with cutting shared savings rates for many ACOs from 50 percent to as low as 25 percent; 51 percent reported concern with designating ACOs as "high" or "low" revenue and requiring more risk sooner for "high revenue ACOs"; 43 percent reported concern with shortening the time for shared savings-only ACOs from six years to two years; and 31 percent reported concern with capping risk adjustment at +/- 3 percent across five-year agreement periods. While risk adjustment proposals were identified as a challenge, they were also identified as an opportunity. Importantly, sixty percent of ACOs reported that if finalized, they would have been unlikely to have entered the MSSP as new ACOs under revised policies laid out in a proposed rule.

In contrast, ACOs expressed support for a number of proposals in the rule and the top three opportunities were clear with the first, selected by over 55 percent of respondents, being the ability to choose an assignment methodology annually, regardless of MSSP track or level. ACO respondents noted their support for proposed changes that would expand use of payment waivers and beneficiary incentives with 42 percent of respondents selecting the expanded use of these waivers and introduction of the beneficiary incentive program as a leading opportunity proposed in the rule. Citing a desire for increased program stability and predictability, slightly more than 30 percent of respondents chose the proposed shift from three-year to five-year agreements as the third most popular opportunity included in the rule.

Summary of Key Recommendations

As detailed in the comments below, in the final Pathways to Success rule we urge the agency to:

- Restructure the MSSP with the proposed Basic and Enhanced Tracks which includes a more gradual ramp up of risk in the Basic Track than currently available and permanent inclusion of Basic Level E (currently Track 1+)
- Finalize the proposal to enact extended, five-year agreement periods
- Alter current proposals to allow all new ACOs entering the program to remain in Basic Track Level A for two years and Basic Track Level B for an additional two years before requiring the move to Level C in the fifth and final year of their agreement (providing four years in shared savings-only models)
- Not cut in half the shared savings rates for shared savings-only ACOs and to apply the following shared savings rates: 50 percent for Basic Levels A and B, 55 percent for Basic Levels C and D, and 60 percent for Basic Level E
- Not to finalize the arbitrary distinction of high and low revenue ACOs. We oppose requirements that high revenue ACOs – or any ACOs – be forced into higher levels of risk beyond Basic Level E
- Not require any ACOs to participate in the Enhanced Track but keep that a voluntary model for ACOs prepared for higher levels of risk and reward
- Update the risk adjustment methodology by allowing risk scores to change by +/-5 percent over an agreement, as opposed to the proposed +/-3 percent range, and to eliminate the distinction between newly and continuously assigned beneficiaries
- Finalize policies that support the move to regional benchmarking, including maintaining the current maximum of 70 percent regional expenditures, and remove ACO beneficiaries from the regional population
- Not finalize the proposal to permit CMS to terminate an ACO's participation agreement if expenditures exceed a certain amount after two performance periods
- Not finalize the proposal to establish a June 30 deadline to voluntarily terminate ACO participation agreements
- Create a policy allowing ACOs with agreements expiring in 2018 the option of extending their current participation agreements from January 1, 2019 through December 31, 2019
- Not move forward with the proposed beneficiary opt-in assignment methodology and instead improve upon the current voluntary alignment process
- Finalize proposals to expand eligibility for the Skilled Nursing Facility (SNF) three-day rule and telehealth waivers, while considering additional waivers for ACOs Finalize proposals to introduce a beneficiary incentive program for MSSP ACOs
- Finalize the proposal to remove ACO quality measure 11 and instead rely on attestation to evaluate the ACO's use of Certified Electronic Health Record Technology (CEHRT), while also excluding ACOs subject to the Merit-Based Incentive Payment System (MIPS) from Promoting Interoperability requirements

NAACOS Detailed Recommendations

Replacing Current Tracks with Basic and Enhanced Tracks

Key comments:

- NAACOS supports restructuring the MSSP with the proposed Basic and Enhanced Tracks which includes a more gradual ramp up of risk in the Basic Track than currently available.
- NAACOS applauds the permanent inclusion of Track 1+ (renamed Basic Level E).

- **NAACOS urges CMS to introduce a glidepath to higher risk between Basic Level E and the Enhanced Track and to not require participation in the Enhanced Track but provide it as a voluntary option for ACOs ready for higher levels of risk and reward.**

Proposals: CMS proposes that effective June 30, 2019 the agency would retire the current MSSP Tracks 1, 1+, 2 and 3 and would replace those with new Basic (including Levels A through E) and Enhanced Tracks effective with a transition to the new tracks beginning July 1, 2019. While there are a number of overall program changes, the new tracks and levels have overall similarities to most of the existing tracks, such that they are roughly equivalent as follows:

Current MSSP Track	Equivalent under Proposed MSSP Structure
Track 1	Basic Level A and B
Track 1+	Basic Level E
Track 2	No equivalent
Track 3	Enhanced Track

Comments:

Renaming and Restructuring the MSSP

We support the transition to the new Basic and Enhanced Tracks, especially with the introduction of a more gradual glidepath to assuming risk in the Basic Track. This allows ACOs to gain exposure to risk in a more incremental manner than what is currently available in the MSSP. We strongly support the permanent inclusion of the Track 1+ equivalent, Basic Level E, which is an important option for ACOs assuming downside financial risk and allows loss sharing limits similar to those required for Advanced Alternative Payment Models (APMs) in the Quality Payment Program (QPP). That said, we have a number of concerns with the specific shared savings and loss rates included in the revised MSSP, which are discussed in detail in later sections of this comment letter. The Basic and Enhanced Track labels are more descriptive than the current labels for the existing MSSP tracks. We recommend that should these name changes be finalized, that they stay in place moving forward to ensure continuity and understanding across the industry.

Moving from Level E to the Enhanced Track

While we are pleased with the more gradual glidepath to risk in the Basic Track, there remains a significant jump from Basic Level E to the Enhanced Track. In 2018, fewer than 7 percent of MSSP ACOs elected to participate in Track 3, the equivalent of the Enhanced Track. Introduced in 2016, Track 3 was meant to provide a more advanced option for ACOs ready for higher levels of risk and reward, but only a very small group of ACOs have chosen to participate. While the proposed rule provides some changes to the Enhanced Track, which also apply to other downside financial risk models in the Basic Track, there remains a massive jump in risk from Basic Level E and the Enhanced Track, with the latter requiring maximum losses based on total cost of care and capped at almost four times those in the Basic Level E. CMS acknowledges this significant increase and requests feedback, stating on page 41818:

“We recognize that the difference in the level of risk and potential reward under the BASIC track, Level E compared to the payment model under the ENHANCED track could be substantial for low revenue ACOs. Therefore, we also considered and seek comment on an approach that would allow low revenue ACOs to gradually transition from the BASIC track’s Level E up to the level of risk and potential reward under the ENHANCED track. For example, we seek comment on whether it would be helpful to devise a glidepath that would be available to low revenue ACOs entering the ENHANCED track. We also considered, and seek comment on, whether such a glidepath under the ENHANCED track should be available to all ACOs. As another alternative, we considered allowing low revenue ACOs to continue to participate in the BASIC track under Level E for longer periods of time, such as a third or subsequent agreement period. However, we believe that without a

time limitation on participation in the BASIC track, ACOs may not prepare to take on the highest level of risk that could drive the most meaningful change in providers'/suppliers' behavior toward achieving the program's goals."

Establishing an ACO and embarking on the related transformations inherent in population health are what drives changes in provider behavior. These changes often take years to generate results, as evidenced by the increasingly positive results for ACOs that are in the program for a longer period of time. We point to August 2017 [findings](#) from the Department of Health and Human Services Inspector General (OIG) and 2017 MSSP results available in the [Public Use File](#) as proof that ACOs need time to generate positive results and demonstrate change. Therefore, we have concerns with the assertion that high levels of risk are the key driver with changing provider/supplier behavior which would help achieve the program's goals. As Harvard Medical School researchers J. Michael McWilliams et al noted in their report, *Medicare Spending after 3 Years of the Medicare Shared Savings Program*, published in the [New England Journal of Medicine \(NEJM\)](#) on Sept. 20, contracts with no downside risk contracts, which appeal to smaller organizations, "maybe effective in lowering Medicare spending." We urge the agency to focus on incentivizing the care transformations tied to population health and value-based care rather than focus on requiring risk as the sole mechanism to change provider behavior.

The significant increase in the Enhanced Track risk level is based on an increased shared loss rate and a much higher benchmark-based loss sharing limit. The downside financial risk models in the Basic Track include lower shared loss rates and a revenue-based loss sharing limit, which caps risk based on provider revenue rather than total cost of care, which is the basis for the benchmark-based loss sharing limit. The Enhanced Track does not include a revenue-based loss sharing limit, and we urge the agency to create one and to create more options for gradual risk increases between Basic Level E and the Enhanced Track. It is also essential that CMS revise its policies to keep the Enhanced Track voluntary, as with Track 3, and not attempt to push ACOs into a model with levels of risk they are unprepared to assume. Requiring ACOs to potentially pay millions of dollars to Medicare is simply not practical or feasible for most of these organizations.

It's important to recognize that ACOs that are not ready for such high levels of risk under the Enhanced Track will not move forward; they will quit the program altogether. As McWilliams and his colleagues noted in the NEJM-published [research](#), MSSP's benefits "could erode if policy changes, such as requiring ACOs to assume downside risk after fewer years of participation, cause ACOs to leave the program." Using a government mandate to assume high levels of provider risk is not the solution to increasing ACO participation and achieving successful results for ACOs. The unintended consequences of forcing high levels of risk 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 reducing costs often overshadows the equally important goal of quality improvement that the ACO model offers, which benefits patients and the Medicare program generally. While some ACOs have not yet been able to experience a return on the investments they have made, they have generated savings to the government while improving patient care, which studies show has a positive downstream impact on spending, but may take years to fully materialize. For example, MSSP ACOs [generated gross savings](#) of \$1.1 billion for PY 2017 based on the CMS methodology for setting financial benchmarks. Sixty percent of ACOs saved Medicare money in 2017 with 34 percent of ACOs earning shared savings and 26 percent of ACOs generating savings for Medicare but not enough savings meet the threshold (i.e., the Minimum Savings Rate (MSR)) needed to earn shared-savings payments. These ACOs are on the right path, and we urge CMS to support them so they continue to generate savings for Medicare and positive quality for beneficiaries. Success does not equal assuming risk. We urge CMS to allow all ACOs to remain indefinitely in Basic Level E without being forced to move to the Enhanced Track.

Moving to Five-Year Agreement Periods

Key comment:

- **NAACOS urges CMS to finalize its proposals to enact extended, five-year agreement periods and to eliminate restrictions that prevent ACOs from re-entering the program after terminating a participation agreement.**

Proposals: CMS proposes to extend the length of agreement periods from three years to five years. Specifically, for agreement periods beginning on July 1, 2019, the length of the agreement would be five years and six months. For agreement periods beginning on January 1, 2020, and in subsequent years, the length of the agreement would be five years. CMS also proposes to remove current restrictions that prevent an ACO from terminating its participation agreement and re-entering the program prior to when the existing agreement period would have ended.

Comments: We support CMS's proposal to extend the length of agreement periods from three years to five years, which will promote program stability. Extended agreement periods allow ACOs a longer horizon on which to plan and to benefit from efficiency gains before benchmark rebasing. Many ACOs have expressed the desire to have more program stability and predictability and shifting to longer agreement periods will enable that. We urge CMS to finalize this change as proposed. We also support the proposal to modify current restrictions that prevent an ACO from terminating its participation agreement and re-entering the program before the existing agreement period would have ended. This "sit out" period is unnecessary and shuts providers out of participating in an essential CMS value-based program. Eliminating this restriction will allow the flexibility for an ACO in an agreement period to terminate its participation agreement and then enter a new five-year agreement period under one of the redesigned participation options proposed in this rule. We recommend CMS finalize this as proposed.

Timeframe to Transition to Risk

Key Comments:

- **NAACOS urges CMS to finalize a policy allowing all new ACOs entering the program to remain in Basic Track Level A for two years and Basic Track Level B for an additional two years before requiring the ACO to move to Level C in the fifth and final year of their agreement.**
- **NAACOS also asks CMS to allow ACOs meeting certain performance criteria to participate for a third year in Basic Track Level B, providing ACOs that demonstrate superior performance with up to five years in Basic Track Levels A and B.**

Proposals: CMS proposes ACOs would progress from shared savings-only to risk-based models under timeframes that apply to ACOs differently depending largely on previous program experience and ACO type (high vs. low revenue). Levels A and B of the Basic Track would be shared savings-only models, and after two years, ACOs would gradually assume more risk over time as they progress along Basic Track Levels C through E. CMS proposes to automatically advance ACOs over time across the levels and allow ACOs to elect annually to move up to higher risk levels in the Basic Track more quickly than what is required. The new proposed structure includes a more gradual glide path for assuming risk between Basic Track Levels A through Level E. However, there remains a significant jump in the risk level required when moving from Basic Level E (losses capped at 4 percent of the benchmark) to the Enhanced Track (losses capped at 15 percent of the benchmark).

CMS proposes ACOs would not be permitted to switch from the Basic Track to the Enhanced Track during their five-year agreement period. However, because CMS proposes to eliminate the current restriction that prevents ACOs that terminate during an agreement from re-entering the program before the contract would have ended, an ACO could terminate its contract and quickly move to the Enhanced Track under a new agreement.

Comments: NAACOS appreciates CMS efforts to encourage providers to move to risk by introducing a structure that includes a more gradual glide path for assuming risk through the Basic Track. However, we have significant concerns that reducing the amount of time available in shared savings-only models would be detrimental to the program and the administration's goals of encouraging providers to participate in APMs. Research shows that ACOs improve over time in the program. ACOs participating in the MSSP over a longer period of time show greater improvement in financial performance, demonstrating the value of such models and the need to allow ACOs sufficient time to demonstrate positive results. For example, as detailed in Tables 1 through 3 below, it took 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 (i.e., expenditures higher than

benchmarks) in one of their first two years of the program. Had CMS’s proposed policies been in place, these ACOs would not have had the opportunity to continue in the program and go on to demonstrate success. A critical component of performance improvement lies in the ACO’s ability to analyze the performance data being provided to the ACO and make targeted improvements based on this information. Under CMS’s current proposal, ACOs would have only one year of performance data before being required to move to a risk-based model. This is not sufficient and will not allow ACOs the opportunity to make strategic decisions regarding performance improvement which allow them to demonstrate success in future program years.

Table 1: Net Savings by ACO Cohort

MSSP Cohort (based on start year)	Net Savings to Medicare, 2017* (millions)	Average Savings per Beneficiary
2012	\$87	\$257
2013	\$118	\$184
2014	\$172	\$135
2015	\$5	\$124
2016	-\$34	\$105
2017	-\$34	\$44
Total	\$314	---

*Net savings factors in bonuses paid to ACOs

Table 2: Share of ACOs with Shared Savings by Start Date and Performance Year

Start Year	N	PY13	PY14	PY15	PY16	PY17
2012	63	32%	37%	42%	42%	51%
2013	62	21%	27%	37%	36%	44%
2014	79	NA	19%	22%	36%	43%
2015	76	NA	NA	21%	26%	28%
2016	96	NA	NA	NA	18%	29%
2017	96	NA	NA	NA	NA	21%

Table 3: Savings Patterns among ACOs with Five Years of Participation

Savings Patterns	Number	Percent
No savings	57	15%
4 years of losses then savings	53	14%
3 years of losses then savings	87	23%
2 years of losses then savings	55	15%
1 years of losses then savings	55	15%
5 years of savings	39	10%
Other patterns	30	8%

Research also shows that ACOs in shared savings-only models save CMS money and improve quality for the patients they serve. The recent MSSP performance year 2017 results show net savings to the Medicare Trust Fund of \$314 million, which is after accounting for shared savings payments made to ACOs. Further, as noted in the June 2018 Medicare Payment Advisory Commission (MedPAC) report, [Chapter 8, Medicare Accountable Care Organization Models: Recent Performance and Long-term Issues](#), there are a number of scientific evaluations that show ACO savings. For example, the aforementioned peer-reviewed [study](#) by Harvard University researchers found that the MSSP saved more than \$200 million in 2013 and 2014 and \$144.6 million in 2015 after accounting for shared savings bonuses earned by ACOs. A [recently released study](#) by Dobson DaVanzo & Associates using similar rigorous methods found that ACOs saved \$1.84 billion from 2013 through 2015 and reduced Medicare spending by \$542 million after accounting for shared savings bonuses. In the proposed rule’s impact analysis, CMS estimates that the overall impact of ACOs, including “spillover effects” on Medicare spending outside of the ACO program, lowered spending by \$1.8 –

\$4.2 billion (0.5 – 1.2 percent) in 2016 alone. These analyses provide important evidence that ACOs save more money for Medicare than what is reflected in basic evaluations of performance compared to CMS benchmarks.

ACOs have also demonstrated impressive quality results. A 2017 OIG [report](#), *Medicare Program Shared Savings ACOs Have Shown Potential for Reducing Spending and Improving Quality*, found that ACOs achieved high quality and in particular noted progress on important measures including reduced hospital readmissions and screening beneficiaries for risk of falling and depression. Recently released MSSP performance year 2017 data shows a mean quality score of 90.5 percent out of 100 percent for ACOs subject to pay-for-performance measures. Further, analysis of MSSP performance year 2016 results shows that ACOs improve quality over time, with average performance improving 15 percent across 25 measures used consecutively across program years. Evidence clearly shows that ACOs improve over time in the program and that shared savings-only models generate savings to CMS and improve quality of care for the patients they serve. Therefore, it is critical that CMS allow ACOs to remain in shared savings-only models (Basic Track Levels A and B) for more than the proposed two years.

If finalized, there will be a detrimental effect on new applicants and participation in the ACO program will be diminished. We request that CMS modify proposals for all ACOs (including both high- and low-revenue ACOs) to allow more time to participate in shared savings-only models. Specifically, NAACOS urges CMS to finalize a policy allowing all new ACOs to remain in Basic Track Level A for two years and Basic Track Level B for an additional two years before requiring the ACO to move to Level C in the fifth and final year of their agreement. These ACOs should then be permitted to begin their second agreement period at Basic Track Level D where they would participate for three years and progress to Level E for the final two years of their second agreement period (with options to progress more quickly if the ACO chooses). This would provide ACOs with four years of participation in shared savings-only models and a fifth year for those that demonstrate exceptional performance, as described below. Providing ACOs with four years in shared savings-only models provides the ACO with only two to three years of performance data, the minimum that would be necessary to identify trends and opportunities for transformation and improvement.

NAACOS strongly believes ACOs who meet superior performance criteria should also be permitted to participate for a third year in Basic Track Level B, allowing high performing ACOs to remain in a shared savings only model for a full five-year agreement period in CMS's proposed Basic Track. Specifically, based on evaluation of the previous three performance years, we urge CMS to allow ACOs that meet at least one of the criteria below to have a third year in Basic Track Level B, giving the ACO a full five-year agreement period in a shared savings only model:

1. **ACOs that generate net savings across three 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, realization of long-term commitments and investments in priorities such as care coordination, quality improvement, and data analytics. This trend is promising and means more savings over time for the Medicare Trust Fund. However, many ACOs generate savings, as defined by having expenditures lower than their benchmark, but do not surpass their MSR and thus do not qualify for earned shared savings. The MSR in Track 1 can be as high as 3.9 percent, which is a considerable hurdle. While these ACOs may not earn shared savings, they are saving Medicare money and delivering high quality care. CMS has no reason to discourage their continued participation. Therefore, we urge CMS to allow ACOs that generate net savings relative to their benchmark across three performance years (including those that do not surpass their MSR) to have the option of continuing in Basic Track Level B for a third year following their participation in Basic Track Level A for two years.
2. **ACOs that score at or above the 50th percentile in quality in one of two performance years:** ACOs that demonstrate superior quality performance have invested significantly in data analytics, clinical improvements, staff training, and operational changes to result in high quality performance scores. Though they may not have earned sufficient shared savings to allow them the financial readiness to assume risk, they have demonstrated high 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. We urge CMS to allow ACOs that score at or above the 50th percentile in quality performance in one of two performance years the option of

continuing in Basic Track Level B for a third year following their participation in Basic Track Level A for two years.

- 3. ACOs that improve their overall quality score by 10 percentage points or greater over the course of performance years:** ACOs that demonstrate a significant improvement in their quality score have made a clear investment in quality and have had a positive impact on the Medicare beneficiaries. These ACOs should be rewarded for these efforts and provided additional time to give their investments in quality an opportunity to materialize into cost savings, rather than being prematurely forced into a two-sided risk track. Therefore, we urge CMS to allow ACOs that improve their overall quality score by 10 percentage points over the course of the two performance years the option of continuing in Basic Track Level B for a third year following their participation in Basic Track Level A for two years.

Adopting these changes would provide ACOs with the time they need to transform health care through meaningful clinical and operational changes to put patients first by improving their care and reducing unnecessary expenditures. These transformations are significant and, as such, require time for implementation and to produce measurable results. ACOs are investing millions of dollars of their own capital to make these care improvements, even though Medicare does not recognize these start-up and ongoing investments in its calculations of ACO savings, losses, and costs. Further, the benefits of these transformations extend beyond the ACO's attributed Medicare fee-for-service patient population and have a broader effect on Medicare Advantage beneficiaries and even patient populations beyond Medicare. Finalizing CMS proposals to drastically reduce the amount of time available to ACOs in shared savings-only models will minimize the positive impact ACOs have on their communities. It is critical that CMS provide ACOs with additional time in shared savings-only models to allow for a successful transition from fee-for-service to value-based care.

Shared Savings and Loss Rates, Loss Sharing Limits

Key comments:

- **NAACOS urges CMS not to cut in half the shared savings rates for shared savings only ACOs and to apply the following shared savings rates: 50 percent for Basic Levels A and B, 55 percent for Basic Levels C and D, and 60 percent for Basic Level E.**
- **NAACOS strongly recommends that CMS emphasize and reward above average quality performance or improvement by providing additional shared savings on a sliding scale up to 10 percentage points.**
- **NAACOS urges the agency to lower the benchmark-based Level E loss sharing limit to equal MACRA's generally applicable nominal amount standard of 3 percent.**

Proposals: As shown in Table A, CMS proposes a number of changes to the shared savings rates for Basic Levels A through D, as compared to the current 50 percent shared savings rate for Track 1. Specifically, under the proposed one-sided model, a final sharing rate would not exceed 25 percent based on quality performance and would apply to first dollar shared savings for ACOs that meet or exceed their MSR.

The shared savings and loss rates would gradually increase across the levels until they reach those in Level E, which has the same shared savings and loss rates as Track 1+. The proposed shared loss rates remain constant at 30 percent across Levels C, D and E while the amount of maximum losses, i.e., the loss sharing limit, gradually increases. CMS proposes to determine the loss sharing limit (benchmark-based versus revenue-based) by calculating both thresholds for a particular level, such as 2 percent of total Medicare Parts A and B fee-for-service (FFS) revenue for ACO participants in a Level C ACO, and compare that to 1 percent of the historical benchmark. The loss sharing limit for Level E would be tied to the Advanced APM nominal amount standard, by setting the Level E loss sharing limit equal to the revenue-based nominal amount standard, currently at 8 percent, and 1 percent higher than the Advanced APM benchmark-based nominal amount standard, currently set at 3 percent. CMS would apply the lesser of the two thresholds for the loss sharing limit, and the agency explains it would determine the ACO's loss sharing limit annually at the time of financial reconciliation.

TABLE A: New Proposed MSSP Structure

Basic					Enhanced
Level A	Level B	Level C	Level D	Level E	
25% sharing rate	25% sharing rate	30% sharing rate	40% sharing rate	50% sharing rate	75% sharing rate
Upside only	Upside only	1 st dollar losses at 30%, not to exceed 2% of revenue capped at 1% of benchmark	1 st dollar losses at 30%, not to exceed 4% of revenue capped at 2% of benchmark	1 st dollar losses at 30%, not to exceed 8% of revenue capped at 4% of benchmark	1 st dollar losses at 40% to 75% not to exceed 15% of benchmark

Comments:*Shared Savings Rates*

NAACOS strongly opposes major reductions in shared savings rates from the current Track 1 shared savings rate of 50 percent to as low as 25 percent under the proposed Basic Track Levels A and B. This severe reduction in shared savings would drastically halt new ACOs from entering the program. Since the release of the proposed rule, many ACOs have expressed concern about these reductions and stated they would not have entered the program as new ACOs with these inadequate proposed shared savings rates. As noted in a comment [letter](#) to this CMS proposal from researchers at Harvard, “shared savings rates have been low in the MSSP, allowing ACOs in Track 1 to keep no more than 50 percent of the difference between its expenditures and its benchmark. Because imperfect quality scores reduce the shared savings rate, it has been even lower, averaging 44.2 percent in 2014 and 47.8 percent in 2017.” Therefore, in addition to the meager proposed shared savings rates for Levels A through D of the Basic Track, it is important to note that these shared savings rates would likely be even lower than what is proposed when CMS reduces them for imperfect quality performance. NAACOS’ members [report](#) spending almost \$2 million a year on average for MSSP participation, including investments made in health information technology, population health management and ACO administration. Such a drastic reduction in shared savings payments will not allow ACOs to recoup those investments and deter future participation in such a needed value-based payment program like MSSP.

The shared savings rates have been debated numerous times with many calls to increase shared savings rates above the current 50 percent in Track 1 and 1+. For example, as shown in the excerpt below from page 67929 of the November 2011 MSSP final [rule](#) which initially set the MSSP shared savings rates, many commenters including MedPAC called for much higher shared savings rates, such as 75 percent, to incentivize ACO participation.

“Commenters suggested sharing rates ranging from 50 to 95 percent (most commonly 75 percent) under the one-sided model and 66 to 95 percent (most commonly 80 percent) under the two-sided model. MedPAC recommended increasing the sharing rates for both models, suggesting, for example, offering a savings rate of up to 75 percent for the one-sided model and 95 percent for the two-sided model for the first agreement period.”

Given repeated calls for CMS to raise shared savings rates, it is very disappointing that the agency proposes to cut these rates in half for ACOs in shared savings-only models. CMS does not provide an adequate rationale for slashing these rates. It appears the agency’s goal to push more ACOs into models with downside financial risk is the driving force behind these proposed lower shared savings rates. Yet NAACOS-commissioned [work](#) published on Sept. 11 in [Health Affairs](#) and elsewhere show MSSP generated \$1.84 billion in savings for Medicare between 2013 and 2015, more than double CMS’s estimates comparing performance to ACO benchmarks. That work, and others like it, tried to replicate what spending would have been in the absence of ACOs, a better judge of savings than CMS-derived

benchmarks. These savings are sure to grow over more recent years as more ACOs participate in MSSP and gain the experience needed to produce positive results.

There have been some public comments from CMS leaders that ACOs in shared savings-only models do not generate savings. However, recent CMS data on PY 2017 MSSP results, available in this Public Use [File](#), shows this claim is not true. ACOs in shared savings-only models and those with downside financial risk both had net positive savings in 2017. In fact, as shown in Table 4, the savings per beneficiary was higher for ACOs in Track 1. Further, one would expect the savings to be higher for ACOs in models with downside financial risk as to date, ACOs have self-selected to move to a risk-based model, which is typically the result of being successful in the shared savings-only model.

Table 4: Net Savings for ACOs based on Track

Track	Net Savings to Medicare (millions)*	Means Savings per Beneficiary	Percent ACOs Generating Savings
Track 1	\$290	\$138	33%
Track 2/3	\$23	\$55	51%

*Net savings factors in bonuses paid to ACOs

Rather than make shared savings-only models less appealing, we urge CMS to focus its efforts on making models with downside financial risk more attractive while continuing to support shared savings-only models. It is essential that CMS structure the program such that it includes a business model attractive enough to retain current participants while bringing in new ACOs to create a pipeline for ACOs to advance on the path to value-based care. The proposed shared savings rates will fall short of that goal. Therefore, we urge CMS to maintain a 50 percent shared savings rate for Basic Levels A and B and to apply a 55 percent shared savings rate for Levels C and D and a 60 percent shared savings rate for Level E.

Further, we request CMS adjust shared savings rates based on quality, which is a primary goal of the ACO program. Unfortunately, ACOs that achieve high-quality performance are not rewarded through increased shared savings or higher benchmarks. In contrast, Medicare Advantage (MA) plans are rewarded with higher benchmarks for higher quality, which puts ACOs at a disadvantage. As MedPAC noted in its Feb. 2, 2015 [letter](#) to CMS, "Otherwise, the ACO with top quality performance would end up with a lower benchmark than an MA plan in the same market with top quality performance. That situation could be seen as inequitable for the ACO."

Efforts to improve quality consume ACO resources and increase spending relative to financial benchmarks in the short term, even if these efforts decrease Medicare spending over the long term. For example, an ACO that does extensive patient outreach for cancer screening, such as colonoscopies, could expend considerable resources delivering these services, which may prevent the need for expensive late-stage cancer treatments for the screened patients. ACOs that make large investments to improve quality performance may be less able to keep spending below their benchmarks as a direct result of their increased investment in quality. We urge CMS to use a similar approach for MA and MSSP by properly rewarding ACOs for high quality. It is important to recognize high-quality performance compared to established measure thresholds as well as to recognize – and reward – quality *improvement* relative to an ACO's previous performance. Therefore, to emphasize and reward above average quality performance or improvement, we urge CMS to provide on a sliding scale up to 10 percentage points of additional shared savings.

Shared Loss Rates

NAACOS supports CMS's efforts to gradually introduce risk with the new Basic Track Levels C and D. However, we support asymmetric models such that the shared loss rates are lower than the shared savings rates. This would be accomplished through CMS raising the shared savings rates as detailed above. Should the agency not follow these recommendations, we urge the agency to lower the shared loss rates such that those for Levels C and D would be set

at 20 percent and 25 percent respectively. This supports a gradual ramp up of assuming risk under an asymmetric approach.

Loss Sharing Limits

CMS notes the proposed approach for determining loss sharing limits would tend to place ACOs that include hospitals under a benchmark-based loss sharing limit because the participants of these ACOs typically have higher total Medicare Parts A and B FFS revenue compared to the ACO's benchmark. We support CMS's proposal to apply a loss sharing limit that is the lesser of the revenue-based or benchmark-based threshold. This allows flexibility for ACOs and does not place them in a particular category as a result of their ACO participant composition. We recommend CMS finalize this as proposed.

We appreciate CMS's proposal to set the loss sharing limits for Level E so those ACOs continue to qualify for Advanced APM bonuses under the QPP established by the 2015 Medicare Access and CHIP Reauthorization Act (MACRA). However, we urge the agency to lower the benchmark-based Level E loss sharing limit to equal the MACRA generally applicable nominal amount standard, rather than setting it one percent higher, as proposed. This would result in a Level E benchmark-based loss sharing limit of 3 percent for 2019, which reflects the level of risk CMS considers sufficient for MACRA Advanced APMs. This represents a more gradual increase in risk and aligns with the approach used for the revenue-based loss sharing limit, which is proposed to be set equal to, not higher than, the MACRA generally applicable nominal amount standard.

CMS explains that the agency would determine an ACO's loss sharing limit annually at the time of financial reconciliation. While the agency notes this is consistent with its current process for Track 2 and 3 ACOs, the timing of this determination is troubling. Financial reconciliation occurs months after the close of the performance year, meaning ACOs would face uncertainty about their maximum potential losses until after the performance year is over. One of CMS's goals with the proposed rule is to promote predictability and stability, a goal shared by NAACOS. However, not knowing the maximum amount of losses an ACOs may face creates significant uncertainty that undermines CMS's focus on improved predictability and stability. Participation in MSSP Tracks 2 and 3 remains low, and the uncertainty about potential losses is one of the reasons that has prevented more ACOs from joining these downside financial risk models. We urge CMS to learn from this lesson and provide the loss sharing limit determination prior to or at the start of the performance year rather than at the time of financial reconciliation.

High Revenue and Low Revenue ACO Designations

Key comments:

- **NAACOS urges CMS not to finalize the arbitrary distinction of high and low revenue ACOs and opposes requirements that high-revenue ACOs – or any ACOs – be forced into higher levels of risk beyond Basic Level E.**
- **NAACOS urges CMS not to require any ACOs to participate in the Enhanced Track but to keep that a voluntary model for ACOs prepared for higher levels of risk and reward.**
- **NAACOS recommends CMS reinstate advanced funding opportunities to help ACOs assume risk.**

Proposals: CMS proposes to create a new distinction that measures Parts A and B FFS revenue compared to ACO benchmarks in order to categorize ACOs as "high revenue" or "low revenue" ACOs. This distinction determines program specifics such as the timing for when an ACO must move to risk. For example, new high revenue ACOs would be required to move to the Enhanced track after one agreement period in the Basic track. Under current Track 1+ requirements, ACOs provide information to CMS about their participants, and CMS uses that information to determine if the ACO falls under the revenue- or benchmark-based risk standard. The proposed method for determining high revenue or low revenue ACOs removes the ACO self-reporting requirement, and CMS would instead use Medicare claims data to make this determination. The new approach would no longer directly consider

ownership or operational interests but would focus on participant revenue compared to benchmarks. The proposed definitions of high revenue and low revenue ACOs are as follows:

- **High revenue ACO** means an ACO whose total Medicare Parts A and B FFS revenue of its ACO participants is at least 25 percent of the total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries
- **Low revenue ACO** means an ACO whose total Medicare Parts A and B FFS revenue of its ACO participants is less than 25 percent of the total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries

The total ACO revenue of participants would be based on revenue for the most recent calendar year for which 12 months of data are available, as would the total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries. CMS notes that low revenue ACOs tend to be smaller, physician-led, and rural ACOs, which the agency explains are less likely to have access to capital to assume risk. Therefore, CMS considers but does not propose benefits to low revenue ACOs, such as providing them with a lower MSR in Levels A and B (1 or 2 percent) or using a higher shared savings rates such as 50 percent for Levels A through D. CMS notes that hospital- or health system-based ACOs will typically be considered high revenue ACOs, but hospital-based ACOs with relatively low ACO participant FFS revenue compared to their benchmark would be low revenue ACOs.

Comments: In the proposed rule, CMS states its belief that ACOs whose participants have greater total Medicare Parts A and B FFS revenue relative to their benchmarks have more ability to control costs and may be better financially prepared to move to greater levels of risk. Accordingly, the agency notes that its comparison of revenue to benchmark would provide a more accurate method for determining an ACO's preparedness to take on additional risk rather than an ACO's self-reported information regarding the composition of its ACO participants and any ownership and operational interests in those ACO participants. We do not support the current self-reporting requirements for Track 1+ that result in ACOs falling under the revenue- or benchmark-based Track 1+ loss sharing limits. We have previously urged CMS to provide Track 1+ ACOs flexibility to select either a revenue- or benchmark-based loss sharing limit, and we support CMS's proposal to apply the lesser of the revenue- or benchmark-based loss sharing limit for Basic Level E.

While we appreciate removing the self-reporting requirements under Track 1+, we question the need to further divide ACOs into arbitrary categories of high and low revenue ACOs and to apply different schedules for how and when they must progress along the risk continuum. The proposed 25 percent threshold appears arbitrary and creates division where none should exist. We oppose categorizing ACOs in this manner and urge CMS to not finalize the high and low revenue distinctions. All ACOs should be on the same path to assuming risk as recommended in this letter, which should include a gradual ramp up of risk, sufficient shared savings rates, and the ability to participate indefinitely in Basic Level E without having to move to the Enhanced Track.

Being "high" or "low" revenue does not determine when an ACO is ready for risk or how much risk they are able to assume. Regardless of structure, significant investments are needed in population health platforms and care process changes for ACOs to bear risk. 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, previous program success, and the resources required to address social determinants of health that influence care and outcomes for patients. 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. Research shows that insurers and venture capital funds are investing millions of dollars in certain ACOs, which are often physician-led. CMS is unable to identify if an ACO is well capitalized through outside sources, such as investors or insurers, and should therefore not use an arbitrary calculation of revenue compared to benchmark to make this assumption. The challenge of being forced into risk is of great importance to ACOs of all sizes, composition, and ownership. It makes more sense to lower the required amount of risk for both high and low revenue ACOs rather than treat them differently.

The proposed high and low revenue distinctions create unnecessary program complexity, which CMS has taken great strides to try to reduce across a variety of Medicare programs in recent months. Furthermore, the move creates uncertainty for ACOs who may have a difficult time predicting the category in which they would fall. This distinction would also change over time as ACO participant composition changes, adding more complexity and making long-term planning very difficult. This uncertainty would be further compounded by the timing of the CMS high/low revenue determination, which the agency explains would not occur until after the ACO's application is submitted. Should CMS move forward with a high/low revenue distinction, we urge CMS provide the final determination as early as possible in the application process, barring notable participant changes during the process which would change the determination. Given the significance of this determination, ACOs must know in advance into which category they would fall.

While we appreciate the gradual ramp up of risk in the Basic Track, the overall restructuring of the MSSP has considerably more complexity with CMS evaluating whether ACOs are new, renewing or re-entering, experienced or inexperienced with performance-based risk, high or low revenue, etc. Eliminating the high/low revenue distinction would help minimize some of the complexity and would remove a significant amount of work required by CMS and ACOs to model, predict, and determine if the ACO would be high or low revenue.

The administration has made comments about supporting market solutions and level playing fields among competitors. We appreciate that perspective and respectfully point out that this proposed policy is contrary to a market-based approach whereby all competitors have similar opportunities for success. 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, and CMS should adopt policies that continue to engage hospitals as key players rather than create incentives to exclude hospitals as ACO participants. 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 healthcare. MedPAC addressed this in its June 2018 [report](#) noting, while hospitals may have certain conflicting interests that create challenges for ACO participation, hospitals should continue to be part of ACOs.

The administration has also noted concerns that ACOs are a potential driver of consolidation in the healthcare industry. There are no studies or data supporting this claim, which is a flawed assumption. Reduced payment rates, increased regulatory burdens and requirements to assume risk are actual drivers of consolidation, and organizations often consolidate to more efficiently manage these challenges. Further, ACOs do not drive physician employment and many effective ACOs engage a majority of independent clinicians. ACOs support greater clinical integration and collaboration among doctors, hospitals and other care providers and align the payment system to incent coordination and cost savings across these silos. This alignment accomplishes what the model is designed to do, and what providers need out of high-value networks, without necessitating consolidation and direct employment of physicians. In fact, these opportunities to collaborate often help providers avoid consolidation. The greatest fear related to consolidation is its potential to lead to higher prices. Ultimately, one of the best ways to protect against escalating costs is to advance alternative payment models that hold providers accountable and rewards them for improving care and reducing costs for an entire population.

In addition to our recommendations not to finalize the distinction between high and low revenue ACOs, we recommend that CMS support ACOs by reinstating advanced funding opportunities to enable ACOs to assume risk. The agency previously offered programs to help fund ACOs up front, with those payments later recouped via shared savings. These programs, such as the ACO Investment Model (AIM) or similar ones, should be reinstated to help ACOs fund activities and transformations early on in ACOs' development.

Minimum Savings Rate and Minimum Loss Rate

Key comments:

- **NAACOS recommends CMS finalize its proposal to allow ACOs in downside financial risk models to select a symmetrical MSR/Minimum Loss Rate (MLR) but requests ACOs be able to update this selection during an agreement period.**
- **NAACOS urges CMS to lower the MSR for shared savings-only models to be set between 2.0 and 2.5 percent.**

Proposals: In order to qualify for a shared savings payment, or to be responsible for sharing losses with CMS, an ACO's average per capita Medicare Parts A and B FFS expenditures for its assigned beneficiary population for the performance year must be below or above the updated benchmark, respectively, by at least the MSR/MLR. For ACOs under Basic Track Levels A and B, CMS proposes to use the same sliding scale for the MSR that is currently used for Track 1, which is based on the number of beneficiaries assigned to the ACO to establish the MSR.

Prior to entering a model with downside financial risk (Basic Levels C, D, E or the Enhanced Track), CMS proposes to continue to have an ACO select a symmetrical MSR/MLR. This selection would be made as part of the application cycle prior to entering a model with downside financial risk and the selection would apply for the duration of the applicable agreement period. The ACO would be able to choose from the following options, consistent with current policy:

- 0 percent MSR/MLR
- Symmetrical MSR/MLR in a 0.5 percent increment between 0.5 and 2.0 percent
- Symmetrical MSR/MLR that varies based on the number of beneficiaries assigned to the ACO

The variable MSR/MLR would be determined based on the number of assigned beneficiaries as is currently used for two-sided model ACOs that have selected the variable option. CMS also proposes to use a variable MSR/MLR when performing shared savings and shared losses calculations if an ACO's assigned beneficiary population falls below 5,000 for the performance year, regardless of whether the ACO selected a fixed or variable MSR/MLR.

Comments: We support allowing ACOs in models with downside financial risk to continue to have choices with selecting a symmetrical MSR/MLR and request CMS finalize this proposal. This flexibility is important for ACOs who may want to set an MSR/MLR higher or lower depending on how conservative or aggressive their goals are for earning savings and having to repay losses. Given the extended five-year agreement periods CMS proposes, we urge the agency to allow ACOs to change their MSR/MLR at the start of a performance year rather than be locked into that decision for up to five years of an agreement period.

While the Secretary has a statutory requirement to determine as MSR based upon the number of Medicare FFS beneficiaries assigned to an ACO, there is no specific statutory requirement for MSRs to rise as high as 3.9 percent for smaller ACOs. This creates a significant hurdle for smaller and rural ACOs – groups of providers CMS [has vowed to help](#) – to earn savings and thus a disincentive to join the MSSP. We urge CMS to use its authority to lower that threshold and revise the MSR schedule for ACOs based on beneficiary population size such that the cap on MSRs for smaller ACOs is 2.5 percent, and to meet statutory requirements, for larger ACOs would be set as low as 2 percent.

Early Termination Policies

Key Comments:

- **NAACOS expresses deep concerns with CMS's proposal to exercise the option to terminate an ACO's participation agreement if the ACO's expenditures exceed a certain amount after two performance periods. We urge CMS not to finalize this policy, or at a minimum, use such a policy only in rare cases where the agency specifically has program integrity concerns.**

- **We oppose CMS’s proposal to establish a June 30 deadline to voluntarily terminate ACO participation agreements.**
- **NAACOS urges CMS to provide ACOs with the ability to engage with high performing providers by allowing ACOs to select their participants by National Provider Identifier (NPI) rather than solely at the Tax Identification Number (TIN) level.**

Proposals: Beginning on January 1, 2019, CMS proposes to monitor whether an ACO’s expenditures for assigned beneficiaries population are “negative outside corridor,” meaning that the expenditures exceed either the ACO’s negative MSR under a one-sided model or the ACO’s MLR under a two-sided model. If the ACO is negative outside corridor for one performance year, CMS proposes the agency may take pre-termination actions, including requiring a corrective action plan. If the ACO is negative outside corridor for another performance year, CMS proposes the agency may immediately or with advance notice terminate the ACO’s participation agreement. CMS also seeks comment on whether ACOs should be permitted to obtain reinsurance.

CMS proposes to reduce the minimum notification period from 60 to 30 days for early termination. This would allow ACOs considering a year-end termination to have three quarters of feedback reports, instead of two. For ACOs that voluntarily terminate after the June 30 deadline, CMS proposes to pro-rate the shared-loss amount by the number of months during the year in which the ACO was a participant in the program. CMS also proposes to pro-rate shared losses for ACOs in two-sided models that are involuntarily terminated by CMS. To calculate the prorated share of losses, CMS will multiply the amount of shared losses calculated for the performance year by the quotient equal to the number of months of participation in the program during the performance year, including the month in which the termination was effective, divided by 12. CMS also proposes special rules for ACOs that participate for a portion of a six-month performance year during 2019 (January 1, 2019 –June 30, 2019 or July 1, 2019–December 31, 2019):

1. If the ACO terminates its participation agreement effective before the end of the performance year, CMS would not reconcile the ACO for shared savings or shared losses (if a two-sided model ACO).
2. If CMS terminates a two-sided model ACO’s participation agreement effective before the end of the performance year, the ACO would not be eligible for shared savings and CMS would reconcile the ACO for shared losses and prorate the amount reflecting the number of months during the performance year that the ACO was in the program.

CMS notes that ACOs starting a 12-month performance year in 2019 would have the option to participate for the first six months of the year prior to terminating their current agreement and entering a new agreement period beginning July 1, 2019. CMS proposes these ACOs would be eligible for prorated shared savings or losses for the six-month period from January 1, 2019 – June 30, 2019.

Comments: NAACOS has deep concerns with CMS’s proposal to exercise the option to terminate an ACO’s participation agreement if the ACO’s expenditures for the assigned beneficiary population exceed the ACO’s updated benchmark by an amount equal to or exceeding either the ACO’s negative MSR under a one-sided model or the ACO’s MLR under a two-sided model after two performance years. CMS notes the provision is intended to remove so-called bad actors from the program, however, NAACOS asserts this policy instead will have the unintended consequence of removing well intentioned ACOs from the program who might otherwise go on to achieve savings and make quality improvements for their patients.

Program integrity is a critical tool for protecting the Medicare Trust Fund. However, CMS’s proposed approach is arbitrary and so broadly applied that it will remove well intentioned ACOs from the program. An ACO with spending that is slightly higher than its benchmark should not be deemed a “bad actor” especially considering there are a number of valid reasons spending for a performance year could be a few percentage points higher than a benchmark. For example, the beneficiary population could experience a worse than usual flu season, the hospital wage index in an ACO’s area could increase relative to their benchmark years, the ACO’s participant TINs could have joined a CMMI program such as CPC+ which increases spending based on new care management fees, or the ACO could have performed well in the Merit-Based Incentive Payment System (MIPS) and earned a MIPS bonus which CMS includes

as an ACO expenditure. These are all valid reasons for higher than anticipated expenditures and should not cause the ACO to be deemed a “bad actor” or penalized by being terminated from the program. While we support addressing valid program integrity concerns, we urge CMS not to consider slightly elevated spending as evidence of fraud, waste and abuse.

Further, CMS’s proposed definition of “negative outside the corridor” sets a very low bar, especially for ACOs in downside financial risk models where the ACO can select an MLR as low as 0 percent. Many ACOs view selection of the MSR/MLR in a two-sided model as a significant incentive to move into a model with downside financial risk, but this proposal would create a double edge sword whereby an ACO that wants to take on greater accountability through a lower MLR would be faced with potentially being kicked out of the program as a result of spending that exceeds their MLR. This proposal also does not make sense in the context of ACOs assuming risk, whereby once they meet or exceed their MLR they must pay back a portion of losses to Medicare. Requiring these ACOs to repay losses protects the Medicare Trust Fund, and it is unnecessary at the same time to implement program policies aimed at removing ACOs from the program for having higher than expected spending.

Should the agency move forward with this type of early termination policy, at a minimum it should be used only in rare cases where the agency specifically has documented program integrity concerns. Alternatively, NAACOS encourages CMS to better serve beneficiaries and American taxpayers by creating a direct channel for ACOs to report suspected fraud and abuse. Value-based delivery models such as ACOs have a unique vantage point and the properly aligned incentives to identify and ultimately report fraud. On average, a Medicare ACO is assigned 17,000 lives and includes hundreds of clinicians. Its success depends on an ACO continuously monitoring its expenditures. Because ACOs are held responsible for the total cost of care for their assigned beneficiaries, ACOs are also monitoring services rendered by clinicians outside the ACO and keep an eye on reimbursements completely removed from their own financial interests other than to achieve shared savings. That close attention to beneficiaries and the services they are accessing through Medicare provides ACOs a frontline perspective to identify and report suspicious activity, yet ACOs have no direct access to CMS program integrity. Making this change would better support CMS’s stated fraud and abuse goals.

Should CMS finalize its proposal to retain the right to terminate an ACO whose expenditures for the ACO’s assigned beneficiary population are “negative outside corridor,” the agency must use a more appropriate standard to identify ACOs who would be subject to such a policy. CMS’s proposed approach would monitor specifically for whether the expenditures for the ACO’s assigned beneficiaries exceed the ACO’s updated benchmark by an amount equal to or exceeding either the ACO’s negative MSR under a one-sided model or the ACO’s MLR under a two-sided model. CMS’s proposed policy would have identified 82 ACOs in 2017 under these proposed criteria. Of the 142 ACOs that earned shared savings payments for 2017 performance and had program experience prior to 2017, 36 percent had losses (i.e., expenditures higher than benchmarks) in one of their first two years of the program. Such a policy would have removed these ACOs from the program prematurely, before they were able to go on and demonstrate success. CMS’s proposed policy is far too broad and contrary to the stated intent of the proposal to identify “bad actors” in the program.

CMS’s proposed approach is overreaching and it is critical that CMS not move forward with this policy. Further, should CMS finalize this approach, the agency must also establish an appeal process for individual ACOs to submit information regarding errors they believe were made in the financial reconciliation calculation, determining the amount of shared savings earned by the ACO or in determining an ACO was “negative outside the corridor”. Currently, CMS does not provide a meaningful appeal process for individual ACOs. If CMS will retain the right to terminate an ACO for exceeding certain spending thresholds, CMS must apply the materiality threshold to individual ACOs and allow ACOs to appeal redetermination decisions they believe were made in error and, therefore, hold ACOs harmless for errors the agency makes in the payment determination process.

NAACOS supports moving to a 30-day notification requirement for early termination if this would be used to modify the existing policy that allows ACOs to voluntarily terminate from the program without financial reconciliation for that performance year as long as they do so at least 60 days prior to the end of the performance year, which would

be 30 days if the proposal is finalized. Shortening this timeframe from 60 days to 30 days would provide more time for ACOs to evaluate program data and performance before deciding to terminate from the program without financial reconciliation for that year.

We have significant concerns regarding the June 30 deadline proposed for ACOs electing to voluntarily terminate from the program. We urge CMS not to finalize this policy as using a June 30 deadline for voluntary termination would mean that ACOs would not have the data they need to make an informed choice about their continued participation in the program. That data would not be available until later in the year due to the timing of distributing performance reports. ACOs should have three quarters of experience available to them to make a decision about their continued participation in the program.

Risk Adjustment

Key comments:

- **NAACOS urges CMS to implement the same risk adjustment policy across Medicare programs.**
- **As an interim step to implementing consistent risk adjustment policies across Medicare programs, NAACOS supports the proposal to modify MSSP risk adjustment by eliminating the distinction between newly and continuously assigned beneficiaries.**
- **NAACOS appreciates CMS's attempt to allow risk score changes during an agreement period but urges the agency to use a more appropriate range of +/- 5 percent and to cap the risk ratios in aggregate across the four beneficiary enrollment types.**

Proposals: CMS proposes to eliminate the distinction between newly and continuously assigned beneficiaries for the purposes of MSSP risk adjustment. The agency also proposes to use a symmetric +/-3 percent risk ratio cap between the performance year renormalized risk score and the most recent benchmark year for all assigned beneficiaries. CMS would continue to use full CMS-Hierarchical Condition Category (HCC) risk adjustment for all assigned beneficiaries between the benchmark period and the performance year, and the risk scores would continue to be renormalized within each of the four beneficiary enrollment types. Similarly, CMS would continue to use full CMS-HCC risk scores when resetting or rebasing the historical benchmark prior to each new agreement period.

Comments: Risk adjustment modifies costs to reflect beneficiary health status and plays a critical role in enabling more accurate comparisons across ACOs and providers that treat beneficiaries of varying clinical complexity. There have been long-standing concerns about the MSSP risk adjustment methodology, which CMS acknowledges in the proposed rule, stating on page 41884:

“We appreciate the concerns regarding our current risk adjustment methodology raised by stakeholders, who have indicated that the current approach may not adequately recognize negative changes in health status that occur at the individual beneficiary level, particularly among continuously assigned beneficiaries who have experienced an acute event, such as a heart attack, stroke, or hip fracture, between the third benchmark year and the applicable performance year. We recognize that such acute events, which almost always require a hospitalization, are likely to have an upward impact on CMS-HCC risk scores that is not attributable to provider coding initiatives.”

Accurate risk adjustment should remove or minimize differences in health and other risk factors that impact performance but are outside the ACO's control. While there are many different approaches to risk adjustment, it is unclear why Medicare uses an array of risk adjustment methodologies across its programs. The same risk adjustment approach should be used across Medicare, creating parity and emphasizing the need to come to consensus on the most appropriate methodology. We urge CMS to invest in studying risk adjustment across Medicare programs and to identify the most appropriate approach that should be applied across all Medicare programs. This would help fix the current MSSP risk adjustment policy, which is biased to produce a downward benchmark adjustment versus the risk adjustment policies in other Medicare programs, including MA. Putting ACOs at a disadvantage compared to providers in other Medicare programs and APMs masks the true effects of ACOs and creates a disincentive to

participate in the MSSP. As an interim step to implementing the same risk adjustment policy across Medicare programs, we offer the following recommendations in response to those proposals in the Pathways to Success rule.

The current MSSP policy that treats beneficiaries differently depending on whether they are considered newly or continuously assigned creates unnecessary confusion and complexity. CMS is in effect limiting risk adjustment due to demographic factors for continuously assigned beneficiaries. It is unreasonable to assume a provider organization, however effective, can manage a population such that patient conditions never worsen over time and it never carries a higher disease burden. Therefore, we strongly support CMS's proposal to eliminate the newly and continuously assigned beneficiary categories and recommend additional changes to the risk adjustment proposals.

We appreciate aspects of CMS's proposal to allow risk scores for beneficiaries to change somewhat over time, which begins to recognize the reality that patient risk scores fluctuate. It is essential that benchmarks reflect these risk changes so that ACOs are fairly judged on their performance without being unfairly expected to manage an overall population's disease burden with virtually no changes during an agreement period. NAACOS has repeatedly advocated for CMS to permit meaningful increases in beneficiary risk scores over time. While the proposal would permit an increase of up to 3 percent, it is important to note that 3 percent is across a five-year agreement period and is not a year-over-year increase.

Though we appreciate the agency allowing risk score increases, the selection of 3 percent is arbitrary and insufficient when applied across a five-year agreement. For example, assuming that an ACO starts in July 2019, the most that the risk score used in the updated benchmark calculation can change in performance year six (2024) would be between 97 to 103 percent of the 2018 risk score (based on 2017 HCC coding practices). This risk adjustment proposal would be reasonable in early years of the agreement period, when most ACOs would hit the 3 percent cap, but it would not be reasonable when applied to later years of the agreement. Using MSSP PY 2017 results, 87 percent of ACOs would have had at least one enrollment type trigger the +/-3 percent cap when looking at the first three years of the agreement period. The average percentage capped in the first performance year of the agreement period is 88 percent, in the second performance year is 85 percent and the third performance year is 92 percent. Over the fourth and fifth performance years we would expect the percentage of ACOs affected by the risk score cap to increase. We recommend CMS finalize a policy that allows risk score adjustments during the course of the agreement period, but we urge a more reasonable threshold of +/- 5 percent. This is the threshold at which the percentage of capped ACO populations within the same enrollment type drops below 25 percent based on the 2017 MSSP results.

Alternative to the proposal, we support CMS capping the risk ratios in aggregate across the four beneficiary enrollment types (ESRD, disabled, aged/dual eligible, and aged/non-dual eligible). The different enrollment types show significantly different cap rates with aged/dual the highest at 59 percent capped and aged/non-dual the lowest at 24 percent capped in 2017 due to smaller sample sizes and volatility for certain enrollment types. We recommend CMS finalize capping the enrollment types in aggregate instead of separately by enrollment type conjunction with the broader +/- 5 percent cap in order to further promote benchmark stability.

Finally, in order to reduce benchmark volatility, the risk adjustment model version should be consistent between the baseline and performance years. For example, the version 23 CMS-HCC model could be used when comparing risk scores in the 2016-2018 baseline period to those in the 2019 – 2024 performance period. The Next Generation ACO program follows this convention demonstrating that it is administratively feasible to maintain a consistent risk adjustment model version throughout the baseline and performance periods.

Benchmarking Methodology

Key comments:

- **NAACOS urges CMS to finalize proposals to introduce regional expenditure data into initial agreement periods and to apply a varying degree of regional expenditure data based on how an ACO's spending compares to its region.**

- **NAACOS opposes CMS’s proposal to decrease the regional expenditure component to 50 percent and recommends that agency maintain the current maximum of 70 percent of regional expenditures in the third agreement and subsequent agreement periods.**
- **NAACOS does not support CMS’s proposal to introduce a symmetric +/- 5 percent cap based on national per capita expenditures and recommends the agency not finalize this.**
- **NAACOS appreciates CMS’s attempt to find an appropriate balance between a national and regional trend rate, but instead of finalizing the proposal we request the agency remove ACO beneficiaries from the regional reference population to address the underlying problem.**
- **NAACOS urges CMS to reverse its position on adjusting rebased benchmarks to account for the average per capita amount of savings generated during an ACO’s previous agreement period by adding those savings back to the rebased benchmark.**
- **NAACOS urges CMS to adjust the MSSP benchmarking methodology to remove certain expenditures such as those related to MIPS payment adjustments, CPC+ care management fees and hospital wage index changes.**

Proposals: CMS proposes a number of benchmarking changes that, if finalized, would go into effect along with the revised MSSP structure. Many of the proposals relate to incorporating a regional expenditure component into the rebased benchmark, a direction the agency finalized in 2016 with the [MSSP rule](#), *Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations – Revised Benchmark Rebased Methodology, Facilitating Transition to Performance-Based Risk, and Administrative Finality of Financial Calculations* (published in the June 10, 2016 Federal Register). Under that regulation, which remains in place as existing policy, CMS incorporates a growing component of regional expenditures into benchmarks as they are rebased for new agreement periods. In this rule, CMS proposes to incorporate regional expenditures into benchmarks sooner, beginning with initial agreement periods and to cap the maximum amount of regional expenditures at 50 percent. This would modify the phase-in schedule such that ACOs would have a regional expenditure component of:

- 25 or 35 percent during the first agreement period,
- 35 or 50 percent during the second agreement period, and
- 50 percent during third and subsequent agreement periods.

Consistent with current policy, ACOs with spending higher than their region would receive the lower adjustment, and ACOs with spending lower than their region would receive the higher adjustment. CMS also proposes to introduce a symmetric +/- 5 percent cap, implemented separately for each beneficiary category, and based on national per capita expenditures. If an ACO is considered a re-entering ACO, CMS proposes to apply the regional adjustment percentage that was used in the most recent agreement. CMS also proposes to use a blend of national and regional trend factors to trend forward benchmark year (BY)1 and BY2 to BY3 when determining the historical benchmark and a blend of national and regional update factors to update the historical benchmark to the performance year (or to calendar year 2019 in the context of determining the financial performance of ACOs for the six-month performance year from July 1, 2019 through December 31, 2019). The national component of the blended trend and update factors would receive a weight equal to the share of assignable beneficiaries in the regional service area that are assigned to the ACO, computed by taking a weighted average of county-level shares. The regional component of the blended trend and update factors would receive a weight equal to 1 minus the national weight.

Comments: NAACOS supports incorporating a component of regional expenditure data into ACO benchmarks. Rather than exclusively relying on regional expenditure data we specifically support blending ACO historical and regional expenditure data for rebased benchmarks. Relying exclusively on regional expenditure data for rebased benchmarks would not properly reflect an ACO’s unique patient population. Relying exclusively on historical ACO expenditure data creates an unattainable situation where ACOs have decreased ability to beat ever-lowering benchmarks. If executed correctly, using benchmarks with a blend of historical and regional expenditure data will attract new ACOs while retaining existing participants and ultimately improve the long-term viability of the program.

We support the proposal to introduce a regional expenditure component into the initial agreement period, rather than waiting until at least the second agreement period. This is especially important with longer, five-year agreement periods. We also strongly support CMS's continued application of one of two regional expenditure components based on how the ACO's spending compares to that of its region, and the proposed 25 percent and 35 percent thresholds are appropriate. We recommend CMS finalize these as proposed.

As CMS gradually introduces regional expenditures, for third and subsequent agreement periods we urge the agency not to finalize its proposal to cap regional expenditures at 50 percent. This is a decrease from the current policy of applying a maximum of 70 percent regional expenditure data. This policy was finalized two years ago and given the phase-in schedule of regional expenditure data, ACOs have not yet reached this level so it is premature to reverse this policy. We support a maximum of 70 percent of regional expenditures in the third agreement and subsequent agreement periods and recommend the following phase-in schedule such that ACOs would have a regional expenditure component of:

- 25 or 35 percent during the first agreement period,
- 45 or 60 percent during the second agreement period,
- 70 percent during third and subsequent agreement periods

We also urge CMS to allow an option for ACOs to gradually incorporate regional expenditure data by 10 percent annually into their benchmarks during an agreement period. Some ACOs will face significant swings in their ACO benchmarks as a result of the revised methodology and allowing a gradual implementation would ease this transition rather than require ACOs to face large swings at the start of an agreement period. We reiterate our recommendation that this should be an *option*, and ACOs that are prepared to face more significant changes at the start of an agreement should be permitted to do so. Overall, ACOs would ultimately reach the 70 percent regional benchmark, but providing program flexibility would keep ACOs progressing on the right path in a more reasonable manner that incentivizes them to stay in the program and continue focusing on reducing costs and improving quality.

In response to CMS's proposal to introduce a symmetric +/- 5 percent cap based on national per capita expenditures, we are concerned that this will unnecessarily limit market forces that would naturally constrain outliers resulting from implementation of regional expenditures into rebased benchmarks. In the proposed rule, CMS notes its concern that the agency should guard against the effect of large positive or negative regional adjustments resulting from the revised benchmarking methodology by imposing a cap on the dollar amount of the regional adjustment. However, we do not agree that CMS should intervene in the market in this manner and instead should allow competition among ACOs and other providers to address and eventually mitigate outlier situations. Should the agency move forward with implementing such a cap, we recommend a more reasonable range of +/- 7 percent as opposed to +/- 5 percent.

In response to concerns raised by NAACOS and others, CMS proposes to no longer use a pure regional update factor, which disadvantages ACOs that make up a large portion of the market in their region. Instead, CMS proposes to modify the update factor by using a national-regional blended trend rate that would be based on the share of assignable beneficiary weighted national FFS and regional update factors. The national-regional blending factor would be determined by averaging the market penetration across all counties where the ACO has assigned beneficiaries. This proposal is a step in the right direction to address some of our concerns with the regional update factor; however, we have concerns that the new methodology may over-emphasize the national trend component. There are pitfalls with solely using a national update factor, which ignores important local market dynamics and regional trends, and with using an exclusively regionally-based update factor, which as currently structured penalizes ACOs in rural areas and those that comprise a large share of their market and, therefore, drive regional trends.

While we appreciate CMS's attempt to find an appropriate balance between a national and regional trend rate, there are pitfalls with the proposal. For example, the proposal dilutes the importance of regional trend in establishing and updating ACO benchmarks. Dampening the effect of regional trend diminishes the incentive that ACOs have to concentrate in high-trend areas of the country and control trend at the local level. Further, this proposal does not

address the underlying problem caused by including ACO beneficiaries in the population from which the regional expenditure data is drawn. In fact, a simpler solution to the proposed national-regional trend rate would be to remove ACO beneficiaries from the regional reference population as NAACOS has previously recommended. By excluding ACO beneficiaries from the regional reference population, the situation where an ACO is being directly evaluated against itself within the same performance year is eliminated.

NAACOS and others have repeatedly made this recommendation to CMS, including in our comment [letter](#) in response to the 2016 MSSP rule, and our concerns remain the same. Rather than comparing ACOs to themselves and other ACOs, CMS should compare ACO performance relative to FFS Medicare by defining the regional population as assignable beneficiaries without ACO-assigned beneficiaries for all ACOs in the region. At the very least, CMS should exclude the ACO itself from the region to prevent an otherwise tautological comparison that essentially double counts those ACO-assigned beneficiaries. In an area where the ACO has significant market saturation, it is especially essential to remove the ACO beneficiaries from the regional population to avoid comparing the ACO to itself.

Excluding all ACO-assigned beneficiaries (those involved in MSSP ACOs and well as other CMS ACO demonstrations such as the Next Generation Model) also allows for a cleaner comparison between ACOs and FFS. By including the ACO-assigned beneficiary population, the regional cost data is skewed by reflecting ACOs' efforts to coordinate care and reduce expenditures for the ACO population. CMS has expressed concerns that removing ACO-assigned beneficiaries would result in an insufficient reference population. However, according to our analysis based on 2017 data, if CMS removed ACO-assigned beneficiaries from the service area no ACOs would have a reference population smaller than about 300,000 beneficiaries. Further, the contribution of beneficiaries from very small and ACO-dominated counties to the regional benchmark is minimal with only 47 (10 percent) 2017 ACOs exposed to one or the other, with such counties contributing only as much as 4 percent of an ACO's overall assigned population. Continuing a flawed program methodology in order to address a small percentage of ACOs is nonsensical and, more importantly, harmful to the majority of program participants. We urge CMS to modify its policy by changing the definition of the reference population to exclude all ACO-assigned beneficiaries.

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

Additionally, we recommend CMS consider using a prospectively determined trend rate which would allow for greater predictability of financial results by ACOs. For example, prospective trend in US Per Capita Cost is used to establish trend rates in the Next Generation Model and Medicare Advantage programs. It is recommended that similar prospective trend approach be used in the MSSP. Finally, we urge CMS to reverse its position on adjusting rebased benchmarks to account for the average per capita amount of savings generated during an ACO's previous agreement period by adding those savings back to the rebased benchmark. CMS has changed its policy on adding ACO savings back to benchmarks a few times, and the most recent policy finalized in the June 2016 MSSP [rule](#) no longer adds these savings to benchmarks. This final policy was disappointing considering CMS had previously expressed support for adding the savings back to benchmarks and in a June 2015 MSSP [rule](#) stated:

"We agree with commenters on the importance of accounting for the financial performance of an ACO during its prior agreement period in resetting the ACO's historical benchmark. In particular, we believe that this adjustment is important for encouraging ongoing program participation by ACOs

who have achieved success in achieving the three-part aim in their first agreement, by lowering expenditures and improving both the quality of care provided to Medicare FFS beneficiaries and the overall health of those beneficiaries. Absent this adjustment, an ACO who previously achieved success in the program may elect to terminate its participation in the program rather than face a lower benchmark that reflects the lower costs for its patient population during the three most recent prior years.” (80 FR 32778)

Savings generated by ACOs are achieved as a result of their hard work to improve quality and lower costs. ACOs should be accountable for their performance relative to FFS Medicare in their region and rewarded – not penalized – for previous savings. Thus, we urge CMS not only to account for the earned shared savings in rebased benchmarks, but also to account for all savings – not just the ACO’s portion – and add that amount to rebased benchmarks. At a very minimum, CMS should return to the policy in the 2015 MSSP rule which accounts for a portion of the ACO’s savings in rebased benchmarks.

Along with the benchmark adjustments discussed above, we urge CMS to implement other benchmark adjustments so as to not hold ACOs accountable for specific expenditures that are inconsistent between the benchmark and performance years. For example, CMS should adjust benchmarks to hold constant changes from the hospital wage index, as these payment changes can be notable and are not reflective of an ACO’s population management efforts but can dramatically effect on an ACO’s ability to accurately demonstrate savings or losses.

As discussed previously in this letter, we also urge CMS to exclude MIPS bonuses as ACO expenditures. The current CMS policy unfairly punishes ACOs for their high performance by both requiring Track 1 ACOs (and Basic Levels A, B, C and D as proposed) to participate in MIPS, excluding such ACOs from Advanced APM bonuses and counting any MIPS bonuses earned for high performance in that program as ACO expenditures. CMS excludes Advanced APM bonuses from ACO expenditures and should do the same for MIPS expenditures. This will be increasingly important over time as MIPS bonuses rise in future program years. Not removing MIPS bonuses as ACO expenditures will result in fewer ACOs being able to surpass their MSR and could cause ACOs in Basic Levels C and D to have to repay losses. CMS makes claim-level adjustments by adding sequestration costs back to paid amounts when calculating ACO expenditures and should follow a similar policy to adjust for MIPS payment adjustments. It was not the intent of Congress to penalize ACOs in MIPS, and therefore CMS must alter this policy.

Finally, we urge CMS to remove CPC+ care management fees from ACO expenditures. While we appreciate the opportunity for MSSP primary care practices to participate in CPC+, the care management fees should not be included as expenditures for ACO benchmarks. These funds are paid to the participant TINs and should be viewed as separate from other payments for furnishing care to beneficiaries. By not removing these care management fees from ACO expenditures, CMS penalizes ACOs with practices that receive these payments which are often used to invest in care coordination activities that will provide long-term benefits to patients. This creates an unhelpful tension between CPC+ and ACOs, rather than an approach that would harmonize the two programs. We urge CMS to address this by removing CPC+ fees from ACO expenditures.

2019 Participation Options

Key Comments:

- **NAACOS urges CMS to provide ACOs with agreements expiring in 2018 the option of extending their current participation agreements from January 1, 2019 through December 31, 2019.**
- **CMS must provide ACOs with opportunities to add and delete participants throughout the performance periods offered in 2019.**
- **NAACOS does not support CMS’s decision to require high-revenue ACOs with experience in performance-based risk models to participate in the Enhanced Track, and we urge CMS not to finalize this proposal.**
- **NAACOS urges CMS not to finalize the arbitrary distinction of high- and low-revenue ACOs and opposes requirements that high-revenue ACOs – or any ACOs – be forced into higher levels of risk beyond Basic Level E.**

- **NAACOS urges CMS to provide Next Gen ACOs with the opportunity to participate in the revised MSSP using the July 1 start date.**

Proposals: CMS is opening a new round of applications for 2019 with a shortened six-month performance period in 2019 due to the late nature of the regulation's release. For ACO agreements that expire at the end of 2018, ACOs will have the option to extend current agreements for six months while offering a special, one-time July 1, 2019 start date for new agreements. The July 1, 2019 start will have a Spring 2019 application period, and this start date option is also available to new ACOs. CMS staff have also confirmed with NAACOS that as proposed ACOs within current agreement periods under MSSP participation options (Track 1, Track 2, or Track 3) would be able to complete the remainder of their current agreement under the existing financial models and requirements.

Program participation options are limited in some cases for ACOs with experience in a performance-based risk model as well as for ACOs designated as high revenue. Additionally, participation options are determined in part based on whether CMS considers an ACO to be new, renewing, or re-entering. CMS proposes to allow new ACOs to begin in Level A of the Basic Track, and they would stay in the shared savings-only option (Level B in performance year (PY) 2) for the first two consecutive performance years. Only ACOs that are inexperienced with performance-based risk can elect to participate in the Basic Track's glidepath. ACOs identified as experienced with performance-based risk must enter the Basic Track at Level E if considered a low-revenue ACO and must enter in the Enhanced Track if considered a high-revenue ACO. Low-revenue ACOs could participate in the Basic Track for up to two agreement periods, while high-revenue ACOs would be restricted to one agreement period in the Basic Track.

CMS proposes to define "renewing ACOs" as those that continue in the program for a consecutive agreement period without a break in participation and are either:

1. ACOs whose participation agreements expired and they immediately enter new agreement periods to continue participation in the program; or
2. ACOs that voluntarily terminated their current participation agreements and they immediately enter new agreement periods to continue participation in the program.

CMS proposes to define "re-entering ACOs" as those that do not meet the definition of "renewing ACO" and are either:

1. The same legal entity as (a) an ACO whose participation agreement expired without having been renewed; or (b) an ACO whose ACO participation agreement was terminated, or
2. A new legal entity with more than 50 percent of its ACO participants included on the ACO Participant List of the same ACO in any of the five most recent performance years prior to the agreement start date. Re-entering ACOs are ineligible for Level A and must begin at Level B of the Basic Track.

CMS proposes to define ACOs as "experienced with performance-based risk" if either of the following are met:

1. The ACO is the same legal entity as a current or previous participant in a performance-based risk Medicare ACO initiative; or
2. 40 percent or more of the ACO's participants participated in a performance-based risk Medicare ACO initiative in any of the five most recent performance years prior to the agreement start date.

Finally, CMS defines "performance-based risk Medicare ACO initiative" as: Basic Track, Enhanced Track (Track 3), Track 2, Track 1+ Model, Pioneer ACO Model, Next Generation ACO Model, and Comprehensive End-Stage Renal Disease (ESRD) Care Model two-sided risk tracks. All ACOs can elect to participate in the Enhanced Track. Tables 6 and 7 in the proposed rule on pages 41833-41834 summarize participation options for low- and high-revenue ACOs based on applicant type and the ACO's experience with risk.

Comments: NAACOS appreciates CMS offering a 2019 participation option, though we are disappointed that the rulemaking delay prevents a new cohort from participating in January 2019. Many ACOs have been eagerly awaiting application details and are prepared to participate in 2019. Offering a July 1 start date provides an opportunity for ACOs to begin or continue their participation in the program. While the timing will present challenges, such as a

compressed timeline to analyze program changes, review application materials, make decisions regarding participation and gather all of the required information to submit applications, it is critical that CMS continue to offer a participation option for 2019. NAACOS has concerns regarding complexity caused by the introduction of two, six-month performance periods with some ACOs operating under current program rules and others operating under new program rules. We request that CMS clarify how such details will be handled (please see our detailed comments below under “Assessing Six-Month Performance Periods in 2019”).

In addition, we urge CMS to provide ACOs with agreements expiring in 2018 the option of extending their current participation agreements from January 1, 2019 through December 31, 2019. Providing this option would give ACOs additional time to analyze program changes and prepare for the application process while reducing complexity. CMS must also provide ACOs with opportunities to add and delete participants throughout the performance periods offered in 2019 and clarify when such opportunities will be permitted.

Additionally, NAACOS urges CMS to provide Next Gen ACOs with the opportunity to participate in MSSP using the July 1 start date option. CMMI has finalized many changes for the final two years of the Next Generation Model, 2019 and 2020, and some ACOs have concerns about certain revisions. As such, we urge CMS to work closely with CMMI to provide an opportunity for interested Next Gen ACOs to transition to MSSP effective July 1, 2019 without having to sit out of an accountable care model for the start of 2019. Allowing a smooth and timely transition will enable interested ACOs and providers to avoid disruption in their accountable care goals while moving from one program to the other.

NAACOS supports the agency’s efforts to define ACOs re-entering or renewing. However, we disagree with the proposal to limit participation options for ACOs with any experience in performance-based risk models. Particularly in cases where the ACO may have only participated in such a model for one performance year, we do not feel it is justified to limit an ACO’s participation to either the Basic Level E or Enhanced Track options. Additionally, as noted previously in this comment letter, the levels of risk required for the Enhanced Track are a large jump from those required in Basic Level E. Given this dramatic increase, CMS should not force ACOs to participate in the Enhanced track. Instead, we recommend CMS only limit an ACO’s participation to Basic Level E if such ACO had completed at least one agreement period in a performance-based risk model. Further, and echoed in our comments above on the proposed high/low revenue distinction, we do not support CMS’s decision to require high revenue ACOs with experience in performance-based risk models to participate in the Enhanced Track. In fact, we urge CMS not to finalize the arbitrary distinction of high- and low-revenue ACOs, and we oppose requirements that high-revenue ACOs – or any ACOs – be forced into higher levels of risk beyond Basic Level E.

Assessing Six-Month Performance Periods in 2019

Key Comments:

- **NAACOS appreciates CMS proposals to offer ACO participation options in 2019.**
- **NAACOS supports CMS’s proposed policies governing how shared savings and losses will be calculated for the six-month performance periods in 2019. However, CMS must clarify and provide additional education to ACOs concerning how certain operational details will be addressed.**
- **CMS must clarify how quality reporting would take place for six-month performance periods that will be based on 12 months of data and how such reporting will be considered in MIPS.**

Proposals: CMS proposes to reconcile the financial and quality performance of ACOs that participated in the MSSP in 2019. Given the varying participation options in 2019, CMS proposes to treat each six-month period separately for purposes of calculating financial and quality performance. These calculations would be reconciled based on the ACO’s performance during the entire 12-month calendar year, but CMS would prorate the calendar year shared savings or losses based on the ACO’s performance during the applicable six-month period.

January 1, 2019 to June 30, 2019

Assignment Window

For ACOs under preliminary prospective assignment with retrospective reconciliation, the assignment window would be calendar year 2019. For ACOs under prospective assignment, CMS proposes the assignment window would be October 1, 2017 through September 30, 2018, with beneficiaries remaining prospectively assigned to the ACO at the end of calendar year 2019 unless the beneficiary meets certain exclusion criteria. Lastly, beneficiary assignment would be based on the ACO's certified ACO participant list for the agreement period beginning January 1, 2019.

Benchmark

CMS proposes to calculate the ACO's benchmark and assigned beneficiary expenditures as though the six-month performance year were the entire calendar year. The ACO's benchmark would be determined according to the applicable methodology of the ACO's track and agreement with CMS, except that data from the entire calendar year 2019 would be used in place of data for the six-month performance year for the benchmarking approaches CMS currently uses to update and adjust historical benchmarks. Thus, the existing methodology would be used to determine the benchmark for the January 1 – June 30, 2019 performance year by performing the following calculations:

- Benchmarks would be adjusted for changes in severity and case mix between benchmark year three and calendar year 2019 using the current HCC risk score and demographic factors methodology; and
- Benchmarks would be updated to calendar year 2019 according to the methodology for using growth in either national or regional Medicare FFS expenditures, depending on whether the ACO is in its first or second agreement period and whether the second agreement period began in 2016 or 2017–2019.

Financial Performance

CMS would apply the methodology for determining shared savings and losses according to the track the ACO is participating in on January 1, 2019, with the following exceptions to the applicable methodology implemented to calculate the expenditures for assigned beneficiaries over the full calendar year for purposes of determining the shared savings and losses for the six-month performance year:

- Average per capita Medicare Parts A and B services expenditures for calendar year 2019 would be calculated for the ACO's performance year assigned beneficiary population;
- CMS would compare the expenditures to the ACO's updated benchmark, determined for calendar year 2019 as listed above;
- CMS would apply the MSR or MLR, if applicable; and
- CMS would prorate any amounts of shared savings or losses by multiplying those amounts by 50 percent, which represents the portion of the calendar year covered by the six-month performance year.

Quality Performance

For ACOs participating in tracks where shared savings or losses are affected by the ACO's quality performance, CMS would multiply the difference between the updated benchmark expenditures by the applicable MSR or MLR based on the ACO's quality performance.

July 1, 2019 to December 31, 2019

CMS proposes to apply the same general methodological steps for calculating prorated shared savings and losses as described above for the six-month performance year from January 1 – June 30, 2019, except where the ACO's agreement and track stipulates a different methodology, for example, the benchmarking methodology or financial calculations specific to the track in which the ACO participates.

Comments: NAACOS supports CMS's proposed policies governing how shared savings and losses will be calculated for the six-month performance periods in 2019. We support CMS providing ACOs with an option to participate in 2019, however, we note there is significant complexity introduced as a result. Therefore, we urge CMS to provide additional guidance and education to ACOs clarifying how six-month performance periods will be handled, for example, when participant list changes will be permitted, if there will be any disruptions in claims files and

performance data provided to ACOs and how ACOs should modify participation agreements for the 2019 performance periods. We also urge CMS to allow ACOs currently participating using prospective assignment who extend current agreements through June of 2019, the option to use the same assignment window for the July-December performance period to avoid unintended consequences and complexity caused by creating two assignment windows for these ACOs.

Additionally, CMS must clarify how quality reporting will take place for six-month performance periods that CMS states will be based on 12 months of data. In the proposed rule, CMS notes the agency would use the certified ACO participant list for the performance year starting on July 1, 2019, to determine the quality reporting samples for the 2019 reporting period for certain ACOs (ACOs that enter an agreement period beginning on July 1, 2019, including new ACOs, and ACOs that extended their prior participation agreement for the six-month performance year from January 1, 2019, to June 30, 2019, as well as ACOs that start a 12-month performance year on January 1, 2019, and terminate their participation agreement with an effective date of termination of June 30, 2019, and enter a new agreement period beginning on July 1, 2019). If an ACO extends its participation to the first six months of 2019 but does not enter a new agreement period beginning on July 1, 2019, CMS proposes to use the ACO's latest certified participant list (the ACO participant list effective on January 1, 2019) to determine the quality reporting samples for the 2019 reporting period. Beneficiary assignment for purposes of generating the quality reporting samples would be based on the assignment methodology applicable to the ACO during its six-month performance year. Given this, we assume all ACOs would only be responsible for reporting quality one time, during the typical January to March timeframe following the performance year. CMS must clarify how such quality reporting will take place. CMS must also clarify how such quality reporting will satisfy MIPS quality reporting requirements for ACOs subject to MIPS.

Beneficiary Notification Requirements

Key Comments:

- **NAACOS disagrees with the agency's assumption that the current beneficiary notification process is underutilized, and we urge CMS to maintain the current beneficiary notification process.**
- **We recommend CMS instead simplify marketing requirements to allow ACOs the flexibility to communicate more effectively with patients about the program.**

Proposals: CMS proposes to modify the current beneficiary notification requirements and instead would require a standard written notification be provided annually to 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, as part of the beneficiary notification process, to inform the patient about the beneficiary's ability to, and the process by which, he or she may identify or change identification of a primary care provider for purposes of voluntary alignment. Under this proposal, an ACO participant would be required to provide this notice during a beneficiary's first primary care visit in the six-month performance year from July 1, 2019 through December 31, 2019, as well as the first primary care visit in the 12-month performance year that begins on January 1, 2020 and in all subsequent performance years. This notice would be in addition to the existing requirement that an ACO participant must post signs in its facilities and make standardized written notices available upon request.

Comments: NAACOS recommends CMS maintain current beneficiary notification requirements. CMS previously implemented and later removed a requirement to provide a written annual beneficiary notification. CMS made this change in response to confusion among beneficiaries and based on comments from ACOs the notification requirement was too burdensome. Specifically, CMS revised the requirement so that ACO providers/suppliers must post signs in their facilities and by make the notice available to beneficiaries upon request. CMS notes the agency is revisiting the program's existing requirement to ensure beneficiaries have a sufficient opportunity to be informed about the program and how it may affect their care and data. CMS also notes concern that the existing information on the program is provided to patients in separate resources, which may be time consuming for beneficiaries to compile and may be underutilized.

NAACOS disagrees with the agency's assumption that the current beneficiary notification process is underutilized, and we urge CMS to maintain the current beneficiary notification process. While CMS states its proposal mitigates

burdens on ACOs by proposing ACOs use a template notification provided by CMS, NAACOS notes that previously CMS provided template language that was confusing to patients. This confusion prompted numerous calls and questions, and it distracted clinicians from providing patient care. As a more effective alternative, we recommend CMS maintain current beneficiary notification requirements and allow ACOs increased flexibility to communicate with patients about the program using methods, such as including language on the ACO websites as well as phone-recorded messages. Currently, ACO communication to beneficiaries is limited due to unnecessary marketing requirements preventing communication with a patient. These requirements inhibit an ACO's ability to explain the benefits and services provided by ACOs. CMS must allow ACOs to invest resources in the ways the organization finds most effective. This requirement is unnecessary and therefore a drain on an ACO's limited resources. Therefore, NAACOS urges CMS to not finalize its proposals and instead focus on simplifying ACO marketing requirements to provide ACOs with more flexibility in communicating effectively with the patients and community they serve.

Beneficiary Assignment Changes

Key Comments:

- **NAACOS supports the proposal to modify the definition of primary care services to include additional services if finalized as proposed in the 2019 Medicare Physician Fee Schedule (MPFS) proposed rule.**
- **NAACOS strongly supports the agency's proposal to provide ACOs with more flexibility in selecting a prospective or retrospective assignment methodology on an annual basis, and we urge CMS to finalize this proposal.**
- **We urge CMS to reconsider its proposal to include specialists in the voluntary alignment process when a beneficiary elects such a professional as their primary care clinician, if the beneficiary does not receive primary care services from an ACO professional in the ACO.**
- **NAACOS opposes CMS's proposed introduction of a new optional assignment method, the beneficiary opt-in assignment methodology, and instead we urge CMS to improve upon the current voluntary alignment process by creating an automated system to support this assignment methodology.**

Proposals: 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. In addition, if finalized as proposed in the 2019 MPFS proposed rule, CMS would add these three new HCPCS codes to the MSSP assignment methodology: (1) GPC1X add-on code, for the visit complexity inherent to evaluation and management associated with certain primary care services; (2) GCG0X add-on code, for visit complexity inherent to evaluation and management associated with endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, or interventional pain management-centered care; and (3) GPRO1, an additional add-on code for prolonged evaluation and management or psychotherapy services beyond the typical service time of the primary procedure.

CMS also proposes to allow ACOs to elect a new "beneficiary opt-in" 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. Additionally, beneficiaries who choose voluntary alignment would be considered in this new assignment methodology. CMS would allow, but not require, ACOs to elect the opt-in-based assignment methodology at the time of application to enter or renew participation. CMS proposes if an ACO chooses not to elect the opt-in-based assignment methodology during the application or renewal process, beneficiaries would continue to be assigned to the ACO based on the existing assignment methodology (i.e., claims-based assignment with voluntary alignment). CMS is considering but not formally proposing to discontinue the existing assignment methodology and applying the opt-in-based assignment

program-wide. CMS also clarifies that this proposal would have no effect on the voluntary alignment process that exists currently.

Additionally, CMS proposes to provide more flexibility in choosing prospective or retrospective assignment for Basic and Enhanced ACOs, as required by the Bipartisan Budget Act (BBA). Specifically, for ACOs entering agreement periods beginning on July 1, 2019 and in subsequent years, CMS proposes to allow ACOs annually to elect the beneficiary assignment methodology (i.e., preliminary prospective assignment with retrospective reconciliation or prospective assignment) to apply for each remaining performance year within their agreement period. CMS also proposes to provide an opportunity for ACOs to switch their selection of beneficiary assignment methodology on an annual basis, which would be done prior to the start of a new performance year.

Finally, as required by the BBA, CMS proposes adjustments to the voluntary alignment process. 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. CMS proposes that the agency will not assign a beneficiary to the ACO when the beneficiary is also eligible for assignment to an entity participating in a model tested or expanded under section 1115A of the Act under which claims-based assignment is based solely on claims for services other than primary care services and for which there has been a determination by Secretary that a waiver is necessary solely for purposes of testing the model.

Comments: NAACOS supports the proposal to modify the definition of primary care services to include additional services if finalized as proposed in the 2019 MPFS proposed rule. Assignment is a critical program methodology that determines the beneficiary population for which an ACO is held accountable. CMS should continue to refine the primary care codes used in assignment to ensure the list used for ACOs is consistent with current billing practices. NAACOS also strongly supports the agency's proposal to provide ACOs with more flexibility in selecting a prospective or retrospective assignment methodology on an annual basis, and we urge CMS to finalize this proposal. NAACOS has long advocated for CMS to provide ACOs with this much needed flexibility, and we strongly support CMS's proposal.

NAACOS has concerns with CMS's proposals to modify the voluntary alignment process to include specialists in the voluntary assignment process if the beneficiary elects such a professional as his/her primary clinician. Specifically, we have concerns regarding unintended consequences of this policy, and we request CMS not to finalize this proposal. We recommend at a minimum if CMS finalizes its proposal to include specialists in the voluntary alignment process it use an approach that overrides the existing claims-based assignment methodology only when a beneficiary has at least one qualified primary care service (based on the existing services used for MSSP assignment) during the previous or current performance year with an ACO professional as defined under Step 1 or Step 2 of MSSP assignment.

NAACOS also opposes CMS's proposed introduction of a new optional assignment method, the beneficiary opt-in assignment methodology. We have concerns regarding the complexity introduced by this methodology and request CMS instead focus its attention on improving the voluntary alignment methodology which remains underutilized. Unlike Medicare Advantage, ACOs cannot restrict a beneficiary's choice of provider. Additionally, the retrospective ACO patient attribution process is such that an ACO does not know which patients are ultimately attributed to the ACO until after the performance period has ended. Therefore, the ACO must employ strategies to coordinate the patient's care regardless of whether the patient may or may not be attributed to the ACO and despite the fact that the patient may ultimately choose a low-performing provider outside of the ACO's network to receive certain portions of his or her care. This makes the model one of the most consumer-directed population health models CMS deploys.

Altering the attribution process to require beneficiaries to actively elect an ACO would create insurmountable administrative complexities and would be confusing to beneficiaries. One of the unique aspects of the ACO program is that the organization cares for all patients in the same manner, not knowing who will ultimately be attributed to the ACO for the purposes of program calculations to determine quality and cost metrics for the ACO. This results in ACOs treating all patients as potentially included in their ACO and results in high quality, coordinated care for all beneficiaries. The current voluntary patient alignment option launched in 2017 has been underutilized and creates confusion among beneficiaries. We urge CMS not to finalize the new beneficiary opt-in approach and continue to make any patient alignment options voluntary.

NAACOS has long [advocated](#) for CMS to incorporate voluntary alignment, and we were pleased that CMS finalized its decision to do so in the final 2017 MPFS. However, as this option was only introduced beginning with performance year 2018, there are several areas CMS must improve on to increase use of the option by beneficiaries. The functionality to designate a primary clinician was added to the MyMedicare.gov website in June 2017. If a beneficiary has existing favorite clinicians from the “My Health” web page on MyMedicare.gov, he or she can select “add as my primary clinician.” If a beneficiary does not have a MyMedicare.gov account, one must be created. Beneficiaries can receive assistance with MyMedicare.gov, including help to set up an account and/or designate a primary clinician by calling 1-800-Medicare (1-800-633-4227). The My Medicare Help Page notes that a primary clinician is the healthcare provider that a beneficiary believes is responsible for coordinating his or her overall care. Once a beneficiary aligns to a qualifying clinician in an ACO, he or she will be assigned to that ACO until he or she removes the clinician as primary practitioner or he or she no longer meets the beneficiary eligibility assignment requirements or the requirements necessary for voluntary alignment. This process can be cumbersome and time consuming for beneficiaries unfamiliar with CMS website. We recommend CMS modify the voluntary alignment process by allowing beneficiaries to make this designation over the phone by calling the 1-800-Medicare or through the Physician Compare website. We also request CMS include more information in beneficiary communications about the importance of this designation and the role ACOs play in providing high quality, coordinated and efficient care. We urge CMS to implement these changes and to consult with ACOs as the agency works to further improve the voluntary alignment process.

Payment Rule Waivers

Key Comments:

- **NAACOS urges CMS to finalize its proposal to expand eligibility for the Skilled Nursing Facility (SNF) three-day rule waiver to include ACOs participating in a two-sided model under preliminary prospective assignment.**
- **We urge CMS to finalize the proposal to include SNF services furnished under swing bed arrangements, as this proposal addresses concerns of ACOs in rural areas that have fewer available SNFs.**
- **NAACOS supports CMS’s proposal to expand certain telehealth waivers to treat the beneficiary’s home as an originating site and not apply the originating site geographic restrictions for telehealth services furnished by a practitioner participating in two-sided ACO models.**
- **We urge CMS to implement proposed telehealth waiver changes effective July 1, 2019, consistent with the proposals for the expansion of the SNF waiver, to increase access and use of the waiver by ACOs.**
- **NAACOS urges CMS to consider adding other critical patient engagement tools for ACOs, such as allowing NPI-level participation, permitting ACOs to establish post-acute care networks, providing ACOs with upfront funding for transportation services, waiving certain post-discharge home visit supervision requirements to allow for broader use of these services by ACOs when clinically appropriate and afford all ACOs with the ability to provide waived co-payments for primary care services provided by the ACO’s providers to encourage patients’ use of these services.**

Proposals: CMS proposes, beginning July 1, 2019, to expand eligibility for the SNF three-day rule waiver to include ACOs participating in a two-sided model under preliminary prospective assignment. The SNF three-day rule waiver would be available for such ACOs with respect to all beneficiaries who have been identified as preliminarily prospectively assigned to the ACO on the initial performance year assignment list or on one or more assignment lists

for Quarters 1, 2, and 3 of the performance year for SNF services provided after the beneficiary first appeared on one of the assignment lists for the applicable performance year. CMS also clarifies that, for purposes of determining eligibility to partner with an ACO for the SNF three-day rule waiver, SNFs include providers furnishing SNF services under swing bed arrangements. In these instances, the three-star quality rating requirement would be waived.

CMS also proposes 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 apply these policies to ACOs under a two-sided model that participate under the prospective assignment method, not a preliminary prospective assignment method.

Comments: NAACOS strongly supports CMS proposals to expand access to certain payment rule waivers for ACOs participating in performance-based risk models. These tools serve as critical patient engagement tools necessary for success. We urge CMS to finalize its proposal to expand eligibility for the SNF three-day rule waiver to include ACOs participating in a two-sided model under preliminary prospective assignment with retrospective reconciliation. We also appreciate the proposal to include SNF services furnished under swing bed arrangements, as this proposal addresses concerns of ACOs in rural areas that have fewer available SNFs. While we support these changes, we also urge CMS to streamline the current SNF waiver process that is burdensome and therefore results in fewer ACOs using the waiver. Specifically, we recommend CMS alter the current requirements that the patient has been evaluated and approved for admission to the SNF within three days prior to the SNF admission by an ACO provider/supplier that is a physician, consistent with the ACO's beneficiary evaluation and admission plan. Instead, we urge CMS to also allow other qualified healthcare professionals to evaluate the patient and approve the admission to the SNF. Requiring a physician to see the patient is arbitrary and results in unnecessary delays that do not improve the patient's care. Further, SNF affiliates must have and maintain an overall rating of three stars or higher under the CMS Five-Star Quality Rating System. As a result, ACOs must currently continually look up a SNF's quality rating which is time consuming and adds significant burden. Under the Bundled Payments for Care Improvement Advanced (BPCI-A) program, CMS provides by email an XLS file to participants with a list of SNFs that are approved by CMS to participate in the three-day rule waiver available in BPCI-A. We recommend CMS take a similar approach with ACOs to minimize burden associated with the current process.

NAACOS also supports CMS's proposal to expand certain telehealth waivers to treat the beneficiary's home as an originating site and not apply the originating site geographic restrictions for telehealth services furnished by a practitioner participating in two-sided ACO models. However, we urge CMS to implement such proposal effective July 1, 2019, consistent with the proposals for the expansion of the SNF waiver, to increase access and use of the waiver by ACOs. ACOs consider telehealth a crucial tool for improving care coordination and reducing costs. In addition to these waivers, we urge CMS to consider adding other critical patient engagement tools for ACOs, as detailed below.

Allowing NPI-level participation/Network Management

If CMS's goal is to enable ACOs to have greater control over managing costs for their assigned beneficiaries, CMS should provide ACOs with the ability to select only the highest performing providers by allowing ACOs to select their participants by NPI rather than solely at the TIN level. CMS should give ACOs the flexibility to build a high performing network of providers who will deliver the most efficient and highest quality care by allowing participation by a subset of providers in a TIN, and each individual provider used in assignment could only be in one ACO. This would allow ACOs to carefully create networks of high performing providers, including those participating in the ACO and those outside the ACO with whom the ACO has a preferred provider relationship. Creating these high performing networks will incentivize providers that want to join or remain in an ACO to focus more on reducing unnecessary costs and maintaining high quality. This would also incentivize ACOs to more closely evaluate providers in their network based on sophisticated data analytics. ACOs should be allowed the flexibility to negotiate discounted FFS contracts with preferred providers without the burden of the ACO having to process claims themselves. Introducing this type of network management is essential to allow ACOs to successfully assume accountability for their patient population. Providers with relationships with the ACO would be more likely to share care coordination data to more effectively

manage patient care as a team, and the ACO would communicate with these providers about the cost and quality implications of their care decisions

Allowing ACOs to Establish Post-Acute Care Networks

CMS does not currently allow ACOs to encourage patients to seek care from providers the ACO has identified as most efficient and high quality. Unlike MA program, ACOs are unable to provide incentives for beneficiary engagement with the ACO's most efficient providers. This in turn creates challenges for the ACO in communicating with beneficiaries regarding their preferred providers for treatment. These are the providers engaged with the ACO and focused on providing coordinated, high quality care. NAACOS recommends CMS allow ACOs the same opportunities that are currently provided to MA plans to increase beneficiary engagement through incentives for beneficiaries choosing high quality, efficient providers that work collaboratively with the ACO, particularly for post-acute care providers to ensure ACO patients receive the highest quality care. In order to facilitate this request, CMS must also provide more transparency around post-acute care admissions and quality metrics for post-acute care providers.

Providing ACOs Upfront Funding for Transportation Services

Lack of transportation is often cited as a barrier to healthcare access and can lead to missed appointments, delayed care, and ultimately poorer health outcomes. This issue is especially important for effectively managing patients with chronic diseases, who require more appointments and timely healthcare interventions as well as ongoing medication management. A literature [review](#) of research on this issue found that patients with a lower socioeconomic status had higher rates of transportation barriers to ongoing healthcare access than those with a higher socioeconomic status. This is a critical issue that, if addressed, could help to improve health outcomes, particularly for the patients that most need ongoing care. Therefore, we recommend CMS provide funding for ACOs to deliver transportation services to allow beneficiaries to seek the treatment they need. This could be provided as an upfront payment or as a defined member benefit. The transportation benefit could be billed by the healthcare provider, for example, providing eight trips for the patient and thereby giving transportation to and from the office for four visits for the patient. Other payers currently utilize this approach, such as Humana and Providence Health Plan, and could be used as models.

Post-Discharge Home Visits and Primary Care Co-Payments

Additionally, we urge CMS to waive certain post-discharge home visit supervision requirements to allow for broader use of these services by ACOs when clinically appropriate. We ask that CMS allow physicians to contract with licensed clinicians to provide these home visit services using general instead of direct supervision requirements specified at 42 CFR § 410.32(b)(3). This will provide all ACOs with needed flexibility during the critical post-discharge time period. Finally, we ask CMS to afford all ACOs with the ability to provide waived co-payments for primary care services provided by the ACO's providers to encourage patients' use of these critical services. CMS should afford all ACOs with every opportunity for success in reducing costs for their patients by allowing ACOs to use these high-value services, and we request that these waivers apply to all ACOs participating in performance-based risk models.

Providing ACOs Upfront Funding for Social Services

There is increasing evidence that social determinants are a greater driver of cost and outcomes than genetics or clinical care. Currently there is little financial incentive or infrastructure to pay for social determinants of health (SDOH) work or to support community agencies that work on SDOH initiatives. Few ACOs have found ways to effectively connect their work to closure of SDOH gaps, but those that have, have been able to demonstrate significant cost reductions and shared savings while improving quality of care. This funding could help ACOs with coordination of social resources as well as allow ACOs to align with the work of community partners that close social determinants gaps. Innovations then could come from not only the healthcare delivery side, such as building community networks, referral systems for social determinants gaps, and screening for SDOH gaps, but also from financing of community agencies. NAACOS recommends CMS provide ACOs participating in performance-based risk models with upfront funding to pay for such closure gaps. Specifically, NAACOS recommends CMS provide existing

ACOs with funds similar to the Accountable Care Organization Investment Model (AIM) program, providing targeted advanced loan payments to ACOs to provide such services.

Beneficiary Incentive Program

Key Comments:

- **NAACOS supports CMS's proposal to introduce a beneficiary incentive program for certain ACOs.**
- **We urge CMS provide the necessary funding for the beneficiary incentive program, as is done in the Next Generation ACO Program.**

Proposals: 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 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 the ACO legal entity, not any participant providers or suppliers, must furnish the incentive directly to the beneficiary and that incentives must not be cash but may be cash equivalent (e.g., check or debit card). Incentives must be non-Medicare covered items and services, and ACOs must keep records of all incentive payments. CMS proposes that ACOs must fully fund the costs of operating the beneficiary incentive program, including the cost of any incentive payments. ACOs are prohibited from accepting or using funds furnished by an outside entity, including, but not limited to, an insurance company, pharmaceutical company, or any other entity outside of the ACO, to finance its beneficiary incentive program.

CMS proposes that incentive payments made by an ACO shall be disregarded for purposes of calculating benchmarks, estimated average per capita Medicare expenditures, and shared savings. CMS also proposes to disregard incentive payments made by an ACO for purposes of calculating shared losses. Lastly, CMS proposes a requirement that ACOs publicly report for each performance year the total number of beneficiaries who receive an incentive payment, the total number of incentive payments furnished, HCPCS codes associated with any qualifying payment for which an incentive payment was furnished, the total value of all incentive payments furnished, and the total type of each incentive payment (e.g., check or debit card) furnished.

Comments: NAACOS supports CMS's proposal to introduce a beneficiary incentive program for certain ACOs. As discussed above, such patient engagement tools are critical to an ACO's efforts to better manage a patient's care. While we support this proposal, we have concerns with the agency's approach to implementation, which would require the ACO fully fund the costs of such a program. There are numerous upfront costs required to establish and maintain an ACO's operations. ACOs invest these dollars to support the model and efforts to transform patient care, sometimes never realizing these investment costs. Those ACOs that do earn shared savings do not see such funds until years after the upfront investments have been made. Therefore, it is unreasonable to expect the ACO to fully fund the costs of such a program, and we urge CMS instead provide such funding as is the case in the Next Generation ACO Program. At a minimum, CMS should consider funding the program for the first year to support the cost of running such a program.

Quality Changes

Key Comments:

- **NAACOS strongly supports CMS's proposal to remove ACO measure 11 and instead rely on attestation to evaluate the ACO's use of Certified Electronic Health Record Technology (CEHRT).**

- **We urge CMS to clarify that ACOs subject to the MIPS would not be required to report Promoting Interoperability (PI) and would instead see PI performance category weights redistributed equally to the Quality and Clinical Practice Improvement Activities performance categories.**
- **NAACOS supports the agency's Meaningful Measures Initiative and asks that CMS consider not only whether a measure is a process measure, but also whether the measure is considered a low-value process measure, before removing from ACO quality measure sets.**
- **We support CMS's efforts to consider the addition of opioid use measures for potential inclusion in ACO quality measure sets in future program years, and we recommend certain changes to such measures as detailed below.**
- **We urge CMS to exclude MIPS bonuses from ACO expenditures.**

Proposals: CMS proposes to discontinue use of the quality measure 11 that assesses an ACO's eligible clinicians' level of adoption of CEHRT. Instead, CMS proposes that for performance years starting on January 1, 2019 and subsequent performance years, ACOs in a track or a payment model within a track, which does not meet the financial risk standard to be an Advanced APM, must attest and certify upon application to participate in the MSSP and subsequently as part of the annual certification process that at least 50 percent of the eligible clinicians participating in the ACO use CEHRT to document and communicate clinical care to their patients or other health care providers. ACOs would be required to submit this certification in the form and manner specified by CMS.

CMS also seeks feedback on ways to reduce burden and focus on meaningful quality measures as part of their Meaningful Measures Initiative. Under this initiative, CMS states it is working towards assessing performance on only those core issues that are most vital to providing high-quality care and improving patient outcomes with an emphasis on outcome-based measures, reducing unnecessary burden on providers, and putting patients first.

Finally, CMS is also considering the addition of one or more measures specific to opioid use to the ACO quality measures set. The potential benefits of such policies would be to focus ACOs on the appropriate use of opioids for their assigned beneficiaries and support their opioid misuse prevention efforts. Specifically, CMS is considering the following relevant National Quality Forum (NQF)-endorsed measures with emphasis on Medicare individuals with Part D coverage who are 18 years or older without cancer or enrolled in hospice: NQF 2940, Use of Opioids at High Dosage in Persons Without Cancer; NQF 2950, Use of Opioids from Multiple Providers in Persons Without Cancer; NQF 2951, Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer.

Comments: NAACOS strongly supports CMS's proposal to remove ACO measure 11 and instead rely on attestation to evaluate the ACO's use of CEHRT. We appreciate CMS responding to NAACOS requests to remove this measure and as a result rely on attestations as is done in the Next Generation ACO Model. We ask CMS to clarify that ACOs subject to MIPS would not be required to report PI and would instead see PI performance category weights redistributed equally to the Quality and Clinical Practice Improvement Activities performance categories. We agree that removal of this measure will reduce significant regulatory burdens; ACOs subject to MIPS (Basic Track Levels A through D as proposed) should not be unfairly excluded from this policy. All ACOs demonstrate a commitment to use of EHRs, including ACOs in models not categorized as Advanced APMs. We support CMS's Meaningful Measures Initiative and, in this role, we feel CMS must also look to reduce the regulatory burden on ACOs to comply with MIPS requirements to the fullest extent possible. This includes making all program criteria and scoring methodologies for ACOs specifically accessible and transparent.

As CMS looks to future quality measure changes for ACOs, we urge the agency to consider not only whether a measure is considered a process measure but also what relative value the measure provides, when considering the burden associated with data collection and reporting of the measure. Further, as CMS considers annual measure changes, we note that each measure change results in administrative costs, such as changing work flows and EHRs for data collection and reporting.

NAACOS also supports CMS's efforts to consider opioid use measures for inclusion in ACO quality measure sets in future program years. ACOs are committed to improving the way opioids are prescribed through increased

measurement and use of clinical practice guidelines to ensure patients have access to safer, more effective chronic pain treatment while reducing the number of people who misuse, abuse, or overdose from these drugs. CMS specifically considers the following NQF-endorsed measures with emphasis on Medicare individuals with Part D coverage who are 18 years or older without cancer or enrolled in hospice: NQF 2940, Use of Opioids at High Dosage in Persons Without Cancer; NQF 2950, Use of Opioids from Multiple Providers in Persons Without Cancer; NQF 2951, Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer. We recommend changes to NQF 2940; this measure should instead align with the Centers for Disease Control and Prevention [guidelines](#) identifying patients for whom opioid prescriptions exceed 90 morphine milligram equivalents. It is important to include these measures on dose and duration of opioids prescribed. However, we urge CMS to initially make such measures pay-for-reporting only as the measures are further refined with stakeholder input for use in the ACO program.

Finally, we urge CMS to exclude MIPS bonuses as ACO expenditures. The current CMS policy unfairly punishes ACOs for their high performance by both requiring Track 1 ACOs (and Basic Levels A, B, C and D as proposed) to participate in MIPS, excluding such ACOs from Advanced APM bonuses and counting any MIPS bonuses earned for high performance in that program as ACO expenditures. CMS currently excludes Advanced APM bonuses from ACO expenditures and we reiterate our request for CMS do the same for MIPS expenditures. This will be increasingly important over time as MIPS bonuses are projected to rise in future program years. While aggregate program data has not yet been made available by CMS, many ACOs have already reported perfect or nearly perfect scores in MIPS for 2017. These bonuses will then count against the ACO when expenditures are calculated for purposes of MSSP calculations. Therefore, the better an ACO and its eligible clinicians perform in MIPS, the greater they will be penalized when calculating shared savings/losses for the ACO. This is an unfair and untenable policy. Although CMS argues that the agency has maintained this policy under the Value-Based Payment Modifier Program, NAACOS believes CMS has the authority and ability to remove MIPS expenditures from ACO benchmark calculations. In fact, CMS does make claim-level adjustments by adding sequestration costs back to paid amounts when calculating ACO expenditures. It was not the intent of Congress to penalize ACOs in MIPS, and therefore CMS must alter this policy.

Repayment Mechanisms

Key comments:

- **NAACOS urges CMS to remove the requirement for tail period coverage and to lower the repayment mechanism amounts for Basic Track Levels C, D and E.**
- **NAACOS supports CMS's proposal to expand the acceptable institutions providing a repayment mechanism to include any insured institution, including credit unions.**
- **NAACOS supports using the most recent data available to establish a repayment mechanism amount, requests CMS increase the threshold that would trigger a higher repayment mechanism amount and provide symmetry by allowing decreases in repayment mechanism amounts during an agreement period.**
- **NAACOS requests that CMS provide new repayment mechanisms, including reinstating reinsurance and introducing an option for a future withhold of Medicare payments.**

Proposals: As with current risk-based models, ACOs in the revised MSSP would be required to demonstrate their ability to repay losses by establishing a sufficient repayment mechanism, including funds placed in escrow, a letter of credit, a surety bond, or a combination of those mechanisms. The agency proposes to expand the acceptable institutions providing a repayment mechanism to include any insured institution, including credit unions. The agency also proposes to extend the duration of the repayment mechanism, which would need to be in place for the number of risk-based years in the agreement period plus an additional 24 months of "tail coverage." CMS proposes to use the most recent calendar year having 12 months of available data to establish the repayment mechanism amount.

ACOs in the Basic Track would have a repayment mechanism amount equal to the lesser of 1 percent of total assigned beneficiary expenditures (benchmark-based standard) or 2 percent of ACO participant revenue (revenue-based standard) prior to entering risk-based Levels C, D or E. ACOs in the Enhanced Track would have a repayment

amount equal to 1 percent of total assigned beneficiary expenditures (benchmark-based standard). The agency notes its efforts to minimize administrative burdens by proposing that ACOs with a repayment mechanism would be permitted to extend its duration for the Basic or Enhanced Tracks. In the event that any of the following occur, CMS proposes that the repayment mechanism may be terminated.

- Shared losses have been fully repaid for all performance years.
- CMS has exhausted the amount.
- CMS determines that shared losses are not owed.

Comments: Securing a repayment mechanism is a regulatory burden, which is time consuming and costly for ACOs. Many ACOs cite the burden and cost of securing a repayment mechanism as reasons not to move to a risk-based ACO model. Instead of requiring a repayment mechanism that pays banks and brokers and takes money away from the ACO executing its core mission of improving patient care, we urge CMS to remove the repayment mechanism requirement when an ACO can prove that it has an investor or financial backer with a demonstrated high credit rating. Financial backers could include outside investors, insurers or hospitals or health systems that are involved with the ACO and providing financial support, which would be available should losses occur. This assurance would protect the Medicare Trust Fund in the event the ACO has losses while avoiding the financial inefficiency and regulatory burden of involving outside financial institutions as third parties that benefit from the repayment mechanism requirements. This would also eliminate the need to have a 24-month tail period.

The additional burden of a 24-month “tail period” heightens concerns and increases financial requirements for ACOs. Should CMS maintain requirements for a repayment mechanism, we request the agency to minimize this regulatory and financial burden by removing the requirement for tail period coverage, which is especially important considering the longer agreement periods CMS proposes. Should the agency retain a tail period, we also urge the agency to ensure that CMS is equally liable to pay for additional shared savings if discovered up to 24 months following the agreement period and this should be noted in the MSSP participation agreements.

We further recommend CMS reduce the repayment mechanism requirements, especially for the lower risk Basic Track Levels C, D and E. For these levels, CMS should only require a guarantee equal to 0.5 percent of total benchmark expenditures or 1 percent of FFS revenue. Those amounts are sufficient to prompt third-party due diligence and establish credit worthiness within the probable range of shared losses. This reduction makes sense especially in light of the 30 percent loss sharing rate in these levels that correspondingly reduces the likelihood of net losses.

We support CMS’s proposal to expand the acceptable institutions providing a repayment mechanism to include any insured institution, including credit unions. This would provide more options than the current requirement to only utilize Federal Deposit Insurance Corporation-insured institutions. Allowing access to credit unions may provide more economical alternatives and increase market competition, which could potentially lower the overall cost of accessing repayment mechanisms. We recommend CMS finalize this expansion of acceptable institutions as proposed.

In an effort to make more timely determinations of the repayment mechanism amount, CMS proposes to use the most recent calendar year having 12 months of available data to establish the repayment mechanism amount. For example, the repayment mechanism amount for an Enhanced Track ACO starting in 2020 would be based on 2018 expenditures. We support the use of the most recent data available. CMS further proposes that repayment mechanism amounts would be recalculated prior to each performance year. If the calculated amount is greater by the lesser of 10 percent or \$100,000, then the repayment mechanism amount would be increased by CMS. In other words, any increases over \$100,000 would trigger a higher amount. This threshold is too low and should be raised to avoid ACOs having to secure larger repayment mechanisms. Further, while CMS proposes details related to increasing the amount of the repayment mechanism, it is proposed that repayment mechanism amounts cannot decrease within an agreement period. It is unfair to hold ACOs accountable for increases without allowing them to benefit from decreases, and we urge CMS to revise its policy to also allow for decreases to repayment mechanism amounts. We also urge CMS to provide flexibility for ACOs that may need to adjust their repayment mechanisms over

time. For example, we request the agency work with ACOs to provide flexibility to release funds for a limited window, such as 60 days, for ACOs changing repayment mechanisms. Updating repayment mechanisms may happen over time as a result of organizational changes, needs, and availability of specific repayment mechanisms.

We also request that CMS provide new repayment mechanisms, including reinstating reinsurance and introducing an option for a future withhold of Medicare payments as repayment mechanisms. We request CMS restore reinsurance as a qualifying repayment mechanism, which it was until CMS removed it 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 considering how few risk-bearing ACOs there were at that time. Further, despite limited initial use of reinsurance for demonstrating ability to repay losses to CMS, this continues to be an option which some ACOs pursue separate from their CMS obligations. Therefore, 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.

Under the MACRA financial risk standards, the agency may allow a reduction of payment rates to the APM Entity and/or the APM Entity's eligible clinicians as one option 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 TIN/ NPI combinations that participate in the ACO for a specific performance period and, similar to downward payment adjustments under 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.

Extreme and Uncontrollable Circumstances Policy

Key Comments:

- **NAACOS urges CMS to revise the extreme and uncontrollable circumstances policy to provide a trend/growth rate that is the higher of the national assignable rate or the regional rate.**
- **We strongly recommend CMS award a quality score that is the greater of the quality score earned in the performance year affected by the extreme circumstance, the prior year quality score, or the national mean quality score.**
- **CMS should consider introducing ways to more accurately account for impact of natural disasters, for example, identifying ways to identify natural disaster related impact at the beneficiary and claims level through the use of modifiers that account for unsafe place of discharge which could be added to claims after the impact of a natural disaster.**

Proposal: CMS previously established policies beginning with performance year 2017 and every year that follows, for using an alternative approach to calculate ACOs' cost and quality performance if deemed affected by an "extreme and uncontrollable circumstance." CMS seeks feedback on this policy.

Comments: We appreciate CMS's thoughtful analysis and proposals related to accounting for the impact of a natural disaster on an impacted ACO's shared losses and quality. CMS proposes a more aggressive transition to risk. Therefore, these policies are even more critical to protect ACOs unfairly harmed by expenses and quality changes beyond their control as a result of a natural disaster. As ACOs have been impacted by several natural disasters in recent years, more data are available to deeply analyze the effect of such extreme and uncontrollable circumstances on an ACO's operations.

In 2017, CMS introduced an [Interim Final Rule](#) containing a policy for extreme and uncontrollable circumstances for ACOs. Unfortunately, this policy went through the formal commenting period before affected ACOs received their performance results to understand the true extent of the impact of such disasters on an ACO's operations. Since

introducing such policies, ACOs have had more experiences with natural disasters and therefore experience with how such events affect an ACO. Based on this experience, we recommend several changes to the current extreme and uncontrollable circumstances policy.

Trend Rate

Without changes to the current policy, natural disasters will negatively affect MSSP ACOs and therefore affect the long-term sustainability of the program and the Medicare Trust Fund. The current policy prorates shared losses by multiplying the shared losses by two factors: the percentage of the total months in the performance year affected by an extreme and uncontrollable circumstance and the beneficiaries who reside in an area affected by an extreme and uncontrollable circumstance. This adequately addresses ACOs that are expected to have shared losses based on performance prior to a natural disaster and have increased shared losses after a natural disaster. However, the current policy does not address an increase in annual per capita expense as compared to the benchmark/MSR/MLR. This point is particularly sensitive around MSR and MLR values where very small changes can have large or 100 percent impact on shared savings or shared losses when either the MSR or MLR is exceeded.

The agency's current policy relies on "use of natural disaster payment modifiers" to allow MSSP ACOs to identify whether a claim would have been denied under normal Medicare FFS rules. There is no evidence to support that Part A providers were or are aware of such natural disaster codes or were using them compliantly. Additionally, there is no policy to use them to account for unsafe place of discharge which creates a longer length of stay. We believe that there is a current disparity between CMS's expectation of compliance with disaster payment modifiers and the current use of such codes (see additional comments below regarding Use of Natural Disaster Codes). Due to these limitations of the current policy, we instead recommend that CMS revise the extreme and uncontrollable circumstances policy to provide a trend/growth rate that is the higher of the national assignable rate or the regional rate. Further, the regional rate should be calculated by excluding the ACO's assigned beneficiaries. Studies have shown that natural disaster materially increase Medicare costs per beneficiary. For example a recent article, "Disaster Impacts on Cost and Utilization of Medicare" shows annual standardized cost per beneficiary increased 7.6% from the mean in the counties most severely impacted by these events ([See Table 1](#)).

Quality Performance Scores

Natural disasters can have a significant negative impact on both ACO process and outcomes measure scores. As an example, for process measures it is not uncommon during a disaster for scheduled annual wellness visits to be canceled due either to clinic closure or beneficiary evacuation. In some instances, these visits aren't subsequently rescheduled which leads to missed opportunities to provide preventative care and identify emerging issues that require care coordination. The current CMS policy awards an average quality score to those affected by extreme and uncontrollable circumstances, which can unfairly penalize high performing ACOs. Instead we recommend CMS should use an approach similar to the policy currently used in the MA program and award a quality score that is the greater of the ACO's quality score for the affected performance year, the ACO's prior year quality score, or the national mean quality score. For ACOs that are in their first year, CMS should award a quality score that is the greater of their actual quality score for the affected performance year or the national mean quality score. We also strongly recommend CMS expand its policy related to ACO quality scores negatively affected by a natural disaster to include all ACOs, not just those who cannot report quality data. We believe that ACOs whose scores on either the All-Cause Readmissions Measure (ACO-8) or the SNF Readmissions Measure (ACO-35) fall below the 30th percentile should be eligible to have their quality score adjusted to account for the natural disaster.

Introducing Ways to More Accurately Account for Impact of Natural Disasters

NAACOS believes it is difficult to fully and accurately use the natural disaster payment modifiers to appropriately capture the negative impact of the event on an ACO's performance. After Hurricane Katrina, natural disaster payment modifiers were introduced in 2005. In 2012, the "disaster related" and "catastrophe related" condition codes [were made mandatory](#) for any claim for which Medicare payment is conditioned on the presence of a formal waiver. This institutional code enables acute and post-acute facilities to use these payment modifier codes for claims submission and payment where the billing would otherwise be out of compliance (e.g., ordering replacement Durable Medical Equipment for a patient). We believe these codes are not being used as CMS has intended.

Additionally, the codes do not allow for capturing instances of 'unsafe place of discharge', which is common during a natural disaster. Furthermore, the timing of the claims submission during a natural disaster does not lend itself to accurate use of the modifiers. At the time of an extreme event or natural disaster, a facility is working tirelessly to address the patient surge, to transfer patients who have clinical needs that cannot be met under emergency operating conditions, and to meet a myriad of other community needs. Training health system providers to use these codes is not common. Given the infrequent nature of these events providers focus their scarce training resources for revenue cycle staff to remain in compliance with Medicare and Medicaid's ever-evolving billing regulations. Therefore, at a time when providers are pushed beyond capacity to manage patient care during emergencies, there is no routine revenue cycle workflow to ensure the disaster modifiers are accurately assigned. Only in instances where a biller knows a claim is out of compliance for payment may the workflow to add the code be triggered. Therefore, we feel the definition of these modifiers must be expanded or new natural disaster payment modifiers should be created with proper education to help isolate the extreme or uncontrollable events by claim or beneficiary during a natural disaster. NAACOS feels this would be a more accurate approach to analyzing impacts of extreme and uncontrollable circumstances such as a natural disaster.

Conclusion

ACOs have been instrumental in the shift to value-based care and a central part of the ACO concept is to transform healthcare through meaningful clinical and operational changes to put patients first by improving their care and reducing unnecessary expenditures. The MSSP remains a voluntary program, and it's essential to have the right balance of risk and reward to continue program growth and success. Program changes that deter new entrants would shut off a pipeline of beginner ACOs that should be encouraged to embark on the journey to value, which is a long-standing bipartisan goal of the Administration and Congress and important aspect of the QPP. We urge the agency to consider the feedback presented from the ACO community outlined in this letter. Thank you for your consideration of our comments.

Sincerely,



Clif Gaus, Sc.D.
President and CEO
National Association of ACOs