March 28, 2016

Andrew Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1644-P
P.O. Box 8013
Baltimore, MD 21244–8013

Re: Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations (ACOs) – Revised Benchmark Rebasining Methodology, Facilitating Transition to Performance-Based Risk and Administrative Finality of Financial Calculations

Dear Acting Administrator Slavitt:

On behalf of the American Osteopathic Association (AOA), which represents 123,000 osteopathic physicians and osteopathic medical students nationwide, we thank you for the opportunity to comment on the Centers for Medicare and Medicaid Services’ (CMS) proposed rule on ACOs in the Medicare Shared Savings Program (MSSP).

We agree with the agency’s intent to make revisions to the Shared Savings program in order to improve the predictability, accuracy, and stability of the program and to encourage continued participation. Revisions to the ACO program also should provide the incentive to continue participation as an eligible Alternative Payment Model (APM) in Medicare’s new payment system under the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA).

Aligning MSSP ACOs with MACRA APMs

As CMS moves forward with refining the benchmark methodology and other aspects of the ACO program, we urge the agency to take steps to ensure a smooth transition to Medicare’s new payment system established under MACRA. As many details of the new Medicare payment system under MACRA have yet to be defined, it is unclear how current MSSP’s ACOs would fare in meeting requirements of the MACRA APM program. We support the establishment of a pathway by which high-performing MSSP ACOs may transition to the MACRA APM program, and encourage CMS to identify a runway and milestones that MSSP ACOs can use to increasingly align their practices with those required of MACRA APMs. We also acknowledge that some current MSSP ACOs may be poorly positioned to meet the requirements of MACRA APMs, and suggest that CMS clarify its intent in continuing with the MSSP ACO program for this subset of ACOs after MACRA is implemented.

MACRA’s intent includes the engagement of physicians in developing and evaluating new payment models as evidenced by the statutorily mandated Physician-Focused Payment Model Technical Advisory Committee. As such, we remain concerned that current Center for Medicare and Medicaid
Innovation (CMMI) efforts are not in the same spirit as MACRA and may not dovetail with the new law, as the current process includes limited physician input. Additionally, the proliferation of APMs without clarity about how they may meet the MACRA eligibility requirements is a disservice to the providers who practice in those models as well as the patients who receive care in those APMs.

Since the proposed rule on MACRA’s Merit-Based Incentive Payment System (MIPS) and APMs has not been released, we do not know if additional changes to MSSP’s calculations and methodologies may be advisable to accommodate transition to the new payment system. We caution that unless there is harmonization between any changes to the current MSSP and requirements for APMs under the new Medicare payment system, transitioning to the new payment system may disrupt ACO efforts to improve cost efficiencies and the overall quality of patient care.

Proposed methodologies and analyses
We appreciate the agency’s effort to address challenges of the Shared Savings program; especially that current benchmarking adjustments tend to penalize high-performing ACOs, creating a disincentive for continued participation. We also share CMS’ expressed concerns regarding its proposals including:

- The potential negative consequence of creating an opportunity for arbitrage;
- Structural shifts by ACOs in ways that would reduce assignment of relatively high-cost beneficiaries and increase assignment of relatively healthy populations;
- Policies in the proposed rule assumed to result in a lower tolerance for renewal after a prior agreement period loss; and
- The possibility that gains in efficiency will fail to materialize and/or selective participation and other behavioral responses will increase costs beyond what is anticipated.

Given that CMS requests additional data, highlights concerns stemming from its own analyses of current data, and acknowledges a wide range of potential outcomes, we suggest that CMS delay finalizing this proposed rule. Ideally, this would be until more information is provided regarding the rule’s potential impact, and regarding the MIPS and APM requirements that will be proposed this spring. When that information is made available, CMS should allow more time for public input.

In addition, we offer the following insights as CMS considers benchmark modifications and other revisions for this program:

The MSSP ACO program must incentivize care to vulnerable patient populations.

- Cost efficiencies should not be at the expense of high quality care. If a payment system incentivizes low cost of care, it may also incur low quality. CMS must ensure that the attribution of cost is viewed in the appropriate way so that ACOs are not penalized for treating patients who suffer from complex chronic illnesses and/or face socioeconomic challenges that exacerbate their conditions.

- The more an ACO strives to improve quality performance, the more it often needs to spend. 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.
Multiple factors influence patient outcomes and should be considered in the performance of ACOs. In addition to differences in patient health status, socioeconomic status and other demographic factors should be accounted for in risk adjustments, which will improve the relevance and accuracy of an ACO’s performance results.

We do not support CMS’s policy of limiting risk adjustment due to demographic factors for all continuously assigned beneficiaries. It is unreasonable to assume a provider organization, however effective, can manage a population such that patient conditions never worsen over time and it never carries a higher disease burden. CMS should, within limits, allow risk scores to increase year-over-year within an agreement period for the continuously assigned.

Higher levels of coding could be the direct result of providing more comprehensive patient-centered care; therefore, we caution CMS against implementing payment adjustments that could potentially penalize ACOs and impede their efforts to care for complex chronically ill patients.

We agree that improving the accuracy of benchmarking calculations to reflect an ACO’s actual costs as well as health and socioeconomic status of patient populations will provide stability and greater predictability within the ACO program. The data used must be statistically valid and sufficient to prevent skewed results.

In defining the region, we urge CMS to increase the population threshold and only include counties with at least one percent of the ACO’s assigned beneficiary population, as they do with other Medicare programs, including the Physician Group Practice demonstration, a precursor to the MSSP.

Moving to regionally-based benchmarks should be budget-neutral and not result in ACOs losing savings they worked so hard to produce.

The MSSP ACO program should provide flexibility for ACOs, especially small and rural practices.

CMS should provide enough flexibility in the effort to prevent the uncertainties it cites. To mitigate unexpected benchmark swings and to ease the transition across the MSSP, we urge CMS to provide a glide path with options for ACOs to decide for themselves how and when to move to the new benchmark methodology.

Once modifications are made under this rule, we agree that CMS should assess what effects the modifications are having to determine whether additional revisions are necessary in future rulemaking.

While CMS expects the average ACO to receive greater shared savings revenue under the proposed changes, the agency acknowledges that the impact on the individual small entity and small rural hospital remains to be seen. When CMS monitors the effects of the changes, it needs to ensure that small entities and hospitals, particularly in rural and underserved areas, are not placed at a disadvantage.
• We commend the agency’s efforts to provide additional flexibilities to enable ACOs to transition to two-sided performance-based risk arrangements and support the agency’s proposal to allow an ACO to defer by one year its entrance into Track 2 or Track 3 by extending its first agreement period under Track 1 for a fourth performance year.

CMS should implement the MSSP ACO program in a manner that minimizes burden on ACOs and maximizes transparency.

• The agency’s proposed timeframe to reopen a payment determination for good cause should be reduced from four years after the date of notification to the ACO of the initial determination of shared savings or losses for the relevant performance year to two years. We believe two years is sufficient time for CMS to make corrections, and will provide more financial certainty for ACOs, allowing them to plan future financial transactions and investments to improve care and reduce costs.

• Individual ACOs should be permitted to appeal a payment determination if they feel that the calculation was made in error. We also believe ACOs should be held harmless for errors made by CMS in the payment determination process. ACOs should not be penalized for payment determination errors that result in the ACO receiving more money (or paying less money) than the ACO should have received (or paid) under the MSSP. Holding ACOs harmless for CMS errors would protect ACOs’ liability, encourage additional investment in care coordination efforts, and enable continued and new participation in the MSSP.

• CMS says it will provide sub-regulatory guidance on what constitutes good cause and how it may consider the materiality of an error. In the interest of transparency, we recommend that CMS provide this information in an interim final rule with an opportunity to provide additional comments.

Conclusion

The Administration has reached its goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through APMs and is on the path to tying 50 percent of payments to these models by the end of 2018. Whether or not current APMs, like ACOs, will succeed in the new Medicare payment system remains to be seen. As CMS makes adjustments to the MSSP and moves toward the new payment system, it should create a fair and flexible playing field to give program participants the opportunity to succeed, so that patients can receive the best care possible. We commend CMS for continuing to solicit feedback and input from stakeholders, and we encourage the agency to continue these collaborative efforts as it works to improve the program.

Sincerely,

John W. Becher, DO
President
The American Osteopathic Association (AOA) represents more than 123,000 osteopathic physicians (DOs) and osteopathic medical students; promotes public health; encourages scientific research; serves as the primary certifying body for DOs; is the accrediting agency for osteopathic medical schools; and has federal authority to accredit hospitals and other health care facilities. More information on DOs/osteopathic medicine can be found at www.osteopathic.org.