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 Proposed Rule

Dear Administrator Verma:

The Medical Group Management Association (MGMA) is pleased to offer the following comments to the Centers for Medicare & Medicaid Services (CMS) regarding the Medicare Shared Savings Program (MSSP) Pathways to Success proposed rule.

MGMA is the premier association for professionals who lead medical practice. Since 1926, through data, people, insights, and advocacy, MGMA empowers medical group practices to innovate and create meaningful change in healthcare. With a membership of more than 40,000 medical practice administrators, executives, and leaders, MGMA represents more than 12,500 organizations of all sizes, types, structures and specialties that deliver almost half of the healthcare in the United States.

MGMA appreciates CMS' efforts in the proposed rule to increase stability, predictability, and regulatory burden relief for accountable care organizations (ACOs) participating in the MSSP. However, we have significant concerns regarding some of CMS' proposals and recommend the Agency revisit proposed policies that would compromise sustained and robust participation in the MSSP. We urge CMS to:

- **Increase stability and predictability in the program by finalizing the proposal to lengthen agreement periods to five years.** Constant change in payment policies across Medicare programs is disruptive and burdensome; CMS should capitalize on efforts to introduce program stability where it can.
- **Allow ACOs more time without downside risk instead of reducing the time in a shared savings-only model from six to two years.** 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.
- **Permit ACOs to remain in a shared savings-only model, as opposed to moving to a risk-based model, so long as they meet cost and quality goals.** As recent results show that Track 1 participants save money and tend to do so based on experience in the program, MGMA recommends that CMS permit ACOs to remain in a shared savings-only model if the ACO meets performance-based criteria that encourages savings and quality achievements.
- **Instead of requiring ACOs move to the Enhanced track, offer this track as a voluntary option for ACOs prepared for higher levels of risk and reward**. As with Track 3, CMS should keep

participation in the Enhanced track voluntary and not attempt to push ACOs into a model with levels of risk they are not prepared to assume.

- **Maintain a shared savings rate of at least 50 percent for all ACOs in all performance years and tracks to ensure a viable business model.** For sustained and robust participation, CMS must structure the program to ensure the MSSP is attractive and viable for new entrants, and MGMA does not believe it is realistic to drop below the current 50 percent shared savings rate.
- **Account for changes in ACO patients' health status over time by allowing for a risk adjustment fluctuation.** MGMA supports updating the risk adjustment methodology to account for risk score changes but maintains there are additional improvements that should be made to benchmarking and risk adjustment methodologies.
- **Increase flexibility in the MSSP by finalizing the proposed policy to permit ACOs to select a prospective or retrospective assignment methodology on an annual basis**. MGMA has long advocated for policies that permit ACOs to choose between prospective and retrospective assignment, regardless of track, and is encouraged by CMS' proposal.
- **Remove ACO quality measure 11 and instead rely on attestation to evaluate use of CEHRT.** MGMA urges CMS to finalize this proposal and to continue to seek ways to reduce unnecessary reporting requirements.

Transition to Risk

Under the proposed rule, ACOs would move from shared savings-only to risk-based models under CMS-mandated time frames that apply differently depending on certain factors, including program experience and ACO type (high versus low expenditure).

While MGMA appreciates CMS' efforts to strengthen incentives for ACOs to reduce unnecessary Medicare spending, we urge the agency to reconsider its policies mandating a rush to risk, as we believe forcing ACOs to take on downside risk at an accelerated pace will force them out of the program.

The MSSP remains a voluntary program, and it is essential to have an appropriate 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 Quality Payment Program. Based on performance results to date, terminating shared savings-only models could increase Medicare spending rather than increasing savings, counter to the Administration's cost reduction goals.

CMS Must Allow More Time in a Shared Savings-only Model

The proposal to decrease the amount of time in shared savings-only from six to two years will deter program participation. MGMA strongly opposes this policy and instead urges CMS to modify proposals to allow more time for all ACOs, regardless of high- or low-expenditure status, to participate in a shared savings-only model and to apply a shared savings rate of at least 50 percent. While there are varying opinions on the exact amount of years an ACO should remain in a shared savings-only model without either progressing to a risk-based model or being subject to performance-based criteria to continue participation in shared savings-only, MGMA submits that the important point to recognize is that two years is insufficient.

A critical component of performance improvement and evaluation lies in an ACO's ability to analyze performance data and use this information to make improvements in future performance. Under CMS's current proposal, ACOs would have only one year of performance data to assess and incorporate into performance before being required to move to a risk-based model. This does not permit ACOs sufficient opportunity to make strategic decisions, implement strategies for future success, or evaluate future business viability before being asked to potentially pay back millions of dollars.

Establishing an ACO and implementing the transformations inherent in population health are what drives changes in provider behavior. These changes can take years to produce results, as demonstrated by the increasingly positive results for ACOs that are in the program for a longer period of time. As policy experts in Health Affairs suggest, there is a "learning curve" that extends more than two years and that ACOs' "shared savings rate doubled with three years of experience, from about 21% for those ACOs in their first MSSP performance year to over 41-43% for those ACOs in their fourth and fifth performance years."[1] Research to date suggests that ACOs improve with experience in the program, supporting the position that ACOs should be permitted additional time to become comfortable in the program without being forced into a risk-based model.

Permit ACOs that Meet Performance Goals to Remain in Shared Savings-Only

MGMA recommends that, instead of requiring ACOs to move to a risk-based model following their initial years in shared savings-only (two years as proposed in Basic Tracks A and B or longer as recommended), ACOs that are still unprepared to assume risk that have met certain performance-based criteria should be permitted to remain in a Track 1 equivalent model for as long as the ACO continues to meet specified cost and quality criteria.

MGMA recommends that, as long as an ACO is not continually losing money for the program and is maintaining high quality scores, it is in the interest of Medicare to keep the organization in the program even if it does not proceed to a risk-bearing model**.** As long as savings and quality standards are met, ACOs in Track 1 or an equivalent shared savings-only model should be eligible for continued participation in the MSSP at the current sharing rate of 50 percent. ACOs that are not successful could be dropped from the program or pushed into a risk-bearing model, such as the proposed glide path to risk, where they would be required to pay back continued losses.

Since the inception of the MSSP, CMS has emphasized the need for ACOs to assume downside risk as the best way to reduce unnecessary expenditures. CMS' policy basis is that ACOs with downside risk achieve greater savings than shared savings only models. However, recent results discredit this assumption: in 2017, the 433 one-sided MSSP Track 1 ACOs saved an estimated $291 million, compared to $23 million in savings generated by Track 2 and 3 ACOs.

Research also shows that ACOs demonstrate an increasing likelihood of achieving shared savings over time, which demonstrates the value of these models and the need to allow ACOs sufficient time to demonstrate positive results. For example, August 2017 findings from the Department of Health and Human Services Inspector General and 2017 MSSP performance results available in the Public Use File serve as evidence that ACOs need experience in the program to generate positive results and demonstrate change. MGMA has concerns with CMS' emphasis on the move to risk and assertion that high levels of risk are the key driver of cost savings and achieving program goals.

Given this backdrop, requiring ACOs to accept downside risk is not the only approach that CMS could use to increase net savings to the Medicare program from the MSSP. We recommend that CMS consider alternative approaches to accomplishing program goals aside from the Agency's emphasis on requiring all ACOs to eventually move to high levels of risk as the only answer. For example, one policy expert identified several alternative ideas for increasing MSSP savings, including:

1. Dropping ACOs from the program if they have not achieved savings after several years;
2. Reducing shared savings payments to ACOs that incur large losses before generating savings; and

[1] "Half A Decade In, Medicare Accountable Care Organizations Are Generating Net Savings: Part 1," Health Affairs Blog, Sept. 20, 2018. Available at: https://www.healthaffairs.org/do/10.1377/hblog20180918.957502/full/

3. Allowing ACOs to take accountability for the specific types of spending they are capable of controlling, rather than total Medicare spending.[2]

We recommend that CMS analyze these ideas and other approaches and consider the advantages and disadvantages of alternatives to mandating a transition to risk-based models.

Glide Path to Risk

For ACOs prepared to take on risk, MGMA would support a voluntary glidepath to higher risk levels. However, MGMA opposes forcing high-revenue ACOs to assume greater risk at an accelerated timeline and opposes requiring any ACO to move into the Enhanced track. Instead, we urge CMS to offer the Enhanced track as a voluntary option for ACOs prepared for higher levels of risk and reward.

ACOs prepared to assume risk should be able to remain in the equivalent of Track 1+ (proposed Basic Level E). As recommended by MGMA and other stakeholder groups, CMS developed Track 1+ as a new participation option that incorporates less downside risk than what is required in existing two-sided ACO models. We greatly appreciate that this participation option qualifies as an advanced alternative payment model, as well as CMS' plans to incorporate Track 1+ policies into Level E of the Basic track. We believe, however, that ACOs should be permitted to remain in Track 1+ or its equivalent indefinitely, without being forced to progress to the Enhanced track. MGMA members have expressed significant interest in the Track 1+ model, and those already participating in it have reported positive feedback about experience.

Shared Savings Rate

Under CMS' proposal, ACOs would have two years in an upside only model, with a shared savings rate that is reduced from the current 50 percent to 25 percent under the proposed Basic track Levels A and B.

MGMA urges CMS to maintain a shared savings rate of at least 50 percent to ensure a viable business model. As MGMA and others have repeatedly indicated, participating in an ACO requires significant upfront investment and continuing financial expenditures for care management and operational changes. According to a report by the National Association of ACOs (NAACOS), ACOs spend nearly $2 million a year on average for MSSP participation, including investments made in health information technology, population health management, and administration. Slashing shared savings payments in half would not allow ACOs to recoup those investments and would deter future participation in the MSSP.

Risk Adjustment Methodology

CMS proposes modifications to its risk adjustment policies, including changes that would allow ACO's risk scores to change over time.

MGMA supports CMS' proposal to account for patient characteristics and changes in patient health status by allowing risk scores to change over time. The risk adjustment methodology used to in the MSSP to date has failed to account for patient characteristics and changes in those characteristics that can result in the need for more care or more expensive care, which unfairly penalizes ACOs that have sicker patients. Physician group practices that treat disadvantaged and vulnerable patient populations can be unfairly penalized by programs that do not have adequate adjustments for clinical complexity and socioeconomic factors.

Although the current proposal would allow ACOs' risk scores to change over time, the risk adjustment methodology still does not account for important factors in patients' health care needs, such as functional status and severity or stage of illness. We are also concerned that the proposed +/- 3 percent over the course of an agreement period is insufficient to account for changes year over year. Without proper risk adjustment, cost and quality metrics could be tainted by any number of confounding variables, which could lead to unfairly penalizing clinicians for treating high-risk patient populations. Accurate risk adjustment is necessary to

[2] Miller HD, "How to Fix the Medicare Shared Savings Program," Center for Healthcare Quality and Payment Reform, June 2018. Available at: http://www.chqpr.org/downloads/How_to_Fix_the_Medicare_Shared_Savings_Program.pdf

minimizes differences in health and other risk factors that impact performance but may be outside the ACO's control.

Benchmarking Methodology

CMS indicates it is continuing to refine its ACO benchmarking methodology and proposes a number of changes, including proposals that relate to incorporating a regional expenditure component into the rebased benchmark. In 2016, CMS sought to create long-term sustainability in the MSSP by introducing a regional benchmarking methodology for ACOs that enter a second or third contract.

MGMA supports incorporating a component of regional expenditure data into ACO benchmarks during the initial agreement period, as currently proposed, rather than waiting until at least the second agreement period. However, while we appreciate CMS' attempt to find an appropriate balance between a national and regional trend rate, there is need for continued improvement in this area. In particular, as MGMA and other have repeatedly pointed out, we take issue with CMS' policy to include an ACO's own attributed population in the regional benchmark. This has the effect of measuring an ACO against itself, thus making it harder for ACOs to realize savings and be comfortable enough to assume downside risk. Rather than comparing ACOs to themselves and other ACOs, CMS should compare ACO performance relative to the fee-for-service Medicare population, by defining the regional population as assignable beneficiaries without ACO-assigned beneficiaries for ACOs in the region. At the very least, CMS should exclude the ACO itself from the region to prevent a comparison that essentially double counts those ACO-assigned beneficiaries.

Quality Measures

CMS proposes to discontinue use of the quality measure 11 that assesses an ACO's level of adoption of CEHRT. Instead, CMS proposes that, ACOs in a track or a payment model within a track that does not meet the financial risk standard to be an Advanced APM, would attest to meeting required CEHRT levels.

MGMA strongly supports the proposal to remove ACO measure 11 and instead rely on attestation to evaluate the use of CEHRT. In announcing new initiatives related to "Meaningful Measures" and "Patients Over Paperwork," CMS acknowledged the challenges associated with administrative tasks and committed to "removing regulatory obstacles that get in the way of providers pending time with patients." CMS should utilize this same approach–mitigating the misdirection of resources and promoting value over volume–in its strategies for future payment reform.

Conclusion

We appreciate the opportunity to share our comments regarding the proposed changes to the MSSP. Should you have any questions, please contact Mollie Gelburd at mgelburd@mgma.org or 202-293-3450.

Sincerely,

/s/

Anders Gilberg, MGA
Senior Vice President, Government Affairs