February 6, 2015

Marilynn B. Tavenner, MHA, RN
Administrator
Center for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-1461-P Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations

Dear Administrator Tavenner:

Trinity Health respectfully submits the following comments and recommendations to the Centers for Medicare & Medicaid Services (CMS) in response to proposed policy and payment changes set forth in CMS-1461-P Medicare Program: Medicare Shared Savings Program: Accountable Care Organizations notice of proposed rulemaking (NPRM). Our recommendations reflect a strong interest in seeing the MSSP achieve the long-term sustainability necessary to reduce health care costs and improve quality in the Medicare program.

Trinity Health is one of the largest multi-institutional Catholic health care delivery systems in the nation. We serve people and communities in 21 states with 86 hospitals, 128 continuing care facilities, and home health and hospice programs that provide nearly 2.8 million visits annually. Trinity Health returns almost $900 million to its communities annually in the form of charity care and other community benefit programs, and employs about 89,000 people including 3,300 employed physicians. We have 28 teaching hospitals with Graduate Medical Education programs providing training for 1,720 residents and fellows in almost 200 programs.

Trinity Health is currently participating in 13 Shared Savings Plan (SSP) ACOs with an additional 8 ACO SSP programs under CMS review. Trinity Health is part of 5 commercial ACO programs. In addition, we have 65 patient-centered medical home programs across our ministry and are already pursuing bundled payment programs in 6 communities. We have filed applications for another 38 hospitals to participate in the Bundled Payments for Care Improvement (BPCI) program starting in April of this year. We are firmly committed to transforming our delivery system into a People-Centered Health System focused on delivering the triple aim in our communities. Our comments, then, reflect our best
suggestions for improvements to the ACO program that we believe will facilitate the transformation of American health care.

**Considering the Existing Industry Conditions**

Trinity Health urges CMS to consider the existing ACO marketplace dynamics as it evaluates opportunities to improve the MSSP regulations. The initial program approach has generated abundant interest and participation. CMS has made great efforts to be an effective payer partner and remarkable progress in providing information, data and claims to the participants. Participants have tried many new approaches to improving and coordinating care. Beneficiaries have no doubt experienced better care and we believe better outcomes. We have all learned a great deal as a result. However, as ACO participants, consultants and industry experts gain greater experience with ACO shared savings models in general, it has become increasingly clear that to be sustainable the financial opportunity must provide sufficient reward to support the investments needed to improve care along with a meaningful return. Unfortunately, many are coming to the conclusion that the Medicare SSP does not meet that test. As demonstrated in the recent report on SSP and Pioneer results, there is no well-established path to success. We are all still very much in a learning phase.

Many aspects of the original ACO Rule made it more difficult for the ACOs to obtain a positive return. The minimum savings rate, the beneficiary opt out process, delay in receiving claims, inability to communicate with beneficiaries, uncertainty of the benchmark, potential rebasing approaches that would remove shared savings from the benchmark thereby at decreasing shared savings opportunities in future years, and the inability to use more advanced approaches with SNF, home healthcare, and telemedicine, all limit ACOs’ ability to generate sufficient savings to provide a payback let alone a return on investments. All of these factors, as well as the newness of attempting to manage a population’s experience in the FFS open network and no referral environment, created significant uncertainty about ACOs ability to deliver sufficient savings to obtain a return on their investment.

The size of the investment required was further increased by the need for new activities to measure and improve 33 quality outcomes in the FFS population. Finally, CMS operated under a stated policy position to not identify a fixed population for practices so that ACOs would make an investment in improving care for their total population. We certainly agree that some investments in practice improvements can be made that will impact all patients without incurring additive cost based on the number of participants included. An example would be instituting a new open access appointment system. However, many new services that are needed to improve care coordination, such as hiring expensive nurse care managers, require investments that are driven by the number of patients to be managed. Given that there is an estimated 20 to 40 percent turnover in ACO attributed populations, CMS was in effect asking ACOs to invest in care for all Medicare patients touched by their practices, even though the potential shared savings would only be available for 60-80 percent of the managed population. This policy created additional uncertainty about the value of making significant investments in improving care.
As a result of these policy decisions, ACOs experience and improved understanding of the Program, it appears that many ACOs have chosen not to make sufficient investments in care coordination to make a difference. The common wisdom in the industry seems to be that it is unlikely for ACOs to generate a sustainable model and that therefore they are, at best, a way station on the road to either full risk or a Medicare Advantage license. This seems unfortunate given that there has not been an adequate test of the potential for an SSP ACO to become self-sustaining. If the program was structured to give more opportunity to explore alternative care approaches, and there was greater potential to share in more of the savings, providers might be willing to invest more in care coordination and therefore produce meaningful improvement. That would make the ACO sustainable.

Understandably CMS in the NPRM expresses a desire to move more providers to accepting risk. We appreciate the commonly accepted wisdom that providers operating under risk will have a stronger incentive to improve care and decrease costs. It would certainly be easier for CMS to have all ACOs move to Tracks with downside risk exposure. However, the reality of the provider marketplace is that as a result of the managed care experience of the 90’s, many providers, both hospitals and physicians, view downside risk as an absolute contraindication to being in the program. The strategy in the NPRM seems to be to penalize ACO’s into accepting risk. This is done by decreasing the savings percentage to 40 percent, and offering more favorable terms and waivers only available to Tracks 2 & 3. We disagree with this approach for many reasons; we are concerned therefore that this “push them into risk” strategy might have the opposite effect of pushing them out of the program.

CMS, many providers and payers are poised to move to a new system that will be focused on delivering the triple aim of better health, better care and lower costs. This would be a remarkable transformation of our health care system. This transition requires time for all parties. Providers are at very different places on the road to this new way of operating. While we understand that CMS would like to obtain as much savings as possible today, we note that the work of the Affordable Care Act (ACA) to date has resulted in lower trends than were anticipated in the ACA. Transforming our health care system permanently is a long-term strategy that should continue to improve outcomes and lower costs. We believe that the best long-term path for CMS and the country is to do everything possible to help every ACO be successful, regardless of the Track they select. Most of our comments therefore advocate positions that increase the attractiveness for providers and offer them a more promising savings opportunity.

Shared Savings is an excellent transition to a value-based payment model and could be a longer-term methodology that would work for some providers. Other changes to the underlying payment system such as full capitation, risk-adjusted capitation, bundled payments and prepayment are potential opportunities that would work for other providers. We encourage CMS to use the final ACO rule to begin a public discussion about where the overall vision for underlying payment system reform should go and to obtain input about timing and different approaches.
While there is much in the NPRM that suggests that CMS understands the need for this approach, there are several areas in the NPRM that we believe should be revised to implement this alternative strategy. Our suggestions are organized as follows:

- Shared Savings and Losses
- Beneficiary Assignment/Attribution
- Quality Performance Implications
- Benchmarks – Establishment, Updates & Rebasing
- Beneficiary Attestation
- Regulatory Flexibility
- MSR/MLR
- Required Process to Coordinate Care
- Expansion of Aggregate Data Reports and Limited Identifiable Data
- Definitions
- ACO Eligibility Requirements

Trinity Health applauds the recently announced HHS initiative to establish a timeline and specific goals for delivery system transformation. However, we have concerns that the strategic path implied by the NPRM to drive providers to risk is inconsistent with HHS’ goal of having 30 percent of provider payments in alternative models by 2016. Requiring providers to take risk or decreasing the savings opportunities available to those participating in one-sided Tracks will result in fewer participants and lower savings for CMS. The SSP ACO program is still in very early stages of implementation and all participants are just learning about many different aspects of the program and Shared Savings programs in general. We believe it would be very premature to attempt to push providers to accept risk given the many uncertainties inherent in the current state. We also believe that ultimately the best road to having providers operate under risk arrangements in the future is to help them succeed in the absence of risk until they gain confidence in their ability to be successful and in the viability of benchmark and trending methodologies. Furthermore, we believe there is real opportunity for different participants and policymakers to come together to jointly investigate open issues and attempt to develop a consensus solution to many of the outstanding program design issues. We would be happy to work with others to formulate a multi-segment two-day work session toward that end.

If you have any questions about our comments or would like to discuss our feedback in more detail, please feel free to contact me at 734.343.0824 or wellstk@trinity-health.org.

Sincerely,

Tonya K. Wells
Vice President, Public Policy & Federal Advocacy
Trinity Health
SHARED SAVINGS AND LOSSES

As of January 1, 2015, of the 405 ACOs participating in MSSP, less than 2 percent have chosen Track 2. About half of the ACOs participating in the program prior to January 1 are small, provider-based, or rural ACOs, each having less than 10,000 assigned beneficiaries. We share CMS’ concern that the current required transition from one to two-sided risk may be too steep for these organizations, resulting in a situation where the ACO must choose between taking on more risk than they can manage or dropping out of the program altogether. We concur with CMS’ concern that existing features of Track 2 may not be sufficiently attractive to ACOs contemplating entering a risk-based arrangement as well.

To maximize MSSP’s impact on quality and costs, CMS must balance its efforts to promote the assumption of greater risk among participating ACOs with additional policy to keep current ACOs in the program and attract new participants. This will ultimately generate the most savings in comparison to the status quo under traditional fee-for-service and is more likely to improve the quality of care.

Financial Barriers to ACO Development

One of the major barriers both to ACO participation, and gradual progression towards acceptance of increased risk, is access to the capital required to develop the necessary administrative, analytic and clinical infrastructure to be successful. In addition, ACOs incur ongoing costs for care management, consultation between different physicians, and other services that are not covered by Medicare FFS payments. They also forego FFS revenue when they successfully reduce hospital admissions and readmissions. It is clear that both start-up and maintenance costs for ACO development is substantial. CMS has already recognized, through establishment of the Advanced Payment Model, that access to this capital is particularly problematic within rural settings and for ACOs initiated through a collaboration of relatively small primary care/multi-specialty care practices. More recently, CMS released the ACO Investment Model to provide needed capital to allow new ACOs to form in rural and underserved areas and current MSSP ACOs to transition to arrangements with greater financial risk. We commend CMS’ efforts to date to address the financial barriers to ACO development. In the future, we recommend that CMS consider additional steps to remove barriers to needed capital and other financial resources. These could include providing monthly care management payments as is done in the Comprehensive Primary Care Initiative, partial capitation payments as authorized in the MSSP statute, and establishment of low-cost and/or federally guaranteed loan programs.

Agreement Period Considerations Entering 2016

We are concerned that some ACOs at the end of their first agreement period will not have sufficient time to understand the implications of the final program regulations prior to having to commit for the 2016 performance year. In particular, if ACOs are required to move to two-sided risk they will need to analyze the latest data, present options to their boards, make their final decision, prepare the appropriate renewal application, arrange for their line of credit, and alter their participation agreements among other needed changes. We believe this will be difficult given that comments are due February 6 with additional time needed for CMS to review comments, conduct data analyses, prepare and issue a
final regulation. In addition, with only one year of fully reconciled data, it will be challenging for the ACOs to make a truly informed decision as to whether they are ready to move to a two-sided risk Track and a reset benchmark.

At the same time, the current program rules – including and especially those related to shared savings and losses, waivers, and the benchmark resetting methodology – must evolve in the near future to improve the attractiveness of the MSSP and sustain and grow provider participation. Over 75 percent of early ACO participants did not generate savings in year one, leading to significant financial losses from start-up and ongoing operating costs associated with running an ACO. Moreover, as we discuss in the benchmark section of this letter, we believe resetting the ACOs by recalculating a purely historical benchmark is not prudent. Those ACOs who were successful would find their new targets reduced. Further, a pure historical rebase would do nothing to improve the chances of retaining those efficient and disadvantaged ACOs located in low spending regions. As a consequence, based on discussions with ACOs, we believe that many will forego participation in MSSP altogether and return to FFS payment. A return to FFS for these providers would not be in the interest of providers, Medicare and most importantly beneficiaries. If CMS is serious about moving 50 percent of its providers to alternative payment methods by 2018, we believe CMS will need multiple concurrent Tracks for the near term.

Therefore, we recommend that CMS allow ACOs the option to extend their current contract by two years, but with the addition of program improvements such as additional payment waivers. By making this decision based on only two years of data, more specifically the first two years of a brand new program, CMS may be inappropriately winnowing the program participants. Of note, most new businesses are not profitable for the first 3 to 5 years. ACOs are certainly new business models. We urge CMS to recognize this and provide more time and opportunity for ACOs to learn how to be successful. By extending the contract period, CMS would provide certain ACOs more time to determine their readiness for and which Track would be the best next move for them. Further, maintaining the option to move into newly defined risk Tracks at any annual recertification, as described below, and with new benchmarking methodologies, would allow those ACOs that are prepared to accept new contract terms and shift to greater risk the flexibility to do so. Moreover, a 5 year contract period would provide more long-term stability for ACOs and enable participating provider organizations greater opportunity to capture, in the same agreement period, the incremental costs savings generated through earlier investments in IT infrastructure and care process redesign. **CMS should give ACOs an option to extend their current contractual agreement period by 2 to 5 years under all models for this and all subsequent agreement periods. CMS should also allow ACOs to change their Track selection every year, assuming they are moving onto Tracks with greater accountability, for example, downside risk from one-sided models.**

**SUMMARY OF SHARED SAVINGS AND LOSSES RECOMMENDATIONS**

Trinity Health summarizes our comments across the three Tracks in the Table 1 below. It assumes CMS adopts our suggestion to lengthen the contract period to 5 years. We believe that for most ACOs, Track 1 will be considered the “on ramp,” but some ACOs, perhaps smaller ones may need to remain in that Track for multiple contracts. Track 2 introduces “gradual risk” along with enhanced rewards. While
Track 3 is for those able to take advanced risk and are likely ready to move to a regional benchmarking system that will recognize their efforts to keep their costs and growth low.

Table 1:

<table>
<thead>
<tr>
<th>Issue</th>
<th>Track 1 &quot;on ramp&quot;</th>
<th>Track 2 &quot;gradual risk&quot;</th>
<th>Track 3 &quot;advanced risk&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract length</td>
<td>5 year contract (2-year extension)</td>
<td>Same as Track 1</td>
<td>Same as Track 1 and 2</td>
</tr>
<tr>
<td>Risk model</td>
<td>One-sided upside only risk</td>
<td>Two-sided risk</td>
<td>Two-sided risk, with global payment option</td>
</tr>
<tr>
<td>Shared savings rate for ACO</td>
<td>50% minimum with an opportunity for 60% for ACOs in top quartile of quality performance</td>
<td>60% minimum with an opportunity for 70% for ACOs in top quartile of quality performance</td>
<td>75% minimum with an opportunity for 85% for ACOs in top quartile of quality performance</td>
</tr>
</tbody>
</table>
| Minimum Savings Rate (MSR)     | Variable 2.0 - 3.9%                                                               | ACOs are able to select their MSR:  
  1. No MSR  
  2. Fixed MSR of 2.0%, or  
  3. Variable 2.0 - to 3.9% | ACOs are able to select their MSR:  
  1. No MSR  
  2. Fixed MSR of 2.0%, or  
  3. Variable 2.0 - 3.9% |
| Minimum Loss Rate              | Not applicable                                                                   | Selection must be aligned with the ACOs selection of MSR option.                      | Selection must be aligned with the ACOs selection of MSR option.                     |
| Loss Cap                       | Not applicable                                                                   | 15%                                                                                   | 20%                                                                                  |
| Loss sharing limit             | Not applicable                                                                   | Limit on losses to be phased in over 5-years starting at 0% for PY1; 2% for PY2; 5% for PY3; 7.5% for PY4; and 10% for PY5 | Limit on losses to be phased in over 5-years if going straight from Track 1 to 2: 2% for PY1; 5% for PY2; 7.5% for PY3; 10% for PY4; and 15% for PY5. |
| Benchmark Update               | National/Regional blend option                                                   | National/Regional blend option                                                       | Regionally based                                                                    |
| Benchmark Reset                | Historical spending (33% weighting and all savings added back)                   | Historical (33% weighting and all savings added back) spending/Regional blend option   | Regionally based, prospectively set                                                  |
| Beneficiary Assignment methodology | Beneficiary attestation and choice of retrospective/prospective assignment       | Beneficiary attestation and choice of retrospective/prospective assignment             | Beneficiary attestation and prospective assignment                                   |
BENEFICIARY ASSIGNMENT/ATTRIBUTION

CMS proposes to implement a prospective assignment methodology for Track 3 ACOs that relies on the same stepwise assignment methodology used for Tracks 1 and 2. The major difference would be that beneficiaries would be assigned to Track 3 ACOs prospectively, at the start of the performance year, and there would be no retrospective reconciliation resulting in the addition of new beneficiaries at the end of the performance year.

Based on discussions with participating ACOs, we believe that prospective assignment can be valuable across all Tracks to stabilize the beneficiary population, which also aids in establishing stable benchmarks. As we note above, there are different reasons an ACO might prefer retrospective or prospective assignment that may not relate to level of risk. Moreover, ACOs would like an ability to get accustomed to prospective assignment under a one-side risk model before moving to a two-sided risk model. Adding the prospective assignment to other models may also give CMS more confidence in providing broader payment waivers as the population to which the waivers would apply would be easier to define. Thus, CMS should also offer prospective assignment in Tracks 1 and 2 in addition to retrospective assignment.

Further, we believe CMS should allow ACOs to move up Tracks at each annual recertification, but remain within its 5-year contract window. Under this arrangement, an ACO that feels comfortable assuming more risk based on its performance does not have to wait until a new contracting cycle to change Tracks. ACOs would be able to more quickly transition toward models with greater risk. Similarly, ACOs should be allowed to move from retrospective assignment to prospective assignment at each recertification.

Exclusion Criteria

CMS proposes to perform a limited reconciliation for prospectively assigned beneficiaries where beneficiaries would only be removed from the prospective assignment list at the end of the year if they were not eligible for assignment at that time. For example, if a prospectively assigned beneficiary chose to enroll in Medicare Advantage (MA) at the beginning of the performance year, that beneficiary would be removed from the beneficiary assignment list at the end of the year and the beneficiary’s expenditures would not be used in determining the ACO's financial performance for that year.

While we support CMS’ exclusion of beneficiaries who are later determined to be ineligible for assignment, we also suggest that CMS should consider a mechanism for removing beneficiaries who have moved out of the ACO service region.

Timing of Prospective Assignment

We support CMS’ plan to use slightly older claims data for prospective assignment in exchange for getting the assignment lists earlier in the performance period.
Interactions between Prospective and Retrospective Assignment Models

We agree that Track 3 prospectively assigned beneficiaries should remain as such unless later determined to ineligible or, as we suggested, moves mid-year.

However, we recommend CMS consider additional scenarios. Specifically, now that CMS is considering allowing beneficiary attestation, it is unclear if that was meant to occur during the year or only once in advance of the performance period. In addition, we have recommended that ACOs in Tracks 1 and 2 also be able to choose prospective assignment. We recommend the following order of precedence:

- Beneficiary choice through attestation at any time during the year;
- Prospective assignment regardless of which Track;
- Retrospective assignment in Tracks 1 and 2.

We believe this creates the most stable population for the ACOs, while first honoring beneficiary choice.

QUALITY PERFORMANCE IMPLICATIONS

Many efforts to improve the quality of care will consume ACO resources and increase spending relative to the ACO’s financial benchmark in the short term, even if they decrease Medicare spending over the long term. Right now, good quality performance is not rewarded, and thus there is a lacking incentive for ACOs to invest in quality improvement.

CMS should establish a methodology that allows achievement of success, and payment of earned savings on either an absolute achievement or improvement basis. Providing many pathways to achieve the quality targets would be consistent with the overall intent of CMS to create a program that involves as many organizations as possible, allows as many to be successful as possible and encourages ongoing investments by making it easier in early years to earn sufficient funds for reinvestment in care improvement.

Trinity Health believes that CMS should recognize high-quality providers under not only Track 1, but also Track 2 and the proposed Track 3. Within the MA program, plans are rewarded with higher benchmarks for higher quality, while under MSSP Track 1, a perfect quality score can only enable you to keep up to half of the savings you earned. This leads to an asymmetry between MA plans and ACOs that would remain even if CMS brings the benchmark methodologies closer together. We believe high quality attainment or significant quality improvement over your base should be rewarded financially. To emphasize and reward top quartile quality performance or improvement, CMS should provide on a sliding scale up to 10 percentage points of additional shared savings for a total of 60 percent. Trinity Health also recommends an additional 10 percentage points be shared under Track 2 and proposed Track 3.
Consistent with our earlier argument about the need to provide opportunities for all ACO’s to be successful, we believe that SSP should not be ratcheted down based on quality scores. This is particularly true given the marked uncertainty about comparing quality measures in the FFS population. We believe CMS should monitor other aspects of ACO quality and at this time not decrease savings opportunities based on quality performance. As was the case with MA, we believe ACOs should have the benefit of learning how to be successful in improving quality before payment penalties are introduced.

In addition to increasing the share of savings provided to top performers as discussed in the sharing/loss rate sections, good performance on quality standards or improvement in quality scores from one performance year to the next should allow ACOs that have achieved savings to more readily be able to meet their MSR and get some of those savings back. **We recommend, therefore, that ACOs in any of the Tracks that are above the 30th percentile in their quality performance, which is the minimum achievement standard set by CMS, and also those ACOs that show above average rates of improvement in their quality performance from one year to the next, should have their MSR reduced.**

The purpose of the MSR is to prevent ACOs from earning savings that might be due to random variation in spending on their patient population. ACOs that are making large investments in improving performance on quality measures, and succeeding, may be less able to exceed their MSR not due to random fluctuations in spending, but precisely because they are investing more in high-quality performance. An MSR reduction is a logical and positive way of acknowledging the importance of these investments. It will allow ACOs that are delivering better quality care to have a better chance of getting at least a small amount of savings, which will help them to recoup their investments in improving quality.

**BENCHMARKS – ESTABLISHMENT, UPDATES & REBASING**

CMS proposes no specific changes to its financial benchmarking methodology in the proposed rule but does discuss five alternatives to present policy in establishing, updating and resetting an ACO’s financial benchmark. CMS seeks comments on these five as well as any "suggestions regarding alternative approaches." It is widely recognized throughout the Medicare provider community that MSSP financial benchmarking needs to be substantially improved. Predictability, accuracy and stability over time are the major goals for improvement. Benchmarking is the most critical component to the success of the MSSP going forward.

There are several well-recognized problems with the current way CMS establishes, updates and resets an ACO's financial benchmark. Resetting the benchmark based on ACO-specific historical spending penalizes certain ACOs for past good performance and forces the ACOs to chase diminishing returns in subsequent contract periods. This also reduces the incentive for ACOs to invest in efforts that will reduce future spending. Here, achievement or success is punished because the reset benchmark is lower based on the lower spending reflected in the prior contract performance period. With benchmark years weighted at 10-30-60, ACOs that have significant success in their third year of performance will
find their new benchmark disproportionately reduced because of that success. Furthermore, calculating the trend for the 3 years of historical benchmark and the annual benchmark update uses a national growth rate that disadvantages ACOs in many regions. There is significant variation in year to year cost trends by market that are not accounted for by using a single national dollar amount.

For these reasons and others, Trinity Health recommends the following. Per CMS’ first option, we support changing the weighting from 10-30-60 to 33-33-33 in second and subsequent contract terms. We recognize that evenly weighting the benchmark years is not advantageous to all ACOs and may actually disadvantage ACOs that are struggling to achieve savings. But conversely, disproportionately punishing an ACO for their success is poor national policy. We agree with CMS’ second option that earned shared savings be added to future benchmark calculations. However, we would go further and argue all savings, not just the ACO’s portion, be added to subsequent contract benchmarks. Adding only the ACOs portion of shared savings is as arbitrary as allowing ACOs only half the savings they achieved. It establishes an approach under which CMS takes more and more of the savings, eliminating the shared savings necessary to fund investments in the program and a fair return on investment for the participants. CMS will still benefit by the 50 percent of savings each year as well as the likely lower national trend.

With respect to trending adjustments, CMS suggests several alternatives to the single national dollar amount. They discuss the PGP comparison group as well as using county, HRR and State trends as the basis for updating. We support a change to the benchmark trending that moves away from a single national amount toward a regional amount reflective of the actual market in which the ACO operates. We also recommend that CMS give each ACO the option to choose for their contract term whether they want to be trended with national or regional adjustment. This allows an ACO to assess whether their system of care is more reflective of the local market behavior or the national market.

As proposed, it will be important to calculate the trend excluding the ACO to avoid creating another methodology that requires an ACO – particularly an efficient ACO – to beat its own best performance. Expanding the geographic area to get a larger reference trend when the ACO is dominant is feasible, as long as that expanded area includes some of the ACOs patients and has the same historical trend profile as the original region. We do not have sufficient data to model whether the HRR, PGP county comparison group, or pure weighted-county or State is the appropriate definition of region and request CMS to work with us in analyzing the appropriateness of each in further rulemaking before adopting these changes.

The remainder of CMS’ NPRM discussion concerns using regional costs to the resetting and/or setting of the benchmark. Per CMS’ discussion this can be done by replicating the PGP methodology using a reference population, by establishing a benchmark under current rules but updating and resetting the benchmark using regional costs, or by resetting the benchmark in subsequent contract periods using a weighted average (that would use either the established benchmark formula or some alternative approach) and risk-adjusted regional costs.
While the historical benchmark captures unobserved clinical risk in the ACO base-year population, the unstable assignment within a contract period causes the constant influx of new ACO members that are assigned from the community and may not be reflective of the historical risk. A study of 34 ACOs currently participating in MSSP showed between a 10 to 40 percent change in the ACO preliminary prospective roster from the start of performance year 1 through Q4 of the performance year. The new ACO assignees result in the ACO’s population becoming less reflective of its historical population and more reflective of its regional or community population. Important to note, this annual population change will occur under both retrospective and the newly proposed prospective assignment methodologies, in which CMS will provide the Track 3 ACO with a new PPR (based on a retrospective look back) each new performance year.

As stated above, we support moving toward regional costs in updating the benchmark. Due to the inherent instability of ACO assigned beneficiary populations during the contract period, we support in concept using regional costs in the setting and resetting the benchmark. One potential approach that accounts for the influx of new beneficiaries is blending the historical and community rates based on the level of roster turnover during the contract period. Since it is unclear at this time what is the best measure of regional (i.e., community) costs or the best method to factor into the benchmark, we recommend any changes in this area be limited to the two-sided risk ACOs in Track 2 and 3 ACOs that have experience in the program. For those Tracks, we recommend CMS consider a similar policy of flexibility as applied to trending and allow ACOs the option to choose, for their contract period, a historical-based or regionally blended benchmark. We further recommend CMS in the future provide more data-supported specific approaches that factor in regional costs upon which the ACO provider community can evaluate and comment more informatively.

Lastly, we urge CMS to explore new policy options to address the inherent disadvantage facing ACOs participating in low-spending regions. A recent analysis using Dartmouth hospital referral regions (HRRs) shows that ACOs in low spending regions face a disadvantage due to the historical benchmark calculation methodology. The ACOs in low spending regions produced significantly less shared savings than ACOs in high spending regions in performance year one. Unfortunately, the current MSSP policy does not provide adequate incentives for continued participation by these ACOs, and further, resetting the benchmark by blending the ACO historical and, in this case, low regional rates may not lift these ACO benchmark significantly to sustain their participation in the program. As CMS stated in the proposed rule, the MSSP is best served by increasing the total number of ACO participants and moving participants into two-sided models. We urge CMS to consider implementing new policies to address the disadvantages currently faced by low benchmark ACOs in low spending regions. One approach would be to establish a longer-term plan to move towards a blend of national and regional benchmarks.

**BENEFICIARY ATTESTATION**

We urge CMS to offer a beneficiary attestation process for all MSSP ACOs, regardless of Track. This process would allow beneficiaries to attest that they consider a particular provider responsible for coordinating their overall care. An attesting beneficiary would be attributed to the ACO with whom that
provider is affiliated. Although CMS would retain its current stepwise attribution process (with modifications as discussed elsewhere in this letter), beneficiary attestation would take precedence over that process when considering to which ACO a beneficiary should be attributed. Further, the beneficiary would remain attributed to that ACO until the beneficiary enrolled in MA, moved out of the ACO’s service area, or attested to a provider affiliated with another ACO.

Providing beneficiaries with the opportunity to voluntarily align with an ACO would balance the important considerations of beneficiaries’ freedom to choose their providers with ACOs’ interest in reducing churn, which would help provide a more defined and stable beneficiary population up front. This, in turn, would allow ACOs to better target their efforts to manage and coordinate care for beneficiaries for whose care they will ultimately be held accountable. In addition, allowing beneficiaries to attest to the provider they want to manage their care may help increase beneficiary engagement in that care.

REGULATORY FLEXIBILITY

As recognized in the NPRM, there are many regulatory policies in place that make sense in a FFS marketplace but limit the ability of ACOs to coordinate and improve care in the MSSP context. The waivers discussed in the proposed notice are all potential tools for an ACO to improve care coordination and reduce costs, and thus generate savings. Consistent with our earlier comments, CMS should give every ACO the maximum opportunity to be successful in the Program. We recognize, however, that CMS may have concerns about potential abuse of waivers by ACO providers still operating in a FFS environment. We suggest that CMS consider whether waiver review protocols, consumer protections, and quality criteria could be built into the waiver application process in such a way that could allow for extension of these waivers to ACOs in both one-sided and two-sided risk Tracks.

CMS asked whether the waivers should be limited to only ACOs in their second contract and whether the waivers should be limited to those beneficiaries who are preliminarily or prospectively assigned to the ACO. Subject to the additional suggestions noted in this section, we see no reason to limit the waivers to ACOs only in their second contract. Furthermore, we support making all waivers available, on a consistent basis, to all beneficiaries for whom an ACO can request data. In addition, we recommend that ACOs be able to educate beneficiaries about the waivers.

SNF 3-Day Rule

Avoiding unnecessary hospitalizations is one of the primary goals of coordinated care and therefore of an ACO. As Medicare beneficiaries are financially barred from using the SNF without a hospitalization, ACOs are unable to prevent an unnecessary hospitalization in the event that the necessary care could be provided in a SNF. We see limited likelihood for abuse of this waiver by most ACOs, with the exception of SNF-based ACOs or a health system with SNFs. CMS should simply monitor at-risk entities for evidence of excessive utilization and waive the 3-day rule for all ACOs. Thus, we support the waiver of the SNF 3-day stay rule.
Tele-Health

When setting a national policy, it is necessary to use national definitions of an originating site. However, granting the waiver and allowing the ACO to use their much more extensive knowledge of local resources aligns the service to the needs of the area. Furthermore, tele-health, with originating site requirements, can also generate savings because it allows for greater access to physicians. To date there has been limited adoption of tele-health services because of limited reimbursement opportunities. The MSSP program presents an opportunity for CMS to learn more about the potential value of tele-health, such as substituting these services for more difficult to obtain specialty visits. To protect against any abuses, CMS should monitor for ACOs that are outliers for these services and do not achieve savings. Thus, we support the waiver of the originating site policy under the tele-health benefit.

Homebound Requirement for Home Health Services

Home health services can be critical to chronic care management and support the waiver of the current homebound requirement. We recommend, however, a change to which beneficiaries are eligible. Those who would most benefit from the services are those beneficiaries who need the full range of services, but do not quite meet the definition of homebound.

Referrals to Post-Acute Care Providers

The ability to develop a care coordination relationship with post-acute care providers is very valuable. However, that relationship only has real value when the patients use those providers. ACOs – regardless of Track – should be able to not only provide information on the quality of care provided by post-acute care providers, but also recommend facilities with which the ACO has an established relationship. This should not stand in the way of beneficiaries choosing another facility if they prefer.

Reducing Barriers to Wellness and Care Coordination

While not proposed by CMS, we ask CMS to consider giving ACOs the ability to offer certain financial incentives that reduce barriers to care and facilitate care coordination. (The private sector offers examples of successfully implementing such incentives.) As well documented in benefit design, people respond to even small increases and decreases in cost-sharing under their health coverage. CMS should consider how ACOs should be able to leverage this effect to provide better care coordination. An example of such services is the new Chronic Care Management code which requires ~$8 a month in co-insurance. This co-insurance may serve as a barrier to accessing care and prevent beneficiaries from using a service that would improve health outcomes and generate savings opportunities. Thus it would make financial sense for ACO participants to waive the co-insurance. Similarly with respect to encouraging beneficiaries to stay within the ACO when seeking care, an ACO may find it beneficial to waive co-insurance for primary care providers. We encourage CMS to carefully consider the possibility of this type of flexibility. We also ask that CMS articulate its reasoning for not granting such waivers, particularly as to whether the barrier to the waiver is a policy position of CMS or a legal barrier.
Securing OIG Feedback on Waivers

Nothing discourages the taking of risk more than uncertainty in policy. In terms of the willingness to take risk, the clarity of the language of the waivers only matters if it successfully reduces the anxiety of providers to utilize the waivers. The power of the waivers is proportional to the providers’ willingness to use them, and that willingness is based on the perception of the clarity of the language not the clarity as determined by long legal review. Providers will be more likely, ultimately, to accept downside risk if they understand clearly what is permitted under the waivers. To improve that clarity, we encourage CMS to work with OIG on a feedback process for ACOs that is simpler and timelier than the current OIG opinion process.

MSR/MLR

Similar to the attribution challenge, it is not really possible to determine the “best” MSR/MLR for all ACOs. As CMS points out, the 2 percent rate was somewhat arbitrary. The scaling by number of beneficiaries in the ACO only accounts for one factor in a multi-factor situation. The MSR/MLR that is appropriate for a given ACO is mostly a function of the ACO’s ability to handle risk, its number of beneficiaries and its local market. While the number of beneficiaries in the ACO is a known quantity to both sides, the local market and ACO’s ability to handle risk are less certain. In other comments, (see section on Benchmarking) we support an option of moving to a regional benchmark, which makes the local market more of a known quantity.

This approach just leaves the ACO’s willingness to absorb financial risk. This is a judgment by the ACO, for which CMS would not be able to make an educated guess. An MSR/MLR of 0 may be seen as heightened risk to some ACOs, but others will view it as more likely to result in shared savings. As discussed under Track 2, there is no evidence that moving the MSR/MLR slightly in one direction or the other will make a dramatic difference. This means the choice of the individual ACO remains one of the most critical factors in the appropriateness of the MSR/MLR. Rather than attempt a guess, CMS should allow an ACO to select from a few MSR/MLR options in the range of 0 to the size based MSR/MLR available if they were under Track 1. The preservation of the symmetry in the MSR/MLR creates protection for CMS.

REQUIRED PROCESS TO COORDINATE CARE

Health Information Technology

We share CMS’ belief that all patients, their families and their health care providers should have consistent and timely access to their health information in a meaningful format that can be securely exchanged. CMS noted in the rule that HHS is committed to accelerating health information exchange through a number of initiatives including: 1) incentives and penalties for HIT and HIT adoption; 2) use of common standards and certification requirements for interoperable HIT; 3) support for privacy and
security for patient information exchanged via health information exchange; and 4) the governance of health information networks.

Health information exchange is critical to the success of ACOs as it will facilitate the data exchange needed to coordinate care and help facilitate higher quality of care. We are concerned, however, that the current data exchange environment largely facilitates the movement of data but lacks the necessary robustness to meet the needs of physicians and clinical staff. Although there has been an increase in the exchange of patient information, the act of two computers sending and receiving data does not constitute functional interoperability—the ability for information to be exchanged, incorporated, and presented to a physician or other health care provider in a contextual and meaningful manner. It is the exchange, consumption, and use of medical information that is at the heart of interoperability. We applaud the Office of the National Coordinator’s (ONC) renewed effort and attention on improving interoperability and its focus on incorporation of enabling data access via open software codes allowing secure applications to facilitate interoperability in cost effective manner; however, charting a multi-year course as outlined in their Interoperability Roadmap does not immediately address concerns medical professionals and health care organizations have with the moderate level of exchange currently taking place today due to vendor lock on EHR systems hindering interoperability, usability and effective work flow.

Providers have expressed a growing frustration with the way their EHRs perform including the lack of functional interoperability. ONC identified the Consolidated Clinical Document Architecture (C-CDA) as the technology to be used for meeting all interoperability requirements in Meaningful Use (MU). Ensuring pertinent electronic health information follows patients during transitions of care (a Stage 2 MU requirement) is one of the most sought after, yet the least successful exchange paradigms in health care today. MU Stage 2, as a core requirement, establishes a process by which EHR technology must certify it can receive, display, and incorporate transition of care/referral summaries. As stated in the ONC certification test for transitions of care, "Both ambulatory EHR technology and inpatient EHR technology presented for certification should be able to receive, display, and incorporate both ambulatory and inpatient summary care records (transition of care/referral summary)." Yet, EHR vendors who follow the C-CDA implementation guidance are left with optionality on the methods they use to create C-CDA documents. This variability in C-CDA construction causes a mismatch between the sending and receiving in EHRs and limits the usefulness of information that is actually viewed by the physician and other medical professionals at the point of care. This is outside the control of practicing physicians and other ACO participants.

We are concerned with assertions being made by some that providers are to blame for the lack of interoperability and are responsible for data lock in. This is inconsistent with our experiences. In fact, it appears as though there are financial and technical barriers that are being erected by others that impede data exchange such as vendors mandating physicians use their Health Information Service Provider (HISP), charging several fees to providers to move information through their HISP, and refusing to enable features that facilitate data exchange.
CMS proposes to require an ACO to describe in its application how it will encourage and promote the use of enabling technologies for improving care coordination for beneficiaries, including EHR and other HIT tools (such as population health management and data aggregation and analytic tools), telehealth services (including remote patient monitoring), health information exchange services, or other electronic tools to engage patients in their care. CMS also proposes to require that an ACO define and submit major milestones or performance targets it will use in each performance year to assess the progress of its ACO participants in implementing electronic quality reporting, connections to HIE services, or elements of their care coordination approach.

Trinity Health strongly opposes these new requirements. ACOs need the flexibility to redesign care in ways that will promote the best care for their patients while achieving quality and shared savings targets. CMS efforts to micromanage the way ACOs utilize information technology are more likely to hinder these efforts than support them. Comments have previously been submitted recommending that quality measure #11, which measures ACOs on the proportion of their participating primary care physicians who have met MU, should be dropped. Instead of imposing mandates, ACOs should be given the flexibility to work with their participating physicians and other health professionals on how best to deploy technology in a manner that drives efficiency and quality improvement.

EXPANSION OF AGGREGATE DATA REPORTS AND LIMITED IDENTIFIABLE DATA

Claims Data-Sharing and Beneficiary Opt-Out

CMS proposes to streamline the process for MSSP participants to access the beneficiary claims data that is necessary for health care operations. MSSP participants would provide written notification at the point of care to their patients through signs posted in the facility that would include template language regarding the sharing of their data. Patients would then call CMS directly at 1-800-MEDICARE rather than going through their health care provider to decline the sharing of their claims data. The signs would likewise include instructions on how beneficiaries can reverse their opt-out decision through the 800 number. Moreover, the ACOs would no longer have to send mass mailings to beneficiaries with opt-out notices. We support this more streamlined approach that will effectively provide greater access to beneficiary data with less confusion by beneficiaries and administrative burden on ACOs. However, if a beneficiary opts-out of data sharing, an ACO will be unable to effectively coordinate the care. Under these circumstances, we do not believe it is fair to then hold the ACO financially accountable for these beneficiaries. Beneficiaries who opt out of sharing their data should be removed from the financial reconciliation process.

Expansion of Beneficiary Identifiable Data Provided

CMS has proposed expanding the number of beneficiaries for whom data is made available to include those that had a primary care visit with an ACO provider during the assignment period, even if they were not preliminarily assigned to the ACO; however, only to Tracks 1 and 2. We recommend that the expanded availability of beneficiary data is also made available for the proposed Track 3
model, since this supports efforts by Track 3 ACOs to encourage high-risk beneficiaries to become more engaged with ACO providers.

Further, we appreciate CMS’s proposal to include health status and utilization rates in aggregate data reports as it will make the data more meaningful and actionable. To further enhance this meaningfulness, we offer our recommendations for additional beneficiary identifiable data elements to include in the quarterly reports:

- Date of the beneficiary’s original Medicare eligibility,
- Date of change in the beneficiary’s eligibility status,
- An indicator identifying the change of an individual beneficiary’s Health Insurance Claim Number (HICN), with the date of the change,
- Hierarchal Condition Category (HCC) score for each beneficiary (we note that providing the information with the quarterly assignment report would eliminate the need to produce Table 2-6, “Count of Beneficiaries” by HCC),
- Opt-out information to the beneficiary attribution file to create a check-and-balance process which will ensure members are not lost in the data reporting process (this may be more important if CMS assumes the role of data opt-out via 800-Medicare),
- For each beneficiary included on each attribution report an indicator of a beneficiary’s institutional/hospice status which will help ACOs identify domiciled patients for which the ACO is unaware,
- Expand the information subsections for outpatient Part A services and physician services on the quarterly reports to help ACOs manage costs, access, quality, and care coordination if physician services were divided into primary care physicians and non-primary care physicians,
- Provide aggregated data on substance abuse claims expenditures.

The ACO’s success is dependent on the timely transfer of patient information and coordination of patient care. Since Medicare patients have the right to seek care from any provider who accepts Medicare, it can be a challenge for ACOs to monitor the services received by their aligned patients. While CMS provides each ACO with a retrospective administrative claims dataset for analysis of health care services to their ACO population, the data represent services that have already been provided by an ACO or non-ACO. These data sets are valuable for evaluating sub-populations of patients with chronic conditions, multiple chronic conditions, and their utilization rates, but they do not provide the ACO with a point-of-care opportunity to provide the right care at the right time while avoiding unnecessary services and optimizing the opportunities for quality improvement.

With respect to applicable laws governing patient privacy and the disclosure of PHI, and since CMS currently receives all eligibility checks from hospitals, emergency departments, and post-acute providers, and maintains a real-time file of these eligibility checks, CMS could make this data available to ACOs. Doing so would offer ACOs a point-of-service notification system that would allow them to know when a beneficiary’s eligibility is being checked by a provider and a near real-time opportunity to intervene appropriately to coordinate their care, redirect the patient to an appropriate setting, or engage
with health care providers who may not be participating with the ACO. **We believe that daily edits data feeds could be leveraged to improve care processes within an ACO and CMS should either provide these data directly to the ACOs or make the files available to security approved organizations for dissemination to ACOs.**

Substance Use Data

CMS does not currently provide data related to substance use diagnoses and services in the monthly Claims and Claims Line Feed (CCLF) files. While we understand the sensitivity of such services and CMS’ exclusion of them in the files, we think there are options that would provide ACOs with more information, but not risk beneficiary privacy by suppressing identifiable elements. **We therefore urge CMS to provide the de-identified cost and claim data for these services. If this is not possible, at minimum, CMS should provide the aggregate payment amount of these services in the monthly CCLF files.**

**DEFINITIONS**

CMS proposes some additions to MSSP-related definitions and a few revisions to existing definitions. First, CMS proposes to add a definition of “participation agreement,” defined to mean the written agreement required under §425.208(a) between the accountable care organization (ACO) and CMS that, along with the regulations at part 425, governs the ACO’s participation in the MSSP. Second, CMS proposes to add the related definition of “ACO participant agreement,” defined to mean the written agreement between an ACO and an ACO participant required at §425.116 in which the ACO participant agrees to participate in, and comply with, the requirements of the MSSP. **We support CMS’ efforts to further define MSSP terms to create greater clarity including that of “participation agreement” and “ACO participant agreement.”**

CMS further proposes to modify the current definition of “assignment” to reflect that CMS’ beneficiary assignment methodology takes into account claims for primary care services furnished by ACO professionals, not solely claims for primary care services furnished by physicians in the ACO. However, CMS emphasizes that the law requires a beneficiary to have at least one primary care service furnished by a physician in the ACO in order to be eligible for assignment to the ACO. What is not clear in the rule is if the services of mid-level clinicians will only be included from the TINs that have a qualifying primary care service provided by a physician, or if that simply puts a beneficiary in the assignment-eligible pool. The latter would allow assignment to run off of services provided by mid-levels without any physician visits in their TIN because another TIN in the ACO satisfied the requirement of primary care visit by a physician. This would be particularly helpful for ACOs that operate in or near rural areas. **We support the use of ACO Professionals to conduct assignment. We further support the use of primary care services provided by ACO professionals, including mid-level clinicians, in the assignment process.**

CMS also proposes to revise the definition of “hospital” for MSSP purposes to mean a hospital as defined in section 1886(d)(1)(B), which would include Maryland acute care hospitals, even though they are not paid under the Medicare hospital inpatient prospective payment system. A number of our
members in Maryland are working diligently on population health accountability, and agree that they should have the opportunity to be treated as the rest of the nation’s hospitals. We support the inclusion of Maryland hospitals under the MSSP definition of hospitals.

ACO ELIGIBILITY REQUIREMENTS

ACO Participants and ACO Providers/Suppliers

CMS notes that it must have a transparent process that results in the accurate identification of all ACO participants and ACO providers/suppliers. CMS, therefore, proposes to add a new §425.118 to reflect with more specificity the requirements for submitting ACO participant and ACO provider/supplier lists and reporting changes to such lists. Specifically, CMS proposes that prior to the start of an agreement period and before each performance year thereafter, an ACO must provide CMS with a complete and certified list of its ACO participants and their Medicare-enrolled TINs. CMS notes that it would provide the ACO with a list of all ACO providers/suppliers (NPIs) that it has identified as billing through each ACO participant’s Medicare-enrolled TIN, and the ACO would be required to review the list, make any necessary corrections, and certify the lists of all of its ACO participants and ACO providers/suppliers (including their TINs and NPIs) as true, accurate and complete. We appreciate CMS providing a list of NPIs under each TIN to assist with the annual submission of the providers/suppliers list.

CMS proposes that an ACO must submit certified ACO participant and ACO provider/supplier lists at any time upon CMS request. CMS should provide a reasonable timeframe, for example 10 business days, in which to comply with a request for a current list during the agreement period.

In §425.118(d), CMS further proposes to require an ACO to report changes in ACO participant and ACO provider/supplier enrollment status in PECOS within 30 days after such changes have occurred. It is reasonable for CMS to require ACOs to ensure that PECOS accurately reflects its providers/suppliers within 30 days of changes occurring.

Although CMS currently requires an ACO to indicate which of its ACO providers/suppliers are primary care physicians (as defined in §425.20), CMS says this information can be derived from submitted claims and thus proposes to remove the current requirement, which appears in §425.204(c)(5)(i)(A). We support the removal of this requirement and the automation of this process using claims data.

CMS says it is considering whether to delay the effective date of any additions to the ACO provider/supplier list until after it has completed a program integrity screening (by, for example, delaying the effective date until the start of the next performance year). It is a rare occurrence that a program integrity screen would identify any problems. We do not believe this process should hold up the inclusion of the vast majority of providers/suppliers. As soon as CMS conducts the screening and determines an issue, the ACO could be notified and immediate action taken. We support the immediate inclusion of provider/suppliers.
CMS also proposes that to remove an ACO provider/supplier from the ACO provider/supplier list, an ACO must notify CMS no later than 30 days after the individual or entity ceases to be a Medicare-enrolled provider or supplier that bills under a billing number assigned to the TIN of an ACO participant. Such removal would be effective as of the date the individual or entity terminates its affiliation with the ACO participant. *The application of a consistent 30-day window to notify CMS including terminations is reasonable.*

**Significant Changes to an ACO**

CMS proposes that a significant change occurs when the ACO is no longer able to meet the eligibility or other requirements of the MSSP, or when the number of ACO participants included on the ACO participant list changes by 50 percent or more during an agreement period. Upon notice that an ACO has experienced a significant change, CMS would evaluate the ACO’s ability to continue to participate in the MSSP. CMS emphasizes that an ACO’s failure to notify CMS of a significant change must not preclude CMS from determining that the ACO has experienced one (this is addressed in a proposed modification to §425.114). We are not clear what the universe of changes CMS expects would trigger the notification requirement proposed. Moreover, we are not sure what CMS would do with advanced notice. *CMS should provide additional guidance on what it considers a significant change. Given that TINs can be added and subtracted regularly due to market dynamics, CMS should not confuse this with the ACO not meeting its eligibility or other requirements. CMS should not require ACO’s to provide prior notice of a significant change.*

**Merged/Acquired Medicare-Enrolled Entities**

Applicants and established ACOs have asked CMS whether there is a way to take into account the claims billed by the Medicare-enrolled TINs of practices acquired by sale or merger for purposes of meeting the minimum assigned beneficiary threshold and creating a more accurate benchmark and preliminary prospective list of assigned beneficiaries for the upcoming performance year. CMS proposes §425.204(g) to add the option for ACOs to request consideration of claims submitted by the Medicare-enrolled TINs of acquired entities as part of their application, and ACOs would be permitted to annually request consideration of claims submitted by the TINs of entities acquired through sale or merger upon submission of the ACO’s updated list of ACO participants. *We support the codification of the ability of ACOs to use wholly acquired or merged TINs in their historical benchmark, minimum beneficiary test and assignment lists.*

**Legal Structure and Governance**

CMS further proposes to revise §425.106(c)(5) to remove the flexibility for ACOs to deviate from the requirement that at least 75 percent control of an ACO’s governing body must be held by ACO participants. CMS notes that experience has shown that MSSP applicants do not have difficulty meeting the requirement. On the other hand, CMS continues to believe that ACOs must have the flexibility to request innovative ways to provide meaningful representation of Medicare beneficiaries on ACO governing bodies (other than by having at least 1 beneficiary serve on the governing body).
However, CMS proposes to revise §425.106(c)(2) to explicitly prohibit an ACO provider/supplier from being the beneficiary representative on the governing body. Just because ACOs thus far have not needed flexibility in terms of the board make up, does not mean it will not be beneficial to applicants in the future. Certainly if it is not commonly used, it will not be a burden on CMS to maintain the option. We do not support the removal of the option to deviate from the 75 percent control requirement, but support the clarification that the beneficiary representative cannot be a provider/supplier.

Leadership and Management Structure

CMS proposes to remove the requirement that the medical director be an ACO provider/supplier. Indeed an ACO’s medical director could have previously been closely associated with an ACO participant, but no longer bills services through an ACO participant. A full-time ACO medical director may not have time to also serve as a provider/supplier. It is not necessary for the ACO medical director to have been closely associated with the ACO or an ACO participant in the recent past. Nothing should preclude the ACO from conducting even a national search for a qualified applicant who could be successful within their ACO. CMS should not dictate what past experience is required. Thus, we support the removal of the medical director provider/supplier requirement and urge CMS not to implement an additional approval process.

CMS further proposes to eliminate §425.108(e), which permits CMS approval of applications from innovative ACOs that do not satisfy the leadership and management requirements related to operations management and clinical management and oversight set forth at §425.108(b) and (c). In doing so, CMS notes that MSSP applicants generally have not had difficulty meeting these requirements. Again, just because ACOs thus far have not needed flexibility in terms of the board make up, does not mean it will not be beneficial to applicants in the future. Certainly if it is not commonly used, it will not be a burden on CMS to maintain the option. CMS should maintain flexibility around the operations management and clinical management and oversight requirements.

CMS also proposes to modify §425.204(c)(1)(iii) to require an MSSP applicant to submit documentation regarding the qualified healthcare professional responsible for the ACO’s quality assurance and improvement program. Personnel decisions should be at the sole discretion of the ACO. CMS should not require the documentation of the qualifications of the ACO’s qualified healthcare professional.

CONCLUSION

On behalf of Trinity Health, we thank you for the opportunity to comment on the MSSP NPRM. We are hopeful that our constructive comments on improvements to the program are helpful and welcome any questions you may have.