



October 15, 2018

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: Administrator Seema Verma
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Comments on the Medicare Shared Savings Accountable Care Organization program

Dear Administrator Verma:

The Healthcare Quality Coalition (HQC) welcomes the opportunity to offer comments on the implementation of the Medicare Shared Savings Program within the Accountable Care Organization framework.

The HQC is comprised of hospitals, physicians, health systems and associations committed to value-based healthcare. Organized in 2009, the HQC supports efforts to create a sustainable Medicare system through incentivizing high-value care. We believe value-based payment policies can drive better quality, lower cost of care, and reduce overall costs for the Medicare program. The HQC strongly supports continued implementation of payment systems that reward value over volume, and we are pleased to provide comments on CMS' proposed rule on the MSSP-ACO programs, which offers substantial policy changes for the upcoming year.

Participation Tracks to Performance-based Risk

- **Overall, the HQC supports the newly re-structured MSSP program tracks.**
- **We are concerned regarding the proposed shortening of the upside-only ACO models. It is important to move quality-based care forward while recognizing different providers have different starting points in the ACO program.**

The proposed rule makes a number of modifications to the MSSP infrastructure. CMS proposes to create a path to risk in the Basic Track that comprises five levels: upside-only model for one or two years (Levels A and B), and three levels of progressively higher risk and potential reward (Levels C, D, and E). In doing so, the existing tracks 1 and 2 of the MSSP are discontinued, and instead a Basic Track with a pathway to risk and an Enhanced Track that mirrors the current Track 3. There

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would be no new applications for the Track 1+ model. The proposal extends the agreement period from three to five years, with July 1, 2019 as the earliest available start date.

Under the Basic Track, eligible ACOs would begin under a one-sided model and incrementally phase-in risk and potential reward over the course of a single agreement period. This approach is referred to as a “glide path” to risk. The Enhanced Track, which is based on the MSSP’s existing Track 3, would offer ACOs the highest level of risk and potential reward. The rule proposes to require ACOs to enter one of these two tracks for agreement periods beginning on July 1, 2019 and in subsequent years. For agreement periods beginning on July 1, 2019, the length of the agreement would be five years and six months. In subsequent years, the length of the agreement period would be five years.

Participation Options – Glide Pathways

- **Overall, the HQC supports the newly developed glide pathways. It is critical the new pathways are clear and consistent for participants and prospective enrollees to understand their journey to risk.**

The proposed rule provides different participation options based on ACO’s status. The criteria helps place an ACO into the glide pathway. One criterion is determined based on the experience of a participant. As such, an ACO is determined to be experienced if either of the following conditions apply:

- The ACO previously participated in a performance-based Medicare ACO initiative or deferred entry into a second MSSP agreement period under Track 2 or Track 3.
- 40% or more of the ACO’s providers participated in a performance-based Medicare ACO initiative or were part of a deferred renewal arrangement in any of the five most recent performance years prior to the agreement start date.

Inexperienced with performance-based risk Medicare ACO initiatives is defined as those that meet *all* of the following criteria:

- The ACO is a legal entity that has not participated in any performance-based risk Medicare ACO initiative, and has not deferred its entry into a second MSSP agreement period under a two-sided model; *and*
- Less than 40 percent of the ACO’s participants participated in a performance-based risk Medicare ACO initiative, or in an ACO that deferred its entry into a second MSSP agreement period under a two-sided model, in each of the five most recent performance years prior to the agreement start date.

Another criterion is based on revenue. Low-revenue and high-revenue ACOs are defined based on the ACO participants’ Part A and B fee-for-service revenue for the most recent 12 months of available data, as follows:

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- High-revenue ACO: If the ACO participants' recent total Part A and B FFS revenue (which may include revenue for beneficiaries not assigned to the ACO) is at least 25% of the total Medicare Part A and Part B FFS expenditures for the ACO's assigned beneficiaries for the 12-month period.
- Low-revenue ACO: If the participants' recent total Part A and B FFS revenue is less than 25% of the total Medicare Part A and Part B FFS expenditures for the ACO's assigned beneficiaries for the 12-month period.

Assignment Methodology

- **Overall, the HQC supports the proposed opt-in procedures. In addition, we would support the ability to ACO's to confirm assignment and patient relationship with the ACO on an on-going basis.**

The proposed rule seeks to permit ACOs to annually elect their beneficiary assignment methodology. CMS uses this rule to explore options for developing a possible opt-in methodology to assign beneficiaries to ACOs, but stops short of actually proposing a methodology. CMS explains its belief that an opt-in methodology could allow ACOs to better target care coordination and provide an incentive to ACOs to compete against one another. CMS also reports that stakeholders that support this methodology believe it promotes beneficiary free choice and engagement and makes assignment more patient-centered.

In its discussion of possible opt-in methodologies, CMS explains the difference between voluntary alignment and an opt-in methodology. With voluntary alignment, beneficiaries directly opt into care by a specific primary clinician, but only indirectly opt in to the clinician's ACO by doing so. With opt-in assignment, beneficiaries would opt-in directly to a specific ACO.

Waivers

- **The HQC supports expansion of the SNF waiver and relaxing restrictions on providing telehealth services to ACO participants.**

Expand access to waivers of the Skilled Nursing Facility 3-Day rule and certain restrictions on the coverage of telehealth. ACOs with prospective beneficiary assignment already qualify for the waiver. CMS also proposes to extend the waiver by allowing application of it to SNF services furnished under swing bed arrangements between Critical Access Hospitals and certain small, rural hospitals, if those services fall under a written agreement between the swing bed operator and a waiver-eligible ACO. CMS proposes to make these changes applicable beginning with waivers approved for performance years beginning on July 1, 2019 and subsequent years.

Consistent with changes included in the BiBA, restrictions on the originating site and geographic location would not apply to payment for telehealth services for these entities. These changes would allow payment for telehealth services originating in a beneficiary's home and from geographic

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locations that would otherwise be prohibited. However, no facility fee would be paid to the originating site when services originate from the beneficiary's home, and no payment would be made for a service delivered in the home if it was not appropriate to do so. The expanded telehealth policy would apply to the proposed risk-bearing ACOs listed above, if they continue to elect prospective beneficiary assignment. CMS also proposes to offer the expanded telehealth policy to current Track 3 and Track 1+ Model ACOs. The HQC supports the expansion of the SNF waiver and restrictions on telehealth services to ACO participants as a positive step toward improved care delivery.

Beneficiary Incentives

- **The HQC supports allowing ACO's to provide beneficiary incentives for participating.**
- **However, the \$20 annual allowable amount is quite low. We would support an increase in the level of incentive, and suggest alignment with the Next Generation ACO program at \$20 allowable per six months.**

Enable ACOs to establish beneficiary incentive programs. CMS proposes that eligible ACOs that establish an approved beneficiary incentive program would be allowed to provide incentive payments directly to assigned beneficiaries upon their receipt of qualifying primary care services³ from an ACO professional with a primary care designation or a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC). In accordance with the BiBA, CMS proposes that the incentive payment could be up to \$20, updated annually. The payment would be required to be identical for each FFS beneficiary, unrelated to any other health insurance policy or plan, and made within 30 days of the delivery of each qualifying service. CMS proposes to allow ACOs to vary the incentive payment type (e.g., gift cards or checks but no cash), but to require ACOs to disburse payment directly to eligible beneficiaries.

The HQC appreciates the ability to provide an incentive to participation that is reasonable. However, we believe \$20 per year is a very low amount. Instead, we suggest alignment with the Next Generation program of \$20 per six months or \$40 annually as a better figure providing an incentive to participate and be part of the care delivery model.

Risk and Benchmarking Methodology

- **The HQC is concerned regarding the capped 3% beneficiary risk score over a five-year period. We suggest increasing the cap to 5%.**
- **The HQC supports the removal of the "continuous" and "newly" assigned methodology in favor of the Hierarchical Conditions Category adjustment policy.**
- **We would also support a rebasing of the benchmark following the first six months of the agreement period. This would better account for the population entering into the program.**

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The proposed rule factors regional expenditures into benchmarks beginning in the first agreement period but reduce the weight of regional factors in calculating the benchmark. Under current regulations, CMS applies a regional adjustment to ACOs' historical benchmarks to rebase them for ACOs entering a second or subsequent agreement period in 2017 or later years. The percentage adjustment is phased in over time and ultimately reaches 70 percent. Due to the more accurate benchmarks CMS believes it has achieved using this method, CMS proposes to incorporate regional expenditures into the historical benchmarking methodology starting with the first agreement period for all ACOs entering the program beginning on July 1, 2019. When calculating the historical benchmark for an ACO in its first agreement period, CMS would weigh the three benchmark years – the three calendar years prior to the start of the agreement period – at 10 percent, 30 percent, and 60 percent, respectively. This differs from the equal weights that are used in resetting the benchmark for ACOs entering a second or subsequent agreement period.

Risk Adjustment: CMS is proposing to do away with the “newly assigned” and “continuously assigned” designations of the existing program. CMS proposes to switch to using full CMS Hierarchical Condition Category (HCC) risk adjustment for all assigned beneficiaries between the benchmark period and the performance year. The resulting risk score would be subject to a symmetrical cap of positive or negative three percent over the length of the agreement period, for agreement periods beginning on July 1, 2019 and in subsequent years. The five-year agreement creates concern regarding the adjustments. The HQC has concern over the capping of risk adjustment and inflation adjustment. Increasing the cap on risk adjustment would eliminate some concerns of the agreement period. A pre-determined inflation trend would also eliminate some concerns with the proposed methodology. In addition, we would support a re-basing of the benchmark after the first six months of the downside risk track to better reflect spending and case mix.

Program Data and Quality Measures

- **The HQC continues to support alignment and implementation of the “Meaningful Measures” initiative at CMS. This has resulted in focusing on measures towards outcomes, and reducing the number of measures that are topped out and/or do not provide value to patient care.**

CMS does not propose changes to the basic methodology for determining ACO quality performance. However, CMS solicits input on ways to enhance the program's measure set. This includes ways to align the MSSP measure set with the agency's “Meaningful Measures” initiative that seeks to streamline and prioritize the measures used across CMS's quality measurement and value programs so they focus on the most important issues.

CMS also expresses an interest in using the MSSP to support the agency's broader effort to address the opioid epidemic. CMS is exploring ways of providing aggregated Medicare part D data on opioid utilization to assist ACOs with efforts to address opioid misuse. CMS also is considering

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adopting three measures for future program years that use Medicare part D data. All three measures are endorsed by the National Quality Forum (NQF), and their NQF identification numbers are included below. All three measures exclude patients with cancer, and those enrolled in hospice in order to focus the measure on the most appropriate population.

The HQC continues to support the alignment between various quality and value-based programs. In addition, we are supportive of the agency strategy to focus on measures that are linked to improved patient outcomes. The focus should be on measuring value, not measuring volumes.

Proposed Changes to Certified Electronic Health Record (EHR) Use and Measurement

- **We support alignment of EHR policies between the MSSP and the Quality Payment Program. This helps support transition and management for organizations that participate in MIPS-ACO scoring standard and advanced Alternative Payment Models (APMs).**

CMS proposes several changes to align participation in the MSSP with provisions in the QPP that promote the use of certified EHRs and the interoperable access, exchange and use of health information. CMS proposes to add a requirement that all ACOs demonstrate that at least 50 percent of eligible clinicians participating in the ACO use a certified EHR to document and communicate clinical care to their patients or other health care providers. This requirement would be included in the attestation and certification upon application to participate in the MSSP and in the annual certification process. CMS proposes that the threshold requirement would be effective with the performance year beginning Jan. 1, 2019.

CMS also proposes to require ACOs in tracks or models that meet the financial risk standard to be Advanced APMs to demonstrate that at least 75 percent of eligible clinicians in each participating Advanced APM use a certified EHR to document and communicate clinical care to their patients or other health care providers. CMS states that this proposal aligns with the proposal in the CY 2019 Physician Fee Schedule proposed rule to increase the threshold level for certified EHR use by eligible clinicians participating in Advanced APMs under the QPP. CMS also states the agency reserves the right to monitor, assess and/or audit an ACO's compliance with the proposed requirement and take compliance actions when ACOs fail to meet or exceed the required certified EHR use threshold. The proposed threshold requirement would be effective with the performance year beginning Jan. 1, 2019.

Conclusion

On behalf of the HQC, we appreciate the opportunity to provide comments on the implementation of the MSSP-ACO program. We urge CMS to work together with physicians, groups, hospitals, associations, and coalitions to ensure value-based payment programs are working in tandem to achieve the goals of better quality and lower cost.

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If you have any questions or need clarification, please feel free to contact us.

Sincerely,

The Healthcare Quality Coalition

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