

December 15, 2016

Mr. Andrew Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W.  
Washington, DC 20201

Re: (CMS-5517-FC) Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician- Focused Payment Models

Dear Acting Administrator Slavitt:

The undersigned organizations submit the following comments and recommendations for developing a new Medicare ACO model, Track 1 Plus (1+), as discussed in the final rule with comment period, *Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician- Focused Payment Models*, published in the *Federal Register* on November 4, 2016. The signatories to this letter include organizations representing physicians, hospitals, medical group practices, academic medical centers and nearly all existing Medicare Shared Savings Program (MSSP) ACOs.

Our recommendations reflect our unified expectation and desire to see the MSSP achieve the long-term sustainability necessary to enhance care coordination for Medicare beneficiaries, lower the growth rate of healthcare spending and improve quality in the Medicare program. Specifically, our key goals for the MSSP include encouraging increased participation, enabling existing ACOs to continue in the program and creating a successful, long-term ACO model for Medicare. It is in Medicare's interest for ACOs to continue in the program in order to provide high quality care for Medicare beneficiaries and to reduce the growth rate of Medicare spending.

CMS's plans to develop Track 1+ represents an important step to ensure the long-term viability of the ACO model by introducing a new ACO track that incorporates less downside risk than what is required in existing two-sided ACO models. Track 1+ must be designed to incentivize ACOs to begin taking on risk in a manner that holds them accountable for cost and quality but does so in an appropriate way, providing a glide path to assuming risk. We applaud CMS's plans to develop Track 1+ and urge the agency to establish it so that it's widely available to ACOs of all sizes and structures and that participation in the model is not restricted to a specific number of agreement periods. We also greatly appreciate CMS's plans to develop Track 1+ as an Advanced APM starting in 2018 under the Medicare Access and CHIP Reauthorization Act of

2015 (MACRA) Quality Payment Program (QPP). It is imperative that CMS finalize Track 1+ in an expedited manner to ensure its availability for ACOs to begin participating in the new model in 2018, and we strongly recommend CMS release finalized Track 1+ details as soon as possible. Below are our recommendations for the key elements of Track 1+.

### **The Need to Create Track 1+**

As developing organizations, many ACOs face challenges achieving success, as defined by lowering spending relative to their benchmark enough to earn shared savings. While success rates have increased each performance year and ACOs that started the program earlier have higher success rates, according to [this](#) CMS Public Use File updated on October 19, 2016, only 119 out of 392 MSSP ACOs earned shared savings in Performance Year 2015. Further, 2016 was the first year when ACOs renewed three-year agreement periods, and only two-thirds of 2012/2013 ACOs remained in the program and renewed their agreements in 2016. To ensure more ACOs are able to be successful and will thus remain in the program, CMS must continue to make program enhancements to ensure the long-term viability of the Medicare ACO model.

Since inception of the MSSP, CMS has emphasized the need for ACOs to assume downside financial risk for their patient population as the best way to incentivize ACOs to reduce unnecessary utilization and lower the growth rate of Medicare expenditures. However, as a portion of total 2016 Medicare ACOs, including those in the MSSP, Next Generation and Pioneer models, those in two-sided risk models only represent slightly more than 10 percent of Medicare ACOs. Track 1 remains by far the most popular option, with 95 percent of MSSP ACOs in Track 1 this year, and from 2012 to 2016 the growth rate for Track 1 has been four times the growth rate of two-sided models. However, ACOs may only remain in Track 1 for two agreement periods before having to move to a two-sided risk model or drop out of the program. Further, the disproportionate emphasis on the goal of reducing costs overshadows the equally important goal of quality improvement that the ACO model offers which, in the long run, will benefit both patients and the Medicare program generally.

With growing calls for ACOs to take on risk, it's important to recognize that ACOs remain in Track 1 in large part due to the high levels of risk required in the two-sided models. The current two-sided models (MSSP Track 2, 3 and the Next Generation ACO model) include risk levels that are significantly higher than what the vast majority of ACOs can bear and therefore are not viable for most ACOs. The decision to take on risk is at the heart of an ACO's choice about which model to select and having to potentially pay millions of dollars to Medicare is simply not practical nor feasible for most of these organizations. This type of risk necessitates that ACOs have considerable financial backing. Many ACOs are unable to access investor capital and face many barriers to obtaining sizeable credit. Without large enough assets to secure loans, many physician owners are left having to personally guarantee debts and obligations. Basing risk on total cost of care creates situations where physicians could be responsible for repaying a substantial amount, if not all, of their Medicare income for a particular year.

The challenges of taking on risk are often exacerbated for those in rural areas and safety-net providers, which care for some of the most vulnerable patient populations. These providers tend to have even fewer resources and may struggle to come up with start-up and investment costs, let alone be in a position to assume down-side risk. Even the promise of higher shared savings rates or the ability to utilize waivers afforded to two-sided ACOs is not enough to overcome the barriers to assuming considerable financial risk. Further, ACOs are in the business of delivering care and are not necessarily well equipped to take on what is essentially actuarial risk more typical of a health insurance company. Finally, while a slight majority of ACOs are physician owned, many others share ownership and financial responsibility with hospitals, which often have the same concerns about such high risk.

Based on these realities, it is critical that CMS develop Track 1+, which would provide a much-needed option that enhances accountability for costs but does so in a manner more appropriate for ACOs. Below are our specific recommendations for establishing Track 1+, and we look forward to working with CMS on these and other key areas of the model's design.

### **Comments on Information Included in the MACRA Final Rule with Comment Period**

#### *Qualification of Track 1+ as an Advanced APM*

In the final MACRA rule with comment period, CMS states that it would design Track 1+ with sufficient financial and nominal risk in order to be an Advanced APM. In passing MACRA, Congress clearly intended to create an accelerated pathway for physicians to move from fee-for-service to APMs, with a particular emphasis on APMs that include accountability for quality and cost. Track 1+ is one example of the type of model Congress intended, and we therefore feel very strongly that CMS should develop Track 1+ as an Advanced APM. Track 1+ represents an important option for Track 1 ACOs to transition to a model that includes risk, and Track 1+ will incentivize new providers to form ACOs, thus bolstering the growth and success of the Medicare ACO model. The Advanced APM bonus and higher payment rates in 2026 and beyond will be key determinants for many ACOs to take on risk under Track 1+. ACOs are on the cusp of so much potential, and we feel that creating Track 1+ as an Advanced APM will benefit ACOs today and moving into the future.

We strongly support CMS finalizing details of Track 1+ so that this model meets the Advanced APM criteria and look forward to working with CMS on its development so that Track 1+ is available beginning with the 2018 performance year.

#### *Track 1+ Risk Levels*

CMS explains that Track 1+ would test a payment model that incorporates more limited downside risk than what is currently required in existing two-sided ACO models. Specifically, the loss sharing limit would be related to the thresholds CMS finalized for Advanced APMs. Therefore, should losses occur, the total annual amount that a Track 1+ ACO would potentially owe CMS or forego would be equal to at least:

1. For performance periods in 2017 and 2018, 8 percent of the average estimated total Medicare Parts A and B revenues of the ACO (the “revenue-based standard”); or
2. For all performance periods, 3 percent of the expected expenditures for which an ACO is responsible under the APM (the “benchmark-based standard”).

We urge CMS to finalize a Track 1+ risk structure and level that equals the minimum amounts of risk required under the final Advanced APM criteria, thus allowing Track 1+ to qualify as an Advanced APM. CMS’s Advanced APM risk levels referenced above are more than sufficient to promote accountability and, in contrast to the amount of risk currently required under existing two-sided ACO models which have loss sharing limits ranging from 5 percent to 15 percent of total cost of care, are more reasonable for ACOs that face considerable obstacles assuming risk. CMS also should maintain the same revenue-based threshold for the duration of the first three-year Track 1+ agreement period to ensure stability for program participants. For additional specific recommendations on the risk thresholds, we refer CMS to our individual organizations’ comment letters.

#### *Benchmarks for Existing ACOs that Move to Track 1+*

CMS states that Track 1 ACOs that move into Track 1+ would have their benchmark rebased using CMS’s new benchmarking methodology which incorporates a component of regional expenditure data into the rebased benchmark. We strongly support CMS applying the new rebased benchmarking methodology to current ACOs that move into Track 1+. Earlier this year we sent a joint comment [letter](#) generally supporting CMS’s proposal to revise the benchmarking methodology to incorporate a component of regional expenditure data into rebased ACO benchmarks, a policy which CMS subsequently finalized. In that letter, we strongly recommended CMS allow ACOs flexibility and provide options for moving to the new rebased benchmarking methodology. Based on the final policy, ACOs that began the MSSP in 2012 and 2013 must wait until 2019 to have their benchmark rebased using the new methodology, and many of these ACOs would like to move to the new methodology sooner. Therefore, we support CMS applying the new rebased benchmarking methodology to current ACOs that move into Track 1+ and recommend CMS finalize this policy.

#### *Track 1+ Availability*

Like other ACO models, CMS states that Track 1+ would be voluntary and available to new ACOs and those currently in Track 1, but ACOs currently in MSSP Tracks 2 and 3 or the Next Generation or Pioneer ACO model would not be eligible for Track 1+. CMS further explains that Track 1+ would be designed to encourage a progression to two-sided risk and is envisioned as an on-ramp to other two-sided ACO models.

We strongly support Track 1+ being a voluntary model available to new ACOs and those in Track 1, but we also urge CMS to also make this opportunity available to ACOs currently in MSSP Tracks 2 and 3, as well as to those in the Pioneer and Next Generation models. ACOs in these tracks/models have demonstrated a clear commitment to value-based payment models and to assuming financial accountability. However, some of these ACOs may not be successful and

could face repayment of losses greater than they anticipated. Should they conclude they are unable to continue in their current ACO track/model, allowing them to participate in Track 1+ would be more beneficial for the ACOs and Medicare rather than requiring them to remain in an unsustainable situation. Faced with this dilemma, many ACOs would likely drop out of the program. Therefore, allowing them to move into Track 1+ would be a better option and would not penalize them for their early commitment to a two-sided risk model. We strongly recommend that CMS allow all current and new ACOs to participate in Track 1+. We also request that ACOs be able to move into Track 1+ at the start of any performance year and not be required to wait until the start of their next three-year agreement period.

### **Comments on Track 1+ Elements Not Addressed in the MACRA Final Rule with Comment Period**

In addition to our comments in the previous section on Track 1+ elements discussed in the final MACRA rule with comment period, this section of the letter includes our recommendations for other Track 1+ program elements and requirements which we urge CMS to incorporate into the design of Track 1+.

#### *ACO Eligibility for Track 1+ Participation*

We strongly urge CMS to allow all ACOs to be eligible to participate in Track 1+ and to not restrict participation based on ACO size or composition (ex. only physician-led ACOs or small ACOs). Such participation limits would unfairly disadvantage ACOs with hospital participants, those from large health systems or health-plan affiliated ACOs. While CMS has stated its belief that certain types of ACOs (i.e., larger ACOs, those with hospital participants or those affiliated with health plans) are better equipped to take on downside risk, we disagree with this assertion. The financial position and backing of a particular ACO as well as the ability to assume risk can depend on a variety of factors, such as local market dynamics, culture, leadership, financial status, and the resources required to address social determinants of health that influence care and outcomes for patients with complex needs. These factors may or may not be related to the type of ACO. Therefore, we urge CMS to make Track 1+ broadly available to all types of ACOs.

We also strongly recommend that CMS allow current ACOs to move into Track 1+ at the start of any performance year and not be required to wait until the beginning of their next three-year agreement period. Currently, ACOs may only switch MSSP tracks at the start of a new three-year agreement, and once that period begins they are locked into their decision until their next agreement. As ACOs consider their options for the future, it will be essential for CMS to adopt a more flexible policy to allow ACOs to move into two-sided risk models such as Track 1+ earlier than the start of their next agreement period. Given that the 5 percent Advanced APM bonus is only in effect for a few years with the last performance year of 2022, it would be incredibly unfair to lock ACOs into decisions for years to come, especially when new options such as Track 1+ become available.

### Length of Agreement Period and Long-Term Participation

We recommend CMS use three-year agreement periods for Track 1+, which is the same as other MSSP tracks and maintains consistency across the MSSP. We urge CMS to allow ACOs to remain in Track 1+ for an unlimited number of agreement periods. While CMS notes that the agency envisions Track 1+ as an on-ramp to other two-sided ACO models, many ACOs will likely never be able to assume the very high levels of risk in the existing two-sided models. This is demonstrated by the current low levels of participation in those ACO tracks/models relative to participation in Track 1. We urge CMS to retain the current two-sided ACO tracks/models as options for ACOs that are ready to assume those levels of risk.

Developing Track 1+ creates an important glide path for assuming risk, representing an option in between Track 1 which has no downside risk and the higher risk levels included in the other two-sided ACO tracks/models. However, it's important to note that we oppose limiting Track 1+ participation to a certain number of agreement periods and forcing ACOs to take on greater risk in other models. If, as we are advocating, CMS develops Track 1+ to meet the Advanced APM risk thresholds, we see no reason that ACOs could not remain in Track 1+ indefinitely. Limiting Track 1+ participation to a certain number of agreement periods would likely result in ACOs eventually dropping out of the program rather than assuming risk they are not prepared for. Retaining ACOs in Track 1+ would benefit ACOs and Medicare by continuing to incentivize them to enhance quality of care and generate savings for themselves and the Medicare Trust Funds. Therefore, we urge CMS not to restrict Track 1+ participation to a particular number of agreement periods.

### **Financial Structure**

#### Minimum Savings Rate (MSR) and Minimum Loss Rate (MLR)

The MSR/MLR are key components of the ACO model design and represent the percentages by which an ACO's actual expenditures differ from their benchmark, after which point the ACO would be eligible to earn shared savings or would be required to repay losses. As with Track 2 and 3, we urge CMS to allow Track 1+ ACOs to have a choice of a symmetrical MSR/MLR: no MSR/MLR; symmetrical MSR/MLR in 0.5% increments between 0.5% and 2.0%; symmetrical MSR/MLR to vary based upon number of assigned beneficiaries (as in Track 1).

#### Shared Savings Rate

As with other MSSP tracks, we recommend Track 1+ have first dollar savings after surpassing the ACO's MSR. As with Track 2, we recommend a specific shared savings rate starting at 60 percent. However, for all ACO tracks and models – including Track 1+ – we recommend the shared savings rate increase based on quality performance/improvement. Specifically, for Track 1+, we urge CMS to allow the shared savings rate to increase from 60 percent up to 70 percent based on quality performance/improvement.

#### Shared loss rate

We recommend CMS implement a shared loss rate of 30 percent for Track 1+. This rate is essential to defining potential losses as it determines what portion of the losses the ACO would have to pay back, should its losses meet or exceed the MLR. In the proposed MACRA rule, CMS

proposed that for an APM to meet the nominal amount standard the specific level of marginal risk must be at least 30 percent of losses in excess of expected expenditures. While the agency did not finalize any required shared loss rate for an Advanced APM, their proposal illustrates that they agency considers 30 percent sufficient to meet the nominal risk criteria, and we therefore recommend CMS finalize a 30 percent shared loss rate for Track 1+.

#### Performance payment limit

We recommend CMS implement a 15 percent performance payment limit, which is the maximum potential payment an ACO could receive and is based on total cost of care. CMS uses a 15 percent performance payment limit with Track 2 and we feel this threshold would also be appropriate for Track 1+.

#### Financial benchmark in initial and subsequent agreement periods

We recommend Track 1+ utilize the same benchmarking methodology used for the other MSSP tracks. While we continue to advocate for specific changes to the existing methodology, we feel it is appropriate to align the methodology across the MSSP. Further, we strongly recommend that existing ACOs entering into Track 1+ in 2018 have their benchmarks rebased using the new methodology, which incorporates a component of regional expenditures into the rebased benchmark.

#### Financial mechanisms to demonstrate ability to repay losses

If they incur losses, Track 1+ ACOs should have a variety of acceptable repayment mechanisms, including those currently permitted by CMS (placing funds in escrow, obtaining a surety bond, establishing a line of credit, or establishing a combination of the approved repayment mechanisms). We also urge CMS to restore reinsurance as a qualifying repayment mechanism. Reinsurance was a permissible repayment mechanism for MSSP ACOs until CMS removed this option in the June 2015 final MSSP rule. The agency's rationale for doing so was that few ACOs were using this option. However, we question that logic especially considering how few two-sided ACOs there were at that time. Further, despite limited initial use of reinsurance for demonstrating ability to repay losses to CMS, reinsurance continues to be an option which some ACOs pursue separate from their CMS obligations. We see no harm in CMS reinstating reinsurance as an option, and we urge CMS to do so for all two-sided ACO tracks/models, including Track 1+.

Under the financial risk standard finalized by CMS, if actual expenditures for which an APM Entity is responsible under the APM exceed expected expenditures during a specified performance period, the agency will allow a reduction of payment rates to the APM Entity and/or the APM Entity's eligible clinicians, among other options for repaying losses. We urge CMS to develop an option for ACOs to repay losses through reduced payment rates of the ACO's eligible clinicians in future years. Through this mechanism, CMS would identify the Tax Identification Number (TIN)/National Provider Identifier (NPI) combinations that participate in the ACO for a specific performance period and, similar to downward payment adjustments under MIPS, CMS would reduce the payment rates for those TIN/NPIs by a certain percent in a future payment adjustment year to recoup the ACO's losses. ACOs would include language in

the agreement between the ACO and its participant TINs and their individual practitioners detailing specifics of this repayment mechanism. Allowing ACOs to choose this as one of the mechanisms to repay losses would provide a new option that some ACOs may prefer over repaying losses in a lump sum. We urge CMS to work collaboratively with us to further develop this concept and the key details that would be needed to implement it.

## **Beneficiaries and Risk Adjustment**

### **Minimum number of beneficiaries**

We recommend CMS implement a minimum threshold of 5,000 beneficiaries for Track 1+, which is consistent with the other MSSP tracks but is lower than the 10,000 (or 7,500 for rural ACOs) beneficiary threshold used in the Next Generation ACO model. We also recommend that for Track 1+ CMS implement the same policy it recently finalized in the final 2017 Medicare Physician Fee Schedule for MSSP Track 2 and 3 ACOs that fall below 5,000 beneficiaries at the time of financial reconciliation. Under that policy, Track 2 and 3 ACOs that choose a non-variable MSR/MLR at the start of the agreement period but subsequently fall below 5,000 assigned beneficiaries at the time of financial reconciliation remain eligible for shared savings (or losses). Further, their MSR/MLR used for financial reconciliation remains the same as what the ACO selected at the start of the agreement period and does not change as a result of the population falling below 5,000. If the ACO selected a variable MSR/MLR based on its number of assigned beneficiaries, CMS will use the same approach it currently uses for Track 1 ACOs in this situation, which relies on an expanded sliding scale for the MSR/MLR to match the number of assigned beneficiaries, should that population fall below 5,000.

### **Beneficiary assignment**

We urge CMS to provide Track 1+ ACOs, as well as ACOs in all MSSP Tracks, the option of using the Track 1 and 2 assignment methodology (preliminary prospective assignment with retrospective reconciliation) or using the method used for Track 3 (prospective assignment). We strongly support allowing ACOs to have the option of choosing prospective or retrospective assignment. Certain ACOs, such as a small ACO worried about dropping below the 5,000 beneficiary threshold, may favor a model where the ACO can add beneficiaries throughout the year, and would thus prefer the retrospective assignment model. However, other ACOs would likely prefer a prospective model, which would help them stabilize their beneficiary population and thus avoid volatile benchmark changes. Further, more advanced ACOs typically employ data analysis and beneficiary engagement techniques from the start of the performance period on a population for whom they know they are responsible. For these reasons, we strongly recommend that CMS provide Track 1+ ACOs, and all MSSP ACOs, the option of choosing either retrospective or prospective assignment.

### **Voluntary beneficiary alignment**

In the recent final 2017 Medicare Physician Fee Schedule, CMS finalized a modification to the MSSP beneficiary assignment algorithm to allow beneficiaries to designate an ACO professional as responsible for their overall care. We are very pleased that CMS finalized the use of voluntary alignment which will allow beneficiary designations to result in the beneficiary being assigned to the designated provider as long as certain criteria are met. Providing beneficiaries

with the opportunity to voluntarily align with an ACO balances the important considerations of beneficiaries' freedom to choose their providers with ACOs' interest in reducing patient churn and having a more defined and stable beneficiary population identified up front. This, in turn, allows 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. CMS finalized this policy for all MSSP tracks, and we recommend this be applied to Track 1+ as well.

#### Adjustments for beneficiary health status and demographic changes

We have previously expressed concerns about CMS's use of different methods for updating risk adjustment for newly and continuously assigned beneficiaries, the latter of which are prohibited from increases to their risk adjustment scores based on health status but may have decreases to risk scores. It is unreasonable to assume an ACO, however effective, can manage a population such that patient conditions never worsen over time and it never carries a higher disease burden. For Track 1+, and all MSSP tracks, we urge CMS to allow risk scores to increase year-over-year within an agreement period for the continuously assigned. Should CMS require limits to risk score changes, we would support a 3 percent cap on average risk score increases or decreases, which is the approach used for the Next Generation ACO model. Therefore, we urge CMS to address the flaws with the risk adjustment methodology for Track 1+ as well as more broadly in the MSSP by allowing risk scores to increase for continuously assigned beneficiaries.

#### **Quality and waivers**

##### Quality reporting requirements

We support CMS implementing the same quality reporting requirements for Track 1+ as with ACOs in other MSSP tracks, including reporting via the CMS Web Interface, evaluation on claims-based measures and patient satisfaction. MSSP ACOs demonstrate positive results with quality, and we see no reason for using different measures or requirements for Track 1+.

However, we strongly urge CMS to allow quality performance and quality improvement to increase the percent of shared savings a Track 1+ ACO may earn, from 60 to 70 percent. Under current MSSP rules, an ACO that achieves CMS's established quality performance levels is not rewarded and is merely prevented from forfeiting the shared savings payments it has earned. In contrast, Medicare Advantage (MA) plans are rewarded with higher benchmarks for higher quality, which leads to an asymmetry between MA plans and ACOs. As noted by the Medicare Payment Advisory Commission (MedPAC) in their Feb. 2, 2015 letter to CMS, "Otherwise, the ACO with top quality performance would end up with a lower benchmark than an MA plan in the same market with top quality performance. That situation could be seen as inequitable for the ACO."

Many efforts to improve quality of care 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. The more an ACO strives to improve quality performance, the more it often

needs to spend. ACOs that make large investments to improve quality performance may be less able to keep spending below their benchmarks as a direct result of their increased investment in quality. We urge CMS to properly reward Track 1+ ACOs, as well as all MSSP ACOs, for high quality. It is important to recognize high quality performance compared to established measure thresholds as well as to recognize – and reward – quality *improvement* relative to an ACO's previous performance. Therefore, to emphasize and reward above average quality performance or improvement, we urge CMS to provide on a sliding scale up to 10 percentage points of additional shared savings to Track 1+ ACOs, from 60 to 70 percent.

### Compliance and Payment Waivers

We urge CMS to use the full scope of the combined authority granted by Congress under the Affordable Care Act to issue waivers of the applicable fraud and abuse laws, similar to those it has issued for ACOs in the Pioneer, MSSP, and Next Generation programs. Specifically, CMS should issue:

- An ACO “pre-participation” waiver of the Stark and Anti-kickback statutes to protect ACO-related start-up arrangements in anticipation of participating in Track 1+;
- An ACO participation waiver of the Stark and Anti-kickback statutes that applies broadly to ACO-related arrangements during the term of the participation agreement;
- A shared savings distributions waiver of the Stark and Anti-kickback statutes that applies to distributions and uses of any earned shared savings payments or internal costs savings;
- A waiver of the Anti-kickback statute for ACO arrangements that implicate the Stark law and satisfy the requirements of an existing exception; and
- A waiver of the Beneficiary Inducements civil monetary penalty and the Anti-kickback statute for medically related incentives offered by ACOs, ACO participants, or ACO providers/suppliers to assigned beneficiaries to encourage preventive care and compliance with treatment regimes.

These waivers are critical to removing legal and regulatory barriers that inhibit providers from working together to provide better-coordinated, high quality care. We also strongly encourage CMS to make available to all Medicare ACOs, including Track 1+, waivers related to the following:

- **Hospital discharge planning requirements** that prohibit hospitals from specifying or otherwise limiting the providers who may provide post-hospital services;
- **The skilled nursing facility (SNF) three-day stay rule**, which requires Medicare beneficiaries to have a prior inpatient stay of no fewer than three consecutive days in order to be eligible for Medicare coverage of inpatient SNF care;
- **Medicare requirements for payment of telehealth services**, such as limitations on the geographic area and provider setting in which these services may be received;
- **Homebound requirements for home health**, which mandate that a Medicare beneficiary be confined to the home to receive coverage for home health services; and

- **Medicare primary care co-payments**, which would reduce or eliminate cost-sharing otherwise applicable under Medicare Part B for some or all primary care services furnished by health care professionals within the network of the ACO.

Waiving these payment regulations is essential so that ACOs can effectively coordinate care and ensure that it is provided in the right place at the right time. These waivers would provide ACOs with valuable tools to increase quality and reduce unnecessary costs and should be available to advance the success of all ACOs, including those in Track 1+. Further, CMS should implement the waivers in a manner that is not prohibitively burdensome to ACOs that utilize them. CMS should ensure that the waivers are easily accessible to ACOs and should rely on the ACOs' existing cost and quality metrics to ensure that ACOs continue to provide high-quality, appropriate care to their ACO populations.

### **Conclusion**

On behalf of the undersigned organizations, we thank you for the opportunity to provide feedback on the development of Track 1+. We are hopeful that our comments are helpful, and we welcome any questions you may have.

Sincerely,

National Association of ACOs  
American College of Physicians  
America's Essential Hospitals  
American Hospital Association  
American Medical Association  
AMGA  
Association of American Medical Colleges  
CAPG  
Medical Group Management Association  
Premier healthcare alliance