

February 22, 2018

Ms. Seema Verma
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: Request for a third agreement period for certain ACOs in Medicare Shared Savings Program (MSSP) Track 1

Dear Administrator Verma:

The undersigned organizations write to request that CMS modify regulations at §425.600(b) to allow certain ACOs to continue in the Medicare Shared Savings Program (MSSP) Track 1 for a third agreement period before having to move to a two-sided model. 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 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 order to provide high quality care for beneficiaries and to reduce the growth rate of Medicare spending.

MSSP Track 1 remains by far the most popular option for ACOs, representing 82 percent of MSSP ACOs in 2018. However, ACOs may only remain in Track 1 for two agreement periods before being required to move to a two-sided risk model or drop out of the program. **Many ACOs remain in Track 1 because they are unprepared to assume risk requiring them to potentially pay millions of dollars to Medicare, which is simply not practical or feasible for most of these organizations.** Providers in rural areas and safety-net providers, which care for some of the most vulnerable patient populations, often face even greater challenges than other providers when considering taking on risk. However, the challenge of being forced into risk is of great importance to ACOs of all sizes, composition and ownership. The financial position and backing of a particular ACO as well as the ability to assume risk depends 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.

ACOs that began the MSSP in 2012 or 2013 entered into second agreement periods in 2016 and are on schedule for their third agreement periods to begin in 2019. This is the first time ACOs will be forced into a two-sided risk arrangement. These ACOs are the first MSSP cohort and those that remain have shown significant dedication to the ACO model. They embraced the MSSP early on and were instrumental in working collaboratively with one another and CMS to help shape the program.

These ACOs have faced a number of challenges, some of which have been addressed by CMS through regulatory changes but many program modifications are still needed. The MSSP and these ACOs have evolved considerably, creating a shifting landscape for these early adopters. In order for ACOs to make a thoughtful business decision to assume risk, they need predictability and positive performance results. Without that, many do not feel confident enough to assume risk. These ACOs need more time to prepare for two-sided risk. While six years may sound sufficient, given the programmatic changes and considerable learning curve for these ACOs, this is not enough time. Further, when they have to make their decision about 2019 participation these ACOs will only have performance data available for four performance years, 2012/2013 through 2016. **Based on evaluation of the four performance years for which data is available, we urge CMS to allow Track 1 ACOs that meet at least one of the criteria below to have the option to continue in Track 1 for a third agreement period.**

ACOs that generate net savings across four performance years

ACOs have demonstrated an increasing likelihood of achieving shared savings over time. This is likely the result of a combination of factors, such as their experience in the program and realization of long-term commitments and investments in priorities such as care coordination, quality improvement efforts and data analytics. This trend is promising and means more savings over time for the Medicare Trust Fund. However, many ACOs generate savings, as defined by having expenditures lower than their benchmark, but do not surpass their Minimum Savings Rate (MSR) and thus do not qualify for earned shared savings. The MSR in Track 1 can be as high as 3.9 percent, which is a considerable hurdle. While these ACOs may not earn shared savings, if they are saving Medicare money and delivering high quality care, CMS has no reason to discourage their continued contributions through MSSP participation. **Therefore, we urge CMS to allow ACOs that generate net savings relative to their benchmark across four performance years (including those that do not surpass their MSR) to have the option of continuing in Track 1 for a third agreement period.**

ACOs that score at or above the 50th percentile in quality in two of three pay-for-performance years

ACOs that demonstrate superior quality performance have invested significantly in data analytics software, clinical improvements, staff training, and operational changes to result in achieving high quality performance scores. Though they may not have earned sufficient shared savings to allow them the financial readiness to assume risk, they have demonstrated high quality and should therefore be given additional opportunities to work on processes focused on lowering costs prior to being forced into a two-sided track. **We urge CMS to allow ACOs that score at or above the 50th percentile in quality performance in two of three pay-for-performance years the option of continuing in Track 1 for a third agreement period.**

ACOs that improve their overall quality score by 10 percentage points or greater over the course of pay-for-performance years

ACOs that demonstrate a significant improvement in their quality score over the course of the pay-for-performance years have made a clear investment in quality and have had a positive impact on the Medicare beneficiaries. These ACOs should be rewarded for these efforts and provided additional time to give their investments in quality an opportunity to materialize into cost savings, rather than being prematurely forced into a two-sided risk track. **Therefore, we urge CMS to allow ACOs that improve their overall quality score by 10 percentage points over the course of the three pay-for-performance years the option of continuing in Track 1 for a third agreement period.**

In addition to the criteria specified above, we urge CMS to consider additional criteria, including for ACOs with spending that is lower than that of their region. These ACOs are saving money compared to other Medicare fee-for-service providers in their region and keeping them in the MSSP incentivizes them to continue focusing on lowering spending and improving quality. ACOs that invested in care transformation prior to participating in the MSSP face lower starting benchmarks than other ACOs. They are often at a disadvantage in their ability to achieve shared savings and are often reluctant to assume risk. While CMS's regional benchmarking methodology aims to address this over time, the implementation is not fast enough for these ACOs. We recommend CMS allow ACOs the option for a faster pace to regional benchmarking and during that time also permit these ACOs to stay in Track 1.

It's important to recognize that Track 1 ACOs that are not ready for risk will not move forward; they will quit the program altogether. Using a government mandate for risk is not the solution to increasing participation and achieving successful results for two-sided ACOs. The unintended consequences of forcing risk will significantly undermine the MSSP and result in diverting valuable investments in care coordination away from Medicare patients and towards other patients under value-based contracts. Further, the disproportionate emphasis on reducing costs often overshadows the equally important goal of quality improvement that the ACO model offers, which benefits patients and the Medicare program generally. While some Track 1 ACOs have not yet been able to experience a return on the investments they have made, they have generated savings to the government while improving patient care, which studies show has a positive downstream impact on spending, but may take years to fully materialize.

While Track 1 is a one-sided risk model, it is important to note the significant investments ACOs make in start-up and ongoing costs, such as those related to clinical and care management, health IT, population analytics and tracking, and ACO management and administration. NAACOS 2016 survey data show that ACOs invest, on average, \$1.6 million annually to operate their ACO. These investments put ACOs at jeopardy of financial losses that have a considerable impact on their organizations, providers and beneficiaries. Congress recognized the principle from the ACO authorizing statute that one of the purposes of creating ACOs is to “encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery.” That investment—the cost of switching to a fundamentally different approach to patient care—constitutes in and of itself a substantial financial risk. ACOs consider and account for their investment costs as risk inherent in MSSP participation and these investments help to fund critical ACO activities designed to achieve the goals of improving beneficiary care and enhancing care coordination to reduce unnecessary spending and hospitalizations.

The MSSP has gained considerable momentum in recent years, and it would be devastating to see a mass exodus of 2012/2013 ACOs in the 2019 performance year if regulations are not changed to allow continued participation in Track 1. In NAACOS' 2016 *ACO Cost and MACRA Implementation Survey*, when asked how likely they were to participate in the MSSP if CMS required them to share losses, almost half of ACO respondents said they “definitely would not” or “likely would not” participate. **Therefore, we strongly urge CMS to modify regulations to allow ACOs that meet certain criteria to continue participating in Track 1 for a third agreement period. Swift action is**

needed by the agency on this issue so that a revised policy is in place in time for ACO planning for the 2019 performance year.

Conclusion

We appreciate your attention to our request to allow certain ACOs to continue in MSSP Track 1 for a third three-year agreement period before being mandated to assume downside risk. We are available to further discuss this issue and can be reached by contacting Allison Brennan at abrennan@naacos.com or 202-640-2685.

Sincerely,

National Association of ACOs
American College of Physicians
American Medical Association
Association of American Medical Colleges
Medical Group Management Association
Premier healthcare alliance