



American Medical Group Association®

February 6, 2015

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

Re: Medicare Shared Savings Program: Accountable Care Organizations; Proposed Rule

Dear Administrator Tavenner:

On behalf of the American Medical Group Association (AMGA), thank you for the opportunity to provide comments on the above-referenced proposed rule regarding revisions to the Medicare Shared Savings Program (MSSP) regulations.

AMGA represents multi-specialty medical groups and other organized systems of care, including some of the nation's largest, most prestigious integrated health care delivery systems. AMGA represents 435 medical groups that employ nearly 160,000 physicians who treat more than 120 million patients. Many of them are also participating in alternative payment models such as the MSSP and the Pioneer Accountable Care Organization (ACO) program.

The participants in the MSSP, and the Pioneer Accountable Care Organization Program (Pioneer, collectively, ACOs) have made significant improvements in care processes and the delivery of high-quality care, while reducing utilization of healthcare services. Although most of these entities have increased quality and achieved the goal of saving money for Medicare, program results have been uneven, at best. Some of AMGA's highest-quality and efficient medical groups have embarked upon the ACO journey, but have been unable to share in savings with the Medicare program due to the existing operational and financial obstacles, and are at risk of leaving the MSSP and Pioneer programs.

Medical groups and all providers participating in ACO programs have invested significant financial, clinical, operational, and leadership resources to establish sophisticated care management infrastructures and the organizational cultures necessary to support the goals of the program. They have done so because it is the right thing to do for their patients and they want to assist Congress, the Centers for Medicare and Medicaid Services (CMS), and other payers create the new payment models that reward coordinated, patient-centered care with measurable improvements in outcomes. We believe that CMS presently has a tremendous opportunity to help ensure the success of the MSSP program, and we are happy to provide AMGA's specific comments on various areas of the proposed regulations in the paragraphs below.

Waivers

Throughout the proposed rule, CMS seeks to incentivize MSSP participants to move into risk tracks or have prospective ACO providers initially agree to at-risk contracts. One strategy in this effort is proposing to offer various payment waivers to those ACOs enrolled in Track 2 or the newly proposed Track 3. All Medicare patients who are attributed to ACOs should have access to these benefit design changes, no matter which participation track their ACO elects, because they permit clinical decision-making to appropriately inform their healthcare. It makes little sense that some beneficiaries would be excluded from the advantages the waivers have to offer simply because they are attributed to a Track 1 ACO.

CMS seeks comments on waiving certain regulations for Track 2 and the proposed Track 3 ACOs for qualifying hospital stays for Skilled Nursing Facility (SNF) admissions, use of telehealth, the homebound requirement for the home health benefit, primary care co-payments, and referrals to post-acute care settings, in an effort to encourage MSSP participants to accept downside risk. AMGA urges CMS to consider extending the use of these waivers to all ACOs, regardless of the selected track, given the low participation in Track 2, and other uncertainties in the program. AMGA understands CMS' desire to move ACOs into risk-taking tracks, however, ACOs need a stable platform that includes a workable financial and operational structure that adequately incentivizes this important work before they are required to take risk in a two-sided model. We believe that the proposed waivers would be immensely beneficial to MSSP participants and the overall success and future viability of the program, and we strongly urge CMS to extend them to Track 1 ACOs and not just Tracks 2 and 3.

Track 1 ACOs must first become confident that they will achieve savings based on successful care management strategies before they are ready to accept downside risk in Track 2 or the proposed Track 3, and they should have the tools to do this at their disposal. We see no distinction between Track 1 and Track 2 ACOs that would somehow lead Track 1 ACOs to improperly utilize these waivers.

While we recognize the agency's desire to encourage risk-taking, there are significant barriers to accepting performance-based risk, given the current areas of uncertainty in the program, including beneficiary attribution, discussed elsewhere in this letter. However, CMS expresses concern about permitting the use of waivers for retrospectively attributed patients. One way to solve this would be to offer Track 1 ACOs the option of having a prospectively attributed patient population as discussed above, so they would know how to best direct their resources from day one.

The ability to plan for years of potential monetary loss due to the acceptance of risk is not workable for the majority of providers. Insurers, for instance, are required to keep significant risk-based capital reserves to allow them to enter into risk contracts, made possible by actuarial data at their disposal, as well as a significant margin/liquidity. Provider organizations are equipped with none of these things in order to make the leap into risk acceptance. We maintain that risk-taking is inherently a part of participation in both tracks of the MSSP program, given the approximately \$2 million investment necessary to establish an ACO. Such an investment represents considerable financial risk for all ACOs at the outset. Such factors should be taken into consideration when evaluating Track 1 ACOs and their relationship with risk, in addition to what would be needed for these ACOs to transition into Track 2 or the proposed Track 3.

While making waivers available to ACOs in all tracks of the MSSP could be a powerful incentive for them to remain in the program, ACOs would also need assurance that they are legally protected for their use

of waivers, which may require additional coordination between CMS and the Department of Health and Human Services Office of the Inspector General.

Skilled Nursing Facility (SNF) Waivers

CMS proposes that patients receive skilled nursing care or skilled rehabilitation services provided by a SNF without a prior inpatient hospitalization or with an inpatient hospital length of stay of less than three days, if they are receiving care from an ACO that has accepted performance-based risk. CMS states that these waivers would be easier to apply to prospectively attributed beneficiaries, otherwise confusion about how to apply them could be a problem. CMS also proposed applying the SNF waiver to all performance-based risk tracks, or to beneficiaries that appear on quarterly lists of preliminarily prospectively assigned beneficiaries, stating: “We believe that under a two-sided performance-based risk ACO model it could be medically appropriate and more efficient for some patients to receive skilled nursing care and or skilled rehabilitation services provided at SNFs without a prior inpatient hospitalization or with an inpatient hospital length of stay of less than 3 days.” **AMGA urges CMS to consider extending use of this waiver to Track 1 ACOs, since we believe that the waiver would be medically appropriate for all beneficiaries in ACOs.**

AMGA believes that SNF waivers would be very beneficial to both ACOs and to Medicare beneficiaries by permitting clinical decision-making to appropriately inform SNF placements instead of arguably outdated pre-hospitalization requirements. We support the requirements that the waiver should only be used with SNFs that have at least a three star quality rating.

Telehealth Waivers

CMS has proposed waiving the originating site requirement that is currently in place for receiving payments for telehealth services for non-rural area ACOs that also have accepted performance-based risk. These ACOs would be required to submit a written plan describing how they would use the waiver to meet the clinical needs of their beneficiaries.

AMGA supports expansion of the telehealth benefit and believes that these services could be very valuable to ACOs by promoting efficient and coordinated care whether in rural or non-rural areas. CMS is behind the private sector in its reimbursement of telehealth services. CMS should promote expansion of originating sites for telehealth services, and incentivizing their expansion in ACOs is a logical step in this direction. **We therefore recommend that CMS permit all ACO tracks to apply for waivers for the expanded use of telehealth services.**

Homebound Requirement under the Home Health Benefit

CMS proposes expanding the homebound requirement under the home health benefit to those who are not truly homebound under the narrowly drawn current definition, but would be otherwise eligible for services under the homebound benefit (i.e. having a need for skilled nursing care on an intermittent basis; physical therapy; speech therapy; or occupational therapy, and is restricted to leaving the home except with the assistance of another individual or the aid of supportive devices). CMS also proposes extending the waiver to prospectively assigned beneficiaries due to its belief that prospective assignment creates a potential pathway for improving the appropriate use of waivers by ACOs and a method for them to monitor their use.

The home health benefit also requires that the “amount, frequency, and duration” of skilled therapy services to be at “reasonable” levels. Operating under this requirement without the benefit of a waiver

could potentially have a harmful effect on providers' attempts to operate efficiently, lead to unnecessary readmissions and higher cost post-acute care services, and limit access for patients who require more intensive services. Waiving this requirement would be beneficial to both the ACO program and patients alike by avoiding these potential pitfalls and providing beneficiaries with increased healthcare plan flexibility.

The status of pre-admission home evaluation services is another issue that CMS should evaluate closely under the home health benefit. Allowing for a waiver of the policy prohibiting home health agencies from performing free pre-operative home safety assessments for patients scheduled to undergo surgery would allow for more informed post-acute care plans, a reduction in readmissions, and a more patient-centered care plan. These entities are experienced in working with clinicians to assess patient care needs and should not be prevented from collaborating to generate care plans at the pre-admission stage that would help transition beneficiaries to lower cost community-based settings.

ACOs would have to demonstrate through the application process or in a request for renewal of their participation agreement that they have the capacity and infrastructure to identify and appropriately manage clinically those qualifying beneficiaries. Home health agencies would need at least 3 out of 5 stars in the home health quality rating system in order to be eligible to participate. CMS proposes limiting this waiver to ACOs electing to participate in its proposed Track 3 given what it says is the "significant financial interest in controlling total patient costs" Track 3 ACOs have. CMS is seeking comment on whether the waiver should apply to all performance-based risk tracks regardless of whether assignment is prospective or retrospective.

Once again, AMGA believes that all ACOs have "significant financial interest in controlling total patient costs" whether they are in Track 1 or Track 2 currently, and we believe that home health waivers should be made available to all ACOs. AMGA agrees with the requirement that home health agencies have high quality ratings, however, and have earned at least 3 out of 5 stars for their quality score.

Referrals to Post-acute Care Settings

CMS states in its proposed rule that ACOs would like to recommend high-quality SNFs and home health agencies to beneficiaries that they believe are superior providers and requests feedback on how to provide clear direction about how preferred providers can be presented to beneficiaries. CMS has therefore proposed to waive the restriction that ACOs present "all options equally," and "not specify or otherwise limit the qualified provider which may provide post-hospital home services."

As a result, discharge planners would have the flexibility to recommend high-quality post-acute providers with whom they have relationships. CMS is seeking comment about whether it would be appropriate to limit such waivers to ACOs participating in performance-based risk or whether such a waiver should be available more broadly to all ACOs participating in the MSSP.

Extending these waivers to all ACOs would also assist in the long-term success of the program due to the overall experience that it would provide to participants. ACOs need to have operational experience utilizing all available tools before accepting risk. Significant clinical re-design and cultural change is needed to implement program requirements, even for sophisticated organizations that are the most willing to enroll in the MSSP program. Allowing Track 1 ACOs to develop this familiarity from the outset rather than limiting it to only those accepting performance-based risk would make Track 1 ACOs stronger and more viable as the program matures and would ultimately encourage greater participation

in Tracks 2 or the proposed Track 3, taken together with other needed operational refinements discussed elsewhere in this letter. **We therefore support expanding the availability of post-acute referral waivers to all ACOs.**

Primary Care Co-Pay Waiver

CMS seeks comments asking if there "are any additional Medicare FFS payment rules that it may be necessary to waive using our authority . . . to increase quality and reduce costs." The President's recently released FY 2016 budget also discusses the need to continue increasing quality and reducing costs. AMGA believes that one possibility for achieving this goal would be to waive primary care co-payments for all ACO tracks for certain services.

Establishing a primary care co-pay waiver would have a positive effect on the assigned beneficiaries, providing them with a strong incentive to seek out appropriate care in an ACO on a timely basis, thus contributing to better management of chronic illnesses. Applying the co-payment waiver to primary care Evaluation and Management codes (99211-99215) and the Chronic Care Management Code (CCM), CPT code 99490, would result in minimal costs to ACOs while producing the desired benefits. Limiting the number of codes that the waiver applies to would also help to ease any concerns over potential overutilization.

In the proposed rule, CMS enumerates the benefits that accrue to patients who are assigned to an ACO, such as having access to infrastructure that improves the coordination of their care, and encourages ACOs to make ongoing investments in patient-centered care. In addition, ACOs have benefited their respective patient populations by their ability to identify unmet needs, such as an inability to adhere to medication regimes independently, a lack of transportation to appointments, and inadequate access to nutritious food. ACOs actively identify and manage such previously unaddressed issues and can factor them into treatment plans. Waiving the primary care co-payment for beneficiaries in all ACO tracks can further the goals of the program by removing potential barriers to seeking care.

Greater primary care engagement among patients also has the potential to assist in stabilizing beneficiary assignment. Patients that are assigned to ACOs that receive outpatient specialty care do so largely when receiving care for chronic conditions. Proper management of their conditions could help to stem the "churn rate" and prevent those patients with chronic conditions from venturing outside the ACO for care. **Waiving primary care co-pays for the above listed specific codes for all MSSP tracks would be of great benefit to both patients and providers, and would improve patient outcomes.**

Beneficiary Attestation

AMGA strongly urges CMS to provide a beneficiary attestation process for all MSSP ACOs, including Track 1 ACOs. This would enhance attribution process and would favor a patient's choice. Voluntary attestation has the additional benefit of being forward looking, and reflecting where a patient presently desires to receive their care, rather than backward looking, i.e., based on where a beneficiary received their care in the past. Beneficiaries should also attest to an ACO, rather than to a specific provider, which would more appropriately reflect the care furnished in group practices.

We recommend that CMS also permit patients who transfer their care during the year to either Medicare Advantage or out of the service area to be removed from the risk pool, resulting in an attributed beneficiary population that is more reflective of the system's true primary care population, and one that

reflects patient choice. Although CMS could retain its current stepwise attribution process (including modifications discussed elsewhere in this letter), beneficiary attestation would take precedence over that process when considering to which ACO a beneficiary should be attributed.

Provision of Aggregate and Beneficiary Identifiable Data

CMS has proposed to add data elements to the beneficiary identifiable information provided to ACOs under Tracks 1, 2, and proposed Track 3. The provision of health status and utilization rates would be a positive development that makes the data more useful for improving care management. In the proposed rule, CMS only provides categorical examples of additional data elements to be provided in the quarterly reports, and we would like to suggest the following data points for inclusion:

- Date of the beneficiary's original Medicare eligibility
- Date of change in the beneficiary's eligibility status (for example, a change from aged to dually-eligible)
- An indicator identifying the change of an individual beneficiary's Health Insurance Claim Number (HICN), with the date of the change
- Hierarchical 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 should be added to the beneficiary attribution file to create a check-and-balance process to ensure no members are lost in the data reporting process
- An indicator, for each beneficiary included on each attribution report, of a beneficiary's institutional/hospice status to help ACOs identify domiciled patients for which the ACO is unaware
- Expanded 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
- Aggregated data on substance abuse claims expenditures

The success of the ACO is dependent on the timely transfer of patient information and coordination of their care, among many other things. Since Part B 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 attributed patients. While CMS provides each ACO with a retrospective administrative claims dataset for analysis of healthcare services to their ACO population, the data represent services that have already been provided by an ACO or non-ACO. These datasets are valuable for evaluating subpopulations 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.

Since CMS currently receives all eligibility checks from hospitals, emergency departments, and post-acute providers, and maintains a file of these eligibility checks in the Health Insurance Portability and Accountability Act's (HIPAA) Eligibility Transition System (HETS), 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 healthcare providers who may not be participating with the ACO. **We believe that daily HETS data feeds could be leveraged to improve care processes within an ACO.**

CMS currently does not 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 suggest that CMS provide the de-identified cost and claims data for these services. If this is not possible, at a minimum, CMS should provide the aggregate payment amount of these services in the monthly CCLF files.**

Beneficiary Opt-Out from Data Sharing

CMS proposes to streamline the process for MSSP participants to access beneficiary claims data necessary for healthcare 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 an 800 number rather than going through their healthcare provider to decline the sharing of their claims data. The signs would likewise include instructions for how beneficiaries can reverse their opt-out decision through the 800 number. **We support this more streamlined approach that will effectively provide greater access to beneficiary data with less administrative burden on the ACO.** However, if an ACO is assigned a beneficiary who opts out of sharing their data, we suggest that these beneficiaries be removed during the financial reconciliation process since the ACO would therefore have difficulty coordinating the care of these patients and should not be held financially accountable for them.

Assignment of Medicare Beneficiaries

CMS proposes to expand the list of codes that define primary care services in the MSSP. New codes would include those that are used to report physician or nonphysician practitioner transitional care management (TCM) and the new chronic care management (CCM) codes, reflecting the addition of these newer codes used to define primary care services. CMS also proposes to review Step 2 of the assignment methodology to remove certain specialty types whose services are unlikely to indicate primary care services, in addition to including nurse practitioners, physician assistants, and clinical nurse specialty primary care services in Step 1 in order to recognize the primary care furnished by these practitioners. CMS also proposes to exclude specific specialties from the beneficiary assignment methodology under Step 2. **Overall, AMGA agrees with these proposals and believes they will be beneficial to ACOs because they will help improve the accuracy of the assignment process and attribute beneficiaries based on primary care services, as intended.**

At its November 2013 meeting, MedPAC discussed ways to improve ACOs, and compared and contrasted Medicare Advantage (MA) plans and ACOs, concluding that the ability of MA plans to advertise why their plans are attractive to prospective patients, and the requirement that beneficiaries select, and remain, with one MA network for a defined enrolled period, contribute to the success of MA. Both of these features are absent from the ACO program in their current form, and **permitting ACOs in all tracks to choose prospective attribution**, would help to level the playing field for ACOs.

AMGA also believes that ACOs are in the best position to determine who is furnishing primary care services in their medical groups, yet Table 2 of the proposed rule continues to include services provided by a number of physicians with non-primary care specialty/subspecialty designations as part of the beneficiary assignment process under Step 2 who may not be furnishing primary care services. Those specialty/subspecialty physicians that predominately limit their services solely to their area of specialty can be inappropriately included in the primary care-oriented attribution process, leading to inaccurately

attributed beneficiaries. **ACOs should therefore have the option to request exclusion of physicians from ACOs by having them complete an attestation stating that they do not provide primary care.**

Modifications to Existing Payment Tracks

Track 1 Proposals

The proposed rule acknowledges that one 3-year agreement period for Track 1 ACOs may not be adequate before the organization is required to transition to Track 2. Moreover, CMS states that the current features of Track 2 may not be sufficiently attractive to ACOs that are considering participation in a risk-based arrangement, and AMGA agrees, given the small number of participants in Track 2, and the difficulties that many Track 1 ACOs have experienced.

CMS therefore proposes to permit Track 1 ACOs that have met the quality performance standards and compliance requirements to remain in their current track for another agreement period. However, this option would include a steep penalty, since CMS proposes to penalize these ACOs by 10 percent of their shared savings, meaning that they would share up to 40 percent, rather than 50 percent, of the savings they have generated under this scheme. This seems overly and unnecessarily punitive, and continues to stack the deck against Track 1 ACOs who are struggling to meet their minimum savings rate (MSR), often the very same ACOs that are already very efficient and should be able to succeed in the program.

The proposal to reduce the MSR to a flat 2 percent in Track 1, rather than one that can go up to 3.9 percent, is positive, however, and will help some ACOs reach the point of sharing in savings generated.

AMGA therefore urges CMS to eliminate the 10 percent reduction in shared savings for Track 1 ACOs who wish to continue for another agreement period, while modifying the MSR to a flat 2 percent in order to provide a more even playing field to Track 1 ACOs so they can continue to build capacity to become successful participants in the MSSP.

CMS is also proposing to modify the agreement period from three to five years for Track 1, and all other potential tracks, and **AMGA would support this extension.**

Track 2 Proposals

CMS proposes to replace the current flat 2 percent MSR and minimum loss rate (MLR) under Track 2 with a variable MSR and MLR, varying the ACOs MSR and MLR based on number of assigned beneficiaries, the methodology currently in used in Track 1. The rationale for this proposal is that such a method could limit the down-side risk for some ACOs. Yet it can also reduce the shared savings for ACOs that exceed the MSR. **AMGA would recommend giving ACOs a choice between no MSR/MLR, the proposed flat 2 percent, or a variable MSR/MLR based on the number of beneficiaries (from 2-3.9 percent).** There is precedent for providing such an option in the Bundled Payment for Care Improvement Initiative (BPCI), and individual ACOs are best situated to determine the amount of risk they are prepared to accept.

In general, ACOs have shown a reluctance to participate in Track 2 of the MSSP program, with only a very small number signing up for this option, due to uncertainty as to whether they will receive a portion of shared savings or be responsible for payments to CMS. AMGA believes that the appropriate focus of this rulemaking is to improve Track 1. The current difficulties must be addressed before

additional ACOs will sign up for Track 2, or the proposed Track 3. A slight modification to the MSR/MLR is the only proposal specifically addressed at improving Track 2, and on its own may prove inadequate to incentivize additional participants in this track without other changes to the regulatory framework.

Proposed Track 3

CMS proposes a new Track 3 in the MSSP for those organizations that are interested in taking on risk in exchange for the potential to earn more shared savings. However, given the current difficulties with participation in Track 1, as with Track 2, we believe that few ACOs will elect to participate in the proposed Track 3. Although the benefits of Track 3, such as prospective attribution, a 2 percent MSR, and up to a 75 percent shared savings rate are attractive attributes, we believe that participation in the proposed Track 3 is aspirational for most ACOs without substantive improvements in Track 1.

That said, CMS is requesting comments on ways to encourage ACOs to participate in performance-based risk arrangements. **We believe that if administered properly, beneficiary attestation and prospective attribution could be helpful to ACOs and could help promote more participation in two-sided risk models, although we believe that prospective attribution should be made available to both Track 1 and Track 2, in addition to the proposed Track 3.** We also suggest that any beneficiary that is aligned to an ACO be eligible to attest because it would allow the aligned population to better reflect the delivery system's primary care populations and it would favor beneficiary choice, as stated earlier. It has the added advantage of being forward looking, reflecting where the beneficiary wants to have their care delivered going forward rather than where they had their care in the past.

CMS could also offer risk-adjusted global payments or a global budget as an alternative to a shared savings/losses model. With such an approach, ACOs would know who their patients are ahead of time, and also know what their budget would be, and could innovate within this model to meet the program requirements. If the ACO kept total fee-for-service (FFS) spending below the budget, it would receive a supplemental payment based on the difference between their spending and the budget. Overall, this approach would provide much-needed certainty and predictability to ACOs, and there is precedent for a similar approach in the Bundled Payments for Care Improvement program.

Benchmarking Alternatives

CMS is seeking comment on alternatives to the current benchmarking methodology that would assist in enhancing the MSSP program's viability. AMGA welcomes this opportunity to comment and believes that MSSP participants should have the choice to transition to benchmarks based on regional FFS expenditures instead of national FFS expenditures, or use a blend of regional and national FFS expenditures. Many AMGA member medical groups have indicated that use of a regional component in the benchmarking process for their ACOs could make a positive difference in their ability to meet the MSR.

Under the current benchmarking methodology that takes into account an ACO's historical costs, benchmarks vary considerably among ACOs. As a result, low-cost ACOs may have more difficulty in achieving shared savings, or simply elect to not participate in the MSSP program at all. Given the goals of the MSSP program to incentivize improvements in population health while slowing the growth Medicare expenditures, the benchmarking framework should provide a way for high-quality, low-cost ACOs to succeed financially.

Weighting the three benchmark years evenly for the purposes of resetting the benchmark in second and subsequent years would help ACOs that are saving money, but have not achieved savings beyond the MSR. In addition, we agree with the CMS proposal to add back earned shared savings to benchmark calculations beyond the first year to provide a pathway for ACOs to realize shared savings and support the policy goal of greater participation by efficient providers.

Additional Comments

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. 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. Capital access assistance would also facilitate ACO development in other areas such as healthcare-provider shortage areas. **Thus, we recommend expansion of the Advanced Payment Model of the Shared Savings program, and consideration of other means of removing barriers to needed capital sources (e.g. low-cost and/or federally guaranteed loan programs).** Some AMGA members who have in excess of 50 physicians, and therefore could not qualify for assistance through the Advanced Payment Model, have sought loans through other sources in order to make the needed investments in infrastructure and clinical transformation to meet program requirements.

Risk Adjustment

Many AMGA members who are MSSP participants have struggled with the current application of the CMS Hierarchical Condition Categories (HCC) prospective risk scores in the program which are currently capped at the ACO's baseline risk. CMS allows an *increase* in the risk adjustment only for demographic changes, but not for changes in the acuity of the health status of the ACO's attributed patient population. Yet CMS allows *reductions* in the risk score adjustment based on demographic factors and HCC scores for the continuously enrolled. This method of risk-adjustment is fundamentally unfair to ACOs who successfully manage the care of their patient populations. **CMS should address this issue in the final rule in such a way to recognize and award ACOs for their success in improving the health of their patients rather than being penalized for these improvements.**

In closing, we respectfully request that CMS consider the following:

- Extend the use of waivers to Track 1 for SNF services, telehealth, the homebound requirement, referrals to post-acute care settings, and primary care co-pays;
- Permit ACO beneficiaries to attest that they receive their care from a specific ACO;
- Provide ACOs with enhanced information on their attributed patient population including de-identified or aggregate data on substance use;
- Finalize proposals to streamline beneficiary opt-out from data sharing;
- Finalize proposals to modify the beneficiary assignment process;
- Eliminate the 10 percent penalty in shared savings to Track 1 ACOs who wish to continue for another agreement period, while modifying the MSR to a flat 2 percent;
- Extend ACO agreement periods to five years for all tracks;

- Give Track 2 ACOs a choice between no MSR/MLR, the proposed flat 2 percent, or a variable MSR/MLR based on the number of assigned beneficiaries;
- Permit ACOs in all tracks to choose prospective attribution of their beneficiaries;
- Assist ACOs with financial barriers that may prevent entrance into, or their success, in the MSSP;
- Improve the current benchmarking process by finalizing several choices that would permit ACOs to choose which methodology would work best for their particular ACO;
- Address the inequities inherent in the current HCC methodology.

We sincerely appreciate the opportunity to comment on these proposals. If you have questions, please do not hesitate to contact Karen Ferguson, Senior Director of Public Policy, at kferguson@amga.org.

Sincerely,



Donald W. Fisher, Ph.D.
President and CEO