March 28, 2016

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Mr. Slavitt:

On behalf of AMGA, we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Service's (CMS) proposed rule titled, "Medicare Program: Revised Benchmark Rebasing Methodology, Facilitating Transition to Performance-Based Risk and Administrative Finality of Financial Calculations (CMS-1644-P). AMGA, founded in 1950, represents more than 450 multi-specialty medical groups and integrated delivery systems representing about 177,000 physicians who care for one-in-three Americans. Our member medical groups also participate in the Medicare Shared Savings Program (MSSP), or the Accountable Care Organization (ACO) program, as well as in the Pioneer and Next Generation ACO demonstrations. AMGA has a strong interest in the proposed changes to resetting and updating ACO financial benchmarks and related proposed changes to the MSSP.

Before detailing our specific responses to the proposed rule we have two relevant general comments and five overarching MSSP comments.

1. **Nomenclature**: The proposed rule is made unduly confusing because CMS does not use the agency's earlier nomenclature. ACO financial benchmarks are "established," "updated" and "reset." Throughout the proposed rule, CMS instead uses the words "rebase" or "rebasing" and "trend" or "trending." MSSP regulatory rules now number approximately 500 Federal Register pages; and, the rules are both extensive and complicated. Going forward we encourage to CMS be precise in its language when discussing and proposing changes to financial benchmarking.
2. **Transparency**: We have four inter-related comments. First, CMS began to make MSSP data available only three months prior to the proposed rule's release. Therefore, the ACO provider community and researchers were unable to adequately assess or model the proposed benchmark changes. Second, the proposed rule should have provided examples of specifically how it will calculate proposed benchmark changes. For example, how CMS will calculate historical benchmarks due to changes in Tax Identification Number (TIN) composition. While we have studied the program intensively over the past five years and have published numerous ACO-related essays, in commenting below we are forced to rely, in part, on our intuition. Third, the lack of program data is compounded by the fact the program lacks any evaluative evidence. Beyond the limited analysis the Research Triangle Institute (RTI) provides each September, is

CMS evaluating the MSSP methodically? Fourth, CMS would substantially advantage the provider community generally, as well as Medicare stakeholders and researchers, if the agency would make publicly available its MSSP "Spotlight" newsletter, the Sharing Saving Program portlet or website and any and all other information materials made available exclusively to MSSP and ACO demonstration participants.

1. **Synchronization with Medicare Advantage (MA)**: In its March 11 comment letter, MedPAC once again used the word "synchronization." The Commission stated, "In cases in which the MA program has crafted solutions to similar problems it might be helpful for CMS to use a similar approach in the MSSP. This also could further the eventual goal of the Commission to bring about synchronization among fee-for-service (FFS), MA and the ACOs so that the programs could be compared more equitably." We could not agree more. Since the MSSP and MA programs compete, they need to be put on a level playing field. In this context, the proposed is incrementally helpful.
2. **Quality Performance Benchmarking**: Per MedPAC's synchronization comment, quality performance benchmarking between MA and MSSP remains distinctly different. As it is phrased, MA quality performance is bonus only and MSSP quality performance is penalty only. Again, MSSP needs to be able to credibly compete with MA; therefore, quality performance needs to be similarly rewarded. Otherwise as MedPAC warned in its February 2, 2015 letter an "ACO with top quality performance would end up with a lower benchmark than an MA plan in the same market with top quality performance. This situation could be seen as inequitable for the ACO."
3. **Regional/National Blend**: CMS notes in the proposed rule during the previous rule making process there was discussion of using a blended approach "whereby benchmarks would reflect a combination of the ACO's historical costs and regional, national or a combination of regional/national costs." As noted below we support the proposal to incorporate regional expenditures to update an ACO's reset benchmark. AMGA believes MSSP and ACO programming needs to comparable and in the long term, CMS should consider factoring in a national expenditure component similar to how the agency calculates MA benchmarks. Among other reasons, CMS should consider a regional/national blend. This would align the MSSP program with the agency's Next Generation demonstration which uses a national efficiency factor in calculating the agency's discount and in calculating a national projected trend similar to MA.
4. **Unstable Assignment**: We realize the current proposed rule is limited to improving MSSP financial benchmarking or improving financial performance. Should these proposed changes be finalized, however successful they are in improving ACO performance and increasing net federal savings, these changes do not address the underlying problem of unstable beneficiary assignment. This problem even exists in the Pioneer demonstration that uses prospective assignment. This problem has been fairly well documented by J. Michael McWilliams and his colleagues in JAMA Internal Medicine, in Health Affairs and in white papers. While voluntary attestation and financial incentives may reduce patient churn, it is likely a more formal solution will be necessary to adequately address or remediate the problem of unstable beneficiary assignment.
5. **Benchmark Resetting**: We understand there continues to be discussion at CMS about foregoing formally resetting an ACO's benchmark. Among other reasons, the current methodology rewards inefficient ACO providers at baseline. This approach would also avoid discouraging comparatively high spending ACOs from participating, continue to participate or move to an at risk track and avoid unduly benefiting comparatively low spending ACOs. As

argued in the Sherri Rose, et al. article noted below, "A strategy to promote growth in ACO savings and facilitate a transition to regional benchmarks without discouraging participation would be to eliminate the rebasing of the historical spending component in CMS's proposed benchmark methodology." We believe this option is worth further consideration.

Proposals for: Alternative Approaches to Reset the ACO's Benchmark; for Establishing the Beneficiary Population Used in Determining Expenditures in ACO's Regional Service Area; and, for Determining County FFS Expenditures

We agree with the proposal to use counties of residence of ACO assigned beneficiaries in integrating regional costs in resetting ACO benchmarks. CMS used counties to define the service area for the Physician Group Practice demonstration and moreover uses county-level FFS expenditure data for setting MA rates. As CMS notes, this would "more closely align the Shared Savings Program with MA when adopting a benchmarking approach that accounts for regional costs." CMS states further, "MedPAC's longer term vision for the program's benchmarking methodology included achieving equity among ACOs in a geographic market and rewarding efficiency across payment models, including FFS Medicare, the Shared Savings Program, and MA." We quote this latter statement because the MSSP and MA programs compete. Therefore, they should be on a level playing field. Moving ACOs to more county-based benchmarks helps accomplish this.

In determining regional costs for the ACO End Stage Renal Disease (ESRD) beneficiaries, CMS proposes to use "state-wide values for the ESRD population." The agency notes this approach is also consistent with the MA program. We support "consistency" between the MSSP and MA and maintain that statewide values would be "more statistically stable" if CMS explains how this approach would be optimal for ACO participants should this proposed change be finalized.

CMS proposes to use all assignable beneficiaries, including ACO assigned beneficiaries, to determine expenditures for the ACO's regional service area. Using assignable beneficiaries is preferable to using all FFS beneficiaries since, as CMS notes, this latter option would include those that have not utilized any services, which would result in lower per capita county expenditures. CMS rationalizes that including assigned beneficiaries is necessary in instances where an "ACO's assigned population makes up a large portion of the population of its region" and therefore their exclusion would limit the accuracy of calculating regional FFS expenditures calculations. Including assigned beneficiaries in calculating regional expenditures undermines the goal of comparing or weighting ACO performance against 35 percent and 70 percent regional performance so that ACO's are not strictly required to compete against past performance. In addition, this argument appears to be a solution to a non-existent problem; that of an ACO making up a "large portion of the population of its region." CMS admits ACO assigned beneficiary populations currently "make up a small fraction of the FFS beneficiaries in an ACO's regional service area." CMS states the median assigned beneficiary population is currently 12 percent. If and when assigned beneficiaries make up a significant portion of a region's FFS beneficiaries, removing assigned beneficiaries from the reference population may bias results. We agree this is a potential problem. In the interim CMS should, as the agency states, "monitor for cases where an ACO tends to serve a large proportion of FFS beneficiaries in its region, and consider the effect of these circumstances on ACO benchmarks." If and when the evidence demonstrates excluding assigned beneficiaries results in an invalid or unstable regional FFS expenditure comparison, the agency could adopt MedPAC's recommendation as detailed in its March 11 letter that a five year rolling average could be used to determine FFS county-level spending estimates.

CMS further proposes to include any county where one or more assigned beneficiary resides and to

weigh county-level expenditures proportionally. We support county weighing but believe CMS should raise the minimum from at least one ACO beneficiary to at least one percent of ACO beneficiaries in any one county.

We agree with the agency's proposal to continue to calculate expenditures for ESRD, disabled, aged/dual eligible and aged/non-dual eligible for the 12 month calendar year for the relevant benchmark or performance year, allowing for a three-month claims run out and applying a completion factor, excluding Indirect Medical Education, Disproportionate Share Hospital, and uncompensated payments, including demonstration program payments, truncating total A and B expenditures at the 99th percentile of national FFS expenditures and risk adjusting. We are particularly supportive of the agency's promise to make "county level data used in [the] Shared Savings program calculations publicly available annually." CMS should do so in a timely manner.

Proposals for Applying Regional Expenditures to ACO's Reset Benchmark; and, for Adjusting the Reset to Reflect Regional FFS Expenditures

CMS proposes to "forgo making an additional adjustment to account for savings generated by the ACO in its prior agreement period." "As a way to encourage ongoing participation by successful ACOs and improve the incentive to achieve savings," CMS proposed in December 2014 to add an ACO's proportion of earned shared of savings to the ACO's reset benchmark, because, CMS stated further, doing so "would more gradually lower the benchmarks of ACOs that perform well in their prior agreement." CMS also stated, "There are clear advantages of this adjustment for ACOs and the Medicare program. In particular, ACOs would have an increased incentive to continue to generate shared savings and improve quality because of the prospect of having a higher benchmark in future agreement periods. Consequently, ACOs may demonstrate improved performance over longer term participation in the program. Further, ACOs may be encouraged to enter the program’s two sided models (such as the proposed Track 3), which offer higher final sharing rates because making an adjustment to the benchmark for these ACOs to reflect successful participation during one agreement period may improve their potential to receive shared savings in the next agreement period. In the June 2015 final rule, CMS adopted this policy change stating, "We believe that this adjustment is important for encouraging ongoing participation by ACOs who have achieved success."

We believe CMS should not reverse its June 2015 final rule largely because program incentives are already seen as insufficient. In context of the proposed changes to the reset benchmark, adding in an ACO's savings would more gradually lower subsequent reset benchmarks for ACOs harmed by integrating regional expenditures, or for those with comparatively higher historical versus regional expenditures. Maintaining this policy would encourage their ongoing or longer term program participation. ACOs with comparatively lower historical versus regional expenditures should be incented to remain in the program.

CMS proposes two options to adjust an ACO's reset benchmark: reset an ACO's benchmark via a regionally trended version of the ACO's prior historical benchmark; or, use regional average spending to transition ACOs to benchmarks based more on regional FFS costs. We support the agency's preferred approach to transition based on regional FFS costs because it more closely aligns with the MA rate-setting methodology.

Proposals for Transitioning to Higher Weight in Calculating the Adjustment for Regional FFS Expenditures

Beginning in 2017, CMS is proposing to account for 35 percent of regional expenditures in an ACO's

first reset benchmark and for 70 percent in second and subsequent reset benchmarks. CMS is considering alternative regional adjustments, such as a maximum of 50 percent or a more gradual transition over three agreement periods, and including first agreement period ACOs beginning in 2017.

We recognize transitioning to including a regional expenditure factor will benefit ACOs with comparatively lower historical spending and harm ACOs with comparatively higher historical spending. For the former group, CMS is concerned about arbitrage opportunities. CMS appropriately recognizes this concern is "likely to be outweighed by the benefits of encouraging more efficient care through a benchmark rebasing [reset] methodology that encourages continued participation by ACOs that are efficient relative to their regional service area." In addition, CMS in its "Anticipated Effects" discussion found that "there is evidence of a bias when compared to their regional service area expenditure level and that bias is likely to be predictable over time." The evidence does not suggest a comparatively low expenditure ACO with a more favorable reset benchmark will exploit the arbitrage opportunity. This inability to change performance substantially year-over-year, however, is problematic for ACOs with comparatively higher historical versus regional spending. The 50 ACOs furthest above their regional service area expenditure in 2013 only marginally improved or reduce their expenditures performance in 2014. Moreover, for comparatively high spending ACOs, which CMS wants to encourage to stay in the program, the agency should allow for a more incremental introduction of regional expenditures in their reset benchmark. For example, CMS could, as proposed, implement over three agreement periods or allow the ACO to integrate regional expenditures incrementally year-over-year over two agreement periods. As Sherri Rose, et al., argue in their recent March Health Affairs article, "Variation in Accountable Care Organization Spending and Sensitivity to Risk Adjustment: Implications for Benchmarking," converting too quickly to average regional FFS spending "will discourage valuable participation by organizations with high baseline spending."

First agreement period ACOs also should be included in the proposed benchmark changes. We agree with MedPAC's February 2, 2015 ACO proposed rule comment letter statement that "perpetuating differences between benchmarks for inefficient and efficient ACOs cannot be considered to be equitable in the long-run, thus moving to equitable benchmarks in a market is necessary." This is particularly appropriate since CMS admits, "ACOs tend to have service areas overlapping those of other ACOs in the same urban or suburban market(s)."

Proposals for Regional Growth Rate Factor For Benchmark Updating

To align with the agency's proposal to use regional FFS expenditures in resetting an ACOs historical benchmark, CMS is proposing to use regional FFS expenditures to update an ACO's financial benchmark using the same weighted average of risk adjusted FFS expenditures in counties where the ACO's assigned beneficiaries reside. CMS believes doing so would "better capture the cost experience in an ACO's region, the health status and socio-economic dynamics of the regional population, and location specific Medicare payments." CMS also is seeking comment on using, instead, the flat dollar equivalent of the projected absolute amount in regional per capita expenditures for Parts A and B FFS services. CMS also is interested in comments concerning applying regional growth to updating ACOs in their first contract period. We agree CMS should use the same formula to reset and update ACO benchmarks. Therefore, we do not support the alternative proposal to use the regional service area's flat dollar equivalent. Consistent with our comment immediately above, we also support applying the revised update methodology to first agreement period ACOs.

Proposals for Modifying the Calculation of National Expenditures, Completion Factors, and Truncation Thresholds Based on Assignable Beneficiaries

CMS proposes to use assignable beneficiaries instead of all FFS beneficiaries in updating an ACO's benchmark in their first agreement period and for those 2012/2013 ACOs in their second agreement period. This change would apply to ACOs with an agreement period that started in 2015 and 2016 and to ACOs with a second agreement period that started in 2016. AMGA supports this proposed change because we believe CMS should apply changes to benchmark resetting and updating to all ACOs equally.

Proposed Timing of Applicability of Revised Rebasing and Updating Methodology
For 2014, 2015, and 2016 ACO starters and subsequent cohorts that enter their second agreement periods on or after January 2017, CMS proposes to reset and update their benchmarks to reflect regional service area expenditures. CMS estimates the proposed changes to benchmarking will increase net federal savings by $120 million between calendar year (CY) 2017 and CY 2019. Since the proposed changes improve program performance, we see no reason why 2012-2013 ACO starters that renewed in 2016 are unable to benefit until their third agreement period, or not until 2019. We do not believe "perpetuating differences between benchmarks" is appropriate.

Risk Adjustment and Coding Intensity Adjustment
We oppose the use of different methods for updating risk adjustment for newly and continuously assigned ACO beneficiaries. We oppose the agency's policy, as stated in the proposed rule, to "take into account changes in severity and case mix for newly-assigned beneficiaries and demographic factors to adjust for changes for beneficiaries continuously assigned to the ACO." CMS limits risk adjustment to demographic factors only for the continuously assigned beneficiary. It is unreasonable to assume an ACO, however effective, can manage its assigned population such that it never carries a higher disease burden. CMS should allow risk scores to increase year-over-year within an agreement period for the continuously assigned.

We oppose this policy also because the proposed rule states, "As a result of normal changes to beneficiary assignment from year to year, beneficiaries whose risk scores were subject to ACO coding initiatives in one year may no longer be assigned to the ACO in the next year." If year-over-year unstable assignment, which CMS estimates at 24 percent, negates or at least mitigates coding intensity concerns, the agency's insistence in persisting with its continuously assigned risk adjustment policy lacks justification. CMS also notes employing regional trend calculations for resetting the benchmark "are expected to mitigate the risk of sensitivity to potential coding intensity efforts by ACO providers/suppliers." For these reasons, we also see no logic to CMS "considering ultimately moving to a coding intensity adjustment similar to the methodology used in the MA program."

In the proposed rule, CMS indicates the agency will "adjust for an ACO's risk relative to that of its region in determining the regional adjustment to the ACO's reset historical benchmark." We support this approach in theory. The rule notes the agency is proposing to comparatively risk adjust "in relation to FFS beneficiaries in the ACO's regional service area," meaning specifically risk adjusting in relation to assignable beneficiaries. This would be consistent with how CMS is proposing to account for regional expenditures in resetting and updating ACO benchmarks. As the proposed rule explains, this is because using all FFS beneficiaries would likely result in inappropriately comparing an ACO's assigned beneficiary to a more healthy FFS population. We are however concerned that in practice ACO providers may inherit the inherent problem in FFS, that of unobserved clinical risk.

CMS states "these [risk adjustment] proposed changes would not apply in calculating the benchmarks for ACOs in their first agreement period, or in establishing and updating the rebased historical

benchmark for the second agreement period ACOs that started in the program in 2012 and 2013." We see no justification, and CMS provides none, for not including a regional adjustment for first agreement period ACOs beginning in 2017 and thereafter. Nor do we see any justification for not including a regional risk adjustment for updating second agreement 2012-2013 ACOs in 2017 and 2018.

Lastly, MedPAC has frequently noted that the ACO and Medicare Advantage programs should be better "synchronized." MedPAC emphasized this point in its June 2015 report to Congress, in its February 2, 2015 letter to Marilyn Tavenner, and again in its March 11, 2016 comment letter to Andrew Slavitt on this proposed rule. In addition, the agency's February 19, 2017 Medicare Advantage and Part D Advance Notice and Draft Call Letter proposed changes to MA risk adjustment to better account for higher acuity patients. If finalized, these MA risk adjustment changes should also be applied to the MSSP.

Adjusting Benchmarks for Changes in ACO Participants (TIN) Composition

We were not surprised to learn in the proposed rule that 74 percent of historical benchmarks for 2012/2013 ACOs for the 2014 performance year and for 78 percent of all ACOs for the 2015 performance years had their historical benchmarks adjusted due to changes in TIN composition. We also recognize the "operational burden" this presents CMS. In concept, we support the proposal to adjust benchmarks for changes in TIN composition using a single reference year, or the third benchmark year, principally because CMS states, "initial modeling suggests that benchmarks calculated using this alternative methodology are highly correlated with those calculated using the current methodology." As previously discussed in our comments concerning transparency, should CMS finalize this proposed change, we would ask that CMS provide an example of exactly how the agency intends to calculate the stayer component, the joiner component, how it will combine the stayer and joiner components, and how it would calculate a single weighted average per capita adjusted historical benchmark. We also are unclear how this proposed change will effect, if at all, calculating regional expenditures. Specifically, we are unclear the meaning of this statement, "In conjunction with the proposals to adjust an ACO's rebased historical benchmark to account for regional expenditures, we would also re-determine the regional adjustment to account for changes to the ACO's certified ACO Participant List".

Based on our comments on the importance of applying the final benchmark changes program wide, we support the agency's proposal to incorporate this change "for changes in ACO participants to all ACOs participating in the program," "apply this approach program wide," and "propose to incorporate this adjustment to the historical benchmark for ACOs in their first agreement period and those ACOs that started a second agreement period on January 1, 2016."

Facilitating Transition to Performance-Based Risk

CMS proposes to allow first agreement period Track 1 ACOs, beginning with ACOs with 2014 start dates, the option to extend their agreement period for a fourth year without having their financial benchmark reset. This means a Track 1 ACO would first apply for a second agreement as Track 2 or Track 3 ACO. If CMS approves an application, the ACO could exercise the option to remain as a Track 1 for a fourth year. The ACO's fifth year would begin its three year agreement as a Track 2 or 3. CMS also is considering allowing ACOs to remain in Track 1 in the first year of their second agreement period and to transition to Track 2 or 3 in the second and third year of their second agreement period. Again, the ACO would have to apply for the second agreement as a Track 2 or 3. Under either alternative CMS would update and reset the ACO's benchmark using the proposed regional/historical blend formula.

We recognize the MSSP is designed to ultimately move ACO participants to risk-bearing agreements. Therefore, we appreciate the agency's interest in finding reasonable ways to accelerate this process. On balance, we are not confident either alternative will be measurably successful. If a first agreement period Track 1 ACO was interested in remaining in the program but uncertain about its ability to manage successfully financial risk, or even qualify to sign a risk bearing agreement, why would the ACO not simply choose to continue as a Track 1 for a second agreement period, particularly when the organization still faces the same problem of unstable assignment as a Track 2 ACO. Unstable assignment or patient churn remains a substantial program weakness even under prospective assignment. In a study of one Pioneer ACO, Partners HealthCare, John Hsu and his colleagues recently concluded in a Health Affairs article in the third year of the demonstration, "only 45 percent of the beneficiaries had been aligned with the ACO since 2012." (See Hsu, et al., "Patient Population Loss At a Large Pioneer Accountable Care Organization and Implications for Refining the Program," Health Affairs, March 2016) While Track 3, like the Pioneer demonstration, attempts to addresses patient churn via the use of prospective assignment, providers may not be willing to accept 75 percent downside risk. These comments aside, we believe these options are nevertheless worth offering. If the proposed changes to resetting and updating ACO benchmarks are made, they alone may measurably improve provider interest and ability to participate in Tracks 2 and 3. In addition, how CMS defines APMs and the MIPS under MACRA will, as CMS recognizes, influence provider interest in accepting financial risk.

In accelerating Track 1 ACOs ability to take on financial risk we note the December 2014 proposed rule discussion of "other possible alternatives" that would allow ACOs to annually "split their ACO participant TIN list into different risk tracks" during an agreement period. In this "segmented lists" discussion, the agency outlined seven criteria to accomplish this. We note this related, previous discussion because we still believe allowing ACOs to annually, incrementally move into risk arrangements would prove to be valuable. Allowing an ACO to "accept varying degrees of risk" within an agreement period would position the ACO to balance its exposure to and tolerance for financial risk. This flexibility would create a true glide path for providers. Quality measurement could remain the same but reported by risk track. Benchmarking could be the same if the option was limited to moving to Track 2. ACOs could as well manage subpopulations by either retrospective or prospective assignment.

Administrative Finality: Reopening Determinations of ACOs Savings or Losses to Correct Financial Reconciliation Calculations, and Conforming Change

In the proposed rule CMS notes "financial reconciliation calculation/methodology and the amount of shared savings an ACO might earn, including all underlying financial calculations, are not appealable."

CMS states the agency is willing to "allow for [financial reconciliation] corrections, under certain circumstances and within a defined time frame." CMS proposes to reopen a payment determination within four years after the initial determination if there is good cause. Good cause is defined as new and material evidence or an obvious error. Good cause however could neither be "established by changes in substantive law or interpretative policy" nor by a change of legal interpretation or policy by CMS in a regulation, CMS ruling, or CMS general instruction, whether made in response to judicial precedent or otherwise. CMS further proposes to retain for itself "sole discretion to determine whether good cause exists." CMS does "not intend to propose specific criteria" for determining material evidence or "materiality" but identifies a preferred threshold of three percent "of the total amount of net shared savings and shared losses for all ACOs for the applicable performance year." CMS, however,

proposes to consider a higher threshold "such as 5 percent" or one lower, "such as 1 or 2 percent." CMS also proposes not to apply the three percent in instances of an individual ACO, because the agency believes it appropriate "to limit re-openings to correct CMS technical errors that more widely affect the program rather than reopening determinations for specific issues for each of the hundreds of ACOs participating in the Shared Savings Program."

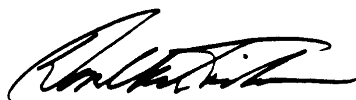
To the agency's credit, they are moving increasingly toward making its data more transparent or publicly available. Consistent with this effort, we believe the agency would be well served in maintaining the provider community and public's trust and confidence if periodic and independent external audits of the agency's ACO financial reconciliation activities were conducted.

Concerning the rule's discussion about when CMS will reopen determinations, the agency is essentially proposing it will make reopening decisions unilaterally using unknown or non-specified criteria. If this is an accurate assessment, the proposed rule's reopening discussion is unhelpful.

Regardless, we do not agree any reopening be exclusively defined as errors that amount to some percent of the total amount of net share savings and shared losses for all ACOs for the performance year. This approach ignores the reality that statistical sums do not account for the individual organization. In summarizing the administrative finality discussion, the proposed rule sates at page 5857, "if CMS determines that the amount of shared savings due to the ACO . . . has been calculated in error, CMS may reopen the earlier payment determination." We specifically cite this sentence because we support the ability of an individual ACO to request its payment determination be reopened within a two year time frame if it can reasonably demonstrate there is good cause or if the payment determination has caused the ACO material financial harm. ACOs should be held harmless if any recalculation is determined to be in the agency's favor. Should the ACO program continue to grow, having to meet the proposed threshold error of five percent "of the total amount of net shared savings and shared losses for all ACOs for the applicable performance year" potentially would amount to billions of dollars. Meeting this test would be far too severe and far too burdensome.

Thank you for offering AMGA an opportunity to comment. We look forward to continuing to work with CMS to evolve further the MSSP. If you have any questions please do not hesitate to contact David Introcaso, Ph.D., Senior Director for Regulatory and Public Policy, at dintrocaso@amga.org.

Sincerely,



Donald W. Fisher
President and CEO