Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

October 16, 2018

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Room 445-G Herbert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

REF: CMS-1701-P

Re: Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations—Pathways to Success

Dear Ms. Verma:

The Catholic Health Association of the United States (CHA) is pleased to submit these comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule on the Medicare Shared Savings Program and Accountable Care Organizations (ACOs) published in the Federal Register on August 17, 2018 at 83 Fed.Reg 41786. We appreciate your staff's ongoing efforts to increase the coordination of beneficiary care, improve quality and manage healthcare costs in the Medicare program. CHA offers the following comments on the proposed rule.

- **Redesigned MSSP Participation Options**

CHA appreciates and shares CMS' goal of encouraging more MSSP ACOs to transition to two-sided risk models. However, we are deeply concerned that the proposed redesigned structure is too aggressive and will deny participants the time and tools they need to realize the potential quality, clinical and business benefits from ACOs. The effect of many of the proposals will be to make providers reluctant to enter or remain in the program.

Glide Path to Performance Based Risk

CMS proposes to end the current Track 1 and Track 2 and replace it with a BASIC track comprising five levels in a five-year program term. Participants at the A and B levels would be eligible to share savings and face no down-side risk. Levels C, D and E would apply increasing levels of both shared savings and shared losses. Level E would correspond to the current Track 1+. CMS also proposes to create a five-year ENHANCED track which would preplace the current Track 3 and

would offer the both the highest potential for shared savings and the highest potential liability for shared loss.

The proposal would allow at most two years in a one-sided model. **We strongly recommend that this period be extended and that ACOs have the opportunity of participating for at least three years before they begin to assume down-side loss.** Studies have shown that ACOs are more likely to achieve shared savings with time, with the shared savings rate doubling over three years of experience.[1] Sufficient time in an upside-only model prior to moving to downside risk will promote ACO success. **Should participants find themselves ready to assume risk sooner, we agree they should have the option to choose to advance more rapidly through the BASIC levels.**

We also urge CMS to increase the shared savings rates in the BASIC track. CMS should maintain the current Track 1 savings rate of 50% for BASIC levels A and B. We agree that, as proposed, the shared savings rate should increase as ACOs begin to assume and increase downside risk, with the opportunity for savings increasing from 50% rising by 5 to 10 percentage points with each step. Shared shavings help participants to recoup the up-front investments that are crucial to the success of ACOs.

CHA urges CMS to incorporate a transition from BASIC level E to the ENHANCED track. Under the current proposal, the only option available for many ACOs would be the ENHANCED track. CMS should either build a glide path to the highest risk level within the ENHANCED track or offer an additional track to help bridge the gap between the BASIC and ENHANCED tracks. We also urge CMS to increase the incentive for ACOs to enter the ENCHANCED track to 80% (same as the Next Generation ACO program).

Annual Participation Elections

As already noted, CHA supports the proposal to allow ACOs to skip levels within the BASIC track. CMS indicates that an ACO can only spend one year at a given level, even if it has skipped ahead to that level, progressing to Level E and remaining there for the duration of the agreement period. We suggest CMS allow ACOs that advance themselves to remain in that track instead of automatically advancing, in other words, not to require them to move beyond the level they would have been in had they not chosen to advance.

CHA also supports allowing ACOs to choose either prospective beneficiary assignment or prospective assignment with retrospective reconciliation, as required by the Bipartisan Budget Act (BBA) of 2018, and to give ACOs an annual opportunity to change their beneficiary assignment choice. Many ACOs will choose prospective assignment to help them manage care as they assume greater levels of risk. Other ACOs may prefer the retrospective

[1] https://www.healthaffairs.org/do/10.1377/hblog20180918.957502/full/?utm_term=Half+A+Decade+In%2C+Medicare+Accountable+Care+Organizatio%E2%80%A6

assignment model so they can add beneficiaries throughout the year. We support giving ACOs this choice, a clinical and business decision each ACO can make according to its situation.

Determining Participation Options based on Medicare FFS Revenue

An ACO's ability to participate in a given BASIC track level will be determined in part by its designation as a high revenue or low revenue ACO, high revenue being a proxy for ACOs that typically include a hospital and low-revenue a proxy for physician group ACOs. CMS states its belief that high revenue ACOs are more capable of accepting higher risk than low revenue ACOs. High revenue ACOs would have fewer participation options, in that those with "experience" would only be eligible for the ENHANCED track whether they are "new", "renewing," or "re-entering" the program. In addition, low revenue (and inexperienced) ACOs may operate under the BASIC track for a maximum of two agreement periods, whereas high revenue ACOs are limited to one agreement period.

CHA opposes the proposed distinction between high and low revenue ACOs. We urge CMS to eliminate it and to treat all ACOs the same. We are concerned that the proposed distinction would discourage ACOs that have the potential to generate substantial savings to the program from participating. We also believe CMS' rationale for the distinction is flawed. An analysis described by Premier in its comment letter of CMS' definition of "hospital-led" (the ACO includes a hospital TIN participant) found it to be inaccurate, with at least 20 percent of health system-led ACOs being designated as "physician-led." CMS also relied on its assertion that low revenue ACOs produce greater savings than high revenue ACOs. However, Premier's analysis found that some of the highest performing individual ACOs are in fact hospital-led.

CHA believes the creation of disincentives for hospital-led ACOs is inappropriate because the purpose of ACOs is to create incentives for providers to work together across care settings in the best interest of the beneficiaries through collaboration, innovation and coordination. Including a hospital in an ACO facilitates the provision of specialty care as well as primary care and enhances the ability to make sure that patients receive care in the most appropriate setting.

- **Fee-For-Service Beneficiary Enhancements**

CMS proposes two new waiver options. A waiver of the Skilled Nursing Facility 3-day rule is currently available to risk-bearing ACOs with prospective beneficiary assignment. CMS proposes to expand the waiver to include risk-bearing ACOs that choose preliminary prospective beneficiary assignment. Consistent with the provisions of BBA 2018, CMS also proposes to waive originating site and geographic restrictions on Medicare-approved telehealth services for risk-bearing ACOs with prospective beneficiary assignment. This would make telehealth services available to beneficiaries in their homes, when appropriate. **CHA strongly supports both of these waiver proposals, which will increase the ability of ACOs to deliver coordinate, quality care.** CHA

also supports efforts to protect from liability beneficiaries who have not been prospectively assigned but are inadvertently provided with telehealth services under a waiver they cannot participate in.

- **Tools to Strengthen Beneficiary Engagement**

Beneficiary Incentives

CMS current authorizes ACOs to provide in-kind items or services as incentives to beneficiaries. The BBA of 2018 provides that risk-bearing ACOs may establish benefit incentive programs. Consistent with the BBA, CMS has proposed that eligible ACOs be allowed to provide incentive payments directly to beneficiaries when they receive qualifying primary care services from designated types of primary care providers, in the amount of $20 and in non-cash form such as gift cards or checks. **CHA supports this proposal to provide beneficiary incentives**, and suggests that CMS provide template language for providers to use when telling beneficiaries about the program, to avoid any issues with fraud and abuse laws.

Beneficiary Notification

Current regulations on beneficiary notification require ACO participants to post signage with relevant information in participating sites and, in some instances, make written notification available to beneficiaries upon request. CMS proposes to expand the content to inform beneficiaries of their option to voluntarily designate an ACO professional to coordinate their care (i.e., "primary clinician" or" main doctor") to implement the voluntary alignment provisions of BBA 2018. CMS also proposes to require that ACO participants provide this information to each Medicare FFS beneficiary at the first primary care visit of each performance year. **While CHA agrees beneficiaries should be provided with notice of their options, CHA does not support this proposal.** We are concerned that the proposal as structured will be administratively burdensome for providers and confusing for beneficiaries. **Instead we recommend that CMS maintain the current notice requirements and provide information about voluntary designation through another means after outreach to beneficiary user groups on what would be most effective.**

Quality Measures

CMS has invited input on possible changes to the quality measure set and modifications to program data shared with ACOs to support CMS's Meaningful Measures initiative and to respond to the nation's opioid misuse epidemic.

With respect to the Meaningful Measures initiative, CHA believes that quality measures tied to payment in existing and new models and programs should be reviewed regularly and be aligned across Medicare programs. We agree that ACO quality measures should emphasize outcomes over process. Industry and CMS must work together to rapidly adopt existing consensus-driven core measure sets – as CMS has set out to do through the Meaningful Measures Initiative - while

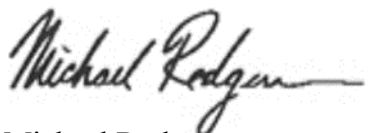
working to identify the next generation of core measures. CMS should seek to identify measures that best reflect the focus of ACOs and other alternative payment models on care coordination and population health and should commit to funding development of such measures.

CHA shares CMS' concern about the public health crisis surrounding the opioid overdose epidemic and the desire to avoid over-prescription of opioids. At the same time, effective pain management is an essential element of patient well-being and a key element in the provision of palliative care services to patients and families facing serious illness. The Catholic health ministry is strongly committed to providing patients with excellent palliative care services, which focus on providing relief from the symptoms, pain and stress of a serious illness. As you consider the addition of opioid-related ACO measures, we urge you to take care to avoid creating incentives that could unintentionally deny access to opioids for those who truly need them for pain relief.

Last, while statutory changes are necessary, we reiterate the importance of aligning 42 CFR Part 2 (Part 2) confidentiality requirements for sharing a patient's substance use disorder records with the requirements in the Health Insurance Portability and Accountability Act (HIPAA). Unlike HIPAA, Part 2 does not allow for sharing or re-disclosure of identifiable substance use disorder information for treatment, payment or health care operations ("TPO") purposes without patient consent. Moreover, Part 2 requires regulated programs to provide a notice to recipients of identifiable substance use disorder information noting that the information cannot be re-disclosed. From a compliance perspective, the different standards between HIPAA and Part 2 have made it extremely difficult for our hospitals and health systems to know when and how this information may be shared, including within individual hospitals – despite the importance of care coordination for individuals with substance use disorders. While supporting Part 2 reform, we also urge CMS to make available to providers engaged in population health management such as ACOs, and bound by a data use agreement with CMS, complete and identifiable data from CMS about substance use disorder-related diagnoses and services furnished to their assigned beneficiaries by providers to whom Part 2 does not apply.

In closing, thank you for the opportunity to share these comments on the proposed Medicare Shared Savings Program and Accountable Care Organizations rule. We look forward to working with you on these and other issues that continue to challenge and strengthen the nation's hospitals and health care system. If you have any questions about these comments or need more information, please do not hesitate to contact me or Kathy Curran, Senior Director Public Policy, at 202-721-6300.

Sincerely,



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