Alliance of Specialty Medicine

Sound Policy. Quality Care.

February 6, 2015

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244
Submitted electronically via www.regulations.gov

RE: Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations

Administrator Tavenner,

The Alliance of Specialty Medicine and its member organizations thank you for the opportunity to provide input on proposed changes to Medicare Share Savings Program (MSSP) Accountable Care Organizations (ACO). The Alliance is a coalition of 14 medical specialty societies representing more than 100,000 physicians and surgeons dedicated to the development of sound federal healthcare policy that fosters patient access to the highest quality specialty care.

Interest in the MSSP ACO program is growing among specialty physicians as a way to improve quality, resource use, and better coordinate care for our patients, particularly those with complex health conditions. Noteworthy attributes of the ACO program are expanded access to meaningful and actionable patient data, and a robust infrastructure that fosters improved communication among providers of care.

We very much appreciate CMS' willingness to meet with the Alliance and its individual members on multiple occasions over the past two years to listen to our concerns regarding challenges that specialists face in regards to the MSSP. We are encouraged that the proposed policies in this rule seek to improve the MSSP ACO program in ways that encourage meaningful specialist participation. In particular, we thank CMS for addressing one of our key concerns by revising how certain physician specialties are considered in the beneficiary assignment process to prevent exclusivity to one ACO.

In the paragraphs below, we outline our strong support for key proposals that have a direct impact on specialists' ability to engage in the MSSP ACO model, as well as make additional recommendations that would further encourage meaningful specialty medicine participation in the program.

Assignment of Medicare FFS Beneficiaries: *Consideration of Physician Specialties and Non-Physician Practitioners in the Assignment Process*

One of the biggest challenges specialty physicians have faced with the MSSP is their inability to participate in more than one ACO. Participation in multiple ACOs is critical for specialty physicians, particularly those in areas

with a high concentration of ACOs that anchor to a particular hospital or hospital system. The difficulty with the current assignment process is CMS' requirement that ACO participants billing for "primary care services" must remain exclusive to a single ACO since those services are used by CMS to assign beneficiaries to the ACO.

We understand the intent behind exclusivity. If CMS were to allow ACO participants to be assigned to two or more ACOs, it would be unclear to which ACO beneficiaries that receive primary care services billed by the ACO participant would be assigned. However, it is our position that this policy may defeat the MSSP's goal of improving care coordination and serves to disrupt long-standing patient–physician relationships.

To alleviate this concern, CMS proposes to exclude primary care services provided by certain CMS physician specialties from the beneficiary assignment process; that is, CMS would exclude Medicare claims for primary care services (i.e., office visit codes) by the "excluded" physician specialties when determining the ACO's assigned population.

The Alliance would like to thank CMS for listening to the concerns of the specialty medical community, and we offer our strong support for CMS' proposed action, as it would allow many specialists to engage in full-fledged participation with multiple ACOs. Alliance member organizations whose specialties were not excluded (Rheumatology and Gastroenterology), however, are concerned about the ongoing challenges they will face if their "primary care services" continue to be included in the beneficiary assignment process. Despite their use of the same office visit codes, these groups contend that their specialties do not routinely serve patients in the same capacity as traditional primary care specialties, such as those listed in Table 1 of the proposed rule. There may be limited instances where these specialties serve in a primary care role, but that is not the typical relationship that these specialists have with their patients. Therefore, **we urge CMS to exclude Rheumatology and Gastroenterology from step 2 of the assignment process.** Finally, **we urge CMS to correct a minor oversight, by adding Interventional Cardiology (C3) to the list of excluded specialties in Table 3.**

ACO Eligibility Requirements: *Agreement Requirements*

Specialty physicians remain concerned about other aspects of the MSSP ACO program, including how their contributions to the success of MSSP ACOs are being considered by the ACO entity. CMS' final ACO regulations and subsequent guidance clarified that ACO participant agreements and any agreements with ACO providers/suppliers must contain, among other things, the following:

> *"A description of how the opportunity to get shared savings or other financial arrangements will encourage ACO participants and ACO providers/suppliers to follow the quality assurance and improvement program and evidence-based clinical guidelines."*

In addition, Section 8 of the MSSP ACO Application, CMS requires a response to the following questions:

> *21. Please describe in a narrative how you plan to use shared savings payments, including:*
>
> *a. How you intend to share savings with ACO participants and ACO providers/suppliers, or to use the shared savings to reinvest in the ACO's infrastructure, redesigning care processes, etc.*
>
> *b. The percentage of savings you intend to distribute to each category. If you intend to distribute shared savings among ACO participants and ACO providers/suppliers, please describe the criteria you intend to use for distributing those payments.*
>
> *b. Describe how this plan will achieve the specific goals of the Shared Savings Program and how this plan will achieve the general aims of better care for individuals, better health for populations, and lower growth in expenditures.*

In this rule, CMS is proposing to retain the requirement that the ACO describe how the opportunity to receive shared savings or other financial arrangements will encourage the ACO participant to adhere to the quality

assurance and improvement program and evidence-based medicine guidelines established by the ACO, as well as add the following new requirement:

> *"The agreement must permit the ACO to take remedial action against the ACO participant, and must require the ACO participant to take remedial action against its ACO providers/suppliers, including imposition of a corrective action plan, denial of shared savings payments (that is, the ability of the ACO participant or ACO provider/supplier to receive a distribution of the ACO's shared savings) and termination of the ACO participant agreement, to address noncompliance with the requirements of the Shared Savings Program and other program integrity issues, including those identified by CMS."*

Specialty physicians support a shared savings model that considers the contributions of each individual ACO provider/supplier and ACO participant. Unfortunately, CMS' previously finalized ACO regulations did not require nor provide any guidelines for ACO's with respect to how shared savings payments may be optimally distributed among ACO providers/suppliers and ACO participants. In fact, according to the final rule, ACOs can choose against distributing any of the shared savings payment to ACO providers/suppliers and ACO participants. Furthermore, in this rule, CMS is proposing a new requirement that ACOs may *deny* a distribution of the shared savings payment to ACO providers/suppliers and ACO participants to address noncompliance with the MSSP requirements. If CMS is going to make a requirement that shared savings payment distributions may be denied, there must also be a requirement that a shared savings payment distribution must be made to all providers who contribute to the quality and savings of the ACO. Given the emphasis on boosting payment to primary care providers, specialty physicians are the least likely of all ACO providers/suppliers to receive a shared shavings payment despite their contribution to the ACOs performance.

We recognize the need for ACOs to have some flexibility in determining what proportion of shared savings will be needed to reinvest in the ACO's infrastructure or to redesign care processes, among other things. However, some portion of the shared savings payment must be fairly distributed to ACO providers/suppliers and ACO participants that have facilitated the ACO's success. The proportion designated for distribution among ACO providers/suppliers and ACO participants should be based on each individual ACO providers/suppliers and ACO participant's contribution to improving the ACOs performance.

For the reasons noted above and to ensure long-term success of the MSSP ACO program, we urge CMS to:

1) **Require a portion of an ACOs shared savings payment to be distributed to ACO providers/suppliers and ACO participants that contributed to its success;**
2) **Develop guidelines for establishing, and require ACO adherence to, a shared savings distribution model that fosters a fair and sustainable shared savings distribution process and bolsters specialty physician confidence in ACOs; and,**
3) **Establish benchmarks to determine whether the ACOs shared savings distribution process is facilitating or limiting care coordination activities and access to specialty care.**

Shared Savings and Losses: *Extension of One-Sided Risk Model While Incentivizing Performance-Based Risk*

The Alliance thanks CMS for proposing to give ACO's more flexibility in terms of choosing a model that is most appropriate for them. This includes extending the time period over which an ACO can participate in the one-sided risk model and creating a new "third track" for ACOs who feel they are ready to take on more risk, but be eligible to earn greater savings.

Currently, ACOs choosing the one-sided risk model have a three-year grace period where they can share in

Medicare savings, but are excused from penalties. Under the new proposal, ACOs, both new and existing, would be given an extra three years before they faced penalties, for a total of six years. Given concerns expressed by ACOs about three years being an insufficient amount of time to prepare for taking on downside-risk, we appreciate this proposed extension. However, we question CMS' proposal to lower the maximum amount of Medicare savings that an ACO can keep from 50% to 40% for those that remain in the one-sided model for an extra three years. We recognize the need to find a balance between providing high enough incentives to encourage ongoing participation in the program while also decreasing the financial attractiveness of the program enough so that it encourages ACOs to transition to performance-based risk models. However, the MSSP is still relatively new and providers have not yet had that much experience with shared savings models, especially smaller ones with less resources. To minimize the impact of this investment and ensure broader participation in the program by providers of all sizes and in a range of practice settings, **we encourage CMS to allow ACOs that remain in the one-sided model for an additional three years to keep up to 50% of savings they bring to Medicare.**

In regards to the newly proposed two-sided track with higher risks and rewards (i.e., "Track 3"), we appreciate CMS' effort to strengthen incentives for ACOs to choose two-sided risk arrangements. Currently, only 5 ACOs have opted for Track 2, which points to a need for better incentives. Track 3 **w**ould be based on the payment methodology of Track 2, but would also integrate certain aspects of the more aggressive Pioneer ACO Model. It would include a maximum shared savings rate of up to 75% based on quality, with a performance payment limit of 20% of the benchmark. The current Track 2, by contrast, caps maximum shared savings at 60%, with a performance payment limit of 15%. Under Track 3, an ACO's shared loss rate would range from 40% to 75% based on quality, with a loss sharing limit of 15% of the benchmark.

What the Alliance finds most attractive about the Track 3 proposal is that CMS would prospectively assign the target beneficiary population to the ACO at the beginning of the performance year, in order to enable the ACO to most effectively focus its care redesign efforts. Beneficiaries could only later be removed from the list based on specific exclusions (i.e., no longer meeting eligibility criteria). This is the method currently used under the Pioneer Model. However, it differs from ACOs participating in Tracks 1 and 2, in which beneficiaries are assigned in a preliminary prospective manner with retrospective reconciliation. While retrospective reconciliation helps to account for the ebb and flow of assigned beneficiaries throughout the year, it may result in significant changes to the assigned population. This is a serious concern and disincentive for ACOs opting for higher risk models, since they do not know ahead of time for whom they will be held accountable. In fact, **the Alliance believes this model is appropriate not only for Track 3, but for Tracks 1 and 2 since it provides ACOs with greater certainty about the population on whom they will be assessed.**

Other Concerns

We want to emphasize our support and gratitude for CMS' aforementioned proposal that would address specialists' ability to participate in multiple ACOs, however, we remain concerned that ACOs may be functioning similar to former managed care models, where incentives to reduce costs and improve quality prompt ACOs, and in particular, their primary care providers/suppliers, to serve as a "gatekeeper" and limit referrals to specialty physicians. While modifications to CMS' exclusivity requirements will help to address this concern, given the likelihood that more specialists will participate in ACOs and clinically appropriate referrals will be encouraged, we continue to worry that there could be problems to the extent an ACO does not include specialty physicians in their "network."

CMS monitors beneficiary access to specialists by including an "Access to Specialists" module as part of the CG-CAHPS Survey measures set that ACOs are required to report. Nevertheless, specialty physicians are concerned that this measure will not be enough to demonstrate whether beneficiaries are being referred for specialty care

at the most clinically appropriate point in their disease progression. Early intervention and referral to specialists may help to limit the development or progression of certain chronic illnesses, ultimately resulting in financial savings for the ACO and the Medicare program. Also, it remains unclear whether results from the CG-CAHPS Access to Specialists module will be reliable, as respondents may be unaware that specialty medical care is necessary in order to properly manage a diagnosed health condition.

We urge CMS to closely examine the referral patterns of ACOs and establish benchmarks that will foster an appropriate level of access to and care coordination with specialty medicine providers, particularly for beneficiaries with chronic health conditions where specialty medical care has been proven to improve patient outcomes.

****

The Alliance thanks CMS for its efforts to improve beneficiary access to specialty care through the ACO program. We are encouraged by proposals in this rule and look forward to additional modifications in the final rule. Should you have an interest in meeting with members of the Alliance to further discuss our recommended modifications in more detail, or if you have any comments or questions about our comments, please contact Vicki Hart, RN, MPH at vhart@hhs.com.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
American Association of Neurological Surgeons
American College of Mohs Surgery
American Gastroenterological Association
American Society for Dermatologic Surgery Association
American Society of Cataract & Refractive Surgery
American Society of Echocardiography
American Society of Plastic Surgeons
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
North American Spine Society
Society for Cardiovascular Angiography and Interventions
Society for Excellence in Eyecare