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Marilyn Tavenner, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1461-P
P.O. Box 8013
Baltimore, MD 21244-8013

SENT ELECTRONICALLY: http://www.regulations.gov

RE: CMS-1461-P Medicare Shared Savings Program: Accountable Care Organizations

Dear Administrator Tavenner,

On behalf of PDA, Inc**.** and the health care providers we serve in North Carolina and other eastern states, I am writing to provide feedback on CMS' proposed rule changes for the MSSP Accountable Care Organization demonstration program. We appreciate the time and dedication that you and your staff give to working for the Centers and understand your requirement to work within the constraints of the statutes.

We recognize that the MSSP program is still in its start-up phase, and that many ACOs see their largest impact after two or more years. Nonetheless, after carefully reviewing the first year performance data and outcomes, we believe that a few changes would serve the interests of both the government and providers.

Our comments are not comprehensive. We are pleased with many of the proposed changes:

- The option to extend the one-sided risk.
- Changes to beneficiary assignment, including the option for patients to opt-in. Ideally, this would extend to all Tracks, for it would be consistent with consumer choice and would encourage ACOs to invest in beneficiary engagement programs.
- Inclusion of non-physician primary care providers in the assignment algorithm, a feature of particular importance to Rural Health Clinics.
- Removal of the beneficiary notification of opt-out.

However, the proposed rule seeks "alternatives to encourage the participation in risk-based models." We believe CMS' proposal, while progressive, does not go far enough to encourage broad participation. Accepting the proposed rule without modification, puts CMS at risk of discouraging providers in lower-cost populations from participating in MSSP. To that end, we have the following suggestions with additional detail and supporting information in comments that follow.

- Update benchmarking methodology in MSSP rules to allow ACOs with lower cost to increase their benchmark by the national Medicare inflation factor between MSSP contracts.
- Use the cost per benficiary benchmark to develop an MSR weighting scale that would reduce MSR for ACOs in low-cost populations.
- Reward quality in low cost populations, even if costs remain flat.
- Continue using a national per capita Medicare cost projection to update benchmarks rather than a regional or local average.
- Establish a minimum cost per beneficiary floor and reward any ACO that meets the floor.
- Reward sustained excellence in MSSP by providing shared savings after three-years if the ACOs did not meet MSRs during the annual reporting periods.
- Retain the value-based modifier exemption.

The Advanced Payment Program provided an excellent jump-start for qualified providers. Institutionalizing this program would create sustained interest on the part of primary care providers who are maintaining reasonable cost services, and who want to take extra steps in the direction of population health. As we note in these comments, and as others are observing around the country, a durable ACO program will need quality incentives. Primary care providers are typically not high earners, and participating hospitals stand to lose more than they would gain. With all ACO rewards paid long after providers contribute improvements at their own expense, cost of entry is a barrier. We hope you will look carefully at the analyses and recommendations on the following pages. Thank you for this opportunity to comment.

Regards,

Nancy M. Lane

President

COMMENTS ON PROPOSED CHANGES TO MSSP ACCOUNTABLE CARE ORGANIZATION RULES

LESSONS FROM MSSP FIRST YEAR RESULTS

Analysis of the Medicare Shared Savings Program Accountable Care Organizations Performance Year 1 Results published by CMS produced the following lessons.

A. High-Cost Populations Fare Better

For comparison, we grouped ACO's in quartiles by benchmark cost.

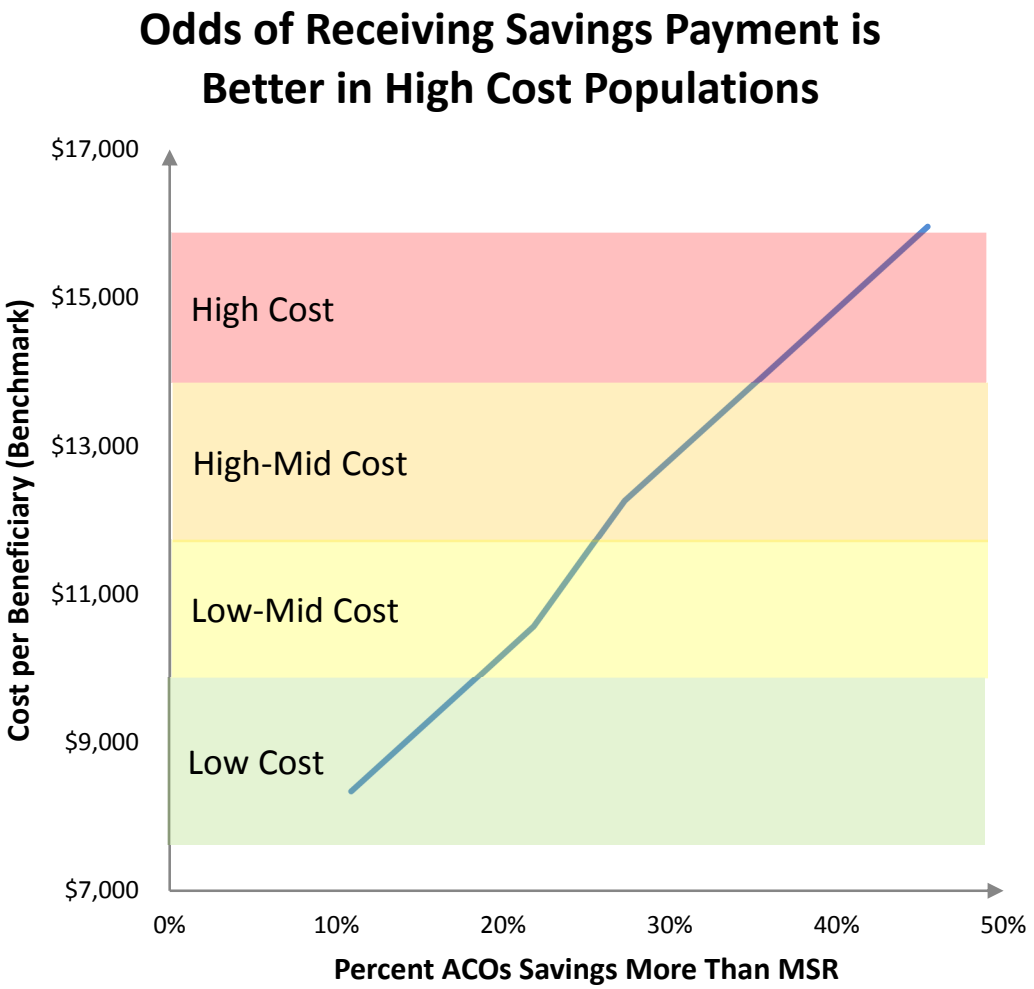
- Largest factor in determining an ACO's ability to generate a payment is initial annual per capita cost.
    - 4th quartile ACOs had an average benchmark of ~$16K.
    - 1st quartile ACOs had an average benchmark of ~$8K.

Comparison of First Year ACO Cost Reduction by Per Beneficiary Cost Quartile

Population Cost Quartile	Avg. MSSP Cost per Beneficiary Benchmark	Cost Quartile Description	Average Per Beneficiary Cost Reduction
1st	$ 8,346	Low Cost Population	($27.51)
2nd	$ 10,574	Low-Mid Cost Population	$41.53
3rd	$ 12,268	High-Mid Cost Population	$7.65
4th	$ 15,959	High Cost Population	$277.43
All	$ 11,786	All	$74.78

Source: Medicare Shared Savings Accountable Care Organizations Performance Year 1 Results, CY 2013

- Among quartiles with average savings, average per beneficiary cost reduction varied 40-fold ($277 per beneficiary reduction in high cost areas, $8 reduction in high-mid cost).
- Lowest cost quartile population per beneficiary cost increased $28.
- 45 percent of ACOs in high cost population areas reduced savings by more than the MSR, compared to only 11 percent of ACOs in low cost populations.
- CMS Paid out $160M to high cost ACOs, only $11 M to low cost ACOs.
- 69 percent of the ACO's that successfully reduced cost were in the high or high-mid cost population quartiles.

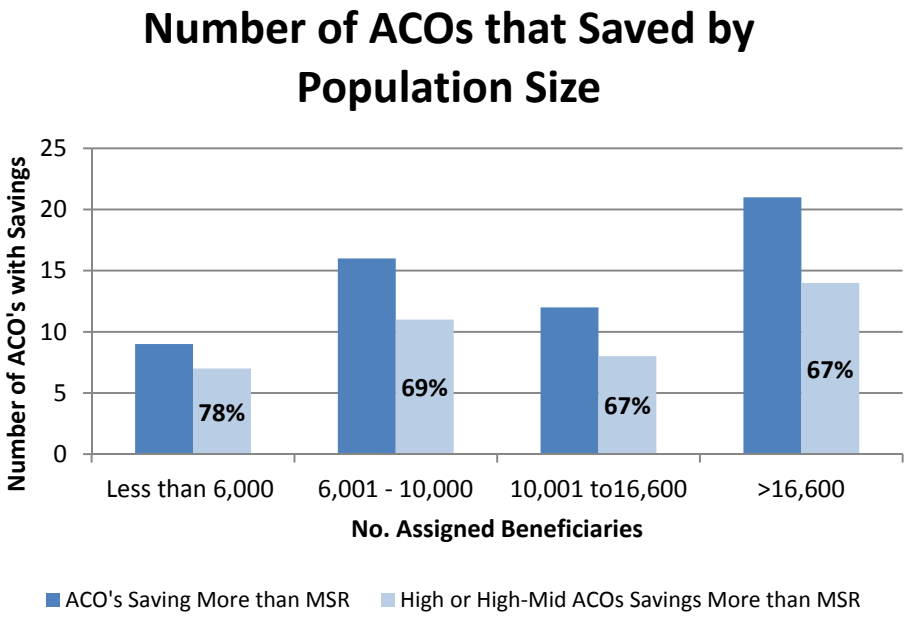


Source: Medicare Shared Savings Accountable Care Organizations Performance Year 1 Results, PDA, Inc analysis 2015

B. Cost per Beneficiary is More Important to Savings than Size of Assigned Beneficiary Pool

- In Track 1, ACOs with larger populations have a lower minimum savings rate (MSR), as low as 2 percent. ACOs with small populations have a high MSR (up to 3.9 percent).
- Though intended to adjust for more expected variation in the low population size group, the rule had the unintended consequence of making it more difficult for this group to achieve savings
- All but one of the low-population ACOs that saved more than the MSR in Year 1 were in high cost areas or high cost states like California, Texas, and Nevada.

- The outlier, Morehouse Choice ACO-ES (the Georgia Patient Centered Medical Home), received no shared savings because it failed to satisfactorily submit quality measures. This group merits closer investigation. Can this ACO achieve and sustain success within the confines of the current MSSP rules?
- Although first year ACO savings occurred in all population groups, more ACOs that saved were associated with larger populations.
- Further analysis of these groups showed that the cost per beneficiary was a more important factor than size of the population.

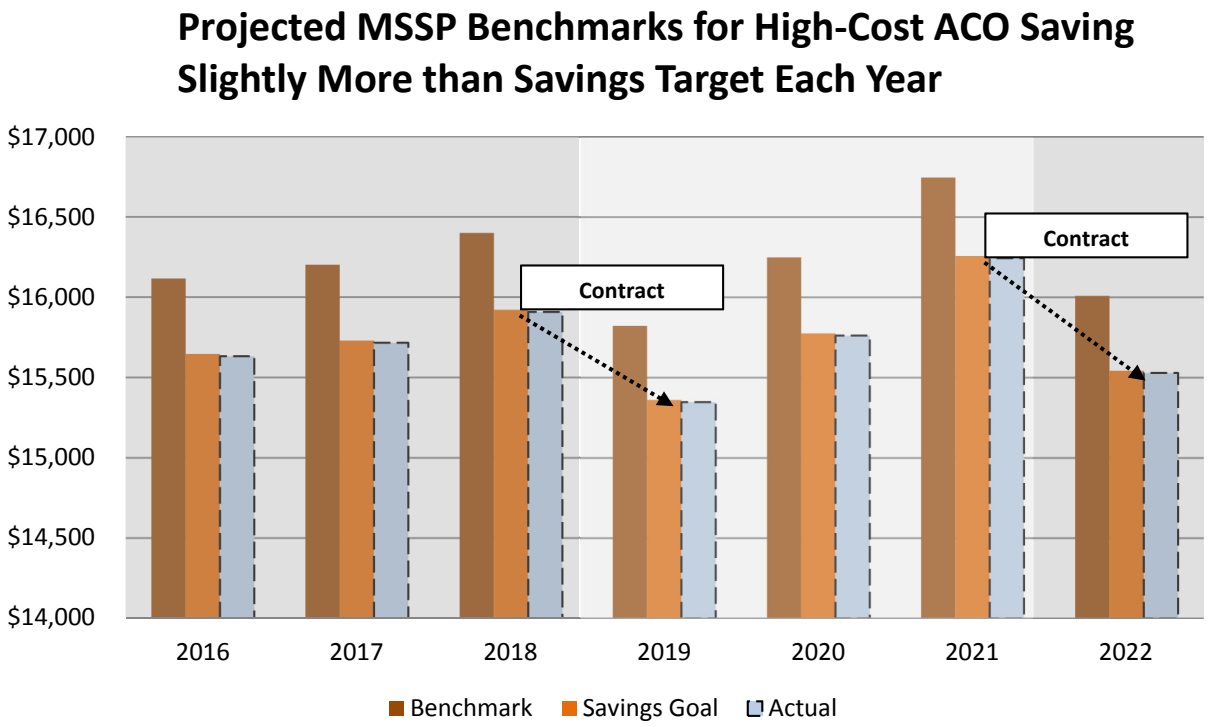


Source: Medicare Shared Savings ACO Performance Year 1 Resouts, PDA, Inc analysis 2015

C. Re-setting Benchmark with Each Three-Year Contract Period Penalizes Good Performance

- Under current rules, CMS will re-base the benchmark at the start of each three-year MSSP agreement period using historical three-year weighted average, with the heaviest weight on the most recent year.
- Unless the ACOs' costs go up significantly in the third year, the ACO baseline will drop in the first year of the new contract.
- The proposal to change the benchmark formula for a new contract to the last three-year average cost per beneficiary does not improve the outcome for the ACO.
- During a contract period, CMS updates the benchmark using an inflation factor equal to the projected flat-dollar change in per capita spending for Medicare Parts A and B, so an ACO has a buffer from year to year during that contract period.

- Entities considering the MSSP ACO arrangement will realize their year-over-year target per beneficiary spending will decrease significantly at the beginning of the second contract (and each contract thereafter), if the ACO actually reduces spending over the course of the contract period.
- This regulatory downshift may discourage entities from joining the MSSP ACO program.
- The chart below demonstrates the impact of re-setting the benchmark at the beginning of each contract year. If the ACO slightly beats its savings targets in the first contract period, the savings goal drops significantly. For example, it drops roughly $500 per beneficiary for a high cost ACO.



Source: PDA, Inc model with data from CMS Office of Actuary, 2014 Medicare Trustees Report; MSSP Year One Results for High-Cost Population Quartile

D. The Track 1 Formula Must Be Changed to Incentivize Entities to Participate in the MSSP ACO Program

- Built in adjustments in MSSP penalize all savers.
- Because the majority of MSSP ACOs (75 percent) did not achieve savings payments in year one, most will fear venturing away from the upside-only Track 1; new organizations may avoid MSSP entirely .

E. Hierarchical Condition Categories (HCC) Formulas Must Incorporate Changes in CMS Fee for Service Payment Policies and Other Community Level Health Care Access Changes

- New costs like the Medicare Chronic Care Payment to primary care providers can show up disproportionately in accountable care organizations.
- Such payments reward population health management, but can have the effect of increasing per beneficiary cost, particularly in a low cost population. However, if the HCC formula used in MSSP incorporates national changes across all ACOs, then ACOs will not be penalized for such changes.
- ACOs located in low cost communities with low access to health care services face higher hurdles to savings. If the ACO improves access to care, costs will initially go up; better screening, newly available services and care management will increase per beneficiary cost.
- Ideally, the HCC formula would also include a regional adjustment to account for changes in access for low-cost populations.

ATTRACTING PARTICIPANTS THAT SAVE IS CRITICAL TO THE MSSP PROGRAM

A. In 2013, Compared to Benchmarks, CMS Paid Out More in MSSP Incentives than the ACOs Saved

- CMS paid out $311M and saved a net $233M relative to its benchmark forecasts; a net program cost of $78M against benchmark.
- The ACO program actually appears to have netted savings of approximately $1 billion, because the benchmarks include savings targets.
- Most ACOs participated in "Track 1", which is upside only.
- If all participating ACOs had been in Track 2, CMS would have incurred a net loss of $30m against benchmark.
- If CMS moves the benchmark down with every new MSSP contract, CMS will realize even more stable spending over time; however, it may come at such a loss that providers will cease to participate.

B. Regulatory Changes Should Enable the MSSP ACO Program to Both Sustain Low-Cost Population Behavior and Reduce High-Cost Population Behavior

- The HCC formulas provide a good mechanism for adjusting regional cost variations.
- The current rules provide a mechanism for annual changes to the HCC.

DESIGN CONSIDERATIONS FOR FUTURE ACO RULEMAKING

A. Update Cost Benchmarking Methodology in MSSP Rules

- Set the benchmark at the beginning of the first MSSP contract using the current formula.
- Use the per capita Medicare cost projection selectively to update the benchmark from one year to the next, including contract transitions.
    - The ACO statute requires CMS to establish the benchmark for new contracts using a three-year history for beneficiaries assigned to the individual ACO.
    - To avoid penalizing savers in low cost areas, first compare the three-year per beneficiary history for the ACO to the national average;
        - If the ACO history is less than the national average, update the new contract benchmark only with the national per capita Medicare cost projection;
        - If the ACO history is above the national average, use the current formula.
- Incorporate in the HCC adjustments: national and regional differences in access to care, amount of chronic care management payments, and possibly other regional factors.
- Proposed Rules discuss the use of regional benchmarks to set the initial MSSP benchmark. Using regional benchmarks would favor low-cost populations and penalize high-cost populations. This could discourage high-cost populations from entering the program. An alternative to using regional benchmarks is to update the HCC formulas to account for certain types of regional variation, as discussed above.

B. Update MSRs "Track 1"

- For "Track 1", Update Minimum Savings Rate methodology.
    - Reduce the MSR for low cost ACOs below the current rate, because it is more difficult for low-cost ACOs to eliminate cost below a certain minimum.
    - Increase the MSR for high cost ACOs because its is easier for high-cost ACOs to reduce cost.
    - Set the MSR with a goal of having at least 25 percent of the ACOs in each of the four cost groups acheive savings distributions. Roughly 25 percent of ACOs received savings in year one, but 45 percent of the high cost populations achieved savings and only 11 percent of the low cost achieved savings.
    - Proposed MSR's for this scenario would be : 2 percent for low cost, 2.75 percent for low-mid, 3.25 percent for high-mid, and 6 percent for high cost.
    - Retain MSR adjustments for the number of beneficiaries as required by the ACO statute, but weight the MSR adjustment to favor per beneficary cost over the number of beneficiaries.
- For "Track 2", the two-sided model, continue to use a two percent MSR for all ACOs.

C. Reward Quality in Low-Cost Populations

- Because ACOs serving low-cost populations are close to the threshold at which they can no longer reduce costs, allow low-cost ACOs to receive a quality payment that is not contingent upon shared savings.
- For high-cost ACOs, continue to use the current MSSP model in which shared savings must be achieved first, then use quality scores to weight the total savings payment.
- Base low-cost ACO quality payments on the PQRS formula used in Medicare physician payments, but for ACOs, apply it to both Part A and Part B.

D. Continue using a Naitonal Per Capita Medicare Cost Projection to Update Benchmarks

- Medicare patients migrate; an average of 16 percent move out of area in any given year[1], and health status explains slightly less than half of migrating patients' health care utilization patterns.[2]
- A national inflation benchmark will accommodate migration without rewarding or penalizing any area.
- Medicare is a national program.

E. Establish a Minimum Cost per Beneficiary Floor and Reward any ACO That Meets the Floor

- Low cost ACOs should enjoy rewards if they meet quality goals.
- Low cost ACOs benefit CMS by maintaining low cost.

[1] Finkelstein, Amy, M Gentzkow and H. Williams, Sources of Geographic Variation in Health Care: Evidence from Patient MIgratin, Working Paper 20789 National Bureau of Economic Research , Cambridge MA, December 2014 http://www.nber.org/papers/w20789.pdf

[2] Ibid

The following table summarizes PDA's proposed design considerations from A,B,C,D and E above.

PDA Proposed Changes to MSSP Model

	Population Cost Group	MSR / MLR*	Cost Payment Method	Cost Benchmark Methodology	Quality Payment Method	Quality Benchmark	Quality Measures
Track 1	**Low Cost Populations**	Low MSR (~2%) after adjusting for population size; No MLR	50% split with payer after MSR up to cost floor, reward for being at or below floor	3-year cost history, then annual per capita adjustment during contract	Payments for good performers, penalty for poor performers	No change to current methodology	No change to current methodology
	Middle Ranges	Avg. MSR (2%-6%) after adjusting for population size; No MLR	50% split with payer after MSR				
	High Cost Populations	High MSR (~6%) after adjusting for population size; No MLR	50% split with payer after MSR, then weighted by quality scores		NA - No separate quality payment available		
Changes from Track 1 to Track 2	**All**	2% MSR/MLR	Apply MLR and penalties for losses	High Cost: 3-year cost history Low Cost: Annual per capita adjustment across contracts	No change	No change	No Change

**MSR = Minimum Savings Rate; MLR = Minimum Loss Rate*

F. Support the Dartmouth Sustained Excellence Reward Concept[3]

- Reward ACOs that sustain savings over a three-year period, even if they miss annual savings targets.
- Base the reward on 30 percent of average savings.

G. Retain the Value-Based Modifier Exemption

- Update the Final Rule for 2016 to retain the value-based modifier exemption without a sunset date.
- Failure to do so means the rules would require ACO participants to participate in two very similar quality programs that have similar measures.

[3] Heiser, Scott, Carrie Colla and Elliot Fisher, Unpacking the Medicare Shared Savings Proposed Rule: Geography and Policy, Health Affairs Blog Comment on January 22, 2015 http://healthaffairs.org/blog/2015/01/22