National Business Group on Health®

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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

October 16, 2018

The Honorable Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1701-P
P.O. Box 8011
Baltimore, MD 21244-1850

Submitted electronically via: https://www.regulations.gov

RE: CMS-1701-P, Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations-Pathways to Success changes to Medicare payment policies and rates under the IPPS for fiscal year (FY) 2019

Dear Administrator Verma:

The National Business Group on Health (NBGH or the "Business Group") appreciates the opportunity to comment on the Center for Medicare and Medicaid Services' (CMS's) Pathways to Success proposal to overhaul the Medicare Shared Savings Program's (MSSP's) Accountable Care Organizations (ACOs).

The Business Group represents 429 primarily large employers, including 74 of the Fortune 100, who voluntarily provide group health and other employee benefits to over 55 million American employees, retirees, and their families. Advancing better and more efficient health care delivery and payment policies is increasingly critical as rising costs affect the ability of beneficiaries, governments, insurers, and employers to afford care.

Below, we offer background on our interest in this topic and expand upon the Business Group's recommendations on specific elements of the proposal.

Background: The role of ACOs, from the employer perspective

For many employers, widespread growth in consumer-directed health plans (CDHP), a demand-side tool, has led them to turn to the supply-side of health care, to consider ways to control costs while continuing to deliver high quality care to their employers. With fewer plan design levers available in a CDHP environment, employers are looking at ACOs, as well as other alternative payment and delivery models, as a promise of potentially higher-quality, lower-cost and more consumer-focused health care. Employers have had to temper expectations about the speed and magnitude of savings from ACOs, as perhaps, the Administration has had to, given that much upfront investment in capabilities, training, and process changes, is required for ACOs to succeed in the longer-term.

To navigate the challenges associated with assessing the value of new ways to organize and deliver care, the Business Group has undertaken a focused effort to help employers assess the potential of ACOs. Through our Executive Committee on Value Purchasing, committee members have developed a toolkit to provide employers with a road map on implementing an ACO strategy from assessing market opportunity, understanding ACO readiness, considering plan design options, improving employee engagement and evaluating ACO performance.

On their own and aided by this work, 21% of large employers actively promoted ACOs in 2018 and another 35% percent of employers are setting up ACOs and High-Performance Networks (HPNs) either by directly contracting with health care providers or by working through their health plans in 2019.[1]

We urge CMS to consider the work carried out by our members, as a resource, as it moves forward with its work on the MSSP, as there are synergies in objectives within both the public and commercial markets. The MSSP creates incentives for ACOs to improve care by allowing them to share savings they generate by achieving defined quality and cost goals. The program allows ACOs to gradually take on financial risk for managing spending growth. Such an approach gives ACOs time to build the infrastructure—the care coordination, information technology, and data analytics capabilities—to transform practice and manage risk successfully.

Thus, while it's important to promote value-based transformation and to push industry momentum forward, that promotion must be tempered with balance to not unduly create barriers to entry in transitioning to value-based care. Further, while direct savings generated by ACOs to Medicare may be modest, there is evidence that the MSSP generates substantial indirect savings due to the spillover effect of delivery system changes on fee-for-service Medicare spending.[2]

Accelerating the requirement to take on downside financial risk

In general, we are supportive of CMS's proposal to ramp up the acceptance of downside financial risk in the ACO environment. However, we have concerns that the speed of the proposed transition could have the effect of slowing the ACO movement. Given the reported savings of the MSSP of approximately $1.8 billion between 2013-2015, we believe it is important to continue fostering the growth of the program.[3]

We support CMS's proposal to simplify the Track structure by retiring the current MSSP Tracks 1, 1+, 2 and 3, replacing those existing MSSP tracks with new Basic and Enhanced Tracks effective July 1, 2019, with the Basic Track containing Levels A through E.

Our concern lies in the speed of the transition to a reduced shared savings rate. The current shared savings rate for Track 1 is 50 percent, which would be reduced to 25 percent under the proposed Basic Track Levels A and B. Although the shared savings rates and shared loss rates gradually increase across the levels until they reach those in Level E, which has the same shared savings and loss rates as the

[1] "2019 Large Employers Health Care Strategy and Plan Design Survey" (The National Business Group on Health, September 2018), https://www.businessgrouphealth.org/pub/?id=B7F87411-A59D-D212-CA59-2A79A7683DF2.
[2] "Medicare Shared Savings Program Produces Substantial Savings: New Policies Should Promote ACO Growth," accessed October 14, 2018, https://www.healthaffairs.org/do/10.1377/hblog20180906.711463/full/.
[3] "Full Report for MSSP Savings 2012-2015," accessed October 16, 2018, https://www.naacos.com/full-report-for-mssp-savings-2012-2015.

current Track 1+, the shared loss rates remain constant at 30 percent across Levels C, D and E, and the amount of maximum losses gradually increases.

We are concerned that while CMS estimates that these proposed changes would save Medicare $2.24 billion across the next 10 years, over the same timeframe, the changes would cause 109 of 561 participating ACOs to exit the program. The projected withdrawal of ACOs is due in large part to the perceived unattractiveness of the new savings rate and risk sharing arrangement. **We urge CMS to consider a more gradual transition to encourage more ACOs to stay in the program, given the savings that even downside-only ACOs have generated to the program to date** – according to CMS's own estimates, one-sided MSSP Track 1 ACOs generated more 2017 savings per beneficiary than those bearing risk under MSSP Tracks 2 and 3.[4]

High revenue and low revenue ACO designations

We support CMS's proposal to create a new distinction that evaluates the percent of the ACO participant Parts A and B FFS revenue compared to ACO benchmarks to categorize ACOs as "high revenue" or "low revenue" ACOs. This distinction will help create clear guidelines for when an ACO must move to risk. **We also support the removal of a self-reporting mechanism for determining high revenue or low revenue ACOs, and instead using Medicare claims data to make this determination**. This approach would provide a more accurate method for determining an ACO's preparedness to take on additional risk rather than an ACO's self-reported information regarding the composition of its ACO participants and any ownership and operational interests in those ACO participants.

Incorporating provider feedback

We support CMS's effort to incorporate new flexibilities that have been requested by providers, including:

- **Allowing ACOs to select and even change their desired beneficiary attribution methodology on an annual basis—and allowing participants in upside-only models to select prospective attribution;**
- **Informing beneficiaries of their ACO participation;**
- **Allowing annual risk adjustment to ACO benchmarks (i.e., during an agreement period);**
- **Reimbursing for telehealth services for prospectively assigned beneficiaries in non-rural areas;**
- **Allowing broader access to the SNF 3-day waiver; and**
- **Accelerating the incorporation of regional adjustments into the program's benchmarking methodology.**

We are encouraged by the nod to the role telehealth plays in delivering high-quality and high-value care to consumers. As the technology continues to advance, more providers and health care systems are incorporating various aspects of telehealth into health care delivery. There is growing evidence about the benefits that the utilization of telehealth can have in both reducing costs for health care and increasing access to specialty and routine health care services. As employers grapple with creative and innovative approaches to addressing health and wellness in the workplace, many employers are considering adding telehealth to the line-up of health benefits provided to employees.

[4] "Medicare Shared Savings Program Produces Substantial Savings: New Policies Should Promote ACO Growth," accessed October 14, 2018, https://www.healthaffairs.org/do/10.1377/hblog20180906.711463/full/.

A mere seven years ago, telehealth was an innovation just being introduced to consumers. Developed by new entrants to the health care marketplace, it was the first sign that virtual care could offer consumers greater convenience and efficiency of care. Since then, the rate of adoption of telehealth has been extraordinary. In 2012, 14% of large employers offered telehealth as an alternative pathway to accessing health care for select services. Today, nearly every large employer offers telehealth for minor non-urgent services, making telehealth available to employees in states where it is allowed.[5]

Increasing beneficiary engagement

We strongly support requiring all ACOs to provide written notification to patients about their participation in the ACO, what that entails, and how the model will impact care. Additionally, we support allowing certain ACOs under performance-based risk models to offer incentive payments to patients in return for participation in the ACO, if those ACOs offering incentives are part of a two-sided risk model.

Currently, 10.5 million Medicare beneficiaries are in an MSSP ACO. However, these patients may not know they are receiving care as a part of an ACO, or what an ACO is. We agree with CMS that these steps will increase transparency, allow patients to make decisions about where to receive their care, and strengthen beneficiary engagement.

Continue technical assistance

As ACOs continue to evolve in maturity, we urge CMS to continue to provide technical assistance to help them better understand risk adjustment and benchmark methodology. A hallmark of the program's success relies on the ability of an ACO to understand how risk scores may affect their financial performance and. We strongly support CMS's ongoing efforts to provide this technical assistance and urge CMS to continue these efforts through providing beneficiary-level risk score information in quarterly and annual reports, as well as by providing detailed explanations of the risk adjustment calculations to ACOs through webinars and other educational opportunities. Further, to the extent possible, we encourage CMS to consider streamlining the risk adjustment methodology. Combined, these efforts could have the impact of making it easier and more efficient for ACOs to continue to participate in the MSSP.

Promotion of interoperability

We support CMS's desire to encourage Certified Electronic Health Record Technology (CEHRT) use by ACOs, to better align with the goals of the Quality Payment Program (QPP) by requiring that all ACOs demonstrate a specified level of CEHRT use for participation. We also support placing a stronger emphasis on measures that require the exchange of health information between providers and patients.

A recent report found that, given the myriad of EHR systems, 36 percent of medical record administrators struggle with the exchange of patient health records:[6]

[5] "2019 Large Employers Health Care Strategy and Plan Design Survey."
[6] "Epic Systems and MEDITECH Rise Atop Black Book 2018 Survey of Inpatient EHR Client Satisfaction Joining Cerner and CPSI," accessed October 11, 2018, https://www.newswire.com/news/epic-systems-and-meditech-rise-atop-black-book-2018-survey-of-20441584.

- 24 percent of administrators were unable to use meaningful patient data they received electronically from outside sources not within a siloed EHR system.
- 85 percent of network physicians believed the task of interoperability between healthcare providers lay with their core EHRs, rather than themselves, to initiate the sharing of information to improve population health, precision medicine and value-based payment models.
- 62 percent of hospitals were not utilizing patient information from outside their EHR system, because outside data is not available in their systems' workflow.
- 72 percent of medical administrators reported the incoming patient information was not presented in a useful format, a 5 percent increase in 2017 compared to the previous year.
- 30 percent of hospital-based physicians reported the data they viewed cannot be trusted when it was sent between different systems from outside providers.
- 22 percent of hospital IT managers reported considering EHR alternative vendors in 2019.

Efficient interoperability is essential to lower costs, improved health outcomes and patient satisfaction.

Opioid misuse strategy

We strongly support CMS's efforts to align policies under the MSSP with the overarching goals outlined by the Opioid Misuse Strategy and to help ACOs and their participating providers and suppliers in responding to and managing opioid use. Specifically, we support:

- **Sharing aggregate Medicare Part D data with ACOs; and,**
- **Adding measures specific to opioid use to the ACO quality measures set.**

Given the enormity of the opioid crisis, the potential benefits of such policies would be to focus ACOs on the appropriate use of opioids for their assigned beneficiaries and support their opioid misuse prevention efforts.

According to a recent survey, employers are increasingly focused on understanding the opioid epidemic's impact on the workplace. This focus has spotlighted for employers that inappropriate use/abuse of prescription opioids expands beyond increased costs or employee absenteeism. Employers have reported overdoses by employees or their family members, sometimes resulting in long-term health consequences. Further, some (12%) employers experienced the death of employees or their family members. Increased awareness and understanding of the epidemic's impact on the workplace has naturally increased concern among employers. Eighty-two percent of large employers are concerned/very concerned about this issue.[7]

Thank you for considering our comments and recommendations regarding the proposed ACO policy changes. We look forward to reading the comments to the docket and following the CMS' progress on this issue. Please contact me or Steven Wojcik, the National Business Group on Health's Vice President of Public Policy, at (202) 558-3012 if you would like to discuss our comments in more detail.

[7] "2019 Large Employers Health Care Strategy and Plan Design Survey."

Sincerely,

Brian Marcotte
President and CEO