



March 28, 2016

The Honorable Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1644-P
P.O. Box 8013
Baltimore, MD 21244-8013

**RE: Proposed Rule for Medicare Program; Medicare Shared Savings Program:
Accountable Care Organizations-Revised Benchmark Rebasing Methodology,
Facilitating Transition to Performance-Based Risk, and Administrative Finality of
Financial Calculations CMS-1644-P**

Dear Administrator Slavitt:

The National Business Group on Health (the Business Group) appreciates the opportunity to comment on CMS' Proposed Rule on Revised Benchmark Rebasing Methodology, which would make changes to the regulations for the Medicare Shared Savings Program (MSSP) that were promulgated in November 2011 and June 2015, and codified at 42 CFR part 425. The Business group writes in strong support of market transitions away from fee-for-service (FFS) payment arrangements to those which place a focus on value-based payments, particularly accountable care arrangements that encourage care coordination and provider accountability for population health. Additionally, we support increased participation by ACOs in two-sided risk models and believe these arrangements are essential to improve patient care and reduce costs for unnecessary, wasteful and ineffective care.

In the addendum, we provide specific suggestions which we believe build upon the intent of the proposed rule. Among our key comments are the following:

- We support rebasing performance benchmarks for ACOs that continue participation in the Shared Savings Program after an initial three-year agreement period by incorporating regional expenditures, which would make the ACO's cost target more independent of its historical expenditures and more reflective of fee-for-service spending in its region;
- We support adjusting the ACO's reset benchmark by a percentage of the difference between the ACO's regional service area average per capita expenditure and the ACO's rebased historical benchmark through a phased in approach; and,

- We support an alternative participation option to encourage ACOs to enter performance-based risk arrangements earlier in their Shared Savings Program participation.
- We support shifting from using “all traditional FFS” beneficiaries to “all assignable beneficiaries” when calculating national or regional expenditures and trend factors.
- We commend CMS for publishing a data set along with the proposed rule, recognizing that commercial ACO contracts are built upon trust and transparency, which includes data sharing to build mutual understanding about the dynamics of the financial model. We encourage CMS to consider this as a precedent for future rule making.

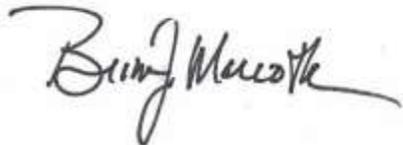
The National Business Group on Health represents approximately 430, primarily large, employers (including 70 of the Fortune 100) who voluntarily provide generous health benefits and other health programs to over 55 million American employees, retirees, and their families.

Underpinning the uptick in adoption of innovative payment models, in both the public and private sectors, is undoubtedly CMS’ pledge to make 50 percent of all traditional, or FFS, Medicare payments for healthcare services tied to value-based care alternatives by the end of 2018. To that end, we also congratulate the agency on the early milestone achievement of tying 30 percent of traditional Medicare payments to alternative payment models that reward the quality of care over quantity of services provided to beneficiaries, as announced on March 3, 2016, ahead of the agency’s end-of-year goal.

However, although the 2015-2016 growth of 100 new participants, to a total 434 MSSP ACOs is impressive, we also recognize this is only a small increase from the 404 that participated a year ago, due to the departure of about 70 existing MSSP entities. Thus, the Business Group strongly supports CMS’ efforts to attract and retain more ACOs to the market, through the proposed revised benchmark rebasing methodology. Setting the benchmarks competitively is essential to ensuring that the MSSP is sustainable and aligns incentives so that high-value care providers are appropriately rewarded.

Again, thank you for the opportunity to comment on this critical program. 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 further detail.

Sincerely,



Brian J. Marcotte
President and CEO

Addendum

Rebasing Benchmarks

We applaud CMS for recognizing that regional trends will more appropriately benchmark participants against their relative region, as we believe this will have the effect of more seamlessly encouraging transformative physician care, while simultaneously discouraging agreements with participants unwilling or unable to make meaningful changes in care delivery. While we support the effort to accurately align benchmarks for shared savings, we also recognize that payment reform is an operational commitment, and broad line payment reform will take time to achieve. As a case in point, while only a quarter of program participants have qualified for a bonus payment, a third of those which have been in the program the longest are now qualifying for bonus payments. This tells us that participants with more experience in the program are more successful at achieving the benchmarks. Broadly, we urge CMS to appropriately balance equitable payment models with quality and efficiency standards. Specifically, we echo the concerns outlined below, as raised by CMS:

- Existing low spending ACOs operating in regions with relatively higher spending and/or higher growth in expenditures may be positioned to generate savings under the proposed methodology because of the regional adjustment to their rebased historical expenditures, rather than as a result of actual gains in efficiency.
- There may be potential for ACOs to alter their healthcare provider and beneficiary compositions or take other such actions in order to achieve more favorable performance relative to their region without actually changing their efficiency.
- An ACO's knowledge of its costs relative to FFS expenditures in its region also creates risk of added cost to the Shared Savings Program by way of –
 - Increasing shared savings payments to ACOs exhibiting expenditures significantly below their region at baseline especially in cases where such differences are related to factors exogenous to efficiency in the delivery of care (where shared savings payments could be further inflated by increased selection of Track 3 over Track 2);
 - Potentially losing participation from ACOs with expenditures high above their region at baseline – reducing the opportunity to impact beneficiary populations with the greatest potential for improvements in the cost and quality of care; and
 - Structural shifts by ACOs in ways that would reduce assignment of relatively high cost beneficiaries and increase assignment of relatively healthy populations or shift the geography of their service area to similarly effect a more favorable benchmark assignment.
- There is a need to safeguard against ACOs that may increase their spending to lock in higher benchmarks for future agreement periods.
- There is a need to maintain strong incentives for ACOs to improve efficiency and to continue participation in the program over the long term.
- And, the program must maintain benchmarks which are sufficiently high to encourage ACOs to continue to meet the three-part aim, while also safeguarding the Medicare

Trust Funds against the possibility that ACOs' reset benchmarks become overly inflated to the point where ACOs need to do little to maintain or change their care practices to generate savings.

Adjusting Reset Benchmarks

We support CMS' proposal to gradually make an ACO's benchmark more reflective of expenditures in its region and less reflective of the ACO's own historical expenditures by phasing in the use of regional cost data over time. However, we would encourage CMS to consider a more accelerated approach to this phase-in. As drafted, the agency would maintain the current methodology for establishing the benchmark for an ACO's first agreement period based on the historical expenditures for beneficiaries assigned to the ACO with no adjustment for expenditures in the ACO's regional service area. During this first agreement period, we would support implementing the regional adjustment by taking 35 percent of the difference between the ACO's regional service area expenditures and the ACO's rebased historical benchmark expenditures.

Beginning with each subsequent three-year agreement period, we would support implementing the regional adjustment amount by taking 70 percent of the difference between the ACO's regional service area expenditures and the ACO's rebased historical benchmark expenditures.

If the goal in adjusting the methodology for the initial benchmark, as well as the methodology for the benchmark in subsequent agreement periods, is to make the MSSP program more attractive to potential participants, we feel strongly this accelerated approach will assist in attainment of that goal. Additionally, we would urge CMS to closely monitor the national and regional weighting overtime, to assure the proper balance has been struck for setting the benchmarks, and continue to be open to future changes in the methodology, as appropriate, to the extent such changes would advance core program objectives.

Alternative Participation Option

Moving more ACOs into risk-bearing agreements is an essential step toward achieving the long-term shift from volume to value. While we recognize that extending the option for ACOs to participate in a fourth year of Track 1 before transitioning to a risk-bearing track may increase the number of MSSP ACOs bearing risk, as well as retain existing ACO participants, we also have a concern that this option may slow the move away from FFS payment arrangements. Our members feel very strongly that the ultimate goal is for providers to take on full financial responsibility for caring for a population of patients for a fixed payment. On balance however, the Business Group prefers the proposal for an alternative participation option in Track 2 or Track 3 as outlined in the current proposed rule, over the allowance for renewal of an additional three-year agreement period in Track 1, as finalized in the June 2015 rule. As consideration is given to comments on the

current rule, we would urge CMS to consider replacing the existing option of an additional agreement period in Track 1, with that outlined in the current proposed rule.

All Assignable Beneficiaries

While we agree with the policy shift to use “all assignable beneficiaries” in calculations for national or regional expenditures and trend factors, we would encourage CMS to consider revising the methodology to exclude the ACO’s own attributed population from the denominator. Including the ACO’s own population in the control group, for comparative analysis, is highly unusual in the commercial ACO contract. If an ACO pours significant investment into care coordination, but the “effect” is calculated in the comparison group, the evaluation limits an ACO’s ability to demonstrate its success in achieving savings.