



March 24, 2016

Andrew 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

File Code: CMS-1644-P

Re: 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; Proposed Rule

Dear Mr. Slavitt:

The Healthcare Financial Management Association (HFMA) would like to thank the Centers for Medicare & Medicaid Services (CMS) for the opportunity to comment on the changes proposed to the Medicare Shared Savings Program (MSSP) contained in “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; Proposed Rule,” published in the Feb. 3, 2016, *Federal Register*.

HFMA is a professional organization of more than 40,000 individuals involved in various aspects of healthcare financial management. HFMA is committed to helping its members improve the management of and compliance with the numerous rules and regulations that govern the industry.

Introduction

On behalf of its members HFMA would like to thank CMS for the proposed changes to the MSSP benchmarking and trending methodologies. In general, HFMA’s members believe the proposed approach to incorporating regional expenditure data is an improvement over the current expenditure benchmarking methodology which has participants in the program “competing” against their historical performance. If implemented, the proposed rule should result in a stable, sustainable benchmark for a large percentage of current participants. However, we are very concerned that the current methodology will severely disadvantage certain types of accountable care organizations (ACOs)—specifically those that include tertiary care centers, those located in rural areas, and those that are located in areas that are lower-cost relative to the national average.

We believe that refining risk adjustment for the continuously assigned population (discussed below in further detail) may ameliorate some of these concerns. However, for the cohort of MSSP participants negatively impacted due to their circumstances (e.g. geographic isolation, adverse patient selection that is not reflected in the risk adjustment methodology, location in a historically efficient region), changes to the benchmarking methodology for these organizations are necessary to create a level playing field.

Otherwise, these organizations will exit the program once they are compelled into a two-sided risk model.

Regarding the specific proposals included in CMS-1644-P, our members would like to comment on the following:

- Definition of assignable beneficiaries
- Transition to regional data for setting benchmarks
- Risk adjustment methodology for continuously assigned beneficiaries
- Calculating regional average expenditures using state-level ESRD data
- Reversal of decision to add savings achieved in prior periods back to the historical benchmark
- Determination reopening criteria
- Inducements to facilitate transition to two-sided risk bearing models

Definition of Assignable Beneficiaries

In the rule CMS proposes to calculate an ACO's historical benchmark using data from its "regional service area." An ACO's "regional service area" includes any county with at least one attributed beneficiary. CMS will then calculate the average per capita fee for service (FFS) expenditures of all beneficiaries eligible to be attributed to an ACO in the county by beneficiary type. A weighted per capita average spending for the ACO in question will be calculated by multiplying each county's average expenditure by the proportion of attributed ACO beneficiaries that reside in that county and summing the products. The rule proposes to include beneficiaries assigned to any ACO in the calculation of the regional component of the benchmark.

As discussed above, HFMA is generally supportive of incorporating regional data into an ACO's benchmark. This is a significant step forward in addressing one of the key flaws in the MSSP program—that participants were penalized in subsequent agreement periods for the efficiencies they generated in prior periods. Had the original benchmarking methodology remained, it would have eventually forced participants to exit the program as there is a limit to cost efficiencies that can be achieved through care coordination. Further, incorporating cost data from counties that comprise a regional service area begins to move the MSSP program closer in methodology to the Medicare Advantage program, an outcome desired by many including the Medicare Payment Advisory Commission.

HFMA believes that beneficiaries assigned to any MSSP or similar model that incorporates one- or two-sided risk during the benchmarking period should be removed from the assignable benchmark population. First, while the use of regional data is an improvement over an ACO competing against its own historical performance, having ACO's compete against one another poses a conceptually similar problem. Removing beneficiaries attributed to MSSP participants and other similar programs also has the added advantage of being able to compare the effectiveness of the MSSP program at controlling cost growth to the trend of "unmanaged" Medicare fee-for-service (FFS).

HFMA recognizes that in some regions, this could reduce the benchmark population below a statistically valid level. In these instances, HFMA suggests that CMS explore including unattributed, assignable beneficiaries from adjacent counties to the ACO's regional service area to create a statistically stable benchmark.

CMS also proposes, on a proportional weighted basis, to include data from any county with at least one beneficiary in the regional benchmark. While proportional weighting alleviates any concern about over-representation in the sample, HFMA questions whether including data from counties with small numbers of beneficiaries sufficiently improves the accuracy of the benchmark to justify the administrative burden. HFMA recommends CMS conduct analysis to determine a threshold (e.g., percentage of the attributed population) below which including data does not materially improve the accuracy of the benchmark. Only counties with populations at or above the threshold should be included in the benchmark calculation.

Transition to Regional Data for Use in Setting Benchmarks

In the rule, CMS proposes phasing regional data into the benchmark calculations over time as shown in the table below.

Agreement Period Effective	Adjust Historical Benchmark for Regional FFS Expenditures	Factor Used to Trend Historical Benchmark from BY1, BY2 to BY3 During Rebasing	Factor Used to Update Benchmark for Growth in FFS Expenditure
First (second for 2012/2013 starters)	Proposed - 0% regional	Proposed - National	Proposed - National
Second (third for 2012/2013 starters)	Proposed - 35% regional	Proposed - Regional	Proposed - Regional
Third and subsequent years (fourth for 2012/2013 starters)	Proposed - 70% regional	Proposed - Regional	Proposed - Regional

HFMA is generally supportive of a phased approach. However, we strongly recommend that CMS make the following changes to its approach to give MSSP participants more flexibility.

- 1) Allow ACOs that recently began their second agreement period on Jan. 1, 2016 (2012/2013 starters) the option of incorporating regional data into their benchmark and trend factors applicable to their 2017 performance year. These early entrants to the program should not be penalized by being forced to “compete against themselves.” It also places them at an unfair disadvantage compared to later entrants to the program who will benefit from regional benchmarking and trending.
- 2) Allow ACOs in their initial agreement period the option of incorporating regional data into their benchmarks and trend factors during their initial agreement period. For ACOs that began the program on Jan. 1, 2016, we believe they should have the option of incorporating regional data into their benchmark and trend factors applicable to their 2017 performance year. We understand the need for basing ACO benchmarks on historical data and believe that having up to 35 percent (see recommendation below) of an ACO’s initial agreement period benchmark based on its historical data is more than sufficient to meet that need. Also, it would entice organizations that historically have delivered care efficiently to participate in the program. Under a benchmark that is calculated using the current methodology, efficient providers are adversely impacted as there is less opportunity to generate shared savings. However, blending in regional expense data more appropriately recognizes and rewards those efficient providers participating in the program.

- 3) Allow ACOs—regardless of when they opt to phase in regional data—to do so on a gradual basis. Our members are concerned that some MSSP participants could be adversely impacted by significant shifts in their benchmark due to the methodological change. We are aware of organizations whose benchmark will decrease by as much as two percentage points based on incorporating regional data. To help these organizations acclimate to the new methodology and encourage them to remain in the MSSP, HFMA believes CMS should offer ACOs the option of incorporating 10 percent regional data in the first performance year (PY1), 20 percent regional data in PY2, and 35 percent in PY3 instead of going straight to 35 percent in PY1 during the transitional agreement period. In the subsequent agreement period these organizations should retain the option of either continuing with a graduated transition to regional cost data or switch directly to the 70 percent contemplated in the proposed rule. If an organization continues with the graduated transition in the subsequent agreement period, CMS would include 45 percent in PY1, 60 percent in PY2, and 70 percent in PY3. For agreement periods thereafter the blend between regional and historical should remain 70/30.

HFMA would like to stress that each of the recommendations above should be optional for MSSP participants. We believe that allowing organizations the flexibility to manage the transition between administrative rules for setting benchmarks in the MSSP program will encourage participation and minimize attrition as a result of drastic changes in the rules that are the underpinning of determining financial performance.

Risk Adjustment Methodology for Continuously Assigned Beneficiaries

HFMA remains deeply concerned that CMS will continue to use different methods for updating risk adjustment for newly and continuously assigned beneficiaries. While newly assigned beneficiaries are adjusted using the CMS-HCC model, continuously assigned beneficiaries are adjusted using demographic factors alone unless CMS-HCC risk scores result in a lower risk score and therefore a lower benchmark. We strongly oppose CMS's continued instance on limiting adjustments to continuously assigned beneficiaries to only decreases in the CMS-HCC risk score. While this policy disadvantages all MSSP participating ACOs, we are extremely concerned that this deeply flawed policy has a significant adverse impact on MSSP participants who care for more complex patients (such as ACOs that include tertiary care facilities).

HFMA strongly believes that the benchmark for a given performance year needs to be fully adjusted for changes in beneficiary health status. Failing to do so ignores the fact that even when care is optimally managed, individuals become sicker and therefore more expensive to care for as disease processes progress (or initially present). For example, when a beneficiary who has been continuously attributed to an ACO is diagnosed with cancer, it seems inappropriate for the ACO to carry that cost with no expectation from Medicare for higher spending related to that member. While we appreciate CMS's concern about the potential for alleged upcoding, we find those concerns to be irrelevant relative to the injury this policy causes MSSP participants. At a minimum, we believe CMS needs to develop a list of conditions that are high cost and not subject to efforts to approve documentation and coding (e.g., end-stage renal disease (ESRD, cancer) and allow the CMS-HCC score to increase to reflect the increased illness of the attributed beneficiary.

Calculating Regional Average Expenditures Using State-Level ESRD Data

HFMA is concerned about CMS's proposal to calculate regional ESRD expenditures using state-level data. Specifically, CMS proposes to compute state-level per capita expenditures and average risk scores for the ESRD population in each state and apply those state-level values to all counties in a state. CMS believes that using statewide cost and risk data for the ESRD population is appropriate given the relatively small numbers of ESRD beneficiaries at the county level. Therefore, a statewide calculation would be more statistically stable.

HFMA shares CMS's concern regarding a having a sufficient sample size to ensure statistical validity. However, based on the limitations of data released by CMS it is unclear if using state-level ESRD data is the best solution. Applying state-level data for all counties within a state may skew results for certain ACOs, a concern which may be particularly acute for ACOs operating in certain areas of a state. Though CMS cites using a similar approach in Medicare Advantage (MA), the agency does not adequately demonstrate that using state-level data is the optimal solution for the MSSP, nor does the agency explain in detail its consideration and analysis of alternatives to state-level data. Further, CMS did not release sufficient data for stakeholders to properly analyze alternatives to state-level ESRD data.

HFMA recommends CMS immediately provide the data files necessary to allow stakeholders to model ESRD expenditures based on other geographic units. Specifically, we request CMS provide county-level ACO assigned data by beneficiary category, which would allow MSSP participants to compare the proposed statewide methodology vs. other geographic units. After releasing the necessary data, we request CMS re-open this issue in future rulemaking.

Reversal of Decision to Add Savings Achieved in Prior Performance Periods Back to the Historical Benchmark

In the MSSP rule finalized in June 2015, CMS established a policy to account for the average per capita amount of savings achieved during the prior agreement period by adding a portion back to the rebased benchmark. HFMA strongly supports this policy as we believe it is only appropriate that ACOs not be penalized for prior success achieving the Triple Aim.

However, in the current rule CMS proposes to reverse this policy. It states that moving to a regional benchmark obviates the need to account for savings in the prior agreement period when rebasing benchmarks. However, it does not provide a detailed explanation for how incorporating regional data (which will include beneficiaries assigned to both the ACO in question, other MSSP ACOs, and beneficiaries in similar payment models) mitigates the need to account for savings achieved from prior agreement periods in the current benchmark.

HFMA strongly opposes this change and believes that CMS needs to maintain its existing policy of adding a portion of the average per capita savings achieved to an ACO's rebased benchmark. As long as data from attributed MSSP beneficiaries (either the ACO for which the benchmark is being calculated or other MSSP ACOs) or beneficiaries attributed to similar models that incorporate one- or two-sided risk during the benchmarking period is included in the regional benchmark, CMS needs to account for the amount of shared savings distributed to providers participating in these programs. First, these are Medicare expenditures and need to be accounted for in the benchmark. Second, (as discussed above) while moving to a regional benchmark ameliorates the issue of an ACO competing against itself to find further

efficiencies, failing to add back a portion of the shared savings lessens the efficacy of the solution. Under the proposed rule, an ACO's benchmark will be comprised of a blend of expenditures from its attributed beneficiaries and "attributable" beneficiaries which not only include the ACO's attributed beneficiaries but others attributed to MSSP participants and similar Center for Medicare & Medicaid Innovation programs.

HFMA believes strongly that if CMS does not maintain its current policy of adding a portion of the per capita savings back to an ACO's rebased benchmark it will force beneficiaries to exit the program due to the limit on achievable cost efficiencies. This is particularly true in both traditionally low-cost regions and those with high densities of MSSP participants and other similar CMMI programs.

HFMA recommends that CMS resolve this issue through one of the following approaches.

- 1) **CMS, as described above in our recommendations related to attributable beneficiaries, must remove any beneficiary attributed to a Medicare ACO or similar initiative (e.g., MSSP, Pioneer, Next Generation, Comprehensive Primary Care Initiative, Comprehensive ESRD Care Initiative, Oncology Care Model) from the assignable benchmark population. For the portion of the benchmark that is based on the ACO's historical expenditure, CMS must add back the related average per capita savings amount generated in the prior agreement period to the rebased benchmark. For example, if the benchmark is comprised of 35 percent regional and 65 percent of an ACO's historical expenditure (as in the second agreement period under the proposed rule for new ACOs) then 65 percent of any per capita savings achieved in the initial performance period must be added back in. This is HFMA's preferred approach to this issue.**
- 2) **If CMS refuses to create a "pure comparison" to Medicare FFS by removing beneficiaries attributed to a Medicare ACO or other similar initiatives, HFMA strongly believes that CMS needs to continue adding back 100 percent of any average per capita savings generated in the prior agreement periods.**

Reopening Determination of ACO Savings or Loss Criteria

In the proposed rule, CMS attempts to codify the circumstances under which it would reopen an initial or final determination of shared savings or loss for a performance year. The rule proposes the following:

- 1) If there is good cause, CMS will have the discretion to reopen a payment determination within four years after the date of notification to the ACO of the initial determination. The agency defines good cause as new and material evidence or an obvious error and states what constitutes this is at CMS's discretion.
- 2) While CMS states that it would consider a materiality threshold based on the impact to the total population of ACOs (not an individual ACO), it does not propose a materiality threshold. If CMS finalizes the policy, the proposed rule states that it expects to provide additional information through the sub-regulatory process as to how it will consider the materiality of an error.
- 3) CMS does not propose to provide ACOs with a right to initiate a reopening of a redetermination.

HFMA applauds CMS for proposing reopening criteria. However, HFMA is deeply concerned that individual ACOs are not afforded an opportunity to request a reopening of a savings or loss determination. First, this right is afforded to other providers who "settle" with CMS based on externally provided data. For example, there is a well-established process that provides hospitals (acute, psychiatric, rehabilitation, and long-term acute), skilled nursing facilities, and home health agencies (to name a few) an opportunity to review any adjustments that CMS has made to their cost report. Not only

does this process allow for the provider to correct errors in the determination before it is finalized, but should the provider not be able to resolve items in controversy with CMS's contractor, there is an appeal process. **HFMA strongly recommends that CMS implement a similar well-defined process in the Medicare Shared Savings Program.** If this program is to evolve into the predominate mechanism through which Medicare providers are paid for their services, there needs to be a well thought out, transparent mechanism for ensuring the accuracy of final determinations that is fair to all parties involved. We believe the need for this process is particularly acute in the early years of the MSSP. The program's evolving rules create opportunities for inadvertent errors on the part of Medicare and its Administrative Contractors.

HFMA also believes that CMS's proposal to base its materiality threshold on total impact to all MSSP participants sets an unreasonably high bar. **HFMA recommends that the materiality threshold be based on the individually impacted organization.**

Inducements to Facilitate Transition to Two-Sided Risk Bearing Models

CMS continues to encourage ACOs to move from shared savings only (Track 1 MSSPs) to shared savings/loss models (Track 2 or 3 MSSPs). The proposed rule adds a participation option that would allow eligible Track 1 ACOs to defer by one year their entrance into a performance-based risk model (Track 2 or 3) by extending their first agreement period under Track 1 for a fourth performance year. ACOs eligible to elect this proposed new participation option would be those ACOs eligible to renew for a second agreement period under Track 1 but instead are willing to move to a performance-based risk track two years earlier, after continuing under Track 1 for one additional year. This option would assist ACOs in transitioning to a two-sided risk track when they need only one additional year in Track 1 rather than a full three-year agreement period in order to prepare to accept performance-based risk. ACOs electing this option would still need to meet all of the criteria to participate in Track 2 or 3 (e.g., meet repayment requirements) in the application process for the second agreement period.

HFMA appreciates CMS's efforts to facilitate the transition to two-sided risk models in the MSSP. However, HFMA questions the overall efficacy of CMS's approach given that organizations that opt for a fourth year under the original agreement would either have to transition into a risk based model or "drop-out" of the program for the remainder of the contracting period. We believe that this all-or-nothing approach overlooks the fact that unanticipated changes can have a material impact on an ACO's readiness to assume risk. For example, a significant change in the list of physician group Tax Identification Numbers (TINs) participating in the ACO can have a material impact on the organization's readiness and ability to bear risk.

Therefore we recommend that CMS create a hold harmless provision for ACOs that avail themselves of this option but are unable to assume risk due to a material change in the ACO's structure. Under this hold harmless provision, the ACO would have its benchmark for the "PY4" rebased so that it would be PY1 of its second Track 1 agreement period. From there the ACO should be allowed to complete its second agreement period under Track 1. We would encourage CMS to work with MSSP participants to define a comprehensive list of material events that would qualify a MSSP participant for the hold harmless period.

HFMA further recommends that CMS incorporate more flexibility into its agreement periods. We believe that a more effective option for facilitating the transition to risk would be to allow MSSPs who initially elect Track 1 for their second agreement period to transition to a risk-bearing track any time after PY1 with a 90-day notice.

HFMA looks forward to any opportunity to provide assistance or comments to support CMS as it attempts to set sustainable benchmarks for MSSP participants. As an organization, we take pride in our long history of providing balanced, objective financial technical expertise to Congress, CMS, and advisory groups. We are at your service to help CMS gain a balanced perspective on this complex issue. If you have additional questions, you may reach me or Richard Gundling, Vice President of HFMA's Washington, DC, office, at (202) 296-2920. The Association and I look forward to working with you.

Sincerely,



Joseph J. Fifer, FHFMA, CPA
President and Chief Executive Officer
Healthcare Financial Management Association

About HFMA

HFMA is the nation's leading membership organization for more than 40,000 healthcare financial management professionals. Our members are widely diverse, employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms, and insurance companies. Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant, and consultant.

HFMA is a nonpartisan professional practice organization. As part of its education, information, and professional development services, HFMA develops and promotes ethical, high-quality healthcare finance practices. HFMA works with a broad cross-section of stakeholders to improve the healthcare industry by identifying and bridging gaps in knowledge, best practices, and standards.