North Carolina Medical Society
Leadership in Medicine

Feb. 4, 2015

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

RE: CMS-1461-P; Medicare Shared Savings Program

Dear Administrator Tavenner:

On behalf of the North Carolina Medical Society (NCMS) and our over 12,000 physician and physician assistant members, I am writing to provide our feedback on CMS' proposed changes to the Medicare Shared Savings Program (MSSP). The NCMS appreciates the opportunity to provide comments on these proposed rules outlining changes to the MSSP. We believe the proposals are a step in the right direction to encouraging more practices to participate in, and continue to participate in the MSSP. CMS has proposed significant improvements, such as the opportunity to continue to operate in Track 1 for an additional three-year transition period. These improvements are welcomed and appreciated, however the NCMS has remaining concerns that we urge CMS to address before issuing final program rules to ensure the program's viability.

The NCMS has convened 10 MSSP ACOs in the state whose recommendations have guided these comments. There are approximately 20 MSSP ACOs approved with service areas in North Carolina, and we remain committed to working with CMS and ACOs to make the program a success. We appreciate this opportunity to outline our specific comments on this proposal.

<u>Transition to two-sided risk</u>

- The NCMS supports the removal of the requirement to transition to a two-sided risk model for an ACO's second agreement period. We believe this additional time will be necessary for organizations to continue improving on care coordination tactics and data analysis, and will allow for more organizations to choose to participate in and continue participating in the MSSP program. This additional time is key, as many sophisticated and high-performing ACOs have yet to recoup their substantial initial investments and generate shared savings under

the current program rules. Successfully changing workflow, care processes, alignment and behaviors takes substantial time, investment and effort and we appreciate CMS' proposal to provide additional time under one-sided risk arrangements in the MSSP. With that said, the NCMS urges CMS to increase the shared savings opportunities provided under this additional, one-sided risk track so that ACOs that have invested significantly can have an opportunity to share in savings substantial enough to make their efforts worthwhile. Without this opportunity, we fear that many ACOs will make the hard decision to exit the program. Incentives are essential to continued participation in the MSSP and to attain the shared goal of achieving the triple-aim.

- In North Carolina, the movement to the Medicare Advantage model is one of the fastest in the nation. Without real opportunities to achieve savings in the MSSP program, we anticipate many ACOs moving to this model of care. The NCMS feels it is important, given the significant investments already made in the MSSP ACO program, to preserve this model by increasing incentives to participate and opportunities to truly share in savings earned by the ACO with CMS. Additional upfront funding should be provided to organizations seeking to move to two-sided risk to provide needed capital to those wishing to take on the necessary practice transformation efforts who lack the capital needed for initial investments necessary for making these changes.
- We also urge CMS to consider providing stop-loss insurance for those entities wishing to take on two-sided risk arrangements, as the current market does not provide sufficient options for ACOs. At a minimum CMS should consider funding this, or lowering the cost for stop-loss insurance to develop a market in this area. It will be important that whichever option CMS chooses to employ, it does not allow for market "capture."

<u>Assignment methodology</u>

- The proposed prospective assignment for both reports and financial reconciliation under Track 3 is a much needed improvement to the MSSP program. We urge CMS to allow this alternative as an option for all ACO participants, rather than Track 3 participants only as proposed by CMS. We believe in order to maximize care coordination, patient engagement and mutual provider and patient accountability, prospective assignment will promote the most conducive environment for achieving the Triple Aim.
- The NCMS supports CMS' proposal to include non-physicians in step one of the patient assignment methodology. We urge CMS to provide safeguards that will ensure only primary care non-physician provider services are included in step one of assignment. The NCMS would support including this designation in the enrollment record (PECOS).

<u>Adjustments for health status and demographic changes</u>

- The NCMS urges CMS to adopt a policy where risk adjustment scores would be adjusted for continuously assigned patients. We feel this change is critical to ensuring ACOs are being fairly evaluated based on a changing patient population. The purpose of risk adjustment is

to identify high-risk patients, and therefore we believe it is appropriate and necessary to continuously update risk scores to encourage identification of such patients. CMS notes the potential for "upcoding" as a potential risk for making this change, however we argue that CMS should focus on accurate coding, which should be promoted and encouraged.

Minimum savings rate and minimum loss rate

- The NCMS calls on CMS to eliminate or significantly decrease the minimum savings rate for all tracks and all ACOs participating in the MSSP. As stated previously, substantial investments are needed to transform practices and delivery of care, and the success of the program depends on these organizations being able to share in savings they have earned as a result of this transformation and investments in changing health care delivery. Of the 2012 and 2013 ACOs in North Carolina, one achieved shared savings above the MSR and was eligible to benefit from those savings. Organizations making vast quality improvements while also generating substantial savings to the health care system and Medicare trust fund who do not meet the MSR should still be able to share in savings earned. All organizations making true efforts to transform our healthcare system who are successful at achieving savings should be able to share in those savings at the first dollar, especially those ACOs that participate in two-sided risk models.

Shared savings

- CMS should increase rewards for taking on risk. We recommend a sliding scale be utilized, providing for a maximum 80 percent shared savings. We also urge CMS to place additional limits on the shared losses to reduce risk, and thereby make two-sided risk arrangements more attractive to participants and potential participants.

Notification

- The NCMS applauds CMS for its proposals to remove the burden of beneficiary notification of opt-out. The recognition of the enormous time and burden associated with this task is truly appreciated, and we ask that CMS implement this provision as soon as possible.

Exemption of certain billing requirements

- The NCMS supports CMS' willingness to provide flexibility around certain Medicare billing requirements that would assist ACOs' efforts in care coordination and quality improvement. In particular, we support the changes proposed to:
    - Provide waivers to the Skilled Nursing Facility three-day rule
    - Waive the Medicare originating site rule for telemedicine reimbursement
    - Remove the Homebound requirement under the Home Health Benefit
    - Allow referrals to postacute care settings

- We believe that these waivers also should be made available to those participants in Tracks 1, 2 and 3 of the MSSP, as all entities should have access to any and all policies that may improve performance and increase beneficiary access to high quality care.

Addition of Track 3

- NCMS supports the availability of multiple risk-sharing options and opportunities to allow organizations across the spectrum of readiness to participate in the MSSP. We are encouraged by the proposed addition of Track 3 to the program and recommend that the maximum shared savings rate be increased to 80 percent to increase participation in this track and further encourage organizations to take on risk. As stated above, we also believe it is necessary to eliminate or significantly reduce the minimum savings rate to make this a viable risk-bearing option. In all cases, CMS should provide flexibility to ACOs to choose the option that would work best for their particular organization.

We appreciate the opportunity to provide comments on these proposed program changes. The NCMS truly believes in the mission of the Medicare Shared Savings Program and works diligently to assist ACOs in North Carolina in being successful in this program as well as other practice transformation efforts. The multitude of MSSP-approved ACOs in North Carolina is a true testament to the state's desire to be leaders in changing our health care delivery system for the better. We urge you to adopt these recommendations needed to encourage the broadest level of participation and success of the program. Should you have any questions, please contact Melanie Phelps or Jennifer Gasperini at 919-833-3836 or NCMSgovtaffairs@ncmedsoc.org.

Sincerely,

Robert E. Schaaf, MD, President

Copy: Devdutta G. Sangvai, MD, Chair, NCMS Accountable Care Task Force
Robert W. Seligson, Executive Vice President, CEO NCMS