AMERICA'S ESSENTIAL HOSPITALS

October 16, 2018

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Ave. SW
Washington, DC 20201

Ref: [CMS-1701-P] Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations—Pathways to Success

Dear Ms. Verma:

Thank you for the opportunity to submit comments on the above-captioned proposed rule. America's Essential Hospitals appreciates the Centers for Medicare & Medicaid Services' (CMS') work to improve the delivery of high-quality, integrated care across the health care continuum. We are concerned about several provisions within the proposed rule that would overhaul the Medicare Shared Savings Program (MSSP) and negatively impact essential hospitals—those that provide stability and choice for people who face barriers to care.

America's Essential Hospitals is the leading champion for hospitals and health systems dedicated to providing high-quality care for all. While our members represent just 6 percent of hospitals nationally, they provide 20 percent of all charity care nationwide, or about $3.5 billion, and 14.4 percent of all uncompensated care, or about $5.5 billion.[1] The high cost of providing care to low-income and uninsured patients leaves essential hospitals with limited financial resources. Even with their limited means, our member hospitals demonstrate an ongoing commitment to serving vulnerable patients. Essential hospitals provide specialized services that their communities otherwise would lack (e.g., trauma centers, emergency psychiatric facilities, burn care); expand access with their extensive networks of on-campus and community-based clinics; furnish culturally and linguistically appropriate care; train health care professionals; supplement social support services; and offer public health programs. Further, our members have worked to implement increasingly efficient strategies for providing high-quality care to their patients; several essential hospitals have made the needed investments to participate in

[1] Clark D, Roberson B, Ramiah K. Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2016 Annual Member Characteristics Survey. America's Essential Hospitals. June 2018. www.essentialdata.info/. Accessed September 19, 2018.

AMERICA'S ESSENTIAL HOSPITALS
401 Ninth St NW Ste 900
Washington DC 20004
t: 202 585 0100
f: 202 585 0101
e: info@essentialhospitals.org

the MSSP as accountable care organizations (ACOs), as well as other CMS value-based payment initiatives.

America's Essential Hospitals is encouraged by CMS' proposals to provide more stability and predictability for ACOs in the MSSP through longer agreement periods, as well as opportunities for reduced regulatory burdens and response to the nation's opioid epidemic. However, we are concerned about the unintended consequences of the proposed mandatory transition of ACOs to performance-based risk, as well as the continued lack of risk adjustment for sociodemographic factors in the quality measures used to evaluate program performance.

Essential hospitals offer comprehensive, coordinated care across large ambulatory networks to bring vital services to where patients live and work. Our members provide comprehensive ambulatory care through networks of hospital-based clinics that include onsite features—radiology, laboratory, and pharmacy services, for example—not typically offered by freestanding physician offices. Our members' ambulatory networks also offer behavioral health services, interpreters, and patient advocates who can access support programs for patients with complex medical and social needs.

Improving care coordination and quality while maintaining a mission to serve the vulnerable is a delicate balance. To ensure our members have sufficient resources to advance their missions and are not unfairly disadvantaged for providing comprehensive care to complex patients, we urge CMS to consider the following recommendations when finalizing the above-captioned proposed rule.

1. **CMS should allow ACOs more time to participate in the savings-only track of the MSSP.**

The MSSP is a voluntary program in which eligible providers create or join ACOs through which they can then share savings with Medicare by demonstrating efficient care delivery along with meeting quality performance benchmarks. Currently, participation in the shared savings program includes ACOs in the savings-only track (or Track 1) and ACOs in two-sided, risk-bearing tracks (Tracks 2 and 3). In the two-sided models, ACOs share in both savings and take on risk of repayment to CMS of losses exceeding the threshold set for costs. CMS also introduced the Track 1+ model, which began Jan. 1 and consists of a two-sided payment model incorporating the upside of Track 1 with more limited downside risk than currently present in Tracks 2 or 3.

In performance year 2018, CMS reported 55 ACOs began in the Track 1+ model, representing the largest cohort to date of ACOs with performance-based risk. CMS reasons that the interest in the Track 1+ model suggests that a lower-risk, two-sided model can effectively encourage Track 1 ACOs to progress to performance-based risk. Using this premise, CMS proposes to redesign the MSSP to require that all ACOs rapidly transition to performance-based risk.

CMS proposes to discontinue Tracks 1 and 2, both for new ACO applicants and participants applying for renewal. The agency also would discontinue future application cycles for the Track 1+ model. A new BASIC track would require eligible ACOs to

incrementally transition to higher levels of risk and potential reward through a glide path. The glide path includes five levels: a one-sided model available only for the first two years (Levels A and B) to eligible ACOs; and three levels of progressively higher risk and potential reward in years three through five of the agreement period (Levels C, D, and E). CMS would restrict ACOs identified as previous participants under Track 1 to a single year under a one-sided model. CMS would maintain the existing Track 3 (two-sided model with highest risk) and rename it the ENHANCED track.

CMS currently allows three-year ACO agreement periods. Under the proposal, ACO agreement periods beginning July 1, 2019, would last five years and six months. Agreements would last five years for agreement periods beginning Jan. 1, 2020, and subsequent years. **We support CMS' proposal to allow longer agreements periods** to give ACOs a greater chance to succeed by allowing them more time to understand their performance, gain experience, and implement redesigned care processes before rebasing the ACO's historical benchmark. However, other provisions in the proposed rule that would reduce the amount of time ACOs can participate in the savings-only track overshadow the benefits of longer agreement periods. All ACOs are not created equal. To impose a timeline for risk adoption that fails to consider the unique challenges of ACOs that serve vulnerable populations discourages essential hospitals from participating in the program.

Under the MSSP, ACOs currently can participate for up to six years before taking on risk—that is, a three-year agreement in Track 1 with the option to renew for an additional agreement period of the same length. In the proposed rule, CMS states that an ACO's "performance would improve through greater incentives, principally a requirement to take on higher levels of performance-based risk." Under this rationale, CMS would reduce the amount of time an ACO can remain in the program without taking on risk to, at most, two years. CMS acknowledges this proposal likely would reduce ACO participation, stating that an expected decline is "mainly due to the expectation that the program will be less likely to attract new ACO formation in future years as the number of risk-free years available to new ACOs would be reduced … to two years in the BASIC track."

Essential hospitals require time and resources to engage in care redesign and targeted interventions that will have the best effect on the vulnerable populations they serve. Our members often face challenges finding the resources necessary to upgrade technology, redesign processes, and develop a network; these challenges can preclude them from participation as ACOs. When they make the decision to participate, it often is with the recognition that costs incurred upfront will, over the course of the agreement period, lead to improved outcomes and shared savings. In this way, Track 1 is not without risk. Our members incur significant administrative and reporting costs to participate in the MSSP, and these costs pose a potential downside even if the risk-sharing is one-sided. **CMS should consider investments in infrastructure and care redesign as a form of downside risk.**

For example, one essential hospital in New York participating in Track 1 of the MSSP has invested in creating an ACO population dashboard. The dashboard guides data-driven standard work, high-risk patient outreach, and performance feedback; integrates

clinical, financial, and administrative data; and links to individual patient and individual physician data. This type of proactive data management is critical to the success of the ACO to generate savings for Medicare and potential shared savings for itself. However, such upfront and ongoing investments incurred by essential hospitals are not recognized by CMS in its calculations of ACO savings, losses, and costs. Further, the benefits of these transformations extend beyond the ACO's defined patient population and have a broader effect on other Medicare beneficiaries. **We urge CMS to allow ACOs to remain in the savings-only level of the BASIC track (i.e., Level A) for at least three years and create a slower glide path for participating organizations that choose to take on more risk.**

2. **CMS should restore the shared savings rates to 50 percent for all ACOs in the BASIC track.**

Under the MSSP, an ACO might be eligible to receive a shared savings payment if it meets specified quality and savings requirements. CMS proposes that under the one-sided, savings-only model years of the BASIC track, an ACO's maximum shared savings rate would not exceed 25 percent based on quality performance, applicable to first-dollar shared savings after the ACO meets the minimum savings rate. This sharing rate is one-half of the maximum sharing rate (50 percent) currently available under Track 1. The savings rate does not reach 50 percent until year five of the BASIC track. The proposed lower shared savings rate for ACOs with no downside risk (i.e., first two years of BASIC track) is a deterrent for existing and new ACOs and makes the program significantly less financially attractive.

Lowering the shared-savings rate offers new ACOs little incentive to join the MSSP or remain in the program. Operating as an ACO and attempting to earn shared savings requires substantial costs, including for quality reporting and efforts to lower spending and improve performance on quality measures. Accordingly, the proposed reduction in the shared savings rate to 25 percent for the savings-only levels of the BASIC track is likely to reduce investments in these ACOs, reduce savings to Medicare, and attract fewer ACOs to the program.

Similarly, the lowered attractiveness of the program to existing ACOs is a very real possibility. When existing ACOs leave the program, there is a direct impact on beneficiaries. CMS reports that for performance year 2018, there are 460 ACOs participating in the Track 1 (savings-only) model, caring for more than 8 million beneficiaries.[2] Essential hospitals often reinvest savings from their participation in the MSSP into programs to coordinate care and improve outcomes for disadvantaged populations, including initiatives to reduce readmissions, ensure medication compliance, and identify high-risk patients in need of ancillary services. **We urge CMS to recognize the proposed policies' negative affect on access to care and services that improve overall health, and to maintain the shared-savings rate at 50 percent for all ACOs in the BASIC track.**

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[2] Performance Year 2018 Medicare Shared Savings Program Accountable Care Organizations. https://data.cms.gov/Special-Programs-Initiatives-Medicare-SharedSavin/Performance-Year-2018-Medicare-SharedSavings-Prog/28n4-k8qs/data. Accessed September 20, 2018.

3. **CMS should further examine the differences in ACO performance before imposing participation options based on Medicare revenue.**

To determine participation options for ACOs, CMS proposes new policies based on a combination of factors: the degree to which ACOs control total Medicare Parts A and B fee-for-service (FFS) expenditures for their assigned beneficiaries (low-revenue ACO versus high-revenue ACO); and the experience of the ACO's legal entity and participants with the MSSP and performance-based risk Medicare ACO initiatives. It is CMS' belief that high-revenue ACOs, which typically include hospitals, have a greater opportunity to control assigned beneficiaries' total Medicare Parts A and B FFS expenditures, as they coordinate a larger portion of the assigned beneficiaries' services across care settings.

Specifically, the proposal defines high-revenue ACOs as those for which total Medicare parts A and B FFS revenue of ACO participants exceeds a threshold of 25 percent of total Medicare parts A and B FFS expenditures for the ACO's assigned beneficiaries. CMS would define low-revenue ACOs as those with a percentage less than the 25 percent threshold. In the proposed rule, CMS states that it expects most hospital-led ACOs to be considered high-revenue and most physician-led ACOs to be low-revenue. The program would limit high-revenue ACOs to one agreement in the BASIC track before transitioning to participation under the ENHANCED track. In contrast, CMS would allow low-revenue ACOs to remain under the BASIC track for two agreement periods. ACOs should aim to encourage all providers to work collaboratively. As such, incentives must focus on driving all providers in a system to work together, innovate, and deliver high-quality, cost-effective care for all. By imposing distinct participation options, CMS is creating a two-tier system for ACOs in the program; this, in turn, creates an unlevel playing field between physician-led and hospital-led ACOs that could have unintended consequences and reduce participation of hospital-led ACOs.

CMS also seeks comment on approaches that potentially would allow greater access to shared savings for low-revenue ACOs compared with high-revenue ACOs, based on the assumption that low-revenue ACOs would need additional capital to encourage their continued participation in the MSSP. One proposed approach is to allow a maximum 50 percent sharing rate at all levels within the BASIC track's glide path for low-revenue ACOs. This contrasts with the proposed approach under which the sharing rate would phase in from a maximum of 25 percent in Level A to a maximum of 50 percent in Level E. As discussed above, the proposed reduced sharing rate would significantly affect essential hospitals participating in the MSSP. **CMS should provide the sharing rate of 50 percent across ACOs in a consistent and equitable manner.**

4. **CMS should continue to refine the measures used to establish ACO quality performance standards under the MSSP to ensure an accurate representation of quality of care.**

America's Essential Hospitals supports programs that encourage quality improvement. However, CMS must verify that quality improvement program measures are properly constructed and do not lead to unintended consequences and administrative burden on

hospitals. This is especially important for essential hospitals, which already operate with limited resources.

a. CMS should account for sociodemographic factors, including socioeconomic status, by risk adjusting the measures used to establish ACO quality performance.

Socioeconomically disadvantaged populations experience a disproportionate share of many diseases and adverse health conditions. Essential hospitals fulfill the complex clinical and social needs of all patients that come through their doors. Our members treat a high proportion of patients with social risk factors—factors outside the control of the hospital, such as lack of transportation or limited access to nutritious food—that can affect health outcomes.

Before including measures in the MSSP, CMS must verify they will not lead to unintended consequences. Currently, more than half of the 31 quality measures in the MSSP are outcome-based. As quality reporting programs move toward outcome-based measures and away from process measures, CMS must ensure measures chosen for these programs accurately reflect quality of care and account for factors beyond the control of a hospital. The agency should ensure the measure set includes metrics that are valid and reliable, aligned with other existing measures, and risk adjusted for sociodemographic factors. **CMS should not include measures in ACO quality performance standards until they have been appropriately risk adjusted for sociodemographic factors, including socioeconomic status.**

In previous comments on hospital inpatient quality reporting programs, we urged CMS to consider the sociodemographic factors—language and existing level of post-discharge support, for example—that might affect patients' outcomes and include such factors in the risk-adjustment methodology. We made these comments out of a preponderance of evidence that patients' sociodemographic status affects outcomes of care.[3] Outcome measures, especially those focused on readmissions, do not accurately reflect quality of care if they do not account for sociodemographic factors that can complicate outcomes. For example, patients who do not have a reliable support structure are more likely to be readmitted to a hospital or other institutional setting. Reducing preventable readmissions is of paramount concern to America's Essential Hospitals and its members. We believe that any program directed at improving outcomes and beneficiaries' health through the episode of care must target readmissions that are preventable and include appropriate risk-adjustment methodology.

Essential hospitals support quality and accountability. What they want, and what their patients and communities deserve, is an equal footing with other hospitals for quality evaluation. When assessing quality measures, Medicare programs should account for the sociodemographic and socioeconomic complexities of disadvantaged populations to ensure hospitals are assessed on their work, rather than on the patients they serve. Differences in patients' backgrounds might affect complication rates and other outcome

[3] See, e.g., America's Essential Hospitals. Sociodemographic Factors Affect Health Outcomes. October 21, 2015. http://essentialhospitals.org/institute/sociodemographic-factors-and-socioeconomic-status-ses-affect-health-outcomes/. Accessed October 10, 2018.

measures; ignoring these differences would skew quality scores against hospitals that provide essential care to the most complex patients, including those with sociodemographic challenges and the uninsured.

As required by the Improving Medicare Post-Acute Care Transformation Act, HHS' Office of the Assistant Secretary for Planning and Evaluation (ASPE) in December 2016 released a report clearly showing the connection between social risk factors and health care outcomes.[4] The report provides evidence-based confirmation of what essential hospitals and other providers have long known: patients' sociodemographic and other social risk factors matter greatly when assessing the quality of health care providers. **We urge CMS to further examine the recommendations found in the ASPE report for future incorporation in MSSP.**

As noted by the National Academies of Sciences, Engineering, and Medicine (the Academies) in its series of reports on accounting for social risk factors in Medicare programs, "Achieving good outcomes (or improving outcomes over time) may be more difficult for providers caring for patients with social risk factors precisely because the influence of some social risk factors on health care outcomes is beyond provider control."[5] We urge CMS to closely examine the considerations provided by the Academies for risk adjustment in federal programs.

Like the growing body of research on socioeconomic risk adjustment, the Academies found that community-level elements outside providers' control can indicate risk unrelated to quality of care.[6] We urge CMS to examine these criteria, as identified by the Academies, when choosing the risk factors for an adjustment methodology:

- conceptual relationship with the outcome of interest;
- empirical association with the outcome of interest;
- risk factor presence at the start of care;
- risk factor modifiability through the provider's actions; and
- risk factor resistance to manipulation or gaming.

We urge CMS to examine the Academies' report for examples of available data to include in measure risk adjustment in the MSSP. The agency also should develop analytic methods for integrating patient data with information about contextual factors that influence health outcomes at the community or population level. Identifying which social risk factors might drive outcomes and determining how to best measure and incorporate those factors into payment systems is a complex task, but

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[4] Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation. Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs. Washington, D.C.; December 2016. https://aspe.hhs.gov/system/files/pdf/253971/ASPESESRTCfull.pdf. Accessed October 10, 2018.

[5] National Academies of Sciences, Engineering, and Medicine. Accounting for Social Risk Factors in Medicare Payment. Washington, D.C.: The National Academies Press; January 2017. http://nationalacademies.org/hmd/Reports/2017/accounting-for-social-risk-factors-in-medicare-payment-5.aspx. Accessed October 10, 2018.

[6] America's Essential Hospitals. Sociodemographic Factors Affect Health Outcomes. April 18, 2016. http://essentialhospitals.org/institute/sociodemographic-factors-and-socioeconomic-status-ses-affect-health-outcomes/. Accessed October 10, 2018.

doing so is necessary to ensure better outcomes, healthier populations, lower costs, and transparency. We look forward to working with CMS to account for social risk factors and reduce health disparities across Medicare programs, including the MSSP.

b. We support CMS' Meaningful Measures Initiative and encourage the agency to continue to refine the MSSP quality measure set.

Essential hospitals have long supported quality measurement and pay-for-performance initiatives as vitally important tools for improving value. However, the rapid growth in measures and measure reporting requirements has jeopardized the effectiveness of efforts to make meaningful quality improvements. Although some measures provide useful information, their sheer number—as well as lack of focus, consistency, and organization—limits their overall effectiveness in improving health system performance. Further, the proliferation of measures combined with a lack of consistency often leads to inaccurate comparisons of providers and confusion for consumers.

Last year, CMS launched its Meaningful Measures Initiative to identify high-priority areas for quality measurement and improvement. **We support CMS' efforts to increase measure alignment across programs and reduce provider reporting burden. We encourage the agency to continue this work, with input from all stakeholders, to promote improved outcomes while minimizing costs.**

c. We urge CMS to further examine measures related to opioid use to ensure their validity and appropriateness before inclusion in the MSSP measure set.

In response to the nation's opioid epidemic, CMS seeks feedback on possible changes to the MSSP quality measure set and modifications to program data shared with ACOs. America's Essential Hospitals supports CMS' efforts to help ACOs and their participating providers respond to and manage opioid use. In considering the addition of opioid-specific measures to the MSSP measure set, we urge CMS to focus on measures that are useful to hospitals and fully vetted to ensure they provide meaningful information and do not lead to unintended consequences. We also encourage CMS to examine existing efforts by hospitals to improve opioid practices before introducing new measures to the MSSP. For example, a Kentucky essential hospital urges providers to first offer non-opioid options—like ibuprofen and acetaminophen—and then to explore alternative pain management, such as localized nerve blocking methods. By engaging physicians, pharmacists, and nurses, this essential hospital ensures all staff are committed to providing non-opioid regimens before prescribing stronger medications.[7]

As key stakeholders in combating the opioid crisis, essential hospitals stand ready to implement practices proved effective in reducing opioid dependence. For example, an essential hospital in Ohio created an Office of Opioid Safety—focused on education, advocacy, and treatment—that has created physician-, practice-, and subspecialty-specific dashboards to collect data on prescribing practices. The data are used to

[7] Susman K. The Opioid Crisis: Hospital Prevention and Response. America's Essential Hospitals. https://essentialhospitals.org/wp-content/uploads/2017/06/Opioid-Brief-1.pdf. Accessed September 20, 2018.

educate providers on policy and best practices for safe opioid use. Further, residents and emergency department physicians at this health system undergo training in a simulation center, where they work with speaking mannequins to learn how to respond to patients who request more pain medication. **ACOs and their participating providers should monitor the administration of opioids and promote evidence-based use through programs tailored to the needs of the ACO and its patient population.** We urge CMS to support and provide flexibility for hospitals working to increase compliance with prescribing protocols and pain management training. The agency should not add measures that increase administrative burden and are not linked to improved outcomes.

5. **CMS should recognize the challenges essential hospitals face in implementing certified electronic health record technology (CEHRT) when setting thresholds for the MSSP.**

The introduction of the Quality Payment Program (QPP) has put greater significance on the transition to performance-based risk. As previously finalized under the QPP, initiatives that require ACOs to bear risk for monetary losses of more than a nominal amount and that meet additional criteria, including the use of CEHRT, can qualify as an Advanced Alternative Payment Model (APM). Eligible clinicians who participate in Advanced APMs are exempt from the Merit-based Incentive Payment System and can earn a lump-sum bonus applied to their payments. Recently, CMS proposed to increase the threshold level under the QPP from 50 to 75 percent of eligible clinicians required to use CEHRT in each participating Advanced APM, as part of the calendar year 2019 Physician Fee Schedule proposed rule.

CMS proposes to discontinue the use of the CEHRT quality measure (ACO-11) and to instead require ACOs to attest, when applying to the program and annually thereafter, that a specified percentage of their eligible clinicians use CEHRT. Starting on Jan. 1, 2019, ACOs in a track (or payment model within a track) that *do not meet* the financial risk standard to be an Advanced APM must attest and certify that at least 50 percent of the eligible clinicians participating in the ACO use CEHRT to document and communicate clinical care to their patients or other health care providers. For ACOs participating in a track (or payment model within a track) that *meets* the financial risk standard to be an Advanced APM, CMS proposes to align this requirement with the CEHRT use requirement for Advanced APMs under the QPP. In other words, for these ACOs, CMS would require the higher of the 50 percent threshold or the CEHRT use criterion as finalized for Advanced APMs under the QPP (i.e., 75 percent).

We support the agency's efforts to improve interoperability among providers, as well as the use of EHR technology to improve the flow of information between providers and patients. However, these proposals introduce additional complexity and resource allocation for essential hospitals participating in the MSSP. Existing EHR technology remains a challenge for essential hospitals as they adapt to requirements across Medicare programs, including the Promoting Interoperability Programs within the QPP. While many essential hospitals are leaders in implementing CEHRT, they face obstacles to adopting the latest edition of the technology. As has been the issue with every update of certification requirements, vendors do not always make certified

products available in a timely manner. The adoption and upgrade of CEHRT involves many different parties—both within and outside the hospital—and requires a substantial investment of time and staff resources. Once providers begin upgrading their EHRs, issues inevitably will arise that the provider's IT staff and vendor must resolve. Fully implementing a new EHR platform and ensuring it is ready to use involves training staff, updating workflows, and testing the technology.

In addition to the difficulties associated with adopting and maintaining CEHRT, providers still are working to fully realize the potential of EHRs. Certification criteria are tailored to enable new capabilities in EHR products, such as the use of application programming interfaces and the electronic exchange of information. However, the health care field overall has not reached a point in which CMS can reasonably expect providers to seamlessly share information, particularly between hospitals and community providers. The Government Accountability Office has highlighted the many remaining challenges to attaining a truly interoperable nationwide health information technology infrastructure.[8] There are multiple private- and public-sector initiatives to improve the interoperability landscape, but much work must be done to enable providers to easily exchange information.

Further, the Office of the National Coordinator for Health Information Technology (ONC) has conducted important work to promote new technology for providers and encourage increased interoperability. As directed in the 21st Century Cures Act, ONC in January 2018 released the Trusted Exchange Framework and Common Agreement, which outlines a set of principles for trusted exchange to enable interoperability.[9] ONC should continue this important. Improved interoperability is critical in enabling providers to use CEHRT to seamlessly exchange health information with patients and other providers. **Before finalizing changes to the MSSP, we urge CMS to consider the unique patient population served by essential hospitals and the challenges to interoperability and information exchange that the industry has yet to overcome.**

6. **CMS should finalize its proposal to allow choice in beneficiary assignment on an annual basis by all ACOs.**

Assignment is a key program methodology used to identify the beneficiaries associated with an ACO—i.e., the population for which CMS holds the ACO accountable. The Department of Health and Human Services determines an appropriate method to assign Medicare FFS beneficiaries to an ACO based on utilization of primary care services furnished by physicians in the ACO. To date, CMS has designated which beneficiary assignment methodology will apply for each track of the MSSP. For Tracks 1 and 2, CMS uses preliminary prospective beneficiary assignment with final retrospective beneficiary assignment. For the Track 1+ Model and Track 3, CMS uses prospective beneficiary assignment. The design of the MSSP locks in an ACO's choice of

[8] U.S. Government Accountability Office. Nonfederal Efforts to Help Achieve Health Information Interoperability. GAO-15-817. September 2015. http://www.gao.gov/assets/680/672585.pdf. Accessed September 20, 2018.
[9] Office of the National Coordinator for Health Information Technology. Draft Trusted Exchange Framework. January 2018. https://www.healthit.gov/sites/default/files/draft-trusted-exchange-framework.pdf. Accessed September 20, 2018.

financial model, which also determines the applicable beneficiary methodology, for the duration of the ACO's three-year agreement period.

Under the proposed rule, CMS would separate the choice of beneficiary assignment methodology from the choice of participation track (i.e., financial model) and allow ACOs to make an annual election of assignment methodology. Beginning July 1, 2019, and in subsequent years, CMS proposes to allow all ACOs to choose either prospective assignment or preliminary prospective assignment with retrospective reconciliation. ACOs are in the best position to make decisions related to beneficiary assignment. For example, with some ACOs might be attracted by the prospective model which provides a more predictable benchmark and a more stable beneficiary population on which the ACO can focus its efforts. **We support CMS' proposed additional flexibility on choice of beneficiary assignment methodology.**

7. **CMS should continue to refine its risk-adjustment methodology to account for changes in health status of ACO assigned beneficiaries over time.**

The MSSP's benchmarking methodology is a complex calculation that incorporates the ACO's risk-adjusted historical expenditures and reflects either national or regional spending trends. To account for changes in beneficiary health status between the historical benchmark period and the performance year, CMS performs risk adjustment using a methodology that relies on Hierarchical Condition Categories (HCC) to account for changes in severity and case mix for assigned beneficiaries.

CMS proposes to refine its benchmarking approach following concerns voiced by ACOs that the current risk-adjustment methodology does not adequately account for changes in acuity and health status of patients over time. For example, negative changes in health status that occur at the individual beneficiary level (e.g., heart attack, stroke) between the third benchmark year and the applicable performance year likely will have an upward impact on HCC risk scores but are not recognized under the current methodology. This lack of upward HCC risk adjustment over time in response to patient acuity makes it harder for ACOs to realize savings and adversely impacts essential hospitals that care for a vulnerable population, often with complex clinical needs and comorbidities.

CMS proposes to use HCC risk adjustment for all assigned beneficiaries between the benchmark period and the performance year, subject to a symmetrical cap of positive or negative 3 percent for the agreement period. While we appreciate CMS allowing risk score increases, **the proposed cap of 3 percent is both arbitrary and insufficient when applied across an agreement period (i.e., five years) and not a year-over-year increase. We urge CMS to consider raising this cap to at least 5 percent.**

CMS states in the proposed rule that the MSSP must continue to remain attractive to ACOs, "especially those caring for the most complex and highest risk patients who could benefit from high-quality, coordinated care from an ACO." Given essential hospitals' low margins, they must find innovative and efficient ways to provide high-quality care. But essential hospitals' diverse mix of patients, in terms of clinical complexity and sociodemographic factors, complicates care and requires extensive resources. **CMS**

should account for these factors when refining the risk-adjustment methodology for the MSSP and ensure that ACOs are not penalized for serving higher-risk patients.

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America's Essential Hospitals appreciates the opportunity to submit these comments. If you have questions, please contact Senior Director of Policy Erin O'Malley at 202-585-0127 or eomalley@essentialhospitals.org.

Sincerely,

Bruce Siegel, MD, MPH
President & CEO