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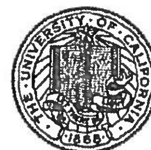

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October 16, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, D.C. 20201

RE: CMS-1701-P, Medicare Shared Savings Program Notice of Proposed Rulemaking "Accountable Care Organizations--Pathways to Success," Proposed Rule

Dear Administrator Verma:

The University of California Health system, referred to as UC Health, appreciates this opportunity to submit comments in response to the Medicare Shared Savings Program "Accountable Care Organizations – Pathways to Success" proposed rule.[1] UC Health system is comprised of five nationally acclaimed medical centers in Davis, Irvine, Los Angeles, San Diego, and San Francisco, along with 18 health professional schools. We care for millions of patients annually and serve as America's largest public instruction program for clinicians, educating and training over 14,000 health professional students, including over 5,000 medical residents.

Our UC medical centers are among California's leading safety net providers, providing not only many tertiary and quaternary care services, but also delivering primary and secondary care to patients regardless of their ability to pay. Each of UC Health's medical centers has taken a proactive approach to managing the health of the patient populations it serves and has embraced using a variety of value-based care models to deliver care to those patients, including the Medicare Shared Savings Program (MSSP).

All five of UC Health's medical centers participate in MSSP Accountable Care Organizations (ACOs) and through those organizations, provide care for more than 100,000 Medicare beneficiaries in total. Four of our medical centers are in their initial period of participating in the MSSP, beginning on January 1, 2018, and UCLA Health has participated in the MSSP since 2013, having renewed its participation in 2016.[2] Three of the UC medical centers voluntarily chose to take on performance-based downside risk by participating in the Track 1+ model, and

[1] 83 Fed. Reg. 41,786 (Aug. 17, 2018).
[2] *See* https://data.cms.gov/Special-Programs-Initiatives-Medicare-Shared-Savin/Performance-Year-2018-Medicare-Shared-Savings-Prog/28n4-k8qs/data.

two UC medical centers are in Track 1. UCLA Health, one of UC's current Track 1+ ACOs, transitioned into being a Track 1+ model in its final year of what was originally a three-year Track 1 ACO agreement. Additionally, UC medical centers participate in several commercial insurer ACOs. UC's participation in both private and public payers' ACOs has made UC Health clinicians keenly aware of the varying patient demographics and consequently, distinct patient needs and the targeted risk adjustment critical to successfully managing each ACO population's health care. Because each of UC Health's medical centers has a National Cancer Institute (NCI)-designated cancer center and is a nationally recognized site for organ transplants, UC's MSSP ACOs have a greater share of beneficiaries suffering from cancer or End Stage Renal Disease (ESRD) than is common of most MSSP ACOs. We believe that through these and other Alternative Payment Models (APMs) currently being implemented at UC medical centers, UC Health can continue to provide more efficient, higher quality and innovative medical care to Medicare beneficiaries along with a better patient care experience.

UC Health generally supports CMS's effort to streamline the existing MSSP options into a simpler two-track program in order to facilitate ACOs taking on performance-based downside risk in a carefully phased-in approach: (1) the BASIC track, which includes an option for eligible ACOs to begin participation in a one-sided model and incrementally phase-in risk over the course of a single agreement period, and (2) the ENHANCED track, based on the MSSP's existing Track 3. However, UC Health is concerned that certain provisions of the proposed rule do not strike the right balance between encouraging ACOs to take on downside financial risk and recognizing the significant upfront investment required to develop and implement an ACO and the time needed to achieve operational changes that will allow an ACO to provide more efficient care. Pushing ACOs to take on downside financial risk too quickly risks discouraging ACOs from investing the time and resources needed to develop the necessary clinical and operational infrastructure changes to successfully transform care delivery and discouraging other providers from participating in ACOs altogether, both of which could undermine CMS's objective of reducing spend in fee-for-service (FFS) Medicare. To encourage organizations located in many regions to participate in an ACO, we recommend the following changes:

- **Do not penalize early Track 1+ risk adopters**. The ACOs participating in the Track1+ in 2018 include some ACOs, like the UCLA Faculty Practice Group ACO (ACO ID A45761) that entered into a Track 1 participation agreement in 2016 and that voluntarily elected to enter Track 1+ in their last performance year in 2018 (rather than remain in Track 1). In other words, these ACOs took the initiative to assume performance-based downside risk earlier than CMS would otherwise have required, which is exactly the behavior that CMS says its proposed rule is designed to encourage. Under the proposed rule, however, these ACOs would be considered "experienced" with performance-based risk Medicare ACO initiatives, and if they are high revenue ACOs, like the UCLA Faculty Practice Group ACO, they would be forced to enter the highest risk (ENHANCED) Track with only one year of Track 1+ experience. In order to treat voluntary early risk adopters on equal terms with other Track 1 participants, ACOs that have participated in only one year of Track 1+ should have the option of entering a new agreement period in the Basic Track at Level E (equivalent to Track1+) or the ENHANCED Track, but not be required to enter into a new agreement period under the ENHANCED Track.

- **Extend the amount of time new ACOs can participate with no downside risk and make the ENHANCED Track voluntary.** Under the existing MSSP, new ACOs participating in Track 1 are allowed to develop up to 6 years of experience in the program without taking on performance-based downside risk. While we understand CMS intends to encourage providers to take on performance-based downside risk, we are concerned the effects of the proposed rule to decrease the time new ACOs are permitted to participate in the program before they take on down-side risk, coupled with CMS's proposal to reduce the percentage of shared savings that an ACO may earn (from 50 percent to 30 percent) while taking on that more limited amount of risk, will result in providers exiting the program prematurely, or just not participating. Participating in a MSSP ACO requires substantial resources to build an infrastructure, analyze the population and apply appropriate population health management initiatives. With substantial risk and minimal shared savings opportunity, organizations will be discouraged from making the investments required to start an ACO. Similarly, by forcing organizations to increase their risk from current levels (as the proposal indicates may occur for current high revenue, experienced Track 1+ participants), CMS risks encouraging providers to cease participating in ACOs altogether. Such a result contradicts CMS's objectives. Instead, UC Health recommends that CMS continue to smooth the transition for ACOs into taking on down-side risk by extending the number of years a new ACO can participate in the program without taking on downside risk or while taking on more limited downside risk, and at the same time, maintaining the shared savings rate at the current rate of 50 percent for those ACOs. For the same reason, UC Health also recommends that CMS allow participation in the ENHANCED track to be voluntary for any ACO and to not finalize its proposal to require "experienced" high-revenue ACOs to participate in the ENHANCED track in new agreement periods starting on July 1, 2019 or in subsequent years.

- **The MSSP ACOs' benchmark should be normalized to reflect current year cost adjustments.** Under the proposed rule, there is a lag in normalizing the benchmark to account for various changing cost factors. Some of these factors change suddenly and significantly resulting in unpredictable adverse impact on an ACO's performance. Due to rising wage indexes and changes in both physician and hospital reimbursement, we recommend that the benchmark be normalized annually. Specifically, the Inpatient Prospective Payment System (IPPS) Hospital Wage Index and other Wage Index Values, Medicare Physician Fee Schedule changes, Market Basket Updates, Merit-Based Incentive Payment System adjustments, Geographic Practice Cost Indices (GPCIs), and hospital reclassifications where significant increases in the Wage Index values occur, should be accounted for fully when normalizing previous years' data to create an ACO's annual benchmark.

- **Risk adjustment methodology should reflect true changes in the ACO's population.** As CMS knows, an ACO often experiences a significant influx of newly assigned beneficiaries each year. An ACO should fully document those newly assigned beneficiaries' risk scores in the first instance (in compliance with coding guidelines), and those risk scores should be included in CMS's risk adjustment model. In addition, any increase or decrease in the acuity of the ACO's continuously assigned beneficiaries should be accounted for in the risk adjustment model. As patients transition to providers and practitioners that are part of an ACO, they are better engaged in their own care. They receive more coordinated care, which will result in greater documentation of appropriate diagnoses and risk. The proposed rule would eliminate the distinction between newly and continuously assigned beneficiaries and use full CMS-HCC risk adjustment for all assigned beneficiaries between the benchmark period and the performance year, subject to a symmetric cap 3 percent. However, UC Health is concerned that applying a 3 percent cap, particularly for newly assigned beneficiaries, will not appropriately take into account the changes in risk associated with new beneficiaries or continuously assigned beneficiaries over the proposed five-year agreement period. This is likely to unfairly penalize ACOs with assigned beneficiaries in a given performance year who have much more complex conditions and co-morbidities than those assigned during the benchmark period. We recommend that CMS consider either (1) increasing the symmetric cap to 6% for both newly assigned and continuously assigned beneficiaries, to be updated on an annual basis or (2) not imposing a cap on risk adjustment for newly assigned beneficiaries to the ACO while maintaining the proposed 3% cap for the ACO's continuously assigned beneficiaries (again updated annually).

- **Termination dates should be modified to allow an ACO to understand its current performance adequately prior to the deadline.** The termination provisions in the proposed rule would force ACOs to decide whether to continue or terminate their participation in the MSSP with little time to evaluate prior year performance year results and with only one Quarter (Q1) of data for the performance year. We recommend a termination date of September 30th with a 30-day notice period. In addition, the prorated model of repayment looks at cost for the whole year including the period post-termination when the ACO is no longer exerting efforts to control cost. Therefore, the cost in the period post-termination may not be reflective of the cost prior to termination. Therefore, we recommend that a terminating ACO's repayment obligation be a reduced percentage of the prorated loss rather than simple proration.

- **High revenue ACOs should not be penalized for their volume.** In this proposed rule, high revenue ACOs are forced into risk faster than low revenue ACOs. High revenue ACOs should not be penalized for the size of their patient population and volume of services, particularly because large hospitals and health systems like the UC medical centers that are likely to meet the definition of "high revenue" also may be in the best position to lead an integrated effort to achieve more efficient care. By not allowing high revenue ACOs to participate in the Basic Track for two contract periods, CMS continues to underestimate the significant investments that are needed in order to improve the

efficiency of the care delivered by those organizations and risks causing high revenue ACOs dropping out of the program early rather than transitioning to the Enhanced Track.

- **ACOs with only one year in Track 1+ should be considered "inexperienced."** One of UC's medical centers, UCLA Health, transitioned from being a Track 1 MSSP ACO to being Track 1+ in the last year of its three-year agreement. In this proposed rule, CMS has not given due consideration to Track1+ ACOs that elected to become a Track1+ ACO voluntarily in the last year of their agreement period (2018). This proposed rule mistakenly considers these ACOs "experienced," thus similar to other ACOs who will have participated in Track1+ for a full three-year period and therefore, are truly "experienced" before moving to the Enhanced Track. UC Health thinks that MSSP ACOs, like UCLA Health, with one year of experience in a Track 1+ ACO should be treated as "inexperienced," since only one year of enrollment in Track 1+ is very little experience with assumption of downside risk to justify the ACO assuming even greater downside risk imposed by the Enhanced Track in the immediate next year.

- **Glide path should be utilized for the Enhanced Track.** This proposed rule would transition an ACO that is participating in the last level of the BASIC Track (Level E) to the ENHANCED Track from risk roughly equal to 4% of the ACO's benchmark (BASIC Track) to 15% (ENHANCED Track). Organizations entering the ENHANCED Track should be provided options much like their counterparts in the Basic Track to gradually increase the level of risk (measured as a % of the benchmark) they take on over the agreement period. UC Health recommends that instead of transitioning from 4% risk to 15% risk (measured as a % of benchmark) between the two tracks, CMS incrementally increase the risk each year for ACOs that choose to transition from the BASIC Track to the ENHANCED track, beginning at 5% in the first performance year of the first ENHANCED track agreement period and increasing by 2.5% each year to 15% in year 5.
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- **A telehealth waiver should be granted to cover all two-sided risk MSSP ACOs this year.** The proposed rule would allow two-sided MSSP ACOs with prospective assignment to benefit from a telehealth waiver, making the home the originating site of a patient's visit in 2020. We think this waiver is critical to our success and the well-being of our patients, and we ask that implementation of this waiver be accelerated by a year, so it is effective in 2019.

- **Beneficiary Notification**. Under the current proposal there is increased notification requirement for providers to the MSSP patients for which they care. CMS should be aware of the additional costs this would place on organizations as well as workflow challenges and investments. Given the cost of such work, CMS should have a clear sense of the value of this notification. In lieu of required notification at the time of a routine or urgent appointment, perhaps encouraging notification of patients at the time of patient education for care interventions and piloting of various notification processes for engagement purposes merits consideration.

- **Beneficiary Incentives.** The use of vouchers and beneficiary incentives should lead to increased innovation among ACO participants. We appreciate CMS's interest in beneficiary incentives. CMS should consider a broader range than the absolute $20 limit. MSSP participants should be given a range of incentive dollars to work with perhaps dependent on the patients' average monthly medical spend or based on their payment means for ancillary services.

UC Health is committed to ensuring that our patients receive affordable, high quality, patient-centered care. The changes that we have recommended ensure that providers and organizations of all sizes and across all geographies will successfully transition to risk-based APMs. We think our recommendations may lead to an increased overall uptake into this voluntary program and without them, CMS may see providers exiting new models of care altogether

We appreciate your consideration of our recommendations. If you have any questions about our comment letter, please contact Julie A. Clements, JD, MPP, Director of Health and Clinical Affairs for the University of California system's Office of Federal Governmental Relations. (Julie.Clements@ucdc.edu/(202)-974-6309).

Sincerely,

John D. Stobo, M.D.
Executive Vice President