March 28, 2016

Andy Slavitt
Administrator
Center for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-1644-P 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

Dear Administrator Slavitt:

Trinity Health respectfully submits the following comments and recommendations to the Centers for Medicare & Medicaid Services (CMS) in response to proposed policy and payment changes set forth in CMS-1644-P 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 notice of proposed rulemaking (NPRM). We support the efforts of CMS to reexamine the methodologies for setting and rebasing ACO benchmarks to increase and maintain broad provider participation in the Medicare Shared Savings Program (MSSP), while also facilitating participants’ transition to performance-based risk. Our recommendations reflect a strong interest in seeing the MSSP achieve the long-term sustainability necessary to reduce health care costs and improve the quality of care for Medicare beneficiaries.

Trinity Health is one of the largest multi-institutional Catholic health care delivery systems in the nation, serving more than 30 million people in 21 states. We are building a People-Centered Health System to put the people we serve at the center of every behavior, action and decision. This brings to life our commitment to be a compassionate, transforming and healing presence in our communities. Trinity Health includes 90 hospitals, 120 continuing care programs — including PACE, senior living facilities and home care and hospice services that provide nearly 2.5 million visits annually. Committed to those who are poor and underserved, Trinity Health returns about $1 billion to our communities annually in the form of charity care and other community benefit programs. We have 31 teaching hospitals with Graduate Medical Education (GME) programs providing training for 1,951 residents and fellows in 184 specialty and subspecialty programs. We employ approximately 95,000 full-time employees, including 3,900 employed physicians, and have more than 11,100 physicians and advanced practice professionals committed to 16 Clinically Integrated Networks across the country.
Currently, Trinity Health is responsible for 1.2 million attributed lives through value-based reimbursement programs. We are participating in 15 MSSP ACOs and 19 commercial ACO programs. In addition, Trinity Health has 41 hospitals, 12 continuing care facilities, and 3 home health agencies participating in 18,000 different bundles – approximating nearly $440 million in revenue – in the Bundled Payments for Care Improvement (BPCI) program. We also have 116 patient-centered medical home programs across our ministry. As demonstrated by these investments in alternative payment models, Trinity Health is an organization that is committed to rapid, measureable movement toward value in the delivery of and payment for health care. We wholeheartedly supported Secretary Burwell’s establishment of specific goals of CMS achieving 30 percent of all payments by 2016 and 50 percent of all payments by 2018 to Alternative Payment Models (APMs). We were excited to hear that CMS has already achieved the 2016 goal. Trinity Health, as a founding member of the Health Care Transformation Task Force (HCTTF), has committed to having 75 percent of our revenue in value-based arrangements by 2020.

Given our strategy we are keenly interested in the evolution of the CMS approach to ACOs and pleased to have the opportunity to provide input. Our views are grounded in the following fundamental principles regarding delivery system transformation.

1. Providers are being called to redesign the way we deliver care so that it is people-centered and produces the triple aim of better health, better care and lower costs. This requires a fundamental change to provider approaches to care, the size and character of our workforce, capital investments, IT systems and virtually all aspects of our operations. In most instances, providers are not receiving additional payments to fund these new investments.
2. The only way to ensure that this delivery system transformation is sustainable, broad-based and deep is to transform the payment system.
3. Delivery system and payment transformation must occur simultaneously.
4. Participation in most CMS Alternative Payment Models is voluntary at this time with the exception of the Comprehensive Care for Joint Replacement (CJR) model.
5. The private sector has not yet created a powerful drive for delivery transformation. Notwithstanding the much discussed marketplace pressure for higher value products, at least on exchanges, most providers have not transformed care to drive lower-cost products. Unit price concessions have been the primary tool used by payers and providers.
6. In a voluntary environment, CMS APMs must present a reasonable business case for returns to make investments today. Specific policy approaches should be developed recognizing that at the present time, for providers and payers, transforming our approaches to care and payment are largely voluntary. Providers need to see a reasonable business case for making investments in transforming care.
7. Recognizing that delivery transformation represents the best long-term solution to our financial challenges, CMS should adopt a long-term strategic approach that engages in the effort as many providers as possible.
8. CMS can most effectively engage providers by offering programs that are attractive, predictable and rewarding from inception. CMS can look for some of the shared savings initially but should expect the majority of impact to be long-term decrease in trend for CMS expenditures.

9. There are few precedents for this approach to transforming an industry. Introduction of APMs should be viewed as tests of new models whose impact is uncertain. We should not prejudge the outcomes of a particular approach. CMS should test a variety of approaches and see what works best.

Our comments, therefore, advocate positions that we believe offer CMS the best chance for accomplishing broad delivery-system engagement, investment and ultimately transformation. Most immediately this means improving the ability of providers to execute programs well and, therefore, drive a more promising, predictable and sustainable savings opportunity. Our specific suggestions to the proposed changes to the benchmarking and rebasing methodologies are organized as follows:

- Movement to Regional Benchmark
- Timing of Applicability of Revised Rebasing and Updating Methodology
- Beneficiary Assignment
- Including Savings in Benchmark
- Extending Participation in Track 1
- Changes to Risk Adjustment
- Definition of Region
- MSSP ACO Alignment with MACRA

**Movement to Regional Benchmark**

As of January 11, 2016, of 434 ACOs participating in MSSP, only 22 – or 5 percent – have chosen to participate in Tracks that include downside risk. To maximize MSSP’s impact on quality and costs, CMS must balance its efforts to promote the assumption of greater risk among participating ACOs with additional policies to keep current ACOs in the program and attract new participants. Finding the optimal balance between these trade-offs will ultimately generate the most savings in comparison to the status quo under traditional fee-for-service Medicare, and it is more likely to improve the quality of care. One of the major criticisms of the MSSP has been its use of a solely historical benchmark and national trend factors, with many providers and other stakeholders calling for a move towards a regional benchmark. Trinity Health believes that such a policy change is critical to attract greater participation in the program, to retain existing participants, and help move more ACOs to risk-sharing agreements.

Trinity Health has long supported a change to the benchmark that moves away from a simple historical amount toward a regional amount reflective of the actual market in which an ACO operates, and generally supports the changes in this proposed rule. **Overall, we support the recent CMS proposal to incorporate a blend of regional FFS cost data along with a portion of the ACO’s historical costs in reset benchmarks.** Under this proposal, CMS would use a blend of 35 percent regional expenditure data and 65 percent historical ACO expenditure data for the second agreement period for
ACOs that began the MSSP in 2014 or later, and for the third agreement periods for 2012/2013 ACOs. CMS proposes to use a blend of 70 percent regional cost data and 30 percent ACO historical cost data in third and subsequent agreement periods for ACOs that began the MSSP in 2014 or later, and for the fourth and subsequent agreement periods for ACOs that began the MSSP in 2012/2013. This proposal builds on benchmarking changes the agency finalized in its June 2015 rule and would strengthen the MSSP by improving one the most critical program policies.

We urge CMS to finalize its proposal to incorporate 35 percent and 70 percent regional cost data in second and subsequent agreement periods, respectively. However, as detailed in the balance of this letter, we urge CMS to adopt more options and greater flexibility to MSSP ACOs as they transition to benchmarks containing regional cost data to ensure that policy changes in a final rule have a net effect of increasing participation in the MSSP and moving more providers to risk on a reasonable timetable.

**Timing of Applicability of Revised Rebasing and Updating Methodology**

Trinity Health urges CMS to provide options for ACOs in the timing of their move toward regional benchmarking. Such options should include the opportunity to select a 35 percent regionally-based benchmark in the first agreement period, incentivizing historically-efficient providers to join the program. Whatever the methodology, CMS should be transparent to the degree that ACOs are able to model/estimate their benchmark under the various options prior to making a selection.

Pioneer ACOs which move into the MSSP should have the option to move directly to a regional benchmark, given they are already subject to regional benchmarking components currently. Pioneer ACOs, particularly those in their third contract period which move into the MSSP will have experience under that model being measured against regional cost, and that should continue. Former Pioneer ACOs who may join the MSSP could potentially be entering their third contract period and should therefore get the same benefits as those MSSP ACOs entering their third contract period. We urge CMS to clarify that Pioneers ACOs entering the MSSP are not expressly tied to the “second or subsequent agreement period” definition in the MSSP program. The same approach to policy appears appropriate for any Next Gen ACOs, which may move into the MSSP program in the future.

Trinity Health urges CMS to allow ACOs that renewed their contracts in 2016 to be given the option to move toward regional benchmarks without having to wait until their third contract period. More than any other cohort, these early adopters deserve this option and we see no significant rationale for their exclusion. These ACOs should not be penalized simply because of unfortunate timing.
**Beneficiary Assignment**

Beneficiary assignment is a critical issue for MSSP ACOs given the relationship between beneficiary assignment and benchmarks – and the ability to earn shared savings and invest in continual quality and cost improvement. Trinity Health offers two recommendations to beneficiary assignment procedures that we believe are critical for fairly evaluating MSSP ACO performance and promoting the movement to risk-sharing with a stable beneficiary population. First, CMS proposes to define assignable beneficiaries as those that receive at least one primary care service from any Medicare-enrolled physician who is a primary care physician (or one of the primary specialty designations used for purposes of assignment in MSSP). **Trinity Health supports this approach to defining assignable beneficiaries, which is a critical step in calculating accurate regional expenditures and costs.**

However, we urge CMS to remove ACO-assigned beneficiaries from the regional service area population (reference population). CMS explains in the NPRM that they considered whether they should include the costs for the ACO-assigned beneficiary population when calculating regional FFS costs, and the agency formally proposes to do so. We recommend that rather than comparing ACOs to themselves and other ACOs, **CMS should compare ACO performance relative to FFS Medicare by defining the reference population as assignable beneficiaries minus ACO-assigned beneficiaries for all ACOs in the region.**

Excluding ACO-assigned beneficiaries (those involved in MSSP ACOs and well as other CMS ACO programs such as Pioneer and Next Generation) allows for a more true comparison between ACOs and FFS. Should the agency not remove the ACO-assigned beneficiary population, the regional cost data would be skewed by reflecting ACOs’ efforts to coordinate care and reduce expenditures for the ACO population. In the NPRM, CMS states its concern that removing ACO-assigned beneficiaries would result in a reference population that is not large enough. However, according to our analysis based on 2014 data, if CMS removed ACO-assigned beneficiaries from the reference population, only 38 ACOs would have had a reference population smaller than 5,000 beneficiaries. Finalizing a flawed program methodology to address a small percent of ACOs is unnecessary and harmful to the majority of program participants; and **we urge CMS to modify the proposal by changing the definition of the reference population to exclude ACO-assigned beneficiaries.**

Second, Trinity Health believes CMS should allow all MSSP ACOs – and not only Track 3 ACOs – to choose between retrospective and prospective beneficiary assignment. A number of factors will determine whether an ACO chooses retrospective or prospective beneficiary assignment, such as the number of beneficiaries it serves and how long it has been in the MSSP program. Prospective beneficiary assignment will be important for ACOs seeking to stabilize the beneficiary population they care for and their spending benchmarks as well as give Track 1 and 2 ACOs the chance to become comfortable with prospective assignment if they wish. Last, the use of prospective beneficiary assignment could also allow CMS to make payment waivers currently only available to Track 3 ACOs (e.g. Skilled Nursing Facility 3-day rule waiver) available to all those choosing prospective assignment, which may incent greater participation in the MSSP and quality and care improvements for beneficiaries. As per the principles outlined above, we believe all ACO tracks should receive a full test
that provides all tools for improving care for patients. Concerns about overutilization in non-risk tracks as a result of making waivers available should be managed through the CMS monitoring activity.

**Including Savings in Benchmark**

In the July 2015 final rule, CMS established a policy that adjusts the rebased historical benchmark to account for savings generated by an ACO during the prior agreement period. In the NPRM, CMS proposes to reverse previous policy and would no longer account for savings in the previous agreement period when calculating the rebased benchmark for a new three-year agreement period. The agency argues that transitioning to a benchmark methodology that incorporates regional expenditures would mitigate the impact of no longer accounting for savings in subsequent agreement periods. **Trinity Health** strongly disagrees and suggests that CMS has not adequately explained how the proposed rebasing methodology would make up for reversing their policy on accounting for previous savings.

For example, an ACO in an area with regional spending lower than the ACO’s historical spending would have its rebased benchmark reduced as a result of incorporating regional spending. In this example the ACO is negatively impacted by incorporating regional cost data, and this would be exacerbated by no longer accounting for previous savings. It is highly unusual and concerning for CMS to propose to abruptly reverse course on its policy to account for shared savings, which was only finalized eight months prior to publication of this NPRM.

CMS should evaluate the rationale of accounting for shared savings apart from its consideration of incorporating regional cost data into benchmarks, as they are separate issues and ACOs will be affected differently by each. Rather than finalizing the proposal to no longer account for shared savings, **we urge CMS to not only account for the shared savings in reset benchmarks, but to account for all savings – not just the ACO’s portion – and add that amount to reset benchmarks.**

Consistent with our principles above we believe that CMS will be best served by creating a benchmark that presents real opportunity for savings, thereby encouraging providers to aggressively invest and manage quality and cost.

**Extending Participation in Track 1**

As per our above principles, we believe that Track 1 deserves a full test. We do not believe that Tracks with downside risk are the only possible path for CMS. In fact we believe limiting the opportunity for Track 1 will result in many fewer participants in the ACO program. Therefore, **we recommend that CMS allow ACOs to stay in Track 1 indefinitely as long as they are producing real shared savings.** Therefore, we suggest that CMS modify the ACO regulations to say that ACOs can remain in Track 1 for the first agreement period, receive a two year extension if they have demonstrated improved costs by year 3, and generated real shared savings by the end of year 4. **We also strongly recommend that CMS allow MSSP ACO participants to have the option to switch Tracks within an agreement period (assuming the switch is to a Track with greater financial performance.**
accountability) so long as the ACO is generating savings. We do not believe that all providers should be forced to accept risk beyond the investments they are already making in transforming their care delivery system, which is considerable. This is especially true for small and/or rural ACO providers with fewer than 10,000 beneficiaries. Providers will be more likely to participate and remain in the program with a “carrot” – as opposed to a “stick” – approach to moving towards greater levels of financial and performance-based risk and accountability.

Trinity Health applauds the accelerated progress of HHS to reaching its goal of having 30 percent of provider payments in alternative models by 2016 one year early. This underscores that provider interest in testing and learning under alternative payment models, such as MSSP is strong. However, to meet the next milestone in the department’s goal – to have 50 percent of provider payments in alternative payment models by 2018 – new providers must participate in programs such as MSSP, and those already participating must see a financially viable path forward to remain in the program. The current structure of the MSSP program, even with the changes proposed in the current rule, is unlikely to result in a financially viable payment model for many providers, which may dampen enthusiasm for participation and stall the early innovation and progress in the healthcare system today. The MSSP is still in the early stages of implementation and all participants are still learning about the complex interactions between the many different policy and operational aspects of the program. We believe it would be very premature to attempt to push all ACOs to accept risk on the proposed schedule, given the many uncertainties inherent in the current state of the program’s development. We also believe that ultimately the best road to having providers operate under risk arrangements in the future is to help them succeed in the absence of risk until they gain sufficient operational experience and confidence in their ability to be successful and in the financial viability of their ACOs under the program’s benchmarking and trending methodologies.

**Changes to Risk Adjustment**

Trinity Health recognizes the need for CMS to strike a delicate balance with risk adjustment to ensure that appropriate coding that enhances analysis and encourages attention to the sickest patients, does not result in unjustified payment increases. **We believe that CMS should use the same approach to risk adjusting for ACOs and Medicare Advantage programs.**

Trinity Health supports the proposed changes to the risk adjustment methodology in updating the benchmark in each performance year, as the existing methodology did not accurately account for the risk profiles of assigned beneficiaries and associated costs of providing necessary care. In particular, **Trinity Health urges CMS to maintain the removal of the “cap” on changes in health status over the course of an agreement period.** The current caps in the rule make the role of the risk scores opaque to participating providers, making it difficult to anticipate how risk scores may affect performance in the MSSP.
**Definition of Region**

In general, Trinity Health supports the CMS proposed definition of region for the purposes of calculating regional expenditures that are reflective of a given ACO’s costs. Defining an ACO’s service areas by the counties of residence of the assigned beneficiaries is a reasonable approach given CMS’ experience with county-level data, the stability of counties as regional units, and their ability to reflect regional variation in costs. However, we recommend that for ACOs which represent a sufficient percentage of their service area (which calls into question the validity of the comparison group), CMS consider including the adjacent counties in the regional measurements, similar to the approach used in the Pioneer model. For this approach, CMS would determine and establish the proportion of ACO-assigned beneficiaries to non-assigned beneficiaries in the county in order to determine whether adjacent counties should be included.

**MSSP ACO Alignment with MACRA**

As CMS engages in rulemaking to implement MACRA, we urge the agency to consider all physicians participating in MSSP ACOs – regardless of Track – to qualify as participating in alternative payment models in MACRA. Even for the ACOs in Track 1, there are financial risks given that only an estimated 25 percent of all ACOs earn shared savings while upfront investments and ongoing costs are sizable. Thus we believe the definition of “more than nominal risk” for an eligible APM should include the very significant investments that ACOs make in developing and operating their new care delivery systems.

**Conclusion**

On behalf of Trinity Health, we thank you for the opportunity to comment on the MSSP benchmarking NPRM. We are hopeful that our constructive comments on improvements to the program are helpful and welcome any questions you may have.

If you have any questions about our comments or would like to discuss our feedback in more detail, please feel free to contact me at 734.343.0824 or wellstk@trinity-health.org.

Sincerely,

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Trinity Health