



October 16, 2018

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1701-P
P.O. Box 8013
Baltimore, MD 21244-8016

RE: CMS-1701-P, Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations--Pathways to Success

Dear Administrator Verma,

Trinity Health appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services' (CMS) proposed rule *Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations-Pathways to Success*. Our comments and recommendations reflect a strong interest in public policies that support better health, better care and lower costs to ensure affordable, high quality, and people-centered care for all.

Trinity Health is one of the largest multi-institutional Catholic health care delivery systems in the nation, serving diverse communities that include more than 30 million people across 22 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 94 hospitals as well as 109 continuing care locations that include PACE, senior living facilities, and home care and hospice services. Our continuing care programs provide nearly 2.5 million visits annually. Committed to those who are poor and underserved, Trinity Health returns \$1.1 billion to our communities annually in the form of charity care and other community benefit programs. We have 35 teaching hospitals with graduate medical education (GME) programs providing training for more than 2,000 residents and fellows in 184 specialty and subspecialty programs. We employ approximately 133,000 colleagues, including more than 7,800 employed physicians and clinicians, and have more than 15,000 physicians and advanced practice professionals committed to 23 Clinically Integrated Networks (CINs) that are accountable for approximately 1.5 million lives across the country through alternative payment models (APMs) across all populations and product lines: Medicaid, Commercial, Medicare Advantage and Medicare ACOs. Trinity Health participates in the Next Generation ACO, Medicare Shared Savings Program (MSSP) Tracks 1, 1+ and 3, the Comprehensive Primary Care Plus (CPC+) program, and the Bundle Payment for Care Improvement (BPCI) and BPCI Advanced programs.

We appreciate CMS' ongoing efforts to improve payment systems across the delivery system and to continue to implement policies that further support delivery of value-based care. Thank you for the opportunity to respond to this proposed rule. If you have questions on our comments, please feel free to contact me at granttw@trinity-health.org or 734-343-1375.

Sincerely,

A handwritten signature in black ink that reads "Tina Weatherwax Grant".

Tina Weatherwax Grant, JD
Vice President, Public Policy and Advocacy

Trinity Health shares CMS' goals of transforming the health care delivery system through person-centered and market-driven approaches that empower beneficiaries as consumers and increase choices and competition to drive quality, reduce costs, and improve outcomes. We work each day to create a People-Centered Health System focused on delivering better health, better care, and lower costs in our communities. Trinity Health is committed to working with CMS to promote innovative model designs and testing, including total cost of care risk models. Today, approximately 25 percent or \$8.5 billion of our business operates through total cost of care models, and we have set a goal of having 75 percent of our billings in value-based payment models. Across our system, we serve 1.5 million patients under total cost of care contracts across all segments: Medicare, Medicaid and Commercial risk. We are aligned with CMS' goal of encouraging participation in models with upside potential and downside risk – and the recommendations we offer below are intended to support these shared goals.

We view the movement to value-based care and payment as essential to advancing high-quality care, improving outcomes for Medicare beneficiaries and reducing costs for the program. This is particularly important given the 2018 Medicare Trustees report, which projects that the Hospital Insurance (HI) Trust Fund will be exhausted in 2026 – three years earlier than the last report.¹ We commend CMS for implementing and evolving the Medicare Shared Savings Program (MSSP), which is a critical component of the movement to value-based care across the industry. CMS' leadership has generated excitement and valuable learnings over the past five years. The industry has responded to the changes CMS has led and we believe that we are much closer to having an accountable healthcare system today as a result.

Overall, we believe the accountable care organization (ACO) model, as a delivery system, has effectively decreased costs and improved quality – when supported by adequate investments. However, many providers have not made sufficient investments because of uncertainties in the program, inadequate upside opportunity, and continued concerns about fee-for-service (FFS) utilization. The current MSSP approach has not driven enough investment by enough providers to fully test the ACO model. Some providers are merely participating today but not fully investing. As a result, the program has not delivered optimal results for the Trust Fund. We view this proposed rule as a real opportunity to build on the lessons learned to date and maximize Trust Fund savings. In order to do this, MSSP should be viewed as an alternative to Medicare Advantage.

Our strong commitment to population-based models and the MSSP is demonstrated by our six years of participation across multiple markets. We serve more than 200,000 Medicare beneficiaries across the MSSP and Next Generation ACO models. To support our transformation work and ability to assume risk, we have made significant investments in - and implemented - market-specific and systemwide infrastructure and operational changes. For instance, we recently initiated systemwide implementation of the Epic platform – the largest "single instance" implementation effort across a health care system to date.

In the last three years (2015-2017), Trinity Health has earned \$31.2 million in shared savings through the MSSP; additionally we earned \$7 million in shared savings through the Next Generation ACO program in 2016. The shared savings earned helped us recoup some of our initial investments and make new ones to generate additional savings and deliver high-quality care. In the past two years, most of our physician-led clinically integrated networks (CINs) have transitioned their Medicare ACOs to downside risk models. As a result, most of our Medicare ACOs are now in a position to assume sufficient risk to qualify for BASIC Track Level E in the proposed rule and Qualify for participation in an Advanced Alternative Payment Model.

¹ The Board of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. (2018). 2018 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

The comments we offer are informed by our experience transitioning to models that align with the more advanced levels of risk under the proposed BASIC and ENHANCED Tracks. Our recommendations fall into three major categories – **increasing upside opportunity for ACOs, aligning Medicare Advantage (MA) and ACO program rules, and reducing regulatory burden on participating providers**. We believe the comments we offer support CMS’ goals to encourage new providers to join the program, to retain existing high-performing ACOs, and to foster the long-term sustainability of the program.

1. Increasing Upside Opportunity to Attract New and Retain Existing Participants

As an organization that has Medicare ACOs in 18 physician-led CINs creating value for patients and commercial, Medicaid and MA payers in 22 different communities, we have substantial experience with the changes that occur when providers come together to form an ACO. We have seen how changes to the care model and delivery system improve coordination across the continuum and generate tangible improvements in patient outcomes. Based on our experience, we believe that if CMS wants ACOs to assume downside risk more quickly than under the current MSSP program, there must be sufficient opportunity for shared savings to support early investments in infrastructure. The upside opportunity must be sufficient enough to account for the business risk of participating in a model that does not meet the level of transparency, predictability and simplicity of other risk models such as Medicare Advantage. We also know that there are significant financial costs and investment risks associated with the start-up of these models. Provider capacity to assume business risk for a population varies depending on the transparency, predictability, and simplicity of the financial model under a contract or program. While most of our ACOs are now capable of taking on advanced clinical risk and accountability, CMS’ proposal to reduce the shared savings opportunity in the MSSP – coupled with the structure of the underlying financial model – is likely to result in fewer participants and a less sustainable model for those remaining. During this period when we are all still learning, there is an alternative. The pathway to success includes increasing upside potential and broadening waivers. This would make it attractive to invest without undue risk. Our proposal provides a stronger case for providers to lean into risk and transition to population-based models.

Trinity Health recommends that 80% upside potential be available at all levels of the BASIC and ENHANCED Tracks. This is necessary to level the playing field with Medicare Advantage, attract new providers into the program and to ensure that participating ACOs make the needed investments in infrastructure and operational changes to support care transformation and the ability to assume greater levels of risk over time. This will result in larger Trust Fund savings. Trinity Health urges CMS to simplify the program by making all shared saving programs 80% upside, this would include the following bold changes to the proposed shared savings levels in the BASIC and ENHANCED Tracks:

- BASIC Track: Levels A and B should include a shared savings rate of 80%;
- BASIC Track: Levels C and D should include a shared savings rate of 80% balanced by an increase in shared risk levels to meet Advanced APM criteria;
- BASIC Track: Level E should include a shared savings rate of 80% and maintain the proposed shared risk structure;
- ENHANCED Track: Include a shared savings rate of 80% and maintain the proposed shared risk structure; and
- ENHANCED Track: Include a full capitation model for advanced ACOs.

This proposed rule does not make a strong enough case for increasing ACO investment. CMS’ proposal to reduce the shared savings opportunity in the MSSP – coupled with the structure of the underlying financial model – creates a less sustainable model for those remaining. Reducing the shared savings opportunity as proposed (especially in upside-only years) will likely lead to fewer new entrants, especially smaller or less experienced organizations that may be unable to recoup their investments. **This policy creates an unintended incentive for smaller, less experienced organizations to seek consolidation with hospital, private equity, or insurance-based entities. CMS’ proposed shared savings reduction in the BASIC track could increase consolidation or favor larger entrants that can take greater business risks and have the capital reserves to**

invest in the care management, CEHRT, and other capabilities needed to successfully manage population health and costs.

Our proposed changes to the shared risk levels under BASIC Track Levels C and D would also qualify these models as Advanced APMs and better prepare ACOs to move into the ENHANCED Track. This would create more opportunity for physicians to participate in Advanced APMs and models that encourage the delivery of value-based care. We believe these changes to BASIC Track Levels C and D would require relatively minor adjustments and would help create a better business case for the ACO model, and achieve CMS' goal of increasing the number of Advanced APMs available to eligible clinicians.

Trinity Health supports the option for all ACOs to choose levels of risk in the BASIC track upon enrollment. Rather than make shared savings-only models less appealing, we urge CMS to focus its efforts on making models with downside financial risk more attractive while continuing to support shared savings-only models. Contracts without downside risk can result in net savings for Medicare as ACOs gain experience. A 2016 study examined ACO results between 2012-2014 and found that net savings were accruing to Medicare by 2014.² Our own experience, and now research, also support that to optimize results for Medicare, ACOs – regardless of revenue level - should have the option to remain in BASIC Track Level A for at least three years. A recent study by NAACOS found that between 2013 and 2015, MSSP ACOs achieved net savings of \$542 million, but found that it takes time for quality improvement and cost reduction to occur and performance improved with time.³ Under this proposal, providers are already at risk because they have only three years to position for downside risk or lose those investments and the network they have built around them when CMS terminates their contract. This creates potent leverage for CMS. In the most recent results on the 2017 performance year, upside only ACOs generated more savings per beneficiary than those bearing risk under MSSP tracks 2 and 3. There is real opportunity to build on the lessons to-date and achieve larger Trust Fund savings.

Agreement Period

Trinity Health supports CMS' proposal to move from three to five year contract agreement periods. We believe that longer contract agreements increase predictability and stability for providers and health systems that are making investments and other system changes to support participation. We also support CMS' efforts to align the contract length with other Innovation Center models.

Termination from Program

Trinity Health supports efforts to encourage continual quality improvement among ACOs. However, it is important to balance encouraging provider participation in the program with incentives to become high-performers. **Given that it often takes several years of participating in a model to see savings, we recommend that providers have three years to demonstrate the ability to generate savings. If at the end of that time, savings cannot be generated, CMS could then terminate contracts with those participants.**

However, we ask that CMS allow ACOs that include CPC+ to remain in upside-only tracks until CPC+ care management fees can be fully incorporated into the benchmark in order to prevent premature termination from the program for those ACOs simply due to program overlap. The CPC+ program fills a critical gap in advanced primary care payment models. While the CPC+ care management fees are accounted for as ACO expenditures, they are not included in the historical cost base for an ACO's benchmark, which harms those entities that both participate as an

² McWilliams, J. Michael, [Changes in Medicare Shared Savings Program Savings From 2013 to 2014](#), JAMA, Research Letter, October 25, 2016.

³ Mechanic, Robert, Gaus, Clifton, [Medicare Shared Savings Program Produces Substantial Savings: New Policies Should Promote ACO Growth](#), Health Affairs, September 11, 2018.

ACO and are also transforming primary care practices. In any market where the vast majority of primary care providers are in CPC+, CMS' proposal will negatively impact ACOs. We have seen this in two of our own markets, where the CPC+ expenditures create an additional hurdle to meeting an already high MSR.

ACO Participation Options Based on High/Low-Revenue and Prior Participation

We ask that CMS allow high-revenue ACOs to remain in Level E of the BASIC Track for a second agreement period. High-revenue ACOs, by nature of their size and inclusion of providers across the continuum of care, are likely to have greater responsibility for care coordination across inpatient and outpatient settings than low-revenue ACOs. However, high-revenue ACOs are also better positioned to drive more appropriate care utilization across the continuum and decrease unnecessary hospital events over time. Allowing high-revenue ACO's to remain in Level E for a second agreement period would help ensure these large entities can successfully move to greater levels of risk that require systemwide investments and operational and infrastructure changes.

As proposed, the increase in risk from Level E to the ENHANCED Track is significant. As a result, we ask that CMS allow high-revenue ACO's to remain in Level E for a second agreement period to ensure these large entities have the time needed to successfully manage the move to greater business and clinical risk. Restricting the ability to remain in BASIC Track Level E for a second agreement period for high-revenue ACOs could lead to significant attrition of current Track 1 participants.

Given that high-revenue ACOs are responsible for a greater share of healthcare spending than low-revenue ACOs, it is reasonable to ask them to assume greater levels of risk and/or at a faster pace than low-revenue ACOs. However, CMS should also take into account that larger systems must invest in change across a much broader delivery "footprint" and so may require additional investments over multiple years to make transformative system changes. When making these higher investments, these ACOs are taking on much greater business risk and so need a longer time to recoup investments.

High-revenue ACOs can include hospitals, physician groups, skilled nursing facilities, and home health agencies. Depending on their starting point, they may require different amounts of time to successfully transform. Increasing the amount of risk assumed can support alignment of incentives for the delivery of person-centered care and savings for the system; however, it also requires additional time and investment to implement changes across the care continuum. For hospitals and health systems, necessary changes are far reaching, including changes to discharge processes, transitions to nursing home care, and delivery of home-based care. Additionally, care delivery transformation entails investing in CEHRT across the system. For example, this year Trinity Health committed to implementing the largest single instance of Epic in the country, an integrated platform for Population Health, EHR and revenue cycle systems. The goal is to enable a better care experience for the people we serve across all our markets, providing a single, comprehensive health record with seamless access to clinical and billing information. Epic also aims to improve the experience for our physicians and clinicians through integrated information to improve patient care and support seamless handoffs.

Because these changes can take longer to implement across larger provider groups and systems, it may also take longer for these entities to see savings. Research shows that ACOs participating in the MSSP over a longer period of time show greater improvement in financial performance, demonstrating the value of such models and the need to allow ACOs sufficient time to demonstrate positive results. Of the 142 ACOs that earned shared savings payments in 2017 and had prior program experience, 36 percent had losses (i.e., expenditures higher than benchmarks) in one of their first two years of the program. Had CMS's proposed policies been in place, these ACOs would not have had the opportunity to continue in the program and go on to demonstrate success. A critical component of performance improvement lies in the ACO's ability to analyze the performance data being provided to the ACO and make targeted improvements based on this information. Under CMS's current proposal, ACOs would have only one year of performance data before being required

to move to a risk-based model. In addition, for those who have chosen a zero or low MSR, “negative outside the corridor” creates a double-edged sword where they are penalized for taking on more downside risk. Our own experience suggests this is not sufficient and will not allow ACOs the opportunity to make strategic decisions regarding performance improvement which allow them to demonstrate success in future program years. As noted above, we have participated in MSSP for six years and most of our ACOs are now in risk-bearing tracks and generating savings—demonstrating savings can be achieved, but can take a longer investment horizon.

Qualifying as an Advanced APM

Trinity Health believes APMs are key to driving system transformation that improves quality and care for beneficiaries and reduces health care costs. As noted in our comments on the BASIC and ENHANCED Tracks, we recommend that CMS make changes to BASIC Tracks C and D to allow them to qualify as Advanced APMs. In addition, many of our other recommendations, including increasing upside opportunity for BASIC and ENHANCED Track ACOs, and allowing high-revenue ACOs to remain in Level E for a second agreement period, will also ensure that ACOs remain in the program and that more join – thereby increasing participation options in Advanced APMs.

2. Creating a Level Playing Field Between MSSP ACOs and Medicare Advantage

We believe it is critical for CMS to align participation rules across the ACO and Medicare Advantage (MA) programs to ensure a level playing field for all providers, access to care for all beneficiaries, and lower costs for the Medicare program. We applaud CMS for moving toward similar waiver opportunities and beneficiary assignment methodology. We offer a number of additional suggestions to align rules across the two including:

- Aligning HCC risk adjustment methodologies between the MSSP and MA;
- Broadening flexibility within MSSP on alternate sites of care where that care can be delivered safely but is currently not allowed (e.g., infusion, hospital at home).
- Aligning care management flexibilities including determinations as to level and site of care;
- Testing value-based insurance design (VBID) features in ACOs as they assume greater levels of risk; and,
- Maintaining the current 70% regional adjustment in the benchmark and moving to a completely regional benchmark, which is more aligned with MA regional benchmarking.

Trinity Health believes that alignment of rules between MA and ACOs will further allow ACOs to lean into risk by assuming full accountability over time. **Trinity Health strongly advises aligning HCC risk adjustment methodologies across both ACO and MA models.** Leveling the risk playing field between MA and ACOs would make the ACO model more attractive to organizations willing to take on greater financial risk and therefore drive greater investment in care transformation. Otherwise, the trend of organizations shifting investments solely to MA will continue. This migration from traditional Medicare to MA creates a perverse outcome, driving up costs for the Medicare Trust Fund. Equalizing the HCC coding rules for MA and ACOs will curb provider movement toward MA only. Additionally, this will curb further depletion of the Trust Fund, reining in overall Medicare spend and slowing this transfer of wealth from taxpayers to investors.

Choice of Beneficiary Assignment Methodology

Trinity Health supports the ability of ACOs to choose either prospective or retrospective assignment. The ability to choose prospective assignment supports an ACO’s ability to manage care as they assume greater levels of risk. However, we support giving ACOs the choice as to whether they use prospective or retrospective alignment. This should be a clinical and business decision made by each ACO.

Beneficiary “Opt-in”

Trinity Health supports affirmative recognition of the relationship between a beneficiary and an ACO, as this can support patient engagement and care management. However, this must be implemented in a way that reduces administrative burden. To this end, CMS should explore ways to implement beneficiary opt-in in more simplified ways than early efforts through the Next Generation and Pioneer ACO programs. For example, the existing process requires managing and tracking mailings, which require financial and human resources without a substantial impact on enrollment. We ask that CMS ensure that implementation of a beneficiary opt-in option not also introduce new administrative costs to ACOs, drawing down of funding that would otherwise support care delivery. Finally, we believe beneficiary opt-in is an opportunity to align ACO and MA rules. However, beneficiaries will need basic education on their choices (e.g. MA, ACOs, and traditional fee-for-service) from CMS so they can make informed decisions about how and where to receive their care.

Waivers

Trinity Health supports the proposed expansion of the telehealth and SNF 3-day waivers, and allowing ACOs to provide beneficiary incentives. We also recommend that CMS reduce the reporting burden related to these waivers by relying on existing claims or other available data. Similarly, we recommend that CMS acknowledge the investment waivers require and include when rebasing benchmarks.

For ACOs to lean into greater levels of risk, additional waivers are needed that facilitate the delivery of the right care at the right time. We urge CMS to make all waivers available to ACOs—as this will support flexibility needed to deliver high-quality, appropriate care—and build in appropriate monitoring to identify potential abuse.

Through existing waivers, ACO participants have been able to better meet the needs of patients in innovative ways. However, there is uncertainty regarding the availability of particular waivers as a result of limited guidance from CMS on the intended scope of, or applicability to, certain ACO participants. The uncertainty has resulted in ACOs not choosing to opt-in to an available waiver due to concerns over noncompliance during implementation. If the expanded waivers are finalized, we urge CMS to expedite regular updates to Frequently Asked Questions (FAQs) and other guidance and/or commentaries in response to ACO questions. We also ask that CMS and the Office of the Inspector General provide options for ACOs to request guidance regarding the applicability and implementation of waivers without having to ask for a traditional Advisory Opinion.

Beneficiary Incentives

We believe that as providers assume greater levels of risk, they should have more levers available to manage and engage patients in their care. As a result, Trinity Health generally supports greater flexibility to provide beneficiary incentives that facilitate greater engagement with - and care management from - a regular set of providers. However, we would encourage CMS to ensure that beneficiary incentives, as described in the proposed rule, do not create an unlevel playing field among small and large ACOs.

In addition to the cash-equivalent incentives described in the proposed rule, CMS should consider health-related incentives such as co-pay waivers for primary care services and preventive services received within the ACO such as immunizations, the Medicare Diabetes Prevention Program (MDPP), and screenings (e.g. cancer, diabetes).

Benchmark Methodology

Trinity Health supports inclusion of regional expenditures in the benchmark in initial agreements, but urges that CMS maintain the current 70% regional adjustment maximum and eliminate rebasing at the start of each new contract term. We are concerned that capping the regional component of the benchmark at 50% could reduce retention of existing – and recruitment of new – high-value and experienced ACOs. Rebasing the benchmark also requires successful ACOs to meet ever lower benchmarks over time – making it more difficult to recoup investments. The ACO program must offer sufficient rewards for efficiency and long-term participation of ACOs that can

share learnings with newer participants and help guide future model evolution. Sustainability of the program is also an important consideration – and we believe that entities should be rewarded that are historically efficient and high-performers in their market.

Last, retaining the current regional adjustment in the benchmark would also align the ACO program with MA given the regional nature of the benchmarking and bid process in that program.

Benchmarking - Risk Adjustment

Trinity Health supports the addition of a symmetrical cap on risk scores given that the health profile of an ACO's patient population is likely to change over time. The +/- 3 percent cap for the MSSP ACO program is also more consistent with the Next Generation ACO program, moving closer to continuity in methodology across tracks and programs. However, extending the cap to five years will penalize ACOs that treat high-risk patients or that retain patients whose burden of illness increases over time.

3. Reducing Regulatory Burden

Trinity Health supports CMS' goal to reduce regulatory burden – and appreciates recent initiatives, such as Patients Over Paperwork. We also applaud the implementation of changes to the MSSP program authorized by Congress in the Bipartisan Budget Act of 2018 that reduce regulatory barriers to providing person-centered care, such as expanding the use of telehealth, promoting beneficiary choice, and incenting the use of necessary primary care services.

CMS can further reduce regulatory burdens by providing greater flexibility or waivers to support the delivery of patient-centered care and services in the home. Often, patients can be safely treated in the home for conditions that would meet hospital level criteria, and yet a DRG can only be paid if that care is delivered in an inpatient facility. CMS should remove site of service barriers to enable the administration of drugs based on clinical appropriateness, patient preference and need, rather than place of service (e.g. permitting ACO providers to perform home infusions or other supportive care when clinically safe and appropriate. Trinity Health also supports the Agency's efforts to create new collaborations between ACOs and standalone prescription drug plans (PDPs) and to examine how Part D drugs could be included in the MSSP to further manage the total cost of care. These actions would also further align the program with Medicare Advantage.

There is also an opportunity to minimize administrative burden and costs related to the mandatory first, face-to-face visit, beneficiary notification provision. CMS can offer flexibility to ACOs in implementing this requirement, which would both reduce administrative costs and facilitate effective communication with beneficiaries. For instance, CMS could allow practices to make a poster prominently available containing the necessary information versus a hard-copy at each patient visits; permit a degree of freedom in how this is recorded and documented from a compliance standpoint; and, provide flexibility in timing of the notification such as tying it to any visit throughout the year versus the first visit of the year.

Last, we support CMS' proposal to require one group practice reporting option (GPRO) reporting period for 2019 and to acknowledge the ACO Participant List as of July 1, 2019 to determine the GPRO quality reporting samples as this will reduce administrative burden for participating providers.

Minimum Savings Rate (MSR)/Minimum Loss Ratio (MLR)

Trinity Health supports CMS' proposal to allow ACOs to decide incremental MSR based on the individual ACO's risk tolerance. These options are important for individual ACOs to assume the level of business risk they are capable of and willing to take, based on their own business decisions.

Quality Measures

Trinity Health believes that quality measures tied to payment in existing and new models and programs should be reviewed regularly and be limited (e.g. no more than five clinical measures and two patient experience measures) – aligned across Medicare programs.

Industry and CMS must work together to rapidly adopt existing consensus-driven core measure sets – as CMS has set out to do through the Meaningful Measures Initiative - while working to identify the next generation of core measures. There should also be an emphasis on advancing and adopting patient-reported outcomes measures (PROMs), which are critical for creating a people-centered health system.

We also support CMS' proposed addition of opioid use measures. These efforts will support and align with our systemwide Opioid Use Reduction (OUR) initiative. Trinity Health is committed to partnering with all stakeholders to address opioid use through prevention, intervention, treatment and recovery initiatives. A comprehensive approach to the opioid epidemic is imperative to reducing opioid harm and promoting people-centered care.

Last, while statutory changes are necessary, we reiterate the importance of aligning 42 CFR Part 2 (Part 2) confidentiality requirements for sharing a patient's substance use disorder records with the requirements in the Health Insurance Portability and Accountability Act (HIPAA). Unlike HIPAA, Part 2 does not allow for sharing or re-disclosure of identifiable substance use disorder information for treatment, payment or health care operations ("TPO") purposes without patient consent. Moreover, Part 2 requires regulated programs to provide a notice to recipients of identifiable substance use disorder information noting that the information cannot be re-disclosed. From a compliance perspective, the different standards between HIPAA and Part 2 have made it extremely difficult for our hospitals and health systems to know when and how this information may be shared, including within individual hospitals – despite the importance of care coordination for individuals with substance use disorders.

CEHRT/Promoting Interoperability

Trinity Health supports alignment across all Medicare programs including the Quality Payment Program (QPP) and the ACO programs. However, we ask that CMS make gradual increases in CEHRT usage requirements in both the QPP and ACO programs from 50 to 75% for Advanced APM status. This is especially critical for small practices and ACOs with limited resources to invest in CEHRT.

Overlap of Other Advanced APMs

Trinity Health has long been concerned about the launch of new models that overlap with existing – and population-based models- such as ACOs. CMS must consider the overlap of the CPC+ and ACO programs in particular. As previously noted, we recommend that CMS allow ACOs that include CPC+ participants to remain in upside only tracks until CPC+ care management fees can be fully incorporated into the benchmark to prevent premature termination from the program.

Social Determinants of Health

Trinity Health is committed to advancing the health of individuals and populations. We strongly believe that payment and delivery models should support addressing the social determinants of health, which research has shown drive health outcomes and costs. As CMS seeks to improve the ACO program, we believe this is an area where the Agency can continue to work with state, regional and local stakeholders to find ways to integrate social services into care management programs. In addition, CMS should examine ways to adjust payment in APMs based upon sociodemographic factors to support holistic care of patients.

Natural Disaster Extreme and Uncontrollable Circumstances

We would also like to take this opportunity to share comments on how adjustments can be made to the MSSP to accommodate natural disasters and uncontrollable circumstances – such as Hurricane Irma in 2017 and Hurricane Florence this year. Accommodations such as this are especially important in models where ACOs are taking on full risk that does not account for extreme circumstances. We submitted more detailed comments in response to the Medicare Program; Medicare Shared Savings Program: Extreme and Uncontrollable Circumstances Policies for Performance Year 2017 NPRM, and ask that CMS consider the following here as well:

- Final reconciliation in years with these circumstances should not only mitigate shared losses, but provide parity for the MSR and MLR for ACOs who just missed their MSR or exceeded their MLR because of the natural disaster and associated the in Part A costs;
- Quality measure reporting exceptions and changes should be available to all ACOs impacted by a natural disaster, not just those who cannot report quality data and all ACOs should receive the higher of the 2018 or the 2019 Star Rating for each CAHPS measure; and,
- Adjusting for natural disaster related impacts at the beneficiary and claims level by expanding the use of the natural disaster payment modifier codes to capture unsafe places of discharge and allowing for an additional 6-12 months to correct and resubmit claims to allow for inclusion of natural disaster modifiers.