September 20, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare & 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: Strengthening the Medicare Shared Savings Program

Dear Administrator Verma:

The undersigned organizations write to express appreciation for efforts to update the Medicare Shared Savings Program (MSSP) and to request the agency move forward with efforts to modernize the MSSP and ensure its long-term success. We also write to provide additional perspective from new data on Accountable Care Organization (ACO) performance and to highlight two specific areas that could result in unintended consequences that diminish the overall shift to value-based care and payment and were included in the recent MSSP proposed rule, entitled *Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations – Pathways to Success*, published in the Federal Register on August 17, 2018. Our recommendations reflect our unified desire to see the MSSP achieve the long-term sustainability necessary to enhance care coordination for millions of Medicare beneficiaries, lower the growth rate of healthcare spending and improve quality in the Medicare program.

The ACO model is a market-based solution to fragmented and costly care that empowers local physicians, hospitals and other providers to work together and take responsibility for improving quality, enhancing patient experience and reducing waste to keep care affordable. Importantly, the ACO model also maintains patient choice of clinicians and other providers. While the origins of Medicare ACOs date back to the George W. Bush Administration, the MSSP has grown considerably in recent years and now includes 561 ACOs, covering 10.5 million beneficiaries. ACOs have been instrumental in the shift to value-based care and a central part of the ACO concept is to transform healthcare through meaningful clinical and operational changes to put patients first by improving their care and reducing unnecessary expenditures.

These transformations are significant and, as such, require time for implementation and to produce measurable results. ACOs are investing millions of dollars of their own capital to make these care improvements, even though Medicare does not recognize these start-up and ongoing investments in its calculations of ACO savings, losses, and costs. Further, the benefits of these transformations extend beyond the ACO's attributed Medicare fee-for-service patient population and have a broader effect on Medicare Advantage beneficiaries and even patient populations beyond Medicare.

ACOs also demonstrate impressive quality results. A 2017 Health and Human Services (HHS) Office of Inspector General report, *Medicare Program Shared Savings ACOs Have Shown Potential for Reducing Spending and Improving Quality*, found that ACOs achieved high quality and in particular noted progress on important measures including reduced hospital readmissions and screening beneficiaries for risk of falling and depression. Recently released MSSP performance year 2017 data shows a mean quality score of 90.5

percent out of 100 percent for ACOs subject to pay-for-performance measures. Further, analysis of MSSP performance year 2016 results shows that ACOs improve quality over time, with average performance improving 15 percent across 25 measures used consecutively across program years.

In addition to the notable ACO care transformations and quality gains, there is growing evidence that ACOs save money. The recent MSSP performance year 2017 results show net savings to the Medicare Trust Fund of $314 million, which is after accounting for shared savings payments made to ACOs. Further, as noted in the June 2018 Medicare Payment Advisory Commission (MedPAC) report, Chapter 8, *Medicare Accountable Care Organization Models: Recent Performance and Long-term Issues,* there are a number of scientific evaluations that show ACO savings. For example, peer-reviewed studies by Harvard University researchers found that the MSSP saved more than $200 million in 2013 and 2014 and $144.6 million in 2015 after accounting for shared savings bonuses earned by ACOs[1]. A recently released study by Dobson DaVanzo & Associates using similar rigorous methods found that ACOs saved $1.84 billion from 2013 through 2015 and reduced Medicare spending by $542 million after accounting for shared savings bonuses[2]. The recent MSSP Pathways to Success proposed rule estimates that the overall impact of ACOs, including "spillover effects" on Medicare spending outside of the ACO program, lowered spending by $1.8 – $4.2 billion (0.5 – 1.2 percent) in 2016 alone. These analyses provide important evidence that ACOs save more money for Medicare than what is reflected in basic evaluations of performance compared to CMS benchmarks.

The recognition of ACO quality improvement and savings is an important backdrop to the work the Administration is undertaking to update the MSSP. The proposed MSSP Pathways to Success rule includes many positive elements that we look forward to working collaboratively with the Administration to implement. For example, we fully welcome efforts to provide more program stability and predictability for ACOs through longer agreement periods, opportunities for reduced regulatory burdens, attempts to better recognize changes in patient risk scores, and mechanisms to increase beneficiary engagement.

The ACO community wants to help CMS work through other issues in the rule which, if finalized as proposed, would have unintended consequences of undermining the broader shift to value-based care. Specifically, we are very concerned with shortening the time new ACOs have in a shared savings only model from six to two years and cutting in half the shared savings rates for these ACOs from 50 percent to 25 percent. This is especially concerning because a spring 2018 survey showed that over 70 percent of ACOs facing mandatory risk for 2019 were likely to leave the program as a result of being forced to assume financial risk. When analyzing the recent performance year 2017 MSSP results, it shows that Track 1 ACOs achieved more savings per beneficiary than ACOs in the two-sided MSSP models. **We request that CMS modify these proposals for all ACOs in the final rule, to allow more time for ACOs in a shared savings only model and to apply a shared savings rate of at least the current 50 percent.** The MSSP remains a voluntary program, and it's essential to have the right balance of risk and reward to continue program growth and success. Program changes that deter new entrants would shut off a pipeline of beginner ACOs that should be encouraged to embark on the journey to value, which is a long-standing bipartisan goal of the Administration and Congress and important aspect of the Quality Payment Program.

We look forward to submitting more detailed comments to the agency in response to the proposed MSSP Pathways to Success rule, feedback which we hope will support the agency's work to update this vital

[1] https://www.nejm.org/doi/full/10.1056/NEJMsa1803388?query=featured_home
[2] https://www.naacos.com/studyofMSSPsavings2012-2015

Medicare Alternative Payment Model. Ultimately, our main goals for the MSSP include encouraging increased participation, enabling successful ACOs to continue in the program and creating sustainable, long-term ACO models for Medicare. We hope that the Administration shares these goals and look forward to working with CMS to ensure that ACOs thrive and continue to provide high quality care for beneficiaries and reduce the growth rate of Medicare spending.

Sincerely,

Association of American Medical Colleges
American College of Physicians
America's Essential Hospitals
America's Health Insurance Plans
American Medical Association
Health Care Transformation Task Force
Medical Group Management Association
National Association of ACOs
Premier