



AMERICAN
COLLEGE of
CARDIOLOGY

Heart House
2400 N Street, NW
Washington, DC 20037-1153
USA

202-375-6000
800-253-4636
Fax: 202-375-7000
www.ACC.org

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*The mission of the American College
of Cardiology and the American
College of Cardiology Foundation
is to transform cardiovascular care
and improve heart health.*

October 16, 2018

Seema Verma

Administrator - Centers 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 Proposed Rule: Medicare Program: Medicare Shared Savings Program; Accountable Care Organizations Pathways to Success (CMS-1701-P)

Dear Administrator Verma,

The American College of Cardiology (ACC) appreciates the opportunity to provide input on the CMS Proposed Rule: Medicare Program: Medicare Shared Savings Program; Accountable Care Organizations Pathways to Success (CMS-1701-P).

The ACC envisions a world where innovation and knowledge optimize cardiovascular care and outcomes. As the professional home for the entire cardiovascular care team, the mission of the College and its more than 52,000 members is to transform cardiovascular care and to improve heart health. The ACC bestows credentials upon cardiovascular professionals who meet stringent qualifications and leads in the formation of health policy, standards and guidelines. The College also provides professional medical education, disseminates cardiovascular research through its world-renowned JACC journals, operates national registries to measure and improve care, and offers cardiovascular accreditation to hospitals and institutions.

General Comments:

The proposed rule reflects an evolution in the Medicare Shared Savings Program (MSSP) for Accountable Care Organizations (ACOs), which has been a key driver for primary care clinicians to adopt value-based payment in the Medicare fee-for-service program for the past seven years. The College believes that alternative payment models have significant potential to enhance patient care and shares the CMS goals of improving quality of care while lowering the costs for Medicare and Medicaid. ACC agrees with Secretary Alex Azar's statement on

value-based transformation in his speech before the Federation of American Hospitals: “There is no turning back to an unsustainable system that pays for procedures rather than value.”

ACC believes that in refining the MSSP, ACOs should reflect the appropriate patient populations and provide a complete picture of care provided by all clinicians involved, including specialist clinicians.

In this letter, ACC is offering detailed comments related to the BASIC and ENHANCED participation tracks, benchmarking methodology, waivers and beneficiary incentives, and ACO and standalone Part D plan collaboration.

BASIC and ENHANCED Participation Tracks:

Under the proposed rule, eligible ACOs would enter an agreement period of not less than five years and be able to choose from two tracks. A "BASIC" track would act as a glide path and allow ACOs to begin under a one-sided model and incrementally phase-in higher levels of risk (referred to as Levels A through E) that, at the highest, Level E, would qualify as an Advanced Alternative Payment Model (APM) under the Quality Payment Program. Notably, the shared savings rate for the first two years of an agreement period in the BASIC track (Levels A and B) is set at 25 percent while the current MSSP Track 1 is set at a 50 percent shared savings rate.

The ENHANCED track has a higher level of risk sharing than what is offered in the BASIC glide path and allows ACOs to qualify as an Advanced APM immediately. ACOs in the ENHANCED track will bear the same level of risk throughout the five-year agreement period, in an arrangement that mirrors the current MSSP Track 3.

ACC believes that the Pathway for Success as proposed should be refined to provide more appropriate levels of risk and shared savings for participating ACOs. The College is strongly concerned that the rapid assumption of significant levels of risk by ACOs will discourage new participants and impede current MSSP ACOs’ ability to make patient-centered infrastructure investments that are necessary for successful participation.

Considering the rule as proposed, ACC asks CMS to provide technical assistance for physician-led ACOs that may not have robust actuarial and analytics capacity and experience with downside risk. Lack of such assistance places physician-led ACOs at a significant disadvantage compared to larger hospital-led ACOs that are more likely to have advanced actuarial and analytics capacities.

50 Percent Shared Savings Rate for BASIC Track Levels A and B

The College believes that Levels A and B in the BASIC track should maintain the 50 percent shared savings rate that is part of the current MSSP Track 1. As proposed, the BASIC track falls short of creating an attractive path for providers to voluntarily follow. A reduced shared savings rate will likely cause fewer ACOs to join the MSSP and adversely impact their ability to invest in clinical practice transformation and IT infrastructure necessary for

successful participation. Providing high value patient care requires large capital expenditures. ACC is concerned that the 25 percent will deter participants from making the investments necessary for successful participation in both one-sided and progressively two-sided financial risk tracks. This is especially the case as physician practices and health systems contend with often conflicting incentives of having a subset of the Medicare fee-for-service patients in an ACO while the remainder are in a purely fee-for-service reimbursement structure.

CMS should ensure that the MSSP remains a viable participation option for physician practices and health systems providing high value patient care. A 50 percent shared savings rate will ensure they receive adequate credit for the infrastructure investments made to optimize patient care.

Allow Successful ACOs to Remain in Non-Risk Bearing Arrangements Longer

ACC supports allowing ACOs to stay in a non-risk bearing agreement longer than the two years that CMS proposes. The 2017 MSSP results confirm that ACO performance improves with longer participation in the program. For ACOs inexperienced with risk, ACO participation requires significant investment in clinical practice transformation and quality measurement and data reporting capabilities. Savings derived from those investments are realized over the lifetime of the ACO, not necessarily in the first or second year of the performance period. Providing a longer window for successful ACOs to continue in the program and achieve a reasonable return on their investment will encourage broader upfront adoption, incentivize better performance, and encourage greater long-term returns by retaining high performing cardiologists.

An alternative that could be adopted is continuation in a non-risk bearing agreement (i.e., for either early participants or small and mid-size ACOs) that is dependent on demonstrable progress. For example, criteria for remaining in MSSP one-sided risk could include factors such as: a) generating savings, but falling short of the shared savings threshold, b) steady improvements in quality and/or costs, or c) evidence of structural investments (e.g., population health analytics, care management, clinical integration governance and management, etc.).

Glide Path for Financial Risk Between the BASIC and ENHANCED Tracks

The change from 4 percent risk in BASIC Level E to 15 percent in the ENHANCED track is a significant increase and may present a barrier to successful participation by smaller and less experienced ACOs. ACC is concerned that ACOs may choose to leave the program rather than transition to the ENHANCED track in their second agreement period due to the large increase in two-sided risk. **The College recommends that CMS consider refining the ENHANCED track with a two-sided risk glide path similar to the BASIC track. For instance, Year 1 of the ENHANCED track could contain a level of 7 percent two-sided risk, move to 10 percent in Year 2, and then 15 percent in Years 3, 4, and 5.**

Benchmarking Methodology:

Risk Adjustment

CMS proposes modifications in the risk adjustment methodology to account for changes in case mix and severity of assigned beneficiaries and eliminate the distinction between continuously and newly aligned beneficiaries. **The College strongly supports eliminating that distinction.**

CMS proposes to cap the risk score growth at +/-3 percent of the risk score for benchmark Year 3. The College is concerned that in capping the growth in risk scores for a defined attributed population, risk adjustment in performance benchmarks is not reflective of the population a physician practice or health system is managing on a year to year basis. This discrepancy could contribute to adverse incentives for program participants and encourage adverse selection of patients. **ACC recommends that CMS raise the cap to at least +/-5 percent to more accurately account for changes in relative patient risk over a five-year performance period.**

Regional Factors

CMS proposes to incorporate regional factors when establishing the benchmark as part of the first agreement period, as well as for updating the benchmark. **The College is supportive of this proposal. As a refinement to the proposal, ACC recommends that CMS remove ACO beneficiaries from the regional comparison group.**

Waivers and Beneficiary Incentives:

The ACC strongly believes that high value patient care is dependent upon clinicians having the tools to appropriately manage the care of a defined patient population. The College appreciates CMS's efforts to implement the following flexibilities in care coordination and offers comments on refining the proposals. **Where statutorily permissible, ACC recommends that CMS allow waivers and beneficiary incentives to be adopted across the spectrum of ACOs, including those in one-sided risk arrangements.**

Attribution

CMS proposes that all ACOs can select between retrospective or prospective attribution at the start of each agreement period, as well as the option to change that selection for each subsequent performance year. **The College strongly supports this added flexibility for MSSP ACOs. Having the option of prospective attribution will allow ACOs to better manage their patient populations and tailor clinical practice transformation efforts to their patients' health care needs.**

Beneficiary Assignment

CMS proposes allowing beneficiaries to designate a physician regardless of specialty or a nurse practitioner, physician assistant or clinical nurse specialist as their “primary clinician” responsible for coordinating their overall care. **The College strongly supports this proposal and appreciates CMS recognizing the diversity in care settings and clinicians from which a patient may receive care.** This added flexibility will allow patients to designate as their “primary clinician” a specialist clinician that may already be responsible for the majority of the patient’s care such as cardiologists.

To inform future work on care coordination across the continuum of primary care clinicians and specialist clinicians, ACC recommends that CMS review the November 2017 JAMA Cardiology article entitled “Payment Reform to Enhance Collaboration of Primary Care and Cardiology: A Review.” This article resulted from an in-person meeting held in January 2016 where ACC collaborated with the Duke-Margolis Center for Health Policy with a group of member participants along with representatives from primary care organizations, payer, CMMI, and health system leaders. Table 1 of the article outlines five models of care under a collaborative management framework between cardiology and primary care. The College would appreciate the opportunity to discuss this work further with CMS.

Telehealth

CMS proposes that beginning in 2020, ACOs in any two-sided risk arrangement with prospective assignment will be reimbursed for telehealth services. **The College encourages CMS to interpret this provision of the FY 2018 Bipartisan Budget Act as allowing for telehealth reimbursement for ACOs in two-sided arrangements prospective assignment with retrospective reconciliation, which will allow more ACOs to utilize this important waiver.**

Skilled Nursing Facility (SNF) Three-day Waiver

CMS proposes that ACOs in any two-sided arrangement will be eligible to use the SNF three-day waiver. This waives Medicare’s rule that a beneficiary must have a three-day inpatient stay before Medicare will reimburse for a SNF stay. **The College encourages CMS to make this important care coordination flexibility available to all MSSP ACOs, including those in one-side risk arrangements.**

Beneficiary Incentives

CMS proposes that ACOs in a two-sided arrangement can create a beneficiary incentive program, paying an assigned beneficiary up to \$20 per qualifying primary care service received. **The College strongly supports this flexibility in patient care management and appreciates CMS implementing an important provision of the FY 2018 Bipartisan Budget Act.**

ACO and Standalone Part D Plan Collaboration:


CMS seeks comment on how MSSP ACOs and the sponsors of standalone Part D prescription drug plans (PDPs) could be encouraged to collaborate to improve the coordination of pharmacy care for Medicare beneficiaries. **The College supports affordable access for all patients to all approved prescription drugs with scientific evidence of net clinical benefit or as articulated in clinical practice guidelines. CMS should ensure that patient access is not impeded through any collaborative arrangement between an ACO and a PDP.** Specifically, CMS should exercise caution regarding the use of prior authorization or other utilization review tools in such an arrangement.

Conclusion:

ACC is committed to working with CMS and providers to enable success in the Medicare Shared Savings Program and the overall value-based payment environment. The College looks forward to ongoing discussion and collaboration with CMS in creating opportunities for cardiologists and the cardiovascular team to participate in the Medicare Shared Savings Program and other alternative payment model initiatives.

If you have any questions or would like additional information regarding any recommendations in this letter, please contact Bryant Conkling, Associate Director, Payment Reform, at (202) 375-6399 or bconkling@acc.org.

Sincerely,



C. Michael Valentine, MD, FACC
President