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February 6, 2015

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1612-FC
7500 Security Blvd
Baltimore, MD 21244

RE: Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations Proposed Rule (CMS-1461-P)

Dear Administrator Tavenner:

The American College of Cardiology (ACC) is pleased to offer comments on the Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations (ACO) Proposed Rule as published in the Federal Register on December 8, 2014.

The American College of Cardiology is a 47,000-member medical society that is the professional home for the entire cardiovascular care team. The mission of the College is to transform cardiovascular care and to improve heart health. The ACC leads in the formation of health policy, standards and guidelines. The College operates national registries to measure and improve care, provides professional medical education, disseminates cardiovascular research and bestows credentials upon cardiovascular specialists who meet stringent qualifications. The ACC also produces the *Journal of the American College of Cardiology*, ranked number one among cardiovascular journals worldwide for its scientific impact.

The ACC supports efforts by the Centers for Medicare and Medicaid Services to seek successful models for a value-based payment system. The proposed rule presents several updates that will make participation in the Medicare Shared Savings Program (MSSP) more accessible to providers and entities. This in turn, will support increasing enrollment in ACO programs and give CMS a better sense of how the ACO model can be best applied in various regions.

Definition of an Accountable Care Organization (ACO) Participant

The ACC supports the proposal to revise the definition of an "ACO Participant" to mean "an entity as defined by a Medicare-enrolled Taxpayer Identification Number (TIN)." We agree with CMS that this will resolve the misperception that an "ACO Participant" refers to an individual provider or supplier. Clarifying this definition will also reinforce the policy that individual providers can participate in multiple ACOs.

We continue to ask CMS to consider creating more explicit regulations to allow participation in multiple ACOs at the specialty group practice level. There is value in the ability for specialty groups at the practice level to participate in more than one ACO. In some regions of the country a single, cardiology group may be the only provider of cardiovascular services within a relatively large geographic area. Allowing multiple ACOs in the vicinity to work with this practice would benefit more beneficiaries.

Accelerating Health Information Technology

The College agrees that the secure, electronic exchange of health information and use of telehealth services can drive efficient care coordination across settings. **The ACC supports the proposal to require ACO applicants to describe how they will encourage and promote the use of technology to improve and coordinate patient care.** As the adoption of new technology within an organization is a large effort, ACOs unable to meet the goals and timelines set forth in their applications should not be penalized. Rather, CMS should use the content in these applications to inform policies to support the adoption of technology by ACOs.

Changes to Program Requirements During the 3-Year Agreement

CMS should proceed cautiously in its proposal to make ACOs subject to additional regulatory changes that become effective during the agreement period. When applying to become an ACO, entities must be able to forecast activities and performance throughout the 3-year agreement period. Certain regulatory changes during the agreement period may interfere or even conflict with an ACO's existing activity. CMS should seek participant feedback as early as possible during the policy development process to ensure that proposed changes will not significantly interfere with existing ACO operations. When a new requirement is implemented that may substantially conflict with an existing ACO's current operations, or in the event that compliance will not be feasible by the start of the next performance year, an ACO should have the opportunity to work with CMS to develop and submit a plan for best or earliest compliance.

Beneficiary Data Sharing

The ACC supports the proposal to expand the beneficiary data set to include data points such as enrollment status, health status information, utilization of service rates, and expenditure information. This additional information will allow ACOs to better design their programs to their specific beneficiary populations.

However, as stated in our comments to the 2011 proposed rule, the ACC opposes the ability for beneficiaries to opt out of data sharing so that their claims information is not shared with ACOs. It should be a requirement that patients receiving primary care services from an ACO be required to share claims information with that ACO. In order to create systems and delivery models that best promote cost-efficient quality care, ACOs need to understand the populations that they treat. Allowing beneficiaries to opt out of data sharing would provide ACOs with incomplete data and would hinder the ability to fully tailor programs to the beneficiary population.

In exchange for this shared information, ACOs must fully comply with all privacy protections under the Health Insurance Portability and Accountability Act (HIPAA) and rules governing the release of Part D beneficiary data.

Consideration of Physician Specialties and Non-Physician Practitioners in the Assignment Process

The ACC strongly supports the continued recognition of cardiology as a physician specialty that may be assigned as a provider of primary care services in an ACO. Under most circumstances, a cardiologist will work with a beneficiary's primary care physician to treat an acute condition. However, for beneficiaries that suffer from severe chronic conditions such as congestive heart failure, the cardiologist may be responsible for the majority of the beneficiary's care, and in this role, serve as a primary care provider. Allowing specialists to serve as a primary care provider is in alignment with the vision that beneficiaries should have the freedom to go to the Medicare provider that best fits their needs while having the opportunity to seek quality care in an efficient delivery system.

The ACC also strongly supports the proposal to attribute primary care services provided by physician assistants, nurse practitioners, and clinical nurse specialists under Step 1 of the assignment methodology for beneficiaries to an ACO. These providers are responsible for the primary care services of many patients; this proposal is in alignment with the movement toward team-based care.

ACO Benchmarks

The ACC supports CMS's proposal to use regional rather than national expenditure amounts for establishing, updating, and resetting ACO financial benchmarks. The ACO model, like many value-based payment models, is dependent on the specific patient population served by the organization. Setting benchmarks at the regional level will ensure that ACO performance is accurately measured against the beneficiaries in that organization's region. The ACC understands the complexity of collecting and calculating data at the regional level as opposed to the national level and appreciates the proposal of this policy.

Proposed Changes to ACO Tracks

Applying to become an ACO requires tremendous administrative and financial commitment by a group. Much of this investment is made even before the entity assumes any financial risk under the program agreement. **The ACC supports the following proposals which support long-term participation in ACOs**:

- Allowing Track 1 ACOs to extend participation in the MSSP under Track 1 at the conclusion of the initial 3-year agreement period rather than requiring that the ACO move to two-sided risk Track 2; and
- Applying a population-based sliding scale to the minimum savings and loss rates that a Track 2 ACO must achieve prior to partaking in shared savings, rather than the flat 2 percent benchmark currently set.

These two proposals will benefit new ACOs, particularly smaller provider-led organizations that want to participate in the MSSP but cannot afford to transition to greater levels of two-sided risk according to the current timelines.

The ACC sees value in the creation of Track 3 to reward ACOs with a higher sharing rate if they are willing to accept greater risk and the prospective assignment of beneficiaries. However, we recommend that CMS extend the prospective assignment of beneficiaries for financial reconciliation to all ACO participants, including those in Track 1 and Track 2. Prospective assignment would allow all ACOs to plan around a more defined beneficiary group without having to account for potentially major changes to the benchmark during the performance year. This is valuable to all ACO participants, especially those that participate in Tracks 1 and 2 because they are unable to assume higher levels of risk. As with the current tracks, the ACC encourages CMS to conduct a periodic review of Track 3 and update requirements as necessary to ensure that the program supports an organization's willing movement toward greater two-sided risk.

The ACC also supports the proposal to waive certain existing regulatory requirements for ACOs that assume two-sided risk; however, these benefits should be extended to both Track 2 and Track 3 participants. Accepting shared losses is a responsibility taken on by ACOs in both Track 2 and Track 3. As such, participants in both models should be offered these waivers.

These waivers would exempt ACOs from the skilled nursing facility (SNF) three-day rule, geographic telehealth originating site requirements, the requirement that beneficiaries must be homebound to receive home health visits, and limits on referrals to post-acute care providers with whom the ACO has a financial and clinical relationship. Rewarding two-sided risk ACOs with these waivers would incentivize them to seek innovative care delivery solutions in primary and post-acute care. CMS should monitor the impact of these waivers to determine if flexibility in these requirements contributes to greater savings and improvements in care and patient outcomes.

Streamlining the Pioneer ACO Application Process and Governing Body Requirements

CMS proposes revisions to certain elements of the ACO application process and governing body structure to encourage groups to take on more risk. **We support the proposals to develop a condensed application for Pioneer ACOs seeking to transition to a two-sided risk model. We also support the elimination of the requirement that an ACO's medical officer be an ACO provider or supplier.** These changes will make it easier for entities to meet the requirements of the MSSP without affecting the goals and intent of the program.

The ACC commends the 424 organizations currently participating in the MSSP on the savings generated to date through innovative care coordination. We are committed to working with CMS to identify successful models for value-based care delivery and are encouraged by continued efforts to refine the ACO program based on participant performance and feedback. Please contact Christine Perez, Manager, Medicare Coverage & Payment Policy at cperez@acc.org or (202) 375-6630 with any questions or requests for additional information.

Sincerely,

Patrick T. O'Gara, MD, FACC
President