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February 6, 2015

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1461-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

Re: CMS-14612-P – Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations Proposed Rule
79 Fed. Reg. 72760 (December 8, 2014)

Dear Administrator Tavenner:

The American Cancer Society Cancer Action Network (ACS CAN), the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. As the nation's leading advocate for public policies that are helping to defeat cancer, ACS CAN ensures that cancer patients, survivors, and their families have a voice in public policy matters at all levels of government.

ACS CAN appreciates the opportunity to comment on the proposed rule implementing changes to the Medicare Shared Savings Program. We applaud CMS for requiring an Accountable Care Organization (ACO) to specify how it intends to improve care coordination for beneficiaries. As part of this process we urge CMS to require an ACO to describe in its application how it will coordinate palliative care services for beneficiaries with serious illness (such as cancer). ACS CAN supports CMS' proposal to include primary care services provided by non-physician practitioners in the assignment process. Finally, ACS CAN is generally supportive of the proposed new Track 3 ACO model. However, we urge CMS to limit the proposed waivers of Medicare rules to entities participating in the Track 3 model.

Need for Additional Beneficiary Education

As more beneficiaries are being aligned with ACOs the need for clear and accurate information becomes vitally important. Information must be provided to beneficiaries in clear and concise manner and through various avenues. Communications must clearly explain to beneficiaries that alignment with an ACO does not alter a beneficiary's Medicare rights or consumer protections, including the freedom to choose a Medicare provider that is outside the Medicare ACO. We encourage CMS to require that all beneficiary materials – particularly any written form of communication – be geared towards lower health literacy levels. We strongly urge CMS to test any messaging intended for beneficiaries with

beneficiaries themselves and/or advocacy groups. This will help CMS gauge whether the information being presented is readily understood by the intended audience.

There are valuable lessons from the first round of beneficiary notifications that were sent out a few years ago. Consumer advocates noted the beneficiary mailings were too complicated and voiced concern offering specific suggestions for making the notices clearer and easier to understand. Unfortunately the agency disregarded most of the suggestions and, as a result, the mailings created a significant level of confusion and angst among beneficiaries who thought they were being automatically enrolled in a managed care plan without their permission. To make matters worse, the ACO alignment notice was sent at the same time as the request for permission to use beneficiary data which created even greater confusion. Key to successful alignment is making sure that beneficiaries clearly understand exactly what alignment means – and does not mean – for them.

Finally, the need for additional beneficiary education is particularly important for some of the newer models of care. ACOs who have successfully waived certain Medicare rules and regulations (see discussion below) have an additional responsibility to provide beneficiaries with information regarding why certain Medicare rules may not pertain to them.

Quality Measurement

Robust quality measurement is essential to evaluating the success of an ACO. CMS finalized the measures for the Medicare Shared Savings Program in the Calendar Year 2015 Medicare Physician Fee Schedule final rule. As CMS considers future improvements to the quality measure set, we urge the agency to prioritize outcomes measures over process measures. In addition, we urge CMS to rely more on patient experience and patient-reported outcomes measures, which are particularly important for beneficiaries with multiple conditions for whom condition-specific quality measures fail to adequately encompass the totality of the care provided. Where appropriate, CMS should also consider including caregiver experience data which can be a particularly helpful proxy to assess the quality of care provided to beneficiaries who may experience cognitive impairments.

B. ACO Eligibility Requirements

8. Required Process to Coordinate Care

CMS proposes requiring an ACO to describe in its application how it will encourage and promote the use of enabling technologies for improving care coordination. CMS also proposes requiring applicants to describe how they intend to partner with long-term and post-acute care providers to improve care for beneficiaries.

ACS CAN applauds CMS for requiring an ACO to specify how it intends to improve care coordination for Medicare beneficiaries. For patients with cancer and survivors coordination of their health care services is critical. To that end, ACS CAN urges CMS to also require an ACO to describe in its application how it will coordinate palliative care services for beneficiaries with serious illness (such as cancer).

Palliative care teams – which include both physicians and non-physician practitioners – provide an important set of services that can help ACOs more effectively manage the care of seriously ill patients including: education about pain management, facilitation of support systems for the patient and the family on-call physician, advance practice nurse symptom management consultations for home-bound patients, review of treatment protocols that are taking place (including reviewing medications, oxygen

regimen, skin care, titration process, and other services), education of family members on stages of palliative care and the physical decline of the patient; and, if necessary, face-to-face evaluations for continued hospice eligibility.

Given that palliative care services have been shown to both increase the quality of care provided to individuals[1] and reduce health care costs[2,3] – two goals of the ACO program – we strongly urge CMS in the future to include provisions in the ACO eligibility rules that require an ACO to describe in its application how it will provide beneficiaries with serious illness access to palliative care services throughout the care continuum.

E. Assignment of Medicare FFS Beneficiaries

3. Definition of Primary Care Services

CMS proposes to include the transitional care management codes (CPT codes 99495 and 99496) and chronic care management codes (HCPCS code GXXXI) as primary care services to be considered in the beneficiary assignment methodology.

ACS CAN supports CMS' proposal to recognize these codes as part of primary care services. Care management is critical to ensuring that patients with multiple chronic conditions (like cancer) receive high quality health care. Care management is particularly important for cancer patients as they frequently have to navigate between multiple providers and different care settings during the course of their treatment.

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

CMS proposes to include primary care services provided by non-physician practitioners (e.g., nurse practitioners, physician assistances, and clinical nurse specialists) in step 1 of the assignment methodology, rather than only in step 2 as they are under the current assignment process.

ACS CAN supports CMS' proposal. Many beneficiaries – particularly those in rural areas and those who use federally-qualified health centers – utilize the services of non-physician practitioners as their primary care providers.

5. Assignment of Beneficiaries to ACOs That Include FQHCs, RHCs, CAHs, or ETA Hospitals

CMS proposes to establish operational processes so that it can consider claims for professional services submitted by federally-qualified health centers (FQHCs), rural health centers (RHCs), critical access hospitals (CAHs), and Electing Teaching Amendment (ETA) hospitals.

ACS CAN supports the proposed policy. Community health centers – including FQHCs and RHCs – provide essential community-oriented primary care in areas that are underserved or lack other health

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[1] Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. N Engl J Med. 2010;363:733-742.

[2] Morrison RS, Dietrich J, Ladwig S, Quill T, Sacco J, Tangeman T, Meier DE. Palliative care consultation teams cut hospital costs for Medicaid beneficiaries. *Health Affairs* 30(3)454-463 (2011).

[3] Morrison RS, Penrod JD, Cassel JB, Caust-Ellenborgen M, Litke A, Spragens L, Meier DE. Cost savings associated with hospital palliative care consultation programs. *Arch Intern Med* 168(16)1783-1790 (2008).

care services. We agree that beneficiaries who rely on these providers for their care should be able to benefit from participation in an ACO.

F. Shared Savings and Losses

2. Modifications to the Existing Payment Tracks

b. Proposals Related to Transition From the One-Sided to Two-Sided Model

CMS proposes to remove the existing requirement that ACOs that enter the Medicare Shared Savings Program (MSSP) under the Track 1 (one-sided) model must transition to the Track 2 (two-sided) model after one (three-year) agreement period if they wish to continue to participate in the MSSP program. CMS proposes to allow ACOs that have completed a three-year agreement period under Track 1 the opportunity to enter into one additional three-year agreement. ACOs that consistently generate losses in excess of the negative minimum savings rate would be ineligible to renew their Track 1 agreement. CMS also proposes that Track 1 ACOs who renew their Track 1 agreement will have their sharing rate reduced by 10 percentage points, in an effort to make staying in a Track 1 model less attractive.

ACS CAN supports CMS' proposed policies. We recognize the MSSP program is relatively new and many participants in the program have expressed the need for additional experience in the program before they feel comfortable enough to move to a two-sided risk model. We strongly support CMS' proposal to limit the potential savings that accrue to entities that have renewed a Track 1 model. We believe that this policy will provide incentive to entities that may be on the cusp of considering moving to a two-sided rick model.

At the same time, we believe that entities should only be permitted the opportunity to renew a one-sided risk model for one additional three-year agreement. Entities that are unable to perform within six years should not be permitted to remain in the MSSP.

3. Creating Options for ACOs That Participate in Risk-Based Arrangements

b. Proposals for Assignment of Beneficiaries Under Track 3

CMS proposes to create a new Track 3 model, which would allow ACOs to obtain a higher level of savings. Beneficiaries would be assigned to a Track 3 ACO on a prospective basis, at the start of the performance year, and there would be no reconciliation resulting in the addition of new beneficiaries at the end of the performance year. CMS only would permit adjustments to be made at the end of the performance year that would exclude beneficiaries who were included on the prospective assignment list at the beginning of the year that no longer meet the eligibility criteria.

ACS CAN supports the new Track 3 model, which should incentivize ACOs to invest in more care coordination for Medicare beneficiaries. CMS would continue to allow beneficiaries – even those prospectively assigned under the Track 3 model – to receive their care outside an ACO. This lack of a "lock-in" creates sufficient incentive for the ACO to provide their beneficiaries with high-quality and low-cost care as an incentive to obtain their care within the ACO.

As part of its evaluation of the Track 3 model, we urge CMS to monitor the extent to which high-cost beneficiaries – such as cancer patients – obtained services outside the ACO. This information will not only show whether the ACO's provider network was sufficient for these patients, but also will provide insights as to whether CMS' policies to discourage gaming or avoidance of at-risk beneficiaries proved sufficient or whether additional policies are needed.

4. Seeking Comment on Ways To Encourage ACO Participation in Performance-Based Risk Adjustments

a. Payment Requirements and Other Program Requirements That May Need To Be Waived in Order To Carry Out the Shared Savings Program

The preamble notes that CMS has received feedback from entities who have expressed interest in participating in the Medicare Shared Savings Program. Some entities have urged CMS to permit ACOs to waive certain Medicare provisions, discussed in detail below. At this time, CMS is considering allowing only Track 3 ACOs to waive these policies.

To the extent that such waivers are to be permitted, we strongly urge CMS to limit any waivers only to participants in the Track 3 model. Limiting these waivers to the Track 3 model – combined with the potential for higher savings – should provide sufficient incentive for an ACO to consider participating in the Track 3 model. We are concerned that expanding the proposed waivers to Track 1 and Track 2 ACOs would create a disincentive for an ACO to accept additional risk.

(1) SNF 3-Day Rule

Currently Medicare will provide skilled nursing facility (SNF) coverage only if the beneficiary had a prior inpatient hospitalization stay of no fewer than 3 consecutive days (i.e., the "SNF 3-day rule"). Medicare Advantage plans and participants in the Pioneer ACO model are permitted to waive the SNF 3-day rule. CMS proposes to allow Track 3 ACOs to also waive this requirement. Under the waiver, CMS proposes to require ACOs to submit to CMS the SNF or group of SNFs with which they wish to partner.

ACS CAN is generally supportive of permitting a Track 3 ACO to waive the SNF 3-day rule requirement. However, we urge CMS to impose certain beneficiary protections. The proposed waiver is unclear to what extent patients (and their caregivers) would be permitted to have a choice of SNF providers. We are concerned that ACOs would have a strong incentive to admit beneficiaries into contracted SNFs, which may not be the preferred entity for the patient and/or the patient's caregivers. ACOs should be required to inform beneficiaries and their caregivers of any non-contracted SNFs available to them.

In addition, we urge CMS to carefully monitor the impact of these proposed changes on beneficiary access and cost-sharing obligations. For example, it is unclear what happens if the contracted SNFs do not have available beds at the time the beneficiary needs SNF care. Similarly, to the extent that any proposed waiver reduces or eliminates beneficiary cost-sharing obligations, we urge CMS to hold the beneficiary harmless if the beneficiary is later determined to be no longer attributed to the ACO.

(2) Billing and Payment for Telehealth Services

CMS notes that it is considering allowing Track 3 ACOs to apply for a waiver of the originating site requirement that limits payment of services furnished within specific geographic areas and a waiver of provisions that specify the particular sites at which the telehealth individual must be located.

ACS CAN supports CMS' proposed waiver. Telehealth services can help cancer patients overcome geographic limitations to access specialist care and allow patients the opportunity to receive services without having to incur additional travel costs.

(3) Homebound Requirement Under the Home Health Benefit

CMS is considering allowing ACOs to waive the requirement that a beneficiary has a condition such that leaving her home is medically contraindicated in order to be eligible for home health services.

ACS CAN supports CMS' proposed waiver. We agree with other stakeholders, including the Medicare Payment Advisory Commission (MedPAC), that appropriate use of home health services may avoid a hospital admission.

(4) Waivers for Referrals to Postacute Care Settings

As a condition of participation in the Medicare program, hospitals are required to have in effect a discharge planning process that meets the needs of the individual patient. This process may involve discharge to a SNF or home health agency, depending on the individual patient's medical needs. Some ACOs and MedPAC have noted that certain post-acute care providers may deliver higher-quality and lower-cost care compared to their counterparts. CMS proposes to waive the requirement that a hospital not limit the post-acute care options presented to the beneficiary as part of the discharge planning process.

ACS CAN supports this proposal to give beneficiaries a complete list of post-acute care providers from which to choose, but would allow hospitals to recommend high quality post-acute care providers with whom they have relationships. However, given the potential for hospitals to steer patients to a limited set of post-acute care providers, we strongly urge CMS to maintain vigilant oversight.

b. <u>Other Options for Improving the Transition to Two-Sided Performance-Based Risk Arrangements</u>

(1) Beneficiary Attestation

Beneficiaries are aligned to ACOs based on their utilization of primary care services provided by physicians who participate in the ACO. Some have suggested that beneficiaries should be able to designate which providers are responsible for their overall care. In the proposed rule, CMS does not propose any specific policies related to beneficiary attestation, but welcomes comments on the appropriateness of offering a beneficiary attestation process to ACOs who chose to participate in a two-sided risk model (e.g., Track 2 or Track 3).

ACS CAN appreciates CMS' interest in ensuring that beneficiaries are aligned to an ACO appropriately. However, absent extensive beneficiary education (which has not yet occurred) beneficiary attestation may be premature. We note that many beneficiaries are provided forms at the point of service and are not provided an opportunity to request additional information or discuss any concerns they may have.

Conclusion

On behalf of the American Cancer Society Cancer Action Network we thank you for the opportunity to comment on the proposed rule implementing changes to the Medicare Shared Savings Program. If you have any questions, please feel free to contact me or have your staff contact Anna Schwamlein Howard, Policy Principal, Access and Quality of Care at Anna.Howard@cancer.org or 202-585-3261.

Sincerely,

Kirsten Sloan
Senior Policy Director
American Cancer Society Cancer Action Network