March 28, 2016

Andy Slavitt

Acting Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS–1644–P

P.O. Box 8016

Baltimore, MD 21244-8013

RE: CMS-1644-P; Comments in response to Revised Benchmark Rebasing Methodology proposed rule

Dear Acting Administrator Slavitt:

On behalf of the North Carolina Medical Society (NCMS) and our over 12,000 physician and physician assistant members, we are pleased to provide our feedback in response to the proposed rule, which makes revisions to the benchmarking methodologies in the Medicare Shared Savings Program (MSSP). We support many of CMS’ proposals and believe finalizing these proposals, with modifications, would make the program stronger and encourage continued participation by Accountable Care Organizations (ACO) in North Carolina.

**Modifying the methodology for rebasing and updating ACO historical benchmarks to incorporate regional expenditures**

The NCMS supports CMS’ proposal to blend ACO historical and regional cost data into ACO benchmarks. Making this change will benefit the program greatly by allowing for ACOs to be successful even when their past performance indicated low spending. We support the CMS proposal to incorporate 35 percent and 70 percent regional cost data in the second and subsequent agreement periods. We also urge CMS to provide ACOs with additional choices in transitioning to benchmarks that comprise a component of regional cost data to provide ACOs with flexibility in making the transition to blended historical ACO and regional cost data for reset benchmarks. Additionally, the NCMS supports CMS’ proposal to use the same regionally-based update formula to reset and update ACO benchmarks. We urge CMS to allow ACOs to begin new agreement periods with rebased benchmarks as soon as possible. Specifically, CMS should allow 2012/2013 ACOs to begin new agreement periods using the revised methodology beginning in 2017.

We support defining regions based on counties, as well as the approach to weight an ACO’s regional expenditures relative to the proportion of the ACO’s assigned beneficiaries in each county. However, when defining the region we urge CMS to only include counties with at least 1 percent of the ACO’s assigned beneficiary population.

When establishing the beneficiary population used to determine expenditures for an ACO’s Regional Service Area, the NCMS supports CMS’ proposal to calculate costs for assignable beneficiaries only, or those who received at least one primary care service from a Medicare-enrolled primary care physician during the assignment period. However, we urge CMS to modify its proposal by excluding all ACO-assigned beneficiaries from the regional service area reference population. CMS’ current proposal to include all assignable beneficiaries could unfairly impact those ACOs who serve a large proportion of fee-for-service (FFS) beneficiaries in its region by essentially creating a reference population that compares the ACO to itself. For those ACOs whose reference population would result in less than 5,000 after removing the ACO-assigned beneficiaries, CMS should explore using a modified approach such as looking to contiguous counties to develop an appropriate comparison population.

The NCMS opposes CMS’ proposal to calculate regional End Stage Renal Disease (ESRD) expenditures using state-level data, and applying these values to all counties in the state. CMS has not released sufficient data for ACOs to model the effects of this policy. Therefore, we urge CMS to revisit this issue through further rulemaking after providing the necessary data to allow stakeholder input.

Lastly, we oppose the CMS proposal to no longer account for savings generated during an ACO’s previous agreement period when calculating rebased historical benchmarks for a new three-year agreement period. Reversing this policy would discourage ACO participation in the MSSP program as an ACO’s hard work to lower spending would ultimately negatively impact their ability to perform well under the program’s requirements for calculating rebased benchmarks for a new three-year agreement period in their continued participation in the program. We urge CMS not to finalize this proposal and instead maintain current policy for adjusting rebased historical benchmarks by accounting for savings generated during an ACO’s previous agreement period for ACOs with net per capita savings through the three-year agreement period.

**Modifying the methodology for risk adjustment to account for the health status of the ACO’s assigned population in relation to FFS patients in the ACO’s regional service area**

The NCMS supports CMS’ proposal to adjust for an ACO’s risk relative to that of its region in determining the regional adjustment to the ACO’s rebased historical benchmark.

**Revising the methodology for adjusting ACO benchmarks to account for changes in ACO participants’ Tax Identification Number (TIN) composition**

The NCMS opposes CMS’ current proposal to adjust the methodology to change benchmarks based on modifications to ACO Participant TINs until CMS is able to provide additional information and data for stakeholders to study and model what impact the current proposal would have on ACOs.

**Providing additional MSSP participation options to encourage ACOs to transition to performance-based risk arrangements**

The NCMS supports CMS’ proposal to provide an optional fourth year in Track 1 for ACOs moving to Track 2 or 3 as well as its proposal to allow Track 1 ACOs to transition to Tracks 2 and 3 before the end of their agreement periods. CMS should continue to offer as many options to ACOs as possible for participation in the MSSP program to encourage continued participation.

**Defining circumstances under which CMS would reopen payment determinations to make corrections after the financial calculations have been performed**

While we support CMS’ proposals to provide a reopening of payment determinations in certain circumstances, we urge CMS to accept redetermination requests by ACOs when ACOs identify an error in the amount of shared savings or losses. CMS should not have the sole discretion to determine whether good cause exists for reopening a payment determination. Additionally, CMS should reduce the 3 percent materiality threshold as even a 1 percent error can have huge financial consequences for ACOs participating in the MSSP program. Lastly, we urge CMS to reduce the timeframe proposed for good cause redeterminations to two years. This will provide ACOs with more financial predictability. Allowing a 4-year lookback period would create uncertainty and discourage continued participation by ACOs.

In conclusion, we appreciate the opportunity to provide feedback on these proposals. We encourage CMS to make these changes to support the MSSP program and to encourage continued participation of North Carolina ACOs in the MSSP program.

Sincerely,

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Docia E. Hickey, MD

President, North Carolina Medical Society