October 16, 2018

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244–1850

Delivered Electronically

Re: CMS-1701-P "Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations-Pathways to Success" 83 Fed. Reg. 41786 (August 17, 2018)

Dear Administrator Verma,

CHRISTUS Health (CHRISTUS) appreciates the opportunity to submit the following comments to the Centers for Medicare and Medicaid Services (CMS) regarding the Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs) proposed rule, published in the Federal Register on August 17, 2018. CHRISTUS is an integrated, not-for-profit international health system that includes nearly 350 services and facilities, including more than 50 hospitals in seven U.S. states. We share the Administration's strong commitment to promoting health and wellness solutions that improve the lives of the individuals and communities we serve.

We appreciate the ongoing efforts by CMS to administer and improve the Shared Savings Program, and we support the agency's goal of better alignment between incentives and high-value care delivery. The CHRISTUS Health Quality Care Alliance (CHQCA) has actively participated in the Shared Savings Program since 2016 as a Track 1 model. Our ACO has 1,000 participating primary care physicians in Louisiana, Texas, Arkansas and New Mexico and 76,475 beneficiaries attributed to the program.

As a "high-revenue" ACO, we are concerned about the accelerated path for ACOs to assume financial risk and the potential negative impact this would have on the Medicare beneficiaries our physicians treat. CHRISTUS is a leading provider of uncompensated care among not-for-profit health care systems and operates in states with some of the highest rates of uninsured, including the states noted above. These proposed policies may have a significant impact on whether CHRISTUS will be able to provide the same level of charity care to our indigent patients and surrounding communities going forward.

Specifically, CMS proposes to discontinue Track 1 (and Track 2) and develop a fast-track pathway for MSSP ACOs to take on financial risk by limiting the time in a one-sided risk model from the current six years to two years. As a current Track 1 participant, CHQCA would actually be restricted to one year under a one-sided model. CMS also proposes to cut the shared savings rate in half for one-sided risk ACOs (from 50 percent to 25 percent). These policies require providers to take on a much higher financial risk, with unpredictable outcomes. CHRISTUS is concerned that the impact of increased financial pressure will cause ACOs to inappropriately focus on reducing costs over achieving high-quality outcomes, and consequently put beneficiaries' access to medical care at-risk.

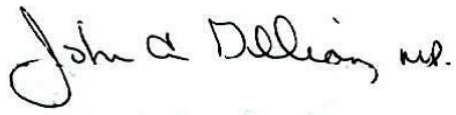
As previously stated, CHQCA falls into the category of "high-revenue" ACOs with a geographic presence across four states. CHQCA has focused on developing a strong ACO foundation by creating trustworthy relationships and operational alignment with independent physicians with little near-term financial value. We have also successfully dedicated our initial establishment as an ACO on quality and patient experience by prioritizing patient well-being, health outcomes, and quality of life. At this point, CHQCA is now prepared to make an impact on "bending the cost curve," but in order to make an impact on cost, the financial investment will become much steeper, and funds have not yet been committed to make significant investments in administration and care delivery.

Based on recent analysis, fewer "high-revenue" ACOs are ultimately successful. We believe this is due to misaligned payment incentives that structurally prohibit change. For example, lack of interoperability and connectivity is an ongoing challenge requiring significant investment of time, money and resources. We expect it will take another 12 to 24 months to become almost fully interoperable and provide actionable results.

Therefore, we would urge CMS to reconsider its proposal to remove risk earlier in an ACO's development. Based on CHQCA's experience, an additional three years as a one-sided ACO would allow for a more comfortable transition to significantly impact cost without considerable financial risk. Even if successful, the investment may not produce savings until at least eighteen months after the first day of a performance year, as CHRISTUS had planned before CMS proposed to reform the Shared Savings Program.

On behalf of CHRISTUS Health, thank you again for the opportunity to provide feedback on this Proposed Rule. We are hopeful that our comments are helpful, and we welcome any questions you may have.

Sincerely,



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