February 6, 2015

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: (CMS–1461–P) Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations

Dear Administrator Tavenner:

The undersigned members of the Coalition to Preserve Rehabilitation (CPR) appreciate the opportunity to comment on the proposed rule Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations. CPR believes that to best ensure patient protections, the federal government must have a strong leading role in regulating accountable care organizations (ACOs). CPR is a coalition of national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities and chronic conditions may regain and/or maintain their maximum level of health and independent function.

**Background on Rehabilitation and the Medicare Beneficiary**

Millions of individuals with injuries, illnesses, disabilities, and chronic conditions rely on the Medicare program for access to the rehabilitation services they need to improve their health, functional ability, and live as independently as possible in their homes and communities. According to the Centers for Medicare and Medicaid Services (CMS), more than two-thirds of Medicare beneficiaries, or approximately 21.4 million individuals, had at least two chronic conditions in 2010.¹ There are over eight million Medicare beneficiaries under the age of sixty-five who qualify for the program based on their disability status. Many people or beneficiaries with all kinds of injuries and illnesses avail themselves of both inpatient hospital and outpatient rehabilitation services at some point in their lives. For all Medicare beneficiaries, the Medicare rehabilitation benefit is a lifeline to improved health and functional status, and enhanced quality of life. And yet, growth in Medicare spending has been extremely low over the past three years: approximately 1.9 percent annually on average.

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Timely and appropriate rehabilitation is critical to a cost-effective Medicare program. Quality rehabilitation services can be provided in a variety of post-acute care settings based on patient needs. Long term acute care hospitals (“LTACH”), inpatient rehabilitation hospitals and units (“IRFs”), skilled nursing facilities (“SNFs”), and home health care agencies all play an important role in the recovery and rehabilitation of Medicare beneficiaries. The services provided in each of these settings cater to beneficiaries with a particular set of medical and functional needs.

Timely, intensive, and coordinated rehabilitation provided in a rehabilitation hospital or unit decreases unnecessary long term dependency costs to the federal government. It also returns beneficiaries to their homes and communities, decreases the need to shift costs onto the states by relying on Medicaid as the payer of last resort for long term nursing home care that might have been averted with early, intensive and coordinated rehabilitation. This level of care is also the linchpin to reduction of costly and unnecessary hospital readmissions for beneficiaries with a wide range of debilitating conditions.

**Overall Concerns with ACOs**

All alternative payment models, including ACOs that seek to return savings to participating providers and eventually will take on greater risk, raise significant concerns with the rehabilitation and disability communities. All reforms to the Medicare program that impact post-acute care, such as ACOs under this proposed rule, should, above all, preserve access to the right level of intensity of rehabilitation, in the right setting, at the right time to meet the unique individual needs of Medicare beneficiaries. This is, of course, much easier said than done.

Meeting this challenge, while making Medicare post-acute care payment policy more efficient, requires serious deliberation. Uniform data needs to be collected across a variety of PAC settings with a major emphasis on appropriate quality standards and risk adjustment to protect patients against underservice. Improving patient outcomes should be the hallmark of any reform to the Medicare program, especially payment or delivery reforms including ACOs, bundled payments, site-neutral payments, and other alternative models that impact the most vulnerable Medicare beneficiaries. It is one thing to maintain or improve quality outcomes while making the system more cost-efficient. It is quite another to ultimately save money in post-acute care by redesigning payment and delivery systems in a manner that does not protect against stinting on patient care and diverting beneficiaries into the least costly setting.

CPR strongly believes that ACOs under the Medicare program should not have the effect of restricting access to rehabilitation provided in post-acute care settings. CMS must insist that ACOs develop and maintain patient safeguards to ensure that beneficiaries are not channeled into settings of post-acute care that do not meet the beneficiaries’ individual medical and rehabilitation needs. Financial incentives to share savings, as well as capitated payment models where ACO’s and participating providers take on a greater share of risk are particularly suspect. These incentives have been shown under publicly-supported health care programs and private health care payers to lead to underservice of patients who need services—particularly rehabilitation services and devices—the most. Unfortunately, this defines the population of people with disabilities and chronic conditions.

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2 Although these settings are commonly referenced when discussing post-acute care policy, there are other providers in the post-acute care continuum that are critical to a well-functioning system. For instance, outpatient therapy, hospice providers, durable medical equipment, prosthetics, orthotics, and supplies all contribute to the Medicare-covered set of post-acute care services.
The CPR Coalition is simply not convinced that the ACO model will achieve its dual goals of lowering health care spending while improving patient outcomes. The data to date are unconvincing. The proposed rule seeks to move ACO participants to accept greater risk over time, and we understand that many commenters will press CMS to adopt final regulations that provide stronger financial incentives for ACOs to save money and share in those savings. These dynamics only raise the sense of alarm of ACOs among the rehabilitation and disability communities for the reasons previously stated.

**Patient Safeguards Must be Enhanced for All ACOs**

ACOs continue to be a grand, national experiment that has not yet been validated as effectively achieving its stated goals. Yet, the proposed rule doubles down on ACOs and proposes many alterations to the existing ACO program that concern the CPR Coalition, particularly in the area of post-acute care. We strongly urge CMS to adopt meaningful patient safeguards in the final rule to prevent underservice of certain patients. Examples of these safeguards include the following:

1. **ACO Entity:** Those in control of the ACO entity should have sufficient expertise to manage patient care in such a manner as to maximize patient outcomes through post-acute care services. This requires a level of understanding of the different levels of intensity and coordination of post-acute care and a willingness to invest on a timely basis in the rehabilitation that is appropriate to truly meet patient needs, not the services that are least expensive in the short term. This places a premium on rehabilitation physicians and other members of the rehabilitation team, including the patient and his or her family, actively participating in treatment decisions and selecting the setting for rehabilitation care that is appropriate for each individual in order to maximize long-term outcomes. There are strong incentives in the ACO model, particularly under a risk-based approach, for entities with little direct knowledge of rehabilitation to divert patients to the least costly post-acute care setting, as long as these patients are not readmitted to the acute care hospital, which typically comes with financial penalties. ACOs must be accountable for the achievement of quality and outcome measures to protect against underservice.

2. **PAC Bundle Coordinator:** Nearly 40% of Medicare beneficiaries receive post-acute care services following a hospitalization. With this in mind, every ACO should have a strong clinical decision maker with expertise in rehabilitation (i.e., a physiatrist) and other members of the rehabilitation team dictating care plans and deciding which post-acute care setting is appropriate for each patient.

3. **Exemption of Certain Vulnerable Patients from ACOs:** Until ACOs have developed a better track record for their ability to treat the most vulnerable Medicare patients, CPR supports an exemption of certain patients from ACO payment models. Among these Medicare patients are people with traumatic brain injuries, spinal cord injuries, moderate to severe strokes, multiple-limb trauma, amputations, and severe neuromuscular and musculoskeletal conditions. While these subgroups constitute a minority of Medicare beneficiaries served on an annual basis, they are very important and very vulnerable subgroups that, we believe, should be exempt from initial phases of ACOs. While such groups of patients could be phased-in at the patient’s option as ACOs establish track record, we believe the most vulnerable patients should only be included in ACOs on either a prospective or retrospective assignment basis. Only when ACOs can demonstrate sufficient
quality outcomes, risk adjusters, and patient safeguards to ensure quality care should they be permitted to accept vulnerable patient subpopulations.

4. **Special Treatment for Certain Customized Devices Including Prosthetics, Orthotics and Custom DME:** CPR believes that payment models that incentivize providers to share savings, especially those under risk arrangements, place great pressure on access to customized devices to assist people with disabling conditions. Prosthetic limbs and orthotic braces are critical to the health and full function of people with limb loss and other disabling conditions. Custom mobility devices and Speech Generating Devices (“SGDs”) serve the individual needs of very specific patients under the Medicare program. Access to customized devices that are relatively expensive and intended to be used by only one person should be closely monitored by all ACOs and CMS, as overseer of the ACO program.

5. **Appropriate Post-Acute Care Quality and Outcome Measures:** Quality measures are critical to the success of any ACO program that shares savings in order to ensure that savings are not achieved by stinting on patient care. Ample use of quality and outcome measures is one of the most important methods of determining whether savings are being achieved through better coordination and efficiency, or through denials and delays in services. However, uniform quality and outcome measures that cross the various post-acute care settings do not currently exist. The existing LTCH CARE instrument for LTACHs, the IRF-PAI for rehabilitation hospitals, the MDS 3.0 for SNFs, and the OASIS instrument for home health agencies are all appropriate measurement tools for each of these settings. But they measure different factors, are not compatible across settings, and do not take into consideration to a sufficient extent a whole series of factors that truly assess the relative success of a post-acute episode of care. ACOs should be required to implement and routinely report post-acute care measures that address the functional status and/or functional improvement of patients, quality of life, individual performance rather than aggregate outcomes, the level of access and choice exercised by ACO participants, and patient satisfaction.

6. **Create Financial Disincentives to Divert Patients to Less Intensive Settings:** In order to protect against diversion of patients to less intensive, inappropriate post-acute care settings, CPR recommends that the final ACO regulation include requirements for ACOs to closely monitor referrals to post-acute care settings and payment penalties to dissuade ACOs from underserving patients.

**CPR’s Specific Comments on the Proposed Rule**

Much of the proposed rule addresses very complex issues that most CPR member organizations are not in a position to comment on. However, there are some key elements of the proposed rule on which we have concerns. The remainder of this comment letter addresses these issues.

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3 Custom mobility devices are often referred to as “Complex Rehabilitative Technology” or “CRT.” In fact, bipartisan legislation has been introduced in both houses of Congress to create a separate designation under the Medicare program for CRT entitled, “Ensuring Access to Quality Complex Rehabilitation Technology Act of 2013,” H.R. 942 and S. 948.
1. CPR Urges Caution in Granting Waivers of the SNF 3-day Stay Rule

Under current Medicare law, patients must stay a minimum of three days in an acute-care hospital in order to be eligible for Medicare coverage of inpatient skilled nursing facility (SNF) care. Under this proposed rule, CMS states that under a two-sided performance-based risk ACO model, it could be “medically appropriate and more efficient” for some patients to receive skilled nursing care and or skilled rehabilitation services provided at SNFs without a prior inpatient hospitalization or with an inpatient hospital length of stay of less than three days.4

CPR recognizes the fact that the SNF three day hospitalization rule was established at a time when hospital lengths of stay were considerably longer than they are today. We also acknowledge that in some instances, it might be inefficient and wasteful to have Medicare beneficiaries who truly need SNF-level services to have to undergo a multiple-day hospital stay before gaining access to a SNF. We also recognize the considerable out-of-pocket costs associated with a SNF stay where a Medicare beneficiary does not qualify under the current three-day rule. For these reasons, the proposed waiver under the ACO proposed rule makes sense and is supported by CPR.

However, CPR also believes that such a waiver not be interpreted to suggest that all rehabilitation can take place in a SNF, and create a pathway to SNF care that may limit access to the more appropriate care for certain individuals – the intensive, coordinated rehabilitation care provided in an inpatient rehabilitation hospital or unit (IRF) or a long term acute care hospital (LTACH). We are concerned that the waiver not create yet another barrier to appropriate IRF and LTACH care. The challenge is to ensure that use of such a waiver does not result in medically inappropriate referrals to less intense settings of post-acute care, largely based on the perception of lower short-term cost, when patients require a more intense and coordinated course of rehabilitation treatment in an IRF or LTACH. Failure to identify the proper post-acute care setting will likely result in one of two outcomes; an increase in hospitalization from the SNF when patients’ needs are too acute for the SNF to handle, or, Medicare beneficiaries receiving insufficient rehabilitation and medical management that produces poor outcomes.

**CMS’s five-pronged test for waiving SNF 3-day stay rule provides insufficient patient protections.** CMS further justifies this waiver by referencing similar waivers for both Medicare Advantage plans as well as Pioneer ACOs. 5 For Pioneer ACOs, the waiver went into effect on April 7, 2014, and CMS stated that “Commenters suggest that a similar waiver of the SNF 3-day rule would be appropriate for certain ACOs under the Shared Savings Program.”6

The waiver applies if all of the following criteria have been met: 1) the ACO has the capacity and infrastructure to identify and manage clinically eligible beneficiaries prospectively assigned to them who may be admitted to a SNF without the required three-day inpatient hospital stay; 2) the beneficiary requires skilled nursing and/or skilled rehabilitation care; 3) the ACO has the capacity to identify and manage patients who would be either directly admitted to a SNF or admitted to a SNF after an inpatient hospitalization of fewer than three days, by describing the staff and processes involved in the clinical management of these beneficiaries; 4) the SNF must also have, at the time of

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5 Id. at p.72818.
6 Id. at p.72818.
application submission, a quality rating of three or more stars under the CMS 5-Star Quality Rating System as reported on the Nursing Home Compare Web site; and 5) must be a FFS Medicare beneficiary prospectively assigned to a Pioneer ACO who does not reside in a nursing home for long-term custodial care at the time of the decision to admit to a SNF.\textsuperscript{7} 

CPR takes issue with three of these prongs below.

“Capacity” and “infrastructure” not defined. CMS states that one of the requirements is that the ACO has the capacity and infrastructure to identify and manage clinically eligible beneficiaries prospectively assigned to them who may be admitted to a SNF without the required three-day inpatient hospital stay, yet CMS does not define “capacity” or “infrastructure.” This lack of specific guidance raises the risk of an increase in caseloads to SNFs that are not clinically appropriate.

Discretion to ACO to “identify and manage patients” through “staff and processes” similarly ill-defined. Similarly, CMS states that another requirement is that the ACO has the capacity to identify and manage patients who would be either directly admitted to a SNF or admitted to a SNF after an inpatient hospitalization of fewer than three days, by describing the staff and processes involved in the clinical management of these beneficiaries. CPR believes this too gives too much discretion to ACOs to simply assert that they meet these two criteria without any real evidence to demonstrate compliance. As a result, use of these criteria raises the risk of an increase in caseloads to SNFs that are not clinically appropriate.

Five-star rating systems of SNFs not dispositive of quality. CPR believes that heavy reliance on the Five-star rating system for SNFs is misplaced. The integrity of the very method by which nursing homes and SNFs report quality data is questioned by many. In October 2014, citing its earlier August 2014 publication, the \textit{New York Times} reported that the rating system for nursing homes “relied so heavily on unverified and incomplete information that even homes with a documented history of quality problems were earning top ratings.”\textsuperscript{8} Key data does not factor into the rating system, including the percentage of residents given antipsychotic drugs, the percentage of residents discharged to the home and community, and the percentage of residents readmitted to a hospital.\textsuperscript{9} An April 2014 report by the Center for Medicare Advocacy found that the “star rating” system “likely reflect[s] facilities’ self-reported and unaudited [assertions] that staffing and quality measures have improved,”\textsuperscript{10} rather than definitely showing improved quality of care. Finally, in November 2014, the Center for Public Integrity stated that nursing facilities report more nursing staff on Nursing Home Compare than indicated in the facilities’ Medicare cost reports.\textsuperscript{11}

\textsuperscript{7} \textit{Id.} at p.72818.
\textsuperscript{9} See The New York Times, \textit{Medicare Revises Nursing Home Rating System}.
Waiver increases chances of clinically inappropriate migration of care to SNFs. CPR thus believes that in the aggregate, the waiver will encourage a migration of patients to SNFs who are not clinically appropriate for that setting. Instead of a blanket waiver of the SNF three-day rule, CPR believes that ACOs should triage patients to the most appropriate post-acute care setting, whether that setting is a SNF, an IRF, or an LTACH. The proposed rule does not indicate any support for such triage. CPR believes that patients should have access to the care settings most appropriate to meet their individual needs, and in many cases, a default decision to a SNF is not appropriate.

2. CPR Opposes Waiver for Referrals to Post-Acute Care Settings

In this proposed rule, CMS proposes waiving the requirement under Section 1861(ee)(2)(G) of the Social Security Act that a hospital not specify or otherwise limit the qualified provider which may provide “post-hospital home services,” i.e., post-acute care services, to beneficiaries. CMS proposes using a “narrow” application of this waiver under authority of the Social Security Act to two-sided risk ACOs, known as Track 2 ACOs, as well as potentially one-sided risk Track 3 ACOs participating in the Medicare Shared Savings Program.

CPR believes that such a waiver will infringe on patients’ rights as stated in the Medicare Conditions of Participation regulations (CoPs). The CoPs grant patients the right to participate in care planning and implementation, as well as to make informed decisions regarding their care. Furthermore, the CoPs require that the hospital, as part of the discharge planning process, inform the patient or the patient’s family of their freedom to choose among participating Medicare providers of post-hospital care services and must, when possible, respect patient and family preferences when they are expressed. The hospital must not specify or otherwise limit the qualified providers that are available to the patient.

A waiver of this bedrock Medicare rule raises serious concerns involving a patient’s right to choose the provider that best suits their needs under the fee-for-service program. It also implicates concerns about ACOs steering patients to certain providers at the expense of others, not based on the appropriateness of care provided, but based on financial incentives. For these reasons, CPR does not support this waiver and urges CMS to reject it in the final rule.

3. Publishing Post-Acute Care Utilization Data Must be Used to Identify Stinting of Patient Care

The proposed rule recommends that, at the beginning of the agreement period, during each quarter and at the beginning of each performance year (and upon the ACO’s request for the data), CMS will provide the ACO with information about its fee-for-service population. Such information includes, among other things, utilization rates of Medicare services such as post-acute services, including dates and the place of service. The proposed rule states that publication of this data is for the purpose of

12 See §1861(ee)(2)(H) of the Social Security Act stating that a hospital “not specify or otherwise limit the qualified provider which may provide post-hospital home services.”
13 Proposed Rule, at 72824-72825.
14 See Medicare Conditions of Participation regulations at 42 C.F.R. § 482.13(b)(1) - (2), available at http://www.ecfr.gov/cgi-bin/text-idx?SID=b46d3c538ca1ac26c28140e9c8f335da&node=se42.5.482_113&rgn=div8.
15 Id. § 482.43(c)(7). See http://www.ecfr.gov/cgi-bin/text-idx?SID=b46d3c538ca1ac26c28140e9c8f335da&node=se42.5.482_143&rgn=div8.
16 Id. § 482.43(c)(7). See http://www.ecfr.gov/cgi-bin/text-idx?SID=b46d3c538ca1ac26c28140e9c8f335da&node=se42.5.482_143&rgn=div8.
17 Id. at 72785-72786, 72871.
“reducing growth in health care costs, process development, care management, and care coordination.”

CPR is concerned that these stated purposes omit the purpose of identifying ACO practice patterns that stint on patient care by diverting patients to less intense, less appropriate settings of post-acute care. Being able to benchmark ACO practice patterns and link this data with outcomes data of ACO participants, such as rates of readmissions to the acute care hospital, return to home and independent living, high quality of life, strong patient satisfaction, return to work or community participation, and other metrics, is invaluable. CPR, therefore, strongly encourages CMS to specifically include as a central purpose under this section the identification of practice patterns that indicate underservice or stinting on patient care.

4. Risk-Based Modification of Shared Savings Program Premature; Still “Untested”

The proposed rule states that CMS, in the November 2011 final rule establishing the Shared Savings Program, considered various “alternative payment models” such as “blended FFS payments, prospective payments, episode/case rate payments, bundled payments, patient centered medical homes or surgical homes payment models, payments based on global budgets, full or partial capitation, and enhanced FFS payments for care management.” CMS ultimately decided not to implement any of these in the November 2011 final rule based on the fact that they were “untested.”

The proposed rule enumerates a comprehensive series of changes that would serve to further incentivize ACOs to participate in the program—or continue participating in the program—by making the shared savings component more lucrative to participating providers, and by incorporating greater performance-based risk into ACOs, particularly under a new risk-based ACO model known as “Track 3.” Recognizing the potential threat that risk-based models pose for the disability population, CMS proposes to make adjustments for beneficiaries with disabilities and End Stage Renal Disease (ESRD) in calculating the shared savings and losses of Track 3 ACOs.

But the fact remains that most of the alternative payment arrangements identified in 2011 as being “untested” retain that same posture. CMS’ efforts to ramp up savings and place ACOs at further financial risk is of great concern to the rehabilitation and disability communities, especially when well-developed quality measures and risk adjusters have not been developed and implemented. We therefore caution CMS to consider the impact these changes may have on patient care, notwithstanding the impact they may have on reduced health care expenditures.

5. Notice to Beneficiaries Need Greater Emphasis on Post-Acute Care Settings

CMS is proposing to modify its processes and policy for claims data sharing while asserting that it continues to support meaningful beneficiary choice over claims data sharing with ACOs. CMS proposes a series of beneficiary protections and methods for beneficiaries to provide notice of their wishes to ACOs and CMS, prohibiting these entities from sharing their claims data. CPR supports this section of the proposed rule but urges more specific steps be taken when post-acute care is needed by beneficiaries.

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18 Id. at 72871.
Customized post-acute care information needed. Because of the risk of underservice under shared savings and risk-based models for people in need of post-acute care, CPR requests that CMS include in its final rule requirements for ACOs to fully inform beneficiaries of their choices and options involving post-acute care. CMS should establish that ACOs are required to distribute in multiple formats information that: 1) clearly explains the differences between all PAC settings; 2) explains the inpatient rehabilitation hospital setting specifically; 3) describes the standardized quality measures and federal requirements of each PAC setting; and 4) details any ownership or preferential relationship between the referring ACO or acute-care hospital, and the post-acute care provider to which the patient is being referred.


According to Section § 425.112(b) of the proposed rule, an ACO must describe how it intends to partner with long-term and post-acute care providers, both inside and outside the ACO, to improve care coordination for their assigned beneficiaries. CPR finds this network adequacy provision insufficient and urges CMS to strengthen the network adequacy provisions in the final rule.

CPR urges CMS to adopt a network adequacy standard that requires ACOs to have a full range of in-network providers that are capable of providing all covered services, from preventative care to the most complex and specialized care. These providers must ensure physical, programmatic, and communication access to people with disabilities. If a service is needed by an ACO participate that cannot be provided in-network, out-of-network providers should be available to meet beneficiary needs at no greater cost-sharing. The use of out-of-network exceptions, a meaningful appeal process, and up-to-date provider directories are important components of provider network adequacy, but cannot be a substitute for robust provider network standards.

CPR believes that the adequacy of an ACO’s provider network dictates the level of access to benefits otherwise covered under the ACO. If an ACO covers a benefit but limits the number of providers or specialists, coverage will be curtailed through a lack of access to providers with sufficient expertise to treat the patient. CPR strongly objects to this practice. Too often enrollees across the country are diverted into nursing homes rather than inpatient rehabilitation hospitals because ACOs do not contract with a sufficient number of these providers. Too often, enrollees with brain injury do not receive the intensive longer term services they need because ACOs do not contract with specialized brain injury programs. And too often, suppliers without sufficient training or expertise are called upon to provide highly complex prosthetic limb, orthotic care, and other specialized services and devices.

ACOs should be explicitly prohibited from using restrictive provider networks to manage their benefit coverage costs, and CMS should insert this language into the final rule.

7. Miscellaneous Provisions of the Proposed Rule

Quality Measures. In the proposed rule, CMS proposes to broaden reporting requirements of ACOs from results of their performance on claims-based measures to all quality measures. CPR supports this proposal and urges CMS to adopt, as expeditiously as possible, measures that truly assess factors

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19 Id. at 72863.
20 Id. at 72847.
such as patient satisfaction, level of function, quality of life, and return to home and community activities in order to measure key metrics for patients and their families.

**Physical Medicine and Rehabilitation Physicians Continue in Assignment Step 2.** In the proposed rule, for purposes of benchmarking, preliminary prospective assignment and retrospective reconciliation and prospective assignment, CMS proposes to continue to include physical medicine and rehabilitation in the physician specialty codes in step 2 of assigning Medicare fee-for-service beneficiaries to an ACO. This means that if CMS is unsuccessful in identifying a primary care provider for a given patient, further inquiry will be made to identify whether that patient is associated with a physiatrist. A link between a patient and a physiatrist (in the absence of a primary care relationship) most likely indicates that the patient has some form of disability or chronic condition and may be using a physiatrist as a primary care provider. CPR strongly supports this provision in the proposed rule and urges CMS to adopt this provision in the final rule as well.

**Patient-Centeredness Criteria.** As stated in § 425.204(c)(1)(ii), applicants to the Shared Savings Program must provide a description, or documents sufficient to describe, how the ACO will implement the required processes and patient-centeredness criteria under § 425.112, including descriptions of the remedial processes and penalties (including the potential for expulsion) that will apply if an ACO participant or an ACO provider/supplier fails to comply with and implement these processes. CPR supports this proposal.

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We greatly appreciate your attention to our concerns. Should you have further questions regarding this information, please contact Peter Thomas or Steven Postal, CPR staff, by emailing them at Peter.Thomas@ppsv.com or Steven.Postal@ppsv.com, respectively, or by calling 202-466-6550.

Sincerely,

**CPR Steering Committee Members**

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21 Id. at 72796, 72869.