BIPARTISAN POLICY CENTER

February 6, 2015

Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue SW
Washington, DC 20201

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

Dear Ms. Tavenner:

On behalf of the Bipartisan Policy Center, we appreciate the opportunity to submit comments in response to the Centers for Medicare and Medicaid Services (CMS) December 8, 2014 proposed rule on the Medicare Shared Savings Program (Shared Savings Program), including provisions relating to the payment of Accountable Care Organizations (ACOs) participating in the Shared Savings Program. Founded in 2007 by former U.S. Senate Majority Leaders Howard Baker, Tom Daschle, Bob Dole and George Mitchell, BPC is a non-profit organization that drives principled solutions through rigorous analysis, reasoned negotiation and respectful dialogue. With projects in multiple issue areas, BPC combines politically balanced policymaking with strong, proactive advocacy and outreach.

BPC health leaders and staff share many of the agency's goals, including encouraging greater stakeholder participation in new models of care that improve quality and value in Medicare, reducing administrative burden for ACOs, and establishing a more viable pathway to accepting risk for spending and care outcomes. We are also pleased to see the agency's continued recognition of the importance of electronic information sharing in new models of care. We support CMS's inclusion of additional requirements associated with the description and tracking of plans that promote the use of enabling technologies (such as electronic health records (EHRs), population health management and data analytic tools, telehealth services, health information exchange services, and patient engagement tools) to improve care coordination and make health information electronically available to support a beneficiary's care. Lastly, we appreciate the agency's recently stated goal of tying 50 percent of Medicare fee-for-service payments to quality or value through alternative payment models (APMs) by 2018. However, we believe there are certain flaws in the current design and implementation of Medicare ACO programs (including some statutory issues) that must be addressed to achieve these goals.

Our comments stem from BPC Health Care Cost-Containment and Delivery System Reform Initiative recommendations for system-wide transformation to improve health outcomes and lower costs, most recently a white paper on near-term recommendations to improve ACOs in Medicare.[i,ii] Our recommendations are focused in the following priority areas:

1. ***Set clear expectations for ACOs;***
2. ***Provide ACOs with Tools to Engage Patients and Providers in Care Coordination; and***
3. ***Establish a viable pathway for ACOs to assume two-sided risk.***

BPC's ACO white paper also includes a set of statutory changes needed to incentivize providers to participate in APMs with greater levels of risk, including ACOs.

<u>Recommendation 1</u>: Set clear expectations for ACOs

To successfully improve and become accountable for quality and cost, providers must know in advance what is expected of them, and expectations must be focused and realistic. Quality and financial targets should be established up front, and should not be subject to change during the year. In addition, while we recognize and commend the ongoing efforts of the agency to consolidate quality measures and make them more outcomes-oriented and user-friendly for patients, providers, and payers, we believe that efforts should be accelerated (*discussed in more detail in Section E. of this recommendation below*).

With respect to proposed rule *Section II.E.4., Consideration of Physician Specialties and Non-Physician Practitioners in the Assignment Process, we recommend:*

A. *Further inclusion of non-physician practitioners in ACO beneficiary assignment process*

While we applaud CMS's proposed addition of non-physician practitioners in determining the plurality of primary care services provided to beneficiaries as part of the ACO beneficiary assignment process, we recognize and regret that CMS is bound by a statutory requirement that the beneficiary must receive at least one primary care service from a physician participating in the ACO as a preliminary step for determining assignment eligibility. Thus one of our recommendations to Congress is to remove this statutory requirement such that beneficiaries can also be attributed to an ACO solely on the basis of visits to non-physician primary-care providers, such as nurse practitioners and physician assistants. Until a statutory change can be enacted, we support CMS's efforts to proceed with its proposed change to the stepwise attribution process and evaluate the effects on access to ACOs for beneficiaries who rely upon the services of non-physician practitioners.

With respect to proposed rule *Section F., Shared Savings and Losses*, we recommend:

B. *Prospective beneficiary assignment*

We support the addition of a new Track 3 which includes both prospective assignment and two-sided risk. However, we hope CMS will consider a transition to this approach across all ACOs over time. We believe that in order for ACOs to

successfully coordinate care and achieve better outcomes for the beneficiaries they actually serve, they should know which patients they are responsible for at the beginning of each contract year. Similar to the Pioneer ACO model currently being tested by the CMS Center for Medicare and Medicaid Innovation (Innovation Center), CMS should apply prospective assignment throughout all Shared Savings Program tracks so that all Shared Savings Program ACOs will be informed of their assigned beneficiaries at the beginning of the contract year.

We support the newly proposed exclusion criteria for prospectively assigned beneficiaries, that is, excluding those prospectively assigned beneficiaries who are no longer eligible to be assigned to an ACO (for example, if they switched to Medicare Advantage). We recommend adding to the criteria beneficiaries who move out of the service area. CMS should also adjust the methodology to increase stability in the prospectively assigned population; for instance, if a beneficiary is initially assigned to an ACO in one year, the threshold in the formula for continued assignment of that beneficiary to the ACO in subsequent years should be lower than for newly assigned beneficiaries, making it more likely that existing assigned beneficiaries will continue to be assigned to the ACO.

In the proposed rule CMS discusses the pros and cons of a prospective assignment methodology. We believe that indeed the improved certainty of a clearly defined target population would help ACOs better focus their care improvement efforts and may better position ACOs to take on increasing risk. Over time, CMS should transition to a patient-choice model in which beneficiaries have the opportunity to make an active decision to designate an ACO and would have incentives for doing so. *This patient-choice model approach and recommendations for mitigating risk selection are detailed in Recommendation 2-B below.*

C. *Prospective spending benchmarks*
ACOs should also know their financial target at the beginning of each contract year. Once prospective assignment for beneficiaries in the Shared Savings Program is adopted, CMS should also adopt the Pioneer method of prospective benchmarks within the Shared Savings Program. Additionally, CMS should, in limited circumstances, allow for upward adjustments to benchmarks to reflect significant statutory changes to Medicare payment policies should they become enacted, such as a permanent fix to the Medicare sustainable growth rate (SGR) physician payment formula, introduction of differential updates within the Medicare fee schedules to reward APM participation, and introduction of high-cost, medically necessary treatments.

D. *Partial shared-savings bonuses for ACOs that reduce spending and achieve significant, relative quality improvement, though national standards are not met*
Under the current formulation, ACOs cannot share in any savings unless they meet minimum quality goals, which are uniform nationwide. It is possible for an ACO to

show significant improvement in performance on quality measures and still not be able to share in any savings if the nationwide minimums are not met. CMS should exercise discretion – as part of the Secretary's statutory authority in Section 1899(1)(B) of the Social Security Act to establish quality performance standards for ACOs – and allow in the final regulation some level of shared-savings bonuses for ACOs that achieve significant annual improvement in quality, even though they do not yet meet nationwide minimum quality standards set forth in §425.502 of the Medicare Shared Savings Program regulation. CMS should also consider limiting the availability of these reduced bonuses for improvement to certain quality measures.

With respect to ACO quality measures more generally, we recommend:

E. A smaller, more outcomes-based set of quality measures

While the proposed rule discusses compliance with the current set of 33 ACO quality performance measures and results on reporting and achieving them, we are disappointed it lacks an assessment of how meaningful these measures are in practice for patients, providers, or the Medicare program or a consideration of whether they should be modified, reduced in number, or better aligned across Medicare and private-sector programs. We recognize that CMS is in the process of working with multiple stakeholders, including health plans and providers, to streamline and align measures that are more focused on outcomes-based quality and patient satisfaction to be implemented across public and private sector programs. We understand that, over time, additional stakeholders will be brought into this informal process and strongly encourage CMS to ensure that employers and consumers have input into the process. In addition, we urge those involved in the establishment and alignment of measures to consult with EHR vendors to ensure feasibility and standardization, such that the measures can be accurately reported through EHRs. Aligned, outcomes-focused measures are an essential precondition for meaningful care transformation. Our next white paper in the Delivery System Reform Initiative series, slated for release in March 2015, will address these issues, and we look forward to sharing a more detailed analysis with CMS.

<u>Recommendation 2</u>: Provide ACOs with Tools to Engage Patients and Providers in Care Coordination

A major concern within the existing implementation of Medicare ACOs is the lack of opportunities for the ACO to engage beneficiaries. Passive beneficiary assignment to ACOs makes it likely that most assigned patients will be unaware that they are even part of an ACO. Given the lack of awareness and absence of incentives for patients to access care from ACO providers, many assigned beneficiaries receive a substantial proportion of services from non-ACO providers, limiting the ACO's efforts to coordinate care and improve quality outcomes.

The following recommendations envision a pathway to a patient-choice ACO designation model that would provide more opportunities for beneficiaries and providers to engage with the ACO and each other in more effective ways. This set of recommendations should be tested and

refined in Pioneer ACOs first; then CMS should seek statutory changes to the Shared Savings Program to enable broad implementation throughout all Medicare ACOs.

With respect to proposed rule section II.A., Definitions, and II.B., ACO Eligibility Requirements, we recommend:

A. *Allowing ACOs to establish provider networks.*
Providers should be able to have two kinds of relationships with an ACO. First, a provider could be an ACO member that is involved in ACO governance, including decisions related to the use of shared savings. Alternatively, a provider should be able to become part of an ACO's provider network. These providers would have a formal relationship with the ACO, which could include receiving referrals from ACO members and participating in certain care-coordination processes, but they would not be involved in ACO governance. Inclusion in an ACO's network could be an ideal form of participation for a provider seeking to serve patients of multiple ACOs, such as certain specialists. We would also recommend to Congress as it considers Medicare legislation that these ACO network providers be eligible for any incentives associated with APM participation, such as bonuses and enhanced fee-schedule updates.

With respect to proposed rule section II.E., Assignment of Medicare FFS Beneficiaries, we recommend:

B. *Transition to a patient-choice model in which beneficiaries have the opportunity to make an active decision to designate an ACO and would have incentives for doing so.*
CMS should develop a system in which patients could select an ACO. Any Medicare beneficiary—whether they have been attributed to an ACO or not—should be able to designate an ACO that serves their location during an annual selection period through Medicare.gov or 1-800-MEDICARE. Using this approach, beneficiaries should be able to designate an ACO and identify a primary care provider (physician, physician assistant, or nurse practitioner) who is part of an ACO member practice or in the ACO's network. ACOs should be allowed and encouraged to offer additional incentives to patients who opt-in. ACOs could choose which benefits to offer, such as cost-sharing waivers for ACO primary-care providers, a 24-hour nurse line, and extended primary-care office visit hours. We recognize that CMS will need to consider proposed incentives to ensure they are not coercive or otherwise designed in a way that would inappropriately affect patient choice. Beneficiaries who designate an ACO could continue to see any Medicare provider, but these incentives (such as cost-sharing waivers for primary care) would be limited to benefits and services to ACO members from network providers. CMS would annually inform attributed beneficiaries of the opportunity to designate an ACO and any incentives. These incentives should not be available to beneficiaries who do not designate an ACO, even if they have been attributed. ACOs would be allowed, but not required, to promote designation opportunities to patients through marketing materials. Beneficiaries could change or cancel their ACO designation at the next annual selection period.

Initially, this patient-choice ACO designation system should run concurrently with passive beneficiary assignment (with more prospective assignment, per our recommendations). While greater patient engagement with ACOs through an opt-in process would have many benefits, passive beneficiary assignment does ensure that ACOs have a critical mass of beneficiaries, and it must continue until it is clear that a patient-choice model is sustainable on its own. Once two-thirds or more of the beneficiaries assigned to ACOs in a region have opted-in through the patient-choice designation process, passive assignment of new beneficiaries to the ACO should cease and patient designation should become the only way for additional beneficiaries to be assigned to ACOs in that region.

Risk selection mitigation
CMS discusses its concerns around opportunities for "gaming" or risk-selection in a prospective, passive assignment model. Active beneficiary designation of ACOs may also raise these concerns – for example, that providers might encourage low-risk patients to designate an ACO and not mention the option to high-risk patients – and whether a type of risk-adjustment process would be needed. We believe this type of "cherry picking" is unlikely to occur, and if it did, there would be little or no benefit to providers. An ACO that sought to attract only low-cost beneficiaries would struggle to generate shared savings because their benchmark-spending target would be low relative to higher-cost beneficiaries under the historical benchmark methodology currently in-use.

We also recommend a transition to regional, risk-adjusted benchmarks (*discussed in recommendation 3 below*), which would also mitigate the potential for risk selection. Additionally, because the designation process would be operated by CMS, which would notify beneficiaries of the opportunity to participate, the impact of provider marketing would be limited. Limiting the ability of beneficiaries to change their ACO designation to an annual selection period should prevent providers from systematically encouraging beneficiaries to opt-out before undergoing expensive procedures. Also, ACOs do not have closed networks; beneficiaries who have designated an ACO could access any Medicare provider, and utilization of non-ACO providers counts against the ACO's budget target. Because of this, ACOs have a strong incentive to encourage these patients to access care within the ACO and to deliver such care in a high-quality, coordinated, and efficient manner.

With respect to proposed rule section II.F.4., Seeking Comment on Ways To Encourage ACO Participation in Performance-Based Risk Arrangements, we recommend that CMS:

C. *Waive certain Medicare regulations for ACOs assuming two-sided risk.*
We support CMS's is consideration of waiving certain Medicare regulations to encourage more provider participation in two-sided-risk ACOs. Many rules in the Medicare program were developed to address concerns about inappropriate utilization in a fee-for-service context. We agree that ACOs that have agreed to accept downside

risk within the current contract period should be granted regulatory relief by CMS, including the authority to waive the three-day hospital stay requirement before admission to a skilled nursing facility, authority to waive the homebound requirement for home health services, and waiver of regulations that could limit ACOs from making referrals to high-quality, low-cost providers, such as those providers that are designated as part of the ACO's network and providers in post-acute settings as described in proposed rule section *II.F.4.a.(4)*.

Recommendation 3: Establish a Viable Pathway to Risk

Two-sided risk is a promising approach to change the incentives in the health care system to reward value. However, this promise will not be realized if providers do not participate in ACOs because the conditions are viewed as too difficult or unsustainable. Launching an ACO requires a considerable investment in time and financial resources.

CMS requested comment on its proposal to allow participation in the Shared Savings Program under Track 1 (upside-risk only, sharing in savings but not losses) for a second agreement period and to reduce the maximum sharing rate to 40 percent for those participants. CMS also requested comment on alternatives that can ease the transition but further incentivize the move to two-sided risk in Tracks 2 and 3. In general, we believe that in order to offer a more viable pathway to risk, ACOs should be able to share in more savings in the earlier years with larger savings accruing to the Medicare program in later years after a transition to risk-adjusted, regional benchmarks. Time at one-sided risk should be limited, however, and providers that demonstrate strong performance and capability should be able to adopt more advanced payment models.

With respect to proposed rule section II.F., Shared Savings and Losses we recommend:

A. *Offer ACOs a larger proportion of shared savings, and do not reset historical benchmarks.*

In the near term, ACOs should be able to keep a greater proportion of savings generated in order to make the model more financially attractive to providers. These changes will provide ACOs with more potential rewards upfront to help offset the cost of investments necessary to improve care delivery and coordination. At the same time, the model will ensure that the Medicare program benefits from savings in the long run, as benchmarks are adjusted over time to reflect community-wide reductions in spending (see next recommendation). CMS should allow all ACOs (at both one-sided and two-sided risk) to share in additional savings by increasing the shared-savings percentage to no more than 80 percent of savings generated from the benchmark (up from the current 60 percent and proposal of 75 percent for Track 3 in this proposed rule). CMS should also allow ACOs to maintain their original historical benchmark (plus annual updates) for each subsequent three-year contract period, until historical benchmarks are phased out (*see below*).

B. *Proposed legislation to replace the Medicare physician sustainable growth rate would provide stronger incentives for physician-fee-schedule providers to participate in APMs, including ACOs. If legislation is enacted, CMS should implement a five-year transition from historical benchmarks to regional, risk-adjusted benchmarks beginning in 2018.* There are substantial drawbacks to provider-specific, historical benchmarks, as they provide little incentive for relatively efficient providers to participate, and they may allow relatively inefficient providers to maintain such inefficiency for long periods without penalty. To the degree that benchmarks are rebased, they undermine the providers' business case for investing in improved delivery.

   Assuming the enactment of legislation to establish stronger incentives for physician-fee-schedule providers to participate in APMs, including ACOs, CMS should implement a five-year transition from historical benchmarks to risk-adjusted, regional benchmarks beginning in 2018. Regional benchmarks could be set for market areas, such as a county or, ideally, by Metropolitan Statistical Area or by grouping rural counties within a state (e.g., Bureau of Economic Analysis Economic Areas). These benchmarks should be risk-adjusted using the same methodology used for Medicare Advantage risk adjustment. Risk-adjusted, regional benchmarks would reward efficient ACOs that deliver high-quality outcomes within each region with shared-savings bonuses while providing strong incentives for high-cost, low-quality providers to improve.

C. *Set an expectation that all Medicare ACOs should eventually accept two-sided risk. Limit one-sided risk to two full three-year contract periods plus one partial contract period.* All Medicare ACOs should be expected to eventually accept two-sided risk, and we agree that CMS should establish limits on the number of contract periods at one-sided risk. We propose that at maximum a Medicare ACO could operate at one-sided risk for up to two full contract periods (CMS's proposed revision to Track 1), plus two years of the third contract period as long as it begins accepting two-sided risk in the third year and in all subsequent contract periods.

D. *Allow ACOs to ease into downside risk by making it easier to earn shared savings and by further limiting potential shared losses during a transition period.*
   CMS should establish special shared-savings and loss parameters for the first two contract periods at two-sided risk. For example, CMS might decrease the minimum-savings rate to 1 percent, limit the shared-loss rate to 30 percent, and set a loss-recoupment limit at 5 percent of the benchmark. These changes, which would make it easier for two-sided-risk ACOs to share in savings and further limit potential shared losses in the first two contract periods at downside risk, would encourage more ACOs to accept downside risk by providing a graduated pathway. Beginning with the third contract period at downside risk, the parameters would return to a 2 percent minimum-savings rate, a shared-loss rate no higher than 60 percent, and a loss-recoupment limit at 10 percent of the benchmark.

We reviewed the proposal in section *II.F.2.h.* with these recommendations in mind. We appreciate and applaud the intent of CMS to balance the need for providers to have a viable risk/reward tradeoff and the need to protect the Medicare Trust Funds. We believe that the migration of Medicare ACOs to two-sided risk is an essential ingredient for both protecting the Trust Funds and achieving the vision of ACOs as catalysts for the improvement of quality outcomes combined with reduced spending. We believe that the CMS proposal to allow Track 3 ACOs a sharing rate ranging from 40 to 75 percent of savings above the benchmark, depending on quality outcomes, with a performance-payment limit up to 20 percent of the benchmark would help to attract providers to this model. However, we have concerns that the proposal to hold Track 3 ACOs accountable for a shared-loss rate of up to 75 percent with a loss-recoupment limit of 15 percent would be counterproductive. The lack of participation in the existing two-sided-risk Track 2, which exposes participants to a shared-loss rate of up to 60 percent and a loss-recoupment limit of 10 percent after the first two years (5 percent in the first year and 7.5 percent in the second) should be a cautionary signal. There will be very limited improvement in quality for beneficiaries and very limited savings for the Trust Funds if provider participation in ACOs, and eventually two-sided-risk ACOs, is not widespread.

Understandably, providers are loss-averse and are more likely to be dissuaded from participation by high potential shared-loss rates than encouraged by high potential sharing rates. Yet, the sharing rates (among other parameters) must be high enough to justify the substantial investment to launch the ACO. Because of this, we would strongly advise CMS to adopt lower shared-loss rates (no higher than 60 percent) and loss-recoupment limits (no higher than 10 percent) and adopt the sharing rates and performance-payment limit as proposed. Additionally, offering even lower shared-loss rates and loss-recoupment limits for the first two three-year contract periods would be an effective way to encourage participation and help providers gradually obtain experience with accepting risk. We realize that this potentially means giving up some savings to the Trust Funds in the short term, but this proposed approach would be more likely to result in greater participation, larger savings to the Trust Funds, and a greater positive impact on beneficiary health in the long term.

E. *Offer more advanced payment models for ACOs that demonstrate strong performance and preparedness for managing risk.*

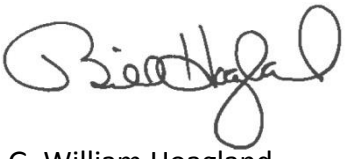
Two-sided-risk ACOs that demonstrate a high level of performance on quality, patient satisfaction, and financial metrics should have the opportunity to adopt progressively more advanced payment models. One such approach would be to allow ACOs to receive Medicare payments for all or a subset of members centrally; this could support ACOs that seek to develop alternative compensation structures for members. For ACOs that have more advanced financial capabilities, a partial-capitation approach may be appropriate. Partial capitation, in which a portion of payments are made upfront to the ACO according to the benchmark with the rest through the fee schedules at commensurately reduced payment rates, should be reserved for ACOs that demonstrate readiness to assume performance risk, which is the ability to deliver promised services

even if costs exceed the capitated prepayments. For example, an ACO might demonstrate such readiness by showing that providers have agreed to accept reduced fees to provide certain services, if necessary. Full capitation should be reserved for fully insured Medicare Advantage plans. The provider-sponsored organization rules already offer a pathway for provider groups that seek fully capitated arrangements to offer their own Medicare Advantage plans.

Conclusion

We appreciate the opportunity to submit comments on the Medicare Shared Savings Program and Accountable Care Organizations. Furthermore we encourage CMS to support new models of care that better address prevention and social determinants of health to drive meaningful improvement in population health outcomes. Strengthening Medicare's Shared Savings and ACO programs, and continuing to test and improve new models of care, is critical to achieving the goals of better health outcomes, patient experience, and cost savings for the Medicare program while addressing the challenges health care providers face in implementing new models of care today.

Sincerely,



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[i] Bipartisan Policy Center, *Transitioning to Organized Systems of Care: Near-Term Recommendations to Improve Accountable Care Organizations in Medicare*. Available at: http://bipartisanpolicy.org/library/transitioning-to-organized-systems-of-care-near-term-recommendations-to-improve-accountable-care-organizations-in-medicare/.

[ii] Bipartisan Policy Center, *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment.* Available at: http://bipartisanpolicy.org/library/health-care-cost-containment/