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June 16, 2014

Ms. Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Suite 314-G
Washington, DC 20201

Dear Ms. Tavenner:

As the Centers for Medicare and Medicaid Services (CMS) prepares for the next evolution of the Pioneer Accountable Care Organization (ACO) model and the next phase of the Medicare Shared Savings Program, the Medicare Payment Advisory Commission (MedPAC) would like to raise several key issues for the ACO model. As the ACO programs have unfolded, we have been speaking to representatives from many ACOs, conducting structured interviews and case studies with Pioneer ACOs, analyzing data on ACO performance, and reviewing progress with CMS staff. As would be expected for a new program, issues have arisen with program operations, for example, the flow of claims data to ACOs. Progress is being made on resolving some of those issues thanks to the efforts of your staff. However, there are other issues essential to the success of the program that will require changes in either regulation or legislation to be resolved; we address five such issues in this letter.

The first two issues concern making the current program work better in the near term. The remaining issues concern a longer-term view of the ACO program. In the longer term, we think the ACO program should transition to a program in which ACOs take on two-sided risk; but that transition would ideally be concurrent with a transition to financial targets that are equitable for all

ACOs in a market and with giving the ACOs stronger tools to engage their beneficiaries. A program with more equitable targets, stronger tools for beneficiary engagement, and ACOs at two-sided risk will provide stronger incentives for providers to make the needed changes to help move the program from one that rewards volume to one that rewards value.

The two near-term issues are:

- ACOs report finding it difficult to manage the program because they do not know who their beneficiaries are and what financial benchmark they are managing to. Improving the methods used for attribution of Medicare beneficiaries to ACOs, using prospective attribution, and having prospective benchmarks are essential for ACOs to have the certainty they need to invest the necessary resources for a successful program.
- ACOs report that quality measurement and evaluation are proving overly complex and expensive. Because ACOs have the responsibility for a defined population, we think quality measurement and evaluation can be simplified by moving away from process measures toward population-based outcome measures. This will benefit the ACOs by eliminating expensive chart-based data collection and reporting. It will benefit the patients by focusing ACO efforts on important outcomes.

In the longer term:

- Almost all MSSP ACOs have chosen to be at one-sided (bonus only) rather than two-sided risk. However, incentives for improvement are much stronger in a two-sided model. Moving to two-sided risk models for ACOs as they gain experience with the program will be important both to strengthen incentives to control costs and to make it possible for CMS to give ACOs more latitude for innovation. But at the same time, benchmarks need to be made more equitable and ACOs need the tools to strengthen beneficiary engagement.
- Many ACO providers we have spoken with currently have patients who are in Medicare Advantage (MA) plans as well as patients in FFS Medicare. For their MA patients they can provide services and use techniques that are not available in FFS Medicare or under ACO rules, such as not requiring a three day inpatient stay prior to SNF admission. The Pioneer demonstration is now allowing ACOs to waive the three-day rule, in part because all Pioneer ACOs are now under two-sided risk. We think that regulatory relief to allow for innovative models of care as the program moves forward should be given to ACOs as they transition to two-sided risk in the MSSP program as well.
- One source of frustration for many of the ACOs we have spoken with is their limited ability to engage with their beneficiaries. ACOs are supposed to be patient-centered, yet their avenues for communication with their patients are limited. In addition, because the benefits and cost sharing in ACOs are the same as in FFS, the value that ACOs bring—such as care coordination or increased responsiveness of ACO providers—is not

immediately evident to the beneficiary. We think CMS could clarify what forms of communication are allowed and continue to improve the process to make any necessary approvals simple to obtain and responsive. In addition, if ACOs are at two-sided risk, we think that ACOs should have the ability to reward their beneficiaries by waiving some or all cost sharing when ACO providers are used.

The issues we have raised are diverse but build on one another. Certainty in attribution and in financial targets is essential for ACOs to want to continue in the program and for new ACOs to want to enter. The lack of certainty is the number one issue ACOs have raised with us over the past year; certainty of who they are accountable for and their financial targets trumps precision of benchmark estimates in their decision making process. Simplifying quality measurement is crucial for ACOs and more broadly for the Medicare program. ACOs represent an ideal opportunity to move beyond process measures and toward population-based outcomes.

Moving to two-sided risk is essential to provide strong incentives for cost control and it also opens up the opportunity for regulatory relief across a broad range of issues. The transition to two-sided risk would optimally be accompanied by a transition to more equitable benchmarks and stronger tools for strengthening beneficiary engagement. Altogether these steps could keep efficient Medicare ACOs in the program and encourage others to join, setting the stage for more coordinated care for beneficiaries at less cost to Medicare.

Improving attribution

The ACOs we have interviewed and surveyed had concerns about which beneficiaries were attributed to their ACO. In general, beneficiaries are attributed to an ACO if that ACO has the plurality of their primary care claims (i.e., qualifying Evaluation and Management claims as specified in regulation). However, ACOs assert that some beneficiaries attributed at the beginning of the year were never seen during the performance year, and other beneficiaries they thought of as their patients were not attributed at all. We address two issues related to attribution: first, which providers are counted when attributing beneficiaries to an ACO, and second, whether attribution should be prospective or retrospective.

Which providers should be used for attribution?

Both the Pioneer demonstration and the MSSP use a two stage method to attribute beneficiaries to ACOs but they differ in some details:

Pioneer demonstration. In the first stage, primary care visits to primary care providers (including non-physician practitioners) are counted. If such visits are below a defined threshold, a second stage of attribution based on qualifying visits with specialists is then made. If the ACO's providers account for the plurality of qualifying care, the beneficiary is attributed to the ACO. ACO providers are identified by a combination of their practice's taxpayer identification number (TIN) and their personal National Provider Identification number (NPI).

MSSP. In the first stage, primary care visits to primary care providers (only physician) are counted. If there are no such visits, a second stage of attribution based on qualifying visits with specialists is then made. (Visits with non-physician practitioners are only counted if there is also a visit to an ACO physician.) If the ACO's providers account for the plurality of qualifying care, the beneficiary is attributed to the ACO. ACO providers are identified by their practice's TIN.

The MSSP attribution process has two issues. First, beneficiaries are not attributed directly on the basis of visits with non-physician providers in the MSSP program. As a result, patients whose usual source of primary care was a non-physician practitioner could be attributed to the "wrong" ACO or not be attributed to any ACO. This is particularly limiting in the case of rural health clinics and federally qualified health clinics (FQHCs), both of which often use non-physician practitioners for patient care. MedPAC and others commented on this provision in the April 2011 proposed rule and CMS allowed a secondary stage attribution to non-physician providers, but only if there was first a visit to an ACO physician. The origin of this issue is the way the statute is written and the issue could be resolved by changing the wording of the law (see text box for details).

Text box. Statutory language on non-physician practitioners and attribution

The statute now reads:

Section 1899 (c) ASSIGNMENT OF MEDICARE FEE-FOR-SERVICE BENEFICIARIES TO ACOs.—The Secretary shall determine an appropriate method to assign Medicare fee-for-service beneficiaries to an ACO based on their utilization of primary care services provided under this title by an ACO professional described in subsection (h)(1)(A).

Subsection (h)(1) reads:

- (1) ACO Professional.—The term “ACO professional” means—
 - (A) a physician (as defined in section 1861(r)(1); and
 - (B) a practitioner described in section 1842(b)(18)(C)(i).

Section 1842(b)(18)(C)(i) reads:

- (i) A physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section [1861\(aa\)\(5\)](#)).

Changing the reference in Section 1899(c) from *subsection (h)(1)(A)* to *subsection (h)(1)* would allow PAs, NPs, and CNSs to be considered when claims for primary care services attributable to the ACO were computed for attribution.

End text box-----

The second issue with attribution is the secondary stage attribution to a specialist if attribution based on visits to primary care physicians fails. The initial theory was that ACOs would want to take responsibility for as many beneficiaries as possible. Thus, one measure taken by CMS to help the ACOs was to allow attribution to specialists in the ACO if no visits to primary care physicians were found in the claims record. The idea was if a beneficiary was using a cardiologist, for example, as his or her *de facto* primary care physician, that fact should be recognized and used for attribution.

However, this second stage attribution to specialists has raised several issues. First, because specialists could potentially be used for attribution, they must be exclusive to one ACO whether beneficiaries are actually attributed to the ACO through them or not. This is because, if they can be potentially used for attribution, the algorithm has to know to which ACO they belong in order to

determine which claims should be attributed to which ACO. Physician groups have objected that this can be a problem for specialists who want to get referrals from several ACOs and do not want to have to be exclusive to one ACO. They feel that they may not be left with enough referrals to stay in business. Also, because attribution in the MSSP program is on the level of the practice's TIN, an entire physician group can end up in an ACO based on the possibility of a single specialist being used for attribution—even if most of the specialists in the group do not think they are part of that ACO. Furthermore, ACOs have asserted that this secondary attribution resulted in beneficiaries being attributed to the ACO who were not seen in the primary care network, which limits the ACO's ability to manage their care.

The attribution method could be simplified and improved by having both Pioneer and MSSP:

- Allow attribution based directly on visits to non-physician practitioners (as discussed in the text box above).
- Identify providers by both their TIN and NPI as is done in the Pioneer demonstration rather than by TIN only, as in MSSP.
- Broaden the definition of 'primary care provider' to include: primary care physicians, non-physician practitioners, and certain designated specialists. The ACO would be allowed to identify certain specialists by NPI and TIN to be considered as 'primary care providers' and visits with them would count for attribution. This would be limited to certain specialties, require that the same types of qualified E&M services be used for attribution for those specialists as are used for primary care physicians, and require that specialists identified as 'primary care providers' be exclusive to a single ACO.
- Attribute beneficiaries only on qualified primary care services provided by the broadened set of primary care providers and eliminate the second step of attribution based on specialists. This should allow visits with non-physician practitioners and specialists who are functioning as primary care providers for some patients to be counted directly. At the same time, it would avoid having beneficiaries attributed to an ACO who are not using their primary care network.

These steps would simplify the attribution method and avoid the above issues with the current attribution process. As discussed, we would define primary care providers as including primary care physicians, non-physician practitioners, and certain identified specialists. Including non-physician practitioners directly in the attribution process requires a change in law. Eliminating the second stage of attribution would be a regulatory change within the Secretary's discretionary authority.

Prospective and retrospective attribution

Another aspect of attribution is whether beneficiaries are attributed prospectively or retrospectively. MSSP has preliminary prospective attribution to give ACOs an idea of which beneficiaries will likely be counted in their population, but for the purpose of calculating shared savings, the attribution is retrospective. That is, they are judged only on the beneficiaries who actually receive the plurality of care from the ACO in the performance year, and that list is updated quarterly. We understand that CMS made this decision for two main reasons: First, CMS perceived it was unfair to make ACOs responsible for beneficiaries who don't actually see them for the plurality of their care; and second, CMS didn't want ACOs to differentiate the way they deliver care based on whether a particular beneficiary is attributed to the ACO or not. While these rationales make sense in concept, according to the ACOs, they caused a lot of uncertainty in practice and have made it difficult for them to track their progress during the performance year.

Another downside to retrospective attribution in the MSSP is that ACOs do not have as strong an incentive to invest the time and effort needed to educate their beneficiaries to avoid unnecessarily intensive treatment. ACOs can instead encourage those beneficiaries to seek care elsewhere because they will then not be retrospectively attributed to the ACO. Beneficiaries who are known to need expensive treatment in a future year that is not likely to be reflected in risk scores (e.g., a beneficiary who will need a knee replacement) could be encouraged to seek care outside the ACO. Because they can gain and lose beneficiaries over the course of the year based on their patterns of use, ACOs may have an incentive to push out more costly beneficiaries. Prospective assignment

would protect against this by requiring ACOs to take responsibility for the beneficiaries who were assigned to them at the beginning of the year, regardless of where they receive their care.

We suggest prospective attribution for MSSP because it is important for ACOs to know which beneficiaries they are accountable for at the start of their participation. Pioneer uses this method; essentially the ACO remains accountable for beneficiaries who are initially attributed to the ACO unless the beneficiary moves out of the area or into an MA plan. We would encourage CMS to move the MSSP to a prospective method because the ACO will know the beneficiaries it is accountable for, and will not have any incentive to send beneficiaries that are known or anticipated to have high future medical expenses to providers who are not in the ACO. This change would be regulatory and could be made by the Secretary. Prospective beneficiary attribution would also allow a different approach to the second concern, setting benchmarks, discussed below.

Improving benchmark calculations

ACOs report that they do not now know with certainty their financial target at the beginning of the year. That is, they are unsure of the benchmark for the calculation of savings or loss. Coupled in the case of the MSSP program with uncertainty about which beneficiaries will be attributed to them, ACOs report this lack of certainty makes it difficult to justify investments in care management and to track their progress through the year. An additional issue is that after the first three-year agreement period, benchmarks are rebased. (That is, the new benchmark for the second three-year period will be based on spending in the first three-year period.) This model may not be sustainable for ACOs that have historically provided relatively efficient care. Changes could be made to the benchmark system to allow for clearer planning on the part of ACOs and to avoid penalizing relatively efficient ACOs.

Setting clear, prospective benchmarks

In the case of the Pioneer demonstration, according to the Pioneer ACOs we have talked with, the original method for setting benchmarks was poorly understood by the ACOs and the source of

much uncertainty. The original method required tracking spending for the individual beneficiaries. A separate decedent adjustment had to be estimated because the population at the beginning of the performance year, by definition, did not include decedents and thus the historical benchmark did not include their end-of-life spending. The calculation of the decedent adjustment was not well understood by the ACOs and became a source of uncertainty. It is our understanding that the Pioneer demonstration is changing the method used to calculate the benchmark to address this issue. It is moving toward the method used by the MSSP in the sense of looking at the cost of the population historically treated by the set of primary care providers in the ACO rather than tracking the set of individual beneficiaries who are attributed to the ACO at the beginning of the performance period. This method is less complex because it eliminates the need for a separate decedent adjustment. The Pioneer demonstration will use the method prospectively to set a budget for the prospectively identified beneficiaries. MSSP uses a similar method but applies it retrospectively. We are encouraged that the new method used to set benchmarks will be more understandable to the ACOs and increase the certainty of the benchmark.

Currently in MSSP, beneficiaries are attributed retrospectively and the benchmark is recalculated for the set of beneficiaries retrospectively attributed to the ACO at the end of the year. Changing to a fully prospective system would create more certainty for the ACOs and allow better planning. (The method used to determine the benchmark and the prospective calculation would become similar to the new method being used in the Pioneer demonstration.) ACOs would have a clearer picture of their financial obligations in advance if they were prospectively (at the start of the performance year) provided with a list of attributed beneficiaries and a prospective benchmark. This change to fully prospective benchmarks could be made in regulation.

Rewarding historically efficient providers

The Pioneer demonstration showed that in some cases even ACOs with historically low levels of spending can reduce the cost of care while maintaining high quality metrics. However, when we interviewed some of these successful ACOs, they were concerned about the sustainability of the ACO model as it now stands. ACO benchmarks are now set for both Pioneer and MSSP assuming

that the ACO should be able to continuously improve over its past performance and grow no more than the average growth in FFS.¹ This formula may not be sustainable over the long term. For example, if ACOs reduce the spending for their attributed beneficiaries in the current ACO cycle, that would lead to a lower benchmark in the next three-year ACO contract cycle.

One way to address the issue of sustainability is to not rebase benchmarks downward in the second agreement period for relatively efficient ACOs that reduce the cost of care in the first ACO contract cycle. For example, ACOs that have relatively low risk-adjusted service use would not have their benchmark reduced in the second cycle if they reduce spending in their first cycle.² In contrast, ACOs that have historically had high levels of risk-adjusted service use would have their benchmark reduced in the second cycle if they improve (as is now true) because they are believed to have more room to continue to improve.

This approach might reduce some of the low-benchmark ACOs' concerns that they are being unfairly treated due to past success in reducing spending. It would also make the ACO program more attractive in low-spending areas than it is now because ACOs in those areas would be more likely to have risk-adjusted service use below the national average. This might have particular significance in low-service-use rural areas.

Simplifying quality measurement and evaluation

A fundamental problem with Medicare's current quality measurement programs, including the one for ACOs, is that they rely heavily on clinical process measures for assessing the quality of care provided by hospitals, physicians, and other types of providers. There are several disadvantages to this type of measure: process measures are often not well correlated to better health outcomes; there are too many measures, which increases complexity for little or no return; and reporting

¹ In the MSSP, the allowed growth rate is the absolute dollar amount of growth in national FFS. In Pioneer it is 50 percent the absolute dollar amount and 50 percent the percentage change in the national amount applied to the ACOs benchmark.

² Relatively low service use could be defined, for example, as below the 40th percentile of FFS markets in the nation.

places a heavy burden on providers and ACOs. In particular, ACOs have told us that non-claims-based process measures are expensive for them to collect, report, and audit. The Commission has been reevaluating quality measurement in the Medicare program (please see the Commission's June 2014 Report to the Congress). Where possible, the Commission would move quality measurement in the direction of a small set of population-based outcome measures (e.g., potentially avoidable admissions for an ACO's population).

Using population-based outcome measures to evaluate and compare quality would be an important step forward; one which the ACO program is in a good position to take. The ACO program has the advantage that there is a defined population for each ACO, unlike the situation in FFS, in which FFS providers have not explicitly agreed to be responsible for a population of beneficiaries. This approach would make it possible to look at outcomes for an ACO's population and compare an ACO's performance to other ACOs, MA plans, and even area-wide FFS performance. The Secretary has statutory authority to set quality performance standards for ACOs and could make these changes.

Move to two-sided risk to strengthen incentives

In both the Pioneer demonstration and the MSSP, CMS has regulatory authority to allow either one-sided risk or to require ACOs to accept two-sided risk. In a shared-savings model, one-sided risk means that an ACO can share in savings it achieves but does not share in any losses. Savings are defined as actual Medicare spending for the defined set of beneficiaries being less than the target spending (i.e., the benchmark); losses as actual spending exceeding the target. The initial decision for the first three-year agreement period was to allow one-sided risk, but CMS signaled that the agency plans to require two-sided risk in an ACO's second agreement period. As ACOs transition to two-sided risk they would ideally also be given more equitable benchmarks and more tools to strengthen beneficiary engagement. For example, new ACOs could still be at one-sided risk as they enter the program, but eventually could be moved to two-sided risk as their benchmarks transition to more equitable benchmarks. ACOs at two-sided risk have a much

stronger incentive to control spending. However, it is not fair to subject historically efficient ACOs to penalties for the same level of performance for which their in-market rivals receive bonuses. We discuss one method for transitioning to more equitable benchmarks below. At the same time, ACOs at two-sided risk could be allowed to use stronger tools to increase beneficiary engagement, as we discuss in the next section.

Currently, ACO benchmarks are calculated based on historical spending. This approach makes sense in the short run, but in the long run (over several agreement periods) a given ACO cannot be expected to lower its spending relative to its historical benchmark indefinitely. Additionally, ACOs in the same market may all have different benchmarks, which could result from their providers having different practice styles. A more equitable way to calculate benchmarks might be to use a risk-adjusted benchmark based on local average FFS spending, similar in principle to how Medicare Advantage (MA) benchmarks are set.³ A benchmark based on local FFS spending would result in all ACOs in a market having the same benchmark before risk adjustment. How ACO benchmarks are set is essential because it affects which ACOs will want to enter and remain in the program.

On the one hand, if benchmarks were set based on the ACO beneficiaries' past experience, as is now the case, it should attract high-cost ACOs into the program. This is because if ACOs are initially high-cost relative to other providers in the county, they have room to improve compared with their own historical benchmark. High-cost ACOs would enter and hope to bring costs down to earn shared savings bonuses. The rationale for using a historically based benchmark is that ACOs could learn to reduce unnecessary services. If this rationale were correct, then FFS spending would decrease in the area (because ACO beneficiaries are 'counted' in FFS). ACOs with historically low

³ We use local FFS spending in this discussion for simplicity, but the benchmark could be set in other ways, such as through competitive bidding or by administrative price setting. As long as there were a single benchmark in the market, the results would be broadly similar in terms of which ACOs would be likely to participate. We would continue to include beneficiaries in ACOs in the calculation of local FFS average spending. Otherwise, the local FFS average could become non-representative if most beneficiaries were in ACOs or MA plans.

costs relative to the local area would be less likely to enter the program because they would have difficulty improving under benchmarks derived from their own beneficiaries' past experience.

On the other hand, if benchmarks were set at the local FFS average, ACOs that were low cost to begin with would be more likely to enter the program. Those ACOs would start with per beneficiary spending below the local FFS average, and thus below the benchmark, which would make it more likely they could achieve savings. The rationale for setting benchmarks at local FFS spending would be to reward low-cost ACOs and expect that they would attract patients and other providers to them over time. This would eventually lower FFS Medicare spending (because ACO beneficiaries remain in FFS).

The transition from ACO-specific, historically-based benchmarks to a common local benchmark would have to be designed carefully to achieve two goals. One goal would be to initially attract high-cost ACOs into the program and have them begin to lower their costs, while transitioning to a common benchmark that would attract low-cost ACOs as well. The second goal would be to maintain a fiscal balance in which bonuses paid to low-cost ACOs that were already treating beneficiaries at below average costs would be more than offset with savings from lower than expected spending in high-cost ACOs and further control of spending growth in the low-cost ACOs.

Transitioning to two-sided risk concurrent with a transition to more equitable benchmarks would result in an ACO program that would attract and retain more efficient ACOs. Combined with more effective tools to further beneficiary engagement, those ACOs would be able to help the Medicare program improve value for itself and its beneficiaries.

Providing regulatory relief for ACOs in two-sided models

Many current Medicare regulations are designed to prevent overuse of services and the resulting increase in Medicare spending. They are a reaction to the incentives built into the FFS system to increase volume of services. If ACOs have two-sided risk, then they will have a strong incentive to

not increase volume. Looked at through this lens, many current regulations could be waived for ACOs at two-sided risk without endangering the Medicare trust funds. They could include regulations relating to:

- Referrals to specific high-quality, low-cost specialist and PAC providers,
- The requirement that beneficiaries have an inpatient stay of at least three days prior to being admitted to a SNF,
- The requirement for beneficiaries to be defined as ‘homebound’ to use home health,
- Relief from Recovery Audit Contractor (RAC) hospital audits for services ordered by an ACO-participating physician for an attributed ACO beneficiary, and
- Relief from certain cost accounting limitations for rural ACO providers.

Waiving or changing these regulations may be in the purview of the Secretary or the HHS-OIG; in some cases they may require changes in statute. If the latter, we would support the Secretary in requesting such changes.

Referrals to high-quality, low-cost providers

As they have started to analyze claims data on their beneficiaries, ACOs are recognizing that certain providers deliver higher-quality and lower-cost care than others. For example, some SNFs have lower rates of readmissions to hospitals than others. ACOs would like to have the ability to recommend high-quality providers with whom they have relationships, rather than presenting all options equally, but it is not clear to them that they have the authority to do so. This is especially true for post-acute care. Where there is wide variation in terms of cost and quality, beneficiaries should retain their choice of whichever PAC provider they would like, but the ACOs providers should have the ability to clearly state which providers they believe are best and why. The ability to do so will enable ACOs to build robust networks across the continuum of care, and thus will help give beneficiaries as much continuity as possible as they move across sites of care. CMS needs to provide clear direction on how preferred providers can be presented to beneficiaries and what represents clear notification of beneficiary choice of providers.

A similar argument can be made for referrals to low-cost, high-quality specialists. Specialists who practice a cost-effective style of care can have a large effect on spending and provide better quality. It should be clear that preferential referrals to such specialists are allowed and can be made while allowing beneficiaries free choice of providers.

Relaxing requirements on use of post-acute care

SNF three-day rule. Medicare will not cover the cost of SNF care for beneficiaries unless it is preceded by a stay in an acute care hospital that lasts at least three days. The Pioneer demonstration has begun to allow Pioneer ACOs to waive this rule. This policy could be extended to all ACOs at two-sided risk.

Requirement to meet homebound definition for home health use. For a home health episode to be paid by Medicare, the beneficiary has to meet the requirements for being defined as home bound. Some ACOs contend that home health care may be appropriate for additional beneficiaries and could result in lower overall costs of care. For example, if a beneficiary is allowed to have home health care visits, that beneficiary may avoid a hospital admission. ACOs have reported that they have done this with some success for their MA patients. ACOs at two-sided risk should have the latitude to make that choice.

Relief from Recovery Audit Contractor (RAC) hospital audits

RAC hospital audits are designed to deter unnecessary hospital admissions. They can be expensive for the hospital and are a source of contention. Because ACOs at two sided risk have a strong incentive to deter unnecessary hospital admissions themselves, RAC audits should not be needed for patients who are attributed to the ACO when admitted on orders of a physician participating in the ACO. The elimination of such audits could encourage hospitals to cooperate and coordinate care with ACOs that do not include the hospital as participants. Once again, ACOs would have to be at risk and beneficiaries would have to be attributed prospectively for this policy to be put in place.

Relief for rural ACO providers

ACOs in rural areas have the potential to help restructure the delivery system in those areas. Many rural areas rely on critical access hospitals (CAHs) to provide access to both emergency and other

care. If local CAHs and other providers were unified within an ACO at two-sided risk, they might have the incentive to rationalize the care provided in the individual CAHs to optimize performance overall. For example, two CAHs that are 10 miles apart, might agree that only one should operate an emergency room and the other should make its EMS system more responsive. The ACO program should seek to encourage such arrangements. For example, it might allow more favorable cost accounting treatment for investments in EMS capability for CAHs that are in ACOs at two-sided risk than is allowed for CAHs that are not in ACOs.

Lower cost sharing and furthering beneficiary engagement

ACOs have told us that they would like to increase attributed beneficiaries' engagement with the ACO. One problem is that there is nothing tangible to attract the beneficiary; from the beneficiary's perspective, the benefits in the ACO are the same as in FFS and their cost sharing is the same. The value of the ACO's efforts to coordinate their care or expedite appointments may not be readily apparent. Indeed, our experience with beneficiary focus groups has shown that few beneficiaries are aware of their providers' participation in an ACO, or what that means for their care. In addition, approaches to furthering beneficiary engagement may be stymied by rules concerning marketing and communication. As the programs evolve, those rules should evolve as well.

Reduced cost sharing

One way of increasing beneficiary identification with the ACO and use of ACO providers would be to provide lower cost sharing when using ACO providers. We have considered in particular eliminating or reducing cost sharing for ACO beneficiaries' visits to primary care providers who are in the ACO and possibly to specialists in the ACO as well. This would both give the beneficiaries a reason to want to be attributed to the ACO and encourage beneficiaries to stay within the ACO network of providers, allowing more effective care management. The cost sharing reduction would be absorbed by the ACO and not change Medicare program payments.⁴

⁴ Because lower cost sharing would not change program spending, it would not change baselines or expenditures calculated for shared savings calculations either.

The interim final rule *Medicare Program: Final Waivers in connection with the shared savings program* does not waive the beneficiary inducement section of the CMP for this purpose.

“The waiver will protect incentives that are in-kind items or services, but not financial incentives, such as waiving or reducing patient cost sharing amounts (that is, copayment or deductible), which we believe are prone to greater abuse.” (Federal Register Vol. 76, No. 212 p. 68007.)

For an ACO in a two-sided risk model, it is not clear why this would be a source of ‘greater abuse.’ The ACO has an incentive to not encourage excessive use of services, and the waiver would be limited to ACO patients seeing ACO providers. This limitation is only possible if there were prospective beneficiary attribution as we have discussed earlier. The greater patient engagement with ACO providers could contribute to improved care management and make attribution more meaningful. ACOs at two-sided risk should be allowed to waive cost sharing under these circumstances.

Furthering beneficiary engagement

More broadly, many ACOs have expressed their frustration as to what they can and cannot do to educate beneficiaries. In order to achieve savings, many ACOs argue that they must engage with their beneficiaries and convince them to stay within the ACO network of providers so that they can have some management of utilization. However, because beneficiary choice is preserved, ACOs cannot simply prohibit beneficiaries from going to low-quality or high-cost providers. (In contrast, MA plans do have the authority to limit beneficiaries to a specified network of providers.) ACOs must convince their beneficiaries of the benefit of their care being coordinated and managed by the ACO.

The ACOs that we spoke with feel they are limited in the ways they are currently permitted to reach out to their beneficiaries. In traditional fee-for-service, inducements and marketing must be tightly regulated because providers have an incentive to increase the volume of services they provide in order to increase their revenue. ACOs should not want to increase the volume of services provided because their goal is to share in savings. Particularly in the two-sided risk model,

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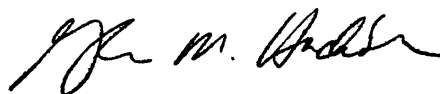
ACOs have an incentive to constrain costs, and a disincentive to inflate them. Current guidance was developed while most ACOs were in a one-sided model. As more ACOs move into two-sided risk arrangements, guidance should be rethought with that fact in mind. In addition, CMS should continue to develop a clear and responsive process for reviewing marketing materials. There should be a single location for ACOs to go to for approval and a set time for a definitive decision.

Conclusion

ACOs represent an opportunity to transform the delivery system, but realizing that opportunity will require providers to change their practices and take a risk on a novel payment system, and CMS to be flexible and responsive as the program evolves. MedPAC appreciates your consideration of these policy issues. Incorporating lessons learned from the first performance years of the ACOs in regulations and pursuing statutory changes when required, although difficult, will be necessary for ACOs to succeed. The Commission values the ongoing cooperation and collaboration between CMS and MedPAC staff on technical policy issues. We look forward to continuing this productive relationship.

If you have any questions, or require clarification of these issues, please feel free to contact Mark Miller, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

A handwritten signature in black ink, appearing to read "Glenn M. Hackbarth". The signature is fluid and cursive, written in a professional style.

Glenn M. Hackbarth, J.D.

Chairman