Consumer-Purchaser
ALLIANCE
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February 6, 2015

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore MD, 21244

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

Dear Administrator Tavenner:

The 13 undersigned organizations are from a collaboration of leading consumer, labor, and purchaser organizations committed to improving quality and affordability of health care through the use of performance information to inform consumer choice, payment, and quality improvement. We appreciate the opportunity to comment on the Medicare Shared Savings Program: Accountable Care Organizations proposed rule.

The Accountable Care Organization (ACO) is a new model of delivering and paying for care that is gaining significant traction in the marketplace. The belief is that ACOs, if done "right," can improve both quality and cost of care through better coordination and collaboration driven by shared financial accountability for a defined patient population. Spurred by the Affordable Care Act's establishment of ACO programs, the number of ACOs has catapulted to over 600 in 2014. Some recent evidence indicates that Medicare ACOs can provide higher quality care at a lower cost, yet not all are successful. Whether it's because the private sector allows more flexibility or more is financially at risk, it has exhibited better results in reducing cost and waste in the system. Much can be learned from all ACOs in developing requirements for the next iteration of Medicare ACOs.

CMS plays an integral role in both the proliferation and design of ACOs. We applaud the agency's leadership in this area and ask for continued strong leadership; now is not the time to slow momentum in driving quality improvement, care coordination, and cost savings. Below, we provide comments on areas that are particularly important to us and include an Appendix with more detailed comments and recommendations.

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Payment that Drives Care Delivery Transformation

In order for ACOs to achieve the full potential of better and more affordable care, they need to move away from fee-for-service payments. This includes making a transition to payments that involve the assumption of greater financial risk – two-sided risk, partial capitation, or full capitation. The Medicare Shared Savings Program (MSSP) is structured in a way that allows for gradual acceptance of financial risk by offering a no-risk option where ACOs can share in savings but are not responsible for losses. Over 98% of ACOs participating in MSSP choose the no-risk option. While it is important to ensure providers can take on risk, the downside of this approach is that beneficiaries have to wait much longer to experience better care. CMS should place greater weight on the benefits to beneficiaries by making risk-bearing contracts more attractive to ACOs to spur innovations and improvements with greater alacrity. CMS can do this by additional safeguards for smaller ACOs taking on risks, greater flexibility in beneficiary assignment options, and regulatory relief.

Care that Supports Patient Engagement

While providers are ultimately accountable for the cost and quality of care delivered within an ACO, individuals can and should play a critical role in improving their own health and helping organizations succeed. Partnering with individuals on a variety of levels – individual care, organizational effectiveness, and policy – holds the potential to better meet their needs by designing care with and for them. CMS should strengthen their requirements for patient engagement in governance, allow beneficiary choice of ACO participation to trump claims-based assignment, and support better outreach and education efforts.

Quality Measures that Drive Meaningful Accountability and Improvement

Performance measurement is integral to improving care delivery as well as evaluating success. Having a robust and parsimonious dashboard of measures is integral in meeting the *Triple Aim*. CMS finalized the measures for MSSP last November through the Physician Fee Schedule. We strongly believe the measure set should focus on outcome measures, both clinical and person-reported, and measures that address care coordination; we greatly appreciate continued movement in that direction. However, we are concerned that there remains an overreliance on process measures in the set.

Public-Private Alignment that Spreads Overall System Transformation

Designing ACOs with the private sector in mind is paramount to both the program's success and to achieving overall system transformation. Given that beneficiaries attributed to a Medicare ACO represent a fraction of the total population served by a single provider organization, it is prudent for ACOs to increase the number of contracts to create more aligned value-based care across the system. Increasing the percentage of individuals being served by value-based contracts will allow the ACO to more easily transform care across the system, rather than selectively targeting interventions to just those patients attributed by Medicare. CMS can support alignment by creating efficiencies between Medicare and private sector ACO requirements and extending the Pioneer ACO

requirement of contracting with other payers. Multi-payer ACOs benefit everyone – patients, providers, and purchasers.

On behalf of the millions of Americans represented by the undersigned organizations, thank you for your efforts to improve the quality and affordability of care. As you seek to transform Medicare, now more than ever, the changes made will have an impact on costs and quality in the private sector. We look forward to partnering with you on transforming the health care system. If you have any questions, please contact either of the Consumer-Purchaser Alliance's co-chairs, William Kramer, Executive Director for National Health Policy for Pacific Business Group on Health or Debra L. Ness, President of the National Partnership for Women & Families.

Sincerely,

The Alliance
American Association on Health and Disability
Buying Value
Consumers' CHECKBOOK/Center for the Study of Services
Health Policy Corporation of Iowa
Iowa Health Buyer's Alliance
Lehigh Valley Business Coalition on Healthcare
Maine Health Management Coalition
Medicare Rights Center
National Partnership for Women and Families
Pacific Business Group on Health
St. Louis Area Business Health Coalition
Virginia Business Coalition on Health

Appendix

The following are comments from a combined consumer, labor, and purchaser perspective on issues and questions raised in the Medicare Shared Savings Proposed Rule. We appreciate your receptiveness to our comments and look forward to providing further input when needed.

Composition of Governing Body

Continuing with current practice, and in keeping with law, the proposed rule requires ACOs to include a Medicare beneficiary on the governing body. The proposed rule also maintains the flexibility for ACOs to request alternative ways to provide meaningful representation of Medicare beneficiaries. We strongly support requiring consumer/beneficiary involvement in governance. We urge CMS to strengthen consumer/beneficiary participation and increase non-ACO participant representation by requiring a multi-stakeholder board that engages key community representatives. We recommend including more patients, consumer advocates, employers, labor organizations, and other community organizations so there is more representation among the members of the ACO governing body. Successful ACOs in the private sector have a more balanced governance structure. Support for meaningful participation should be provided to community representatives (e.g., mentorship, processes that facilitate their active participation). As part of the application process, CMS should require ACOs to provide evidence that the governing body is diverse and includes key stakeholders in the community. Stakeholders selected to participate on the governing body must not have a conflict of interest with the ACO or have an immediate family member with conflict of interest with the ACO. CMS should provide guidance on what constitutes conflict of interest (e.g., those with a vested interest in the ACO, those who work or have worked as medical providers). In general, while we understand the legal constraints some ACOs face in states with Corporate Practice of Medicine laws, it is important that ACOs implementing alternative approaches to engaging community representatives ensure a strong link and process for regular communication with the governing body. Otherwise, there is risk that the community voice will be marginalized.

Accelerating Health IT

The rule proposes to add a new requirement of describing in its application how an ACO will encourage and promote the use of enabling technologies for improving care coordination for beneficiaries. Specifically, CMS proposes that MSSP applicants include plans for making health information electronically available to all practitioners involved in beneficiary care. The plan should include major milestones or performance targets the ACO will use in each performance year to assess progress towards implementing elements of the Health IT Acceleration plan.

We strongly support the new requirement for applicants to describe their plan to promote use of health IT and identify performance targets for assessing progress. We encourage CMS to explicitly require ACOs to include in their plans proposals for giving beneficiaries electronic access to their health information (in a way that is aligned with the

"View/Download/Transmit" criteria in Meaningful Use – at least among providers that are eligible for MU) and including person-generated data. Moreover, we recommend that CMS require health IT-enabled monitoring of performance on person-reported outcomes.

ACO Model Options

The Medicare ACO models are structured in a way that allows for gradual acceptance of financial risk. The current MSSP model includes two tracks. Track 1 is a shared savings model and ACOs are not responsible for any loss. Currently, Track 1 ACOs are required to transition to Track 2 for continued participation. Track 2 is a two-sided risk model where ACOs have the potential to earn more savings, but also must take on risk for sharing in losses. Additionally, the Pioneer program is a two-sided risk model that requires a population-based payment in the third and final year of the contract.

CMS proposes to relax the requirement that Track 1 ACOs move to two-sided risk in the second contract by allowing qualified MSSP participants to remain in Track 1 shared savings for an additional 3 years (for a total of 6 years) to gain more experience before moving to two-sided risk. After the 6 years, ACOs can choose to participate in two-sided risk or return to traditional fee-for-service payment. In an effort to make accepting financial risk more attractive, CMS proposes to adjust Track 2 to reduce the level of risk that Track 2 ACOs must accept. The proposed rule also creates an additional track (Track 3) option for ACOs that want to assume increased levels of two-sided financial risk.

- We strongly support the addition of Track 3 to allow greater flexibility in ACO participation. We believe this will also help beneficiaries realize the benefits of better care faster. As we've seen in the private sector, many ACOs have been successful at taking on two-sided risk.
- While we understand the desire to allow repeating Track 1, we recommend CMS continue to explore additional ways to provide Track 1 ACOs with a glide path to two-sided risk and articulate a defined point at which Track 1 ACOs must move into Track 2 or 3.
- We strongly support providing additional protections for beneficiaries (such as criteria to prevent avoidance of high risk individuals) and safeguards for ACOs that take on two-sided risk, particularly smaller ACOs.
- We strongly support making two-sided risk more attractive to ACO participants, such as waivers mentioned in the proposed rule.

Assignment of Beneficiaries

Currently, there is a step-wise assignment process to determine whether beneficiaries are assigned to an ACO. In the first stage, primary care visits to primary care physicians are counted. If there are no such visits, a second stage 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.

Assignment Option for Models

Currently, Tracks 1 and 2 use retrospective beneficiary assignment. The Pioneer program uses prospective beneficiary assignment. CMS is proposing that Tracks 1 and 2 remain retrospective and Track 3 use prospective beneficiary assignment (as a way to make more risk attractive). We support greater flexibility in the program by allowing ACOs to choose either retrospective or prospective beneficiary assignment regardless of financial track to encourage ACOs to take on more risk and support their preferred mechanism for patient alignment.

Voluntary Beneficiary Alignment

Currently, beneficiary assignment is claims -based and beneficiaries do not choose voluntary alignment with an ACO. Voluntary alignment is being piloted in the Pioneer program. The proposed rule seeks comments on whether or not it would be appropriate to offer voluntary alignment for MSSP ACOs participating in two-sided risk financial arrangements.

We support allowing beneficiaries to actively choose assignment and remain attributed despite billing patterns. However, before beneficiaries can be expected to elect into their chosen primary care provider's ACO, they should have access to materials that help them understand the ACO, how this new model of care functions, and what alignment means to them (including access to care inside and outside the ACO). Such an outreach and education effort will require CMS, ACOs, and providers to take a more rigorous and focused approach to educating beneficiaries and communicating with them. Alternatively, we believe non-attribution to ACOs should be allowed for patients who opt out of data sharing (regardless of voluntary or claims-based assignment).

Definition of Primary Care Professionals

CMS proposes to expand the definition of primary care providers in step 1 to include nurse practitioners, physician assistants, and clinical nurse specialists. In step 2, CMS proposes to exclude specific specialty providers whose services are not likely to be indicative of primary care services (e.g., surgeons, radiologists). Internal medicine subspecialties of nephrology, oncology, rheumatology, endocrinology, pulmonology, and cardiology are proposed for inclusion in step 2.

We support CMS's continued efforts to strengthen primary care. We support including nurse practitioners, physician assistants, and clinical nurse specialists as primary care providers. We recognize the important role non-physician primary care providers play in providing better care. We also support including internal medicine providers with subspecialties in nephrology, oncology, rheumatology, endocrinology, pulmonology, and cardiology as we know these providers play an important role in providing coordinated care for people with chronic conditions.

Assignment to ACOs that include FQHCs and RHCs

Currently, federally qualified health centers (FQHC) and rural health clinics (RHC) participate in the Shared Savings Program by becoming an ACO, or by joining an ACO as an ACO participant along with other organizations. The proposed rule offers changes aimed at improving the assignment procedures for FQHCs and RHCs to better identify primary

care providers and services for the purpose of assignment, acknowledging the important role that nurse practitioners, physician assistants, and other non-physician providers play in FQHCs and RHCs. We strongly support continued inclusion of FQHCs and RHCs in ACOs. Of the nearly 19 million medically underserved individuals served by federally qualified health centers nearly 1.4 million are Medicare beneficiaries. Many of these beneficiaries live with multiple chronic conditions and could significantly benefit from improved access to primary care services and better care coordination. We also support the inclusion of non-physician primary care providers in the assignment process. Medically underserved communities (both urban and rural) depend heavily on a full range of primary care professionals.

Alternative Benchmark Methodology

CMS is seeking feedback on alternatives to the current benchmark methodology. While historically efficient ACOs can still reduce spending, as seen in the Pioneer program, in the long term this is not sustainable. The benchmark methodology needs to take into account how efficient ACOs are when entering the program and maintaining participation in subsequent contracts. Conversely, extremely inefficient ACOs should be encouraged to participate in MSSP by not having such unattainable benchmarks. This inevitably means that ACOs will not always be held to the same benchmark standard.

Public Reporting

Public reporting is required for certain information regarding the operations of the ACO. This includes information on: 1) providers and suppliers participating in ACOs; 2) parties sharing in the governance; 3) shared savings distribution; and 4) quality performance scores.

We recommend that CMS augment the information on shared savings by requiring ACOs to publicly report cost information. ACOs should publicly report Medicare total costs for beneficiaries assigned to the ACO and total costs for the commercially insured receiving care in the ACO. ACOs should also publicly disclose their prices for routine procedures for Medicare and an average price (blended fee schedules) for commercial payers. This information will provide insight on whether or not an ACO is meeting the savings targets by increasing prices in the commercial market.

The amount of transparency on quality performance in the proposed rule is minimal and problematic, especially if reporting is only at the ACO level. This moves us steps backwards from the individual provider-level and provider group-level reporting currently happening in public and private sectors. Other provisions in the ACA require provider-level reporting and we think that was the intended spirit of the law for ACOs as well. Therefore, CMS should require both provider-level and ACO-level reporting. It is not sufficient for measurement and reporting to take place at the ACO-level alone. Research has shown that much of the variation occurs at the individual provider level, not the practice site, group, or health system level. Reporting at an aggregate level does not motivate individual providers to make changes. Moreover, for a program to be truly person-centered, it must give consumers information at the individual provider level. To not do so is misleading given all the variation in quality that will be present in ACOs.