



**American Hospital
Association**

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Patrick Conway, M.D.
Acting Director of the Innovation Center
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445-G
Washington, DC 20201

Re: Evolution of ACO initiatives at CMS

Dear Dr. Conway:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) would like to take the opportunity to comment on the evolution of accountable care organization (ACO) initiatives at the Centers for Medicare & Medicaid Services (CMS). The agency indicates that it is gathering input on policy considerations for the next generation of CMS ACO initiatives. Specifically, it is interested in: (1) approaches for increasing participation in the current Pioneer ACO Model through a second round of applications; and/or (2) suggestions for new ACO models that encourage greater care integration and financial accountability.

Hospital and health system leaders are committed to improving health and health care while becoming more efficient in the delivery of services. Many hospitals and health systems are transforming care delivery to provide more “accountable care” through greater care integration and financial accountability. While our members are committed to the concept of accountable care – and many are pursuing public and private models – we continue to have significant concerns about the design of the current Pioneer ACO Model and the Medicare Shared Savings Program (MSSP).

The Pioneer ACO and MSSP programs place too much risk and burden on providers with too little opportunity for reward in the form of shared savings. In order to increase participation in the current ACO programs, we recommend the following changes:

- **improve the timeliness and accuracy of performance data;**
- **extend the Track 1 agreement period;**
- **set a standard minimum savings rate of no more than 2 percent, regardless of the number of attributed beneficiaries;**



- **create more achievable financial thresholds in the early years;**
- **implement technical adjustments to the benchmark to account for policy changes outside the control of provider;**
- **allow beneficiaries to “opt in” to the ACO programs;**
- **allow ACOs to vary beneficiary cost sharing; and**
- **simplify and align quality measures, and set the required thresholds prior to the performance year.**

SECTION 1: ADDITIONAL APPLICANTS TO THE PIONEER ACO MODEL AND FEEDBACK ON CURRENT MODEL DESIGN PARAMETERS

The AHA believes that very few – if any – additional health care organizations will apply to participate in the Pioneer ACO Model as currently constructed. The Pioneer program started three years ago with 32 participants. For various reasons, a number have exited the program so that only 23 Pioneer ACOs remain. While we support allowing a second round of applications to the program, we believe that several refinements will need to be made to make it more attractive to potential participants and operationally viable. To increase potential participation in the program, we urge CMS to adopt the changes delineated below in the MSSP section related to performance data, patient attribution and quality metrics.

In general, we encourage CMS to allow for multiple “paths” toward more accountable care. Health care providers are in very different place in terms of their ability to coordinate care and manage financial risk. In general, we support developing various options for provider participation. This might include partial capitation for certain services (such as Medicare Parts A or B) or partial capitation for certain beneficiaries (such as those with multiple chronic conditions). Additionally, full capitation is important for those providers with the capability and desire to move toward full financial risk for a population. Providers need options along a spectrum so that they can move away from fee-for-service (FFS) toward managing the health of a population. However, CMS must move forward judiciously to ensure it has the staff and resources necessary to support and analyze various options.

Specifically, more flexibility should be allowed to help Pioneer ACOs to transition to population-based payments (PBPs). Those in the first two years of the Pioneer ACO Model participate in a shared savings payment arrangement. Starting in year three, organizations that have earned shared shavings over the first two years are eligible to move to a PBP arrangement and full-risk arrangements that can continue through optional years four and five.

Eligible Pioneer ACOs may elect to receive PBPs that represent a selected percentage of either their expected Medicare Parts A and B FFS revenues or their expected Part B FFS revenues. In turn, these ACOs will receive these PBPs, as well as FFS payments for services furnished to aligned beneficiaries that are reduced by the same selected percentage, which will serve to offset the PBPs. However, given the vast differences

between the services provided under Parts A and B, we urge CMS to allow ACOs to select different percentages for Part A and Part B services, which, under the current policy, is not allowed. In addition, providers who are still developing a workable financial and operational infrastructure may prefer a lower level of population-based payments – such as 10 or 15 percent. Others, who have more experience in accountable care, may find it easier to have a larger portion of their revenue be population based – such as 80 or 85 percent. Allowing wide flexibility may help increase interest in the Pioneer ACO model, and move more Pioneer’s towards population-based payments.

In all cases, however, we urge CMS *not* to require that Pioneer ACOs establish significant financial reserves. Providers may prefer to reinvest earnings in care delivery and infrastructure to improve care coordination and patient outcomes. Rather, we support CMS requiring that Pioneer ACOs generate a certain level of savings in the previous year to be eligible to elect population-based or full-risk payment.

SECTION II: EVOLUTION OF THE ACO MODEL

Similar to the Pioneer ACO Model, we believe that significant changes must be made to the MSSP in order to encourage greater – and sustained – participation.

Data Accuracy and Timeliness. **The timeliness and accuracy of claims data from CMS has been a major challenge to the success of the ACO program.** ACO providers not only need to know which Medicare beneficiaries are attributed to the ACO (see below) but also their utilization patterns in order to improve the quality and cost of their care. CMS has put in place extremely complicated and onerous provisions in order for ACOs to receive beneficiary-level data for their assigned population. In addition, the agency permits beneficiaries to “opt-out” of allowing their data to be shared with the ACOs.

Our ACO participating hospitals have stressed that the data provided are inadequate, incomplete and often erroneous. Moreover, the data are often six to nine months delayed. It is critical for an ACO to know its aligned beneficiaries on a *monthly, not quarterly*, basis. This is necessary to measure and track beneficiary utilization, as well as quality and financial indicators. Coordinating patient care needs to be done in *real time*, not retrospectively. Moreover, access to timely Medicare claims data is necessary to obtain a complete picture of the care received by the beneficiary inside *and outside* of the ACO. Additionally, the inclusion of claims data related to behavioral health services would allow for better care coordination and management of high risk patients.

Shared Savings Determination. **CMS’s overall risk versus reward equation continues to tilt too much toward risk and too little toward reward.**

In January, CMS announced first-year results of the ACOs in the MSSP. Interim financial results for the 114 ACOs that began work in 2012 show \$128 million in savings for the Medicare program. However, only 29 of the 114 MSSP ACOs lowered expenditures enough to share in program savings. And two of these ACOs were excluded from shared savings because they failed to “successfully report” quality

measures. Thus, just less than a quarter of MSSP ACOs (27) were able to qualify for shared savings in the first year of the program.

Providers have invested significant time, energy and resources to develop the clinical and operational infrastructures necessary to better manage patient care. The number one way to increase participation in ACO programs is to modify the shared savings determination to ensure that more ACOs are able to receive a bonus – and a larger bonus – so that they can continue to invest in the program. Suggestions include:

- **Extend the Track 1 agreement period to six years.** Currently under the MSSP, ACO participants could choose to participate in one of two tracks. Track 1 is a “one-sided” model, which has no downside risk for participants. It was designed for less experienced ACOs and allows these organizations to share in the savings but not in the losses. Track 2 is a “two-sided model” in which participants share in both the savings and the losses. According to CMS, as of March 2013, almost all MSSP participants (98 percent) were participating in Track 1. However, Track 1 is currently available only for the first three-year agreement period.

As the first three-year agreement period comes to an end, we urge CMS to extend the Track 1 option for another three years. It takes several years to put in place the clinical and financial infrastructure necessary to transform care delivery. The ACO program needs to provide ample time for the less-experienced participants to fully organize themselves into an effective ACO structure. ACO participants should be allowed to continue under Track 1 for another three years, or as long as progress is being made. If necessary, CMS could require adoption of down-side risk in the sixth year of the agreement.

- **Hold all MSSP ACOs accountable to a standard minimum savings rate (MSR) of no more than 2 percent, regardless of the number of attributed beneficiaries.** In talking with our small and rural members who are participating in the ACO program, they feel that they are disadvantaged by being held to a MSR of 3.9 percent when their larger colleagues have a MSR of 2.0 percent. This policy provides a strong disincentive for small and rural entities to participate in the ACO program, as they need to achieve almost twice the amount of savings as their larger colleagues in order to receive a shared savings bonus. If CMS is interested in encouraging participation of small and/or rural ACOs, it should set a maximum 2 percent MSR for all organizations.
- **Create a more achievable financial threshold in the early years, even if it means setting a more difficult threshold in later years.** ACOs require significant capital and upfront investments in their care coordination infrastructure. We appreciate that CMS created the Advance Payment Model whereby certain ACO participants receive upfront and monthly payments. Yet there are only 35 ACOs participating in this model. Many more small ACOs have limited ability to obtain the capital required to participate in the shared savings program. CMS estimated it would cost approximately \$1.8 million to form an ACO and operate in the first year. AHA’s analysis, performed by McManis Consulting, estimated that these costs are much

higher – \$11.6 million for a small ACO and \$26.1 million for a medium ACO. Given the substantial costs to move toward accountable care, we urge CMS to alter the shared savings formula to allow providers to achieve a larger bonus. This could be done, for example, by lowering the MSR to 1 percent, or raising the minimum sharing rate to 80 percent, or altering the quality policies to result in bonus payments rather than penalties.

- **Implement technical adjustments to the benchmark to account for policy changes that are outside of the control of providers.** We continue to urge CMS to standardize both the benchmark and performance year expenditures for all policy adjustments so that they reflect only actual resource utilization. This includes: indirect medical education (IME), disproportionate share hospital (DSH), area wage index (AWI), geographic practice cost index adjustments, hospital value-based purchasing and meaningful use payments. Changes in these adjustments are often beyond the control of individual providers, are highly volatile from year-to-year and are subject to substantial uncertainty in today's political environment. For example, the president's fiscal year 2015 budget calls for cutting IME payments by 10 percent. If Congress adopted this provision, those ACOs with teaching hospitals would see a significant decline in their total Medicare expenditures. Thus, they would potentially be eligible for a shared savings bonus when they did little to become more efficient. Similarly, a hospital could have a significant gain or loss to their AWI due to, for example, a geographic reclassification decision or change in the rural floor. This could cause an ACO to either earn or lose a bonus payment, not because of its own actions, but because of policy or market factors outside of its control. To encourage greater participation in ACOs, CMS should standardize expenditures to account for policy adjustments.

Patient Attribution and Beneficiary Engagement. **Hospital and health system leaders are frustrated that they do not know which Medicare beneficiaries are attributed to the ACO program, and that they have little ability to influence where these patients receive their care.** To take responsibility for the health of a population, it is essential to understand the population for which the ACO is accountable. Providers cannot do this unless they know, in real time, which beneficiaries they are responsible for managing. While CMS assigns patients on a preliminary prospective basis based on historical claims, and provides quarterly updates, the true assignment of patients is determined after year-end based on a retrospective analysis. Some providers have seen shifts in their ACO population by as much as 30 percent. Providers cannot effectively identify high-risk individuals, develop specific outreach programs, and proactively work with patients and their families to establish care plans unless they can pinpoint their assigned population upfront.

The AHA recommends that CMS implement a voluntary sign up process whereby Medicare beneficiaries can choose to receive their care from an ACO. This would provide clarity as to the Medicare beneficiaries for which the ACO is responsible. It also creates a deliberate process whereby beneficiaries actively choose to participate in the philosophy and intent of the ACO care delivery model. Patients will better understand that their care will be coordinated among a group of hospitals, physicians, nurses and

other providers that will work together to provide high-quality care. This simple act of choosing would help engage patients in their health and health care.

Additionally, we recommend that beneficiary cost sharing be modified to incentivize the use of high-value care provided by the ACO. We acknowledge by law that Medicare beneficiaries in the ACO program may receive care from any Medicare provider, including those not affiliated with the ACO. This is a challenge for providers, who are held fully responsible for the cost and quality of the beneficiary's total care, which they cannot control. We urge CMS to create some financial incentive on the part of the beneficiary to choose to stay "in network" so that their care can be coordinated. This could be done through varied cost-sharing. For example, CMS could allow those beneficiaries that choose to have their care delivered by an ACO to have little or no co-pays or deductibles when they obtain services from ACO providers. Alternatively, beneficiaries could be asked to pay more if they receive care from non-ACO providers.

Quality Measures. **The complicated quality metrics and thresholds are a deterrent to joining the ACO programs,** especially given that ACOs that do not meet quality performance standards in year two and beyond will not be eligible for shared savings, regardless of whether they reduced expenditures below their benchmarks.

We urge CMS to determine and set quality benchmarks prior to the beginning of the performance year, so that ACOs will know what thresholds they will be required to meet. Given that an ACO's full shared savings bonus requires that providers meet certain quality targets, we urge CMS to ensure that these targets are set well in advance. In addition, the agency should be transparent in its development of the benchmarks, and ensure that the results are replicable by providers.

CMS should align the ACO quality metrics with those reported for other programs. While we appreciate CMS decreasing the number of measures reported from 65 to 33, we continue to have concerns that the metrics chosen do not effectively reward high-quality care nor appropriately measure care improvement across a population and over time. We urge CMS to align the ACO quality measures with those reported under more developed programs such as HEDIS, the Medicare Star Program.

An ACO's quality score should be used to award additional shared savings, rather than as a means to reduce the shared savings amount. Currently, the program is structured such that an ACO's quality score can only reduce the ACO sharing rate. Given ACOs must meet minimum quality standards and thresholds in order to receive any shared bonus, we urge CMS to reward those ACO providers that exceed certain threshold levels. The more potential there is to earn a shared savings bonus, the more attractive the program will become to prospective participants.

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The ACO model is a good step forward towards transforming our delivery system, but its current structure is not sustainable given diminishing returns for providers. We look forward to continued discussions on improvements and modifications to the ACO programs. If you have any questions, please contact me or Ashley Thompson, vice president and deputy director of policy, at (202) 626-2688 or athompson@aha.org.

Sincerely,

/s/

Linda E. Fishman

Senior Vice President, Public Policy Analysis and Development