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February 14, 2011

Donald M. Berwick, M.D.
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Additional Input regarding Accountable Care Organizations (ACOs) and the Medicare Shared Saving Program

Dear Dr. Berwick:

The Pacific Business Group on Health (PBGH) appreciates the opportunity to offer additional comments in advance of the proposed regulations regarding Accountable Care Organizations (ACOs) and the Medicare Shared Saving Program. PBGH is a business coalition of 50 purchasers that seeks to improve the quality and availability of health care while moderating cost. Since 1989, PBGH has played a leading role both nationally and statewide in health care measurement, trend moderation, and provider accountability through public reporting.

We believe that ACOs have a significant potential to advance the "Triple Aim" of improving health care for individuals, the health of the general population, and affordability through the redesign of the health care delivery system, promotion of provider accountability and acceleration of payment reform. At the same time, we are concerned about the potential for adverse consequences resulting from the rapid development of ACOs that may offset the intended benefits. In particular, we have three areas of concern:

- The development of ACOs may lead to *increased market power* on the part of increasingly consolidated hospitals and physician groups, resulting in higher costs.
- Unless ACOs are required to operate with a high degree of *transparency*, they will not be adequately accountable to public and private sector purchasers and the general public.
- The development of the ACO and shared savings program within Medicare may lead to *higher prices for private sector* purchasers and consumers.

There is a tremendous opportunity to align the forthcoming ACO regulations with other legislation and Affordable Care Act implementation processes, such as the "meaningful use" requirements in HITECH. Furthermore, to maximize adoption and dissemination, alignment of public and private sector initiatives is critical to provider engagement. We offer a more detailed explanation of these issues and a set of recommendations to address our concerns.

Market Power

Accountable Care Organizations offer the potential to address the problem of limited integration of providers and inconsistent coordination of care for patients. There are many benefits of improving integration and coordination, but there are potential adverse effects. If the creation of

an ACO in a particular community results in significant market power for the new entity, it creates the potential for pricing above competitive levels. Recent trends in hospital consolidation and purchase of physician practices have increased our concern in the current environment. ACOs should not be allowed to achieve the scale or market dominance that would permit price-setting or other anti-competitive behavior.

Recommendations:

- Given that the goal of the new program is to promote "high quality and efficient service delivery" (Sec. 3022), the proposed regulations should explicitly state that the creation of an ACO should not increase the market power of affiliated hospitals and physicians, which has the potential to increase costs to purchasers and the community;
- The Federal Trade Commission and Department of Justice should conduct an expedited review of proposed ACOs prior to participation in program in order to identify potential market concentration issues;
- In reviewing applications for ACOs, CMS should gather data regarding current market shares, market entries and exits and pricing trends. This information should be collected initially to establish a baseline, and it should be gathered on an ongoing basis to monitor and report on potentially adverse market impacts of ACOs;
- As a condition of participation, ACO applicants should be prohibited from establishing new exclusive arrangements with affiliated providers for purposes of contracting with insurers and other purchasers; and,
- Safe harbors from anti-trust regulations should be provided very carefully, following a explicit and exacting set of criteria for awarding (and terminating) a safe harbor. Criteria for safe harbors should include:
    - adherence to a rigorous application process (for example, ACO applicants should submit a plan that details their strategy to hold down costs) and requirements for ACOs to demonstrate regularly that they continue to meet the criteria;
    - availability of the ACO to private sector insurers and purchases, not just Medicare;
    - prohibition on "gag rules" or non-disclosure provisions in provider contracts that preclude community-level quality and efficiency measurement, consumer access to information and comparative performance reporting;
    - commitment to staying within a target rate of growth below historical trends;
    - participation in public and/or privately organized collaborative reporting efforts to support the availability of consumer information;
    - prohibition of contractual terms that limit health plans from differentiating providers based on quality and cost (unit price, efficiency and/or resource management); and,
    - requirement for public reporting of performance data.

Transparency

Disclosure of clinical performance at a level that is meaningful to consumers and transparency of financial arrangements are critical to performance accountability. Organizations should report publicly dashboard measures at multiple levels, including individual physician and/or facility site and service line. Plan and provider participation in collaborative measurement and reporting performance at the level that matters for individual decision making is essential to helping consumers access the right care at the right price based on their needs.

ACOs must be outcomes-focused by using metrics that hold providers accountable for evidence-based care that improves health outcomes and reward results. ACOs must use a robust measurement dashboard that: 1) is outcomes-focused and patient-centered, 2) leverages quality reporting from clinical registries and electronic health records and 3) is not limited to present day measures of structure and process. ACOs should set minimum benchmarks that providers must meet in order to qualify for bonus payments. ACO performance measures must be relevant for patients, and include cost and patient-experience.

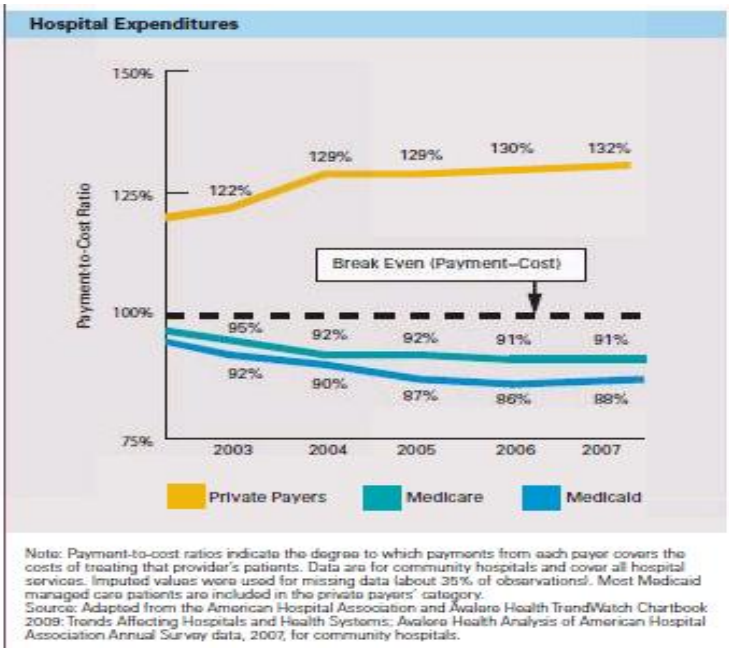
Recommendations:

- In order to support a competitive marketplace and operate in a transparent way, ACOs must make information regarding provider financial arrangements available to the public. Participating organizations in the Medicare Shared Saving Program should be required to report administrative expenses and Medical Loss Ratios consistent with the guidelines released by the National Association of Insurance Commissioners and incorporated as the Interim Final Rule (OCIIO-9998-IFC). Disclosure of administrative expenses should extend to the financial results of an entity and/or holding company that owns more than a 20 percent interest in the ACO;
- To qualify for bonus payments, ACOs should be required to demonstrate that at least 80 percent of its providers, including subcontractors and ancillary providers, meet the in-force Stage 2 and 3 Meaningful Use criteria.
- To qualify for bonus payments, ACOs should be required to report publicly dashboard measures at multiple levels, including individual physician and/or facility site and service line. The metrics should include benchmarks and performance thresholds in <u>*each*</u> of the following categories:
    - Clinical outcomes,
    - Functional status,
    - Appropriateness,
    - Patient experience,
    - Care coordination and care transitions,
    - Cost, and
    - Resource use.

<u>Cost Shift to Private Sector</u>

Cost-shift to private payers due to shortfalls in public spending has been a longstanding concern for large purchasers, as depicted in the chart below on Hospital Payment-to-Cost Ratios for Medicare, Medicaid and Private Payers. If a major goal in health care reform is for current beneficiaries of employer-sponsored coverage to retain access to affordable health care options, care must be taken to assure that trend moderation achieved through the Medicare Shared Saving Program does not result in cost-shift to private payers. Many studies have shown that increased out-of-pocket costs for medical services have contributed significantly to consumer household debt and that such costs often deter patients from accessing routine diagnostic services and adherence to best-practice evidence based care.

CMS could mitigate potential efforts by providers to shift costs to private payers by implementing a robust bonus and performance reward program while holding providers accountable for meeting the transparency requirements delineated above.



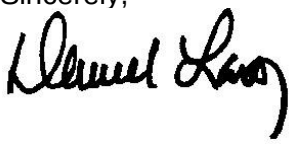
[1]Source: Blue Cross Blue Shield Association 2009 Healthcare Trends in America, accessed at http://www.bcbs.com/blueresources/healthcare-trends-report/2009/pdfs/2009-healthcare-trends-in-america.pdf

Recommendations:

- Implement a robust performance reward program that provides a 10 to 20 percent differential bonus opportunity to multi-payer ACOs that includes private carriers, and perhaps an additional opportunity if the program extends to Medicaid;
- Require ACOs to maintain sound fiscal policies and financial management practices that assure oversight of risk-based contracts. A potential model for such regulations can be found in the California Financial Solvency regulations administered by its Department of Managed Health Care;
- Require public reporting of cost to charge ratios for inpatient, outpatient facility, and professional services such that undue increases in charge masters or professional fee billing rates are transparent to consumers and purchasers. Cost may be indexed at the prevailing Medicare DRG, OPPS, and RBRVS rates (regionally adjusted). Private payers have also used contractual provisions to limit charge master increases to manage consistency of pooling charges at established reinsurance/large case pooling ratios;
- As part of the qualification process, require that ACOs address affordability and cost management by demonstrating the ability to manage financial performance with specific objectives such as management of trend at CPI + 1%; and
- Set expectations for resource stewardship and waste reduction, with public reporting of quality and efficiency metrics such as hospital acquired conditions, ambulatory care sensitive admissions and avoidable readmissions.

We appreciate the opportunity to offer these additional comments, and we hope you will find our comments useful as CMS develops ACO criteria that will help achieve the goals of affordability, quality care and improved population health. We look forward to the opportunity to provide additional input on the forthcoming regulations.

Sincerely,



David Lansky, PhD
President & CEO

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