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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 Pacific Business Group on Health (PBGH) appreciates the opportunity to comment on the Medicare Shared Savings Program: Accountable Care Organizations (ACOs) proposed rule. For twenty-five years, PBGH has helped purchasers improve the quality of health care and moderate health care cost increases. PBGH consists of 60 member organizations, which provide health care coverage to 10 million Americans and their dependents. Our members include many large national self-insured employers as well as public sector purchasers. We believe it is critical to maintain high standards and high expectations for payment reform and delivery redesign initiatives in the public and private sectors in order to drive needed and lasting change in the quality and efficiency of health care.

PBGH and its members have been leaders, both in California and nationally, in implementing innovations in transparency, care delivery, benefit design and provider payment. Many of our members, through their health plans, offer their employees the opportunity to participate in an ACO model. A handful of others offer the ACO model to employees through a direct contracting arrangement with providers. Many of these private sector models have been successful in reducing cost and waste in the system. Much can be learned from the private sector in developing requirements for the next iteration of Medicare ACOs.

In order for ACOs to achieve their full potential, 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. Notably, many private sector ACO models incorporate two-sided risk. CMS should place greater weight on the benefits to system transformation by making risk-bearing contracts more attractive to ACOs to spur innovations and improvements with greater alacrity. CMS can also support the development of effective ACOs I by creating alignment between Medicare and private sector ACO requirements and extending the Pioneer ACO requirement of contracting with other payers.

Clearly, CMS plays an integral role in both the proliferation and design of ACOs. We applaud the agency's initiatives and ask for continued leadership; now is not the time to slow momentum in ACOs meeting their full potential of driving quality improvement, care coordination, and cost

savings. In the Appendix we provide additional comments on areas in the proposed rule that are particularly important to us. If you have any questions, please contact Jennifer Eames Huff (jeames@pbgh.org), Director of Advancing Policy for PBGH, Bill Kramer, Executive Director for National Policy (wkramer@pbgh.org), or myself.

Sincerely,

David J. Lansky, PhD
President & CEO

Appendix

Composition of Governing Body

Continuing with current practice, and in keeping with the law, the proposed rule requires ACO governing bodies 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 amongst 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 board 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, etc.). 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 HIT

The rule proposes to add a new requirement for an ACOs to describe in its application how it 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 HIT Acceleration plan.**

We strongly support the new requirement for applicants to describe their plans 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 **for incorporating patient generated data**. Moreover, **we recommend CMS require HIT-enabled monitoring of performance on patient-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. 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.
- We are concerned that the proposal to allow ACOs to repeat Track 1 will slow down the pace to realize the benefits of system transformation -- not only in Medicare, but also in the private sector. As the nation's largest purchaser, CMS plays an important role in moving the entire market. **We recommend CMS consider alternatives to removing the current requirement that Track 1 ACOs transition to Track 2.** Alternatives include extending the contract period to 5 years and requiring two-sided risk in the last two years or requiring commitment to continuing in Track 2 if ACOs achieve certain milestones.
- **We strongly support making two-sided risk more attractive to ACO participants**, such as the waivers mentioned in the proposed rule or consumer incentives, which we discuss below.

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, qualifying visits to specialists are identified. (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 Tracks 1 and 2 remain retrospective and Track 3 use prospective beneficiary assignment (as a way to make this track more attractive). We support using prospective beneficiary assignment in both two-sided risk models as a way to make those models more attractive to ACOs.

Voluntary Beneficiary Alignment

Currently, beneficiary assignment is claims based, and beneficiaries do not voluntarily choose 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 financial risk 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.

Consumer Incentives

While providers are ultimately accountable for the cost and quality of care delivered within an ACO, admittedly this is more challenging when patients are not required in any way to see providers within the ACO. A common practice in the private sector is to use benefit design as one way to encourage patients to stay within a network or adopt healthy behaviors, while still making other choices available. PBGH members implementing ACO initiatives have used benefit enhancements including lower share of premiums, lower or no co-pays for preventive services or for chronic condition management services delivered by ACO providers, and digital access to medical information and communication with providers. These benefit enhancements help direct patients to utilize care within the ACO network where care can be most effectively managed. **CMS should consider ways to make benefit enhancements a tool ACOs in Track 3 can use in managing their patient population.**

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, this is not sustainable in the long term. **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 invariably means that ACOs will not always be held to the same benchmark standard.

One method that is used in the private sector for financial targets that CMS should consider as an option is a global budget. Large purchasers have set global budgets using recent years' expenditures with a target percentage reduction. These global budgets rely on local and regional reference expenditure growth trends, which may serve as a glide path for ACOs interested in population-based payment arrangements that are not able to immediately meet a national target. CMS could offer Track 3 ACOs the option to have a risk-adjusted prospectively determined global budget as an alternative to the shared savings/losses model. The ACO would keep any savings below an agreed upon discount, and would have to absorb the cost of services above the global budget. The statute

also allows CMS to use partial capitation approaches, not just shared savings. These concepts – prospectively set benchmarks, partial capitation, or per patient per month payments – would make it much more attractive for the ACO to move up the risk/return continuum that Track 3 provides by providing more predictability. The ACO could plan specific compensation changes for the individual physicians, practices and other providers participating in the ACO, and determine how to distribute surpluses or allocate overages based on the extent to which these providers achieved their specific responsibilities.

Public Reporting

Public reporting is required for certain information. 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 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 backwards from the individual provider and provider group reporting currently happening in the public and private sectors**.** Other provisions in the ACA require provider-level reporting, and we believe 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 only. 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 patient-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.

Quality Measures

Having a robust and parsimonious dashboard of measures is integral in evaluating an ACO's success and meeting the *Triple Aim*. CMS finalized the measures and quality benchmarks for MSSP last November through the Physician Fee Schedule. **We strongly believe the measure set should focus on outcome measures, both clinical and patient-reported, and measures that address care coordination;** we greatly appreciate continued movement in that direction. However, we are concerned that **there remains an over reliance on process measures in the set**. In terms of benchmarks, we support both attainment and improvement. Finally, we remain steadfast in our belief that consumer decision-making and purchasing accountability should be primary drivers in determining both quality measures and benchmarks.

Market Power

PBGH members experience annual increases in health care costs well above inflation. These increases are eroding their profitability and global competitiveness and undercutting employee wages – and workers and companies do not appear to be receiving any increase in value for these expenditures. Even for our public sector and non-profit members, health care costs directly impact operational performance and workforce attraction and retention. Price is a major driver of high health care costs, with extreme variations driven by provider consolidation and market power. Private purchasers absorb some of the price increases by paying more for health insurance, and some increases are passed on to consumers. In other situations, health plan benefits are scaled back to make them more affordable.

It is important to address potential adverse consequences that can result from market dominance of ACO providers that contradict the aim of reducing costs to the system. CMS should add requirements to the ACO program to build a more robust monitoring system for costs. In particular, CMS should:

1. Require all participating ACOs have a mechanism for assessing performance on private sector per capita costs by the second year of the program. An ACO itself does not necessarily have to create the mechanism internally; it could work with other stakeholders (e.g., using data from local purchasers or all-payer claims databases).
2. Gather data regarding current market shares, market entries and exits, and pricing trends for the ACOs. This information should be collected initially in the application process to establish a baseline, and then on an annual basis to monitor and report publicly on potentially adverse market impacts of ACOs.
3. Set expectations for resource stewardship and waste reduction, including public reporting of quality *and* cost metrics (e.g., cost to charge ratios, professional fee billing rates, prices for episodes for public and private payers, total costs for beneficiaries assigned to the ACO for public and private payers, etc.).
4. Hold ACOs to a maximum threshold of price increase with their commercial market clients.
5. Include community representatives, especially consumers and purchasers, on ACO governing boards.