February 28, 2014

Re: Request for Information on the Evolution of ACO Initiatives at CMS

AMGA represents multi-specialty medical groups and other organized systems of care, including some of the nation’s largest, most prestigious integrated health care delivery systems. AMGA represents 430 medical groups in 49 states that employ nearly 130,000 physicians who treat more than 130 million patients. Our member medical groups are working diligently to provide innovative, patient-centered medical care, while being respectful of Medicare resources. Several of our member medical groups are participants in either the Pioneer Accountable Care Organization Model (Pioneer ACO) or the Medicare Shared Savings Program in order to further the transformation of health care delivery to a value-based payment system, and we applaud their efforts.

These entities have encountered significant obstacles to their success. We therefore appreciate the opportunity to provide comments on the Request for Information on a potential second round of applications for the Pioneer ACO Model, and other issues related to evolving ACO programs.

Section I-A

CMS is considering giving additional organizations the opportunity to become Pioneer ACOs. To that end, CMS seeks input on the level of interest in the field for CMS to open a second Request for Applications for the Pioneer Model.

1. Would additional health care organizations be interested in applying to the Pioneer ACO Model? Why or why not?

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The Pioneer model, as it currently exists, will appeal to only those organizations that have a high tolerance for risk, along with significant capital reserves. Suggestions for retaining current Pioneers, and attracting others, include increasing the transparency around the financial model so that Pioneers are clear about how they are achieving savings or losses. Many AMGA members are concerned about the lack of information regarding the calculation of their financial benchmarks, and request that CMS make this process more transparent, since there is concern that the data may not be completely accurate. Investments that ACOs make in
infrastructure and care process redesign should also be taken into account when
determining financial benchmark or when rebasing the benchmarks after the first
performance period. Provider organizations must also have confidence that the
measures in use are clinically relevant and data extraction for use in benchmarking
must be accurate and consistent across all organizations. CMS could appeal to
potential future Pioneer applicants if they observed that CMS was making
improvements based on the feedback of existing Pioneers, which would thereby
promote confidence in the model and encourage broader participation.

2. **If additional applicants were solicited for the Pioneer ACO model, should CMS
limit the number of selected organizations or accept all organizations that meet
qualifying criteria?**

CMS should limit the number of organizations to those that are most likely to
succeed. The small number of Pioneer ACOs has been beneficial to the learning
collaboratives, and has promoted transparency. We recommend that CMS increase
opportunities for Pioneer ACOs to have learning experiences and to develop
relationships with CMMI staff.

3. **Should any additional refinements be made to the Pioneer ACO Model that would
increase the number of applicants to the model?**

CMS should consider ways to encourage low-cost providers to participate in the
program. This could be done by allowing ACOs to choose a local or regional
benchmark in the financial modeling, not just national data. Such an approach
could more appropriately reward providers in all markets by incorporating the
differences in regional cost levels into the trend methodology. Several AMGA
members have suggested that this approach would accurately reward low-cost
providers, and provide greater incentives to remain in the program. It would also
encourage others, who have been observers thus far, to become participants. CMS
should also consider making their contractors and actuaries available to work with
individual ACOs so they will understand how the model, and the changes to it, will
play out for them.

Medical groups and all providers participating in ACO programs have invested
significant financial, clinical, operational, and leadership resources to establish
sophisticated care management infrastructures and organizational cultures
necessary to support the goals of the program. They have done so because it is the
right thing to do for their patients and they want to assist CMS to create the new
payment models that reward coordinated, patient-centered care with measurable
improvements in outcomes. ACOs need a workable financing and operational
structure that adequately incentivizes this important work, and we suggest the
following additional refinements to the program.

*Beneficiary Attribution/In Network Issue*

Under the current rules, ACOs agree to assume collective responsibility of a defined
patient population. Shared savings are based on how ACOs perform on various cost
and quality measures for this population. However, AMGA members have expressed significant concern that the ACO patient attribution methodology does not accurately align patients who have actual encounters in their ACOs, making it difficult for the ACO to manage care appropriately and resulting in inaccurate views of ACO performance. Annual beneficiary turnover may range from 10 to 40 percent, inhibiting the investments ACOs make in programs that have long-term impact, such as care management initiatives. ACOs cannot succeed without understanding who their patients are.

Additionally, allowing beneficiaries to deny, or opt-out, of sharing claims data hampers an ACO’s ability to understand the care patients are receiving. It is not unusual for more than 15 percent of beneficiaries to opt out of sharing this data. That effectively means an ACO has an incomplete picture of a large percentage of its patient population. It is difficult, at best, when ACOs are not aware of diagnosis, services, and procedures, a patient receives outside its four walls. Having the complete administrative data picture of the beneficiary is a key piece of the information puzzle for ACOs.

The Pioneer ACO framework places an emphasis on patient engagement, and places the responsibility for this on the ACO, while not permitting ACOs to incentivize their patients to seek care there. The Medicare Payment Advisory Commission (MedPAC) discussed this issue, among other ideas for improving ACOs, at their November, 2013 meeting. Among the ideas discussed was the possibility of incentivizing an ACO’s attributed beneficiaries to seek their care in the ACO by permitting lower cost-sharing, or letting the beneficiary share in the savings generated by the ACO, since currently, patients may not understand they are in an ACO, or what that means for them.

MedPAC also compared and contrasted Medicare Advantage (MA) plans and ACOs, concluding that the ability of MA plans to advertise why their plans are attractive to prospective patients, and the requirement that beneficiaries select, and remain, within one MA network for an enrollment period, contribute to the success of these programs. Both of these features are absent from ACO programs in their current form.

In order to understand how “accountable” ACOs truly are, and to address a key issue that serves as a disincentive to enrolling as an ACO, we recommend that beneficiaries should select an ACO for their total care, or at a minimum, identify their primary care provider (PCP), for a defined enrollment period. The designated ACO or PCP could be indicated on the beneficiaries Medicare card. We understand CMS and Congress’ sensitivities to beneficiary freedom of choice, however, requiring providers to be accountable, while ignoring the need for accountability on the beneficiary side, provides significant barriers to success in the program.

*Timeliness/Quality of Data from CMS*

There have been numerous issues surrounding the data ACOs receive from CMS. The timeliness and the utility of data have all been problematic. Some ACOs
received data on their cohort’s Hierarchical Condition Categories (HCC) scores more than a year after entering the program. Other ACOs have stated that the quarterly run-up data provided by CMS does not have the level of granularity needed for ACOs to make actionable changes.

The data file structures should be consistent, as well. Otherwise, it becomes necessary to involve the ACO’s Information Technology staff to convert the data into a consistent format, and the whole process becomes more resource-intensive and administratively burdensome. Experienced delivery systems are more likely to apply if they have confidence in the claims files content and process, and they look more like formats and processes that are common among other payers. Necessary improvements include the provision of consistent file formats. We believe a joint ACO/CMS/Center for Medicare and Medicaid Innovation (CMMI) committee should be formed that would work on creating a consistent format for data submissions and prioritize requested modifications to the standardized data set. The committee would also focus on other data-related matters such as improving its utility to both ACOs and CMS/CMMI.

**Quality Benchmarks/Measures**

Another issue of great concern to ACOs is the use of flat percentages for meeting quality benchmarks, rather than empirical data sources. Currently, nearly a third of the 33 quality measure thresholds employ flat percentages, rather than being based on actual Medicare program data. AMGA members have expressed that flat percentages are unattainable, and their continued use harms high-performing ACOs and will discourage future participation in the program.

The measures themselves are not always the best or true indicator of quality care. We believe CMS and ACO providers should work together to develop a measurement set that better reflects the quality of care provided in ACOs.

**Fraud/Abuse**

ACOs are permitted to utilize waivers that exempt them from possible violations of the Stark self-referral law, the Anti-Kickback Statute, and the Civil Monetary Penalty laws as they restructure healthcare delivery for their patients. We ask that ACOs be able to keep these waivers, along with the efficient delivery of healthcare they afford, after leaving the program, rather than having to unwind such arrangements. Many of the efforts around quality metrics, data gathering, and technology sharing are permissible under waivers, and are activities that should continue even if an ACO departs from the program at some point in the future.

The legal and operational tasks needed to create new arrangements that incentivize improved care delivery are enormous and costly. These system changes are meant to result in improved care at lower cost. Requiring providers to unwind these transactions, in absence of any fraud or abuse activities, after leaving the program, is a significant disincentive to becoming an ACO. Waivers should remain in place so
long as the ACO continues to provide high-quality care as evidenced by satisfying ACO program quality measurements.

Another issue that has to our attention concerns the ability of ACOs to share data derived from CMS claims. For example, let’s say an ACO has nearly 2,000 physicians, with some being employed, and some being in different groups across states lines. The health care system has all of these physicians come together to discuss care improvement at certain times throughout the year. It would be beneficial to share de-identified data from CMS claims at these sessions, but sharing is limited to those physicians who are in the ACO, according to the current requirements for Data Use Agreements. We strongly suggest that CMS consider allowing ACO participants to share de-identified claims data openly with all physicians and providers within its broader ACO network, medical staff, or organized system of care so they may engage in a productive dialog about strategies to improvement care management processes. Currently, non-ACO physicians and providers must leave the room when CMS claims data is discussed, and the non-ACO physicians and providers miss out on the benefit of important dialog concerning such things as emergency room visits per 1,000 patients, and the impact of regional variation. Removing this barrier would allow productive discussion on performance improvement activities.

Lastly, AMGA and its member organizations fully support the ACO program. However, we feel financial and operational changes need to be made to allow current and future ACOs to succeed. When viewing the issues that are raised here in a vacuum, they are not fatal to programmatic success. However, when combined, these issues present current ACOs with a difficult path to success and future ACOs with little incentive to enroll. CMS should focus on making the program more attractive to prospective ACOs that may want to participate by removing as many barriers as possible.

Section II-B.
Current laws and regulations allow ACOs to establish business arrangements with Part D sponsors in order to align incentives in support of improving care coordination and outcomes.

1. What factors, if any, pose barriers to the effectiveness of such collaborations?

Some AMGA members are wary of the idea of taking on risk directly by partnering with Part D sponsors due to the volatility in drug markets that would limit their ability to control risk.

1.A. What could CMS do in administering an ACO program to help ACOs and sponsors mitigate or avoid these barriers?

ACOs with pharmacies should have the option of developing a “branded” private Part D plan, and offer benefit designs that would not only insure good stewardship of Part D dollars, but also provide opportunities for patient engagement in the ACO by encouraging the use of the ACO’s pharmacy. In addition, an ACO should be able to be accountable for Part D without having to be a Part D sponsor itself.
C. Integrating accountability for Medicaid Care Outcomes—as part of the State Innovations Model, CMS is working with States to tailor payment reforms that reflect health care priorities identified by States and local stakeholders. CMS seeks input on approaches for ACOs to assume increasing accountability for Medicaid outcomes.

1. CMS has encouraged States to explore the use of integrated care models including ACOs for the care of Medicaid populations. Should ACOs caring for Medicare outcomes also assume accountability for Medicaid outcomes?

ACOs that have patients who are dually-eligible for both Medicare and Medicaid in their aligned population, particularly those who do not have managed care options for this patient population in their state, should have the option of taking full accountability for Medicaid costs and outcomes. This could provide incentives to build more coordinated benefits for those with Medicaid. However, doing so should be an option, and not a requirement, because many ACOs do not have the experience or expertise in being accountable for the full Medicaid benefit, given the different requirements this would entail. The infrastructure required to serve this patient population would be vastly different than what is required for Medicare beneficiaries. The array of necessary services would be geared more toward social support, behavioral health, and transportation.

Thank you for considering our comments. Please contact Karen Ferguson at kferguson@amga.org with any questions you may have.