



American Medical Group Association®

Accountable Care Organization Refinement Brief

The participants in the Medicare Shared Savings Program (MSSP), the Physician Group Practice Transition Demonstration (PGP-TD), and the Pioneer Accountable Care Organization Program (Pioneer, collectively, ACOs) have all made significant improvements in care processes and the delivery of high-quality care, while reducing utilization of healthcare services. Although most of these entities have increased quality and achieved the goal of saving money for Medicare, program results have been uneven, at best. These entities have also encountered significant obstacles in program design that threaten not only their own success, but the future viability of these programs.

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 Congress, the Centers for Medicare and Medicaid Services (CMS), and other payers 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.

Congress has invested considerable time and energy into the development of a legislative proposal to repeal and reform the Medicare Sustainable Growth Rate (SGR). We support that effort. However, the legislation relies on ACOs and other alternative payment models (APMs) to incentivize provider transition to value-based care. Unless the financing and operational models for ACOs and other potential APMs are improved, we are concerned that the foundation for a new Part B payment mechanism is structurally unsound. Congress continues to have an unprecedented opportunity to transform the way healthcare is delivered and financed, and we would like to continue to work with you to encourage increased participation in ACOs, specifically, and APMs generally.

Minimum Savings Rate

Under the law, CMS established a Minimum Savings Rate (MSR) for ACOs to account for the potential random variation in savings that may not be linked to improvements in quality and efficiency. The MSR is determined by the number of beneficiaries assigned to an ACO, and runs from a minimum of 2 percent to 3.9 percent for MSSP participants in both ACO tracks. While we understand the concept of random variation, the MSR continues to serve as a strong disincentive for providers to enroll in the ACO program. This is particularly true for smaller ACOs or even sophisticated integrated delivery systems in rural areas that have small numbers of Medicare beneficiaries. Further, as ACOs are required to take risk, the need to account for random variation is eliminated or at least, greatly minimized. Meeting quality metrics also minimizes the impact random variation may have. The MSR, when coupled with risk adjustment

scores that cannot increase, among other operational challenges discussed below, force ACOs to meet increasingly difficult savings margins. Given the investment ACOs must make to successfully manage a patient population's care, the MSR serves only to dissuade providers from becoming accountable and hampers the goals of CMS and Congress to transform the delivery system. We believe the MSR needs to be minimized as much as possible during the performance years and eliminated once an ACO takes risk. An alternative would allow CMS to perform a cumulative review of savings. If an ACO saved 1% each year over the 3 years, the chances that the improvement was random are virtually eliminated.

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 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 a very 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 ACO regulations place an emphasis on patient engagement, and place 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.

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. 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.

Risk Adjustment

Accurate risk adjustment is an important aspect of the evaluation of an ACO's performance. At present, the CMS HCC prospective risk scores may be lowered if the ACO's continuously assigned patient population shows an improvement in health status or if coding is not maintained at its prior level. Conversely, HCC scores are not increased if that same population becomes sicker or if an ACO increases its coding level. This leads to a scenario where historical benchmarks can only decrease and ACOs are left to chase a dropping reimbursement figure. As a result of this recalculation, many ACOs lost shared savings on their interim payment calculation.

We understand the concern that ACOs might utilize more accurate coding to augment risk scores and increase expected cost for a given patient population. However, we do not believe the answer to the problem is to cap HCC scores. If an ACO's patient population's HCC scores increase, CMS needs to adjust for the health status of this population using the higher risk score. Alternatively, Congress and CMS could allow ACOs to choose to use historical cost as the only determinant for the benchmark for the continuously assigned population. CMS has supported that method in the past. We also recommend creating a CMS/ACO task force to more fully consider this issue.

Financial Benchmarks Transparency

While we appreciate CMS' efforts to communicate clearly and be transparent with ACOs, many AMGA members are concerned about the lack of information regarding calculation of their financial benchmarks. We understand that CMS' Office of the Actuary reviews the benchmarking data prior to making their calculations, yet the process for this review is not communicated clearly to ACOs. We request that CMS make this process more transparent. In addition, an external review of the data by a neutral third party should be conducted. Currently, ACOs do not understand how financial benchmarking calculations are determined, and there is concern that the data may not be wholly accurate.

In order to assure that an ACO's benchmark accurately reflects the composition of its patient population, CMS plans to reset the benchmark at the beginning of each agreement period. We understand the rationale behind this decision, since an ACO's assigned population may vary significantly from the historically assigned population used to calculate the initial benchmark, by the end of the agreement period. However, this policy, in conjunction with the other challenges inherent in the program design outlined here, make savings that much more difficult. We therefore request that rebasing of the benchmark for future agreement periods take into account the investments an ACO has made in infrastructure and care process redesign that enable it to provide high-quality, coordinated, patient care.

Accepting Downside Risk

The current regulatory framework for the MSSP requires them to accept downside risk in the first year of the second performance period. While it is generally accepted that all providers will eventually accept risk, a longer transition period is necessary. Accepting risk requires significant clinical re-design and cultural change that medical groups make at varying rates, even those that have stepped-up to the challenges inherent in the ACO program requirements. The competencies necessary to succeed in a risk-based model, including patient stratification, data analytics, and utilization management, for example, have to be newly learned by organizations that have operated in a fee-for-service model for decades. Three years is not a sufficient time period to learn how to understand and take risk. We believe that ACOs should have completed two three-year performance periods before being required to accept downside risk.

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.

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 above 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. We look forward to working with Congress and CMS to create program changes that will lead to better health for ACO beneficiaries while also incentivizing providers to enroll as ACOs.

Summary

AMGA asks for the following program refinements:

- Modify the Minimum Savings Rate
- Create an accurate beneficiary attribution methodology/patient engagement incentives
- Create an effective data sharing process/methodology
- Revise the current Quality Measure provisions
- Create options for an appropriate risk adjustment policy
- Financial benchmarks transparency
- Downside risk in Track 1 after the second performance period
- Continuation of fraud and abuse waivers beyond the term of an ACO