MEDPAC Medicare Payment Advisory Commission

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November 22, 2010

Dr. Donald M. Berwick
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Suite 314-G
Washington, DC 20201

RE: File code CMS-1345-NC

Dear Dr. Berwick:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Request for Information Regarding Accountable Care Organizations and the Medicare Shared Savings Program, published in the *Federal Register*, vol. 75, no. 221, pages 70165 to 70166. Your request regards certain aspects of polices and standards that will apply to accountable care organizations (ACOs) participating in the Medicare program under section 3021 or 3022 of the Patient Protection and Affordable Care Act (PPACA). If structured carefully, a shared savings program for ACOs could present an opportunity to correct some of the undesirable incentives inherent in fee-for-service payment and reward providers who are doing their part to control costs and improve quality. It could do so most effectively by having those providers share risk with Medicare for cost growth for their patients. The program could also help beneficiaries receive more coordinated care and become more engaged with their care management, particularly if beneficiaries are informed when they are assigned to ACOs. Your regulations will be instrumental in enabling the shared savings program to reach these goals and we expect to provide you more detailed comments on those regulations as rule making proceeds. Our comments here reflect broad directions for the program that we hope will be helpful in your deliberations on both the shared savings program and possible ACO demonstrations under the Center for Medicare and Medicaid Innovation (CMMI).

There are many aspects of the program that will have to be addressed in regulation. Among them are the specific qualifications ACOs will need to demonstrate—such as a clear management and leadership structure and clear arrangements to assure the continuum of patient care. We expect that these criteria, among others, will be required for participation in the ACO program. Although we have not opined on what specific criteria should be required, such criteria are necessary for two reasons—to assure that the organizations that become ACOs have a reasonable chance to be successful over the long run and because we think some attention to these details will improve the quality of care for patients. Quality performance measurement will be an essential component of

ACO monitoring, but we do not think all important aspects of ACO performance can be assessed with available metrics. Although, the standards should not be rigid—particularly as ACOs are starting up they should have flexibility in meeting the criteria—clear criteria should be part of the requirements to qualify as an ACO.

In this letter, we would like to comment on the following three areas that you raised in your request and we think will be crucial to the program's success:

- Strengthening the incentives for ACOs by offering a two-sided risk model in addition to the bonus-only model outlined in the statute.
- Informing Medicare beneficiaries of their assignment to ACOs so that those beneficiaries can be fully engaged with improved care management.
- Focusing on a set of quality measures that reflect the outcomes ACOs are designed to achieve.

In addition, we also discuss constructing growth targets and thresholds that will help to assure providers will participate in the program and view the program as equitable.

Although it appears that the statute permits CMS to address most of our comments in these areas through regulation, if certain provisions are found to be beyond the scope of the agency's discretion within the shared savings program, you should pursue them concurrently through the CMMI.

MedPAC appreciates your staff's ongoing efforts to administer and improve Medicare's payment systems, particularly considering the competing demands on the agency.

Strengthening incentives by offering a two-sided risk model as an additional choice for ACOs

The basic shared savings model outlined in the statute provides a bonus payment to ACOs that meet quality targets and keep spending for the population for whom the ACO is responsible below a target level. The amount of the bonus payment will depend on the amount of savings and the proportion of the savings allocated to the ACO and Medicare. For example, if the ACO were allocated 80 percent of the savings, Medicare's share would be 20 percent. The higher the ACO's share, the greater the incentive and the less Medicare would save. If the ACO exceeds target spending, fails to meet quality targets, or both, it nonetheless receives its full FFS revenue—this is a bonus-only model. Because the model is bonus-only, all the risk of poor performance is on the Medicare program, including the risk of paying bonuses to ACOs that experience favorable random variation in their assigned patients' rate of sickness for that year.

This random variation in the need for health care is an important factor. We find that Medicare spending for a population of 5,000 can vary substantially from year to year. For example, 25 percent of such groups could see spending growth about 2 percent lower or higher than the national average, even with no change in practice patterns. To avoid paying bonuses resulting from

random variation in Medicare spending, the program will have to set a threshold for savings. If ACOs do not meet this threshold they will not be eligible for a bonus. In the physician group practice demonstration, in which groups averaged around 20,000 beneficiaries, Medicare set a threshold of 2 percent. Only groups that saved over 2 percent were eligible for a shared savings bonus. The magnitude of the threshold will likely vary inversely with the population of an ACO. That is, smaller ACOs would have larger thresholds and vice-versa because random variation would be greater for smaller ACOs than for larger ACOs.

Yet, thresholds will weaken the incentive for ACOs to control spending. In a bonus-only model there is some incentive to control spending for services from providers outside the ACO. But that incentive is weaker for services the ACO provides directly because the ACO still receives FFS payments for those services and those payments are certain. Receiving a bonus is uncertain because of random variation and even more uncertain if there is a high threshold to overcome. Thus, the incentives in a bonus-only model for controlling spending are relatively weak and become weaker as the threshold is raised. This will likely be a particular concern to smaller ACOs because they may face higher thresholds. But even larger ACOs may find thresholds discouraging. (See appendix for an illustration of the incentives in a bonus-only model versus a two-sided risk model.)

To increase the strength of the underlying incentives Medicare should consider implementing a two-sided risk model in addition to a bonus-only model. In a two-sided risk model the ACO would share in some portion of savings (and be at risk for the same portion of spending over the target). Because the ACO would know that its actions to reduce spending would count towards its bonus payment (or toward reducing any loss), it would have a stronger incentive to control spending even when doing so would decrease its own FFS revenues (see appendix). The share of savings (or losses) allocated to the ACO could vary. For example, if one assumed that small changes from the target reflected random variation, the ACO's share in that range could be small. As spending diverged from the target, the ACO's share could be larger and then decrease again at extreme levels. This mechanism would function as a risk corridor to protect ACOs from high levels of losses in return for ACOs forgoing high levels of bonuses.

Because volume-increasing behavior would be discouraged under this model, it might be possible to grant some relief from regulations designed to prevent such behavior (such as self-referral rules); this step appears to be contemplated in the law. It might also be possible to allow for lower levels of beneficiary cost sharing as well. But that step may require explicit legislative authority or be better pursued through the CMMI. These steps would increase the attraction of forming an ACO for providers and would be a concrete benefit for beneficiaries whose providers were in an ACO.

Offering a two-sided risk model, which incorporates a share of first-dollar savings and some form of risk corridors to protect ACOs from high levels of risk, is necessary for the shared savings program to meet its potential. Such a model would increase the strength of the incentives to control spending and volume, remove thresholds for savings, and encourage entities that want to share in first-dollar savings to become ACOs. To further encourage participation, the share of the savings in the two-sided model could be made larger than the share in the bonus-only model. If CMS

cannot offer a two-sided model as a component of the shared savings program as presently constructed, it should do so through the CMMI. Over time, the two-sided risk model should become the dominant or the only model available. The Commission will consider making recommendations for legislative changes, if that is necessary, to make a two-sided risk model part of the program.

Informing the beneficiary

In any new Medicare program the rights and responsibilities of Medicare beneficiaries should be a primary consideration. Beneficiaries should know if their health care providers are operating under a new incentive structure. At the same time, for an ACO program to work well, beneficiaries will need to have greater engagement in their own care management (for example, medication adherence). Properly structuring how the beneficiary is informed of his or her assignment to an ACO provider could help accomplish both of these goals.

Not informing beneficiaries would run the risk of a repeat of the managed care "backlash" experienced in the 1990s. The backlash resulted from patients feeling that they were being forced into managed care by their employers and that the financial benefits were accruing to employers or health plans, not them. Some providers, many of whom were losing revenue due to managed care, were more than willing to feed patient concerns that the savings from managed care were being produced at the expense of the quality of care. This toxic combination of concerns resulted in the backlash: it behooves Medicare to pay close attention to patient notification so as not to repeat history.

Beneficiaries will have to be assigned prospectively if they are to be informed of their assignment to an ACO before care is delivered to them under that model. Prospective assignment uses claims data from a prior year to make the assignment. An ACO would first identify its primary care provider members to Medicare. Medicare would then assign beneficiaries to the ACO whose primary care had been provided in prior years by those members. Some have argued that retrospective assignment is superior to prospective. Retrospective assignment would use data from the performance year to make the assignment. However, if retrospective assignment were used, neither the ACO nor the beneficiary would know at the beginning of that year who was assigned to the ACO and prior notification would be impossible.

Involving the primary care provider in beneficiary notification would contribute to the beneficiary understanding what is different under an ACO, how the new approach to care could benefit them, and what their new responsibilities would be. Receiving higher quality care, improved care coordination, enhanced after-hours access, and greater engagement in their own care should be meaningful improvements from the beneficiaries' perspective, and having the provider describe them would increase the beneficiaries' trust in the value of those benefits. However, there would be no direct economic benefit to the beneficiary, which could once again raise the concern that somehow the providers and the program were saving money at the beneficiary's expense. Although strong quality safeguards should allay this concern, it could be that reduced beneficiary cost sharing or even giving beneficiaries a share of the savings would be helpful for increasing

beneficiary acceptance of ACOs. The Commission may consider making recommendations for legislative changes, if that is necessary, to provide a direct incentive for the beneficiary.

Providing the beneficiary notification may not be sufficient in itself; providing the beneficiary choices when faced with the assignment notification could be necessary as well. We suggest that, unless beneficiaries indicate otherwise, they remain in the ACO. If they decide that, despite the potential benefit to them of being in an ACO the change in incentives for their provider makes them too uncomfortable, Medicare should provide them some choice. One choice that the beneficiary always has is to switch from the assigned primary care provider to another provider who is not in an ACO. Another choice, some suggest, is to allow beneficiaries to stay with their providers who are in the ACO yet "opt out;" that is, not have their data count toward the ACO's performance. On the one hand, this option would give the beneficiaries more choice and allay worries they might have about the incentives in ACOs. On the other hand, allowing beneficiaries to opt out would create administrative complexity for CMS and an opportunity for the ACO to discourage participation by beneficiaries who could harm the ACO's performance.

This selection problem is mitigated somewhat, because spending targets for an ACO will be based on their patient's history over several years. In essence, that means payments will be risk-adjusted primarily on historical spending rather than on diagnosis codes recorded by the ACO's physicians. In other words, a high-cost beneficiary is one who has had high costs, not one who has a high risk score, hence dropping a high-cost beneficiary would lower the ACO's target. However, ACOs encouraging beneficiaries to opt out whose cost is expected to grow quickly (e.g., a beneficiary who has a new diagnosis of cancer) could still be a problem. One strategy to address this problem would be to have CMS ensure the beneficiary is informed, and to reconsider an ACO's participation in the shared savings program if more than a small percentage of beneficiaries chose to opt out. A large share making that choice could indicate either that the ACO did not provide reasonable care or that it was engaging in selection.

Under an opt-out approach, beneficiaries who prefer the ACO care coordination activities, or are not sure, will be assigned to the ACO and will receive the benefits of being in the ACO. As has been seen in other programs such as assignment into Part B by the Social Security Administration (94 percent accept assignment), dual eligible beneficiaries into Part D drug plans, and private-sector employees into retirement plans, the opt-out approach preserves choice while preventing low take-up rates.

Finally, notification should strengthen beneficiaries' engagement with their care management. Many think that patient engagement in programs such as medication adherence and shared decision making will be essential for ACOs to succeed. Part of the notification process should inform beneficiaries of their opportunities and responsibilities to influence their own health and the health care coordination that the ACO is offering.

Quality measures

ACOs should report a focused set of quality indicators that reflect the outcomes ACOs are designed to achieve: keeping the population healthy, better care coordination to reduce unnecessary and sometimes harmful spending, and better patient experience. New measures may be necessary for ACOs because the current measures reflect the limitations and incentives of the current FFS payment system. A focused set of measures would help assure Medicare that the ACO is doing its job and help assure beneficiaries that they are receiving high quality care. The ACO metrics could include population-based outcomes measures such as:

- Emergency room use
- Potentially preventable admission rates
- In-hospital mortality rates, and possibly patient safety measures
- Readmission rates

In addition to outcomes measures, CMS could also consider measuring patient experience with health care provided under the ACO and health status. Patients may be more willing to stay assigned to the ACO if they know the provider's payments are dependent on patients' review of the quality of care provided. Some also argue that particular process measures could also be tracked that indicate whether or not ACOs are stinting on particularly important preventive care. But in general, there should be a focused set of measures tracking how well care is provided, rather than how many services are provided.

Growth targets and benchmarks

A key question is whether the target level of spending growth for all ACOs should be the same. ACOs with historically low use may feel that ACOs with historically high-levels of service use per beneficiary have an unfair advantage because they have more leeway to reduce spending. To some extent, low-use ACOs may feel the policy is penalizing them for past good behavior. There is also some evidence that growth rates in low-use areas are greater than growth rates in high-use areas. The program should not want to discourage ACOs with low use from participating because they could be models that others could learn from. Using a common growth amount (e.g., the expected growth in FFS expenditures per beneficiary) across the country helps with this disparity because it would result in a larger percentage increase for low-use ACOs and a smaller percentage increase for high-use ACOs. It would thus decrease the percentage difference between high-use and low-use areas. However, the absolute difference would not change and low-use ACOs may feel the program is not leveling down the effect of high historical spending quickly enough.

One alternative would be to set differential growth targets for ACOs at very low or very high levels of service use. One could set a larger growth target for ACOs whose patients have had consistently very low use and pay for the additional expected bonuses by having a smaller growth target for ACOs with consistently very high use. However, Medicare would have to be careful not

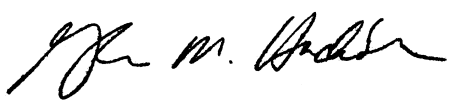
to set the growth target so low that providers in high-spending areas do not form ACOs. ACOs in those areas might be the ones that could save the program the most. Differential growth targets should only affect ACOs with either very high or very low use, for the most part, the common growth amount would be appropriate.

Conclusion

MedPAC appreciates your consideration of these policy issues. Thoughtful and effective regulations and demonstration designs will be necessary for ACOs to succeed. The Commission also values the ongoing cooperation and collaboration between CMS and MedPAC staff on technical policy issues. We look forward to continuing this productive relationship.

If you have any questions, or require clarification of these issues, please feel free to contact Mark Miller, MedPAC's Executive Director.

Sincerely,



Glenn M. Hackbarth
Chairman

GMH/dg/j

Appendix: The magnitude of financial incentives to constrain volume

The ACO bonus structure is designed to affect group practices' joint decisions, such as those involving purchasing equipment or recruiting specialists. In an illustrative example, we examine how an ACO bonus structure could reduce a practice's incentive to purchase or lease an MRI machine. In Table A-1 we look at the decision to lease an MRI machine for the practice under a two-sided risk model and a one-sided (bonus-only) model. Absent any ACO incentive, the profit per physician from leasing and operating the machine would be $3,000 in this example. This assumes a $500 payment per MRI scan, 1,000 MRI scans per year, and marginal costs as shown.

A-1. Illustrative example of ACOs' effects on capacity decisions

	Two-sided risk model	**One-sided risk model**
Payment per MRI (all payers)	$500	$500
Practice revenue from the additional MRI machine	$500,000 (1,000 per year)	$500,000 (1,000 per year)
Practice marginal cost	$350,000 (lease and operating)	$350,000 (lease and operating)
Profit per physician	$150,000/50 = **$3,000**	$150,000/50 = **$3,000**
Effect of the action on the ACO bonus per physician		
Change in Medicare spending for ACO's patient population	$250,000 annually*	$250,000 annually*
Probability of spending resulting in a decreased bonus (or an increased penalty)	**100%**	**60%**
Share of savings given to practices meeting threshold	80%	80%
Expected reduction in bonus (or penalty) per physician	$250,000/50 x **1.00** x. 80 =**$4,000**	$250,000/50 x **.60** x. 80 =**$2,400**
Net incentive per physician To purchase MRI machine	**$3,000 −$4,000 = −$1,000**	**$3,000 −$2,400 = +600**
Decision	**Do not lease machine**	**Lease machine**

* For illustrative purposes, assume a 50 physician practice would bill Medicare for 500 more MRI scans per year and bill private insurers for 500 scans for every additional MRI machine leased by the practice. We assume that the physician practice would receive 80% of any shared savings in both cases, changing the percentage could change the results.

In the first column, we show the two-sided risk model. In this model, if the ACO reduces spending, it keeps 80% of the savings either as a bonus or as a reduced penalty.[1] In the illustrative model this would result in an expected reduction in payments (either a smaller bonus or a penalty) of $4,000 per physician. The net incentive is -$1,000 meaning the lost bonus is bigger than the profit on the MRI machine and the decision would be to not lease the machine.

In the second column, we present the bonus only model. The difference is that there is no penalty for spending above the target, and the bonus is uncertain. In the example, we assume there is only a 60% chance of reducing spending enough to qualify for a bonus. As we see in the second column, the expected reduction in the bonus is now $2,400. The net incentive to lease the machine is $600 in this hypothetical example and the decision would be to lease the machine. The incentive to constrain capacity is clearly less in the one-sided, bonus-only model.

The first key point from this example is that there needs to be a large incentive to offset the FFS incentive to increase the volume of profitable services. The second point is that the incentive is more likely to be large enough to change decisions in the two-sided model.

[1] As we discuss in the letter, in the two-sided model the percentage of savings should vary as a function of the difference between actual spending and the target. In addition, the percentage of savings going to the ACO could be larger in the two-sided model than in the bonus-only model. The assumption of a constant 80 percent in both cases in this example is to simplify the calculation for illustrative purposes.