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Re: CMMI Request for Information: Evolution of ACO Initiatives at CMS

Dear Dr. Conway:

On behalf of the physician and medical student members of the American Medical Association (AMA), we appreciate the opportunity to respond to this Request for Information (RFI) from the Center for Medicare and Medicaid Innovation (CMMI) of the Centers for Medicare & Medicaid Services (CMS). The AMA appreciates CMS' efforts, pursuant to Section 3022 of the Patient Protection and Affordable Care Act (ACA), to evaluate and implement accountable care organizations (ACOs). ACO models can be effective tools to improve quality and coordination of care for patients, reduce the costs of health care, and create a supportive environment for practicing physicians. We offer the following detailed responses to suggest areas of potential improvement in support of the goals of the ACO model, to enhance ACO implementation, and encourage wider participation.

SECTION I: Additional Applicants to the Pioneer ACO Model and Feedback on Current Model Design Parameters

A. Second Request for Applications for the Pioneer ACO Model

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

Many health care organizations are likely to be interested in applying if the details of the program are changed in ways that better support redesign of care and predictability of payment. The AMA particularly believes that restrictive ACO models result in limited participation in ACOs by physician groups. We urge CMS to consider the following improvements as the ACO program moves forward.

For both Pioneer ACOs and ACOs in the Medicare Shared Savings Program (MSSP), CMS should allow beneficiaries to designate their preferred primary care or principal care physician, and base the ACO's accountability on the beneficiaries who designated a physician affiliated with the ACO. CMS allows new Medicare enrollees to designate the ACO as their primary care provider, but does not allow other beneficiaries to do so. Beneficiaries could still be allowed to change physicians at any time. Patient assignment to ACOs should be based on voluntary agreements between patients and their physicians. The core of any successful effort to reduce costs and improve quality in health care is a strong patient-physician relationship. This, in turn, is founded in a voluntary choice by both the patient and physician to begin and maintain that relationship. CMS should encourage and reinforce such voluntary relationships between Medicare beneficiaries and physicians.

The current method for ACO patient assignment puts CMS in the position of deciding which patients and physicians have a relationship, rather than leaving that decision to the physicians and patients themselves. While CMS gives ACOs a list of patients who are **predicted** based on past years' data to be assigned to the ACO, neither the patient nor the physician knows for certain that CMS is assigning accountability to the physician for the costs of all of the patient's care until after retroactive adjustments are made at a much later date. In a dynamic health care system where patients can and do see multiple physicians over the course of a year, it cannot simply be assumed that patients will continue to receive the plurality of their care from the same physician from year to year. The median Medicare beneficiary sees two primary care physicians and five specialists working in four different practices each year. Medicare patients with diabetes typically see eight physicians in five practices. The median beneficiary with cardiac disease sees ten physicians in six practices (Pham et al., *NEJM* 2007). Clearly, it is more fair, effective, and reliable to assign patients to an ACO based on a clear choice by the patient to be part of an ACO physician's panel.

If a beneficiary has maintained a relationship with a particular physician for a number of years or even decades, but does not want to participate in the ACO network, the beneficiary should not be required to switch to a new physician because all of the physician's patients are automatically attributed to the ACO. This would disrupt continuity of care. It could also be extremely detrimental to the physician's practice, which could lose a substantial number of patients who are confused or concerned about what participation in the ACO could mean for their care. The AMA, therefore, urges CMS to allow patients to affirmatively opt out of being part of an ACO while still maintaining their physician of choice.

CMS should hold Pioneer ACOs and ACOs in the MSSP accountable only for those patients who voluntarily choose its physicians to provide or manage their care and allow the ACO to access their data. Patients are currently allowed to opt out of having their data provided to their assigned ACO, but the ACO is not allowed to opt out of accountability for the costs of patients who refuse to share their data. This leaves the physician and ACO in the dark with regard to other services the patient receives outside the ACO. It also creates a disincentive for ACOs to provide primary care services to new Medicare patients with high cost conditions, which can lead to attribution of all of the beneficiary's health care costs to the ACO. ACO assignment without active patient support and participation limits the ability of physicians to help patients improve their health, avoid unnecessary hospitalizations, and reduce the use of unnecessary and duplicative services. An ACO should not be held accountable if a Medicare beneficiary is unwilling or unable to participate in efforts to better coordinate and manage their care. And if a beneficiary and a physician mutually agree to work together, that physician's ACO should benefit from the savings achieved as a consequence of that partnership.

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 the qualifying criteria? What are the advantages and/or disadvantages of either approach?**

CMS should accept any organization that wishes to participate in its payment models and that meets the conditions of participation, with no restrictions on the number or locations of the organizations. It is inappropriate to give one provider in a community access to a different payment approach, and prohibit others in the community from also participating if they wish to do so. It is also inappropriate to allow only certain beneficiaries in a community to benefit from improved care delivery, and prohibit others.

3. **Other than the options for refining population-based payments outlined in Section B below, should any additional refinements be made to the Pioneer ACO Model that would increase the number of applicants to the Pioneer ACO model?**

CMS should also consider adopting additional improvements that would:

- **Define a population-based payment/budget amount for the ACO in advance**, with adjustments based solely on the health status of the participating beneficiaries and changes in Medicare fee schedule amounts; and
- **Define quality measures and target levels for the ACO in advance**, avoid changes to the quality measures or targets mid-stream, and use the measures to ensure that quality is not decreasing, instead of requiring significant improvements on the quality measures if the primary goal is to reduce costs.

B. Population-Based Payments (PBPs)

1. **Would being able to choose different fee-for-service (FFS) reduction amounts for Part A and Part B services be of significant import when deciding to participate in the PBP? Why or why not?**

Ideally, ACOs should be able to select different FFS reduction amounts for different types of providers as well as for Part A vs. Part B services. In cases where a provider's services are going to be completely redesigned, a 100 percent population-based payment may be preferable to a mix of FFS and PBPs, whereas in other cases, 100 percent FFS payments may be the most appropriate. A standard element of most global payment arrangements is a Division of Financial Responsibility (DOFR) through which the provider and payer agree on which specific services the provider will be accountable for and which the payer will retain accountability for. CMS should provide this same flexibility for ACOs.

2. **Should CMS allow suppliers of durable medical equipment (DME) to be included on the list of participating Pioneer providers/suppliers that will receive reduced FFS payments? Why or why not?**

An ACO should have the flexibility to receive PBPs for any provider that is delivering services to the ACO's patients, including DME suppliers.

3. **Should CMS reconsider the requirement that a Pioneer ACO generate a specified level of savings in previous years in order to be eligible to elect to receive PBPs, and instead establish clear requirements for financial reserves? Why or why not?**

CMS should definitely reconsider this requirement. A Pioneer ACO will have very limited ability to redesign care and generate savings under a pure shared savings model since the underlying payment system is still based on FFS. With true PBP, a Pioneer ACO would have much greater ability to redesign care and achieve savings. Consequently, the ability or inability to generate savings under shared savings is not an accurate predictor of a Pioneer ACO's ability to manage a PBP.

Any requirement for financial reserves should be limited to the minimum amount necessary to ensure that the ACO can cover normal variation in the cost of services delivered by participating providers in between disbursements of the population-based payments. Unnecessarily high requirements for financial reserves will make it more difficult for small provider organizations to participate than for larger organizations.

4. **Should any additional refinements be made to the current Pioneer ACO PBP policy?**

The current structure of PBPs is biased against physician-led ACOs since the payments only replace the payments made to the providers who are part of the ACO. This means that a Pioneer ACO led by a large health system could receive a large PBP in place of both inpatient payments and professional fees, but a Pioneer ACO led by a physician group or IPA could only receive a payment based on professional fees, while the hospitals continue to be paid as they always have. A growing number of physician groups and IPAs have the capability to accept a global payment and pay claims to hospitals and other providers, but they cannot do this under the Pioneer ACO program. ACOs that are able to pay claims directly should also have the option to receive a population based payment in place of all FFS payments to all providers serving their patients, if they wish to do so.

SECTION II: Evolution of the ACO Model

CMS should offer the option for current ACOs in the MSSP to continue in the "Track 1" option with one-sided risk until they are ready to transition to two-sided risk. Under the November 2011 final rule for the ACO program, this option is only available during an ACO's initial three-year agreement period. Then the ACO must shift to "Track 2," with two-sided risk of shared savings and shared losses. ACOs have many concerns about the way the attribution, shared savings, and quality measures are working in the current model, and also concerns about the usability of the data they are receiving from CMS. Extending the Track 1 option could prevent providers from leaving the ACO program altogether until these problems are addressed, as well as encourage new providers to consider entering the ACO program. In addition, CMS needs to make the Advance Payment Model a regular part of the ACO program, rather than a temporary demonstration program. The vast majority of office-based physicians are in practices comprised of fewer than 10 physicians, and they have limited access to capital needed to cover the losses they can experience under fee-for-service payment until shared savings payments are made.

A. Transition to greater insurance risk

1. Should CMS offer ACOs capitation with insurance risk, similar to Medicare Advantage (MA) organizations? What are the potential benefits and risks to the Medicare program and beneficiaries?

The goal of the ACO program should be to enable health care providers to accept as much *performance* risk as possible, without being forced to take on *insurance* risk. "Insurance risk" is the variation in costs due to the number and types of health problems in a patient population. By contrast, "performance risk" is the variation in costs due to the way those health problems are treated. The term "capitation with insurance risk" literally means paying a provider organization a fixed amount per patient, without regard to the patient's health status. Medicare does not even do this with MA plans. An MA plan receives a risk-adjusted payment from CMS based upon the *health characteristics* of its members. Capitation with insurance risk would be an inappropriate way to pay providers.

CMS should offer ACOs the ability to be paid a risk-adjusted global payment for all of the providers in the ACO instead of individual FFS payments from Medicare. The providers would not be taking on true insurance risk, because the payments would be risk adjusted. But the providers would be taking on full performance risk, since all of the services provided to the patients would need to be paid from the pre-defined global payment.

2. What categories of spending should ACOs at full insurance risk be responsible for? (For example: Medicare Parts A and B, Medicare Parts A, B, and D, or Medicare Parts A, B, and D and Medicaid for Medicare-Medicaid beneficiaries)

No ACO should be expected to take on full insurance risk. However, ACOs which are willing to accept performance risk need the ability to redesign *all* aspects of patients' care, including professional services, inpatient services, post-acute care, and medications. Consequently, all or part of the types of services covered by Medicare Parts A, B, and D should be included in the ACO's payment.

3. Are there services that should be carved out of ACO capitation? Why?

The Affordable Care Act explicitly authorized CMS to offer "partial capitation" and "other payment models" to ACOs, and it should use that authority to do so. Each ACO should have the ability to define specific services that it wants to have included and excluded from a global payment. Because of the dramatically different structures of health care markets in different communities, providers in some communities will be able to accept accountability for a smaller range of services than providers in other communities. If a provider is willing and able to help CMS control a portion of Medicare costs, CMS should support that, rather than taking an "all or nothing" approach.

4. What type of agreements with non-ACO providers would the ACO need to adopt to take on full insurance risk for a beneficiary population?

In order to truly take accountability for costs, most ACOs will need and want to have the ability to pay non-ACO providers directly, rather than having those providers paid directly by Medicare.

5. **What key elements of the regulatory and compliance framework for MA should be adopted for ACOs assuming full insurance risk? What regulatory and compliance elements in Medicare Advantage would not be appropriate for ACOs assuming full insurance risk?**

ACOs should not be expected to take on full insurance risk. In order to enable ACOs to accept maximum performance risk, ACOs should have the ability to modify cost-sharing requirements for patients to enable more effective coordination of care and encourage the use of high-value services.

6. **What challenges would ACOs encounter in meeting state licensure requirements for risk-bearing entities? What types of waivers to current regulations and/or fraud and abuse laws, if any, would be necessary for ACOs to take on full insurance risk for a beneficiary population?**

ACOs should not be expected to take on full insurance risk. CMS should work with the National Association of Insurance Commissioners to develop a common set of regulations governing ACOs that do not force them to meet the same standards as insurance companies, since the ACOs will not be taking on insurance risk. In regard to the fraud and abuse laws, in general, we believe that the waivers created by the Department of Justice (DOJ) and the Office of Inspector General (OIG) for ACOs that participate in the MSSP should apply to ACO programs developed by CMS. In the event that CMS broadens the scope of risk for ACOs and does not apply the MSSP waivers, CMS should work with stakeholders to develop waivers which will allow ACO innovation. At a minimum, such waivers should be at least as flexible as those developed by the DOJ and the OIG for the MSSP program.

7. **MA organizations have significant infrastructure that ACOs do not currently have such as member services. What additional infrastructure would ACOs need to develop to be able to manage full insurance risk?**

ACOs should not be expected to take on full insurance risk. Medicare should retain responsibility for enrolling Medicare beneficiaries in the Medicare program and dealing with issues related to insurance coverage, and the ACO should focus on connecting beneficiaries with appropriate providers and services. Although ACOs will need to develop appropriate capabilities for care management, patient education, shared decision-making, etc. in order to be successful, CMS should not attempt to prescribe how these capabilities should be implemented.

8. **What are approaches for setting appropriate capitation rates? The Pioneer ACO program currently uses a national expenditure growth trend for benchmarking. What are the advantages and disadvantages of using national expenditure growth trends? What about for using a local reference expenditure growth trend instead?**

ACOs should not be paid using traditional capitation. ACOs should be paid using a risk-adjusted global payment with appropriate risk corridors, risk exclusions, and risk limits.

The method being used by the Pioneer ACO program to set expenditure benchmarks is highly problematic. ACOs in high-spending regions could slow Medicare spending growth significantly but still not be credited with "savings," while ACOs in low-spending regions can potentially be credited with savings even if they have above-average rates of spending growth. Moreover, the methodology does not adjust for variations in Medicare payment rates due to geographic adjustment factors or similar payment policies.

In theory, using a local benchmark would be fairer than a national benchmark, but the only way to estimate what local spending would have been in the absence of the ACO is to compare it to a comparable population in the local market, and if the ACO is large enough, or if there are multiple ACOs in the market, there may be no "comparable" population.

As more and more providers participate in accountable care arrangements, it will become increasingly difficult for CMS to determine what spending would have been in the absence of those arrangements. Consequently, CMS needs to define a different methodology. For example, ACOs could receive a population-based payment that is based on its expenditures during the prior year, updated by an inflation factor such as the MEI, and adjusted for both changes in the risk profile of the beneficiaries and also adjusted for any changes in Medicare fee schedules. This would give CMS a predictable amount of spending with affordable increases from year to year, and it would also give the ACO a predictable budget to work with.

9. **What are the advantages or disadvantages of different strategies for risk-adjustment? (Examples include demographic risk adjustment only and/or any of the MA risk adjustment methodologies.)**

There is no perfect method of risk adjustment. Since many ACOs will likely be participating in performance-based payment contracts with MA plans as well as with CMS, it would make sense for CMS to use a common risk adjustment methodology for both ACOs and MA.

CMS has been experiencing problems with risk adjustment in both MA and ACOs because a patient's risk scores inherently increase once the patient joins one of these programs. Providers in ACOs have both a reason and a mechanism for documenting all of a patient's health issues, rather than merely recording the diagnoses needed to bill for particular services. The solution to this is not to eliminate risk adjustment entirely or to use flawed methods (such as "risk adjusting" based on the prior years' expenditures on that patient). Rather, CMS needs to modify the risk adjustment methodology to address these problems. Most increases in RAF (risk) scores under the Hierarchal Condition Category (HCC) methodology likely occur because for the first time, conditions are being documented that patients had long before they entered the ACO or MA program. These preexisting, but newly documented, conditions should not only increase the patient's RAF score after they join the ACO. That would imply the patient is sicker than they were before they joined. The patient's *baseline* RAF score should *also* be increased using the newly documented but pre-existing conditions. That way, only *new* health problems that occur after the patient joins the ACO would actually increase the RAF score and signal the need for a higher payment. If this change is made, it would then be possible to adopt risk adjustment models that incorporate new data and medical conditions on a rolling basis thereby improving the accuracy of the scoring.

10. **What benefit enhancements (e.g. reducing co-pays for services delivered by ACO providers) would be appropriate for ACOs at full insurance risk to offer to their patients and how would these benefit enhancements improve care outcomes? How would benefit enhancements differ depending on integration across Medicare Parts A, B, D, and/or Medicaid?**

ACOs should not be expected to take on full insurance risk. ACOs should have the flexibility to adjust cost-sharing for patients based on the specific types of care changes the ACO is trying to implement. For example, if an ACO is focusing on an initiative to help patients with COPD avoid exacerbations, it would likely want to reduce cost-sharing on long-acting bronchodilators and nebulizers, whereas if the ACO is

focusing on more cost-effective testing for ischemic heart disease, it might want to reduce cost-sharing for tests ordered by physicians who use decision supports and shared decision-making tools based on appropriate use criteria. No single change in benefits will be appropriate, because the needs of Medicare beneficiaries differ from region to region and the opportunities for savings that ACOs will pursue will also differ.

11. What are potential program integrity issues that ACOs transitioning to full insurance risk may encounter and what are appropriate preventative safeguards?

ACOs should not be expected to take on full insurance risk. Giving an ACO full insurance risk could penalize an ACO that cares for patients with multiple or expensive health conditions. Conversely, paying the ACO on a risk-adjusted basis encourages the ACO to treat sick patients and to find higher-quality, lower-cost approaches to treatment. As we stated in Section II.A.6., the DOJ and the OIG have issued clear guidance for fraud and abuse issues concerning ACOs that participate in the MSSP program. This prospective guidance has become the standard for developing ACOs and, at a minimum, should be applied or closely replicated for CMS ACO programs going forward. In regard to other potential program integrity safeguards, we urge CMS to work closely with stakeholders in developing such safeguards, so as to minimize the burden on physician ACO participants.

12. What types of precautions should be taken by ACOs assuming full insurance risk to protect beneficiaries from potential marketing abuses limiting beneficiary freedom of choice? What are additional protections beyond those in MA that would be important for beneficiaries aligned to ACOs with full insurance risk to avoid adverse selection?

ACOs should not be expected to take on full insurance risk. Risk adjusted payments protect the ACO against adverse selection and protect beneficiaries against being excluded from care because of pre-existing conditions.

If ACOs are going to be successful, CMS needs to support them by educating beneficiaries about the value of getting medical care from a coordinated group of physicians and other health providers. While beneficiaries should have the freedom to change physicians or other providers when they believe they are receiving poor care, they should be encouraged to seek care from high quality health care teams.

13. Currently, beneficiaries are aligned to a Pioneer ACO through claims-based attribution. Pioneer ACOs are accountable for improved quality and lower expenditures for aligned beneficiaries. If Pioneer ACOs were at full insurance risk, should a beneficiary be allowed to elect alignment to a Pioneer ACO even if the beneficiary would not be aligned to the Pioneer ACO through the attribution methodology? What are advantages/disadvantages of allowing beneficiaries to voluntarily align themselves to an ACO at full insurance risk rather than sole reliance on claims-based attribution?

ACOs should not be expected to take on full insurance risk. Under any method of paying ACOs, the primary method of aligning beneficiaries to ACOs should be the beneficiary's voluntary designation of a physician associated with an ACO to provide the beneficiary's care (or designation of one of the ACO's primary care providers as the beneficiary's medical home), and designation of the ACO to make sure the beneficiary's care is well coordinated. Claims-based attribution, which is already seriously flawed as an approach, will become increasingly problematic as more physicians and other providers use flexible payments to deliver care in non-traditional ways. If a patient is getting good care without having to make

billable office visits to a physician in an ACO, the ACO should be able to get "credit" for such a patient even if there are no billable visit claims to trigger a claims-based attribution methodology.

B. Integrating Accountability for Medicare Part D Expenditures

1. **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. What factors, if any, pose barriers to the effectiveness of such collaborations? Are there any considerations, such as marketing considerations, that are relevant to the promotion of these business arrangements? What could CMS do in administering an ACO program to help ACOs and sponsors mitigate or avoid these barriers?**

In many cases, use of medications paid for under Part D can enable a beneficiary to avoid much more expensive services under Part A or Part B. In other cases, an appropriate set of Part B services can enable a beneficiary to avoid the need for expensive medications under Part D. In other words, an expense under Part D can generate savings in Part A or B, and an expense under Part B can generate savings under Part D. However, if the revenues and costs for Parts A, B, and D are kept segregated, there is no way to resolve the true net savings. Consequently, CMS needs to create a mechanism whereby ACOs can make cost sharing and coverage decisions for pharmaceutical benefits with recognition for the impacts of those decisions on all of the related Medicare spending, not just Part D. Similarly, the ACO should be able to get credit for reducing expenditures under Part D, particularly if it requires more expenditures under Part B to do so.

2. **Would ACOs be interested in and prepared to accept insurance risk as Part D sponsors or through contracting with pharmacy benefits management companies? If ACOs assume accountability for Part D expenditures, what are the advantages/disadvantages of CMS requiring ACOs to be licensed under state law as a risk bearing entity and relying on the current Part D bidding process, versus creating a unified expenditure target for Part A, B, and D combined, with a unified risk adjustment method?**

ACOs should not be expected to become pharmaceutical insurance companies merely to enable integration of pharmaceuticals into overall efforts to redesign care.

3. **Do ACOs currently have access to enough data to accept full risk for Part D expenditures? What other mechanisms would allow ACOs to assume accountability for Part D outcomes?**

ACOs should not be expected to accept full risk for pharmaceutical costs or full risk for any type of cost. Both the price of pharmaceuticals and the health conditions of beneficiaries are outside the control of an ACO, and they should be treated as insurance risk. Conversely, decisions about the types of drugs to prescribe to treat a patient's conditions are an appropriate part of the performance risk that ACOs should be expected to manage.

C. Integrating Accountability for Medicaid Care 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?

Depending on the community, the providers who care for the majority of Medicaid recipients may be very different from those who care for the majority of Medicare beneficiaries, so it would not be possible to simply assume that a Medicare ACO would have the same ability to manage care for Medicaid recipients as for Medicare beneficiaries. In particular, maternity care is one of the largest components of healthcare spending in Medicaid, but an almost non-existent component of the Medicare program. A Medicaid ACO is most likely to be able to take accountability for Medicaid outcomes for dual-eligible individuals.

2. What populations should CMS prioritize in integrating accountability for Medicaid outcomes? For instance, should ACOs be accountable for outcomes among all Medicare-Medicaid beneficiaries treated by the ACO historically? Or, should the ACO be accountable only for those Medicare-Medicaid beneficiaries over 65 years old or under 65? Alternatively, should the ACO be accountable for outcomes of all Medicaid beneficiaries as well as CHIP beneficiaries? Should they be accountable for all those beneficiaries residing in a specified geographic area, regardless of whether they had been cared for by the ACO?

It would be extremely difficult, if not impossible, for an ACO to accept accountability for Medicaid-only beneficiaries if they are "attributed" to the ACO using the same types of rules that CMS is using for Medicare. The fact that so many Medicaid recipients only receive benefits for a limited period of time means that an individual may no longer be on Medicaid by the time they are attributed to an ACO. Most Medicaid managed care plans require Medicaid recipients to choose a primary care physician (or assign them if one is not chosen), and CMS would need to require this for Medicaid ACOs to be successful. For young women on Medicaid, their primary source of care may come from a maternity care provider, and so visits to a maternity care provider should be an option for the attribution or assignment of patients to the ACO as well as visits to a primary care provider.

Similarly, the Medicaid outcomes that an ACO can reasonably accept accountability for are those that are directly related to services that the ACO can provide while the Medicaid beneficiary is (a) eligible for Medicaid and (b) receiving care from the ACO's providers.

3. What should the role of States be in providing appropriate incentives to foster the development of an integrated care system? What roles should States play in supporting model design and implementation? Do States have adequate resources to support an ACO initiative in collaboration with CMS?

States can play a key role in fostering coordination of care and accountability for costs by:

- Using accountable payment models to pay ACOs, not only through the Medicaid program, but also for state employees;
- Facilitating discussions among providers and payers to agree on common approaches to payment;

- Deterring large provider organizations from refusing to provide services under contract to smaller ACOs that cannot provide a full range of services themselves; and
- Ensuring that providers forming ACOs are not subject to unnecessary or burdensome insurance regulations.

4. **What are the current capabilities of ACOs and other providers in integrating and using Medicare FFS and Medicaid FFS data to drive care improvement and performance reporting? What are the capabilities of providers in integrating this data with electronic health records? What are the capabilities of integrating information for care received in the community or from other non-traditional care providers?**

It is inefficient to expect every ACO to independently develop the capability to merge and analyze multiple sources of claims data. Moreover, requiring this capability will make it more difficult for smaller, physician-led ACOs to participate. CMS should proactively support the efforts of multi-stakeholder Regional Health Improvement Collaboratives to become Qualified Entities, to merge Medicare, commercial, and Medicaid claims and combine them with clinical registry data, and to provide analyses to providers interested in forming ACOs as well as to existing ACOs to help them succeed. In addition to providing timely access to data, CMS needs to provide funding to support the analytic work and to provide technical assistance to physicians.

5. **What financial arrangements would be most appropriate for ACOs assuming risk for Medicare and Medicaid expenditures? Should CMS and States offer separate but coordinated shared savings arrangements to ACOs? Should CMS and States offer a unified shared savings arrangement that reflects combined Medicare and Medicaid expenditures?**

For dual eligible individuals, it is inappropriate for the state and CMS to try and calculate and pay "shared savings" separately, since some Medicare expenditures can help avoid a Medicaid expenditure and vice versa. The only way to create a patient-centered payment approach to support these individuals is for CMS and states to acknowledge that they are each "partial payers" for the patients, and to combine their separate payments into a single, risk-adjusted global payment to the ACO. CMS and the states can then decide how to divide any net savings between them, rather than forcing the ACO to do so.

For individuals who are on Medicaid or Medicare but not both, states and CMS can pay the ACO separately for their respective beneficiaries, but they should do so using payment methodologies that are as similar as possible, so the ACO can make changes in care based on the patients' needs, not based on the source of their payment.

D. Other Approaches for Increasing Accountability

1. **A provider-led community ACO would be an ACO that would be held accountable for total Medicare, Medicaid and CHIP expenditures, and quality outcomes, for all Medicare, Medicaid and CHIP beneficiaries residing in the ACO's service area, regardless of those beneficiaries' historical care patterns. What are options for accountable care models that are geared specifically for geographically aligned populations of beneficiaries? What are the most critical design features of a provider-led community ACO model and why? What additional quality measures should be**

considered if an ACO is responsible for all covered lives in a geographic area? Are there models to consider that better integrate community-based services beyond the traditional medical system?

If all of the providers in a community come together to manage overall outcomes for the residents of a community, CMS could support that through the same mechanisms it uses to support any other ACO. However, a "community ACO" should be a voluntary effort by the community. It should not be imposed on the providers in a community either directly or indirectly, e.g., by setting minimum thresholds for the number of beneficiaries in an ACO that make it impossible for multiple ACOs to form in a community. In many cases, it will be preferable for beneficiaries to have a choice of ACOs, and CMS should not preclude or discourage that.

In regard to quality measures, "community ACOs" should have the ability to decide which areas of quality improvement they are going to target and the measures they are going to utilize to tackle the quality of care in their community. Each community has different quality improvement needs. Therefore, it should be left up to the discretion of each "community ACO" to decide the quality measures that are most appropriate to address the particular areas that need improvement in that community.

Community-based services can be part of what any ACO offers or supports if CMS provides the ACO with a sufficiently large and flexible population-based payment; it is not necessary to have a community-wide ACO for that to be possible.

2. **In certain permissible circumstances, organizations are able to pursue multiple service delivery and payment reform initiatives. Should CMS formalize an accountable care model where various service delivery and payment reform initiatives are combined? More specifically, would there be interest in a model that tests comprehensive primary care within an ACO context and/or an ACO that incorporates episode-based payments. If so, what would the most critical features of such a "layered" ACO be and why?**

One of the biggest weaknesses of the current shared savings payment system used by CMS to support ACOs is that it does not actually change the underlying FFS payment system, which makes it difficult for providers to significantly redesign the way they deliver care. Conversely, other CMS initiatives which do make changes in payments, such as the Comprehensive Primary Care Initiative, attempt to hold individual providers accountable for the total costs of care for beneficiaries, even though those providers cannot control or even influence all aspects of cost. Consequently, both the ACO program and other CMS payment initiatives would benefit by not only allowing, but encouraging the use of payment reforms for primary care practices, specialists, hospitals, post-acute care providers, etc. inside of ACO payment structures.

For example, CMS could make medical home payments to primary care practices, condition-based payments to specialists, and episode payments to hospitals that are part of an ACO. The overall ACO accountability for total cost would help ensure, for example, that episode payments did not cause more episodes to be delivered, while the shared savings calculation or the population-based payment for the ACO would be adjusted to account for any extra payments made by CMS to providers in the ACO or any discounts provided to CMS by the ACO as part of the individual payment models. This "layering" of payments to an ACO would be analogous to the way many physician groups, physician IPAs, physician-hospital organizations, and health systems "sub-capitate" portions of an overall capitation payment to subgroups of providers.

CMS should also make other payment models available to ACOs besides the current shared savings model. Although Section 1899 of the Social Security Act is entitled "Shared Savings Program," section 1899(i) explicitly gives CMS the authority to "use other payment models," including a partial capitation model. These other payment models would likely be more attractive to many physician groups than the pure shared savings model that CMS is currently using.

E. Multi-Payer ACOs

1. How can CMS encourage the adoption of ACO contracts among other payers of Medicare ACOs?

Many other payers already have "ACO" contracts with providers. A key challenge these providers face is obtaining comparable payment reforms from CMS. Even if CMS feels it is improving on commercial ACO contracts when it defines the way that Medicare will contract with ACOs, using a different payment structure or different administrative requirements than other payers means that CMS is creating extra costs and complexity for the ACO and its providers that will reduce their ability to focus on the primary goals of care improvement and cost reduction.

In order to encourage participation by payers that are not currently supporting ACOs, CMS could offer more favorable Medicare requirements or payment terms to ACOs that have multiple payers participating.

2. How can CMS and other payers focus reporting of quality measures on the most important priorities while minimizing duplication and excess burden?

CMS could encourage alignment of quality measurement among payers in several ways. First, CMS should align its own quality measurement programs. In both its ACO and CPCI programs, CMS has chosen different quality measures than it uses in its Medicare Advantage 5-Star Quality Rating program; this means that Medicare Advantage plans that want to support an ACO or CPCI physician practice typically want to use 5-Star measures instead of or in addition to the CMS measures for ACOs and its other payment models. Physicians who are part of an ACO should be able to satisfy their Physician Quality Reporting System (PQRS), Meaningful Use Quality Measures, and Value-Based Modifier requirements through their affiliation with an ACO. If the purpose of an ACO is to improve quality and care coordination while reducing costs, then physicians who are taking the steps to align themselves with an ACO should not have to duplicate quality reporting requirements.

Second, CMS should allow case-by-case changes in the quality measures it requires of individual ACOs in order to align with the measures that commercial and Medicaid payers want to use for those ACOs. It is unreasonable for CMS to expect other payers to adjust their quality measures if CMS is not willing to do so itself.

Finally, CMS should give ACOs the flexibility to propose quality measures that are directly related to the aspects of care delivery where the ACO will be focusing its cost containment efforts. Requiring the ACO to focus on quality improvement for patient conditions or services different from where the ACO is attempting to reduce costs not only forces the ACO to spread its care transformation resources more thinly than would be desirable, it also means that CMS is not measuring quality in the areas where beneficiaries have the most potential to be harmed by cost reduction efforts.

ADDITIONAL ISSUES

I. ACO Exclusivity

CMS is applying exclusivity rules for the MSSP more broadly than indicated in the initial regulations, and is effectively precluding any practice that performs evaluation and management services from full-fledged participation in more than one ACO regardless of specialty. As noted in the rule, the goal of this policy is to ensure that only one ACO can claim savings on any given Medicare beneficiary. While the intent is laudable, a growing number of physician organizations have found that the policy is creating significant disruptions in current care networks and physician-patient relationships. This policy has the potential to limit patient choice, and may restrict the number of hospitals and practice networks that physician practices affiliate with. It has also discouraged ACO participation by some large physician group practices. In fact, the Medicare Payment Advisory Commission (MedPAC) has been discussing this issue and seems likely to recommend modifications in the process that CMS now uses.

ACOs participating in the MSSP must provide primary care to at least 5,000 patients. Initially, CMS proposed to define primary care as evaluation and management (E&M) services (not including hospital inpatient or emergency room care) provided by general internists, general practitioners, family physicians and geriatricians. Also, in order to ensure that only one ACO could share in any savings related to these patients, the Tax Identification Number (TIN) used to bill for their care could only be a full-fledged "participant" in one ACO (i.e., all the primary care physicians in a TIN had to be "exclusive" to that ACO unless they created another TIN for the purpose of participating in another ACO).

In the final rule, CMS expanded the attribution process to include a second step where beneficiaries who had not received relevant E&M services from a primary care physician could still be attributed to an ACO based on E&M services provided by another specialty. The rule also specifically stipulated that "each ACO participant TIN *upon which beneficiary assignment is dependent* must be exclusive to one ACO for purposes of the Shared Savings Program" and that "*ACO participant TINs upon which beneficiary assignment is not dependent are not required to be exclusive.*" Because CMS applies exclusivity at the TIN level, however, this means that if even one member of the practice meets the exclusivity requirement, all physicians billing under the same TIN are also exclusive.

Because the vast majority of beneficiaries are assigned based on care from a primary care specialist, this provision was initially expected to have little impact on physicians outside the specialties CMS had designated as primary care. However, in two Frequently Asked Questions (FAQs) posted on the agency's web site, CMS stated that it requires exclusivity whenever any physician in the ACO-affiliated group, regardless of specialty, provides any of the relevant evaluation and management services *even if none of those services were used to attribute patients to the ACO*. CMS also pointed out in the FAQ that physicians do not have to be "participating" in an ACO in order to treat beneficiaries assigned to the ACO. Physicians can get around the exclusivity requirement and participate in multiple ACOs using a different TIN for each one, and they may affiliate with multiple ACOs using a single TIN if they sign up as "other entities" rather than full-fledged "participants." These additional options have some significant downsides, however, such as increased administrative burden and costs.

Together with a number of medical specialties, the AMA has developed a list of possible solutions which we have previously shared with CMS staff and which preferably would apply to both primary care and other specialties. This includes a prioritized list of alternative exclusivity policies from which CMS could choose, along with a list of changes that are needed in whatever final policy, including continuation of the

current one that CMS adopts. It should be noted that movement to prospective assignment would eliminate the need for the more complicated process CMS is now using and could facilitate adoption of a more flexible exclusivity policy.

Our preferred alternative would be to allow participation in multiple ACOs unless the individual physician (as reflected in the NPI) chooses to be exclusive (i.e., the physician would have to opt in to the exclusive arrangement). It would also be possible, though less desirable, to make exclusivity optional at the practice or TIN level.

Whatever exclusivity policy CMS adopts, including retaining the current policy, certain other steps are needed to improve the process. One critical change is to eliminate nursing home visits (HCPCS codes 99304-99318) in skilled nursing facilities (SNFs) from the definition of primary care services. This would correct a policy that misrepresents the type of care that is delivered in SNFs and has exacerbated exclusivity problems for the physicians who practice in this setting. In addition, CMS should provide additional guidance that would help physicians understand the way the attribution process works, when exclusivity to a particular ACO is required, and the potential pros and cons of using an "other entity" arrangement to avoid being locked into a single ACO. Based on feedback from our physicians, we believe that hospitals, ACOs and physicians are all confused about the current rules. We also believe CMS should:

1. Warn hospitals, ACOs and ACO applicants about making false or misleading statements to physicians and patients regarding the consequences of ACO assignment and participation.
2. Provide beneficiaries with a clear statement from Medicare or the ACO that they may continue to receive care from their current physicians whether or not these physicians are part of the ACO.
3. Create an expedited process to help physician practices obtain new TINs and provide "safe harbors" regarding potential Stark, anti-kickback, civil monetary penalties, and Internal Revenue Service liabilities resulting from using multiple TINs.

II. ACO Leadership

As CMS' ACO programs evolve and progress, we urge CMS to ensure that physicians have the opportunity to contribute in a substantial way to the ACO's governance and management activities. For ACOs to achieve the goals of the MSSP and other ACO programs, physician perspectives on matters such as the mission and goals of the ACO, clinical quality improvement, and overall management of patient care activities should be an integral part of ACO leadership activities. In the context of the MSSP, while CMS initially proposed that ACOs be required to have a governance structure specific to the ACO, CMS later finalized a policy that permits hospitals, in some cases, to use their existing governance structure to govern the ACO, providing that they otherwise meet the program specific governance requirements. In our view, this approach can fail, in some cases, to accomplish the level of physician leadership necessary for the long-term success of the ACO. Irrespective of governance model, it is imperative that ACOs develop a functionally integrated leadership model that incorporates physicians into the key decision making processes of the ACO. The AMA and the American Hospital Association recently held a conference which highlighted such integrated leadership models as they currently exist in ten successful delivery systems in the United States. A summary of this conference and these models will soon be available, and can be supplied upon request. We look forward to continuing to work with CMS on this issue as CMS examines best practices for ACOs.

In closing, the AMA appreciates this opportunity to provide our recommendations, and we would be happy to provide additional information and assistance. We look forward to continuing to work with CMMI and CMS to support the successful implementation of ACOs that can benefit the Medicare program, patients, and physicians.

Sincerely,

James L. Madara, MD