National Business Group on Health

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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

February 6, 2015

The Honorable Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services (CMS)
Room 314 G
U.S. Department of Health and Human Services (HHS)
7500 Security Boulevard
Baltimore, MD 21244–1850

RE: Proposed Rule for Medicare Shared Savings Program (MSSP): Accountable Care Organizations (CMS–1461–P)

Dear Administrator Tavenner:

The National Business Group on Health appreciates the opportunity to comment on CMS' proposed rules for the Medicare Shared Savings Program for Accountable Care Organizations (ACOs). The Business Group strongly supports Medicare's recently announced commitment to accelerate its move toward alternative payment methods and believes that ACOs are a critical part of improving the effectiveness and efficiency of the Medicare program, and ultimately, for its long-term financial sustainability.

The National Business Group on Health represents approximately 415 primarily large employers (including 67 of the Fortune 100) who voluntarily provide health benefits and other health programs to more than 50 million American employees, retirees, and their families. A growing number of our members have considered commercial ACOs and some have signed contracts with ACOs for the care of their employees' health.

The structure of the next phase of the ACO program, after its initial three years, and its operating rules will be critical to its success and to Medicare's reform efforts. With this in mind, the National Business Group on Health makes the following recommendations and provides more details for each in the attached addendum:

We support:

- The creation of the new ACO Track 3, which increases the possibility for more advanced, experienced ACOs to share more of the savings gains as long as they are willing to take on more of the risk of losses.
- Rewarding bonuses to ACOs who score higher on quality of care than fee-for-service (FFS) providers in their local area.

- Regulatory relief from certain Medicare coverage restrictions for those ACOs willing to bear downside risk.
- Prospective assignment of beneficiaries, especially for ACOs bearing downside risk, so they know at the beginning of the year which beneficiaries they are responsible for.
- Allowing ACOs that take on downside risk the option to lower cost sharing for beneficiaries as an incentive to select these ACOs.

We do not support:

- Extending the ability for Track 1 ACOs, which share no downside risk, to stay in Track 1 for an additional three years. Current rules require them to transition to Track 2, which is a two-sided risk model, after the first three years.

Again, thank you for the opportunity to comment on this critical program. Please contact me or Steven Wojcik, the National Business Group on Health's Vice President of Public Policy, at (202) 558-3012 if you would like to discuss our comments in further detail.

Sincerely,

President and CEO

Addendum

Support for the new Track 3 for ACOS

This new track would provide incentives for the pioneer ACOs, those with long experience and success as ACOs well before the creation of the ACO program, to continue to participate in the program and be increasingly rewarded for the value they add to Medicare. Track 3 ACOs would have an opportunity to increase their share of savings from 60% to 75% up to 20% of the benchmark (spending target), which is greater than either the Track 1 ACOs (maximum bonus up to 40% of savings up to 2% of the benchmark) or Track 2 ACOs (maximum bonus up to 60% of savings up to 4% of the benchmark), as long as they are willing to accept greater risk for losses, which would be capped at 60% of the benchmark. Track 1 ACOs have no downside risk and Track 2 ACO's downside risk is smaller than that proposed for Track 3 ACOs.

Ultimately, Track 3 represents a future state for all ACOs with possibilities for bigger gains if they meet quality and cost savings targets and strong financial incentives to coordinate care and reduce unnecessary utilization to keep costs down. It will create strong incentives for more recently formed Medicare ACOs to take on more risk and eventually move to Track 3.

Rewarding ACOs Who Exceed Quality Targets

We strongly believe that CMS should establish quality bonuses for ACOs whose quality exceeds FFS. Currently, exceeding quality targets is not rewarded. Rather, ACOs that meet or exceed quality targets merely preserve their ability to share savings at the highest rate while a lower quality score reduces the rate at which they share any savings achieved. It is a penalty model, penalizing lower quality rather than rewarding higher quality. Improving quality relative to FFS should be important enough in the ACO program to warrant CMS' serious consideration of bonus payments. This would also be an additional tool to attract high quality ACOs to the program and encourage current ACOs to improve quality.

Relief from Certain Medicare Coverage Rules

Granting regulatory relief to ACOs that take on two-sided risk (Tracks 2 and 3) would enable them to pursue more innovative care management. For example, it could allow beneficiaries to be discharged to skilled nursing facilities (SNF) from hospitals prior to meeting the current 3-day minimum inpatient stay requirement for Medicare coverage of SNF care. Similarly, waivers of rules for billing and payment for telehealth services, the requirement to be homebound for coverage of home health services, and the ban on referrals to specific providers for post-acute services would give ACOs more flexibility to control costs by enabling care in lower cost settings, improving care coordination, and reducing inpatient hospital use.

Prospective Beneficiary Assignment

Moving from retrospective attribution to prospective assignment of beneficiaries would enable ACO providers to know which beneficiaries they are accountable for at the beginning of the year. Currently, most assignment of beneficiaries occurs at the end of the year and is based on the percentage of primary care services beneficiaries receive through an ACO's providers. In many cases, ACO providers do not know until at the end of the year which patients will be attributed to them. If providers know who they are accountable for at the beginning of the year, they will know who to focus their care coordination efforts on and it would increase their willingness to make the investment to improve care since they could share in any savings that result. In addition, if beneficiaries in a two-sided risk model are known at the beginning of the year, ACO providers will have stronger incentives and to engage them and their caregivers in partnering in care management to reduce costs and improve quality.

Allowing Track 3 ACOs the Option to Reduce Beneficiary Cost Sharing

Track 3 ACOs could also be given the option to waive certain beneficiary cost sharing requirements, which current Medicare rules prohibit. Permitting reduced cost sharing for visits with ACO providers will increase beneficiary identification with an ACO and make it easier for the ACO to effectively manage care and control costs if it leads to less beneficiary use of non-ACO providers and encourages them to stay within the network of ACO providers. It would also be a tool for the better-performing ACOs to attract more beneficiaries.

No Extension of One-Sided Risk Model for Current ACOs

We do not believe that ACOs that have currently been in the bonus only, one-sided risk, model should be permitted to stay in Track 1 for another three years. Current rules require them to take on downside risk and move to Track 2. Eliminating this requirement sends the wrong signal to ACOs and to Medicare providers in general. It runs counter to the Secretary's recent public commitment to accelerating Medicare's move to alternative payment models. The proposed changes to Track 2, particularly the greater opportunity for sharing in savings, should encourage more ACOs to take on increased risk. If CMS does extend the length of time an ACO is permitted to remain in Track 1, the ACO should demonstrate year over year improvements in controlling costs and improving quality each year that it remains in Track 1 or be dropped from the program.