Health Program

Health Project

Transitioning to Organized Systems of Care:

Near-Term Recommendations to Improve Accountable Care Organizations in Medicare

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BIPARTISAN POLICY CENTER

ABOUT BPC

Founded in 2007 by former Senate Majority Leaders Howard Baker, Tom Daschle, Bob Dole, and George Mitchell, the Bipartisan Policy Center (BPC) is a non-profit organization that drives principled solutions through rigorous analysis, reasoned negotiation, and respectful dialogue. With projects in multiple issue areas, BPC combines politically balanced policymaking with strong, proactive advocacy and outreach.

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DELIVERY SYSTEM REFORM INITIATIVE

In April of 2013, BPC issued A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment, a report which laid out a comprehensive set of policy recommendations for lowering costs, improving quality, and reducing inefficiency across the health care system. As a continuation of that work, the Delivery System Reform Initiative's four co-chairs – former Senate Majority Leaders Tom Daschle and Bill Frist, former White House and Congressional Budget Office Director Dr. Alice Rivlin, and former Ways and Means Health Subcommittee Chair Jim McCrery – are developing meaningful policy solutions to facilitate and accelerate the transition to a value-based health care system.

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Background

The Bipartisan Policy Center (BPC) Delivery System Reform Initiative leaders and staff, in collaboration with a diverse set of health care experts and stakeholders, are developing solutions to meaningfully facilitate and accelerate the transition to higher-value, more coordinated systems of health care payment and delivery.

This work builds on comprehensive policy recommendations in BPC's 2013 report, *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment*, such as Medicare Networks[i] in which providers are accountable for quality, cost, and satisfaction for a defined population of patients.[1] Since its publication, experts and officials have had nearly two years of additional experience with reformed payment in Medicare, Medicaid, commercial insurance, and self-insured plans. What's more, in early 2014, an agreement was forged among leaders of the congressional committees of jurisdiction (Senate Finance, House Ways and Means, and House Energy and Commerce) on long-term physician payment reform legislation that would, among other provisions, establish clear incentives within the physician fee schedule for the adoption of alternative payment models (APMs).[2] While final action on this tri-committee bill has not occurred, it represents an important bipartisan step toward transitioning from fee-for-service payment to new models that reward value, including improved health outcomes, patient experience, and cost. The recommendations in this series are intended to build on that framework and early APM implementation, improve the viability of APMs, and make progress toward the long-term vision for the health care system presented in *A Bipartisan Rx*.

1. *Transitioning from Volume to Value: Opportunities and Challenges for Health Care Delivery System Reform* discusses progress and next steps toward payment and delivery systems that increase provider accountability for health outcomes, patient experience, and cost. [August 2014][3]

2. *Transitioning to Organized Systems of Care: Medical Homes, Payment Bundles, and the Role of Fee-for-Service* addresses early implementation of two APMs in Medicare, bundled payment and patient-centered medical homes, as well as adjustments to the Medicare fee schedules. [January 2015][4]

3. This paper, *Transitioning to Organized Systems of Care: Near-Term Recommendations to Improve Accountable Care Organizations in Medicare*, reviews implementation of accountable care organizations (ACOs) in Medicare and offers near-term recommendations to improve this model. [January 2015][5]

[i] BPC's April 2013 report proposed to accelerate the transition to value-based payment models by creating an enhanced version of ACOs, called "Medicare Networks," which would be provider-led and would feature an enrollment model and stronger incentives for beneficiaries and providers to participate.

4. *Up Next:* The fourth paper in this series will address the imperative to have a more workable number of user-friendly, meaningful, and outcomes-oriented quality measures integrated within all alternative payment and delivery reform models

Introduction

The results from the first two years of Medicare's ACO programs are in, and those results show a mix of modest successes and significant challenges. Specifically, quality results were disappointing in many cases, and most ACOs generated modest or no savings—especially in the Medicare Shared Savings Program. The Medicare ACO programs are the only APMs to be implemented so far with a scope that incorporates the vast majority of health services (essentially all Medicare-covered services except for prescription drugs); other APMs, such as bundled payment and patient-centered medical homes, focus on smaller subsets of services. Because of the broad scope of services covered and coordinated, advocates for a population health approach to payment and delivery system reform point to ACOs as a promising concept to ensure that providers have more responsibility for health outcomes, patient satisfaction, and spending across a broad range of care settings and service types. Some of the performance challenges of ACOs in the first two years may result from implementation issues and the short timeframe for results. But many of the challenges are due to program design issues, which can and should be addressed.

In 2013, BPC outlined a long-term vision for payment and delivery system reform in Medicare, which included a proposal for three Medicare options for both providers and beneficiaries: (1) a reformed fee-for-service option with modernized cost-sharing and improved protections for beneficiaries; (2) an enrollment-based ACO model called *Medicare Networks* with strong incentives for providers and patients to participate; and (3) a reformed, competitively priced Medicare Advantage program. Medicare's current ACO programs lack many of the features that were proposed in BPC's Medicare Networks concept. Many of these features—such as giving providers clearer expectations, engaging beneficiaries directly with the ACOs, and establishing stronger incentives for both providers and beneficiaries to participate—could help improve the success of Medicare ACOs.

The transition from pure volume-based payment to assuming responsibility for quality, patient satisfaction, and cost is difficult, requires upfront investments of time and financial resources on the part of providers, and maximal outcomes are likely to take many years to achieve. The establishment of a clear and viable pathway from the status quo to greater amounts of responsibility and risk is one of the most significant and important challenges for the long-term success of ACOs as an APM. For example, most current Medicare ACOs are only accepting upside risk (also known as one-sided risk), meaning that they can potentially share in savings, but have no liability for spending that exceeds a target. The addition of downside risk (also known as two-sided risk) creates much stronger incentives for ACO providers to control excess spending because they—not just the Medicare program—would have to share in any losses. Significant progress could be made administratively by the Centers for Medicare & Medicaid Services (CMS) in this area; however, some of these adjustments would require statutory changes. In December 2014, CMS issued a proposed

rule addressing changes to Medicare ACOs.[6] While the proposal is a step in the right direction, more aggressive changes are needed, as outlined in the recommendations of this report, to maximize the likelihood of success for Medicare ACO programs. Additionally, in 2014, Congress failed to act on a promising bipartisan legislative proposal to replace the Medicare physician payment formula, which included provisions to encourage and advance the formation of APMs in Medicare, including ACOs. With the opportunity to revise and finalize the proposed ACO rule and with the upcoming March expiration of the most recent patch to Medicare's physician payment formula, both CMS and Congress will have opportunities in 2015 to make regulatory and statutory changes to encourage and enhance Medicare ACOs.

This paper is organized in two sections. The first includes a review of Medicare ACO programs so far and itemizes key challenges. The second makes recommendations to address these challenges and improve the ACO programs.

Medicare ACOs: The First Two Years

Medicare has launched two ACO programs: the Pioneer ACO model, which is a demonstration operated by the Center for Medicare and Medicaid Innovation (CMMI), and the Medicare Shared Savings Program (MSSP), which is specified in statute and operated by the Center for Medicare. There are more than 350 Medicare ACOs, to which more than five million Medicare beneficiaries have been assigned.[7] While there are many details to these programs, the concept is straightforward. Each ACO, formed and governed by providers, is responsible for a population of beneficiaries, a set of quality goals, and a budget target for each year. At the end of the year, if actual spending for an ACO's attributed beneficiaries is under the budget target and quality goals are met, the ACO would share in a portion of those savings. In more advanced versions of this model, ACOs have to repay shared losses if actual spending exceeds the budget target. The Pioneer ACOs are already subject to sharing in losses, also known as downside risk; most MSSP ACOs are not, but might in the future. Operational results covering quality and financial performance are now available for both Pioneer and MSSP ACOs. Participating providers and expert observers have also offered considerable feedback about the programs' challenges.

Initial Outcomes

The smaller Pioneer ACO model, which is in its second year of operation, was intended for more advanced providers who were prepared to assume more risk early on. There are now 19 participants, as 13 of the original 32 Pioneer ACOs either switched to the MSSP or dropped out entirely. In September, CMS announced that in the second year of the program, Pioneer ACOs increased mean quality scores by 19 percent (showing improvement on 28 of 33 measures), generated total savings of $96 million, qualified for shared-savings payments of $68 million, and delivered per capita spending growth 0.45 percent lower than fee-for-service Medicare.[8] A Brookings Institution analysis of the first two years of Pioneer ACO results noted that the largest improvement in quality in the second year was in the group of measures focused on at-risk populations, suggesting that these ACOs are better at coordinating care for patients with multiple chronic conditions.[9] However, the analysis also found a discouraging pattern in the data: the seven Pioneer ACOs with the highest-quality performance were associated with very small shared savings or even shared losses, while the group of six ACOs with the largest savings had relatively average quality scores.

The larger MSSP has 220 ACOs participating that have completed their first year of operation. (About 100 more are too new to report results yet.) The vast majority of the

MSSP ACOs are only taking one-sided risk, meaning that they can share in savings but are not responsible for paying shared losses back to the Medicare program if spending exceeds the budget target. CMS announced that 53 MSSP ACOs, about a quarter of the total, produced $652 million in savings under their targets, qualifying for $300 million in shared-savings payments. Another 52 ACOs had spending under their targets but did not meet the minimum threshold to earn a shared-savings payment; the other half of the ACOs did not generate savings. While CMS indicated that MSSP ACOs overall showed improvement on 30 of the 33 quality measures, an Avalere analysis noted that the majority of ACOs that earned shared savings also had quality scores that were below the MSSP national average.[10] In the program's first year, ACOs could share in savings as long as they reported performance on all 33 quality measures, regardless of the actual quality results. Beginning with the second year of the program, ACOs will be required to meet minimum quality standards to share in any savings, and meeting even higher quality standards will be a precondition for the maximum shared-savings bonuses.

Challenges

There have been a multitude of challenges for participating providers and CMS during the implementation of the Medicare ACO programs. Some of the key problems are:

ACOs lack certainty about the patients and budget target for which they will be held responsible. Because beneficiaries are attributed to each ACO retrospectively based on claims data during the year, ACOs do not know their designated patient population until the year is over. Many ACO providers have been surprised to learn that the patients they expected to be attributed to the ACO were not. For example, a patient who typically sees ACO providers who are non-physician practitioners, such as physician assistants, might not be attributed to the ACO because of shortcomings in the attribution methodology. Because the benchmark-spending target is determined retrospectively as well, ACOs are limited in their ability to manage to the target during the year.

ACOs have very limited ability to engage patients in care-improvement efforts. A recent study found that two-thirds of specialty office visits for attributed beneficiaries occurred outside of the assigned ACO.[11] This is a natural consequence of a program design that limits beneficiary engagement, as it does not provide patients with a choice about participating, along with information and education about the model with a clear value proposition. It is also one of the most serious problems with Medicare's ACO model. Because beneficiaries do not necessarily know they are part of an ACO, let alone have any incentives, financial or otherwise, to seek care from ACO providers, efforts by the ACO providers to improve outcomes through better coordination and management of chronic conditions are constrained.

The programs use far too many quality measures that are too focused on process. The number and nature of the quality measures requires significant time and resources for ACOs to monitor and report, and it is not clear if the 33 measures currently in use are

meaningful for patients, providers, or the Medicare program. Since other parts of the Medicare program and other private payers have their own quality measures and reporting requirements, the burden on providers for the sum of these has become quite high.[ii]

The potential rewards for participating in the program often don't justify the expense and risk. In many cases, Medicare ACO program parameters do not allow enough savings to be shared with providers in order to justify upfront investment to start the ACO (typically around $2 million) and the level of risk that ACO providers assume going forward.[12] A prime reason is the calculation of benchmarks, which serve as spending targets, in both Pioneer and MSSP ACOs. Because ACO benchmarks are based on provider-specific, historical spending and are reset after every three-year contract period, ACOs must continually improve to share in any savings over the long-term. For providers that are relatively efficient to begin with, which have to work harder to find additional efficiencies, this is a particularly unattractive proposition. While less-efficient providers should be able to earn significant shared savings based on historical benchmarks in the near-term, the frequent resetting of the benchmarks is likely to make the model unsustainable for them over the long-term. While the intent may have been to allow the Medicare program to benefit from savings as quickly as possible, the unintended consequence has been that Medicare ACO contracts are less attractive to providers that are already relatively efficient, which limits the model's potential impact on both quality and spending.

Many providers that want to participate in ACOs struggle to access capital. A related issue for providers is financing the investments necessary to adopt this new payment and delivery model. Because the potential rewards come later, ACOs need to find a different source of funds for implementation. An Advance Payment ACO model is being demonstrated by CMMI, but has had low take-up and is structured as a grant, rather than as a loan that must be repaid. Existing public-lending programs are focused on hospital facilities, not delivery system transformation.

Providers have weak or no incentives to accept more risk. Since most ACOs are currently at one-sided (upside) risk and can only share in any savings but not two-sided (downside) risks and costs, understandable concerns have been raised that there will be too little incentive to manage costs well. In contrast, two-sided risk, which combines the potential rewards of upside risk with the potential penalties of downside risk, would motivate providers to ensure that spending does not rise above the benchmark. However, providers have little incentive to adopt payment models that include greater risk. The tri-committee bill proposes an important step to address this lack of incentives by conditioning future physician fee-schedule payment-rate updates on participation in APMs. But this reform has not yet become law, and the proposal does not address incentives for providers that are not affected by the Medicare Sustainable Growth Rate (SGR), such as hospitals, to participate in APMs.

[ii] The next paper in this series will address the need for a smaller set of core quality measures for ACOs and other payment models that could be widely adopted among payers, as well as a process to identify the appropriate set of measures.

Medicare's regulatory system, designed to prevent inappropriate utilization in a fee-for-service system, is ill-suited for providers that have accepted responsibility for quality and spending. Much of the regulatory systems that were designed to address counterproductive incentives in the fee-for-service context have not been updated for an environment in which providers are at risk for cost and quality outcomes. For example, ACOs trying to steer attributed beneficiaries to high-quality, efficient providers might run afoul of laws and regulations designed to prevent kickbacks. If ACOs are held accountable for spending over the target, regulations intended to address problems associated with fee-for-service incentives would seem to be unnecessary. Additionally, the lack of a safe harbor from these regulations may prevent ACOs from implementing promising approaches to enhancing care coordination, improving quality outcomes, and lowering costs.

Recommendations to Improve Medicare ACO Programs

Recommendations are presented in four categories. First, Medicare should establish clear expectations for ACOs. Second, ACOs need more tools to engage beneficiaries and providers in care-coordination and health-outcome improvement efforts. Third, CMS should establish a viable pathway for ACOs to assume two-sided risk. Finally, policymakers should create differential payment-rate updates that would incentivize providers to participate in APMs with greater levels of risk, including ACOs. Within each of these categories, BPC recommends concrete steps that can be taken to improve the program.

Set Clear Expectations for ACOs

To successfully improve and become accountable for quality and cost, providers must know in advance what is expected of them, and expectations must be focused and realistic. **Quality and financial targets should be established up front, and quality measures should be consolidated, rationalized, and made more user-friendly for patients, providers, and payers by focusing more on health outcomes.**

Recommendation: Attribute beneficiaries prospectively across Medicare ACO programs. ACOs should know which patients they are responsible for at the beginning of each contract year. The Pioneer ACO model has used prospective attribution from the beginning; the MSSP assigns beneficiaries retrospectively to each ACO at the end of the contract year. While the Pioneer approach runs the risk that beneficiaries will change their care-utilization patterns mid-year, with a risk of holding ACOs accountable for beneficiaries they didn't significantly serve, the MSSP approach leaves ACOs without critical information they need to improve care for the beneficiaries they do serve.

CMS should establish a prospective attribution system for MSSP in which ACOs will be informed of their attributed beneficiaries at the beginning of the contract year. Under this approach, attributed beneficiaries would be dropped from the ACO during the year if they were to move out of the service area or switch to Medicare Advantage. Attribution methodology should be adjusted to increase stability in the attributed population; for instance, if a beneficiary is initially attributed to an ACO in one year, the threshold in the attribution formula for continued assignment of that beneficiary to the ACO in subsequent years should be lower than for newly attributed beneficiaries, making it more likely that

existing attributed beneficiaries will continue to be attributed to the ACO. In addition, policymakers should work to modify the statute to allow beneficiaries to be attributed to an ACO on the basis of visits to non-physician primary-care providers, such as nurse practitioners and physician assistants.[13] Currently, many patients who are clearly receiving most of their care from an ACO are not being attributed because services provided by non-physician providers are not properly included in the attribution formula.

While prospective attribution would be superior to retrospective attribution, an assignment model that engages patients in actively selecting an ACO would have many additional advantages. After a transition period, prospective attribution should be replaced with a patient-choice model in which beneficiaries would designate an ACO (see recommendation II-B).

HOW ARE BENEFICIARIES ASSIGNED TO ACOS?

Medicare beneficiaries are assigned to ACOs using a process called attribution. CMS monitors claims data to determine whether beneficiaries access care from providers that are part of an ACO. Beneficiaries who receive a plurality of care from primary-care providers and specialists that are part of an ACO are assigned to that ACO. The exact methodology differs somewhat between the Pioneer and MSSP programs. A very important difference is that beneficiaries cannot be attributed to an MSSP ACO solely on the basis of receiving primary care from a non-physician practitioner, such as a physician assistant.[14]

Recommendation: Set benchmarks prospectively across Medicare ACO programs. ACOs should know their financial target at the beginning of each contract year. Pioneer ACOs use prospective benchmarks, but MSSP ACOs do not know their benchmarks until the end of the year. Once prospective attribution for beneficiaries in MSSP is adopted, CMS should also adopt the Pioneer method of prospective benchmarks within MSSP. Additionally, CMS should, in limited circumstances, allow for upward adjustments to benchmarks to reflect significant changes to Medicare payment policies, such as a permanent fix to the SGR physician payment formula, introduction of differential updates within the Medicare fee schedules to reward APM participation (see recommendation IV-A), and introduction of high-cost, medically necessary treatments.

Recommendation: Reduce the number of quality measures, establishing a smaller set of measures for ACOs, which should be more focused on health outcomes (ultimately measured on the basis of the broader patient population) and patient satisfaction, not simply process measures. CMS should work with multiple stakeholders, including providers and private-sector payers, to establish a smaller number of measures that are more focused on outcomes-based quality and patient satisfaction, to be implemented for Medicare ACOs. An additional benefit of pursuing this course is that it would increase the likelihood that other payers in the private sector would adopt these

measures, thus reducing burdens on providers and enhancing usefulness of measures for patients and payers.

Recommendation: Allow partial shared-savings bonuses for ACOs that reduce spending and achieve significant, relative quality improvement, even though national standards are not met. Under the current formulation, ACOs cannot share in any savings unless they meet minimum quality goals, which are uniform nationwide. It is possible for an ACO to show significant improvement in performance on quality measures and still not be able to share in any savings if the nationwide minimums are not met. CMS should exercise discretion in allowing for some level of shared-savings bonuses for ACOs that achieve significant annual improvement in quality, even though they do not yet meet nationwide minimum quality standards. CMS should also consider limiting the availability of these reduced bonuses for improvement to certain quality measures.

Provide ACOs with Tools to Engage Patients and Providers in Care Coordination

The most significant design flaw within the existing implementation of Medicare ACOs is the lack of opportunities for the ACO to engage beneficiaries. The attribution method of beneficiary assignment to ACOs, for example, makes it likely that most attributed patients will be unaware that they are even part of an ACO. Given this lack of awareness and absence of incentives for patients to access care from ACO providers, it is no wonder that many attributed beneficiaries are receiving a substantial proportion of services from non-ACO providers, which limits the ACO's efforts to coordinate care and improve quality outcomes. **The following recommendations envision a pathway to a patient-choice ACO designation model that would provide more opportunities for beneficiaries and providers to engage with the ACO and each other in more effective ways.** This set of recommendations should be tested and refined in Pioneer ACOs first; then CMS should seek statutory changes to MSSP to enable broad implementation throughout all Medicare ACOs.

Recommendation: ACOs should be able to establish provider networks; inclusion in an ACO's network should be considered a form of APM participation. Providers should be able to have two kinds of relationships with an ACO. First, a provider could be an ACO member that is involved in ACO governance, including decisions related to the use of shared savings. Alternatively, a provider should be able to become part of an ACO's provider network. These providers would have a formal relationship with the ACO, which could include receiving referrals from ACO members and participating in certain care-coordination processes, but they would not be involved in ACO governance. Inclusion in an ACO's network could be an ideal form of participation for a provider seeking to serve patients of multiple ACOs, such as certain specialists, and it should count for incentives associated with APM participation, such as the proposed bonuses and enhanced fee-schedule updates in the tri-committee physician payment reform legislation.

Recommendation: Transition to a patient-choice model in which beneficiaries have the opportunity to make an active decision to designate an ACO and would have incentives for doing so. CMS should develop a system in which patients could select an ACO. Any Medicare beneficiary—whether they have been attributed to an ACO or not—could choose to designate an ACO that serves their location during an annual selection period through Medicare.gov or 1-800-MEDICARE. When designating an ACO, beneficiaries would be asked to identify a primary-care provider (physician, physician assistant, or nurse practitioner) who is part of an ACO member practice or in the ACO's network.

ACOs should be allowed and encouraged to offer benefits to patients who opt-in. ACOs could choose which benefits to offer, such as cost-sharing waivers for ACO primary-care providers, a 24-hour nurse line, and extended primary-care office visit hours. CMS should review proposed benefits to ensure they are not coercive or otherwise designed in a way that would inappropriately affect patient choice. Beneficiaries who designate an ACO could continue to see any Medicare provider, but special benefits (such as cost-sharing waivers for primary care) would be limited to services to ACO members from network providers. CMS would annually inform attributed beneficiaries of the opportunity to designate an ACO and any benefits that they would receive for doing so. These special benefits should not be available to beneficiaries who do not designate an ACO, even if they have been attributed. ACOs would be allowed, but not required, to promote designation opportunities to patients through marketing materials. Beneficiaries could change or cancel their ACO designation at the next annual selection period.

Initially, this patient-choice ACO designation system should run concurrently with attribution. While greater patient engagement with ACOs through an opt-in process would have many benefits, the existing attribution process does ensure that ACOs have a critical mass of assigned beneficiaries, and it must continue until it is clear that a patient-choice model is sustainable on its own. Once two-thirds or more of the beneficiaries assigned to ACOs in a region have opted-in through the patient-choice designation process, attribution of new beneficiaries to the ACO should cease and patient designation should become the only way for additional beneficiaries to be assigned to ACOs in that region.

IMPACT OF SUPPLEMENTAL COVERAGE

Waiver of beneficiary cost-sharing for primary-care services delivered by ACO providers would be a promising tool to encourage beneficiaries to designate an ACO and access care from ACO providers. However, it is complicated by the reality that many beneficiaries have supplemental insurance that pays most or all cost-sharing to begin with. One possible approach to address this issue, short of comprehensive Medicare cost-sharing and supplemental coverage reforms recommended in BPC's 2013 report, would be to develop ACO-specific Medigap plans that provide incentives for beneficiaries to access care within the ACO.

RISK SELECTION: IS IT A PROBLEM?

Beneficiary designation of ACOs does raise issues of risk selection and whether a type of risk-adjustment process would be needed. Some worry that providers might encourage low-

risk patients to designate an ACO and not mention the option to high-risk patients. This is unlikely to occur, and if it did, there would be little or no benefit to providers. ACOs currently use provider-specific, historical benchmarks, which act as a form of risk adjustment. Therefore, beneficiaries with a history of high spending present an opportunity for the ACO to generate shared savings by reducing costs, such as through better care coordination and by encouraging beneficiaries to use high-quality, efficient providers. An ACO that sought to attract only low-cost beneficiaries would struggle to generate shared savings because their benchmark-spending target would be low to begin with. The proposal below (recommendation III-B) to transition to regional benchmarks would address this concern by risk-adjusting the benchmark. Additionally, because the designation process would be operated by CMS, which would notify beneficiaries of the opportunity to participate, the impact of provider marketing would be limited. Limiting the ability of beneficiaries to change their ACO designation to an annual selection period should prevent providers from systematically encouraging beneficiaries to opt-out before undergoing expensive procedures. Also, ACOs do not have closed networks; beneficiaries who have designated an ACO could access any Medicare provider, and utilization of non-ACO providers counts against the ACO's budget target. Because of this, ACOs have a strong incentive to encourage these patients to access care within the ACO and to deliver such care in a high-quality, coordinated, and efficient manner.

Recommendation: Waive certain Medicare regulations for ACOs assuming two-sided risk. Many rules in the Medicare program were developed to address concerns about inappropriate utilization in a fee-for-service context. ACOs that have agreed to accept downside risk within the current contract period should be granted regulatory relief by CMS, including the authority to waive the three-day hospital stay requirement before admission to a skilled-nursing facility, authority to waive the homebound requirement for home-health services, and waiver of regulations that could limit ACOs from making referrals to high-quality, low-cost providers, such as those providers that are designated as part of the ACO's network.

Establish a Viable Pathway to Risk

Two-sided risk is a promising approach to change the incentives in the health care system to reward value. However, this promise will not be realized if providers do not participate in ACOs because the conditions are viewed as too difficult or unsustainable. Launching an ACO requires a considerable investment in time and financial resources. **To offer a more viable pathway to risk, ACOs should be able to share in more savings in the earlier years with larger savings accruing to the Medicare program in later years after a transition to risk-adjusted, regional benchmarks. Time at one-sided risk should be limited, and providers that demonstrate strong performance and capability should be able to adopt more advanced payment models.**

Recommendation: Offer ACOs a larger proportion of shared savings, and do not reset historical benchmarks. In the near-term, ACOs should be able to keep a greater

proportion of savings generated in order to make the model more financially attractive to providers. These changes will provide ACOs with more potential rewards upfront to help offset the cost of investments to improve care delivery and coordination, while continuing to ensure that the Medicare program benefits from savings in the long-run, as benchmarks are adjusted over time to reflect community-wide reductions in spending (see next recommendation). To start, CMS should allow ACOs to share in additional savings by increasing the shared-savings percentage to no more than 80 percent (up from the current 60 percent) of savings generated from the benchmark. CMS should also allow ACOs to maintain their original historical benchmark (plus annual updates) for each subsequent three-year contract period, until historical benchmarks are phased out (see below).

Recommendation: Beginning in 2018, implement a five-year transition from historical benchmarks to regional, risk-adjusted benchmarks. There are substantial drawbacks to provider-specific, historical benchmarks, as they provide little incentive for relatively efficient providers to participate, and they may allow relatively inefficient providers to maintain such inefficiency for long periods without penalty. To the degree that benchmarks are rebased, they undermine the providers' business case for investing in improved delivery. The tri-committee physician payment reform legislation proposes to establish stronger incentives for physician-fee-schedule providers to participate in APMs, including ACOs, beginning in 2018. Assuming this approach or a similar one is implemented (see below for additional recommendations), CMS should implement a five-year transition from historical benchmarks to risk-adjusted, regional benchmarks beginning in 2018. Regional benchmarks could be set for market areas, such as a county or, ideally, by Metropolitan Statistical Area or by grouping rural counties within a state (e.g., Bureau of Economic Analysis Economic Areas) and should be risk-adjusted using the same methodology used for Medicare Advantage risk adjustment. Risk-adjusted, regional benchmarks would reward efficient ACOs that deliver high-quality outcomes within each region with shared-savings bonuses while providing strong incentives for high-cost, low-quality providers to improve.

Recommendation: Set an expectation that all ACOs should eventually accept two-sided risk. Limit one-sided risk to two full three-year contract periods plus one partial contract period. All ACOs should be expected to eventually accept two-sided risk, and CMS should establish limits on the number of contract periods at one-sided risk. For example, an ACO could operate at one-sided risk for a maximum of two full contract periods plus two years of the third contract period as long as it begins accepting two-sided risk in the third year and in all subsequent contract periods.

Recommendation: Allow ACOs to ease into downside risk by making it easier to earn shared savings and by further limiting potential shared losses during a transition period. CMS should establish special shared-savings and loss parameters for the first two contract periods at two-sided risk. For example, CMS might decrease the shared-savings threshold to 1 percent, reduce the shared loss percentage to 30 percent, and cap maximum shared losses at 5 percent of the benchmark. These changes, which would make

it easier for two-sided risk ACOs to share in savings and further limit potential shared losses in the first two contract periods at downside risk, would encourage more ACOs to accept downside risk by providing a graduated pathway. Beginning with the third contract period at downside risk, the existing parameters would return, including a 2 percent shared-savings threshold, a shared loss percentage of 60 percent, and a cap on maximum shared losses at 10 percent of the benchmark.

Recommendation: Offer more advanced payment models for ACOs that demonstrate strong performance and preparedness for managing risk. Two-sided-risk ACOs that demonstrate a high level of performance on quality, patient satisfaction, and financial metrics should have the opportunity to adopt progressively more advanced payment models. One such approach would be to allow ACOs to receive Medicare payments for all or a subset of members centrally; this could support ACOs that seek to develop alternative compensation structures for members. For ACOs that have more advanced financial capabilities, a partial-capitation approach may be appropriate. Partial capitation, in which a portion of payments are made upfront to the ACO according to the benchmark with the rest through the fee schedules at commensurately reduced payment rates, should be reserved for ACOs that demonstrate readiness to assume performance risk, which is the ability to deliver promised services even if costs exceed the capitated prepayments. For example, an ACO might demonstrate such readiness by showing that providers have agreed to accept reduced fees to provide certain services, if necessary. Full capitation should be reserved for fully insured Medicare Advantage plans. The provider-sponsored organization rules already offer a pathway for provider groups that seek fully capitated arrangements to offer their own Medicare Advantage plans.

Incent More Providers to Participate in ACOs

The bipartisan agreement in the tri-committee physician payment reform legislation proposes to establish a 5 percent bonus for physician-fee-schedule providers participating in APMs for five years beginning in 2018. The tri-committee bill includes another provision that would tie future fee-schedule updates to APM participation beginning in 2023. Under this provision, physician-fee-schedule providers participating in APMs would receive annual 1 percent updates to fee-schedule payment rates going forward; those not participating in APMs would be limited to 0.5 percent annual payment-rate updates. This is a promising approach that, over time, would provide stronger incentives for physician-fee-schedule providers to participate in ACOs and other APMs. **This section includes recommendations to refine this approach by implementing it earlier, reserving the highest updates for providers that adopt two-sided-risk APMs, and expanding it to include non-physician-fee-schedule providers, as well as help new ACOs meet their capital needs.**

Recommendation: Provide incentives through the fee schedules for all Medicare providers to adopt APMs with increasing levels of risk. Transition to a permanent 5 percent differential between Medicare fee-schedule payment rates for APM

participants at two-sided risk and non-participants. Providers should be incented to adopt APMs and progress toward two-sided risk. Congress should establish differential fee-schedule payment-rate updates for all Medicare providers.

Beginning in 2018, annual Medicare fee-schedule payment-rate updates should be adjusted so that:

- payment rates for Medicare providers not participating in APMs grow at a rate 1 percentage point slower than those participating in two-sided-risk APMs; and
- payment rates for Medicare providers participating in one-sided-risk APMs grow at a rate 0.5 percentage points slower than those participating in two-sided-risk APMs.

Normal annual updates would resume after five years, once fee-schedule payment rates for providers at two-sided risk are 5 percent higher than for providers that are not participating in APMs. Providers participating in ACOs, either as members or as part of an ACO's network, would receive the higher payment rate when providing services to a beneficiary who has been attributed to or designated the ACO. Services to beneficiaries who are not attributed and did not opt-in would not be eligible for the higher rate. CMS should adjust ACO benchmarks upward so providers adopting APMs are not penalized through the shared-savings calculation for these differential updates.

Recommendation: Facilitate access to start-up capital for rural and physician-led ACOs. Many providers continue to report challenges in obtaining capital to fund the considerable start-up costs associated with forming an ACO. Existing private-sector lenders and public-sector lending programs have historically focused on facilities and equipment acquisitions supported by the fee-for-service business model; whereas, the business model of taking risk for quality outcomes and the cost of services requires a different sort of infrastructure to support care coordination. Moreover, the design issues of the current ACO program described earlier undercuts the attractiveness of ACOs to investors and lenders. With the changes recommended in this report, ACOs should become more attractive to investors. Some provider organizations already have the financial wherewithal to make these investments, and more will have access to capital if the design changes recommended here are implemented. Nevertheless, others still may not because the purpose of ACOs is in part to break new ground and to provide networked services in less commercially viable areas, such as some rural locations. Because beneficiaries and the public will be best served by the formation of a diverse array of ACOs in a wide range of locations, temporary, targeted efforts to help newly forming ACOs obtain access to capital may well be warranted. BPC's 2013 report recommended two approaches. The first would be to authorize the secretary of Health and Human Services to provide additional technical and financial resources, such as low-interest loans, to help ACOs form in rural areas. The second would be to establish a federal loan-guarantee program for multi-specialty or primary-care-physician-led organizations seeking to form an ACO. These efforts would complement other approaches to improve the viability of the ACO model in rural and other areas where they are slower to form—approaches such as a bipartisan proposal from Rep. Diane Black (R-TN)

and Rep. Peter Welch (D-VT) to ease regulatory burdens on two-sided-risk ACOs that utilize telehealth to improve care coordination.[15]

Conclusion

As operating Medicare APMs that establish provider responsibility for population health outcomes and spending, the Pioneer ACO model and the MSSP are crucial contributors to the transition away from fee-for-service payment and toward organized systems of care. ACOs have potential to improve Medicare by providing a third option between fee-for-service and Medicare Advantage that introduces the benefits of networks, coordination, and accountability, while retaining the familiarity of fee-for-service. The early experience of Medicare ACOs shows the need to make adjustments to maximize the likelihood that this model will be successful in improving the care experience and health outcomes for beneficiaries and reducing health care cost growth over the long-term. The ability of Medicare ACOs to achieve these goals would be greatly improved by setting clearer expectations for ACOs, providing more opportunities and tools for ACOs to engage beneficiaries and providers, designing a pathway to risk that is financially viable for more providers, and establishing stronger incentives through the Medicare fee schedules for providers to participate. Policymakers should build on the ideas in existing bipartisan efforts, such as the tri-committee physician payment reform legislation, and the executive branch should use its administrative authority to make improvements to Medicare ACO programs.

Table: Summary of Recommendations – The Transition to Risk

ALL MEDICARE ACOS		
Attribution and patient-choice designation	Implement prospective attribution and a patient-choice designation process concurrently. Once two-thirds of beneficiaries assigned to ACOs in a region have opted-in through the designation process, attribution of new beneficiaries should end and opting-in should be the only method for new beneficiaries to be assigned to an ACO. ACOs could offer special benefits, such as waiver of cost-sharing for primary-care services delivered by ACO providers, limited to beneficiaries who opt-in.	
Historical benchmarks	Implement prospective benchmarks. Do not rebase historical benchmarks between contract periods.	
Regional, risk-adjusted benchmarks	Begin a five-year transition from historical benchmarks to regional, risk-adjusted benchmarks starting in 2018.	
Shared-savings percentage	Increase up to 80 percent (from 60 percent). The Medicare program would continue to benefit from savings due to spillover effects from non-attributed beneficiaries and differential updates.	
	ACOS AT ONE-SIDED RISK	**ACOS AT TWO-SIDED RISK**
Transition to two-sided risk	Establish time limit on one-sided risk: two full three-year contract periods, plus one partial (such as two years at one-sided risk, one year at two-sided risk).	During the first two contract periods at two-sided risk, reduce maximum shared loss percentage to 30 percent (down from 60 percent), cap total shared losses at 5 percent of the target (down from 10 percent), and reduce the shared-savings threshold to 1 percent (down from 2 percent). In subsequent contract periods, the existing, higher parameters would apply.
Regulatory flexibility	Allow ACOs to waive beneficiary cost-sharing for primary-care services provided by ACO providers.	Allow ACOs to waive cost-sharing for primary-care services, waive three-day skilled-nursing facility rule, waive homebound requirement for home health, allow referrals to high-quality, low-cost providers.

Endnotes

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[4] Available at: http://bipartisanpolicy.org/library/transitioning-to-organized-systems-of-care-medical-homes-payment-bundles-and-the-role-of-fee-for-service/

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[15] ACO Improvement Act of 2014 (H.R. 5558), as introduced September 18, 2014. Available at: https://www.congress.gov/bill/113th-congress/house-bill/5558.

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