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The Implications of the CMS Proposed Regulations for ACOs

An Important First Draft, But Fixes—and Private Sector Efforts—are Needed

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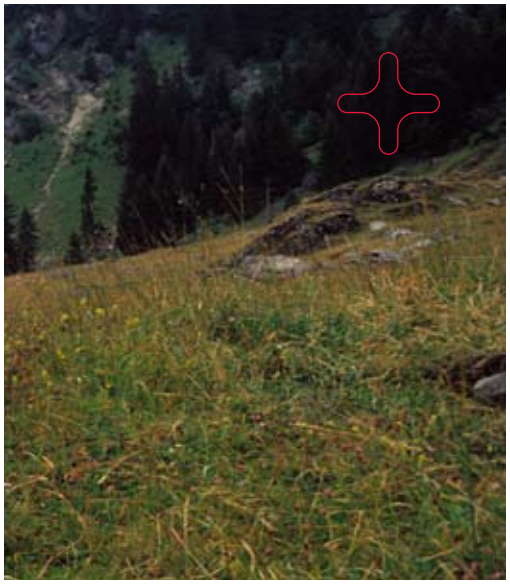
EXECUTIVE SUMMARY

On March 31, 2011, the Centers for Medicare and Medicaid Services (CMS) released its draft regulations for the Medicare Shared Savings Program: Accountable Care Organizations (ACOs). Before we offer the analysis that makes up the bulk of this paper, it's important to place that analysis in the context of why the ACO model emerged.

In brief, there is widespread consensus that the current health care system is flawed and unsustainable. Costs are too high and quality of care is inconsistent due to a complex array of factors including practice variation, defensive medicine, fraud and abuse, a fee-for-service system (FFS) that pays for volume, and a lack of accountability by all stakeholders for the health and health care costs of individuals and populations.

When ACOs first appeared as part of the Affordable Care Act, many health care leaders rallied around them as a way to begin addressing these problems. ACOs would be a new practice and payment model that would give interested physician groups and hospitals the opportunity to voluntarily partner with Medicare to test innovative ways for achieving the triple aim of "better care for individuals, better health for populations, and slower growth in costs through improvements in care," said Donald Berwick, CMS Administrator, in an online commentary published March 31, 2011 in the *New England Journal of Medicine*.



The Triple Aim has three objectives: better care for individuals, better health for populations, and slower growth in costs through improvements in care

The idea was to use the "carrot" of shared savings (and the draft rules include the stick of shared risk) to encourage different types of organizations in disparate markets to integrate and innovate. The hope was that in fleshing out that idea, the regulations would encourage small primary care group practices to sponsor ACOs as readily as large integrated delivery systems. Organizations with little or no experience in coordinating care and population health could participate, as could organizations with years of experience in managing care and accepting risk. Successes would demonstrate how to effectively transform the traditional Medicare reimbursement system. Consequently, health care leaders were anxiously awaiting the details of how CMS would shape these experiments.

Those details first arrived on March 31, 2011, in a document that would eventually be accompanied by others from the Federal Trade Commission (FTC), Internal Revenue Service (IRS), and Office of Inspector General (OIG). The draft, as opposed to the one entered in the Federal Register a week later, not only documented the proposed rules, but offered an extensive rationale and requested comments. In this context, the draft rules are a Herculean first effort with much to admire, especially given the enormously complicated health care system that health reform is trying to reshape, the often conflicting stakeholder views, and the ambitious nature of the ACO concept.

Specifically, the draft seems an honest attempt to move the ball forward by balancing divergent views and addressing unanswered questions. The triple aim goals are in clear sight throughout. That alone makes the regulations an important step in the transition from Medicare FFS. Other positive elements include:

- A strong focus on primary care as the basis for defining ACO populations and managing population health
- Strong encouragement to bring actionable information to the provider at the point of care
- Provisions that help physicians and hospitals to join together to form ACOs and collaborate on care coordination and care transitions
- The opportunity for different organizations to participate at various levels, including payers and management services organizations that can supply needed expertise and financial backing
- The use of standard, objective performance measures that combine claims and clinical data and simplify data collection and reporting
- A sincere effort at transparency through public reporting of ACO performance and independent reviews of shared savings
- The welcome overlap of ACO standards with established initiatives including the EHR Incentive Program, eRX Incentive Program, "meaningful use" standards, and Physician Quality Reporting System
- Caps on "shared loss" so as to ensure reasonable risks
- Waivers that recognize that the clinical integration necessary to making ACOs work is in conflict with some existing regulatory frameworks


Our bottom line is that
change is necessary, and
the direction is clear.

Despite these strengths, we believe that the draft rules could significantly undermine ACO development and the broader, nascent movement towards what we call Sustainable Health Communities. It is always easy to find flaws in a large and complex piece of legislation, but our reaction is rooted in three overarching concerns:

1. THE PROPOSED RULES DISCOURAGE BROAD PARTICIPATION.
   They impose a tight timeline for application, as well as a significant financial, regulatory, organizational restructuring and reporting responsibility—and set the bar so high for shared savings—that they will demand a rapid and substantial re-engineering of most organizations that could, in turn, discourage participation in all but a smattering of well-financed organizations that already look quite similar to the ACO vision. In this paper, we recommend and define an option that encourages broader provider participation. This option is simpler, without risk, and improves the opportunity to earn and retain shared savings that are greater than the costs of participation.

2. THE PROPOSED RULES DISCOURAGE INNOVATION.
   Innovation requires a melting pot of ideas and enough freedom to pursue them. But as noted in number one, without wider participation or the involvement of the small groups that comprise the bulk of how health care is delivered in this country, there may not be enough ideas in play to understand what works best where. Moreover, the numerous and complex proposed rules and requirements don't adequately recognize the varying levels of readiness within the provider population or the diversity of health care practices in local markets. In addition, the costs are so high that even groups willing and able to participate will find it difficult to innovate within the many restrictions.

3. THE PROPOSED RULES DON'T DO ENOUGH TO TRULY ALIGN INCENTIVES.
   The draft retains a FFS model and builds incentives on top of it. That's an understandable approach for those just beginning to assume risk, but it doesn't enable more sophisticated organizations to distance themselves from the volume-based incentives of FFS. That's why we also recommend and define an option that allows capable organizations to accept risk and apply innovative methods of payment reform that field test alternatives to FFS. In addition, because there is too little acknowledgement of the need for all stakeholders—not just providers—to be accountable for the health of individuals and defined populations, we recommend that the guidelines be modified to motivate other stakeholders, especially patients, to be held accountable.

If the final rules don't address these concerns, we fear that, at the end of three years, there may be too little movement toward the triple aim goals. Momentum will be lost, stalling a movement that began with hard-earned insights, high hopes, and good intentions.

A CALL TO ACTION

In its Notice of Proposed Rulemaking (NPRM), CMS requests comments. This paper interprets the request for comments as a call to action. We address the implications of key aspects of the proposed regulations, make recommendations for change, and suggest what groups can do now to move forward, either as participants in the program, or in one of the many private sector ACO-type options beginning to proliferate.

Bottom line: change is necessary and the direction is clear. CMS has helped spark a movement that is gathering steam, but if the final rules don't address widespread concerns, the CMS program will yield its leadership role to the private sector, which is already implementing various types of ACO models. That would pose at least a small dilemma because traditionally, the force of Medicare has stimulated widespread system change and adoption. Nevertheless, it's encouraging that the private sector seems poised to move, with or without Medicare's leadership. In the wake of the NPRM, those organizations that have been preparing for change should fully assess their options to make sure that when the final rules are issued, they are participating in the program that best suits their needs.

ANALYZING THE IMPLICATIONS OF THE DRAFT RULES

For many organizations, both CMS and private sector ACOs require significant operational re-engineering including re-staffing, retraining, incorporating new technologies into daily routines, and new workflows that will take time and effort to create and implement successfully.

The most important implication of the draft regulations is that, despite good intentions, they may not do enough to align incentives and help organizations respond to these demands. In fact, they may even exacerbate the demands which could discourage participation and innovation. Five challenges drive these overarching concerns:

Complicated regulatory demands for ACO formation, application, operation, and reporting.

- Given that many provider organizations have few, if any additional resources at their disposal, there are too many requirements just to apply to be an ACO, too many tools and processes to put in place.
  - > For example, from a clinical integration and care coordination perspective requiring 50 percent of providers to qualify for meaningful use (MU) incentives makes sense, but the reality is that far fewer are likely to meet that threshold and may decide not to apply. We recommend staging the 50 percent threshold to encourage broader participation: 30 percent qualify for MU the second year, and another 20 percent the third.
  - > Similarly, we are absolutely in favor of rigorously measuring quality, but it seems unnecessarily burdensome that, in advance of application, ACOs must demonstrate the ability to measure 65 quality measures across five domains. That's more than Medicare Advantage (MA) plans, which only have 36 measures for 2011, Prescription Drug Plan (PDP)-only plans, which have 17, and combined MA-PDP plans, which have 53 measures. In addition, by adding data gathering requirements beyond what is asked of MA plans, organizations could incur additional costs to implement and sustain the gathering of that data. Again, our concern is that such requirements and costs will discourage broad participation.
- The process for demonstrating shared savings also is a time-consuming and unnecessary burden that will delay payments and undermine the power of the incentive. Why ask organizations to go through the arduous process of verifying CMS' shared savings calculations, especially if most won't feel a need to appeal and don't have the means to legitimately verify anyway? There are examples of similar administrative burdens throughout the draft rules.

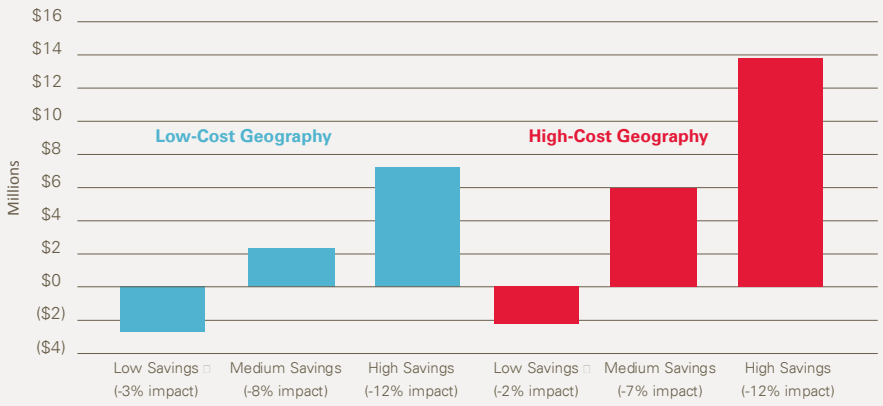
Difficult to achieve return-on-investment (ROI)

The proposed rules will demand a substantial financial and operational commitment for ACO application, start-up, and operation with a high bar for reaching shared savings in these first three years. This implies very real risk, even for those groups that choose the first of two tracks, which CMS says has "no risk" for delivering quality outcomes and lower costs during the first two years of participation.

- For context, remember that, despite the fact that the bar was set lower, few in the Medicare Physician Group Practice Demonstration projects achieved shared savings.
- Efficient, high-performing groups will be especially pressed to attain ROI, because achieving improvements from their baseline will be much more difficult than it will be for groups that start with high baseline utilization and expenditures.
- The complex formulas for assessing ACO performance and determining shared savings require advanced financial modeling and don't lend themselves to fast-track decision-making.
- Consider the following graph (Figure 1) depicting the net present value for the CMS "no-risk" track over the three-year agreement period. For both a low-cost and high-cost geography, we modeled three potential savings levels for an ACO with 15,000 attributed members that achieves 80 percent of its quality measures and a 40 percent net sharing rate. That's a strong performance and, probably, an aggressive assumption, given that participants in this first CMS track are likely those with less experience in managing population health or assuming risk.

Figure 1

Net Present Value of ACO Revenue/Expenses Over the 3-Year CMS Agreement Period—Track 1 [1]



[1] Assumes 15,000 ACO members, $500,000 pre-operational cost plus $125,000 in monthly operational expense, 40% net sharing rate (assumes ACO achieves 80% of quality performance targets : 80% x 50% = 40%), 5% discount rate for net present value calculation and 9 month reconciliation period after year end before ACO receives CMS net shared savings payment. Note that we have not reflected any provider incentive payments nor any additional increase to the shared savings rate due to FQHC/RHC participation rates.

Despite optimistic assumptions about performance, those with low savings impact will *lose money* over the three-year agreement. Those who achieve the highest savings impact—a very unlikely scenario in this track—in a high-cost area would earn a substantial ROI, but as later charts make clear, they might not see a positive cash position until about 45 months after implementation. Equally important, Figure 1 shows that the field is clearly tilted towards practices in high-cost geographies. Those that already have lower costs will have much less of an incentive, a disparity the proposed rules don't address.

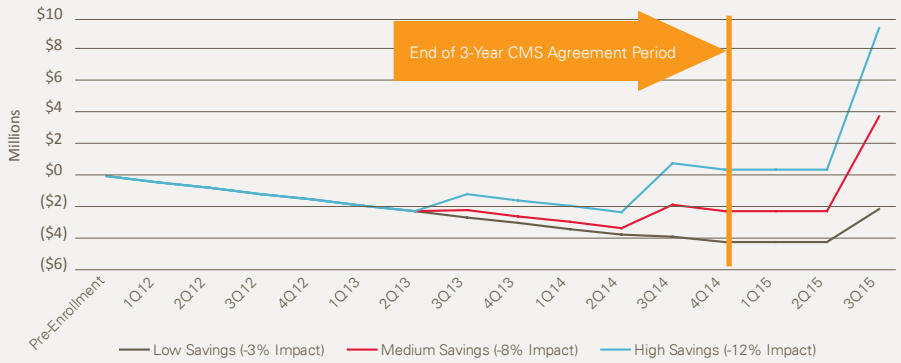
Delays in access to data that will delay shared savings payments

The proposed six-month run-out on claims evaluations means that organizations could end up waiting as much as 45 months before receiving their first shared savings payment. Most provider groups simply don't have the resources to wait that long for a reduced return-on-investment. Therefore, the delays essentially eliminate smaller groups with fewer resources, as well as outside investors who will not want to wait. Moreover, the delays make it harder to innovatively adjust clinical programs for more effective performance. In addition, the proposed sharing of Medicare Parts A, B, and D information is of limited use if individual member data cannot be applied to a known ACO population in real time.

- To illustrate the cash flow challenges, we have modeled the cash flow at the end of each quarter for two scenarios: a low-cost geography under the CMS Track 1 rules (Figure 2) and a high-cost geography under CMS Track 2 rules (Figure 3). In both cases, we've assumed a solid performing ACO that meets 80 percent of the quality requirements. This is good performance and it's important to note that the graphs do not depict the downside risk of groups failing to achieve quality outcomes or the savings threshold. Moreover, groups will not know how well they did before they have to decide about participation in the next round.

Figure 2

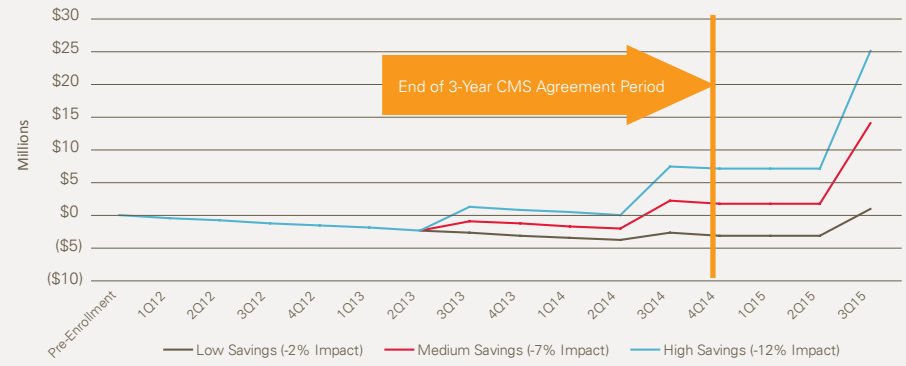
Low-cost Geography—CMS Proposed Rule Track 1
Cash Position by Quarter Before Any Provider Incentive Payments [1]



[1] Assumes 15,000 ACO members, $500,000 pre-operational cost plus $125,000 in monthly operational expenses, 40% net sharing rate (assumes ACO achieves 80% of quality performance targets: 80% x 50% = 40%) and 9 month reconciliation period after year end before ACO receives CMS net shared savings payment. Note that we have not reflected any additional increase to the shared savings rate due to FQHC/RHC participation rates.

Figure 3

High-cost Geography—CMS Proposed Rule Track 2
Cash Position by Quarter Before Any Provider Incentive Payments [2]



[2] Assumes 15,000 ACO members, $500,000 pre-operational cost plus $125,000 in monthly operational expenses, 48% net sharing rate (assumes ACO achieves 80% of quality performance targets: 80% x 60% = 48%) and 9 month reconciliation period after year end before ACO receives CMS net shared savings payment. Note that we have not reflected any additional increase to the shared savings rate due to FQHC/RHC participation

> In the low-cost, Track 1 model, even if a group achieves high impact savings, they will not attain a positive cash position until 3Q 2015 or 45 months after implementation. Yet as noted previously, few groups eligible for Track 1 will have the capabilities to achieve high savings. Medium impact savings are much more realistic and and once again reflects as much as a 45-month waiting period before a positive cash position is attained.

> Even in the Track 2 scenario, where the payoff is better and there is greater likelihood of high impact savings, for medium impact savings there is still a delay of as much as 45 months after implementation before attaining a positive cash position. And, as noted earlier, for low impact there will be no ROI.

A weak, retrospective attribution mechanism

Without the ability to clearly define which Medicare beneficiaries are part of the ACO from the outset, and without recognition that specialists sometimes deliver primary care for Medicare beneficiaries, costs could increase because organizations will struggle to make efficient, targeted investments that effectively manage individual and population health.

- High-performing provider organizations already use identification and stratification methods to find the patients who need the highest level of coordination and management. This higher level of intervention is more resource intensive and, therefore, more costly. Prospective attribution and/or access to concurrent member data would be a motivator, enabling physicians to prioritize their time and resources upfront and allow them to phase changes to their clinical workflows across their entire population over time.
- The regulations also fail to recognize the high percentage of patients—particularly Medicare patients with complex, chronic conditions—who quite appropriately receive primary care from specialty physicians, such as oncologists, non-invasive cardiologists, endocrinologists, rheumatologists, and others. Consider that a report from the National Center for Health Statistics, dated August 2010, found that "in 1978, 62 percent of visits by patients aged 65 and over were to primary care physicians compared with 45 percent in 2008. The percentage of visits to physicians with a medical or surgical specialty increased (over that same period) from 37 percent to 55 percent." The failure of the regulations to accommodate this trend could limit participation, exacerbate the primary care shortage, and has potentially negative implications for the quality and efficiency of care patients receive.

Not enough movement toward properly aligned incentives

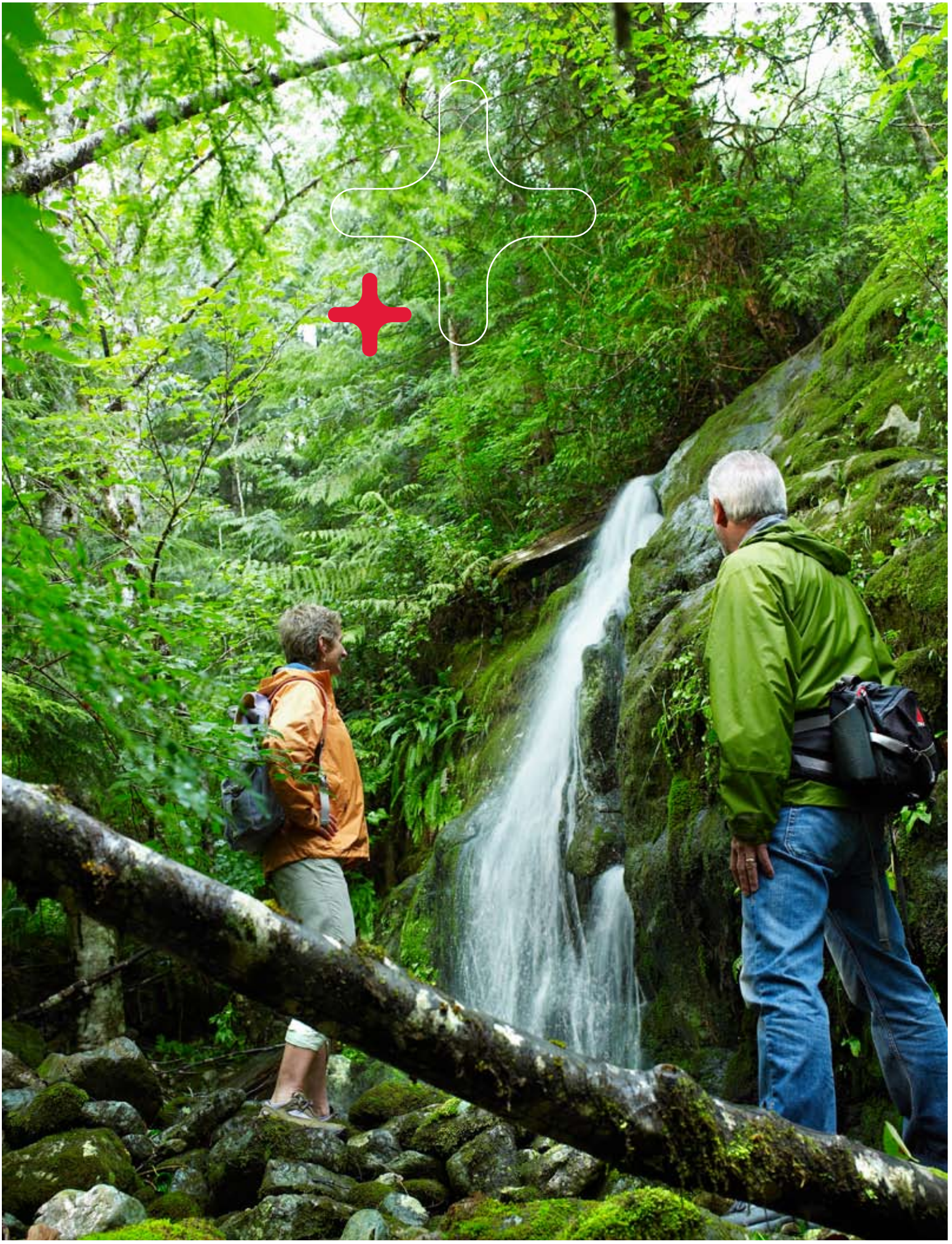
The proposed rules are still built almost entirely on FFS payments. While there are incentives to earn extra for delivering value (high quality, lower costs), the underlying incentive is still for volume. And while we applaud the proposed rules for moving providers toward clinical integration, we also are concerned that the incentives as currently constituted miss two opportunities to further advance the triple aims. First, they ignore some key stakeholders, particularly patients. Second, they do not do enough to align the incentives among all providers: PCPs, specialists, hospitals, and ancillary care.

On the first, for example, CMS should consider incentives that would motivate patients to adhere to their treatment plans and drug regimens. On the second, though the draft rules acknowledge alignment with programs such as the community health systems concept in PPACA, CMS also should consider: 1) ways to integrate the Shared Savings program with hospital programs aimed at improving care and efficiency, and; 2) the impact ACOs could have on specialists' clinical practice and income. If the ecosystem of a Sustainable Health Community is to be achieved, incentives for each of these component parts must be aligned and working in concert, not opposition.

High-performing, well-financed provider organizations are *best positioned to apply* for ACO certification but have *the least to gain from participation* while less experienced organizations *face huge hurdles to applying* as ACOs but have the most to gain from participation.

When combined, these five challenges illustrate how the rules could discourage both participation and innovation. First, high-performing, well-financed provider organizations that are *best positioned to apply* for ACO certification have *the least to gain from participation.* In most areas, the rewards simply do not match the investment. These organizations—comfortable assuming financial risk, with patient-centered medical home certification, existing referral relationships that match nicely with ACO recommendations, and deep experience with clinical tools and resources—may find that they are better served by continuing their efforts at innovation outside of the restrictive playing field CMS has defined.

Of equal concern, less experienced organizations face significant hurdles to applying as ACOs but have the most to gain from participation. Before even considering application, these groups must learn better how to engage providers, invest in clinical integration tools and resources, develop ways to clinically integrate, understand better how to assume financial risk, and establish referral relationships within a defined delivery system. For many, these challenges could combine with a very tight timeline to cut short their interest in applying. As a result, the CMS program will lose some very creative, smaller practices that could break new ground in the regions and delivery systems that need it most. And unless these smaller, less experienced groups find the help they need to engage in private sector ACOs, even if successful models emerge, smaller groups could struggle to become close followers because they will have done little to prepare over these next three years.



RECOMMENDATIONS FOR CHANGE

We believe that a more robust CMS program that attracts more players would also stimulate more innovative private sector models and drive faster, more productive change throughout the system. To create such a program, we recommend changes to the proposed rules that don't require a wholesale rewrite and reflect important ways that private sector ACOs are already working with commercial payers as they structure their own incentive programs for achieving the triple aim goals.

First and foremost, we believe a modification of the CMS two-track model is essential.

In the NPRM, CMS Track One allows qualifying groups to participate as ACOs on FFS reimbursement and with "no risk" for failing to meet thresholds during the first two years (other than their substantial investments) of a three-year agreement period. On this track, the maximum shared savings will be 50 percent for the first two years. In the third year and subsequent periods, Track One ACOs are required to accept risk, as per Track Two below.

For CMS Track Two, qualifying groups continue on FFS, but assume risk for all three years; in exchange, they can receive as much as 60 percent of shared savings.

This approach is fundamentally flawed for the reasons stated previously. On the one hand, it doesn't do enough to bring less experienced groups into the process, because the investments required pose too much risk with too little chance at attaining the rewards. On the other hand, except in high-cost geographies, this model doesn't do enough to entice larger, more experienced groups, because the shared savings formulas generate too little too late in the way of rewards for these high-performing groups.

MODIFYING THE MODEL

To encourage much broader participation, we suggest three tracks: A, B, and C. Our **Track A** would be a true no-risk FFS model that has less complexity and cost than what CMS has proposed. This model would

- simplify the application process;
- eliminate the 25 percent withhold of shared savings;
- eliminate the requirement for a repayment mechanism;
- reduce the regulatory burden by simplifying quality reporting requirements;
- eliminate the two percent discount; and
- institute a sliding scale that would, for example, make organizations whose assigned members' baseline expenditures are in the lowest quintile nationally eligible for a shared savings percentage of up to 80 percent. Organizations with baseline expenditures in the second quintile nationally might be eligible for a shared savings percentage of up to 70 percent, and so on.

We understand that there are widespread objections to any no-risk track, but because ACOs are supposed to be an important vehicle for determining how to get from one system to another, we believe widespread participation is critically important. The advantage of this no-risk track is that it acknowledges the diversity of how groups practice in this country and would encourage high-performing primary care groups and multispecialty groups, who can't afford to assume risk, to participate and continue to improve their performance.

With their involvement, it is likely that important ideas will emerge. This approach also puts more groups on the path of trying to manage population health, engage patients more actively, and measure their results. There are few or no disadvantages, and the potential for very real benefits.

To test our alternative Track A against the proposed CMS tracks, we've created a hypothetical ACO that parallels the models we created. Tables 1 and 2 and Figure 4 illustrate what we discovered about ROI, cash positions, and shared savings if the ACO performs consistently well. In brief, while there is still a long wait before achieving a positive cash position, our Track A has the potential to generate substantial shared savings for distribution among ACO participants, especially primary care physicians. We believe this is a win-win that would foster further improvement in the ACO model. It would be a strong incentive for primary care physicians to invest time and money in genuine practice change for managing population health and would still earn savings for CMS.

Table 1

CASH POSITIONS	CMS Track 1 Cost Geography		CMS Track 2 Cost Geography		Alternative Option Cost Geography	
Description	Low	High	Low	High	Low	High
Net Present Value (excludes any provider incentive payments) [1]	$2,300,000	$5,900,000	$5,500,000	$11,000,000	$7,300,000	$8,500,000
Date that ACO Achieves Positive Cash Position [2]	Sept 15	Sept 15	Sept 15	Sept 14	Sept 14	Sept 14
# of Months to Achieve Positive Cash Position	45	45	45	33	33	33
Cash Position at End of Calendar Year (12/31)						
Year 1	($2,000,000)	($2,000,000)	($2,000,000)	($2,000,000)	($2,000,000)	($2,000,000)
Year 2	($3,100,000)	($3,100,000)	($2,200,000)	($1,800,000)	($1,500,000)	($1,600,000)
Year 3	($2,700,000)	($1,800,000)	($700,000)	**$1,400,000**	**$1,700,000**	**$2,100,000**
Assumed Net Shared Savings Payout (09/03) (assumes 9 month reconcilitation period after year end)						
Year 1	($2,700,000)	($2,700,000)	($1,800,000)	($1,400,000)	($1,100,000)	($1,200,000)
Year 2	($2,300,000)	($1,400,000)	($300,000)	**$1,700,000**	**$2,000,000**	**$2,400,000**
Year 3	**$3,300,000**	**$7,600,000**	**$7,000,000**	**$13,500,000**	**$9,000,000**	**$10,400,000**
Largest Negative Cash Position	($4,100,000)	($4,100,000)	($3,200,000)	($3,000,000)	($3,000,000)	($3,000,000)
Date of Largest Negative Cash Position	Aug 14	Aug 14	Aug 14	Aug 13	Aug 13	Aug 13

[1] Net present value (NPV) calculated using 15,000 ACO members, $500,000 pre-operational cost plus $125,000 in monthly operational expenses, Medium savings assumptions: 7%-8% average savings per year, 9 month reconciliation period after year end before ACO receives CMS net shared savings payment and 5% discount rate; assumed net sharing rate: CMS Track 1: 40%, CMS Track 2: 48% and Alternative Option: Low-cost 56%, High-cost 40% (reflects 80% target achievements; Low: 80% x 70% from baseline in second quintile = 56%, High 80% x 50% = 40%). Alternative options have $0 withholds, 0% discount threshholds and tiered maximum shared savings rates of up to 80% for ACO's with low baseline costs. Does not reflect any payouts of provider incentive payments nor any additional increases in net sharing rate for FQHC/RHC participation rates.

[2] Defined as month/year when cash position becomes and remains positive for CMS 3–year contract period. Assumes 3–year contract period begins on January 1, 2012 and net shared savings payment occurs 9 months subsequent to year end for which savings are earned.

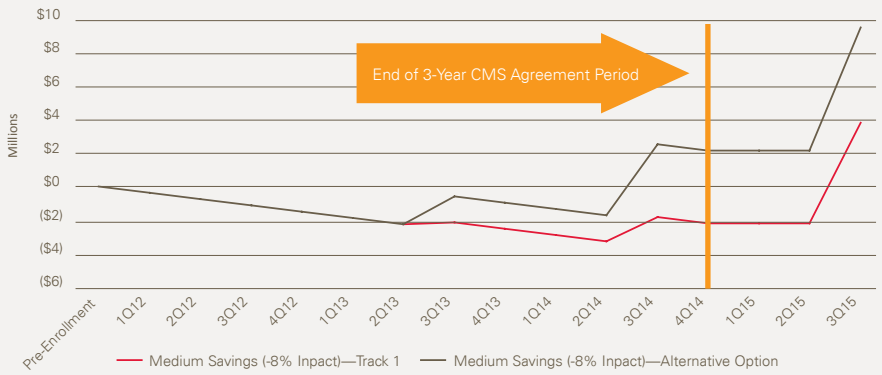
Table 2

POTENTIAL BONUS PAYOUTS	CMS Track 1 Cost Geography		CMS Track 2 Cost Geography		Alternative Option Cost Geography	
Description	Low	High	Low	High	Low	High
Shared Savings Available for Incentive Payments and Reinvestments [1] (amounts available at end of reconciliation period)						
Year 1	$0	$0	$0	$0	$0	$0
Year 2	$00)	$0	$0	**$1,700,000**	**$2,000,000**	**$2,400,000**
Year 3	**$3,300,000**	**$7,600,000**	**$7,000,000**	**$13,500,000**	**$9,000,000**	**$10,400,000**
Assumed PCP Incentive Payment (50%): Total $ [2]						
Year 1	$0	$0	$0	$0	$0	$0
Year 2	$0	$0	$0	$0	**$1,000,000**	**$1,200,000**
Year 3	**$1,650,000**	**$3,800,000**	**$3,500,000**	**$6,750,000**	**$4,500,000**	**$5,200,000**
Remaining Shared Savings Available for Specialists, Hospitals, and Reinvestments (50%)						
Year 1	$0	$0	$0	$0	$0	$0
Year 2	$0	$0	$0	**$1,700,000**	**$1,000,000**	**$1,200,000**
Year 3	**$1,650,000**	**$3,800,000**	**$3,500,000**	**$6,750,000**	**$4,500,000**	**$5,200,000**
Potential PCP Incentive Payments: Average $ Payment Per PCP [3]						
Small PCP Network (assumes 20 PCPs)						
Year 1	$0	$0	$0	$0	$0	$0
Year 2	$0	$0	$0	$0	**$50,000**	**$60,000**
Year 3	**$82,500**	**$190,000**	**$175,000**	**$337,500**	**$225,000**	**$260,000**
Medium PCP Network (assumes 50 PCPs)						
Year 1	$0	$0	$0	$0	$0	$0
Year 2	$0	$0	$0	$0	**$20,000**	**$24,000**
Year 3	**$33,000**	**$76,000**	**$70,000**	**$135,000**	**$90,000**	**$104,000**
Large IPA Network (assumes 150 PCPs)						
Year 1	$0	$0	$0	$0	$0	$0
Year 2	$0	$0	$0	$0	**$6,667**	**$8,000**
Year 3	**$11,000**	**$25,333**	**$23,333**	**$45,000**	**$30,000**	**$34,667**

[1] Assumes provider incentive payments only distributed when positive cash position is obtained and is expected for remainder of CMS agreement period. [2] Assumes 50% of net shared savings will be paid to PCPs as an incentive payment and remaining 50% distributed to specialists, hospitals, and for reinvestment. [3] Assumes the same incentive payments for each PCP. ACO's are more likely to distribute payments based on performance and to support advanced PCP practices.

Figure 4

CMS Proposed Rule Track 1 and Alternative Option Comparison—Low-cost Area Cash Position by Quarter Before Any Provider Incentive Payments [1]



[1] Assumes 15,000 ACO members, $500,000 pre-operational cost plus $125,000 in monthly operational expenses. CMS Track 1 reflects 40% net sharing rate, 25% withhold, 2% threshhold discount (Yr 1 and 2 only) and 9 month reconciliation period after the year end before ACO receives CMS net shared savings payment. Alternative option reflects 56% net sharing rate, no withhold, no threshhold discount and 9 month reconciliation period after year end before ACO receives CMS net shared savings payment. Note that the net sharing rates have been adjusted to reflect an 80% achievement in the quality performance targets and no additional increases due to FQHC/RHC participation rates.

Our **Track B** would be the same as CMS Track Two. This gives certain ACO-ready groups that prefer FFS the opportunity to participate. The additional ten percentage points of shared savings in this track—60 percent, rather than 50 percent—helps generate reasonable returns for solid performance, especially in high-cost areas that need improvement in terms of generating savings. For low-cost areas, we recommend modifications to this track so it is tiered like our Track A.

Our **Track C**, on the other hand, would be aimed at encouraging experienced, high-performing, well-financed organizations to innovate further via a capitation model that allows flexibility in payment reform and encourages elimination or reduction of FFS volume-based incentives. We recommend offering capable organizations a range of capitation options from partial to global. ACOs that accept capitation would "own" any savings or losses and would be required to reinvest a portion of their savings to benefit their patients. To make capitation viable, this track would allow prospective assignment of patients and more patient engagement features, such as the ability to reduce member co-pay or co-insurance when they use the ACO for services; this would enable the ACO to bear upside and downside risk from day one. In addition, to facilitate the targeted interventions necessary for managing population health, ACO members could not opt out of data sharing. In return, these organizations would have to meet repayment and reserve requirements as well as Medicare Advantage-like reporting and quality requirements.

We understand that many may object to capitation, but we believe their objections fail to understand how much has changed to eliminate the perceived disadvantage of this payment method.

First, in this model of capitation, clinical decisions remain with the care team.

Second, as opposed to the early days of capitation, today's tools and technologies significantly reduce the risk of inappropriate withholding of care and enhance the quality of care, especially for managing chronic illness and reducing errors. The tools include:

- Evidence-based medicine guidelines
- Decision support at the point-of-care
- EHRs, PHRs, and e-prescribing
- Disease registries
- Autodialers with interactive voice response, and other call center technologies
- Online self care
- e-visits

Third, there have been extraordinary advances in the predictive sciences, including severity adjustment, risk adjustment, and predictive modeling that can identify gaps in care and help physicians negotiate rates and payments that are appropriate for their particular patient panels.

We believe these factors—and the potential a capitated track has for encouraging the most advanced organizations to innovate further—makes this an important addition to the ACO program. It's worth noting that in private sector ACO models, capitated plans can offer employers more affordable health benefits, are fully in line with the current movement toward value-based benefit designs, and would be familiar and acceptable to employee groups.

Our point is simple: the best way to address the challenges to participation and innovation that the draft rules have erected is to begin with a set of shared savings options that fit a range of situations and that encourage the widespread participation and innovation that will ultimately lead to the best models for meeting the triple aim goals.

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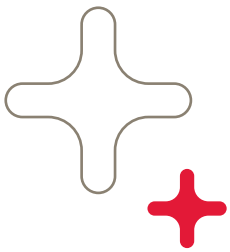


ADDRESSING THE FIVE BARRIERS

With our three-track model as a starting point, there are numerous options for addressing the five key barriers we noted previously.

Simplify regulatory demands: Regulation and oversight are necessary, but they must be pared back for groups to have a reason and time to apply. While there are many ways this could be done, we've included three specific examples:

- Expedite the application process. While groups seeking to be eligible for a higher proportion of shared savings will understandably have to demonstrate a greater degree of readiness, for a no-risk or low-risk track with fewer shared savings, the process could be considerably simpler. For these groups, we suggest removing most of the processes and tools that need to be verifiably in place before applying in order to make the costs and the efforts needed to participate less daunting. This includes scaling back the percentage of providers needed to qualify for MU incentives in year two to 30 percent and adding the other 20 percent the third year. It also could require scaling back what applicants must have in place to gather data on quality to what CMS demands of MA plans.
- Simplify the reporting requirements and formulas for achieving shared savings. Again, as noted above, we believe that perhaps matching the quality requirements with those of MA plans would be a more reasonable expectation for burgeoning ACOs. And our actuaries believe it is reasonable for CMS to calculate the shared savings in a more timely fashion. Once calculated, CMS could then simply send participating organizations a check, with an option for appeal. To require that organizations verify the calculations before a check can be issued, is to ask organizations to complete work that in most cases, they simply don't have the capacity to do.
- Don't require board restructuring. Few organizations today meet the requirement for community stakeholder organization or Medicare beneficiary board member representation. The intent is good here, but most groups would have to restructure their board as a prerequisite for applying as an ACO. That is just too much to ask during this initial phase.

Put ROI in reach: This appears to be the biggest challenge, if for no other reason than the program cannot be overwhelmingly expensive in a time when the government is concerned with spiraling debt. Yet without a meaningful shared savings incentive—one that is not painfully complex to apply for and difficult to attain—participation and innovation could shrivel, which would be a deterrent to one of the triple aims: reducing increases in costs.

We believe that the complex formula for calculating shared savings misses an opportunity to motivate improvement in traditional Medicare utilization and costs across a geographic region. Instead, it focuses on assigned patients who may already be benefiting from efficient practice patterns. At the same time, potential ACOs with the most opportunity for improved quality and reduced costs could be hamstrung by the magnitude of investment needed in information technology and the extent of provider transformations necessary to achieve clinical integration. These groups may not be able to execute quickly enough, which means the new ACO has little chance to break even by the end of the defined three-year cycle, delaying any limited shared savings potential to year four or five.

Solving these issues requires rethinking at several levels. Certainly, our proposed modification to the two-track model can play the biggest role, but other fixes could include:

- Defray costs on the front end and foster participation, perhaps by establishing a low interest revolving loan fund for organizations that want to become ACOs, but lack the needed funds
- Eliminate the proposed 25 percent withhold of shared savings
- Ensure that the recommended proportion of incentive retained by the ACO to repay initial investment and fund reinvestment in infrastructure and other resources to improve alignment is timely and sufficient to fund meaningful investments in IT, staffing, and other tools that advance the goals of ACO performance
- Simplify the formula for calculating shared savings so ACOs can model and measure performance in a timely manner

We believe that aligning incentives for care improvement is so dependent on improved primary care that the incentives must work toward that end.

Strengthen attribution: Attribution is, of course, closely linked with the opportunities for shared savings and the ability to fully provide accountable care. Therefore, we recommend that CMS:

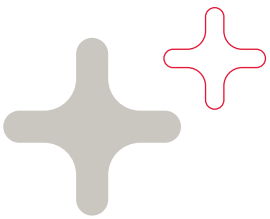
- Adopt a model for prospective attribution (as in our **Track C**)—or primarily prospective attribution, with retrospective reconciliation—and provide access to concurrent member data. This will support the stated intent for member engagement, as well as enable providers to intervene in a timely way with appropriate individuals to better coordinate care. This will also help ensure that providers are not at risk for pre-ACO care they cannot reasonably control, as the current draft seems to allow.
- Change the assignment algorithm to include specialty physicians who provide primary care services, as is allowed in the PGP Demonstration attribution model. This would acknowledge the fact that many Medicare beneficiaries receive primary care from specialists. It also would expand the assigned membership pool and recognize the limited supply of primary care in many markets. Specialists that provide primary care could be required to be exclusive for primary care, but could still participate in multiple ACOs for specialty services.
- Clarify how the attribution model would define attribution for Medicare beneficiaries who change seasonal residence; or, alternatively, exclude them from the ACO. This would limit the risk for providers that are not in a position to manage care as they would for a full-time resident.

Speed access to data and, therefore, the shared savings incentive: Reducing the claims run-out to three months—an actuarially defensible and reasonable time period—could expedite the cycle for identifying and implementing quality improvements and shared savings determinations. This would make the funding needed to reinvest available on a timely basis.

Move further toward aligning incentives: In addition to our proposed modification of the two-track model, we have two recommendations for further aligning incentives.

- First, encourage patient engagement by allowing ACOs to reinvest savings to benefit patients who demonstrate compliance with their individual plan of care. In the patient-centered ACO model, patients must also be aligned from both a behavior and incentive standpoint. In the best cases, highly engaged patients have the tools and resources they need to proactively seek care rather than rely solely on providers to guide them. For example, engaged and empowered patients diligently adhere to therapeutic regimens, seek memberships in fitness facilities, and explore other health improvement tools. This care approach ensures compliance among patients through incentives in the form of reduced co-pays and deductibles and direct cash rewards. In return, we recommend that members who are part of an ACO not be able to opt out of sharing their data. Allowing the member to opt out contradicts the ideal of a clinically integrated, deeply informed provider population that has all the tools it needs to effectively manage care. It is not realistic to expect providers to be held accountable for the care of members whose information they cannot fully access.

  We also believe that aligning incentives for care improvement is so dependent on improved primary care that the incentives must work toward that end. ACOs will need to adapt to a care model that requires new types of provider/patient "partnerships" that allow for shared decision making, new processes across caregiver environments, and interdisciplinary community support to measure, monitor, and improve the care experience. We have two complementary recommendations. First, ACOs can invest their shared savings, particularly the significant shared savings that can be achieved in our no-risk Track A, to foster the development and support of advanced primary care practices.
- Second, though we recognize significant budget constraints, Medicare could improve reimbursement for advanced primary care practices that meet NCQA Level 3 criteria. For example, they could provide a fixed per member per month payment (care coordination fee) for each primary care beneficiary assigned to the advanced primary care practice, provide FFS payment for an expanded list of specified services (e.g., e-visits), and add incentive payments for patient centered performance (e.g., expanded P4P for documenting shared decision making or advance directives). Such a program would both support the early adopters of Advanced Primary Care and provide strong incentives for current primary care practices to evolve to Advanced Primary Care Practices. Perhaps most important, it signals an improved form of reimbursement and strong policy support for Advanced Primary Care Practices that will hopefully encourage more medical students and other health care providers to choose primary care at a time when the need is increasing dramatically.
- Finally, we recommend that ACO applicants that don't include a hospital have the means to understand which hospitals in their region have implemented programs that address concerns central to the ACO concept, such as emergency room usage, length of stays, episodes of care, and readmission rates. This is valuable, even essential information for aspiring ACOs. Similarly, ACOs that don't include certain specialty groups should have access to specialist practice patterns so they can refer accordingly.



SUSTAINABLE HEALTH COMMUNITIES

The vision is similar to ACOs: All participants of a community work in harmony to achieve enduring community health by optimizing care quality and consumer experience, while creating efficiencies that will keep cost increases under control.

CONCLUSION: WHAT NEXT?

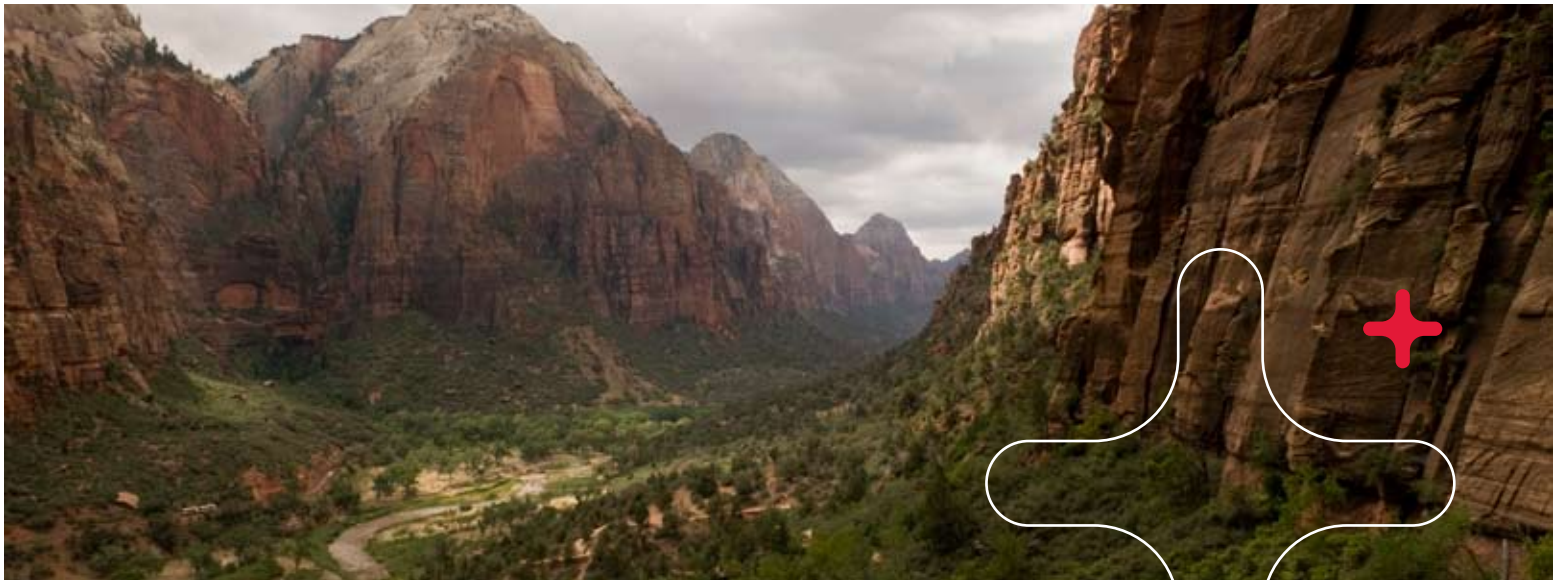
During the 60-day public comment period, we look forward to a vigorous discussion. We also encourage submission of comments, as CMS requests, particularly on the specific proposals that may deter motivated organizations from pursuing ACO status.

Regardless of how CMS responds, those organizations that remain interested in applying to CMS should get started immediately on development and start-up services that include the application process as well as selecting a management team and a governance structure that complies with the rules. If they haven't already, these groups also should conduct a feasibility study, develop their network of ACO participants, develop their criteria and methodology for distributing shared savings and repayment mechanisms for shared losses, identify important improvement and savings opportunities, plan for care and data management infrastructure, determine funding sources, and survey, define, and implement health information technology improvements needed to achieve and document the triple aim goals.

As they do, we would make one important note about developing a provider network, which will coincide with the industry-wide trend toward hospital-owned physician groups (where permitted), or close contractual arrangements between hospitals and large physician groups. The costs of delivering care and investing in technology are driving this trend; ACOs' focus on clinical integration and care coordination will accelerate it, which raises some alarm. Many of us remember this trend not working so well when it was last attempted approximately 15 years ago. There are certainly anti-trust and anti-competitive concerns that run high, particularly if groups approach the 50 percent market share highlighted in the draft rules, but the government seems intent on addressing those concerns.

Nevertheless, this type of physician-hospital integration should be an important and positive development that will boost the ability of ACOs, both the CMS version and those emerging in the private sector, to improve care and increase efficiency. The key to success is that groups positively build on the lessons learned about consolidation from that earlier era.

The most important of those lessons is to use consolidation to better integrate and coordinate care. First, maximize technology advances. Timely data sharing and clear communication among treatment teams are much easier to accomplish than they were 15 years ago. Second, use hospitalists to facilitate inpatient care coordination while reducing medical errors. Third, engage high-quality physician to achieve numbers. Rather, engage high-quality physicians, particularly primary care physicians with strong expertise in managing chronic disease and end-of-life concerns. And, fourth, strike a balance, informed by benchmarks, that rewards strong primary care, but avoids overpayment that can compromise organizations.



Other Options

Even if our recommendations are adopted, ACOs will not be for everyone. Once the final regulatory structure is in place, we encourage those organizations not suited for ACO certification to investigate and pursue other options for payment and delivery system reform.

Those options are increasingly interesting. We are energized by the creativity that the ACO movement has spurred in the private sector, as various groups of stakeholders band together to work toward a vision that we call Sustainable Health Communities.

The vision is similar to ACOs: All participants of a community work in harmony to achieve enduring community health by optimizing care quality and consumer experience, while creating efficiencies that will keep cost increases under control. The difference is that Sustainable Health Communities focus on engaging all local stakeholders. All are connected. All are aligned. And all share both risk and reward.

There are multiple examples of movement in this direction: Some groups of stakeholders are transforming hospital incentive structures so hospitals can be more active participants and supporters of the sustainable health community. Some are working with the CMS Center for Innovation to pursue alternative forms of payment reform. Some are implementing cash flow solutions through financing, revenue cycle, and cost management to fund the multiyear investment required by care providers. In turn, they are ensuring access to longitudinal actionable intelligence, in real time, at the point of clinical and financial decision-making. This access supports the time, resource, and skill set requirements needed for physicians to lead these efforts and address chronic and complex patient care needs. Finally, some are finding creative ways to better engage individuals, regardless of health care coverage, to be active participants in their own health and wellness.

We think these options present compelling alternatives to ACOs and a genuine opportunity for groups to move toward what appears to be an inevitable framework. Although we believe the CMS draft regulations contain some fixable flaws, we strongly believe the concept is sound. This is a pivotal moment in which the will, expertise, and technology exist to make this concept a reality. The challenge is to bring all the pieces together to create lasting, positive change.

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