HEALTH POLICY ISSUE BRIEF

JUNE 2014

How to Improve the Medicare Accountable Care Organization (ACO) Program

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The Brookings Institution | Washington, DC
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Issue Brief: How to Improve the Medicare Accountable Care Organization (ACO) Program

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Introduction

Recent data suggest that Accountable Care Organizations (ACOs) are improving important aspects of care and some are achieving early cost savings, but there is a long way to go. Not all ACOs will be successful at meeting the quality and cost aims of accountable care. The private sector has to date allowed more flexibility in terms of varying risk arrangements—there are now over 250 accountable care arrangements with private payers in all parts of the country—with notable success in some cases, particularly in ACOs that have been able to move farther away from fee-for-service payments. Future growth of the Medicare ACO program will depend on providers having the incentives to become an ACO and the flexibility to assume different levels of risk, ranging from exclusively upside arrangements to partial or fully capitated payment models.

Given that the first three year cycle of Medicare ACOs ends in 2015 and more providers will be entering accountable care in the coming years, the Centers for Medicare and Medicaid Services (CMS) has indicated that they intend to release a Notice of Proposed Rulemaking (NPRM) affecting the Medicare ACO Program.

In anticipation of these coming changes, the Engelberg Center for Health Care Reform has identified a number of critical issues that warrant further discussion and considerations for ensuring the continued success of ACOs across the country. To support that discussion, we also present some potential alternatives to current Medicare policies that could address these concerns. These findings build on the experiences of the Engelberg Center's **ACO Learning Network** members and other stakeholders implementing accountable care across the country. In some cases, the alternatives might have short-term costs, but could also improve the predictability and feasibility of Medicare ACOs, potentially leading to bigger impacts on improving care and reducing costs over time. In other cases, the alternatives could lead to more savings even in the short term. In every case, thoughtful discussion and debate about these issues will help lead to a more effective Medicare ACO program.

The authors would like to acknowledge the following individuals for their contributions and editorial support: Alice M. Rivlin, Director, Engelberg Center for Health Care Reform, Senior Fellow, Economic Studies; and Christine Dang-Vu, Project Manager.

Introduction

Accountable Care Organizations (ACOs) represent an increasingly widespread approach to address inefficiencies, lack of coordination, poor quality care, and increasing costs in the US health care system. While there is considerable diversity in organizational structure and payment models among ACOs, they all have the common goal of controlling health care costs while improving the quality of care they deliver. Ultimately, an ACO aims to move toward a payment and delivery system that provides high value person-focused care.

The number of Medicare ACOs continues to increase since the first round of participants was announced in 2012. The Medicare Shared Savings Program (MSSP) is an example of a "shared savings" model, in which participating ACOs are eligible to earn an additional payment on top of existing FFS payments if they reduce spending below a benchmark and meet quality standards. In almost all cases, these ACOs are not subject to penalties ("downside risk") if they spend more than projected—only a handful of MSSPs have assumed downside risk to date. This one-sided risk model is a first step toward provider accountability to encourage work across the care continuum to reduce overall costs. There are currently 338 MSSP participants. ACOs with more experience and infrastructure to support care reforms may take on "two-sided" risk, including partial capitation, to provide more incentive and flexibility to redirect resources to high-value services. This includes the 23 participants in the Medicare Pioneer Program, as well as a growing number of ACOs working with private plans.

First year financial results are now available for both the MSSP and Pioneer ACOs. Of the 114 MSSP ACOs that joined the program in 2012, 54 were able to keep costs below their budget benchmark, but only 29 were able to hold down costs enough to qualify for shared savings. These successful ACOs received $126 million in savings, while the CMS trust fund realized savings of $128 million, around 1 percent of costs. The other 60 MSSP ACOs experienced spending above their set benchmark, two of which had losses because they chose to assume two-sided risk upon entering the program. Meanwhile, the Pioneer program generated $147 million in total savings, with approximately $76 million in savings returned to ACOs and $69 million returned to Medicare, around 2% of costs. Of the original 32 Pioneer ACOs, 12 qualified for shared savings, one shared in losses, and 19 did not share in savings or losses. Almost all MSSP participants and Pioneer ACOs successfully reported on quality metrics, a majority of which performed better than comparable organizations where data was available.

These results suggest that ACOs are improving important aspects of care and some are achieving early cost savings, but there is a long way to go. Not all ACOs will be successful at meeting the quality and cost aims of accountable care. The private sector has to date allowed more flexibility in terms of varying risk arrangements—there are now over 250 accountable care arrangements with private payers in all parts of the country—with notable success in some cases, particularly in ACOs that have been able to move farther away from fee-for-service payments. Future growth of the Medicare ACO program will depend on providers having the incentives to become an ACO and the flexibility to assume different levels of risk, ranging from exclusively upside arrangements to partial or fully capitated payment models.

Given that the first three year cycle of Medicare ACOs ends in 2015 and more providers will be entering accountable care in the coming years , the Centers for Medicare and Medicaid Services (CMS) has indicated that they intend to release a Notice of Proposed Rulemaking (NPRM) affecting the Medicare ACO program. In anticipation of these coming changes, the Engelberg Center for Health Care Reform has identified a number of critical issues that warrant further discussion and considerations for ensuring the continued success of ACOs across the country. To support that discussion, we also present some potential alternatives to current Medicare policies that could address these concerns. These findings build on the experiences of ACO Learning Network members and other stakeholders implementing accountable care across the country. In some cases, the alternatives might have short-term costs, but could also improve the predictability and feasibility of Medicare ACOs, potentially leading to bigger impacts on improving care and reducing costs over time. In other cases, the alternatives could lead to more savings even in the short term. In every case,

thoughtful discussion and debate about these issues will lead to a more effective Medicare ACO program.

I. Make Technical Adjustments to Benchmarks and Payments

In order for ACOs to qualify for shared savings, they must be able to hold spending below a financial benchmark set using historical spending patterns and meet a certain threshold of person and population-level quality metrics. How these benchmarks are set can substantially impact the chances of succeeding as an ACO and being able to attain shared savings.

Financial Benchmark Calculations: The financial benchmark for Medicare ACOs is calculated using Part A and Part B fee-for-service expenditures from the previous three years for beneficiaries attributed to the ACO. Beneficiaries are attributed in MSSP based on a prospective-retrospective attribution model in which CMS makes a preliminary assignment of individuals to ACOs at the beginning of the performance year, which is then adjusted retrospectively at the end of the year based on whether patients received a plurality of their services from ACO providers. ACOs that are able to make significant progress against their historical spending trend are able to share in savings. However, because the benchmark depends in part on actual trends in Medicare spending as well as on beneficiary attribution that is not fully determined in advance, one of the biggest concerns for many ACOs is the lack of predictability about how they are performing, and the specific standards they are being held to, in their efforts to improve care.

Further, the benchmark is recalculated at the beginning of each performance cycle using the preceding three years of spending. As a result, ACOs that are most successful at reducing costs will see their financial baseline continue to shift downward. Given the limited updates built into fee for service payments which form the basis for the benchmark, ACOs will have to achieve continuing improvements in efficiency be able to make financial progress against their financial baseline every year. Furthermore, the minimum savings rate (MSR) creates disincentives for smaller ACOs to participate in the ACO program, since it is based on the number of attributed beneficiaries and results in these smaller organizations being held to a minimum savings rate (MSR) that is higher than their larger colleagues.

One key challenge for the next round is to refine the financial benchmark calculation in such a way that it provides more predictable targets for participating organizations, and that it encourages real and continuous improvement without becoming unachievable.

Regional Variation in Financial and Quality Performance: Regional health care markets vary substantially. Some ACOs worry that their cost and quality benchmarks might not accurately reflect what is in fact possible within their given region or with their attributed patient population. While using a national growth rate for Medicare Part A and Part B services to calculate financial benchmarks encourages more convergence in costs over time, it means that ACOs in areas with lower "intrinsic" growth rates may have an easier time meeting their benchmark than ACOs in areas that have been growing at higher rates. On the other hand, because the benchmarks also depend on baseline cost levels, ACOs in high-cost areas of the country will have initial financial benchmarks above those of other areas of the country and require less work against the benchmark in order to qualify for shared savings. Altogether, because implementing an ideal benchmark for each market is difficult, cost reduction or quality improvement in one market may be significant and qualify for shared savings, while the same change in another market might not qualify the ACO for savings.

Risk Adjustment: A central piece of calculating an ACO's financial benchmark is effective risk adjustment for the attributed patient population. The benchmark is adjusted according to expected health care costs for the organization's assigned patients over the coming year. This risk adjustment is meant to account for the fact that some ACOs will have a disproportionately sicker and more costly patient population that requires additional work in order to keep costs controlled while also improving quality. One challenge, however, is that the risk adjustment is done prospectively and only accounts for patient diagnoses and conditions in the prior year; this approach is intended to deter additional coding after an ACO is implemented that reflects changes in reporting and not health status. However, it also prevents real changes in patient or population health

status after the performance year has begun to be reflected in the benchmark.

Potential Policy Alternatives

Refine how national and regional factors are incorporated into the calculation of the baseline. For example, to reflect regional variations in spending), and refine risk adjustment methods used in calculating benchmarks.

Hold all ACOs accountable to a standard minimum savings rate (MSR) of no more than 2 percent, regardless of number of attributed beneficiaries.

Add optional years 4 and 5 to performance cycle without spending rebasing, or transition to a rolling average calculation, in order to allow ACOs more time to succeed in transitioning to accountable care.

II. Transition to More Person-Based Payments

The ultimate goal of an ACO is to improve quality at the patient and population level and control the growth of health care costs. In order to successfully achieve this goal, ACOs likely need more flexibility in moving away from fee-for-service payments. This involves making a transition to payments that involve the assumption of more risk by the provider organization with rewards for better health outcomes for groups of patients. This could begin with two-sided risk in the MSSP but eventually move toward partial or full capitation. However, taking on greater accountability for costs is challenging, particularly for organizations that have limited data and experience to understand and address financial risks.

Create Transition Path for Increasing Accountability: Each organization is approaching accountable care with different levels of experience and capacities to assume financial risk for delivering high quality care. Given the diversity of organizational knowledge and comfort, the Medicare program must be able to accommodate needs that reflect these differences. The biggest financial challenge for ACOs is the transition from one-sided to two-sided risk—very few MSSP participating organizations assumed two-sided risk in their first performance cycle, yet under current regulations, they will all have to transition to two-sided risk in subsequent cycles. Not all ACOs are certain that they can make this shift without significant additional support. The Pioneer program helps to facilitate this process for more advanced systems succeeding under accountable care by providing the option of moving to Population Based-Payments, but MSSP does not have a similar path for its participants. Less advanced ACOs question if and when they would be able to move to a more capitated payment system, whereas some more advanced provider organizations have already moved in this direction through Medicare Advantage arrangements. There is no one determined path for an ACO to assume increasing levels of risk.

Include Medicare Part D in ACO Arrangements: Medicare Part D expenditures are currently not a part of the benchmark calculation for ACOs and this effectively protects ACOs from risk for pharmaceutical costs and utilization. Pharmacy services can play a major role in generating savings and improving quality. Increased integration or inclusion of Part D holds the potential to address some obstacles currently facing ACOs in their efforts to align with pharmacies, PBMs, and pharmaceutical manufacturers to improve care. Inclusion of Part D data for ACOs would also be extremely helpful in identifying opportunities for quality improvement and thus reducing uncertainty about improving performance in the program.

Potential Policy Alternatives

Add additional "tracks" in MSSP to allow ACOs to advance to different levels of risk depending on experience and goals.

Create a transitional path towards prospective Population Based Payment or other capitation-based payment models. How those rates should be set will need to be decided. CMS would require assurances of financial viability such as through capital reserves or surety bonds.

Require two-sided risk for large organizations after first performance cycle, but permit extended one-sided risk for smaller organizations.

Create opportunities for coordination to improve care and to share the associated savings and risks between ACOs and groups involved in Part D services.

III. Increase Beneficiary Engagement

While providers are ultimately accountable for the cost and quality of care delivered within an ACO, patients can play a critical role in improving their own health and helping to achieve the goals of the organization. Health outcomes are determined by whether patients adhere to prescribed therapies—taking prescribed medications, participating in follow-up appointments and engaging in healthy behaviors. Costs are also significantly influenced by patient choices about providers and therapies. Increasing beneficiary engagement holds the potential to make patients more activated members of the ACO who can contribute to its success. Structural elements, including the current attribution model, and lack of financial incentives have precluded effective beneficiary engagement to date.

Current Attribution Methodology Hinders Care Coordination: As described above, the prospective-retrospective attribution model in MSSP uses preliminary assignment at the beginning of the performance year, which is then adjusted retrospectively at the end of the year. Retrospective attribution means that providers cannot accurately determine which patients they are responsible for providing care to within the ACO. Likewise, despite the requirement that patients be notified of their attribution and allowed to opt out of data sharing, many patients are often unaware that they are part of an ACO. Without a complete understanding of the attributed population or patients, the ACO can struggle to effectively implement practice transformation targeted at these individuals. Many organizations experience significant "leakage" as patients seek care from providers outside of the ACO, which the ACO is still financially responsible for managing. Similarly, this leakage causes significant challenges for effective care coordination.

Patients Lack Incentives to Seek Care in the ACO: The leakage described above is also due in part to the fact that patients currently lack incentives to stay within the ACO's "network" of providers. Without seeing a positive effect of remaining with the ACO, patients may defer to providers that are more convenient, including going to the Emergency Department for services that could be provided by a primary care physician. Adding financial incentives for patients to see certain providers may help the ACO to achieve its goals and lead to better overall health management for patients. These behavioral levers can also help foster a stronger patient-physician relationship in which providers and patients have a shared vision for how to improve patient health and well-being.

Patients are Not Activated Members of the Care Team: More fundamentally, even if patients know that they are attributed to an ACO, they may have little to no understanding about what makes an ACO unique and how it can help them improve their health or lower their medical spending. Without knowledge of the ACO's purpose or goals, patients have little incentive to become a part of the care team. ACO providers are often not equipped or fail to take the time to describe to patients why they have created an ACO and how it can benefit the patients' care. Patients who are informed about the goals of an ACO and its dual mission of improving quality and reducing costs can feel more activated and contribute positively to the success of the ACO.

Potential Policy Alternatives

Allow beneficiaries to actively choose ACO assignment and remain attributed despite billing patterns. Alternatively, permit ACO non-attribution for patients who opt out of data sharing.

Create benefits to incentivize use of ACO providers and institutions (reduced copays, deductibles).

Create more opportunities for fostering engagement between the ACO and beneficiaries (e.g. add a "welcome to ACO" visit, or permit more extensive communications between the ACO and its beneficiaries).

Allow shared savings for beneficiaries, contingent upon a set of conditions, such as active participation of patient in care.

IV. Enhance and Improve Alignment of Performance Measures

A central tenet of Medicare ACOs is delivering high quality health care as reflected in performance on 33 measures established by CMS. ACOs must meet performance benchmarks in order to be eligible for shared savings, to help ensure that these organizations are delivering high value, rather than simply cheaper, care. While these measures are

critical for holding ACOs accountable for high quality care, the measures themselves and the process of collecting and reporting them have been criticized.

Administrative Burdens: The current quality reporting program requires extensive chart reviews and imposes significant administrative burdens on ACOs. Despite the introduction of electronic health records and other IT systems to capture more clinical data, many ACOs find the process of collecting and translating the data into a form that can be used by CMS to be very time consuming. While CMS does conduct webinars to assist ACOs with understanding how to report data via the GPRO (Group Practice Reporting Option) Web Interface, many ACOs have expressed a desire to have more assistance from CMS, including expanding the reporting period or being able to seeing a sample set of reporting data. Regardless of support from CMS, most providers will need to invest in new support technologies or services to develop clinical workflows capable of both improving care and meeting requirements for measure reporting.

Lack of Measure Alignment Among Payers: Even if able to accurately collect and report quality measures, ACOs struggle with the volume of measures that they are held responsible for improving. This is particularly problematic for ACOs with commercial accountable care arrangements, since these payers typically require performance reporting on their own set of measures. In most cases, commercial payers have more quality measures than Medicare and some measures that may not align at all with those required by CMS. Many providers may also be held accountable for measures beyond their accountable care arrangement, such as through Medicare Star Program or Medicaid. Some ACOs have reported upwards of 200 quality measures that they are held responsible for across their Medicare and commercial accountable care arrangements. While the measures may align conceptually, they often differ in their technical specifications, such as the calculation of the numerators and denominators or the actual benchmark used for assessment. As the number of measures continues to increase, the time and administrative burdens mount. The dispersion of measures may prevent ACOs from concentrating their efforts in the most cost-effective way that improves care for patients.

This overall lack of alignment between payers creates an environment where ACOs must cater to different measures that may not complement, or could in fact conflict, with each other.

Effectively Rewarding Quality Improvement: In order for an ACO to be eligible for shared savings, they must reach minimum attainment level for 70% of the measures in each domain; performance at or above the 90th percentile is necessary to earn maximum points. The Medicare ACO program is currently structured such that an ACO's quality score can only reduce the ACO shared savings, rather than increase it. As a result, some ACOs feel as though the quality improvement program is penalizing rather than rewarding performance. Another barrier to effective quality improvement for ACOs is the fact that quality benchmarks are not fully set prior to the performance year. Given the importance of meeting the benchmarks, ACOs would benefit greatly from having a target in advance of the beginning of the performance year.

Concerns about Measure Selection: More fundamentally, some ACOs believe that even the 33 measures they are held responsible for in the Medicare program are not the most meaningful available. This includes concerns that measures may not accurately reflect appropriate patient care, as well as that measures for outcomes that might be more reflective of high-value care are not included. Some of the current Medicare ACOs measures focus on process, rather than outcomes, which some believe do not capture the true impact on care. For example, conducting a falls risk assessment may help to understand which patients are at highest risk of injury, but does not necessarily ensure that the ACO is taking action to prevent those injuries from occurring. Moving toward more outcome-based measures could better capture the true quality of care being delivered to patients. In addition, adding measures that better reflect functional status or patients' level of engagement in their care could help the ACO to foster a more collaborative care environment that meets the patients' needs. When ACOs do not see the value of certain measures they struggle to understand how to use these measures to transform care. The burden of collecting less meaningful measures prevents an ACO from focusing their efforts on meaningful practice transformation.

Potential Policy Alternatives

CMS could enable easier and more streamlined electronic reporting from the data systems used in care delivery. Better integration with existing health IT systems, meaningful use requirements, and registries would allow ACOs to spend less time reporting their performance and more time focusing on meaningful clinical interventions.

An ACO's quality score could be used to award additional shared savings for improvement in measure scores, rather than as a means to reduce the shared savings amount.

Greater CMS efforts could be devoted to bringing more convergence with commercial plans around the priorities defined by the National Quality Strategy and other quality programs.

CMS could support more interaction and greater transparency with existing ACOs on the measure selection process.

CMS could consider dropping measures, such as falls risk assessment, which many ACOs believe is not a meaningful metric of success, while adding other metrics that might better capture clinical transformation and improvement, such as functional status, safety-related metrics, medication therapy, resource use, patient engagement, and mental health status.

V. Enable Better and More Consistent Supporting Data

In order to succeed, ACOs must be able to effectively collect, interpret, and use clinical and claims data to transform care of their patients. ACOs need to adopt new health IT systems and other technologies in order to collect and use the growing amount of data.

Reconciling Data: One of the biggest challenges for ACOs, particularly those that are less experienced, is reconciling their own clinical data with the claims data that they receive from CMS. Without sufficient technical expertise, many providers struggle to match the data and understand how the information they receive from CMS can best be used to transform care. Further complicating the reconciliation process is the fact that there are often discrepancies between the quarterly and monthly reports that ACOs receive from CMS. When patient or system level data is inconsistent between reports, the providers struggle to assess their true performance over time. In addition, CMs provides patient data according to TINs (Taxpayer Identification Number), which is inconsistent with other health data reported according to NPIs (National Provider Identifier). This lack of alignment makes it challenging to assess individual provider performance.

Patient Data Opt-Outs: Patients are currently allowed to opt out of having their data provided to their assigned ACO, but the ACO is not allowed to opt out of accountability for the costs of these patients. As a result, physicians and ACOs are not made aware of health services that the patient receives outside of the ACO. If and when the patient is attributed to the ACO, they are then held responsible for all of the beneficiary's health care costs without having the benefit of data to know how to intervene in order to improve care.

Lack of Timeliness in Receiving Data: One of the biggest challenges that ACOs report is the time lag on data from CMS related to both quality and assignment. Quarterly assignment files are sent to ACOs after that quarter of the year has passed, meaning that the organization is constantly using attribution data that is several months behind and may no longer be relevant for targeting clinical interventions to the right patients. ACOs report similar delays in receiving claims data and feedback from CMS on their quality performance relative to the benchmark and to other ACOs. This lag also makes it harder for an ACO to assess when and how to intervene until it is perhaps too late to make a meaningful impact.

Difficulty Tracking Patients Throughout the Health Care System: In addition to issues related to receiving data from CMS, ACOs also struggle to collect meaningful clinical data on all of their attributed patients. This is particular relevant when it comes to knowing when a patient has a relevant medical event, such as a hospital admission or discharge, or a transfer to another health facility. While more advanced systems are using Admission-Discharge-Transfer (ADT) notifications that interface with their patients' electronic health records, not all ACOs are readily equipped to know all relevant clinical events. Without lack of notification for these changes in patient health status or care, ACOs can struggle to

track their attributed patients through the health system. In tandem with related attribution issues, the ACO must be able to know when their patients receive care outside of their network of providers in order to appropriate manage both the cost and quality of that patient care.

Delay in Performance Feedback: Given these lags in data from CMS and the need for time consuming reconciliation at year's end, many ACOs do not know how they are doing until months after a clinical event or a new intervention. These delays raise serious concerns for ACOs in terms of undertaking timely interventions that will make a real impact on cost and quality.

Potential Policy Alternatives

Open source the algorithm that CMS uses for calculation of the quarterly reports.

Include both Taxpayer Identification Number (TIN) and National Provider Identifier) information in CMS data reports.

Permit ACOs to exclude attributed patients who opted out of monthly data sharing.

Provide aggregate or de-identified information on patients that are not included in the monthly data.

Increase the availability of Admission-Discharge-Transfer (ADT) notifications by focusing federally funded health information exchanges on them, and through the Stage 3 Meaningful Use requirements for eligible hospitals (as proposed by the Health IT Policy Committee).

VI. Link to Additional Value-Based Payment Reforms

ACOs are just one of many payment reforms that health care organizations across the country are implementing to improve quality and reduce costs. Aligning the vision and components of these other initiatives with ACO reforms has the potential to reinforce the shared goals of the initiatives and provide much more effective support for reforming the health system. However, there are barriers to achieving this alignment.

Linking Bundled Payments for Episodes with ACOs: There are now thousands of contracted bundles between providers and payers across the country, which include both more traditional episodic care, such as joint replacement or cardiac procedures, as well as chronic and acute conditions, such as cancer and pregnancy. Many of these bundles now contain downside financial risk. The Medicare Bundled Payment for Care Improvement (BPCI) program now includes hundreds of providers covering over $1 billion in totaled bundled payments per year and increasing to $15 billion in a few months. Bundled payment programs in both the public and private sector are already showing evidence of better quality and lower costs. More importantly, these bundles for primary care and specialty care are increasingly being viewed as complementary payment models to ACOs and patient-centered medical homes. While bundles hold great potential to align and reinforce the goals of an ACO, there are also concerns about the potential for "double dipping," or the same providers being rewarded twice for the same care in different payment models. Identifying more effective ways to foster multiple alternative payment models may well intensify the potential impacts of accountable care.

Multi-payer ACOs: Many Medicare ACOs have already established accountable care arrangements with private payers. These commercial accountable care contracts differ quite a bit between payers and regional markets, which provide unique opportunities to develop arrangements that meet the needs of a patient population. However, they often do not align well with Medicare ACO requirements. Many ACOs feel as though CMS has done little to help their organizations develop new commercial accountable care arrangements, aside from the requirement that Pioneer ACOs contract with other payers such that a majority of their revenue is in outcomes-based contract by the end of the second performance year. Given that the patients attributed to a Medicare ACO represent only a fraction of the total population served by a given provider organization, it is prudent for ACOs to expand the number of contracts to create more aligned value-based care across the system. Increasing the percentage of patients being served by value-based contracts will allow the ACO to more easily transform care across the system, rather than selectively targeting interventions to just those patients attributed by Medicare.

Defining an ACO Based on Tax Identification Number (TIN) Limits Other Payment Innovation: CMS has stated that providers with a single TIN cannot participate in more than one shared savings program in order to avoid a provider being rewarded twice for generating savings, sometimes referred to as "double dipping." While this makes sense, it precludes some physician group practices from experimenting with more than one shared savings program. CMS is trying to prevent overlap of beneficiaries between different shared savings programs, but it has the adverse effect of not allowing the same organization to participate in multiple Medicare alternative payment arrangements. If attribution were based on National Provider Identification (NPI) or a blended TIN/NPI approach, it would allow physicians with the flexibility to choose which CMS program they wish to participate in and give provider organizations with the opportunity to experiment with additional payment models.

Potential Policy Alternatives

Allow providers to implement multiple alternative payment models—bundles, ACOs, with options for accounting for savings attributable to each model

Support the development of commercial ACO arrangements.

Consider modifying the MSSP regulation to attribute ACOs by NPI or a blended TIN/NPI approach

VII. Develop Bonus Payments and Other Participant Incentives

In order to effectively transform clinical practice, ACOs must create or procure significant financial and human capital, as well as transform their information technology and delivery infrastructure. A recent survey estimates the average start-up cost for creating an ACO to be $2 million, with some ACOs investing significantly more in their first few years.

Smaller ACOs Struggle to Secure Ramp Up Funding: An increasing number of physician groups and smaller provider networks are beginning to realize the potential value of becoming an ACO. However, their small size and lack of capital can be a barrier to transition into an ACO arrangement and structure. The significant upfront costs of practice and infrastructure transformation can impede the ACO movement and prevent organizations of all sizes from achieving success. While the Center for Medicare and Medicaid Innovation has provided upfront and monthly payments to 35 small and rural ACOs as part of the Advance Payment program, the program did not support payments to any ACOs in the latest round of MSSP program participants beginning in January 2014. Early results suggest that the Advance Payment Model can make a difference—30% of Advance Payment ACOs beginning in 2012 achieved shared savings, compared to 28% of other physician-led ACOs. Physician-led ACOs now account for more than half of all MSSP participants, so a real opportunity exists to assist these providers.

Many Organizations are Uncertain if They Can Assume Risk and Succeed as an ACO: In addition to the financial investment necessary to become an ACO, many organizations are simply uncertain about whether they can succeed as an ACO. These questions are particularly pertinent for organizations without risk-based contracting experience. These organizations must be able to prove that they can adopt alternative payment models that move away from fee-for-service. These new payment paradigms are simply unchartered territory for many organizations. Providers considering becoming an ACO or moving to increasing levels of risk would benefit from more guidance on how to make this transformation and estimates of what kind of financial and quality improvements they will have to make in order to share in savings. Guidance might also provide more clarity for potential partners for the ACO who could provide assistance with up-front capital. Increasing the predictability of success for a given organization could significantly encourage participation in accountable care arrangements.

Transforming Care Requires Significant Staffing and Clinical Changes: Becoming an ACO requires expanding the provider workforce and investing in new staff capabilities. New personnel may include care coordinators, internal health IT experts or contracted IT providers, clinical transformation use of health IT, and clinical transformation staff. Increasing clinical and support staff can be financially burdensome and time-consuming. Furthermore, many ACOs feel as though they are not actively

rewarded for the clinical transformation that they undertake, since there are few billing codes to capture the non-traditional clinical work necessary to succeed as an ACO. In sum, ACOs must significantly increase their clinical and staff capabilities without the promise of long-term success or shared savings.

Potential Policy Alternatives

CMMI could expand the Advance Payment Models, which are under-powered with only 35 participants. They could also experiment with new payments specifically for ACOs which provide eligible participants with upfront or monthly payments or "vouchers" to support their care coordination infrastructure.

Provide more clarity and/or flexibility regarding the program requirements for the interim payment option, and provide more clarity about the clinical and financial needs of ACOs based on experience to date, potentially helping to create a more robust marketplace for the reinsurance products required.

Create a "pre-qualification" phase where the ACO is given an estimate of what their financial benchmarks will be prior to agreeing to enter MSSP.

Facilitate fee for service billing codes that capture the various coordination and case management services provided by the ACOs; for example, through the use of monthly chronic care management fees due to be defined in the 2015 Physician Fee Schedule.

VIII. Support Clinical Transformation

Providers Need More Support in Undertaking Clinical Transformation: Becoming and succeeding as an ACO is a vast undertaking that nonetheless requires a strategy and immediate steps to begin to transform practice, finance, and operations. However, many providers, particularly those that are less experienced at systemic practice transformation, simply do not know where to begin with such changes. All ACOs are responsible for reporting and meeting the same 33 quality measures, some of which they may have never collected data on before. Depending on patient populations and experience in certain clinical areas, each ACO will be able to more effectively tackle different areas of quality improvement. At the same time as meeting quality measures, the ACO must also be reducing costs, and as many are learning, quality improvement and cost reduction do not always go hand in hand.

In order to meet quality and cost benchmarks, ACOs need to learn lessons from each other on what works and what does not work. Each ACO has different strengths, weaknesses, and needs, which other ACOs have likely experienced at some point in their formation or operation. Peer organizations offer perhaps the best opportunity for shared learning and spreading of best practices among ACOs. A number of peer organizations and networks for ACOs exist today. If CMS were able to take more steps to support these organizations, either through financial or data support, ACO adoption could accelerate.

Potential Policy Alternatives

CMS could encourage and support a range of efforts to promote the sharing of best practices for quality improvement and cost reduction among providers, through peer-to-peer communication and other means.

CMS could support a database of provider-reported interventions, implementation learnings, and subsequent clinical outcomes.

CMS could identify and provide support to partnering organizations to assist with the collection and sharing of best practices.