

Refining the ACO Program: Issues and Options

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Executive Summary

The Affordable Care Act (ACA) is transforming Medicare with new payment models pushing the program away from Fee-For-Service (FFS) payment. The most prominent of these are the Accountable Care Organization (ACO) programs, which give qualified provider organizations the opportunity to make profits in exchange for accepting some financial risk and meeting some quality targets. While major elements of the ACO programs were delineated in the ACA, the Centers for Medicare and Medicaid Services (CMS) retains considerable design authority. The regulatory framework must continue to evolve as experience accumulates.

Under the ACO programs, including the Medicare Shared Savings Program (MSSP), which offers both a one-sided model (Track 1) and a two-sided model (Track 2) and the two-sided Pioneer ACO Model, provider organizations agree to operate under a benchmark global budget (i.e. the benchmark) to cover all care for patients attributed to them (based on patterns of utilization derived from claims data). The provider organizations can share in the savings if spending is below the benchmark and, in the two-sided models, they must share the cost if spending exceeds the benchmark.

In this paper, we make several recommendations:

- 1) Benchmark setting
 - a. Benchmark rates should continue to be set based on organization-specific experience for the first year of the initial three-year contracting period.
 - b. Updates during the first contract period should be disconnected from ACO-specific performance and based on increases in local FFS spending.
 - c. Benchmarks in subsequent contract periods, should be disconnected from ACO-specific performance and set by trending benchmarks at the end of the previous contract based on an update factor based on increases in local FFS spending
 - d. ACOs with risk adjusted spending above the local FFS average should have lower updates and ACOs with risk adjusted spending below the local average should have higher updates.
- 2) The shared savings percentage should increase.
- 3) One-sided risk models should be retained as an option for ACOs, but the attractiveness of two-sided models should be enhanced by rewarding ACOs taking the two-sided option with relief from certain Medicare rules.
- 4) Participation in the ACO program should be encouraged by:
 - a. Avoiding excessive increases to payments to providers remaining in traditional Medicare.
 - b. Improving the ability of ACOs to engage patients.
 - c. Reducing the regulatory and administrative burden of ACOs.

Introduction

The Affordable Care Act (ACA) is transforming Medicare in many ways. A number of new payment models push the program away from Fee-For-Service (FFS) payment and encourage provider accountability for costs and quality. The most prominent of these are the Accountable Care Organization (ACO) programs, including the Medicare Shared Savings Program (MSSP), which offers both a one-sided model (Track 1) and a two-sided model (Track 2) and the two-sided Pioneer ACO Model. These payment models allow providers to aggregate in a new contracting form that will share financial risk with Medicare for a set of beneficiaries attributed to the primary care providers associated with the new form. While the major elements of the ACO programs were set out in the ACA, the Centers for Medicare and Medicaid Studies (CMS) retains considerable design authority. As is true of virtually every Medicare payment area, the regulatory framework needs to evolve as experience accumulates.

This white paper identifies and discusses important program design issues and key tradeoffs related to ACO payment and regulation. We focus on the two fundamental goals of encouraging participation and creating appropriate incentives once ACOs are in the program. We recognize that providers have alternatives, both to continue to work within traditional Medicare (TM) and the FFS payment system, and to participate in Medicare Advantage (MA), which shares some goals with ACOs but is structured as an insurance option for beneficiaries as opposed to an innovative form of contracting with providers.

The ACO programs are designed around two fundamental considerations. The first consideration is participation. Expected profits for ACOs must be at least as high as providers might receive in their alternative choices (FFS, MA) in order for ACO participation to make economic sense. Because the ACO payment allows providers to share savings, they *may* actually be able to achieve the same level of profits with lower revenue. The second consideration is the incentive to provide high-quality care at an efficient cost. This requires some reward for investing in organizational changes that improve quality and reduce spending. Given evidence of widespread waste in the FFS system (estimated by some to be as high as thirty percent of spending) and substandard quality, success should be achievable.^{1,2} However, changing practice patterns takes time and effort. Identification and elimination of waste and improving practice patterns may require detailed interventions, and thus may be difficult and costly.

The ACO programs must also be designed with national rules. Given the variability of spending and voluntary nature of the program, the rules must be designed so that the program is not adversely affected by attracting only those organizations that would receive bonuses without altering behavior or by random chance. The latter concern is particularly salient in upside-only models.

In sum, the aim of the ACO programs is to create incentives which are strong enough to encourage providers to change behavior, but not so stringent that providers will not participate. While encouraging participation in the programs is important, it is only a means to an end. The ultimate goal is to optimize both clinical and economic outcomes for the program overall, balancing beneficiary well-being with the fiscal sustainability of the program. In this spirit, we believe that, apart from any transitional issues, policy should not inherently value one financing arrangement (ACOs, Medicare Advantage, or FFS) over others.

¹ Berwick, Donald M., and Andrew D. Hackbarth. "Eliminating waste in US health care." *Jama* 307.14 (2012): 1513-1516.

² Olsen, LeighAnne, and Pierre L. Young. *The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary*. National Academies Press, 2010.

Early experience with the ACO program is emerging. CMS reports that ACOs have generally reduced spending, but, in most cases, these reductions are not large enough to qualify participants for shared savings. Although all of the 32 Pioneer ACOs improved quality in 2012, the first year of their performance, only 13 saved enough to meet the threshold to share in savings. Overall, this generated \$87.6 million in gross savings. Medicare's share of savings was only \$33 million.³ In year two, Pioneer ACOs generated total savings of approximately \$96 million. However, only eleven Pioneer ACOs shared savings while three generated shared losses and three chose to defer reconciliation until after the completion of the third performance year. 53 MSSP ACOs kept their costs below budget benchmarks, only 29 of those saved more than two percent and thus qualified for savings.⁴ These ACOs cumulatively held spending \$652 million below their targets and earned more than \$300 million in savings. The remaining 60 MSSP ACOs spent above their set benchmark.

Despite general evidence of success, organizations have been leaving the Pioneer program.⁵ In July 2013, nine Pioneers left this ACO model after the preliminary results for the first performance year were released. In August 2014, another Pioneer dropped out, followed by three more in September shortly after the second year performance results were announced, leaving 19 remaining Pioneer ACOs. The apparent paradox of generally positive results but declining participation in the downside risk model may signal shortcomings in the program structure.

In this paper, we address the following aspects of that structure, with an eye toward encouraging participation while maintaining incentives to generate Medicare program savings:

- Benchmark (and fee) setting and updating
- Shared savings percentages
- Requirements for acceptance of two-sided risk
- Encouraging participation in the ACO program

Benchmark (and Fee) Setting and Updating

Savings and losses at an ACO are assessed in relation to a "benchmark" level of spending. In the first year of the initial contract period, Medicare sets a benchmark for an ACO based on the spending of beneficiaries who would have been attributed to the ACO's primary care providers during a three-year baseline period just prior to the upcoming three-year contract period. The benchmark is updated within a contract period by the national rate of growth in Medicare spending. If the ACO's spending is below the benchmark during the performance period, the ACO is eligible to share the difference between the benchmark and the actual spending (i.e., "savings"). To share savings, the ACO must meet certain quality metrics. In some cases, the ACO accepts downside risk, which requires the ACO to reimburse Medicare for part of spending above the benchmark. After the end of the three-year performance

³ <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-07-16.html>

⁴ Petersen, M. and Muhlenstein, D. (2014, May 30). ACO Results: What We Know So Far. *Health Affairs Blog*. Retrieved from <http://healthaffairs.org/blog>

⁵ McWilliams, J. Michael, et al. "Change in Patients' Experiences in Medicare Accountable Care Organizations." *New England Journal of Medicine* 371.18 (2014): 1715-1724.

period, a new benchmark is set based on spending during the preceding three years, which correspond to the first performance period (See Figure 1).

The use of ACO-specific benchmarks to set payment in the initial year has two main advantages. First, it adjusts for differences in case mix across ACOs. But it is not the only way to accomplish this goal. For example, ACO payments could be risk adjusted using existing algorithms from MA.^{6,7,8} How well the MA risk adjustment system captures risk heterogeneity in the ACO program, where populations covered, network size and geographic breadth all vary from the MA program, has not been established. Second, ACO specific benchmarks encourage participation in the program because higher cost ACOs (perhaps more inefficient organizations or perhaps those with more costly patients that risk adjustment cannot capture) are given higher baseline benchmarks.⁹ Use of a national average benchmark, or even a local area benchmark, (risk adjusted or not), would likely discourage participation from high cost ACOs and such organizations may be where the biggest opportunities for savings exist.

Yet, there are a number of concerns with the use of organization-specific benchmarks. First, existing evidence, though not conclusive, suggests that differential risk is not the only cause for differences in benchmarks. Organizational inefficiency contributes as well. Organizational specific benchmarks reward this inefficiency. Second, the specific approach to weighting the three baseline years to generate a performance period benchmark is problematic. Its heavy weighting on the last year of the benchmark period (60%) discourages attention to cost savings in the year immediately preceding the performance period.¹⁰ This may have minimal effects because organizations may find it difficult to temporally target cost savings efforts, but nevertheless, the problem could be addressed by a simple reweighting of the years in the baseline period.

Third, and most importantly, the use of an organization-specific benchmark that is updated over time and rebased based on organization specific performance diminishes the incentive for organizations to invest in programs to reduce spending. For example, if an organization makes a one-time investment of four percent of spending to reduce readmissions such that spending drops two percent per year while operating costs of the program are one percent of spending (so there is a one percent of spending net savings on an ongoing basis), then the program would have a four year payback period. But in year three, the benchmark would drop two percent, so the program would lose money once the contract is renewed even if FFS spending in the area, among providers without the program, did not drop by two percent. Essentially, organization-specific rebasing creates incentives similar to “FFS with a lag” and discourages investment in programs that reduce spending.

Finally, the benchmark system for MA plans is based on FFS spending in the counties where plan beneficiaries live, whereas ACO benchmarks are based on spending for the organization in a baseline period. This creates a distinction between the ACO and MA benchmark that could distort provider

⁶ Newhouse, Joseph P., and Thomas G. McGuire. "How Successful Is Medicare Advantage?." *Milbank Quarterly* 92.2 (2014): 351-394.

⁷ Newhouse, Joseph P., et al. "Steps to reduce favorable risk selection in Medicare Advantage largely succeeded, boding well for health insurance exchanges." *Health Affairs* 31.12 (2012): 2618-2628.

⁸ McWilliams, J. Michael, John Hsu, and Joseph P. Newhouse. "New risk-adjustment system was associated with reduced favorable selection in Medicare Advantage." *Health Affairs* 31.12 (2012): 2630-2640.

⁹ McWilliams, J. Michael. "ACO Payment Models and the Path to Accountability." *Journal of general internal medicine* (2014): 1-3.

¹⁰ Douven, R., McGuire, Thomas G., and McWilliams, J. Michael, "Avoiding Unintended Incentives in ACO Payment Models," *Health Affairs*, forthcoming.

choices about organizational form. For example, a large organization may have the option of becoming an ACO or developing an MA plan. Such an organization, whose spending exceeds the local MA benchmark based on local FFS spending, would have an incentive to become an ACO. The more efficient organizations would have an incentive to create MA plans. This could create higher FFS costs in the area (because ACOs spending is included in FFS spending) which would raise MA benchmarks. More generally, such incentives bias organizational choices. To take another example, it may not be efficient for a low cost organization to undertake the expense of creating an MA plan, but the existing incentives encourage that. Similarly, it may be efficient for a high cost organization to become an MA plan, as opposed to an ACO, but existing incentives discourage that.

This argues for a benchmark methodology that does not distort organization choice of program. Basing benchmarks off of local FFS costs would be a move in that direction. Because MA rates themselves may not be set optimally, because the efficiency of ACOs and the MA plans may differ and because other aspects of ACO and MA program differ, it is not so simple as to say optimal ACO benchmarks should be the same as MA benchmarks. We do believe that the updating process for ACO benchmarks should narrow the gap with the MA methodology and more research proceeds on the best way to think about paying these two program options for providers.

In sum, we propose baseline benchmarks be set based on organization-specific spending but updated and rebased based on trends in local area FFS spending. The use of organization-specific initial year benchmarks addresses unobserved risk selection and encourages participation in the program. Updating and rebasing based on local FFS spending would remove the negative incentives associated with organization-specific rebasing and, with differential updates for high and low spending organizations, allow convergence over time (at least partially) within the ACO programs and between the ACO programs and MA rates.

Specifically, we propose a revision to benchmark rules that uses organization-specific benchmarks to set the starting point for the initial three-year performance period and uses local spending trends, perhaps adjusted for whether the ACO has an initial benchmark above or below local spending, to update the benchmark over the three year contract. We further recommend rebasing the benchmark for subsequent contracting periods based on methods similar to the updates during the contract period using local area spending trends as opposed to organization-specific rebasing. This moves away from the current rule of rebasing benchmarks to an ACO's prior spending every three years. Each ACO would have its initial benchmark set based on performance in a baseline period, but this benchmark would be updated and rebased by the rate of growth in local average costs, adjusted for the starting level of spending. For example, an ACO might receive an update or rebased payment equivalent to an increase in FFS costs in its market minus X if its spending is above the local FFS average or plus Y if it is below the local FFS average. If it were equally easy to save money in organizations with ex ante high vs. low spending, this approach would clearly encourage participation of organizations with low spending and discourage those with higher than average spending. However, there are several reasons to think higher than average spending organizations might participate. The pressure on FFS rates encourages them to participate in the ACO program, and because they are starting with higher spending, there may be more room for success. Moreover, if participation is skewed, X and Y can be adjusted to maintain fiscal neutrality. For example, if high cost organizations are not joining initially, X and Y could be set to zero in early years. In this model, benchmarks would need to be risk adjusted. We recommend the use of existing MA methodology for this, though further research and refinements may be needed.

Shared Saving Percentage

Both participation and incentives for an organization to reduce spending depend crucially on the share of savings they can keep. We believe the existing shared savings percentage is too low and should be raised. Specifically, in an ACO environment, the profitability of an initiative to lower spending depends on the shared saving percentage and the extent to which reduced use lowers costs. (If costs are fixed, lower use does not lower costs for the providers. If costs are all variable, then lower use does reduce provider costs). Specifically, if an ACO reduces utilization (say avoids an MRI) such that Medicare spending drops by 1000 dollars, the revenue drops only by $\$1000 \times (1 - \text{the shared saving percent})$ and costs drop by the variable cost of the MRI (assume \$400). Thus the profit of such a program is the avoided variable cost (\$400) – $(1 - \text{shared saving percent}) \times \1000 . If the shared saving percent is 50%, the net program actually loses \$100. That is because the MRI had contributed \$600 to the bottom line (\$1000 revenue less \$400 variable cost). When the MRI is not done, the provider loses that \$600 but only gets back \$500. Moreover, because ACO activities to control utilization have operating costs, the loss is even greater. In general, programs are only profitable if the costs of the program are lower than the foregone revenue times $[\text{variable cost ratio} - (1 - \text{shared saving percent})]$ where the variable cost ratio is the fraction of reduced spending that is avoided when utilization drops (40% in our example above). Profitability is further hampered by losses on FFS beneficiaries that may also be affected by the program (for example, a program to reduce readmissions may affect all Medicare beneficiaries even though only about 40 percent are aligned with the ACO). If the ACO is physician based, the variable cost may be full spending and the spillover effect may be reduced.

For an organization serving only Medicare FFS beneficiaries, the formula for the profitability of reducing spending for ACO beneficiaries by \$1 is:

$$\text{Profit} = (\text{Sav}) * (\text{VCR} + \text{SS}\% - 1) - (1 - \theta) / \theta * (\text{VCR}\% - 1) * \text{Sav} * \text{SP}\% - \text{MPC} - \text{FPC} / \theta N$$

Where:

Sav = savings in ACO group (i.e. pre spending – post spending for ACO folks. It will be negative)

VCR = avoidable incremental cost as share of revenue

SS% = shared savings percent

θ = share of enrollees in the ACO

SP% = reduction in revenue of Medicare beneficiaries not in ACO per \$ of Medicare revenue

MPC = marginal cost of operating the program

FPC/ N = fixed cost of the program per Medicare beneficiary

A few points are worth noting:

- A) Profitability is greater when variable costs are higher. This is because more costs are reduced when spending drops and because the loss in profits from any spillover reduction in use is less if variable costs are high (non-ACO volume is less profitable). The variable cost ratio will depend on both the timeframe and perspective of the ACO. Specifically, empirical estimates suggest variable costs could be as low as 16% of total costs¹¹ (an even smaller share of revenue), but they will be greater as the adjustment time grows and non-hospital based services are included. Moreover, variable costs from the perspective of the ACO are greater if the ACO is not

¹¹ Roberts, Rebecca R., et al. "Distribution of variable vs fixed costs of hospital care." *Jama* 281.7 (1999): 644-649.

integrated with hospitals or post-acute providers because, in this case, avoided hospitalization or use of post-acute care is valued at the full price as opposed to the cost of production.

- B) Profitability is greater if the shared saving percentage is higher. As noted, at a minimum shared savings must be greater than variable cost ratio.
- C) Profitability is greater in organizations with more patients in the ACO because spillover losses are less and savings are generated on more patients.

If the organization serves non-Medicare patients or MA enrollees, there will be an analogous spillover term representing any losses (or gains) in the commercial and MA sectors associated with the changes in care induced by the ACO program. For example, if much of the commercial business is FFS, programs that reduce use may create losses in the commercial sector if volume drops in that sector as well. Similarly, if the organization assumes risk for MA patients, an ACO program that reduces use could increase profitability of MA. The crucial parameter is how much of the organization's revenue, overall is FFS vs. a risk-based model. As the share of risk-based contracting increases so does the profitability of cost-reducing programs.

Not all of this is under the control of CMS, but it does suggest several policy enhancements. First, if rebasing remains organization specific, a longer contract would be appropriate because the avoidable incremental cost percentage is higher in the long run. Second, a higher shared saving percentage seems reasonable. Note that Medicare can still save money if the shared saving percentage (Medicare's share of savings) is low because the lower spending will lead to lower benchmarks (if ACO spending is counted in local FFS spending) and the spillover effects directly benefit Medicare.

Requirements for Acceptance of Two-Sided Risk

ACOs have some choice about the form of shared savings, and whether they would also be willing to accept the risk of some shared "losses." In the case of Pioneer and some MSSP ACOs, the ACO is also responsible for a portion of spending above the benchmark (this downside risk is mandatory for Pioneer ACOs and optional for MSSP ACOs, with greater shared savings rates for those that elect two-sided risk).

The existing system of risk sharing differs for ACOs in the Pioneer model vs. MSSP. In the Pioneer model, organizations that volunteer are selected based on criteria related to their size and capabilities to take two-sided risk. In MSSP, organizations that generally meet less stringent requirements are only incented by gain sharing (except for a few that have opted to assume downside risk as well). Because of the stochastic nature of spending, ACOs can only share in savings if their savings exceed a threshold designed to prevent random fluctuation in spending in any year from generating savings. The MSSP threshold is generally set to require greater savings before shared savings is activated.

Some have expressed concern that the MSSP program may have incentives that are too weak to be effective and may discourage movement to a two-sided model.¹² Yet, the existence of a one-sided risk model (MSSP Track One) provides organizations that believe they can improve the efficiency of care and want to share some of the associated savings a way to participate in alternative payment models without meeting the structural requirements of the Pioneer program.

¹² McWilliams, J. Michael. "ACO Payment Models and the Path to Accountability." *Journal of General Internal Medicine* (2014): 1-3.

Thus, the key issues in deciding whether to force ACO to accept downside risk in subsequent contract periods is how the existence of MSSP affects participation in models with downside risk (vs. no model at all) and how able are organizations willing to participate in MSSP to become more efficient? We believe that the MSSP program has value in that it permits organizations to begin the journey away from FFS. By maintaining pressure on FFS rates, the organizations should be pushed on that journey. They can be moved toward two-sided models by pressure on the amount of gain sharing. For example, as is the case now, organizations that accept two-sided risk should be allowed to keep a greater portion of the savings, and the difference in shared savings rates between one-sided and two-sided models could be widened.

It is important as these parameters are structured to take into account the multi-year nature of the programs. Even if MSSP systems are unlikely to qualify for savings in any given year purely by chance, the likelihood of savings due to random fluctuation increases over multiple years. So it may be reasonable to set program parameters so that they make the MSSP program less attractive over time. For example, in the first year of the contract MSSPs that do not accept downside risk must achieve a threshold that ranges from 3.9 percent for smaller ACOs (5,000 beneficiaries) to 2.0 percent for larger ACOs (at least 60,000 beneficiaries). Assuming this threshold is right (which it might not be), one could raise it over time to reflect the multiyear nature of the program. More research to assess the appropriate threshold at a point in time, and over time, is called for.

Encouraging Participation

FFS Rates

Because of the uncertainty associated with changing business models, as well as inherent organizational inertia, participation in the ACO program is unlikely if the FFS environment is highly profitable. Therefore, to foster robust participation in the ACO program, it is crucial to avoid excessive increases in FFS fees. While lower FFS fees would also reduce ACO benchmarks, the potential gain sharing in an ACO model can allow organizations to be successful even with lower revenue because they can capture gains from reducing utilization. Specifically, revenue and costs move together in the FFS system. Low FFS rates can make a system unprofitable in a FFS environment. Yet in an ACO model revenue is independent (at least in the short run) of utilization. Thus for any amount of total revenue, an organization can be more profitable as an ACO if it can reduce utilization. This allows an ACO to succeed financially at FFS rates that would render them unprofitable in a FFS model. We believe that if organizations can prosper under FFS, they will be unwilling to undertake the difficult task of transformation. But if FFS looks less attractive, they may be willing to invest in generating efficiencies and able to succeed under an ACO model. Thus, we believe lower FFS fees will induce ACO participation even though they would be associated with lower ACO benchmarks. However, because not all providers are structured in a way that facilitates success as an ACO, fees must be adequate to sustain the FFS program. With the exception of the SGR, we believe the current law fee trajectory is reasonable and any SGR fix should try to constrain future physician fee increases to no more than the CPI.

Promoting Beneficiary Engagement

Beneficiaries assigned to ACOs continue to have unrestricted choice of providers like other beneficiaries in traditional Medicare and may be unaware that they have been assigned to an ACO. In this context, incentives for ACOs to generate savings are substantially diluted and their ability to manage care may be hampered. Specifically, there is substantial instability in beneficiary assignment to ACOs. On average,

only 80 percent of beneficiaries assigned to an ACO in one year are assigned to the ACO in the next, and this percentage is even lower among the highest risk patients (76 percent).¹³ Flux in the assigned population diminishes ACO returns and patient-specific investments in care management. There is also substantial leakage of specialty care outside of ACOs. For example, even among the more specialty-oriented ACOs, over half of specialty office visits for an ACO's assigned population occur outside of the ACO. Greater leakage implies greater care coordination challenges and more limited reach of ACO influence. In addition, the proportion of outpatient care billed by ACOs in Medicare that is actually devoted to assigned population is low (approximately 38 percent overall and 60 percent among ACOs with specialty mixes more oriented toward primary care).¹⁴ This low penetration of ACO contracts into the care delivered by ACOs weakens incentives to invest in changes in structure or care systems that would constrain spending for all Medicare patients served by an ACO because any shared savings generated by such changes would be offset by lost FFS revenue among Medicare patients served by an ACO but not assigned to it.

ACOs have some ability to address the fragmented and unstable care patterns that weaken contract incentives and undermine care coordination efforts. For example, they could partner with an insurer to offer a Medigap Select plan that could have a provider network designed to minimize leakage. This may work well for low spending ACOs because the premium might be lower than other options, but the benchmark rules, described above, would suggest that such ACOs might be more interested in becoming an MA plan. For high spending ACOs, the premium for the Medigap Select plan might be higher than alternatives because the ACO network is high spending. In order for a Medigap select plan to be successful for these plans, it is likely the provider would need to subsidize some of the premium, which could be possible if they are integrated with the plan or have the ability to waive copays for in-network use. The attractiveness of this to the organization depends on if the lower premium or foregone premium revenue is offset by the benefits of reduced leakage.

Apart from Medigap Select plans, there are a number of policy reforms that could enhance beneficiary engagement. These include:

Clarifying referral rules to specific high quality, low cost specialists and post-acute care providers

Under the existing framework, it is unclear whether ACOs currently have the ability to recommend to their beneficiaries high quality, low cost providers with whom they have relationships. Many interpret differentiating between providers in this way as conflicting with program requirements that all providers be presented equally. So long as beneficiary choice is preserved, giving ACOs the ability to indicate which providers they think offer the highest value care, especially where wide variation exists, should benefit both quality and spending.

Clarifying beneficiary communication rules

ACOs are now limited in their ability to communicate with and engage beneficiaries. As risk bearing ACOs have greater incentives to control costs, concerns about aggressive practices to increase volume are significantly reduced. If marketing inducement rules were relaxed, beneficiaries could have a better understanding of the benefits of ACO attribution and play a greater role in achieving positive outcomes.

¹³ McWilliams, J. Michael, et al. "Outpatient Care Patterns and Organizational Accountability in Medicare." *JAMA Internal Medicine* (2014).

¹⁴ McWilliams, J. Michael, et al. "Outpatient Care Patterns and Organizational Accountability in Medicare." *JAMA Internal Medicine* (2014).

Regulatory Changes to Support Program Success and Participation

Central to the preceding discussion is the concern over participation in the various ACO programs. More generous treatment of ACOs (higher benchmarks, less risk) increases participation but also increases program costs and may diminish incentives for efficiency. To some extent, participation incentives can be bolstered by regulatory changes that reduce the regulatory burden on ACOs and support ACO efforts to transform the delivery system. Such changes would encourage ACO participation, which would allow somewhat more stringent setting of parameters around benchmarks and risk sharing.

Several examples of regulatory changes are worth consideration. They include:

Waiving of RAC hospital audits for admissions for which the ACO assumes risk

Recovery Audit Contractor (RAC) audits are intended to reduce unnecessary hospitalization. Two-sided risk ACOs have incentives to reduce such admissions, and thus the administrative cost of RAC audit may outweigh their benefits. Current RAC audits are limited to requesting additional documentation from providers for a certain number of claims based on volume (more claims are audited from bigger providers). One concern is that if claims relating to certain patients assigned to ACOs were excluded from RAC audits, the RAC auditors would just substitute claims from non-ACO patients. We recommend selecting claims before identifying ACO beneficiaries and then excluding the ACO beneficiaries from the audit, thereby reducing the total number of claims audited.

Waiving of three day stay rule for SNF admissions

Currently, a stay in an acute care hospital of three days or more is required for Medicare coverage of a skilled nursing facility (SNF) stay and post-acute services. Concern about unnecessary hospitalization and delivery of care in an appropriate setting is minimized under a two-sided model. Pioneers and Bundled Payments for Care Improvement (BPCI) participants now have waiver ability and this could be expanded to all two-sided risk bearing ACOs. Yet the waiver process is complex, in part to receive waiving authority, but more importantly, the requirements for who is eligible for the waiver is complex, making it costly to implement. The existing waiver process should also be streamlined so that the administrative and monitoring requirements of the waiver don't counteract its benefit to the ACO.

Waiving the "homebound" requirement for home health services

Patients must now meet the definition of homebound in order to trigger Medicare payment for home health. However, home health services may also be appropriate in other cases, resulting in fewer hospitalizations and lowering the overall costs of care. Two-sided ACOs should have discretion to provide care in this setting without adherence to the homebound definition.

Reducing legal and regulatory barriers to integrated care delivery

The current legal and regulatory framework of federal fraud and abuse laws, while providing beneficiary and program safeguards, can serve as an undue constraint on ACO integration and the implementation of financial incentives. It is important to reduce any chilling effects and strike an appropriate regulatory balance in CMS' recently extended process¹⁵ of promulgating a final rule on fraud and abuse law waivers in MSSP and in further development of specific guidance on Stark law exceptions, additional Anti-

¹⁵ "Medicare Program; Final Waivers in Connection With the Shared Savings Program; Continuation of Effectiveness and Extension of Timeline for Publication and Final Rule." *Federal Register* 79, No. 201 (17 October 2014) 62356-62357.

kickback law safe harbors and Civil Monetary Penalty (CMP) law clarification regarding medical necessity and care reduction.

Conclusion

It is our hope that, through the structural reforms and regulatory changes to incentivize participation suggested above, the ACO programs will be better positioned to move the health care system away from FFS in order to both generate fiscal savings and produce better outcomes. The ACO programs must be governed by national rules with enough flexibility to account for variations in spending. The policy suggestions here are designed to strike the right balance of encouraging participation and encouraging beneficial changes to provider behavior.

Figure 1¹⁶:

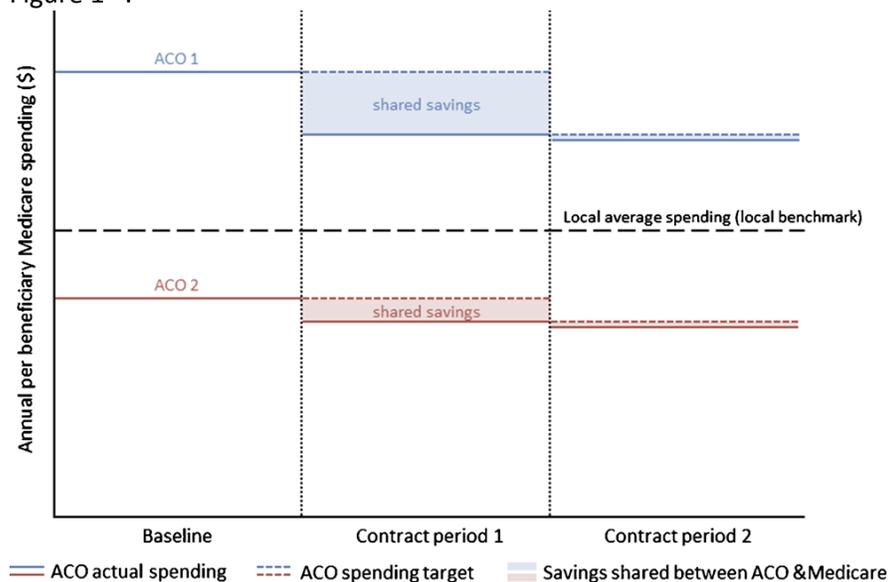


Figure 1. Two ACOs with different baseline spending levels. Two hypothetical ACOs are depicted, one with per-beneficiary Medicare spending above and one with per-beneficiary spending below local average spending for beneficiaries served by non-ACO providers. The ACO with high spending (ACO 1) achieves a lasting reduction in spending in the first contract period, but no further reduction in the second period. Under the current pay-for performance model that bases spending targets on ACO-specific spending histories, ACO 1 receives a substantial shared savings bonus in the first period but not in the second, because its spending target is reset at its new spending level. Under a payment model using local benchmarks as the basis for spending targets, ACO 1 would not be rewarded in either period, despite achieving substantial and lasting gains. The ACO with low spending (ACO 2) achieves a smaller spending reduction in the first contract period and no further reduction in the second period. Under the current model, it receives a small shared savings bonus in the first contract period and no bonus in the second. Relative to a target based on the local benchmark, however, it would receive a large bonus in both periods despite minimal improvement. Thus, the current model rewards ACO 1 for improvement (or at least mitigates its losses) in the short-term, but provides weak long-term incentives for ACO 1 to achieve and sustain below-average spending like ACO 2. In contrast, a spending target based on a local benchmark would remove short-term incentives for ACO 1 to lower spending, but would provide strong long-term incentives for ACO 1 to achieve and sustain below-average spending. The advantages and disadvantages of the different methods for setting spending targets would depend further on the extent to which the ACO's deviations from local average spending reflect differences in efficiency vs. differences in patient characteristics that are not described well by data available to Medicare.

¹⁶ McWilliams, J. Michael. "ACO Payment Models and the Path to Accountability." *Journal of general internal medicine* (2014): 1-3.