

December 3, 2010

Donald Berwick, MD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Program; Request for Information Regarding Accountable Care Organizations and the Medicare Shared Savings Program; 75 *Fed. Reg.* 70,165 (November 17, 2010); CMS-1345-NC.

Dear Dr. Berwick:

The Washington State Medical Association (WSMA), on behalf of our over 9,200 physician members in Washington State, appreciates the opportunity to provide our views regarding the Centers for Medicare and Medicaid Services' (CMS) request for information concerning accountable care organizations (ACOs) and the Medicare Shared Savings Program. While many of our comments mirror those made by the American Medical Association (AMA), we also have additional comments that reflect the specific health care delivery environment in Washington State. We urge CMS to incorporate our detailed responses below as the agency develops its proposal to implement the ACO and Medicare Shared Savings Program.

1. What policies or standards should we consider adopting to ensure that groups of solo and small practice providers have the opportunity to actively participate in the Medicare Shared Savings Program and the ACO models tested by CMMI?

About half the physicians in our state practice in smaller practice settings (50 physicians or less). We are extremely pleased that CMS is pursuing policies to help these practices in the new payment environment being contemplated. Small practices provide efficient, cost effective, high quality services and will be an important aspect of improving health care delivery in the future. To ensure that small physician practices can successfully serve as ACOs, CMS and other federal agencies should:

- Create explicit policy that requires at least 50% of an ACO's formal governance structure be practicing physicians. Medical leadership is essential to ensure clinical practice and patient care related policies remain central to an ACO's agenda. Hospital executives, health plan expertise, and consumer input are also necessary, and we expect they will be involved. We are concerned that, because so many physicians are in small practices, they could be easily overlooked as the governance of an ACO is established. Additionally, we believe that a balance of primary care and specialist physicians are also essential to assuring that the entire system of care is adequately represented on an ACO Board.

- Create policy guidelines that ensure small practices have an opportunity to participate. The following guidelines should be mandated:
 - Create payment policies that ensure small practices are entitled to receive an equitable distribution of shared savings and economic rewards based on their performance and that nothing regarding the “size” or economic power of participating physician groups can be used to discriminate against the small practice.
 - Create guidelines that ensure any provider willing to participate on an equitable financial basis and who meets the published quality criteria can participate in the ACO, provided that the patient population being served by the ACO has the need for the services of the physician.
- Create explicit safe harbors from antitrust enforcement and waivers of the Civil Monetary Penalty statute, the Anti-Kickback statute, and the Ethics in Patient Referrals (Stark) statute so that small, independent physician practices can work closely with each other and collaborate with hospitals and other providers to deliver coordinated care for both Medicare beneficiaries and commercially-insured patients. Currently, all of these laws and associated guidelines favor hospital-based systems with employed physicians, yet the best way to preserve opportunities for appropriate competition in health care and choice for patients is to allow physicians to form ACOs in ways that enable them to continue to practice without becoming directly employed by hospitals and large health systems.
- Permit ACOs to participate with no more than 5,000 beneficiaries, the minimum number required by law. CMS has an understandable desire to require that ACOs serve a large number of Medicare beneficiaries in order to increase the statistical confidence of cost and quality measures and reduce the likelihood of making shared savings payments based on purely random variation in patient utilization. Physicians also support accurate measurement and have concerns about basing quality and cost measures on inappropriately small patient populations. However, the larger the number of patients required for the creation of ACOs, the more difficult it will be for small physician practices to participate, and the more likely it will be that there is only one ACO in many communities. This will decrease choice for patients and reduce competition. Consequently, the requirement for the minimum number of beneficiaries should not be increased beyond the 5,000 established in the Affordable Care Act (ACA) until and unless actual implementation of ACOs clearly demonstrates that a higher level is necessary.
- Limit requirements for the structure or internal systems of ACOs to items where there is clear evidence that high-quality, affordable care *cannot* be provided without such structures or systems. For example, having an initial requirement for an integrated electronic health record system for all practices participating in an ACO would create a serious barrier for many small practices. While having such integrated systems are *desirable*, and clearly a long term objective for successful ACOs, there is no evidence that they are *essential* for physician practices to successfully coordinate care and manage costs. Indeed, there are many examples where physician practices deliver high quality, affordable, coordinated care without such systems, and there is evidence showing that implementation of such systems can have initial negative impacts on the quality and cost of care, particularly during implementation phases. Consequently, making acquisition and implementation of such systems a prerequisite condition for being designated an ACO would be inappropriate. In other words, if EHRs and other tools improve performance but the evidence for this is not clear, then let the market drive change as opposed to up front mandates.

- Require that an ACO and/or CMS provide timely, detailed data to physician practices to enable them to identify opportunities to make improvements in cost and quality. These data need to (a) include information on all services received by patients who have been treated by a physician in the practice during the previous year; (b) be provided in an electronic format that allows detailed analysis and simulation of the potential impact of changes in care delivery on costs, (c) include the ability to risk adjust the information to allow for the natural diversity in acuity and patient condition, and (d) include routine (e.g. monthly) reports on which patients are attributed to which physicians.

2. Many small practices may have limited access to capital or other resources to fund efforts from which "shared savings" could be generated. What payment models, financing mechanisms or other systems might we consider, either for the Shared Savings Program or as models under CMMI to address this issue? In addition to payment models, what other mechanisms could be created to provide access to capital?

Create payment models that enable ACOs to self-finance improvements.

The problems small practices (as well as many larger providers) will face under the shared savings model are broader than just "limited access to capital." Even practices which have access to capital (either from their own financial reserves or from lines of credit extended by lenders) may not be able to construct a feasible business case for the investment of that capital if CMS does not address the issues outlined in the previous section or as defined in Section 7. Practices must be able to overcome these issues so as to recoup their investments in a reasonable time period. In particular:

- CMS should create payment systems that enable physicians participating in ACOs to be paid immediately for key services that are not currently paid under Medicare, *e.g.*, phone calls and email communications with patients and other physicians, and use of nurse care managers to provide education and self-management support for patients with chronic disease. The prospective payment options described in Section 7 below can achieve this without increasing the net costs of the Medicare program.
- Payment systems created by CMS should enable ACOs to accurately project the savings they will be able to retain or the additional payments they will be able to receive if they are successful in restructuring care delivery in specific ways. This requires knowing in advance which patients the ACO will be accountable for, knowing the current levels of utilization for those patients and the cost targets the ACO will be expected to achieve, and receiving timely data on the ACO's performance so that mid-course corrections can be made. Knowledge about specific performance areas that can be improved upon will be essential.
- The FTC should remove barriers preventing ACOs from successfully contracting with private payers to support shared services. Joint contracting makes it more practical for physicians to make and sustain the investments in infrastructure necessary to support quality improvement. Physicians cannot and should not be forced to organize their patient care delivery systems differently for Medicare patients and commercially insured patients. The per-patient costs of investments to sustain care improvement efforts can be reduced if multiple physicians are sharing in the services those investments support and multiple payers are paying for those services.
- Avoid imposing unnecessary requirements that require significant upfront capital. As clear evidence from successful practices becomes apparent, then the market will adopt and innovate and additional regulation and enforcement can be minimized to only those things that are truly necessary.

- CMS should only establish requirements for ACOs that require large capital investments if it provides specific financing mechanisms to enable physician practices to make those investments or CMS arranges it such that the ACO can receive the essential service from another CMS sponsored program.
- Create loan, loan guarantee, and technical assistance programs to help small physician practices make the investments needed to become ACOs.

Taking the actions above will significantly reduce the need for upfront investment, as well as reduce risks and delays in recouping those investments. However, many small physician practices and newly formed IPAs will still need new financing mechanisms in order to make the upfront investments needed. Commercial lenders are unlikely to respond quickly or favorably to requests by ACOs for loans or lines of credit given the complexity of healthcare payment and the radical change that ACO payment systems represent. **Physician practices should not be forced to enter into partnerships with hospitals simply to obtain access to capital.** CMS could take several actions to increase the ability of small physician practices to obtain the financing needed to become ACOs or to participate successfully in partnerships with other providers to form ACOs:

- Work with ACOs and physician groups to educate banks and other commercial lenders about the ways that physician practices participating in ACOs will have access to new revenue streams that can be used to repay loans. Having CMS publicly support access to capital for start-up ACOs will be extremely helpful in convincing conservative lenders to make funds available.
 - Create a loan guarantee program, similar to the Small Business Administration's successful 7(a) program for small businesses, which would enable small physician practices and IPAs to more easily obtain financing from commercial lenders.
 - Make grants to non-profit community organizations, such as Regional Health Improvement Collaboratives, to provide grants, loans, and technical assistance to help small physician practices and IPAs form ACOs, particularly in communities where market conditions warrant special assistance. We also expect and have reasonable assurances that our local Health Information Technology Regional Extension Center (WIREC) and Health Information Exchange programs established under the HITECH Act will also provide important infrastructure components for our ACO. Having the Office of the National Coordinator (ONC) provide these federally funded programs with specific guidance that their cooperation is a critical expectation would be helpful.
3. **The process of attributing beneficiaries to an ACO is important to ensure that expenditures, as well as any savings achieved by the ACO, are appropriately calculated and that quality performance is accurately measured. Having a seamless attribution process will also help ACO's focus their efforts to deliver better care and promote better health. Some argue it is necessary to attribute beneficiaries before the start of a performance period, so the ACO can target care coordination strategies to those beneficiaries whose cost and quality information will be used to assess the ACO's performance; others argue the attribution should occur at the end of the performance period to ensure the ACO is held accountable for care provided to beneficiaries who are assigned to it based upon services they receive from the ACO during the performance period. How should we balance these two points of view in developing the patient attribution models for the Medicare Shared Savings Program and ACO models tested by CMMI?**

We believe that getting the “attribution issue” successfully resolved is likely to be the most important element underlying the success of the entire ACO concept. Subpar performance here, especially at the outset, will ruin the entire concept.

The core of any successful effort to reduce costs and improve quality in health care is a strong patient-physician relationship. This, in turn, is founded in a *voluntary* choice by both the patient *and* physician to begin and maintain that relationship. CMS should adopt ACO policies that encourage and reinforce such voluntary relationships between Medicare beneficiaries and physicians, not weaken them or create substitutes for them.

Any method for “attributing” patients to physicians puts CMS in the position of deciding which patients and physicians have a relationship, rather than having that decision made by the physicians and patients themselves. Moreover, all attribution methodologies use inherently rigid statistical rules that can easily create misclassifications, misattribution, and chaos. If physicians feel they are being arbitrarily rewarded or punished then the ACO concept will not succeed.

Retrospective attribution is particularly problematic, since neither the patient nor the physician knows that CMS is assigning accountability to the physician for the costs of all of the patient’s care until after the care has already been delivered. Use of retrospective attribution could create an undesirable incentive for ACOs to avoid providing primary care services to new Medicare patients, since a single visit could result in all of that beneficiary’s healthcare costs being attributed to the ACO. Furthermore, retrospective attribution proactive “bonding” in the physician-patient relationship and will not result in meaningful and active care management.

Without active patient support and engagement, the ability of physicians to help patients improve their health, avoid unnecessary hospitalizations, and reduce the use of unnecessary and duplicative services is inherently limited. If a Medicare beneficiary is unwilling or unable to participate in efforts to better coordinate and manage their care, then an ACO should not be held accountable for the overall costs of services associated with that beneficiary simply because a physician in that ACO provided the beneficiary with a needed primary care service (and as a result had the beneficiary “attributed” to the ACO). Conversely, if a beneficiary and a physician mutually agree to work together to provide high-quality care for the beneficiary’s most critical needs, the ACO that the physician is associated with should not have any savings resulting from that care attributed to other providers based on retrospective statistical rules.

As a result of these considerations, the WSMA strongly urges CMS to design an ACO system in which Medicare beneficiaries select their primary care physician in advance. While this is more administratively cumbersome (and therefore costly) than the current Medicare fee-for-service system under Parts A and B, we believe this type of up-front, voluntary selection will be critical to the success of the ACO program. We therefore make the following recommendations:

- CMS policies should maximize the extent to which an ACO is held accountable only for those patients who voluntarily choose its physicians to provide or manage their care, and it should seek to minimize (and ideally eliminate) the use of statistical attribution methodologies, particularly retrospective attribution after care has already been delivered after the end of the reporting period. At a minimum, CMS should create one payment option as part of the regulations under the Shared Savings Program that

allows beneficiaries to elect participation in an ACO and makes ACO-related payments based only on the beneficiaries who make that election. This method has been in use for many years with Medicare Advantage programs and other commercial models and can easily be applied to the ACO program. Ideally, several different payment models could be offered (as described in Section 7 below), each of which is based on up-front patient selection rather than retrospective statistical attribution.

- CMS should undertake a proactive effort to educate and encourage beneficiaries to take actions that will help make ACOs successful, *e.g.*, to choose and consistently use a primary care physician as a medical home, to work closely with their primary physician to select specialty physicians, hospitals, and other providers that coordinate effectively with their primary care medical home and with each other, to engage in shared decision-making processes with their physicians about appropriate treatments for their conditions, and participate in other types of programs developed by their physicians that can maintain and improve their health at an affordable cost. This education effort should be developed in cooperation with physicians and launched well in advance of the initiation of the ACO program.
- Patients who select a primary care provider should be allowed to change their physician relationship whenever they choose and the performance attributed to that provider should be calculated accordingly. This has added administrative costs and complexity, but is essential to preserve patient freedom of choice of provider. Additionally, CMS should develop measures to identify why the patient has changed their relationship and this feedback should be gathered and used to improve the overall system. Sometimes changes are expected and appropriate, other times changes are important indicators of quality failures. This information needs to be captured and used to improve the provider's and/or overall system's performance.
- To the extent retrospective, statistical measures must be used to attribute beneficiary costs to providers, create an efficient and timely notification and appeals process to deal with possible mis-classifications. A multi-year audit and review process is not feasible, especially for smaller practices where margins are thin and an extended appeals process can have serious impacts.

Finally, attention must be paid to creating policies that deal equitably with “problem” patients. If patients are non-compliant and physicians have explicitly taken the patient thru a non-compliance process, then the physician (and therefore the ACO) should be able to “de-select” the patient. We realize that this should only occur rarely, and in very specific circumstances, and that CMS must closely monitor this process. Physicians should not be allowed to de-select a patient because the outcomes are poor. CMS should develop a very specific and tightly managed process to allow patient de-selection.

4. How should we assess beneficiary and caregiver experience of care as part of our assessment of ACO performance?

We believe both beneficiary and caregiver experience are very important components of assessing overall ACO performance, and encourage CMS to implement efficient and standardized measures for these components as quickly as possible. However, we are concerned that the current state of the art in measuring caregiver experience has not yet resulted in reliable, efficient, and broadly used standards for this assessment, and we strongly encourage CMS to consider the added reporting burdens to avoid cumbersome and expensive primary data

collection for both components. Phasing-in these requirements, with careful pilot-testing, is strongly recommended to ensure the reporting burden does not overwhelm ACOs.

Considerable effort and resources have been devoted to developing, testing, and implementing the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, and CMS should build on this work by using CAHPS to help measure the patient experience of care in ACOs. It is important to recognize, however, that patient and caregiver experience measures such as CAHPS cannot be collected through existing data systems such as claims data and electronic health records. They require special surveys of consumers, and the lack of resources available to conduct these surveys has been a principal barrier slowing their implementation.

Consequently, CMS will need to provide financial support for the collection and reporting of consumer experience data. To ensure both objectivity and adequate participation, we recommend this be done through existing, independent, community-based organizations, such as Quality Improvement Organizations (QIOs) or Regional Health Improvement Collaboratives (RHICs). Several RHICs, including Massachusetts Health Quality Partners (www.mhqp.org) and Minnesota Community Measurement (www.mnhealthscores.org), already collect and report measures of patient experience along with quality of care measures based on clinical and claims data. RHICs can provide an ideal platform for administering patient experience data with appropriate involvement of physicians and other providers. We believe the Puget Sound Health Alliance or the Foundation for Health Care Quality in Washington State are also candidates to consider for this purpose.

Since CAHPS was developed to measure the care delivered by individual types of providers in a fee-for-service environment, additional survey questions will likely need to be developed to measure patient experience issues that will be particularly affected by ACOs. CMS should work with AHRQ and NQF to ensure there is adequate funding for the development, testing, and implementation of new measures. Particularly in the near term, different measures may be needed in different communities because the areas where ACOs will focus their cost reduction efforts may vary significantly from region to region. An efficient way to address this would be for CMS to provide support to multi-stakeholder Regional Health Improvement Collaboratives to develop and test new patient experience measures working in collaboration with the physicians and ACOs in their communities. More information on Regional Health Improvement Collaboratives is available from the Network for Regional Healthcare Improvement (www.NRHI.org).

The ACA does not require public reporting of ACO performance information, and we urge that CMS approach both the collection and any reporting of such information, including patient experience data, thoughtfully to avoid having unintentional adverse consequences for patients or providers.

As noted earlier, standardized measures of caregiver experience are not yet in widespread use, and further testing and development are needed before these measures can be reliably used as part of assessing ACO performance. We recommend phasing-in caregiver experience measures over time, especially to the degree that caregiver experience data are used to reduce financial payments to ACOs.

5. The Affordable Care Act requires us to develop patient-centeredness criteria for assessment of ACOs participating in the Medicare Shared Savings Program. What aspects of patient-centeredness are particularly important for us to consider and how should we evaluate them?

To promote patient-centered care, ACOs will need measures that apply across disciplines and settings, account for multiple chronic conditions, and provide information on the outcome of care. The medical community is working through the NQF (National Quality Foundation), the Physician Consortium for Performance Improvement (PCPI), and other organizations to develop these measures as well as a framework for blending individual measures into a composite score that creates a more comprehensive picture of where improvement, resources, and incentive payments should be focused.

While physicians support the development and use of increasingly sophisticated measures, there are also significant methodological limitations regarding risk adjustment, attribution, and aggregation that must be taken into account. At this time, there are no widely accepted models that accurately attribute care provided through multidisciplinary teams, or when a patient's care is provided by multiple physicians or across two or more care settings. CMS' plan for evaluating patient-centered care should clearly address and resolve all attribution issues prior to requiring the collection and use of this information. The costs and reporting burden for these measures, especially if they involve primary data collection, are also important to consider.

The WSMA believes that an ACO's success in being "patient-centered" is best evaluated by patients' experience with the care provided by the ACO, and less so by whether the ACO meets specific standards established by CMS. Creating effective mechanisms for assessing patients' and caregivers' experience, as discussed in the previous section, should be the primary way that CMS measures patient-centeredness.

- ACOs should be measured on how well they meet the following attributes which reflect the level of "patient centeredness":
 - Patients believe they have received adequate information about their disease or clinical condition.
 - Patients believe they have been adequately informed about the proposed care path that is being recommended and treatment options available.
 - Patients believe they have been involved in making important decisions about their care and clinical care path.

CMS can play a critical role in promoting patient-centeredness, because an ACO's ability to be patient-centered will depend heavily on the way CMS structures the payment systems and requirements for ACOs. In particular:

- An ACO needs to know who its patients are and have each patient actively working with the ACO to successfully manage his or her care. Consequently, allowing patients to select ACOs in advance—rather than using retrospective statistical attribution methods—and encouraging patients to work proactively with their physicians and other providers, as described in more detail in Section 3, are essential to promote patient-centered care.
- Physicians need the flexibility to customize care for each particular patient in ways that work effectively for that patient, rather than being forced to provide a particular type of care simply because that is what Medicare will pay for. For example, a physician should be able to be paid for answering a patient's phone call or e-mail if that will provide more

timely and effective assistance than an office visit. CMS should make the kinds of changes to the fee-for-service system—or allow the ACO itself to set certain payment policies as described in Section 7—so that physicians can be paid upfront for currently unreimbursed and under-reimbursed services that will improve care for patients and save money for the Medicare program.

- Physicians should not be penalized for accepting sick patients into their care or customizing a patient’s care to meet their unique needs. Consequently, the kinds of effective risk adjustment and risk limits described in Section 7 must be included as part of any payment models implemented.

6. In order for an ACO to share in savings under the Medicare Shared Savings Program, it must meet a quality performance standard determined by the Secretary. What quality measures should the Secretary use to determine performance in the Shared Savings Program?

Types of Quality Measures

Ensuring ACOs meet quality performance standards is an essential component of a successful ACO program. We recommend that CMS initially implement quality performance metrics using existing, validated measures and that, over time, these measures be expanded as the state of the art advances.

At least in the initial years of the ACO program, CMS should avoid requiring ACOs to collect and report new or different quality measures beyond those that are already being required under other CMS programs, such as the Physician Quality Reporting System (PQRS), formerly the PQRI. Existing measures are extensive and are heavily focused on preventive health care, which is the type of service for which providers are least likely to be rewarded under short-term ACO contracts. Because of the costs associated with data collection of quality metrics, sticking to currently required measures seems to us to be the best way to initiate the ACO program.

Additional quality measures may ultimately be warranted, but it is impractical to develop a single national set of such measures prior to implementation of the Shared Savings Program, because the areas where ACOs will focus their cost reductions will likely vary significantly from region to region, and measures that may be appropriate for one ACO model may not be appropriate for another. ACOs should be allowed to report on a hybrid of nationally and locally focused quality measures related to their particular patient population. CMS should consult with measure developers like the NQF and PCPI as it seeks to define new performance measures, including whether this information supports benchmarking for improvement at the population, organizational, or group practice level. At this early stage, when there is so much we do not yet know about ACOs, we believe a one-size-fits-all approach for new metrics would be a mistake. Obviously, any new measure must also have sufficient sample sizes to be statistically significant and should include provisions to ensure that patient acuity and co-morbidities are accounted for in the calculation of the measure.

Further, CMS should support the ability of multi-stakeholder organizations, such as RHICs and QIOs, to work with ACOs in the community to collect and report additional quality measures tailored to the unique needs of individual communities.

Moreover, any requirements for new measures applicable to all ACOs should be limited to measures of outcomes and patient experience, not measures of process or structure, which could inhibit the ACO's flexibility to dramatically restructure the way they deliver care and reduce costs while maintaining or improving outcomes. All new measures should be developed in cooperation with the NQF and should require reporting on measure sets that include intermediate and long-term outcome measures based on a patient population. We also have concerns over the accuracy of claims based measures but have come to accept some of these measures once the measures have been thoroughly reviewed and proven to be reasonably accurate.

Because some subspecialties currently lack measures, and also lack a data collection and reporting system that addresses their scope of practice, new reporting requirements should be phased-in to ensure that all physicians have the opportunity and resources to participate on a widespread basis.

Standards of Performance

The initial standard of performance on any quality measures that CMS chooses should be "no decrease in quality," for the first year. CMS should not seek to force arbitrary improvements in quality measures on ACOs at the same time they are creating ACOs to seek ways to reduce costs. We believe it is likely that in many cases, providers will improve quality either as a means of reducing costs or in conjunction with cost reduction efforts, it is impossible to predict in advance where those improvements will occur because, as noted earlier, the areas where cost reductions will be sought and the methods of doing so may differ from ACO to ACO.

CMS policies should assure patients that ACOs will not result in lower quality care, but not promise that any particular aspect of quality will improve immediately. CMS should also support the flexibility of ACOs to choose the areas where they focus quality improvement and cost reduction efforts, not distract them by imposing unrelated quality improvement goals (particularly without corresponding changes in payment).

Over time, however, we believe ACOs are an ideal vehicle to improve quality of care, and we support CMS efforts to use ACOs in this manner beginning as early as 2013.

7. What additional payment models should CMS consider in addition to the model laid out in Section 1899(d), either under the authority provided in 1899(i) or the authority under the CMMI? What are the relative advantages and disadvantages of any such alternative payment models?

Overall the following policies should apply to any payment model.

- Implement effective risk-adjustment methodologies and risk caps on the costs associated with individual patients so that ACOs are managing performance risk, not insurance risk. ACOs should be rewarded for how well they help Medicare beneficiaries manage health problems, not simply rewarded for attracting patients who have relatively few such health problems. Any payment models that CMS implements should use an effective risk adjustment methodology so that ACOs are rewarded, not penalized, for accepting sick patients and for addressing their needs in the most effective way possible. Selection of risk adjustment systems should be based on input from physicians and other experts and the methodology should be transparent to all stakeholders. Medicare Advantage programs

have made considerable progress in this area over the past few years and this work should be advanced.

However, risk adjustment alone is not enough, since some patients will have unique problems requiring unusually expensive care that will not be adequately captured by any risk adjustment methodology. Even a single such patient could be financially devastating for a small physician practice, while having a relatively small impact on a large health system. Consequently, in addition to good risk adjustment methodologies, CMS needs to establish limits on an ACO's financial accountability for the total costs of services to any individual patient. Stop loss and episode of illness carve outs must be included in the final rules.

- Limit the extent to which ACOs are accountable for the costs of certain services if they are delivered by only one provider in the community. In addition to risk adjustment and risk caps on an ACO's accountability for any individual patient, ACOs should be permitted to have exceptions to the types of services they will be accountable for where there is only one choice of provider in the community and that provider is not part of the ACO or is unwilling to provide services at a CMS determined "reasonable rate". This will avoid penalizing ACOs for the actions of an uncooperative monopoly provider or forcing the ACO into an imbalanced partnership with such a provider.

Additional Payment Models CMS Should Implement

In order to support ACOs' ability to redesign care delivery and substantially reduce costs, CMS should implement several proven capitation based models in addition to the "shared savings" approach envisioned for the fee-for-service payment model:

- Partial and Global Capitation: Under this payment model, an ACO would agree to accept a pre-defined, risk adjusted monthly per-patient payment, during a multi-year period, that would be used to cover all of the costs of care for a defined group of patients. If traditional Medicare benefits are enriched then the capitation would also increase in proportion to the enhanced benefits. This model would enable physician practices and health systems with experience in successfully managing capitation contracts under Medicare Advantage and commercial insurance to deliver better care to Medicare fee-for-service beneficiaries as well as ensure guaranteed savings to the Medicare program. For example, the Center for Healthcare Quality and Payment Reform has developed a detailed description of how this model could be implemented and its advantages compared to shared savings, and we urge that CMS use it as a framework for implementing Section 1899(i)(1) of the ACA.
- Virtual Partial Capitation: A variant of the model above would define a per-patient budget for a defined group of patients who have selected the ACO, but instead of CMS making an upfront capitation payment to the ACO, individual providers who are in the ACO will bill CMS for individual services, the total billings would be compared to the pre-defined budget, and the payments to the providers in the ACO would be adjusted up or down to keep the total payments within the budget. This model is also known as "shadow capitation" and has been successful in the commercial market.

In addition, it would be desirable if CMS would implement two additional transitional payment models within its traditional Medicare fee-for-service system in order to make it more feasible for primary care practices and specialty practices to transition successfully to more accountable care delivery:

- An Accountable Medical Home payment: This would give a primary care physician practice, multi-specialty group, or IPA participating in an ACO the upfront resources needed to restructure the way primary care is delivered to its patients. The fixed payment is in return for a commitment to reduce the rate at which those patients use emergency rooms for non-urgent visits, are admitted and readmitted to the hospital for ambulatory care sensitive conditions, and use high-tech diagnostic imaging where it is not necessary or appropriate. This augmented payment model would enable primary care practices to improve care for Medicare beneficiaries and achieve savings for the Medicare program in several key areas without being penalized for the costs of specialized services they are not in a position to control. The Puget Sound Health Alliance and the Washington State Health Care Authority are working to put this model in place in the state of Washington next year for commercial payers and Medicaid plans, and CMS could use the approach they have developed in the Medicare program. They have requested Medicare participation in their multi-payer demonstration, and agreeing to participate could give CMS direct experience in using this payment model.
- Condition Specific Capitation: This would be a defined prospective payment—rather than unlimited retrospective fee-for-services payments—covering all of the services related to a particular condition or combination of conditions for a population of patients. Under condition-specific capitation, a specialty physician practice, multi-specialty group, IPA, or health system participating in an ACO would be paid a pre-defined amount to cover the costs of all of the care needed to address the particular condition, whether that care is delivered directly by the provider receiving the payment or other providers. For example, a multi-specialty group or IPA could be paid a fixed amount to cover the costs of all services associated with care related to its patients’ congestive heart failure, including all physician services, hospital care, rehabilitation, etc. (This payment model could also be structured as a “virtual” payment or budget, as described above for virtual partial capitation.) This would enable primary care and specialty physician practices to work together to take accountability for the subset of patients and patient care they felt they could most effectively manage. Over time, this type of payment model could expand to additional types of patients in order to become a broader partial capitation payment.

Method of Implementing the Payment Models

We believe all of the above payment models could be implemented under Section 1899(i) of the ACA. Each of them can be structured in a way that meets the ACO eligibility requirements of Section 1899(b)(2) and the budget neutrality criterion of Section 1899(i)(2)(B).

However, if CMS determines it cannot implement some of these payment models under the Shared Savings Program and chooses to do so under the Center for Medicare and Medicaid Innovation (CMMI), we strongly recommend it be structured in a way that enables maximum ACO participation by a wide range of providers:

- The criteria for participation should be clearly defined in advance, and any provider which meets the eligibility requirements should be permitted to participate in the ACO, provided the capacity for their involvement is warranted by the size of the patient population.
- The criteria should avoid structural requirements or require major capital investments that preclude small physician practices from participating.
- There should be no arbitrary limits on the number of providers who can participate in a payment model that is structured to assure budget neutrality. CMS should only place

limits on the number of providers that can participate in payment models if the payment models are not explicitly structured to ensure budget neutrality.

- Providers should be able to participate without regard to whether other CMS demonstrations are implemented in the same geographic area. Since CMS has indicated that ACOs can be implemented under Section 1899 regardless of whether other demonstrations are underway in the same areas, it would be counter-productive to prohibit alternative models of ACO payment from being implemented in those areas.

We appreciate the opportunity to provide our views concerning CMS' request for information about ACOs and the Medicare Shared Savings Program, and we look forward to working with CMS to implement this program in a manner that addresses the concerns above and allows participation by a wide range of physician practices.

Sincerely,

A handwritten signature in black ink that reads "Dean Martz". The signature is written in a cursive, flowing style with a long horizontal stroke at the end.

Dean Martz, MD
President
Washington State Medical Association