

## Evolution of ACO Initiatives at CMS: Wufoo Entries

The Wufoo entries in this document are in response to a Request for Information (RFI) titled “Evolution of ACO Initiatives at CMS.” For each entry, only questions that received responses are displayed. If an entry does not have certain questions listed, that indicates the Center for Medicare and Medicaid Innovation did not receive comments for that question from the respondent.

Wufoo, the online tool used to collect responses, truncated some comments submitted by respondents; therefore, some responses may not be displayed in their entirety. If an organization submitted comments in another form in addition to the online tool, the Center for Medicare and Medicaid Innovation will display those comments instead of the Wufoo entries.

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**Organization Name: Alliant Management Services**

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**A provider-led community ACO would be an ACO that would be held accountable for total Medicare, Medicaid and CHIP expenditures, and quality outcomes, for all Medicare, Medicaid and CHIP beneficiaries residing in the ACO's service area, regardless of those beneficiaries' historical care patterns. 1. What are options for accountable care models that are geared specifically for geographically aligned populations of beneficiaries?**

Community health systems that provide more than 50% of the primary care for a given zip code should be assigned all of the beneficiaries in that zip code.

**1A. What are the most critical design features of a provider-led community ACO model and why?** The community ACO should agree to act as the Medical Home for its community, coordinate care outside the community and provide comprehensive support for patients with 6 or more chronic diseases. This will provide the highest level of care for the community

**1B. What additional quality measures should be considered if an ACO is responsible for all covered lives in a geographic area?** Pediatric measures, generic drug utilization and ED utilization measures should be added.

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**Please select the option that best describes you.:** Part of both a Medicare ACO and a Commercial ACO

**1. Would additional health care organizations be interested in applying to the Pioneer ACO Model? Yes**

**1A. Why or why not?** I believe more organizations would be interested if the model was revised. I don't believe very many health care organizations would be interested under the current model.

**2. If additional applicants were solicited for the Pioneer ACO model, should CMS limit the number of selected organizations or accept all organizations that meet the qualifying criteria? Limit the number of selected organizations**

**2A. What are the advantages and/or disadvantages of either approach?** At this time it is challenging for CMS to support all of the existing organizations and stakeholders to adding unlimited organizations would be very challenging.

**3. Other than the options for refining population-based payments outlined in Section B below, should any additional refinements be made to the Pioneer ACO Model that would increase the number of applicants to the Pioneer ACO model? We recommend that CMS rewards low cost providers and takes into consideration geographical differences. We would also recommend a simplified model that is easier to understand how costs and trends are being calculated, particularly the decedent adjustment**

**1. Would being able to choose different FFS reduction amounts for Part A and Part B services be of significant importance when deciding to participate in the PBP? Yes**

**1A. Why or why not?** Any flexibility would be beneficial. So many markets and ACOs are different, that the one size fits all approach doesn't work.

**2. Should CMS allow suppliers of DME equipment to be included on the list of participating Pioneer providers/suppliers that will receive reduced FFS payments? Yes**

**2A. Why or why not?** It's another opportunity for expense management and for organizations that provide this service, it's helps with the continuum of care.

**3. Should CMS reconsider the requirement that a Pioneer ACO generate a specified level of savings in previous years in order to be eligible to elect to receive PBPs, and instead establish clear requirements for financial reserves? Yes**

**3A. Why or why not?** Too limiting and not realistic. If organizations want additional risk, CMS should let them take it on. It will provide a strong incentive to perform.

**1. Should CMS offer ACOs capitation with insurance risk, similar to Medicare Advantage organizations? Yes**

**1A. What are the potential benefits and risks to the Medicare program and beneficiaries?** Yes, but not under the current Pioneer model. The model would need to be changed significantly in order for organizations to feel comfortable taking capitation risk.

**2. What categories of spending should ACOs at full insurance risk be responsible for? (For example: Medicare Parts A and B, Medicare Parts A, B, and D, or Medicare Parts A, B, and D and Medicaid for Medicare-Medicaid beneficiaries)** Because costs can shift between the different parts of Medicare, I would recommend full risk for all, but some consideration for cost changes in Part D that are out of the ACOs control such as cost.

**3. Are there services that should be carved out of ACO capitation? Why?** We recommend carving out specific populations from the alignment methodology: patients who receive more than 30% of their care outside of an ACO's service area and patients who transfer their care during the year (e.g. follow a PCP who moved)

**4. What type of agreements with non-ACO providers would the ACO need to adopt to take on full insurance risk for a beneficiary population?** The ACO would want the ability to negotiate payment rates with the providers who are at risk. The ACO would need to negotiate and maintain the agreements.

**Medicare Advantage Organizations have significant infrastructure that ACOs do not currently have such as member services. 7. What additional infrastructure would ACOs need to develop to be able to manage full insurance risk?** Depending on the agreement, many of the same infrastructure that a health plan has (e.g. claims processing, marketing, member services.). Would need to invest more in care management and data analytics.

**The Pioneer ACO program currently uses a national expenditure growth trend for benchmarking. 8. What are approaches for setting appropriate capitation rates?** Using national expenditures advantages and disadvantages specific ACOs in certain other areas of the country. Traditional actuarial approaches with some data-based factor that incents eliminating waste; for instance quantifying opportunity and assuming a small percent of change each year.

**8A. What are the advantages and disadvantages of using national expenditure growth trends?** The advantages are that the model is easier to administer for CMS. The disadvantage is that it doesn't take in account geographical difference and payment adjustment that leads to ACOs being advantage or disadvantaged based on where they are located.

**8B. What about for using a local reference expenditure growth trend instead?** Use of a local or regional trend could more appropriately budget and reward providers, but even more importantly, would incorporate differences in regional cost levels into the trend methodology.

**9. What are the advantages or disadvantages of different strategies for risk-adjustment? (Examples include demographic risk adjustment only and/or any of the Medicare Advantage risk adjustment methodologies.)** We don't believe that the current Pioneer ACO risk adjustment is a good one. We support an HCC risk adjustment because it take into account the patient. Although no risk adjustment models are perfect, we believe an HCC risk adjuster is much more accurate than what CMMI is currently using for the Pioneer model.

**10. What benefit enhancements (e.g. reducing co-pays for services delivered by ACO providers) would be appropriate for ACOs at full insurance risk to offer to their patients and how would these benefit enhancements improve care outcomes?** I believe this would be a large incentive and it should cross over to receiving care in the most appropriate setting as well. Removal of homebound status for homecare services would also be beneficial.

**10A. How would benefit enhancements differ depending on integration across Medicare Parts A, B, D, and/or Medicaid?** They should be designed holistically without regard to integration, but rather what is the right incentive for patient to select the most cost-efficient path for treatment.

**11. What are potential program integrity issues that ACOs transitioning to full insurance risk may encounter and what are appropriate preventative safeguards?** The same infrastructure requirements required for Medicare Advantage.

**12. What types of precautions should be taken by ACOs assuming full insurance risk to protect beneficiaries from potential marketing abuses limiting beneficiary freedom of choice? What are additional protections beyond those in Medicare Advantage that would be important for beneficiaries aligned to ACOs with full insurance risk to avoid adverse selection?** CMS could have limits on marketing like they do today and require approval of all marketing materials. Regular audits could also be conducted.

**Currently, beneficiaries are aligned to a Pioneer ACO through claims-based attribution. Pioneer ACOs are accountable for improved quality and lower expenditures for aligned beneficiaries. 13. If Pioneer ACOs were at full insurance risk, should a beneficiary be allowed to elect alignment to a Pioneer ACO even if the beneficiary would not be aligned to the Pioneer ACO through the attribution methodology?** Yes

**13A. What are advantages/disadvantages of allowing beneficiaries to voluntarily align themselves to an ACO at full insurance risk rather than sole reliance on claims-based attribution?** CMS should allow patients to change providers, but we recommend that they provide strong incentives for patients to choose their primary care provider. We believe an assigned population would be much more effective than attribution.

**Current laws and regulations allow ACOs to establish business arrangements with Part D sponsors in order to align incentives in support of improving care coordination and outcomes. 1. What factors, if any, pose barriers to the effectiveness of such collaborations? Are there any considerations, such as marketing considerations, that are relevant to the promotion of these business arrangements?** We have so many Part D providers in our geographical area, that it didn't make sense to partner with any of them because they made up

such a small percentage of the business. It's very difficult to manage where patients get their prescriptions.

**1A. What could CMS do in administering an ACO program to help ACOs and sponsors mitigate or avoid these barriers?** CMS could allow ACOs the option of creating their own Part D plan with incentives to use the ACOs pharmacies.

**2. Would ACOs be interested in and prepared to accept insurance risk as Part D sponsors or through contracting with pharmacy benefits management companies?** Yes

**2A. Why or why not?** It depends on how it's structured. We would be interested in being responsible for the areas we control such as % of generics prescribed, not the cost of the RX.

**3. Do ACOs currently have access to enough data to accept full risk for Part D expenditures?** No

**CMS has encouraged States to explore the use of integrated care models including ACOs for the care of Medicaid populations. 1. Should ACOs caring for Medicare outcomes also assume accountability for Medicaid outcomes?** No

**1A. Why or why not?** Because they are very different populations and Medicaid patients have no incentive to stay with a provider

**2. What populations should CMS prioritize in integrating accountability for Medicaid outcomes? (For instance, should ACOs be accountable for outcomes among all Medicare-Medicaid beneficiaries treated by the ACO historically? Or, should the ACO be accountable only for those Medicare-Medicaid beneficiaries over 65 years old or under 65? Alternatively, should the ACO be accountable for outcomes of all Medicaid beneficiaries as well as CHIP beneficiaries? Should they be accountable for all those beneficiaries residing in a specified geographic area, regardless of whether they had been cared for by the ACO?)** ACOs should be allowed to choose the dual-eligible populations they are accountable for.

**3. What should the role of States be in providing appropriate incentives to foster the development of an integrated care system?** States should have a role in organizations sharing data to more effectively manage care and reduce duplicate utilization. They also should have incentives for patients to choose a provider and receive the majority of their care with that provider.

**3B. Do States have adequate resources to support an ACO initiative in collaboration with CMS?** Not sure.

**4. What are the current capabilities of ACOs and other providers in integrating and using Medicare FFS and Medicaid FFS data to drive care improvement and performance reporting?** We are capable of aggregating and analyzing our own data, but we are unable to generate meaningful risk adjusted, disease specific comparisons to other ACOs.

**4A. What are the capabilities of providers in integrating this data with electronic health records?** We have strong capabilities, but it will take time to integrate patient level treatment purposes.

**4B. What are the capabilities of integrating information for care received in the community or from other non-traditional care providers?** Easier for analytic purposes than for treatment purposes. We need a standard transaction process and new interfaces built to truly integrate data into our EMR.

**5. What financial arrangements would be most appropriate for ACOs assuming risk for Medicare and Medicaid expenditures? (Should CMS and States offer separate but coordinated shared savings arrangements to ACOs? Should CMS and States offer a unified shared savings arrangement that reflects combined Medicare and Medicaid expenditures?)**  
A unified and simplified approach

**1B. What additional quality measures should be considered if an ACO is responsible for all covered lives in a geographic area?** Socioeconomic factors need to be incorporated into the measures. Need to complement current measures.

**1C. Are there models to consider that better integrate community-based services beyond the traditional medical system?** Yes, daycare, schools, and churches. Don't medicalize health by making doctors and clinics the sole forces addressing the issues.

**In certain permissible circumstances, organizations are able to pursue multiple service delivery and payment reform initiatives. 2. Should CMS formalize an accountable care model where various service delivery and payment reform initiatives are combined?** Yes

**2A. More specifically, would there be interest in a model that tests comprehensive primary care within an ACO context and/or an ACO that incorporates episode-based payments?**  
Yes

**2B. If so, what would the most critical features of such a "layered" ACO be and why?**  
Align incentives for efficient hospital care besides efficient total cost of care for primary care based patients to get hospital dominant systems more engaged.

**1. How can CMS encourage the adoption of ACO contracts among other payers of Medicare ACOs?** Reconsider ERISA laws that limit the amount of risk sharing.

**2. How can CMS and other payers focus reporting of quality measures on the most important priorities while minimizing duplication and excess burden?** Coordinate with other established and meaningful measures already in place. Coordinate among HEDIS, MU, PQRS, Value Based Purchasing etc.. Make sure the measures are meaningful and useful.



## Organization Name: Alzheimer's Association

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**Please select the option that best describes you.:** Not part of a Medicare ACO or a Commercial ACO

### **1. Would additional health care organizations be interested in applying to the Pioneer ACO Model? Yes**

**1A. Why or why not?** CMS should seek out provider organizations serving dementia-specific populations, as they have experience in coordinating care and may be able to share best practices.

**9. What are the advantages or disadvantages of different strategies for risk-adjustment? (Examples include demographic risk adjustment only and/or any of the Medicare Advantage risk adjustment methodologies.)** The Alzheimer's Association encourages CMS to account for dementia in any of its risk adjustment models. Providers must not be discouraged from taking on this population, or ACO initiatives risk failure, and beneficiary access to care may be limited.

**13A. What are advantages/disadvantages of allowing beneficiaries to voluntarily align themselves to an ACO at full insurance risk rather than sole reliance on claims-based attribution?** We do not believe that allowing beneficiaries to voluntarily align would advance the goals of ACOs. This could create the risk of an ACO taking on a significant proportion of high-risk patients or no patients. We support beneficiaries' provider choice.

**CMS has encouraged States to explore the use of integrated care models including ACOs for the care of Medicaid populations. 1. Should ACOs caring for Medicare outcomes also assume accountability for Medicaid outcomes? Yes**

**1A. Why or why not?** The Association supports ACOs' accountability for both Medicare and Medicaid outcomes. Dual eligible beneficiaries, which include a significant number of those with dementia, are among the most costly and could benefit most from these models.

**2. What populations should CMS prioritize in integrating accountability for Medicaid outcomes? (For instance, should ACOs be accountable for outcomes among all Medicare-Medicaid beneficiaries treated by the ACO historically? Or, should the ACO be accountable only for those Medicare-Medicaid beneficiaries over 65 years old or under 65? Alternatively, should the ACO be accountable for outcomes of all Medicaid beneficiaries as well as CHIP beneficiaries? Should they be accountable for all those beneficiaries residing in a specified geographic area, regardless of whether they had been cared for by the ACO?)** CMS should prioritize dual-eligibles and individuals with dementia as high-risk populations

whose outcomes should be integrated. This process could also yield valuable data on this population.

**3. What should the role of States be in providing appropriate incentives to foster the development of an integrated care system?** A study in the January 2014 issue of Health Affairs notes that beneficiaries currently participating in Medicare ACO initiatives are of slightly higher socioeconomic status than the average fee-for-service Medicare beneficiary. CMS should consider ways in which states can incentivize ACOs to target underserved communities, through such mechanisms as flexibility with Medicaid dollars.

**1B. What additional quality measures should be considered if an ACO is responsible for all covered lives in a geographic area?** Regardless of geography, the Alzheimer’s Association respectfully suggests the incorporation of a quality measure reflecting the percentage of beneficiaries who received their Annual Wellness Visit, including assessment for cognitive impairment.

**1C. Are there models to consider that better integrate community-based services beyond the traditional medical system?** While many care delivery models are backed by strong evidence of their effectiveness, most don’t translate well into the community due to the required time commitment. CMS should support more research on models that can be successfully disseminated.

**2B. If so, what would the most critical features of such a “layered” ACO be and why?** The Alzheimer’s Association strongly encourages CMS, a federal member of the Advisory Council on Alzheimer’s Research, Care, and Services, to align the design of future ACO initiatives and models with the recommendations in the National Alzheimer’s

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**1. Would additional health care organizations be interested in applying to the Pioneer ACO Model?** Yes

**2. If additional applicants were solicited for the Pioneer ACO model, should CMS limit the number of selected organizations or accept all organizations that meet the qualifying criteria?** Accept all organizations that meet the qualifying criteria

**2A. What are the advantages and/or disadvantages of either approach?** Recent evaluation of the Pioneer model illustrates both its success and failures in managing costs, increasing patient satisfaction, and achieving quality performance objectives. But these models are a needed start in reshaping the health care delivery system and early results should not serve to question their performance but rather to build upon their experiences in developing criteria for new entrants. However, the Academy would like to point out that one of the problems the first series of Pioneer ACO models encountered was an inadequate risk adjustment mechanism. Current methodologies are not designed to create a level playing field to ensure effective and sound approaches to care coordination. Given the essential contributory role pediatrics plays in constructing a solid primary care backbone to Pioneer ACOs, it is imperative that a pediatric risk-adjustment mechanism should be in place to guarantee adequate and appropriate payment to children, particularly those with special health care needs. Payments should be risk-adjusted to reflect differences in the complexity of patients and their families and the severity of their conditions. Adult-driven risk adjustment methodologies should not be used for pediatric patients. Rather, private and public payers should commit to the development, testing, and implementation of a risk adjustment methodology designed for pediatric patients. For example, methodologies designed for adults with chronic obstructive pulmonary disease are not appropriate for use in children with cystic fibrosis. These are 2 distinctly different conditions requiring dramatically different approaches to risk adjustment. Furthermore, pediatric performance measures should be developed and deployed that take into account risk adjustment methodologies that incorporates severity of illness and comorbidities and nonmedical risk factors that affect health outcomes. The Academy encourages CMS to be receptive to the future inclusion of various types of health care organizations. The more diverse the pool of organizations provides greater opportunities to learn more about the challenges and successes of the Pioneer model. The Academy strongly recommends CMS to closely examine future applicants to ensure they have a strong and healthy presence of primary care pediatric practices, pediatric medical subspecialists, pediatric surgical specialists, children's hospitals, and other key clinicians who have the training and experience in pediatrics (eg, physical therapists, pediatric dentists,

occupational therapists, speech therapists, child psychologists, etc.). Absent a strong pediatric component, there is the risk of a weak and ineffectual primary care infrastructure. Additionally, specific attention to the ACOs' interaction with Medicaid should be prioritized as Academy members have expressed anecdotally that certain ACOs have encouraged pediatricians to no longer serve Medicaid patients.

**3. Other than the options for refining population-based payments outlined in Section B below, should any additional refinements be made to the Pioneer ACO Model that would increase the number of applicants to the Pioneer ACO model?** There are many challenges associated with a shift to a population-based payment methodology. Managing population health involves improving health outcomes of the group as a whole by identifying, monitoring and addressing the health need of individuals wi

**3. Should CMS reconsider the requirement that a Pioneer ACO generate a specified level of savings in previous years in order to be eligible to elect to receive PBPs, and instead establish clear requirements for financial reserves?** Yes

**3A. Why or why not?** An ACO's ability to access and use sophisticated data analytics is critical to determining the financial risk and clinical impact of its population of patients. As critical as data analytics is, its use remains limited. In 2013, only 18 percent of hosp

**4. Should any additional refinements be made to the current Pioneer ACO PBP policy?**  
Yes

**4A. Why or why not?** Managing population health involves improving health outcomes of the group as a whole by identifying, monitoring and addressing the health need of individuals within the group. Outcomes measurement in pediatrics is a complex and sophisticated undertaking.

**3. Are there services that should be carved out of ACO capitation? Why?** AAP policy recommends the following: When primary care is capitated, contracts should include fee-for-service carve-outs for unexpected or high-cost services, including but not limited to, neonatal and routine newborn hospital care, pregnancy and other r

**The Pioneer ACO program currently uses a national expenditure growth trend for benchmarking.** **8. What are approaches for setting appropriate capitation rates?** For the ACO in general, the development and use of a local reference expenditure growth trend would be more beneficial and realistic. To aid in comparative analysis, CMS also may want to consider constructing a comparative analysis approach to enable ACOs to compare their local experiences to national trends. In addition, capitated rates for children's services should factor in modifiers for children with special health care needs and be adjusted based on a pediatric diagnostic classification system.

**9. What are the advantages or disadvantages of different strategies for risk-adjustment? (Examples include demographic risk adjustment only and/or any of the Medicare Advantage risk adjustment methodologies.)** Current Academy policy strongly recommends CMS deploy a separate risk adjustment system for pediatric services. Differences between adults and children strongly indicate that risk adjustment should be considered separately for children. If Pioneer ACOs op

**CMS has encouraged States to explore the use of integrated care models including ACOs for the care of Medicaid populations. 1. Should ACOs caring for Medicare outcomes also assume accountability for Medicaid outcomes? Yes**

**1A. Why or why not?** Current Academy policy strongly recommends CMS deploy a separate risk adjustment system for pediatric services. Differences between adults and children strongly indicate that risk adjustment should be considered separately for children. If Pioneer ACOs op

**2. What populations should CMS prioritize in integrating accountability for Medicaid outcomes? (For instance, should ACOs be accountable for outcomes among all Medicare-Medicaid beneficiaries treated by the ACO historically? Or, should the ACO be accountable only for those Medicare-Medicaid beneficiaries over 65 years old or under 65? Alternatively, should the ACO be accountable for outcomes of all Medicaid beneficiaries as well as CHIP beneficiaries? Should they be accountable for all those beneficiaries residing in a specified geographic area, regardless of whether they had been cared for by the ACO?)**

The Academy strongly recommends that if a Pioneer ACO enrolls Medicaid and CHIP children that they be the first priority. However, any decisions specific to establishing a program of accountability for children's health care services must be made in consultation with primary care pediatricians, pediatric medical subspecialists, pediatric surgical specialists, pediatrician leaders in children's hospitals and other integrated delivery systems, and other clinicians with demonstrated skill and experience in managing the care of children. Furthermore, local ACOs should directly consult with the AAP State Chapter in the design and application of a program of accountability

**5. What financial arrangements would be most appropriate for ACOs assuming risk for Medicare and Medicaid expenditures? (Should CMS and States offer separate but coordinated shared savings arrangements to ACOs? Should CMS and States offer a unified shared savings arrangement that reflects combined Medicare and Medicaid expenditures?)**

It is critical to manage and report out separate expenditures for children enrolled in Medicaid who are part of the ACO patient base. This will contribute to a more accurate accounting of the shared savings associated with the delivery of pediatric care.

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**Please select the option that best describes you.:** Not part of a Medicare ACO or a Commercial ACO

**2A. What are the advantages and/or disadvantages of either approach?** Our member hospitals are committed to improving health and health care while becoming more efficient in the delivery of services. Many hospitals and health systems are transforming care delivery to provide more accountable care  through greater care integration and financial accountability. It is unlikely, however, that additional hospitals will apply to participate in the Pioneer ACO Model as currently constructed. The AHA recently received input from several of our members participating in the Pioneer ACO Model and the Medicare Shared Savings Program. Significant changes will need to be made to the ACO model to make it more attractive to potential participants and operationally viable. We will submit detailed comments to CMS shortly under a separate cover. This will allow us to share the broader themes, concerns and suggestions for improvement that we heard from our members.

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**1. Would additional health care organizations be interested in applying to the Pioneer ACO Model?** No

**1A. Why or why not?** I believe last year's withdrawal of approximately 1/3 of the Pioneers as well as the press coverage of the quality metrics would have to be clearly explained before others would likely enter Pioneer.

**2. If additional applicants were solicited for the Pioneer ACO model, should CMS limit the number of selected organizations or accept all organizations that meet the qualifying criteria?** Limit the number of selected organizations

**2A. What are the advantages and/or disadvantages of either approach?** If the distinction between MSSP and Pioneer is to be maintained and/or widened to include such innovation as the SNF waiver, then the number of Pioneers should be limited perhaps even to those that are remaining.

**3. Other than the options for refining population-based payments outlined in Section B below, should any additional refinements be made to the Pioneer ACO Model that would increase the number of applicants to the Pioneer ACO model?** If the PBP's include additional waiver, such as SNF 3 day stay, opportunities then maximum flexibility would be achieved.

**1. Would being able to choose different FFS reduction amounts for Part A and Part B services be of significant importance when deciding to participate in the PBP?** Yes

**1A. Why or why not?** With greater flexibility with FFS reduction amounts, would come increased participation.

**3. Should CMS reconsider the requirement that a Pioneer ACO generate a specified level of savings in previous years in order to be eligible to elect to receive PBPs, and instead establish clear requirements for financial reserves?** Yes

**3A. Why or why not?** At this juncture, or certainly by the middle of payment year three, the remaining, or new Pioneers, will already have stop loss insurance in place, therefore, clear requirements for financial reserves would be appropriate.

**4. Should any additional refinements be made to the current Pioneer ACO PBP policy?**

Yes

**1. Should CMS offer ACOs capitation with insurance risk, similar to Medicare Advantage organizations? Yes**

**1A. What are the potential benefits and risks to the Medicare program and beneficiaries?**

While it would be critical to know the details, I believe this should be an option for certain Pioneers.

**2. What categories of spending should ACOs at full insurance risk be responsible for? (For example: Medicare Parts A and B, Medicare Parts A, B, and D, or Medicare Parts A, B, and D and Medicaid for Medicare-Medicaid beneficiaries) Full insurance risk would mean responsibility for all Medicare spending, assuming timely data can be provided.**

**4. What type of agreements with non-ACO providers would the ACO need to adopt to take on full insurance risk for a beneficiary population? A negotiated fixed pricing, or if the non-ACO provider represents a large enough portion of total spend perhaps a shared savings arrangement.**

**Medicare Advantage Organizations have significant infrastructure that ACOs do not currently have such as member services. 7. What additional infrastructure would ACOs need to develop to be able to manage full insurance risk? Unless the ACO already has an insurance product, they would either need to partner with an entity with that capability or develop a highly functioning care coordination/data analytic infrastructure and then purchase other needed components on an ad hoc ba**

**Currently, beneficiaries are aligned to a Pioneer ACO through claims-based attribution. Pioneer ACOs are accountable for improved quality and lower expenditures for aligned beneficiaries. 13. If Pioneer ACOs were at full insurance risk, should a beneficiary be allowed to elect alignment to a Pioneer ACO even if the beneficiary would not be aligned to the Pioneer ACO through the attribution methodology? Yes**

**3. Do ACOs currently have access to enough data to accept full risk for Part D expenditures? No**

**3B. Do States have adequate resources to support an ACO initiative in collaboration with CMS? Not in my opinion**

**5. What financial arrangements would be most appropriate for ACOs assuming risk for Medicare and Medicaid expenditures? (Should CMS and States offer separate but coordinated shared savings arrangements to ACOs? Should CMS and States offer a unified shared savings arrangement that reflects combined Medicare and Medicaid expenditures?)**

It would seem most appropriate to have a unified shared savings arrangement, provided CMS (rather than individual State Medicaid agencies) managed the program.

**2A. More specifically, would there be interest in a model that tests comprehensive primary care within an ACO context and/or an ACO that incorporates episode-based payments? No**



**2B. If so, what would the most critical features of such a “layered” ACO be and why?**  
Would not a truly capitated model provide maximum flexibility?

**1. How can CMS encourage the adoption of ACO contracts among other payers of Medicare ACOs?** Our experience has been that payers prefer instead a national quasi fee for service models. It is not clear how CMS can encourage participation, other than requiring it in order to be a Medicare Advantage provider.

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**1. Would additional health care organizations be interested in applying to the Pioneer ACO Model?** No

**1A. Why or why not?** The BJC HealthCare ACO will not apply for the Pioneer model at this time, for reasons discussed more thoroughly in our cover letter and Section II.A below.

**1. Should CMS offer ACOs capitation with insurance risk, similar to Medicare Advantage organizations?** No

**1A. What are the potential benefits and risks to the Medicare program and beneficiaries?**  
At this time we do not believe either the CMS or many ACOs are prepared to administer risk-based contracts in a meaningful way. To move to capitation, the CMS must be willing to model beneficiary assignment similar to Medicare Advantage plans.

**2. What categories of spending should ACOs at full insurance risk be responsible for? (For example: Medicare Parts A and B, Medicare Parts A, B, and D, or Medicare Parts A, B, and D and Medicaid for Medicare-Medicaid beneficiaries)** Medicare Parts A, B would be acceptable at full insurance risk. Medicare Part D would require additional discussion. Due to the variation among the state Medicaid programs, we recommend Medicaid for Medicare-Medicaid beneficiaries be excluded.

**3. Are there services that should be carved out of ACO capitation? Why?** In order to adequately address what services should be carved out of ACO capitation, complete and full cost information for services such as DME, Home Health, and Mental Health would need to be evaluated. We recommend Medicaid services be excluded.

**4. What type of agreements with non-ACO providers would the ACO need to adopt to take on full insurance risk for a beneficiary population?** ACOs would need to enter into written provider agreements with non-ACO providers to take on full insurance risk. Compensation arrangements would depend on the scope of available Stark, Fraud & Abuse and Civil Monetary Penalties protections.

**5. What key elements of the regulatory and compliance framework for Medicare Advantage should be adopted for ACOs assuming full insurance risk? What regulatory and compliance elements in Medicare Advantage would NOT be appropriate for ACOs assuming full insurance risk?** We recommend that CMS align the risk adjustments for

Medicare Advantage and Medicare ACOs. Additionally, in the absence of uniformity of capital and other regulatory requirements imposed by the states for Medicare Advantage plans, the CMS should consider adopting state-based Medicare Advantage requirements.

**6. What challenges would ACOs encounter in meeting state licensure requirements for risk-bearing entities? What types of waivers to current regulations and/or fraud and abuse laws, if any, would be necessary for ACOs to take on full insurance risk for a beneficiary population?** ACOs would encounter such challenges to meeting state licensure requirements as meeting capitalization and network adequacy requirements, as well as potential complexities involved for multi-state providers (Missouri and Illinois, for example). In terms of additional waivers, clarification is required to explicitly provide for the current ACO waivers to extend to arrangements between ACO's and non-ACO providers, since not all providers necessary to include in a risk-bearing network would want or need to be participants in the ACO. We believe that many participants have interpreted the waivers to cover this, but would ask the CMS to clarify this point more directly. It would also be helpful if the CMS would finalize the proposed Stark exception for Risk-Sharing Arrangements.

**Medicare Advantage Organizations have significant infrastructure that ACOs do not currently have such as member services. 7. What additional infrastructure would ACOs need to develop to be able to manage full insurance risk?** Additional infrastructure may include credentialing and provider relations, payment and claims processing administration, increased scope of compliance and auditing responsibilities, stop-loss insurance protection, and information systems interoperability

**The Pioneer ACO program currently uses a national expenditure growth trend for benchmarking. 8. What are approaches for setting appropriate capitation rates?** More data is required to answer this question. We welcome an opportunity to partner with the CMS on defining an approach to establishing an appropriate capitation rate.

**9. What are the advantages or disadvantages of different strategies for risk-adjustment? (Examples include demographic risk adjustment only and/or any of the Medicare Advantage risk adjustment methodologies.)** We recommend a risk-adjustment methodology that accounts for illness burden as well as socio-economic risk to mitigate the risk of physicians being hesitant to assume full accountability for vulnerable patients.

**10. What benefit enhancements (e.g. reducing co-pays for services delivered by ACO providers) would be appropriate for ACOs at full insurance risk to offer to their patients and how would these benefit enhancements improve care outcomes?** ACOs should be allowed to waive co-payments for maintenance drugs and maintenance supplies for chronic conditions. Additionally, rules associated with the length-of-inpatient stay to qualify for skilled nursing payment should be discontinued.

**11. What are potential program integrity issues that ACOs transitioning to full insurance risk may encounter and what are appropriate preventative safeguards?** In addition to the infrastructure needs previously mentioned, prospective patient attribution would enhance program integrity.

**12. What types of precautions should be taken by ACOs assuming full insurance risk to protect beneficiaries from potential marketing abuses limiting beneficiary freedom of choice? What are additional protections beyond those in Medicare Advantage that would be important for beneficiaries aligned to ACOs with full insurance risk to avoid adverse selection?** Maintaining beneficiary participation in the governance of the ACO's provides a measure of protection; however, incentives for beneficiaries to coordinate their care within the network offered by the ACO would facilitate the ACO's ability to manage full insurance risk. We believe the protections built into the design of the Medicare Advantage program are reasonable to protect beneficiaries.

**Currently, beneficiaries are aligned to a Pioneer ACO through claims-based attribution. Pioneer ACOs are accountable for improved quality and lower expenditures for aligned beneficiaries. 13. If Pioneer ACOs were at full insurance risk, should a beneficiary be allowed to elect alignment to a Pioneer ACO even if the beneficiary would not be aligned to the Pioneer ACO through the attribution methodology?** Yes

**13A. What are advantages/disadvantages of allowing beneficiaries to voluntarily align themselves to an ACO at full insurance risk rather than sole reliance on claims-based attribution?** The current claims-based attribution process is not completely effective as patients can, and are, aligned to non-primary care providers (specialists, hospitals, skilled nursing facilities) due to the current assignment methodology.

**Current laws and regulations allow ACOs to establish business arrangements with Part D sponsors in order to align incentives in support of improving care coordination and outcomes. 1. What factors, if any, pose barriers to the effectiveness of such collaborations? Are there any considerations, such as marketing considerations, that are relevant to the promotion of these business arrangements?** We have no comment in response to this question at this time.

**2. Would ACOs be interested in and prepared to accept insurance risk as Part D sponsors or through contracting with pharmacy benefits management companies?** No

**2A. Why or why not?** Due to the complexities surrounding Medicare Part D, including its administration, and the potential changes to the bidding process, we are not prepared to accept full insurance risk for Medicare Part D at this time.

**3A. What other mechanisms would allow ACOs to assume accountability for Part D outcomes?** ACOs currently do not have access to enough data to accept full risk; such acceptance would require, at a minimum, full Medicare paid Part D claims data.

**CMS has encouraged States to explore the use of integrated care models including ACOs for the care of Medicaid populations. 1. Should ACOs caring for Medicare outcomes also assume accountability for Medicaid outcomes?** No

**1A. Why or why not?** Because Medicaid programs vary from state to state, ACO's should have the option, but not be required, to participate in Medicaid integrated care models.

**2. What populations should CMS prioritize in integrating accountability for Medicaid outcomes? (For instance, should ACOs be accountable for outcomes among all Medicare-Medicaid beneficiaries treated by the ACO historically? Or, should the ACO be accountable only for those Medicare-Medicaid beneficiaries over 65 years old or under 65? Alternatively, should the ACO be accountable for outcomes of all Medicaid beneficiaries as well as CHIP beneficiaries? Should they be accountable for all those beneficiaries residing in a specified geographic area, regardless of whether they had been cared for by the ACO?)**

As previously identified, the variation of state Medicaid programs is significant, and it is unlikely one solution set would be appropriate or effective. Until such time as there becomes uniformity amongst state Medicaid programs, the CMS may be in a position to encourage state participation in integrated care models; however, it may be most practical for ACOs to contract directly with a given state for Medicaid population health management.

**3. What should the role of States be in providing appropriate incentives to foster the development of an integrated care system?** States would likely be most effective in fostering the development of an integrated care system by designing state programs that align clinical quality and patient satisfaction outcome measures, as well as attribution methodologies with the state's existing CMS ACOs. A state's willingness and/or ability to support Medicaid innovation is subject to many factors.

**4. What are the current capabilities of ACOs and other providers in integrating and using Medicare FFS and Medicaid FFS data to drive care improvement and performance reporting?** Our ACO's infrastructure to process and analyze FFS data to drive clinical improvement and performance reporting is continuing to evolve. While it is an objective, we are not yet positioned to integrate Medicare FFS data with electronic health records data. We are developing the capability to integrate information for care received in the community and from other non-traditional care providers.

**5. What financial arrangements would be most appropriate for ACOs assuming risk for Medicare and Medicaid expenditures? (Should CMS and States offer separate but coordinated shared savings arrangements to ACOs? Should CMS and States offer a unified shared savings arrangement that reflects combined Medicare and Medicaid expenditures?)** It is ideal to have the CMS and the state Medicaid programs aligned; however, the option to run separate but coordinated arrangements should be provided.

**A provider-led community ACO would be an ACO that would be held accountable for total Medicare, Medicaid and CHIP expenditures, and quality outcomes, for all Medicare, Medicaid and CHIP beneficiaries residing in the ACO's service area, regardless of those beneficiaries' historical care patterns.**

**1. What are options for accountable care models that are geared specifically for geographically aligned populations of beneficiaries?** Without the presence of a robust local/regional health information exchange, and with competing priorities of various provider based organizations in our region, it is difficult to identify an accountable care delivery model that would be successful and include all Medicare, Medicaid and CHIP beneficiaries residing in the service area. We recommend beginning with a model that allows beneficiaries to enroll in provider-led community ACOs.

**In certain permissible circumstances, organizations are able to pursue multiple service delivery and payment reform initiatives. 2. Should CMS formalize an accountable care model where various service delivery and payment reform initiatives are combined? Yes**

**2A. More specifically, would there be interest in a model that tests comprehensive primary care within an ACO context and/or an ACO that incorporates episode-based payments? Yes**

**1. How can CMS encourage the adoption of ACO contracts among other payers of Medicare ACOs?** Through additional resources for care management support (e.g., per-member-per-month payment), an increase in shared savings to fund ACO infrastructure expansion and greater transparency and data sharing between the CMS and ACOs.

**2. How can CMS and other payers focus reporting of quality measures on the most important priorities while minimizing duplication and excess burden?** We recommend that the CMS facilitate discussion of national quality standards with other payers. Quality measures should align with all payer groups for consistent, standard quality reporting, regardless of payer.

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**Please select the option that best describes you.:** Part of a Commercial ACO

**The Pioneer ACO program currently uses a national expenditure growth trend for benchmarking.** **8. What are approaches for setting appropriate capitation rates?** Risk-adjustment models developed for pediatric populations to inform capitation rate development require a different approach from those currently applied to adult populations due to the heterogeneity of the complex pediatric population and the outliers. Some alternative approaches that have tried to address the pediatric population are 3M's Clinical Risk Grouping software (CRGs). We have also had some success learning from the Milliman analysis of standard risk adjustment models and necessary changes in those models to more effectively adjust for the differences of the pediatric populations, however continued analysis is needed (see Milliman's white paper ("Risk adjustment for Pediatric Populations" November 2013). The major finding was that despite similar service acuity levels as provided by our peer group of academic medical centers, the utilizing population of stand-alone children's hospitals was vastly more complex. We understand that financial risk adjustment models necessary for payment calculations can be effective through the use of claims-based data, however risk adjustment models developed for the purpose of population health and service delivery management should be based on clinically derived data; we have had some success with models developed in our cardiology research. We strongly recommend that a pediatric risk-adjustment models for payment and population management be developed to inform ACOs that manage Medicaid and CHIP populations and we welcome continued discussion on this topic.

**9. What are the advantages or disadvantages of different strategies for risk-adjustment? (Examples include demographic risk adjustment only and/or any of the Medicare Advantage risk adjustment methodologies.)** Risk-adjustment models developed for pediatric populations require a different approach from those currently applied to adult populations due to the heterogeneity of the complex pediatric population. See question 8 response for details.

**2. What populations should CMS prioritize in integrating accountability for Medicaid outcomes? (For instance, should ACOs be accountable for outcomes among all Medicare-Medicaid beneficiaries treated by the ACO historically? Or, should the ACO be accountable only for those Medicare-Medicaid beneficiaries over 65 years old or under 65? Alternatively, should the ACO be accountable for outcomes of all Medicaid beneficiaries as well as CHIP beneficiaries? Should they be accountable for all those beneficiaries residing in a specified geographic area, regardless of whether they had been cared for by the ACO?)** We appreciate CMS's work to date to further improved quality of care and reduced health care costs through accountable care organizations (ACOs) for Medicare populations. We also acknowledge the Medicaid related questions mainly address dual-eligibles who are indeed high

cost populations who could benefit from more integrated care models. However, we respectfully request an equivalent focus on Medicaid eligible children. Through Medicare, CMS has supported infrastructure, data collection and quality improvement efforts across states and sites which will benefit these complex populations. We recommend a similar focus and support for children. Medicare has a national set of well-developed and tested quality measures, while the Medicaid program does not. Federal investment in children's health measures has lagged behind investment in adult measures. As a result, there are not the same robust measures available to capture important aspects of quality to be addressed by ACOs focused on children that are found in the adult population. It would be inappropriate for CMS to apply the Medicare quality measures on the pediatric population. We support continued investment in the development of pediatric quality measurement and appreciate the recent work to date through the Demonstration Grants and Centers of Excellence funded through the Children's Health Insurance Program Reauthorization Act. The Centers of Excellence are developing and testing new measures for children so they should be looked to for appropriate children's measures. The Demonstration Grants have also been an excellent source of quality measurement field research and innovative pediatric care models that increase care coordination and inform accountable care infrastructure needs. We also strongly suggest that these grants inform the care models and quality measures used in pediatric ACOs. The question of including children in adult ACOs is an important one and we would strongly recommend that this question be tested by researching ACOs that currently treat adults and children in comparison with pediatric-only ACOs to better understand the nuances and clinical infrastructure necessary to ensure quality care is provided to children in ACOs. Children are not little adults and have unique health care needs. When structuring accountable care initiatives for this population, these unique needs should be taken into account. It would not be effective to take models created for adults and wholesale apply them to children. Particularly for children with medical complexity, they are a very heterogeneous group that requires more tailored care approaches and a system that allows and supports that care. There may be lessons we can learn from the Pioneer ACOs, but we need to think about these models in the context of what works best for children and their families. Boston Children's Hospital(BCH) is exploring ACOs for children generally or focused on children with complex medical conditions. We are engaged in an accountable care agreement through the BCBSMA alternative quality contract. This and accountable care activities similar to it are developing but are state specific endeavors that often are not able to link with other equivalent efforts across the country or leverage the same level of support for infrastructure, data collection and quality improvement that has been experienced under the Medicare program. BCH has partnered with the Children's Hospital Association in research showing that children with medical complexity (those with one severe or multiple medically complex conditions) account for 6 percent of children on Medicaid, but account for over 40 percent of the costs for children on Medicaid. We see this as an opportunity to improve care for children through accountable care organizations/structures, and reduce Medicaid costs. Examining how best to organize care for children with medical complexity is a focus of the Association and we welcome the opportunity to discuss in more detail as CMS considers initiatives in this area. CMS' ACO work for children must include implementation of new payment models that better aligns with the best outcomes for the nation's children. Currently, if a hospital does a great job of organizing and coordinating care and the child is kept out of the hospital, the hospital is penalized rather than rewarded for keeping the child in their community. Exploring risk-based payment models to better align care to the best outcomes for children is critical. The regional nature of pediatric care needs to be addressed.



Children often must travel to another state or region of their state to receive the best care or sometimes the only care for their conditions, much more so than adults. This is even more frequently true for children with complex conditions. Therefore, the pediatric ACO design and payment methodologies must allow for regional and multi-state structures for children's health care. This a particular issue in the New England Region and while we continue to work with neighboring State Medicaid agencies many including Massachusetts lack the necessary data, administrative, and quality measurement functions to implement an effective pediatric ACO initiative. The Affordable Care Act authorized a Pediatric ACO demonstration and we recommend that CMS work to implement with existing funds. We believe that children would benefit from federal support for ACOs and ask that CMS put the resources and time into fostering these organizations as you have for Medicare beneficiaries.

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**Please select the option that best describes you.:** Not part of a Medicare ACO or a Commercial ACO

**1A. Why or why not?** BMC encourages CMS to devote specific attention to ACOs for the care of Medicaid populations rather than using the Medicare Pioneer Model as a framework.

**2. What populations should CMS prioritize in integrating accountability for Medicaid outcomes? (For instance, should ACOs be accountable for outcomes among all Medicare-Medicaid beneficiaries treated by the ACO historically? Or, should the ACO be accountable only for those Medicare-Medicaid beneficiaries over 65 years old or under 65? Alternatively, should the ACO be accountable for outcomes of all Medicaid beneficiaries as well as CHIP beneficiaries ? Should they be accountable for all those beneficiaries residing in a specified geographic area, regardless of whether they had been cared for by the ACO?)**

Question 1A (continued here given form space constraints): BMC encourages CMS to devote specific attention to ACOs for the care of Medicaid populations rather than using the Medicare Pioneer Model as a framework. Although it is BMC's position that an ACO should be designed to ultimately involve all contracted payers, BMC believes that safety-net delivery systems focused primarily on Medicaid patients are fundamentally different than those focused on Medicare and/or commercial patients. These differences include, but are not limited to: the scale of the patient services, differing systems of care, and different financial challenges given lower Medicaid payment levels compared to Medicare and commercial rates. In the case of safety-net systems such as BMC, Medicaid patients are dominant in the overall patient population; this presents a need for a unique ACO model designed to address Medicaid reimbursement challenges and specific patient needs. Once a Medicaid ACO model is operational, BMC believes it can expand and incorporate other payers including Medicare. BMC therefore encourages CMS to consider ACO demonstrations serving the needs of Medicaid patients. The need is timely because Medicaid is not only a larger program than Medicare, it is growing as a result of the Affordable Care Act's (ACA) Medicaid expansion provision. As you evaluate this important issue, we urge you to consider the following: Importance of a Medicaid ACO Demonstration: In its February 2014 Medicaid Baseline, CMS projected that by 2023, 84 million people will receive care annually through Medicaid, thereby putting Medicaid on a path to exceed Medicare enrollment and match Medicare spending. Additionally, states consistently identify the growth of Medicaid costs, which are per capita dependent, as their primary budgetary challenge. For these reasons, as well as the proven effectiveness of integrated and coordinated care models for low-income, diverse, high-risk populations, it is worthwhile for CMS to assess the unique framework and structures necessary for the establishment of successful Medicaid ACOs. Moreover, Section 2705 of the ACA, the Medicaid Global Payment System

Demonstration Project (Demonstration Project), contemplated the need for a unique focus on accountable care at safety-net health systems in particular. While not implemented, the ACA intended to establish the Medicaid Global Payment System Demonstration Project, where participating states would move toward a global capitated payment model with participating safety net health systems. BMC has embraced the ACA's vision and is working toward establishing a safety-net ACO, which will manage and coordinate all care for enrolled primary care patients, accept full financial risk for quality care delivery, and operate under a risk-adjusted global payment reimbursement structure.

**Uniqueness of the Medicaid Population:** A State Medicaid program is not one program, but four programs serving the following distinct populations: children, non-disabled adults, individuals with disabilities, and low-income seniors. As States and the Federal government have made substantial investments in data collection, mining, and analysis in recent years, there is increasing awareness of the wide variation in costs associated with serving these different Medicaid populations. The utilization of Medicaid services across these four groups is quite different, yet each group has its own high expenditure □ faction. The characteristics of these high expenditure groups were highlighted in a recent report by the Government Accountability Office (GAO), *Medicaid Demographics and Service Usage of Certain High-Expenditure Beneficiaries*. Nearly one-third (1/3) of total Medicaid expenditures were made on behalf of five percent of Medicaid-only beneficiaries. Two-thirds (2/3) of these individuals are eligible for Medicaid because of a disability; 16 percent were children; 15 percent were non-disabled adults; and 2 percent were eligible because of their age (65+). GAO found that these high-expenditure Medicaid enrollees cost 18 times more than all other Medicaid-only enrollees on a per capita basis. Medical conditions that are frequently found among the high-expenditure population include: mental illness, HIV/AIDS, asthma, diabetes, substance abuse, and high-risk pregnancy. Among these high-expenditure Medicaid-only individuals, the GAO found that hospital services accounted for the single largest share of expenditures, approximately 30.6 percent, thereby confirming the importance of the role of safety-net hospitals and other providers in serving the high-risk Medicaid population.

**Uniqueness of the Medicaid Reimbursement Structure:** Unlike Medicare rates established through a uniform rule-making process, which applies throughout the United States, Medicaid is funded by both State and Federal contributions. Medicaid reimbursement rates as well as the Federal Medicaid match □ varies across States and Medicaid populations. And in most States, these rates are significantly below commercial and Medicare rates.

**Question 2:** CMS should prioritize all Medicaid beneficiaries when considering Medicaid ACO models. A global payment Medicaid ACO model can be used for all four groups of Medicaid patients — children, non-disabled adults, individuals with disabilities, and low-income seniors. We note though, in order for such an ACO model to be successful, adequate size and the commitment of patients and providers is critical.

**Medicaid ACO Demonstrations Must Be Significant in Size:** It is important to have a critical mass of Medicaid patients receiving services through an ACO structure in order to manage risk and drive change in the delivery of care amongst physician and provider participants. The Dartmouth Institute recommended the following minimum size for ACOs (which we believe should be the absolute floor and suggest larger panels are necessary): at least 15,000 patients in each participating commercial plan; at least 10,000 Medicaid-covered patients; and at least 5,000 Medicare-covered patients. Even at these levels, an ACO may not possess the critical mass of patients who share similar clinical concerns (e.g., pediatric asthmatics or high risk pregnancies) to allow for the development and monitoring of appropriate quality improvement initiatives.

**Medicaid ACO Demonstrations Must Be Comprised of a Committed**

Population: Under a Medicaid ACO model, BMC recommends that patients may choose or be assigned to an ACO, just as they are a Medicaid Managed Care Plan or Primary Care Clinician Plan. Patients should be required to stay in the ACO for care with the exception of emergency care or certain specialty care that may be unavailable within the network. Therefore, an ACO serving Medicaid patients must have both the community-based services, including CHC's easily accessible for patients, as well as a full-range of medical and specialty services. The ACO must ensure that the patient has access to a complete range of services with an adequate number of providers. Services not directly available from a participating ACO provider should be contracted by the ACO. It is also important that individual providers used for patient assignment to the ACO should only participate in one ACO. Providers who are not used for patient assignment (e.g., some specialists) should be permitted to participate in multiple ACOs. Additionally, in order for primary care to be at the core of the ACO and patient care, patients/enrollees must be assigned to a primary care provider (PCP). Patients/enrollees must also be expected to receive care within the ACO network in which their PCP participates. Information gathering and sharing should be primary care-based where reports are generated per patient, on a primary care panel. Outcomes, utilization and cost data can then be attributed to at the PCP level as well as the overall ACO.

**3. What should the role of States be in providing appropriate incentives to foster the development of an integrated care system?** The role of the State is critical in establishing an effective Medicaid ACO. Most important is the area of data support. An ACO will require certain data associated with its assigned patient population. Without complete data across the spectrum of care for an individual, ACOs will not have a complete picture of the patients' needs, patterns of care, utilization and cost. For Medicaid and Medicaid-like programs where the State is the payer, this information should be provided by the State to the ACO to assist in developing the initial ACO financial model and each patient's care plan. The minimum data required for publicly insured individuals assigned to the ACO should include: patient name; date of birth; Medicaid coverage type, rating category; PCP name; claims associated with each patient; provider number associated with each claim; and other information that may be required to reasonably assess the patient acuity and projected care needs. Many States currently collect cost and utilization data from payers via an all payor claims database system. ACOs must have the ability to provide the same level of information currently expected of payors. Question 3A (continued here given form space constraints): States play a critical role in developing Medicaid ACO initiatives. However, CMS leadership on Medicaid ACOs is worthwhile given state demands on, for example, ACA implementation. BMC encourages states to launch initiatives that are unique to their Medicaid patients and healthcare landscape. CMS can support these efforts by providing demonstrations/pilots that lessen the policy development load of individual states. Question 3B (continued here given form space constraints): Many states do not currently have the existing resources or expertise to support an ACO initiative. In particular as States continue the implementation of other ACA requirements, resources are becoming increasingly strained. We would recommend, therefore, that CMS provide guidance, support and leadership to the States to assist with the development of Medicaid ACOs. CMS may also consider granting funds to the States to allow them to contract for the financial and administrative expertise necessary to launch a Medicaid ACO program and support on-going operations.

**4. What are the current capabilities of ACOs and other providers in integrating and using Medicare FFS and Medicaid FFS data to drive care improvement and performance**

**reporting?** BMC has developed many of the necessary capabilities of an ACO to drive care improvement. The following are critical capabilities that are essential building blocks for any Medicaid provider contemplating transitioning to an ACO. Managed care expertise is essential: Currently, many providers seeking to form an ACO lack the data needed to drive care improvement and performance reporting. Most of the types of data that are required for an effective ACO are currently only captured by managed care organizations. While provider systems generally capture information on a patient visit, they generally do not have the capabilities to track data on the overall care of patients across the spectrum of providers such as total utilization by patient, by provider, or by primary care panel, or patient outcomes. Many hospitals and other providers are also generally not experienced with development and management of risk-based budgeting and payments, and may not even possess the infrastructure to issue payments within the ACO. To help counter this weakness, ACOs should include managed care expertise either directly within their current structure, or on a contracted basis. Numerous safety net health systems, such as BMC, have launched safety net health insurers to provide coverage to their patients and, as such, have managed care expertise. Routine System-wide Sharing of Information and Best Practices: On a daily basis, HealthNet reviews patient quality and outcomes data from BMC and CHCs, identifying areas of concern throughout the system or at specific sites. Best practices are also culled from this data, and disseminated across the system. CHCs, by their nature, struggle with the financial challenges of developing technology and systems necessary for improving patient safety, quality and outcomes. Being part of a larger, integrated delivery system provides a platform to move the CHCs in parallel with BMC. Care Integration: Boston HealthNet has led to integration among providers at the CHCs, specialty care facilities, and BMC. One example of this integration in practice is the inpatient rounder system. Before implementing this system, CHC doctors who had patients admitted to BMC called it “the Bermuda Triangle” of health care; they had no information on what transpired when the patient was in the hospital and, similarly, the BMC doctors had little information on previous medical treatment at the primary care provider. Often the CHC doctor did not even know their patient had presented at the emergency room and been admitted. As part of implementing a managed care model for inpatient hospitalizations, several key changes eliminated “the Bermuda Triangle”. When a patient is admitted now, the administrative staff contacts the PCP and provides the information. CHC doctors are required to round with the BMC doctors that are treating their patients in the hospital. And discharge planning includes communication with and transfer to the CHC PCP. 5. (inserted here as space does not allow for full answer on form below) As mentioned earlier, BMC believes that CMS should devote specific attention to ACOs serving Medicaid patients, before expanding the model to include other payors including Medicare. As explained above, it is important for ACOs serving a primarily Medicaid population to focus on developing a payment methodology that will allow the ACO to succeed despite low Medicaid reimbursement rates. This will allow the care delivery framework and flexibility to provide needed services that may not be reimbursable. Based on BMC’s experience, the most appropriate financial arrangement for a predominantly Medicaid population ACO is a per capita, risk-adjusted, global payment. Under this new payment methodology, the ACO will be at risk for the full cost of care relating to the services that are included within the global payment rate. This transition from fee-for-service reimbursement to global payment reimbursement is a fundamental change necessary for a Medicaid ACO Demonstration Project. Under a risk adjusted global payment methodology, the ACO would receive a single, prospectively paid, risk-adjusted, per member per month (PMPM) amount for

all enrolled patients. The global payment would be set for the population enrolled in the ACO based on an actuarially sound methodology that takes into account the general population health of the low-income population served by the ACO and specific health of the patient population. The Medicaid ACO would be at risk for the full cost of care relating to the services that are included within the global payment rate, but would be able to operate with the flexibility to provide services not typically covered under Medicaid. This would provide the ACO with the potential to improve care and lower overall costs. Because the PMPM global payment is prepaid, financial exposure for government payers would be significantly reduced, and the States would see increased budgetary certainty from this financial model. To ensure the financial viability of the ACO, a reserve account, at a level agreed upon by the ACO, the State, and CMS should be maintained by the ACO. Also, to ensure that CMS and the States accrue savings associated with the anticipated cost containment achieved under this model, a trend rate should be set for the ACO's annual global payment increase. For example, BMC engaged a consultant to provide a review of the impact on cost-growth trends under the prospective global payment model for the BMC/HealthNet ACO and determined that an annual trend rate of 3% (or 33% less than the CMS Office of the Actuary projected growth rate in per capita health care expenditures) as the base year global payment over each year of the demonstration period would provide savings for government payers while still allowing continued improvements in quality of care delivery. We strongly believe the transition to a prospective, PMPM payment methodology for Medicaid patients should be the subject of a demonstration by CMMI. The transition from fee-for-service to global payment in this structure will result in measurable improvements to quality of care, cost containment, and access to care.

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**Please select the option that best describes you.:** Not part of a Medicare ACO or a Commercial ACO

**1. Would additional health care organizations be interested in applying to the Pioneer ACO Model? Yes**

**1A. Why or why not?** Healthcare organizations have shown a strong interest in the ACO movement. CAPG believes more organizations will be interested in applying for a population-based payment ACO model with strong beneficiary incentives.

**2. If additional applicants were solicited for the Pioneer ACO model, should CMS limit the number of selected organizations or accept all organizations that meet the qualifying criteria? Accept all organizations that meet the qualifying criteria**

**2A. What are the advantages and/or disadvantages of either approach?** CMS should accept all organizations that meet qualifying criteria. CAPG believes that there exists a relatively small pool of organizations across the country that are currently prepared to accept population-based payment in the Pioneer ACO program. The program should be open to those that are qualified, willing and able to participate. [answer to question 3] CAPG has developed the concept described below, the Third Option, in response to our members' experience in various ACO models. The Third Option presents various aspects of a new Medicare program option – one that would sit between fee-for-service ACOs and Medicare Advantage. We believe that a Pioneer program that embraced each of these elements would increase the number of applicants, but more importantly, drive the evolution of the healthcare delivery system toward value. Clinically Integrated Organizations Under our proposed Third Option, CMS would contract directly with clinically integrated organizations (“CIOs”). Some CIOs may be existing physician organizations, while some may be newly formed. The CIO would be explicitly physician group-centric, but may be co-owned and comprised of physicians, hospitals, nursing homes, home health organizations and other entities wishing to be accountable for the delivery of coordinated care to a defined population across the continuum of care. The CIOs would feature team-based care, led by primary care physicians and supported by other primary care providers operating at the top of their licenses (e.g., nurse practitioners, physicians' assistants, pharmacists, social workers and others). Active Beneficiary Selection Beneficiaries could sign up to participate in a CIO at any time. Beneficiaries would have a choice between traditional fee-for-service Medicare, Medicare Advantage, and a CIO. When the beneficiary selects the CIO, the beneficiary would also select a primary care physician associated with the CIO. The beneficiary would then commit to receiving services in the CIO model for one year. To facilitate the selection of the Third Option, quality and service information about available CIOs would be made readily available to the consumer. This CIO level information would be developed by

stakeholders, including physicians, would be approved by CMS, and then disseminated by CMS to allow consumers to make fully informed choices about their care. Consumers would be empowered with information regarding the package of services available under each of the three models, including any additional care management programs or benefits. Benefits The Third Option would cover the standard Medicare Part A and Part B benefits. Part D benefits would continue to exist alongside the Third Option. Premium In the Third Option, the Part B premium would be reduced for beneficiaries that: (1) select the Third Option for a fixed one year period; and (2) actively select a primary care physician within the CIO who will be charged with coordinating all aspects of the enrollee's care. The percentage to be waived is to be determined with the aim of providing sufficient incentive for beneficiaries to select our proposed Third Option, while at the same time providing sufficient funding for the program. This partial waiver of premium, coupled with the provisions relating to Medicare Supplemental insurance below, should make the Third Option an attractive alternative for seniors. Beneficiary Alignment As with Original Medicare, beneficiaries would be free to access services from any Medicare contracted physician. However, to incentivize beneficiaries to access care in-network as directed by their chosen primary care physician, services rendered by out-of-network providers would be subject to higher out-of-pocket costs. Prior authorization for certain high cost services would be required. The higher cost sharing for use of services outside the CIO is designed to achieve the twin goal of allowing freedom of choice, but incentivizing the efficiencies and higher quality that can be obtained by consistently accessing a highly organized, financially aligned, and electronically connected network of team-based providers. To encourage beneficiaries to seek needed care, including preventive care services, beneficiaries would pay no deductible and would have no copayments for these preventive services. To provide beneficiaries with an additional incentive to access services in-network, their Medicare supplemental insurance policies would provide coverage for in-network services only. Beneficiaries would remain free to access services out-of-network, but would do so without the benefit of supplemental insurance coverage. Payment to CIOs Using regional historical Part A and B cost information, CMS would each year establish an actuarially sound, risk adjusted, global capitation payment to be made to the CIO for the entire population assigned to it through the beneficiary selection process described above. CIOs would be free to accept these cap rates, or elect not to enter into a contract with CMS. CMS would pre-pay this amount to the CIO each month in lieu of Medicare Part A and Part B fee-for-service payments for those beneficiaries, thus creating the alignment and incentives to produce lower cost trend and higher quality than experienced in the past. The CIO would be responsible for the downstream payment for all professional and hospital services. In addition, CIOs would be eligible to receive incentive payments for meeting certain quality criteria, much like Medicare Advantage organizations currently do in the Medicare Advantage Stars program. Importantly, the incentives would be paid to the CIO organization, not to individual physicians or health plan intermediaries. This will foster alignment of incentives with high performing physicians within the CIO. Administration and Operations Rather than building expensive health plan infrastructure and capacity, CMS would, at its expense, contract with one or more highly capable Affiliated Service Organizations ("ASO") to administer the eligibility and enrollment process; make the global capitation payments; receive encounter data from the CIOs; operate the quality and incentive bonus program; and conduct all other functions necessary to operate the Third Option. In particular, the ASO will be necessary to handle the complexities associated with administering differential cost sharing for the out-of-network benefit. CMS may elect to contract with one or more major insurance carriers with the existing



infrastructure and systems necessary to rapidly implement this program at scale. Quality and Efficiency Measurement To ensure that the CIOs have a strong business case for the delivery of high quality care, CIOs would be required to maintain a pay-for-excellence program to incent their providers to deliver high quality care. The compensation that would be payable to providers under these programs would be paid by the CIO from the global capitation it receives; it would not be deducted or withheld from the capitation paid by CMS to the CIO. Under this program, incentive compensation of as much as 15% of total compensation will be tied to high performance on quality measures, which has been demonstrated to drive behavior. Aggregate CIO performance would be publicly reported. Quality measures would be developed, tested, and rolled out consistent with accepted practices. These measures would apply and be reported at the physician organization, rather than the individual physician level. To the greatest extent possible, CIO quality metrics should align with existing quality programs and would be approved by CMS. Once these measures have been rolled out, stakeholders, including physicians and consumer groups, would evaluate the measures that would be meaningful to consumers when selecting participation. Such information should be made public as appropriate to inform and facilitate decisions among care model options. Organization Eligibility CIOs that wish to participate in the Third Option must be credentialed and certified by an independent third party organization, potentially URAC. We believe that the criteria for certification should include: (1) ability to accept and distribute population-based payments and incentives; (2) care management processes; (3) health information technology; (4) patient centered care; (5) primary care team-based approach; (6) physician leadership; and (7) meeting State financial solvency standards and licensing requirements.

**3. Other than the options for refining population-based payments outlined in Section B below, should any additional refinements be made to the Pioneer ACO Model that would increase the number of applicants to the Pioneer ACO model?** CAPG has developed the concept described below, the Third Option, in response to our members' experience in various ACO models. The Third Option presents various aspects of a new Medicare program option – one that would sit between fee-for-service ACOs and Medicare Advantage. We believe that a Pioneer program that embraced each of these elements would increase the number of applicants, but more importantly, drive the evolution of the healthcare delivery system toward value. Clinically Integrated Organizations Under our proposed Third Option, CMS would contract directly with clinically integrated organizations (“CIOs”). Some CIOs may be existing physician organizations, while some may be newly formed. The CIO would be explicitly physician group-centric, but may be co-owned and comprised of physicians, hospitals, nursing homes, home health organizations and other entities wishing to be accountable for the delivery of coordinated care to a defined population across the continuum of care. The CIOs would feature team-based care, led by primary care physicians and supported by other primary care providers operating at the top of their licenses (e.g., nurse practitioners, physicians' assistants, pharmacists, social workers and others). Active Beneficiary Selection Beneficiaries could sign up to participate in a CIO at any time. Beneficiaries would have a choice between traditional fee-for-service Medicare, Medicare Advantage, and a CIO. When the beneficiary selects the CIO, the beneficiary would also select a primary care physician associated with the CIO. The beneficiary would then commit to receiving services in the CIO model for one year. To facilitate the selection of the Third Option, quality and service information about available CIOs would be made readily available to the consumer. This CIO level information would be developed by

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infrastructure and systems necessary to rapidly implement this program at scale. Quality and Efficiency Measurement To ensure that the CIOs have a strong business case for the delivery of high quality care, CIOs would be required to maintain a pay-for-excellence program to incent their providers to deliver high quality care. The compensation that would be payable to providers under these programs would be paid by the CIO from the global capitation it receives; it would not be deducted or withheld from the capitation paid by CMS to the CIO. Under this program, incentive compensation of as much as 15% of total compensation will be tied to high performance on quality measures, which has been demonstrated to drive behavior. Aggregate CIO performance would be publicly reported. Quality measures would be developed, tested, and rolled out consistent with accepted practices. These measures would apply and be reported at the physician organization, rather than the individual physician level. To the greatest extent possible, CIO quality metrics should align with existing quality programs and would be approved by CMS. Once these measures have been rolled out, stakeholders, including physicians and consumer groups, would evaluate the measures that would be meaningful to consumers when selecting participation. Such information should be made public as appropriate to inform and facilitate decisions among care model options. Organization Eligibility CIOs that wish to participate in the Third Option must be credentialed and certified by an independent third party organization, potentially URAC. We believe that the criteria for certification should include: (1) ability to accept and distribute population-based payments and incentives; (2) care management processes; (3) health information technology; (4) patient centered care; (5) primary care team-based approach; (6) physician leadership; and (7) meeting State financial solvency standards and licensing requirements.

**1. Would being able to choose different FFS reduction amounts for Part A and Part B services be of significant importance when deciding to participate in the PBP? No**

**1A. Why or why not?** Wholesale changes to the program structure must be made to encourage organizations to take PBP. Specific recommendations provided above.

**3. Should CMS reconsider the requirement that a Pioneer ACO generate a specified level of savings in previous years in order to be eligible to elect to receive PBPs, and instead establish clear requirements for financial reserves? Yes**

**3A. Why or why not?** CMS should request that organizations have experience managing PBP in other contexts, like Medicare Advantage, prior to being allowed to use this option. But shared savings should not be required.

**4. Should any additional refinements be made to the current Pioneer ACO PBP policy? Yes**

**4A. Why or why not?** See description of Third Option above.

**1. Should CMS offer ACOs capitation with insurance risk, similar to Medicare Advantage organizations? Yes**

**1A. What are the potential benefits and risks to the Medicare program and beneficiaries?**

There are numerous benefits for patients including a team-based care approach; providing the right care at the right time in the right setting; and treating total care needs of beneficiaries

**2. What categories of spending should ACOs at full insurance risk be responsible for? (For example: Medicare Parts A and B, Medicare Parts A, B, and D, or Medicare Parts A, B, and D and Medicaid for Medicare-Medicaid beneficiaries) Medicare Parts A and B**

**3. Are there services that should be carved out of ACO capitation? Why?** This should be agreed to between CMS and the Pioneers it contracts with.

**4. What type of agreements with non-ACO providers would the ACO need to adopt to take on full insurance risk for a beneficiary population?** In some cases, the Pioneer ACO may need to enter an agreement with a health plan for provision of administrative services, as described above in CAPG's Third Option.

**5. What key elements of the regulatory and compliance framework for Medicare Advantage should be adopted for ACOs assuming full insurance risk? What regulatory and compliance elements in Medicare Advantage would NOT be appropriate for ACOs assuming full insurance risk?** We believe there must be appropriate safeguards in place to ensure financial solvency for ACOs accepting full risk. Otherwise, we encourage CMS to adapt requirements -- for example, marketing requirements and beneficiary protections -- to ACO capabilities and resources.

**Medicare Advantage Organizations have significant infrastructure that ACOs do not currently have such as member services. 7. What additional infrastructure would ACOs need to develop to be able to manage full insurance risk?** Will depend on the individual organization and its experience managing risk in other contexts.

**The Pioneer ACO program currently uses a national expenditure growth trend for benchmarking. 8. What are approaches for setting appropriate capitation rates?** There are a number of organizations, including those among the CAPG membership, with robust experience in developing capitated payments. This expertise comes from decades of successful experience in capitated payment models. We would be pleased to offer this expertise to CMS should you choose to pursue a capitated payment model in the Pioneer program.

**10. What benefit enhancements (e.g. reducing co-pays for services delivered by ACO providers) would be appropriate for ACOs at full insurance risk to offer to their patients and how would these benefit enhancements improve care outcomes?** See discussion of Third Option above

**2. Would ACOs be interested in and prepared to accept insurance risk as Part D sponsors or through contracting with pharmacy benefits management companies? Yes**

**2A. Why or why not?** Some ACOs may be interested in and prepared to accept risk for Part D, either immediately or over time. Others may not. CMS should make this option available to, but not required of, Pioneer ACOs.

**CMS has encouraged States to explore the use of integrated care models including ACOs for the care of Medicaid populations. 1. Should ACOs caring for Medicare outcomes also assume accountability for Medicaid outcomes? Yes**

**1A. Why or why not? Yes.** With the proviso that CMS develops an actuarially sound rate for Medicaid beneficiaries, ACOs may also wish to assume accountability for Medicaid outcomes.

**Organization Name:** Children's Hospital Association

**Point of Contact First Name:** Liz

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**Phone Number:** 7037976192

**Please select the option that best describes you.:** Not part of a Medicare ACO or a Commercial ACO

**2. What populations should CMS prioritize in integrating accountability for Medicaid outcomes? (For instance, should ACOs be accountable for outcomes among all Medicare-Medicaid beneficiaries treated by the ACO historically? Or, should the ACO be accountable only for those Medicare-Medicaid beneficiaries over 65 years old or under 65? Alternatively, should the ACO be accountable for outcomes of all Medicaid beneficiaries as well as CHIP beneficiaries? Should they be accountable for all those beneficiaries residing in a specified geographic area, regardless of whether they had been cared for by the ACO?)**

We appreciate CMS's work to date to further improved quality of care and reduced health care costs through accountable care organizations (ACOs) for Medicare populations. We also acknowledge the Medicaid related questions mainly address dual eligibles who are indeed high cost populations who could benefit from more integrated care models. However, we respectfully request an equivalent focus on Medicaid eligible children. Through Medicare, CMS has supported infrastructure, data collection and quality improvement efforts across states and sites which will benefit these complex populations. We recommend a similar focus and support for children. The Children's Hospital Association (the Association) could envision ACOs, either for children generally or specifically focused on children with complex medical conditions. And some have already sprung up within specific states already. However, these are state specific endeavors that often are not able to link with other equivalent efforts across the country or leverage the same level of support for infrastructure, data collection and quality improvement that has been experienced under the Medicare program. Working closely with children's hospitals across the country, the Association has done research to show that children with medical complexity (those with one severe or multiple medically complex conditions) account for 6 percent of children on Medicaid, but account for 40 percent of the costs for children on Medicaid. We see this as an opportunity to not only improve care for children through accountable care organizations/structures, but also the chance to reduce Medicaid costs. Examining how best to organize care for children with medical complexity is a focus of the Association and we welcome the opportunity to discuss in more detail as CMS considers initiatives in this area. CMS's ACO work for children must include implementation of new payment models that better align with the best outcomes for the nation's children. Currently, if a hospital does a great job of organizing and coordinating care and the child is kept out of the hospital, the hospital is penalized " that is, loses money " rather than being rewarded for improving care and keeping the child in their community. Exploring risk-based payment models to better align care to the best outcomes for children is critical. Children are not just little adults and they have unique health care needs. When structuring accountable care initiatives for this

population, these unique needs should be taken into account. It would not be effective to take models created for adults and wholesale apply them to children. Particularly for children with medical complexity, they are a very heterogeneous group that requires more tailored care approaches and a system that allows and supports that care. There may be lessons we can learn from the Pioneer ACOs, but we need to think about these models in the context of what works best for children and their families. In addition, risk-adjustment models developed for pediatric populations require a different approach from those currently applied to adult populations due to the heterogeneity of the complex pediatric population and the outliers. The Association recommends that a pediatric risk-adjustment model be developed to inform ACOs that manage this population. The regional nature of pediatric care also needs to be addressed. Children often must travel to another state or region of their state to receive the best care “ or sometimes the only care “ for their conditions, much more so than adults. This is even more frequently true for children with complex conditions. Therefore, the pediatric ACO design and payment methodologies must allow for regional and multi-state structures for children’s health care. Children are also more likely to have coverage from the Medicaid program than the Medicare program. With such a large percentage of kids receiving coverage via Medicaid and the Children’s Health Insurance Program, pediatric ACOs will need to be able to work closely with state Medicaid programs in order to receive adequate and complete data, such as claims detail files, for these children. Without such transparency, pediatric ACOs cannot develop appropriate care delivery and payment models that successfully align. Only a small number of children are eligible for Medicare so ACOs under Medicare do not impact children for the most part. This needs to be taken into account when thinking about CMS’s work in this area. Medicare has a national set of well-developed and tested quality measures, while the Medicaid program does not. Federal investment in developing and validating children’s health measures has lagged behind investment in adult measures. As a result, there are not the same robust measures available to capture important aspects of quality to be addressed by ACOs focused on children that are found in the adult population. It would be inappropriate for CMS to apply the Medicare quality measures on the pediatric population. The Centers of Excellence funded through the Children’s Health Insurance Program Reauthorization Act are developing and testing new measures for children so they should be looked to for appropriate children’s measures. The Affordable Care Act authorized a Pediatric ACO demonstration and we recommend that CMS work to implement with existing funds. We believe that children would benefit from federal support for ACOs and ask that CMS put the resources and time into fostering these organizations as you have for Medicare beneficiaries. Lastly, the Children’s Hospital Association and Nationwide Children’s Hospital are conducting a survey on existing pediatric ACO-like models. We would be happy to share our findings with CMS once they are available.

**Organization Name:** Cleveland Clinic

**Point of Contact First Name:** Blair

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**Phone Number:** 2163124030

**Please select the option that best describes you.:** Not part of a Medicare ACO or a Commercial ACO

**1A. Why or why not?** There is uncertainty among healthcare organizations around the question of application because of the general understanding that nearly one third (1/3) of the initial participants left the program during the first phase and only eight (8) experienced shar

**2. If additional applicants were solicited for the Pioneer ACO model, should CMS limit the number of selected organizations or accept all organizations that meet the qualifying criteria?** Limit the number of selected organizations

**2A. What are the advantages and/or disadvantages of either approach?** CMS should review and revise the criteria guidelines to ensure that the future participants are poised for success. If organizations continue to fail to meet the goals despite their diligent efforts, we are concerned that this will undermine the program over time.

**1A. Why or why not?** Any flexibility CMS can offer would be attractive to applicants to be an ACO.

**3. Should CMS reconsider the requirement that a Pioneer ACO generate a specified level of savings in previous years in order to be eligible to elect to receive PBPs, and instead establish clear requirements for financial reserves?** Yes

**3A. Why or why not?** There is concern that if the participant is a physician group without a hospital that they will not be able to generate a fixed amount of reserves, whereas a large integrated healthcare system does have the ability to generate the reserves.

**4. Should any additional refinements be made to the current Pioneer ACO PBP policy?**  
Yes

**4A. Why or why not?** Refinement of the current Pioneer ACO PBP policy should be based on the experience of current ACO participants. Further exploration of infrastructure costs, transition from FFS to capitation, attribution, data accuracy and management concerns will be nece

**1A. What are the potential benefits and risks to the Medicare program and beneficiaries?** It might become important for providers to assume capitation with insurance risk in the future, however, that would depend on the organization and its affiliates' risk readiness. Considerations on whether the ACO has 1) access to timely and accurate inf



**2. What categories of spending should ACOs at full insurance risk be responsible for? (For example: Medicare Parts A and B, Medicare Parts A, B, and D, or Medicare Parts A, B, and D and Medicaid for Medicare-Medicaid beneficiaries)** ACOs at full insurance risk should be responsible for Medicare Parts A, B and D as they all relate to providing components of a patient's healthcare. ACOs should be given the Medicare data for the beneficiaries attributed to their organization in advance

**3. Are there services that should be carved out of ACO capitation? Why?** Consideration must be given to carving out high-cost and high-risk services from the ACO capitation payment. Outlier protection should be offered to protect organizations against catastrophic and high-risk cases. Some examples of such services that should

**4. What type of agreements with non-ACO providers would the ACO need to adopt to take on full insurance risk for a beneficiary population?** Relationships should be developed whereby selected providers for transplants or other high cost services would have separate arrangements in either a fee for service or bundled payment scenario to provide these services.

**5. What key elements of the regulatory and compliance framework for Medicare Advantage should be adopted for ACOs assuming full insurance risk? What regulatory and compliance elements in Medicare Advantage would NOT be appropriate for ACOs assuming full insurance risk?** While further investigation is needed to respond fully, the parts of the Medicare Advantage regulations that relate to marketing and the Medicare Advantage bidding process would be some examples of regulatory and compliance elements that would not be appropriate.

**Medicare Advantage Organizations have significant infrastructure that ACOs do not currently have such as member services. 7. What additional infrastructure would ACOs need to develop to be able to manage full insurance risk?** ACO's would need to develop significant capabilities to be able to successfully manage full insurance risk. Since infrastructure is very important, a few examples of these capabilities would include the ability to manage and account for capitation payment

**The Pioneer ACO program currently uses a national expenditure growth trend for benchmarking. 8. What are approaches for setting appropriate capitation rates?** While there is general agreement with the concept of the local growth trend model, as variability exists at a national level, considerations regarding the type of services the ACO provides such as primary, and secondary, versus tertiary, also become important in benchmarking.

**9. What are the advantages or disadvantages of different strategies for risk-adjustment? (Examples include demographic risk adjustment only and/or any of the Medicare Advantage risk adjustment methodologies.)** There are advantages to a risk adjustment strategy similar to the Medicare Advantage risk adjustment methodology that is transparent to the ACOs and can be used in coordinating member care while compensating the ACOs equitably for the risks that they assume

**10. What benefit enhancements (e.g. reducing co-pays for services delivered by ACO providers) would be appropriate for ACOs at full insurance risk to offer to their patients**

**and how would these benefit enhancements improve care outcomes?** Introducing meaningful benefit incentives for remaining in the ACO network, or reducing/eliminating co-pays for patients would encourage patients to access lower cost care options (e.g. a physician's office, urgent care) rather than accessing the same c

**12. What types of precautions should be taken by ACOs assuming full insurance risk to protect beneficiaries from potential marketing abuses limiting beneficiary freedom of choice? What are additional protections beyond those in Medicare Advantage that would be important for beneficiaries aligned to ACOs with full insurance risk to avoid adverse selection?** Concerns remain among providers regarding insurers who limit choices for their beneficiaries in restrictive networks. One approach for addressing this issue is through transparency and disclosure of benefit design and product limitations to providers in a timely and consistent manner.

**Currently, beneficiaries are aligned to a Pioneer ACO through claims-based attribution. Pioneer ACOs are accountable for improved quality and lower expenditures for aligned beneficiaries. 13. If Pioneer ACOs were at full insurance risk, should a beneficiary be allowed to elect alignment to a Pioneer ACO even if the beneficiary would not be aligned to the Pioneer ACO through the attribution methodology?** No

**13A. What are advantages/disadvantages of allowing beneficiaries to voluntarily align themselves to an ACO at full insurance risk rather than sole reliance on claims-based attribution?** Appropriate patient population distribution is necessary for an ACO's success. We believe that allowing a patient to elect alignment with an ACO implies that the patient is motivated to participate in their care which may or may not be the case. If a c

**2A. Why or why not?** This would depend on the specific business arrangement and further investigation would be needed.

**2B. If ACOs assume accountability for Part D expenditures, what are the advantages/disadvantages of CMS requiring ACOs to be licensed under state law as a risk bearing entity and relying on the current Part D bidding process, versus creating a unified expenditure target for Part A, B, and D combined, with a unified risk adjustment method?** Since requiring ACO's to go through the Medicare Advantage Part D bid process will add administrative expenses to the process, evaluating the current Part D bidding process versus a unified expenditure model is crucial.

**3. Do ACOs currently have access to enough data to accept full risk for Part D expenditures?** No

**3A. What other mechanisms would allow ACOs to assume accountability for Part D outcomes?** Complete and timely data sets will help ACOs understand their baseline performance and opportunities for improvement. Plan Design will help to assume accountability for Part D outcomes; however, understanding what ACOs are responsible for under Medicare P

**CMS has encouraged States to explore the use of integrated care models including ACOs for the care of Medicaid populations. 1. Should ACOs caring for Medicare outcomes also assume accountability for Medicaid outcomes?** No

**1A. Why or why not?** Accountability is a goal to be pursued once the program has matured and patient accountability has been built into Medicaid. Building the right business and clinical model will also gain importance for success in managing this population. Programs that e

**2. What populations should CMS prioritize in integrating accountability for Medicaid outcomes? (For instance, should ACOs be accountable for outcomes among all Medicare-Medicaid beneficiaries treated by the ACO historically? Or, should the ACO be accountable only for those Medicare-Medicaid beneficiaries over 65 years old or under 65? Alternatively, should the ACO be accountable for outcomes of all Medicaid beneficiaries as well as CHIP beneficiaries? Should they be accountable for all those beneficiaries residing in a specified geographic area, regardless of whether they had been cared for by the ACO?)** While a historical review of the ACOs population is important to determine which population the ACO should manage, ACOs should be accountable only for populations that they have the capability to manage effectively. The patient attribution should be reviewed and updated on a regular basis. For example, patients that have left the area or expired should be removed from the list permanently. Data sharing and reconciliation for validation is key in managing a population successfully.

**3. What should the role of States be in providing appropriate incentives to foster the development of an integrated care system?** States should play a role in the development of integrated care systems. They should examine their resource challenges and capacity with ongoing and open communication to the ACO. State resources could also be directed towards aligning incentives for quality metrics between payers and providers that will reduce both the redundancy and misalignment of quality measures between payers.

**4A. What are the capabilities of providers in integrating this data with electronic health records?** The capabilities vary by provider and the technical capacity of their EHR.

**4B. What are the capabilities of integrating information for care received in the community or from other non-traditional care providers?** While this is a growing capability, this is best achieved with mature EHR systems that effectively exchange health information electronically. There is a large gap in this capability currently that places effective care coordination at increased risk

**5. What financial arrangements would be most appropriate for ACOs assuming risk for Medicare and Medicaid expenditures? (Should CMS and States offer separate but coordinated shared savings arrangements to ACOs? Should CMS and States offer a unified shared savings arrangement that reflects combined Medicare and Medicaid expenditures?)** There is a need to further explore unified shared savings as a model that combines Medicare and Medicaid expenditures to determine whether it is appropriate for ACO assuming risk.

**A provider-led community ACO would be an ACO that would be held accountable for total Medicare, Medicaid and CHIP expenditures, and quality outcomes, for all Medicare, Medicaid and CHIP beneficiaries residing in the ACO's service area, regardless of those beneficiaries' historical care patterns.** **1. What are options for accountable care models that are geared specifically for geographically aligned populations of beneficiaries?** While these efforts are laudable, there are many providers that may not be ready for this model of care

for the specific population. Traditionally, certain patient populations like Medicaid have not been fully engaged in managing their care. Further, a substantial minority face significant behavioral health challenges which create barriers to patient engagement, activation and medication adherence. Finally, some face unstable living conditions which hampers healthcare engagement when more pressing housing issues are diverting their attention.

Providers are hopeful that the government will be instrumental in leading and removing barriers that exist in today's healthcare environment and allow hospitals and physicians to work together to be successful managing this population. Allowing providers time to build a solid infrastructure and capabilities along with support from the government in the form of timely data and information sharing is key.

**1C. Are there models to consider that better integrate community-based services beyond the traditional medical system?** In an ideal system, the patient would be at the center of the healthcare experience with the provider focusing on integrating services for the patient that include primary, acute, mental health, rehab and post-acute care type settings. Providers outside t

**2B. If so, what would the most critical features of such a "layered" ACO be and why?** Cleveland Clinic currently participates in the CMS BPCI program and we are very interested in how a program such as this would be layered in the Shared Savings model.

**1. How can CMS encourage the adoption of ACO contracts among other payers of Medicare ACOs?** Medicare should encourage and work with commercial payers to standardize the quality metrics.

**2. How can CMS and other payers focus reporting of quality measures on the most important priorities while minimizing duplication and excess burden?** CMS and commercial payers should work collaboratively with health systems to determine which measures are the most clinically relevant.

## Organization Name: Express Scripts

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**Please select the option that best describes you.:** Not part of a Medicare ACO or a Commercial ACO

**Current laws and regulations allow ACOs to establish business arrangements with Part D sponsors in order to align incentives in support of improving care coordination and outcomes. 1. What factors, if any, pose barriers to the effectiveness of such collaborations? Are there any considerations, such as marketing considerations, that are relevant to the promotion of these business arrangements?** Express Scripts, a Pharmacy Benefit Management company (“PBM”) that operates a mail-order pharmacy, supports the integration of prescription drug management as part of an approach to improve the quality of care, reduce overall costs and transform health care delivery. The optimal use of medications is an effective tool in meeting the goals of managing costs and improving quality. Express Scripts has proven capabilities that drive positive patient outcomes through cost-effective pharmacy management. These capabilities are aligned with and can support ACOs – which typically do not have focused, out-patient drug management resources—in their attainment of meeting quality measures and lowering costs. In order for Express Scripts to fully participate (and assume risk) with ACOs in their effort to achieve population quality and cost goals, Express Scripts would require recognition as a provider/supplier under an ACO participant and inclusion under the safe harbor for gain-share. Currently PBMs and pharmacies are not specifically included under regulation as an ACO provider/supplier. Additionally, the proposed Part D regulation appears to prohibit risk-based payment to pharmacies which is counter to an ACO model evolution that seeks to incorporate a transition to greater risk inclusive of Part D. Express Scripts hopes to work collaboratively with the CMS on innovative approaches in which PBMs and pharmacies can fully participate in this arena.

**Organization Name:** Fairview Health Services

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**Please select the option that best describes you.:** Part of both a Medicare ACO and a Commercial ACO

**2. If additional applicants were solicited for the Pioneer ACO model, should CMS limit the number of selected organizations or accept all organizations that meet the qualifying criteria?** Limit the number of selected organizations

**2A. What are the advantages and/or disadvantages of either approach?** As a current Pioneer, we would want to ensure adequate CMMI staff resources to accommodate any number of new Pioneers. New members will require significant staff time to acclimate to the program. There is also some question as to whether the results of the current group of Pioneers could be fairly compared against a group of future Pioneers, given the changes in the methodology over the first years of the program.

**1. Would being able to choose different FFS reduction amounts for Part A and Part B services be of significant importance when deciding to participate in the PBP?** Yes

**1A. Why or why not?** It would give Pioneers greater flexibility for engagement and alignment with providers and suppliers if they were allowed to select different FFS reduction amounts for Part A and B.

**3. Should CMS reconsider the requirement that a Pioneer ACO generate a specified level of savings in previous years in order to be eligible to elect to receive PBPs, and instead establish clear requirements for financial reserves?** Yes

**3A. Why or why not?** Yes, we believe CMS should reconsider the minimum performance requirements in order to allow more Pioneers to ability to use PBP to drive engagement and alignment. One option would be to change minimum criteria to be any Pioneer producing any amount of sa

**1. Should CMS offer ACOs capitation with insurance risk, similar to Medicare Advantage organizations?** Yes

**2. What categories of spending should ACOs at full insurance risk be responsible for? (For example: Medicare Parts A and B, Medicare Parts A, B, and D, or Medicare Parts A, B, and D and Medicaid for Medicare-Medicaid beneficiaries)** Medicare Part A, B and D.

**4. What type of agreements with non-ACO providers would the ACO need to adopt to take on full insurance risk for a beneficiary population?** We would need to create contracts, fee schedules and an infrastructure to receive and pay claims for services delivered to beneficiaries. There would be significant infrastructure needed.

**5. What key elements of the regulatory and compliance framework for Medicare Advantage should be adopted for ACOs assuming full insurance risk? What regulatory and compliance elements in Medicare Advantage would NOT be appropriate for ACOs assuming full insurance risk?** We do not currently hold a Medicare Advantage contract, so we aren't familiar with the regulatory or compliance framework of the MA program.

**6. What challenges would ACOs encounter in meeting state licensure requirements for risk-bearing entities? What types of waivers to current regulations and/or fraud and abuse laws, if any, would be necessary for ACOs to take on full insurance risk for a beneficiary population?** Re: waivers—we believe all the waivers that apply to MA plans should apply to risk-bearing ACO models. Some key waivers include the 3-day stay, homebound status for home health, and other waivers which allow for greater flexibility in care management.

**Medicare Advantage Organizations have significant infrastructure that ACOs do not currently have such as member services. 7. What additional infrastructure would ACOs need to develop to be able to manage full insurance risk?** We currently do not have a member services function, nor a provider network contracting and claims payment function. We would need marketing and outreach if the model involved enrollment or attestation.

**The Pioneer ACO program currently uses a national expenditure growth trend for benchmarking. 8. What are approaches for setting appropriate capitation rates?** The disadvantage of using a national growth trend to set the goal for benchmarking is that there is no recognition for ACOs that are currently outperforming the national average. Those ACOs will have a more difficult time of beating the trend and could actually be penalized for their prior good performance. Even the capitation rates that are paid to Medicare Advantage products are adjusted regionally based on historical TCOC of the populations in those regions. Again, this approach penalizes parts of the country that have delivered high quality low cost care.

**9. What are the advantages or disadvantages of different strategies for risk-adjustment? (Examples include demographic risk adjustment only and/or any of the Medicare Advantage risk adjustment methodologies.)** Because we are not currently structured to accept insurance risk, we would want a risk adjustment model that removes selection risk from the population and rewarded the ACO for performance in managing the population.

**10. What benefit enhancements (e.g. reducing co-pays for services delivered by ACO providers) would be appropriate for ACOs at full insurance risk to offer to their patients and how would these benefit enhancements improve care outcomes?** We want our members to have financial incentives to stay healthy. One way to do this would be to increase the out-of-pocket costs for members who receive care outside of the ACO and offset that with lower costs to see primary care providers within the ACO

**Currently, beneficiaries are aligned to a Pioneer ACO through claims-based attribution. Pioneer ACOs are accountable for improved quality and lower expenditures for aligned beneficiaries. 13. If Pioneer ACOs were at full insurance risk, should a beneficiary be allowed to elect alignment to a Pioneer ACO even if the beneficiary would not be aligned to the Pioneer ACO through the attribution methodology? No**

**13A. What are advantages/disadvantages of allowing beneficiaries to voluntarily align themselves to an ACO at full insurance risk rather than sole reliance on claims-based attribution?** The ACO needs to be able to manage the care of its members. If the member can elect to be included in the ACOs risk pool without interaction with the ACOs primary care network, the main mechanism to manage the member's health and avoid risk is gone.

**A provider-led community ACO would be an ACO that would be held accountable for total Medicare, Medicaid and CHIP expenditures, and quality outcomes, for all Medicare, Medicaid and CHIP beneficiaries residing in the ACO's service area, regardless of those beneficiaries' historical care patterns. 1. What are options for accountable care models that are geared specifically for geographically aligned populations of beneficiaries?** It's an interesting idea in concept, but incredibly complex to understand in real life. Myriad providers serving all variety of populations who has accountability for what population? How do you measure performance of the participating entities? What data sources would you use (and merge together) to create a measure of performance?



**Organization Name:** Forest Canyon

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**Please select the option that best describes you.:** Not part of a Medicare ACO or a Commercial ACO

**1. Would additional health care organizations be interested in applying to the Pioneer ACO Model? Yes**

**1A. Why or why not?** Yes if CMS can address the issue of venture capitalist groups trying to exploit the ACO loophole in STARK law

**2. If additional applicants were solicited for the Pioneer ACO model, should CMS limit the number of selected organizations or accept all organizations that meet the qualifying criteria? Accept all organizations that meet the qualifying criteria**

**2A. What are the advantages and/or disadvantages of either approach?** The more groups involved should result in more innovations, the only concern is that this test market will become too large to undo if the net results are unsustainable.

**3. Other than the options for refining population-based payments outlined in Section B below, should any additional refinements be made to the Pioneer ACO Model that would increase the number of applicants to the Pioneer ACO model? Consider how the population served is defined to make it more accessible to rural markets.**

**1. Would being able to choose different FFS reduction amounts for Part A and Part B services be of significant importance when deciding to participate in the PBP? Yes**

**2. Should CMS allow suppliers of DME equipment to be included on the list of participating Pioneer providers/suppliers that will receive reduced FFS payments? Yes**

**3. Should CMS reconsider the requirement that a Pioneer ACO generate a specified level of savings in previous years in order to be eligible to elect to receive PBPs, and instead establish clear requirements for financial reserves? No**

**3A. Why or why not?** Requirements for financial reserves will limit innovation and include large players and for-profit schemes like Atlantis Healthcare Group.

**4. Should any additional refinements be made to the current Pioneer ACO PBP policy? No**

**4A. Why or why not?** Let the experiment be completed first. We need data driven decisions to be successful.

**1. Should CMS offer ACOs capitation with insurance risk, similar to Medicare Advantage organizations? Yes**

**1A. What are the potential benefits and risks to the Medicare program and beneficiaries?** Smaller more cost effective providers, such as ASCs may not be able to participate, skewing the data toward dominate organizations.

**2. What categories of spending should ACOs at full insurance risk be responsible for? (For example: Medicare Parts A and B, Medicare Parts A, B, and D, or Medicare Parts A, B, and D and Medicaid for Medicare-Medicaid beneficiaries) Parts A, B, and D and both Medicare and Medicaid**

**3. Are there services that should be carved out of ACO capitation? Why?** Ambulatory surgery is proven more cost effective than hospital out patient surgery centers. Most ASCs are small and may not be able to accept the full risk.

**4. What type of agreements with non-ACO providers would the ACO need to adopt to take on full insurance risk for a beneficiary population?** Quality based metrics and partnership, not ownership

**5. What key elements of the regulatory and compliance framework for Medicare Advantage should be adopted for ACOs assuming full insurance risk? What regulatory and compliance elements in Medicare Advantage would NOT be appropriate for ACOs assuming full insurance risk?** There needs to be clear guidance regarding STARK and Anti-kickback arrangements that incentivize PCPs to refer for shared profits rather than shared savings.

**6. What challenges would ACOs encounter in meeting state licensure requirements for risk-bearing entities? What types of waivers to current regulations and/or fraud and abuse laws, if any, would be necessary for ACOs to take on full insurance risk for a beneficiary population?** The common ownership requirements of the current legal structure appear to open up a lot of potential fraud/kickback issues.

**Medicare Advantage Organizations have significant infrastructure that ACOs do not currently have such as member services. 7. What additional infrastructure would ACOs need to develop to be able to manage full insurance risk?** A mechanism to pay for required member services

**8B. What about for using a local reference expenditure growth trend instead?** Region specific

**10. What benefit enhancements (e.g. reducing co-pays for services delivered by ACO providers) would be appropriate for ACOs at full insurance risk to offer to their patients and how would these benefit enhancements improve care outcomes?** The structure needs to benefit patients not venture capitalist groups

**12. What types of precautions should be taken by ACOs assuming full insurance risk to protect beneficiaries from potential marketing abuses limiting beneficiary freedom of**

**choice? What are additional protections beyond those in Medicare Advantage that would be important for beneficiaries aligned to ACOs with full insurance risk to avoid adverse selection?** There needs to be clear marketing guidelines and accountability for violations.

**Currently, beneficiaries are aligned to a Pioneer ACO through claims-based attribution. Pioneer ACOs are accountable for improved quality and lower expenditures for aligned beneficiaries. 13. If Pioneer ACOs were at full insurance risk, should a beneficiary be allowed to elect alignment to a Pioneer ACO even if the beneficiary would not be aligned to the Pioneer ACO through the attribution methodology?** Yes

**CMS has encouraged States to explore the use of integrated care models including ACOs for the care of Medicaid populations. 1. Should ACOs caring for Medicare outcomes also assume accountability for Medicaid outcomes?** Yes

**1A. Why or why not?** This will encourage more resources and innovation for savings with quality.

**5. What financial arrangements would be most appropriate for ACOs assuming risk for Medicare and Medicaid expenditures? (Should CMS and States offer separate but coordinated shared savings arrangements to ACOs? Should CMS and States offer a unified shared savings arrangement that reflects combined Medicare and Medicaid expenditures?)**  
Seperate but coordinated shared savings arrangements

**A provider-led community ACO would be an ACO that would be held accountable for total Medicare, Medicaid and CHIP expenditures, and quality outcomes, for all Medicare, Medicaid and CHIP beneficiaries residing in the ACO's service area, regardless of those beneficiaries' historical care patterns. 1. What are options for accountable care models that are geared specifically for geographically aligned populations of beneficiaries?**  
Provider driven, not hospital driven. However this will not be feasible until funding is included for running/coordinating the ACO.

**1A. What are the most critical design features of a provider-led community ACO model and why?** Open access, and choice, support to run the program appropriately, consideration towards rural providers

**1B. What additional quality measures should be considered if an ACO is responsible for all covered lives in a geographic area?** Clinical quality against national benchmarks should be priority

**In certain permissible circumstances, organizations are able to pursue multiple service delivery and payment reform initiatives. 2. Should CMS formalize an accountable care model where various service delivery and payment reform initiatives are combined?** Yes

**2A. More specifically, would there be interest in a model that tests comprehensive primary care within an ACO context and/or an ACO that incorporates episode-based payments?**  
Yes

**2B. If so, what would the most critical features of such a “layered” ACO be and why?** This may help rural markets that have large mobile seasonal populations (snowbirds)

**1. How can CMS encourage the adoption of ACO contracts among other payers of Medicare ACOs?** Insurance regulation and oversight

**2. How can CMS and other payers focus reporting of quality measures on the most important priorities while minimizing duplication and excess burden?** Have quality measures that reflect scope of services by each provider included, otherwise providers are left to duplicate services to avoid a poor score

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**Please select the option that best describes you.:** Not part of a Medicare ACO or a Commercial ACO

**A provider-led community ACO would be an ACO that would be held accountable for total Medicare, Medicaid and CHIP expenditures, and quality outcomes, for all Medicare, Medicaid and CHIP beneficiaries residing in the ACO's service area, regardless of those beneficiaries' historical care patterns. 1. What are options for accountable care models that are geared specifically for geographically aligned populations of beneficiaries?**

Community health systems that provide more than 50% of the primary care for a given zip code should be assigned all of the beneficiaries in that zip code.

**1A. What are the most critical design features of a provider-led community ACO model and why?** The community ACO should agree to act as the Medical Home for its community, coordinate care outside the community and provide comprehensive support for patients with 6 or more chronic diseases. This will provide the highest level of care for the community

**1B. What additional quality measures should be considered if an ACO is responsible for all covered lives in a geographic area?** Pediatric measures, generic drug utilization and ED utilization measures should be added.

**1C. Are there models to consider that better integrate community-based services beyond the traditional medical system?** The Patient Centered Medical Home integrates community-based services, but does not pay for them. Community ACO's should be required to share up to 10% of the \$10 PMPM payment and shared savings with community resources that agree to provide social support

**Organization Name:** Franciscan Alliance

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**Please select the option that best describes you.:** Part of both a Medicare ACO and a Commercial ACO

**1. Would additional health care organizations be interested in applying to the Pioneer ACO Model?** No

**1A. Why or why not?** The willingness of other organizations to join the Pioneer ACO model is questionable:

**2. If additional applicants were solicited for the Pioneer ACO model, should CMS limit the number of selected organizations or accept all organizations that meet the qualifying criteria?** Limit the number of selected organizations

**2A. What are the advantages and/or disadvantages of either approach?** Section A, Question 1 response: 1. We are not sure there is a large enough incentive differential for organizations to pursue Pioneer –in which they must accept downside risk—and the MSSP program, which offers an upside-only option. 2. The total lack of penalties or incentives for beneficiaries to utilize the ACO/ACO providers is a major factor contributing to the lack of participation of many capable ACO entities. Without any type of “tools” traditionally associated with risk networks, providers are left at the mercy of patient choice. Attributed beneficiaries zero responsibility for their own health in this model: there must be something to incent Medicare beneficiaries to utilize ACO participants (or discourage them from using non-ACO participants). Without something to encourage beneficiary engagement, you will never gain robust participation from providers in this model, nor the cost savings you desire. Question Sections A, Q2A Response We do not feel the addition of more organizations to the Pioneer ACO model is appropriate, for two main reasons: 1) Impact to current program/Pioneer participants: Onboarding of organizations to this model will inevitably slow the progress of the program, as newly-joining organizations will likely want to address many of the care questions/processes already addressed by current Pioneers. Additionally, this would take away time and resources from current Pioneers, which are already slim. We currently struggle with getting timely responses/action on many items, and addition of more ACOs would only exacerbate this problem. 2) Impact to future programming efforts: Other organizations had the same initial opportunity to join and did not. Current Pioneers took a risk, venturing into the great “unknown”. This should continue to be recognized by CMS by keeping their initial stance, that this group would remain exclusive. This also sets a bad precedent for CMS for future innovation models: potential participant may “wait and see” how the initial round goes before opting to join a model. Question Section A, Q3 Response In the current environment of reduced payments to providers and low margins, the model is not feasible long-term. Waiting 18 months post-performance period to receive cash flow (if any) is

not a workable business model. Providers will need some type of cash influx to support efforts.

1. Consider addition of a base care management fee for Pioneers, with option to increase. Pay-back provision for anything above base if Pioneer experiences a loss (after MSR exceeded). 2. Additionally, provide data analytics. CMS has a wealth of information on beneficiaries, far beyond individual providers, AND access to actuaries. Many ACOs do not and the cost incurred in contracting for these services is quite cumbersome. Use CMS actuaries to provide ACOs monthly reports on their population's conditions, financial trends, and estimated trend for year-end. 3. Redesign FFS Medicare benefit plans to incent healthy behaviors, incorporate patient responsibility, and/or payment incentives, such as a differential payment for using ACO vs. Non-ACO providers. Section B, Q1 Response The ability to choose different FFS reduction amounts will allow ACOs to better incent providers participating in the ACO. Reducing Part B payments does not provide physicians incentive to treat the patients in their offices, or at all. Section B, Q4 Response: Consider Part B payment increases to providers meeting ACO quality metrics or instituting a care management fee to offset the decreased Part B reimbursements participating providers may receive. If reducing Part B payment to physicians, the final settlement cannot be 18 months post-year, as is currently the case. Physician practices will drop out of the program because they will not have timely cash flow to sustain their practices.

**3. Other than the options for refining population-based payments outlined in Section B below, should any additional refinements be made to the Pioneer ACO Model that would increase the number of applicants to the Pioneer ACO model?** In the current environment of reduced payments to providers and low margins, the model is not feasible long-term. Waiting 18 months post-performance period to receive cash flow (if any) is not a workable business model. Providers will need some type of

**1. Would being able to choose different FFS reduction amounts for Part A and Part B services be of significant importance when deciding to participate in the PBP?** Yes

**1A. Why or why not?** allow ACOs to better incent providers participating in the ACO

**4. Should any additional refinements be made to the current Pioneer ACO PBP policy?** Yes

**4A. Why or why not?** See text box 2A above

**1. Should CMS offer ACOs capitation with insurance risk, similar to Medicare Advantage organizations?** Yes

**1A. What are the potential benefits and risks to the Medicare program and beneficiaries?** lower costs for Medicare, more coordinated care - Section II A, 1: If ACOs are going to accept full risk, then beneficiaries' choice of providers needs to be narrowed. Without some type of built-in dis/incentive for the beneficiary, the model will not feasibly work for ACOs. There must be some type of stick or carrot for the beneficiary to engage them and encourage participation. Patient responsibility IS A MUST.

**5. What key elements of the regulatory and compliance framework for Medicare Advantage should be adopted for ACOs assuming full insurance risk? What regulatory and compliance elements in Medicare Advantage would NOT be appropriate for ACOs**

**assuming full insurance risk?** Section II A, 1: If ACOs are going to accept full risk, then beneficiaries' choice of providers needs to be narrowed. Without some type of built-in dis/incentive for the beneficiary, the model will not feasibly work for ACOs. There must be some type of stick or carrot for the beneficiary to engage them and encourage participation. Patient responsibility IS A MUST.

**Medicare Advantage Organizations have significant infrastructure that ACOs do not currently have such as member services. 7. What additional infrastructure would ACOs need to develop to be able to manage full insurance risk?** See text box 8

**The Pioneer ACO program currently uses a national expenditure growth trend for benchmarking. 8. What are approaches for setting appropriate capitation rates?** Section IIA, Q7 Response 1. Additional billing capabilities. ACOs would be required to run a 'double' billing function (i.e. process information for a cap payment and simultaneously have to run a Coordinated Business Office/Ambulatory Business Office to send/collect traditional bills. 2. Waivers. Successful ACOs should also be exempt from programs such as RAC audits, given the time/money involved and the fact the ACOs run counter to this tenant. This highlights unnecessary wastes of resources on the provider end. 3. Robust data and data analysis. Management of all aspects of beneficiaries' care will require REAL-TIME data and internal actuarial/data analysis teams to identify opportunities, gaps, and track ACO performance. Section IIA, Q8: A critical element missing from today's ACO model is patient responsibility. ACO providers can do "everything right" as far as treatment, quality care metrics, preventive care, and follow-up, but if there is no patient buy in, the process will ultimately not work. Future ACO models need to both: 1) Integrate some type of patient accountability into the model, whether this be by penalty or incentive. Possible incentives could include waiving of/reimbursement of a Part B deductible for seeking all services within the ACO. 2) Factor patient compliance into the equation. ACOs should be able to "dismiss" patients/have patients removed from financial calculations if shown that they are taking no responsibility for their care. Population health improvement must be attacked from both the provider and patient side; it will not work if just one of these is being addressed. Ultimately, you will lose buy-in from the provider side.

**10. What benefit enhancements (e.g. reducing co-pays for services delivered by ACO providers) would be appropriate for ACOs at full insurance risk to offer to their patients and how would these benefit enhancements improve care outcomes?** SEE TEXT BOX 8

**Current laws and regulations allow ACOs to establish business arrangements with Part D sponsors in order to align incentives in support of improving care coordination and outcomes. 1. What factors, if any, pose barriers to the effectiveness of such collaborations? Are there any considerations, such as marketing considerations, that are relevant to the promotion of these business arrangements?** Section IIB, Q1A, 2B: CMS must make it less burdensome for providers and provider systems to engage in the ACO model. Piling on regulatory burdens will only discourage effective entities from entering this realm. Lack of legal precedents, along with the costs of legal fees and setup for this type of management, will stop these types of initiatives dead in their tracks, especially for entities with minimal cash resources. Section IIB, Q3A: ACOs do not currently have enough information to accept full part D risk. In order to take on responsibility for Part D outcomes, ACOs must be ensured they receive all



claims data on Part D beneficiaries (there can be no opting out) and data must be received real-time. Claims data information every 30-days is not effective in managing patients. ACOs must first be able to tell if a patient has gotten their prescription filled before they can start addressing medication adherence and polypharmacy issues.

**2. Would ACOs be interested in and prepared to accept insurance risk as Part D sponsors or through contracting with pharmacy benefits management companies? Yes**

**2B. If ACOs assume accountability for Part D expenditures, what are the advantages/disadvantages of CMS requiring ACOs to be licensed under state law as a risk bearing entity and relying on the current Part D bidding process, versus creating a unified expenditure target for Part A, B, and D combined, with a unified risk adjustment method? see text box Section II,B1 above**

**3. Do ACOs currently have access to enough data to accept full risk for Part D expenditures? No**

**3A. What other mechanisms would allow ACOs to assume accountability for Part D outcomes? see text box, section II, B1 above**

**CMS has encouraged States to explore the use of integrated care models including ACOs for the care of Medicaid populations. 1. Should ACOs caring for Medicare outcomes also assume accountability for Medicaid outcomes? Yes**

**1A. Why or why not? economies of scale, see text box below**

**2. What populations should CMS prioritize in integrating accountability for Medicaid outcomes? (For instance, should ACOs be accountable for outcomes among all Medicare-Medicaid beneficiaries treated by the ACO historically? Or, should the ACO be accountable only for those Medicare-Medicaid beneficiaries over 65 years old or under 65? Alternatively, should the ACO be accountable for outcomes of all Medicaid beneficiaries as well as CHIP beneficiaries? Should they be accountable for all those beneficiaries residing in a specified geographic area, regardless of whether they had been cared for by the ACO?)**  
Section IIC, Q1 Response: We believe that CMS should work with States on the development of Medicaid ACOs. This would not only help ACOs realize economies of scale, but would also assist CMS in the quest to control healthcare spending: introduction of effective Medicaid ACO programs would lower the federal spending contribution to each State to support the Medicaid program. Pioneers should get preferred treatment in networking with States, as they have more experience than newer ACO programs and are able to accept higher-risk programs/populations.

**3. What should the role of States be in providing appropriate incentives to foster the development of an integrated care system? Readiness to support ACOs will inevitably vary state to state. States should offer incentives to ACOs willing to participate and take on risk, such as higher reimbursement and/or care management fees. Additionally, those currently participating in Medicare ACO programs should be given highest priority for these types of partnerships.**

**3B. Do States have adequate resources to support an ACO initiative in collaboration with CMS?** varies state to state

**4. What are the current capabilities of ACOs and other providers in integrating and using Medicare FFS and Medicaid FFS data to drive care improvement and performance reporting?** Limited. While useful, many ACOs do not have access to robust analytics/actuaries. Many times, this function needs to be outsourced, at a large additional cost. We suggest Medicare provide ACOs with data analytics, considering the resources available to CMS internally. Additionally, the information provided by CMS is often not timely or accurate. Quarterly reports are often received far past the time they will be effective for population management, and are often “pulled back”, as they are found to be inaccurate. Additionally, on the MSSP side, quarterly attribution is often received 2-3 months post-quarter...making it nearly impossible to provide any type of effective care management to many beneficiaries. Without accurate and timely data, a critical piece for effective care management, ACOs cannot be effective at achieving the triple aim.

**A provider-led community ACO would be an ACO that would be held accountable for total Medicare, Medicaid and CHIP expenditures, and quality outcomes, for all Medicare, Medicaid and CHIP beneficiaries residing in the ACO’s service area, regardless of those beneficiaries’ historical care patterns.**

**1. What are options for accountable care models that are geared specifically for geographically aligned populations of beneficiaries?** Section IID, Q2B Response: We believe there would be interest in multi-layered models. A critical feature that would need incorporated into this type of model is some type of up-front payment, such as a care management fee, to help with costs of implementation of ACO care management features. Additionally, more education about ACOs needs to be relayed to beneficiaries. Currently, the burden is on ACOs to explain the concept and benefits of ACO. The “Medicare and You” handbook has only a single paragraph about ACOs buried in it. Lack of education and readily available information about ACOs makes beneficiaries reticent to engage in the model. CMS needs to engage with beneficiaries, better educating them about the model or assist ACOs via subsidies to educate beneficiaries.

**In certain permissible circumstances, organizations are able to pursue multiple service delivery and payment reform initiatives.**

**2. Should CMS formalize an accountable care model where various service delivery and payment reform initiatives are combined?** Yes

**2A. More specifically, would there be interest in a model that tests comprehensive primary care within an ACO context and/or an ACO that incorporates episode-based payments?** Yes

**2B. If so, what would the most critical features of such a “layered” ACO be and why?** upfront care management payments; see text box Section IID, Q1 above

**2. How can CMS and other payers focus reporting of quality measures on the most important priorities while minimizing duplication and excess burden?** Standardize quality reporting requirements across all payers, focusing on those that are known to most heavily impact outcomes.

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**Please select the option that best describes you.:** Not part of a Medicare ACO or a Commercial ACO

**1. Would additional health care organizations be interested in applying to the Pioneer ACO Model?** No

**1A. Why or why not?** It is very bad PR for anyone to limit care

**2. If additional applicants were solicited for the Pioneer ACO model, should CMS limit the number of selected organizations or accept all organizations that meet the qualifying criteria?** Limit the number of selected organizations

**2A. What are the advantages and/or disadvantages of either approach?** ACOs reduce care, so the number of ACOs should be limited as small as possible

**1. Would being able to choose different FFS reduction amounts for Part A and Part B services be of significant importance when deciding to participate in the PBP?** No

**1A. Why or why not?** Bad PR to participate

**2. Should CMS allow suppliers of DME equipment to be included on the list of participating Pioneer providers/suppliers that will receive reduced FFS payments?** No

**2A. Why or why not?** Bad to limit payments for equipment

**3. Should CMS reconsider the requirement that a Pioneer ACO generate a specified level of savings in previous years in order to be eligible to elect to receive PBPs, and instead establish clear requirements for financial reserves?** No

**3A. Why or why not?** PBP (payments based on people, not disease) destroy the catastrophic-insurance purpose of Medicare, and remove coverage for patients with biggest expenses, because risk pools smaller than the country cannot afford them.

**4. Should any additional refinements be made to the current Pioneer ACO PBP policy?**  
Yes

**4A. Why or why not?** Abolish payments based on people. Pay for treatment of disease. That is why the country adopted Medicare.

**1. Should CMS offer ACOs capitation with insurance risk, similar to Medicare Advantage organizations? No**

**1A. What are the potential benefits and risks to the Medicare program and beneficiaries?**

Paying per capita turns the ACOs into HMOs, with no coverage of expensive patients, and duplicates what Medicare already offers. Most seniors do not want HMOs

**2. What categories of spending should ACOs at full insurance risk be responsible for? (For example: Medicare Parts A and B, Medicare Parts A, B, and D, or Medicare Parts A, B, and D and Medicaid for Medicare-Medicaid beneficiaries)** Many patients only need an annual physical. ACOs should be responsible for that. Anything else creates an incentive to reduce care.

**3. Are there services that should be carved out of ACO capitation? Why?** All services other than the annual physical, should be insurance based, not flat rate.

**4. What type of agreements with non-ACO providers would the ACO need to adopt to take on full insurance risk for a beneficiary population?** An ACO with full insurance risk is an HMO, and not feasible.

**5. What key elements of the regulatory and compliance framework for Medicare Advantage should be adopted for ACOs assuming full insurance risk? What regulatory and compliance elements in Medicare Advantage would NOT be appropriate for ACOs assuming full insurance risk?** Doctors and patients who want Medicare Advantage should sign up for that. None of it should apply to ACOs.

**6. What challenges would ACOs encounter in meeting state licensure requirements for risk-bearing entities? What types of waivers to current regulations and/or fraud and abuse laws, if any, would be necessary for ACOs to take on full insurance risk for a beneficiary population?** ACOs are too small and powerless to be stable insurers, except when they send all their sick patients to hospice.

**Medicare Advantage Organizations have significant infrastructure that ACOs do not currently have such as member services. 7. What additional infrastructure would ACOs need to develop to be able to manage full insurance risk?** Medicare Advantage services should stay there

**The Pioneer ACO program currently uses a national expenditure growth trend for benchmarking. 8. What are approaches for setting appropriate capitation rates?** There is no way to set per capita payments for groups smaller than the nation, which provides the biggest and best risk pool. Small risk pools drive practices to cream the healthiest patients and send the rest to hospice or slow patients. Lack of mortality measure in ACO quality standard shows that Medicare accepts higher death rates from ACOs. Omission of hospice deaths from other medicare death rates shows that Medicare accepts ACOs which give patients no alternative to hospice.

## Organization Name: Individual

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Phone Number: 5138288947

Please select the option that best describes you.: Not part of a Medicare ACO or a Commercial ACO

**1. Would additional health care organizations be interested in applying to the Pioneer ACO Model? Yes**

**1A. Why or why not?** FQHCs are perfectly suited to run an ACO - Follows the PCMH model

**2. If additional applicants were solicited for the Pioneer ACO model, should CMS limit the number of selected organizations or accept all organizations that meet the qualifying criteria? Accept all organizations that meet the qualifying criteria**

**2A. What are the advantages and/or disadvantages of either approach?** FQHCs are all about monitoring outcomes and working to reduce costs as part of a PCMH. We also serve a challenging population.

**1. Would being able to choose different FFS reduction amounts for Part A and Part B services be of significant importance when deciding to participate in the PBP? Yes**

**2. Should CMS allow suppliers of DME equipment to be included on the list of participating Pioneer providers/suppliers that will receive reduced FFS payments? No**

**2A. Why or why not?** They are not the leader of the PCMH.

**3. Should CMS reconsider the requirement that a Pioneer ACO generate a specified level of savings in previous years in order to be eligible to elect to receive PBPs, and instead establish clear requirements for financial reserves? Yes**

**4. Should any additional refinements be made to the current Pioneer ACO PBP policy? No**

**1. Should CMS offer ACOs capitation with insurance risk, similar to Medicare Advantage organizations? Yes**

Currently, beneficiaries are aligned to a Pioneer ACO through claims-based attribution. Pioneer ACOs are accountable for improved quality and lower expenditures for aligned beneficiaries. **13. If Pioneer ACOs were at full insurance risk, should a beneficiary be allowed to elect alignment to a Pioneer ACO even if the beneficiary would not be aligned to the Pioneer ACO through the attribution methodology? No**

**CMS has encouraged States to explore the use of integrated care models including ACOs for the care of Medicaid populations. 1. Should ACOs caring for Medicare outcomes also assume accountability for Medicaid outcomes? Yes**

**Organization Name:** John C. Fremont Healthcare District

**Point of Contact First Name:** Alan

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**Please select the option that best describes you.:** Part of a Medicare ACO

**CMS has encouraged States to explore the use of integrated care models including ACOs for the care of Medicaid populations. 1. Should ACOs caring for Medicare outcomes also assume accountability for Medicaid outcomes? Yes**

**1A. Why or why not?** Similiar health issues will be present in both populations leading to similiar poor health outcomes. It is necessary to incorporate and coordinate healthcare services from outside organizations, such as mental and public health.

**3A. What roles should States play in supporting model design and implementation?** very limited but depending on the state

**3B. Do States have adequate resources to support an ACO initiative in collaboration with CMS?** no

**4. What are the current capabilities of ACOs and other providers in integrating and using Medicare FFS and Medicaid FFS data to drive care improvement and performance reporting?** Very limited at this time. Bringing capabilities up to what is necessary for effective care coordination is, and going to be, very expensive

**4A. What are the capabilities of providers in integrating this data with electronic health records?** very limited at this time due primarily to volume

**4B. What are the capabilities of integrating information for care received in the community or from other non-traditional care providers?** very limited with a steep learning curve

**5. What financial arrangements would be most appropriate for ACOs assuming risk for Medicare and Medicaid expenditures? (Should CMS and States offer separate but coordinated shared savings arrangements to ACOs? Should CMS and States offer a unified shared savings arrangement that reflects combined Medicare and Medicaid expenditures?)**  
separate but coordinated

**A provider-led community ACO would be an ACO that would be held accountable for total Medicare, Medicaid and CHIP expenditures, and quality outcomes, for all Medicare, Medicaid and CHIP beneficiaries residing in the ACO's service area, regardless of those beneficiaries' historical care patterns. 1. What are options for accountable care models that are geared specifically for geographically aligned populations of beneficiaries?** Rural facilities need to have full access for care management and integration for all beneficiaries within their catchment area. There is higher risk for financial failure due to outlier payments when

dealing with smaller populations. Rural ACOs need to have full shared savings participation with CMS. Participation is currently limited to 12.5% instead of the full 50% participation. Rural ACOs, at least, need to be exempt from all 'Stark' violations. Low income rural communities are going to be resistant to any increase in primary care initiatives if they are required to pay out of pocket deductibles and coinsurance amounts. Critical Access Hospital based ACO need to be exempt from the 96 hour rule and other regulatory requirements that are self defeating for managing a quality care/financially responsive healthcare model.

**1B. What additional quality measures should be considered if an ACO is responsible for all covered lives in a geographic area?** Health status improvements over time with a statistically valid population

**In certain permissible circumstances, organizations are able to pursue multiple service delivery and payment reform initiatives. 2. Should CMS formalize an accountable care model where various service delivery and payment reform initiatives are combined?** Yes

**2A. More specifically, would there be interest in a model that tests comprehensive primary care within an ACO context and/or an ACO that incorporates episode-based payments?** Yes

**2. How can CMS and other payers focus reporting of quality measures on the most important priorities while minimizing duplication and excess burden?** current law requires 33 quality measures to be reported by ACOs. Perhaps only statistically significant quality measures need to be reported that actually reflect quality of care instead of the 'shotgun' approach of trying to find all quality indicators



**Organization Name:** Mammoth Hospital

**Point of Contact First Name:** Melanie

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**Phone Number:** 7609244012

**Please select the option that best describes you.:** Part of a Medicare ACO

**A provider-led community ACO would be an ACO that would be held accountable for total Medicare, Medicaid and CHIP expenditures, and quality outcomes, for all Medicare, Medicaid and CHIP beneficiaries residing in the ACO's service area, regardless of those beneficiaries' historical care patterns. 1. What are options for accountable care models that are geared specifically for geographically aligned populations of beneficiaries?**

Community health systems that provide more than 50% of the primary care for a given zip code should be assigned all of the beneficiaries in that zip code.

**1A. What are the most critical design features of a provider-led community ACO model and why?** The community ACO should agree to act as the Medical Home for its community, coordinate care outside the community and provide comprehensive support for patients with 6 or more chronic diseases. Community ACO's should receive a \$10pmpm pymt to finance these additional services. This will provide the highest level of care for the community.

**1B. What additional quality measures should be considered if an ACO is responsible for all covered lives in a geographic area?** Pediatric measures, generic drug utilization and ED utilization measures should be added.

**1C. Are there models to consider that better integrate community-based services beyond the traditional medical system?** The Patient Centered Medical Home integrates community-based services, but does not pay for them. Community ACO's should share upto 10% of the \$10pmpm and shared savings with the community resources that agree to provide support to these patients.

**Organization Name:** Mammoth Hospital

**Point of Contact First Name:** Gary

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**Please select the option that best describes you.:** Part of a Medicare ACO

**A provider-led community ACO would be an ACO that would be held accountable for total Medicare, Medicaid and CHIP expenditures, and quality outcomes, for all Medicare, Medicaid and CHIP beneficiaries residing in the ACO's service area, regardless of those beneficiaries' historical care patterns. 1. What are options for accountable care models that are geared specifically for geographically aligned populations of beneficiaries?**

Community health systems that provide more than 50% of the primary care for a given zip code should be assigned all of the beneficiaries in that zip code.

**1A. What are the most critical design features of a provider-led community ACO model and why?** The community ACO should agree to act as the Medical Home for its community, coordinate care outside the community and provide comprehensive support for patients with 6 or more chronic diseases. Community ACO's should receive a \$10pmpm pymt to finance these additional services. This will provide the highest level of care for the community.

**1B. What additional quality measures should be considered if an ACO is responsible for all covered lives in a geographic area?** Pediatric measures, generic drug utilization and ED utilization measures should be added.

**1C. Are there models to consider that better integrate community-based services beyond the traditional medical system?** Pediatric measures, generic drug utilization and ED utilization measures should be added.

**Organization Name:** Margaret Mary Health

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**Please select the option that best describes you.:** Part of a Medicare ACO

**1. Would additional health care organizations be interested in applying to the Pioneer ACO Model?** No

**1A. Why or why not?** Too much risk associated with the plan. As a small organization we risk our very existence with only a few complex cases that cannot be treated at our facility.

**2. If additional applicants were solicited for the Pioneer ACO model, should CMS limit the number of selected organizations or accept all organizations that meet the qualifying criteria?** Limit the number of selected organizations

**3. Other than the options for refining population-based payments outlined in Section B below, should any additional refinements be made to the Pioneer ACO Model that would increase the number of applicants to the Pioneer ACO model?** Allow patients to opt-in so a whole community could be assigned in situations where there is only one hospital in the community.

**1. Would being able to choose different FFS reduction amounts for Part A and Part B services be of significant importance when deciding to participate in the PBP?** Yes

**1A. Why or why not?** It would apply more options to adapt to specific provider situations.

**2. Should CMS allow suppliers of DME equipment to be included on the list of participating Pioneer providers/suppliers that will receive reduced FFS payments?** No

**2A. Why or why not?** Keep the group narrow at this point.

**3. Should CMS reconsider the requirement that a Pioneer ACO generate a specified level of savings in previous years in order to be eligible to elect to receive PBPs, and instead establish clear requirements for financial reserves?** Yes

**3A. Why or why not?** Apply what we know now.

**4. Should any additional refinements be made to the current Pioneer ACO PBP policy?** Yes

**4A. Why or why not?** Rework the attribution formula to allow more rural providers to be included.

**1. Should CMS offer ACOs capitation with insurance risk, similar to Medicare Advantage organizations? Yes**

**1A. What are the potential benefits and risks to the Medicare program and beneficiaries?** More movement toward value.

**2. What categories of spending should ACOs at full insurance risk be responsible for? (For example: Medicare Parts A and B, Medicare Parts A, B, and D, or Medicare Parts A, B, and D and Medicaid for Medicare-Medicaid beneficiaries) ??**

**3. Are there services that should be carved out of ACO capitation? Why? ??**

**4. What type of agreements with non-ACO providers would the ACO need to adopt to take on full insurance risk for a beneficiary population?** It's difficult to include everyone.

**6. What challenges would ACOs encounter in meeting state licensure requirements for risk-bearing entities? What types of waivers to current regulations and/or fraud and abuse laws, if any, would be necessary for ACOs to take on full insurance risk for a beneficiary population?** We are 40 miles from another state so there is some issue with this. It varies so much with each situation that it is difficult to have a concise answer.

**The Pioneer ACO program currently uses a national expenditure growth trend for benchmarking.** **8. What are approaches for setting appropriate capitation rates?** I am convinced this will be educated guess with trial and error based on population data.

**8A. What are the advantages and disadvantages of using national expenditure growth trends?** It omits movements in technology or best practices based on population health.

**8B. What about for using a local reference expenditure growth trend instead?** Too much variation in geographic regions.

**12. What types of precautions should be taken by ACOs assuming full insurance risk to protect beneficiaries from potential marketing abuses limiting beneficiary freedom of choice? What are additional protections beyond those in Medicare Advantage that would be important for beneficiaries aligned to ACOs with full insurance risk to avoid adverse selection?** This could work very well in a sole community environment where one organization is the only major healthcare provider in a community. However if the program fails and risks the existence of the only provider in the community the entire healthcare infrastructure is at risk.

**Currently, beneficiaries are aligned to a Pioneer ACO through claims-based attribution. Pioneer ACOs are accountable for improved quality and lower expenditures for aligned beneficiaries.** **13. If Pioneer ACOs were at full insurance risk, should a beneficiary be allowed to elect alignment to a Pioneer ACO even if the beneficiary would not be aligned to the Pioneer ACO through the attribution methodology? Yes**

**13A. What are advantages/disadvantages of allowing beneficiaries to voluntarily align themselves to an ACO at full insurance risk rather than sole reliance on claims-based**

**attribution?** The ability for the existing healthcare entity to function as the main health resource for a community could be very positive.

**CMS has encouraged States to explore the use of integrated care models including ACOs for the care of Medicaid populations. 1. Should ACOs caring for Medicare outcomes also assume accountability for Medicaid outcomes? Yes**

**1A. Why or why not?** The bigger the pool the greater the chance for success.

**2. What populations should CMS prioritize in integrating accountability for Medicaid outcomes? (For instance, should ACOs be accountable for outcomes among all Medicare-Medicaid beneficiaries treated by the ACO historically? Or, should the ACO be accountable only for those Medicare-Medicaid beneficiaries over 65 years old or under 65? Alternatively, should the ACO be accountable for outcomes of all Medicaid beneficiaries as well as CHIP beneficiaries? Should they be accountable for all those beneficiaries residing in a specified geographic area, regardless of whether they had been cared for by the ACO?)**  
Pediatrics

**3. What should the role of States be in providing appropriate incentives to foster the development of an integrated care system?** Getting States involved could create several State line issues.

**Organization Name:** Marion Surgery Center

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**Phone Number:** 6189972578

**Please select the option that best describes you.:** Not part of a Medicare ACO or a Commercial ACO

**1. Would additional health care organizations be interested in applying to the Pioneer ACO Model? Yes**

**2. If additional applicants were solicited for the Pioneer ACO model, should CMS limit the number of selected organizations or accept all organizations that meet the qualifying criteria? Accept all organizations that meet the qualifying criteria**

**2A. What are the advantages and/or disadvantages of either approach?** Allow all that meet the criteria so that it is truly a competitive market place for healthcare costs. Limiting will increase healthcare costs because they will self refer and control all the dollars. It allows those that are innovative, cost conscious and high quality deliver a cost effective product. I must allow the flexibility for care to be directed to the appropriate setting. Example: there is no reason a cataract surgery should be reimbursed at \$1200 in a hospital setting, and \$891 in a outpatient surgery setting. Cataracts are one of the highest costs to the Medicare system. The only reason it should be done in a hospital if the patient has co-morbid conditions that put them at a higher risk and that should be clearly documented. All care needs to be done at the appropriate setting if we really want to control healthcare costs.

**1. Would being able to choose different FFS reduction amounts for Part A and Part B services be of significant importance when deciding to participate in the PBP? Yes**

**1A. Why or why not?** All should have A and B. A is for a patient with higher co-morbid conditions should get reimbursed more.

**2. Should CMS allow suppliers of DME equipment to be included on the list of participating Pioneer providers/suppliers that will receive reduced FFS payments? Yes**

**3. Should CMS reconsider the requirement that a Pioneer ACO generate a specified level of savings in previous years in order to be eligible to elect to receive PBPs, and instead establish clear requirements for financial reserves? Yes**

**3A. Why or why not?** It should not just be based on savings but quality data and appropriate coordination of care otherwise it will be abused for financial gain.

**4. Should any additional refinements be made to the current Pioneer ACO PBP policy? Yes**

- 1. Should CMS offer ACOs capitation with insurance risk, similar to Medicare Advantage organizations? Yes**
- 2. What categories of spending should ACOs at full insurance risk be responsible for? (For example: Medicare Parts A and B, Medicare Parts A, B, and D, or Medicare Parts A, B, and D and Medicaid for Medicare-Medicaid beneficiaries) Medicare A,B and D**
- 3. Are there services that should be carved out of ACO capitation? Why? no**
- 5. What key elements of the regulatory and compliance framework for Medicare Advantage should be adopted for ACOs assuming full insurance risk? What regulatory and compliance elements in Medicare Advantage would NOT be appropriate for ACOs assuming full insurance risk? Implants should not be included. They should be strictly at cost but would need to be pre-approved for implantation to help control costs.**
- 10. What benefit enhancements (e.g. reducing co-pays for services delivered by ACO providers) would be appropriate for ACOs at full insurance risk to offer to their patients and how would these benefit enhancements improve care outcomes? All patients should have a co-pay no matter how small to have skin in the game to control costs.**

**Organization Name:** Marshfield Clinic Health System

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**Phone Number:** 2027565027

**Please select the option that best describes you.:** Part of a Medicare ACO

**1. Should CMS offer ACOs capitation with insurance risk, similar to Medicare Advantage organizations? Yes**

**1A. What are the potential benefits and risks to the Medicare program and beneficiaries?**  
The following comments are submitted on behalf of the Marshfield Clinic Health System.

**5. What key elements of the regulatory and compliance framework for Medicare Advantage should be adopted for ACOs assuming full insurance risk? What regulatory and compliance elements in Medicare Advantage would NOT be appropriate for ACOs assuming full insurance risk?** There are certain aspects of the program that must be refined for CMS to continue to attract ACO participants. We recommend that CMS must be cautious not to overpromise regarding its capability to provide tools and resources necessary for effective participation in the ACO/MSSP programs. It is without question that Marshfield Clinic might have performed better in the PGP demonstration program if CMS' program data and measurement features were optimized. For the Marshfield Clinic an important lesson that we have learned is not to rely on CMS for accurate and timely data. CMS has not convinced Congress to make all of the resources necessary for CMS to buy or build the necessary data systems to supplement the population health objectives of the Triple Aim. CMS cannot assure that those resources will be there in coming years. If Congress does not provide the resources for CMS to improve its data and analytic capabilities, then CMS should show restraint in its claims regarding: Medicare Data to Calculate ACO Primary Service Areas Download files available Physician, Inpatient Facility, and Outpatient Facility ACO Program Application files Quality Measures and Performance Standards CMS can promote the movement toward value based care. CMS can also promote a program that facilitates a comfortable glide-path toward greater efficiency for organizations that are high dollar and high volume participants in the Medicare program. There are enormous opportunities for savings in this cohort of the provider population. At the same time however, CMS must be cautious not to thwart the good intentions of high value/low cost participants in the MSSP programs. CMS should be asking how it will distinguish between ACOs that are moving towards efficiency, and ACOs that have achieved efficiency and might be encouraged, supported, or incentivized to further integrate care and emphasize financial accountability, and coaxed towards full capitation. We support CMS ACO three major goals which are outlined in the RFI: • Increase integration of total Medicare and Medicaid expenditures and populations in accountability models; • Give providers more tools and resources to improve care outcomes and efficiency; and • Continue to preserve beneficiary freedom of choice in FFS Medicare. A. Transition to greater insurance risk We believe that the CMS objective for transitioning fee-for-service ACOs to full insurance risk is desirable but not



within CMS' current capabilities. We do not believe that the ACO model should necessarily shift to assumption of full risk. Instead, the model should be developed as a vehicle for provider accountability through shared risk, and CMS can test a range of models, including its current Pioneer approaches, with partial capitation and partial fee-for-service (FFS) payments. It could also consider a variant of a medical home model for ACOs, combining some portion of FFS payments with a monthly prepaid management fee, along with shared risk for performance. We suggest that CMS consider that when an ACO decides it can better serve its community as a fully-insured, full-risk model, it should be transitioned into the Medicare Advantage program. Monthly population based payments are much more desirable than fee for service reimbursement as an ACO, however the current ACO program is compromised by inadequate staffing, inaccurate data collection, data skills gaps, and protracted reconciliations of quality performance and the risk burden in the population. If CMS adds additional layers of complexity it will add expense, and may interfere with participants ability to effectively navigate from pure fee-for-service to a higher value-oriented capitation strategy. Modern medicine is moving in the direction of requiring an evidence basis for care protocols. The policies, regulations and decisions of CMS must also be grounded on evidence. Marshfield Clinic's demonstrated improvement in quality while working to decrease expenditures in the PGP Demonstration illustrates ongoing work in progress to achieve the Triple Aim thereby showing the promise of redesigning payment methodologies to tie incentives to results and value. The experience of Marshfield Clinic demonstrates that proactive and coordinated care can serve to improve the health of populations of patients while achieving large savings. To accomplish Patient-Oriented Quality Improvement Marshfield Clinic

- Developed best practice models for core conditions.
- Provided Continuing Medical Education opportunities.
- Instituted care management programs (i.e. 24/7/365 Nurse line and heart failure care management program).
- Provided population-based feedback for providers.
- Redesigned the EMR to be team-based and centered on the development of care plans.
- Developed a Population Economic Analysis Dashboard to understand and reduce unjustified variation in utilization of healthcare services
- Created Physician/Clinical Nurse Specialist regional teams.
- Rebased primary care as team-based and as the first contact for patients with health concerns in an efficient model focused on right care, right time, right place.
- Developed partnerships with other PGP demonstration sites to discuss effective care processes and review standards and approaches.
- Marshfield Clinic has 34 primary care sites recognized by NCQA as Level 3 Patient Centered Medical Homes.
- Embedded 45 Registered Nurse Care Coordinators into practice sites.
- Implemented care coordination and care management for chronic care and transitions of care.

These tools and resources are essential to facilitate program corrections to increase integration in the Medicare and Medicaid programs, where improvements in outcomes and efficiency must occur to maintain the health of the population and the long-term solvency of the programs. All of these activities have added value to the patient care continuum, but none are compensated. Our decision to enter into the Medicare Shared Savings Program was not taken lightly in that we recognized that "demand destruction" would likely occur to fee for service utilization. These activities position Marshfield Clinic for success in a full risk environment, but they result in significantly lower Medicare FFS revenue. Rebased of the benchmarks for each ACO turns these efficiency achievements into liabilities. Benchmarking to an internal baseline has advantages for systems with lots of opportunity (high utilizers) but is a liability for organizations that are further along the value-based path. CMS' rebasing methodology makes it continuously more difficult for efficient delivery systems to make forward progress on quality and cost. Information

management is not one of CMS' core competencies. CMS does not currently have the resources or tools to measure risk accurately. The HCC methodology currently utilized by CMS is not ideal in risk adjusting. CMS has not established and implemented appropriate criteria for quality performance. More appropriate benchmarks for quality are necessary. Some metrics need to be at or near 100% to achieve full quality scores which is not only impossible for a large system/ACO but is actually inappropriate, wasteful, and potentially harmful for patients. Some metrics are not evidence-based or NQF supported (Pre-HTN metric for example) and should not be utilized. There has also been incomplete alignment of metrics with other governmental metrics (HEDIS for example). CMS does not have the computational resources to assure fair, accurate, and timely reimbursement. Claims data has significant inaccuracies and is difficult to utilize in a meaningful way; and we have had difficulties in obtaining consistent answers to basic questions. Too long of a lag in feedback on quality and utilization/cost. CMS does not have the boots on the ground familiarity with patients to inspire or encourage desirable beneficiary choices. CMS' decision to require ACOs to provide beneficiaries an option to Decline to Share Personal Health Information has created mistrust and confusion among patients, some of whom have contacted their member of Congress for explanation. Beneficiaries should be engaged rather than frightened. How can Medicare beneficiaries in an ACO be of greater help in this effort? Beneficiaries need to have a "motivation" to be an active participant in their healthcare. There should be "rewards" for those that are engaged, seek appropriate preventative care, and seek appropriate care for chronic illnesses. Beneficiaries need to be incented to seek care within the ACO when possible, otherwise it is nearly impossible to control cost and ensure value. Beneficiaries and providers require access to a consistent set of metrics across programs in order to promote informed choices. CMS should advance steps to align cost, quality and patient experience metrics among ACOs, MA and Part D plans, and the FFS program. If an incentive program were put in place to recognize high performance across these three areas of metrics, it would be a powerful mechanism to drive accountability across the system. In summary we recommend that certain ACO Rules/policies be changed to enable us to be more effective in improving quality and reducing cost:

- More appropriate benchmarks for quality (some metrics need to be at or near 100% to achieve full quality scores which is not only impossible for a large system/ACO but is actually inappropriate and wasteful).
- Rebasing of the benchmarks for ACOs whose expenditures are below the national average is self-defeating for the program and the participants, making it continuously more difficult to make forward progress on quality and cost.
- HCC methodology is not ideal in risk adjusting.
- Claims data has significant inaccuracies and is difficult to utilize in a meaningful way.
- Too long of a lag in feedback on quality and utilization/cost.

We recognize that each of these recommendations/requests will require CMS to invest in new infrastructure, but each would add substantial value to what we believe is a very valuable national initiative. We are very impressed with CMS dedication to improving value, and look forward to opportunities to work with CMS to improve the program. We thank you for your consideration of our concerns. Brent Miller Director, Federal Government Relations  
Marshfield Clinic Health System 202-756-5027

**Organization Name:** McKenzie Health System

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**Please select the option that best describes you.:** Part of a Medicare ACO

**A provider-led community ACO would be an ACO that would be held accountable for total Medicare, Medicaid and CHIP expenditures, and quality outcomes, for all Medicare, Medicaid and CHIP beneficiaries residing in the ACO's service area, regardless of those beneficiaries' historical care patterns. 1. What are options for accountable care models that are geared specifically for geographically aligned populations of beneficiaries?**  
assignment of beneficiaries to the local health system, much easier to describe in rural zip codes.

**1A. What are the most critical design features of a provider-led community ACO model and why?** Patient Centered Medical Home designation is a natural precursor for a provider-led community ACO model.

**Organization Name:** MedChi Network Services

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**Last name:** Behm

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**Please select the option that best describes you.:** Part of a Medicare ACO

**1. Would additional health care organizations be interested in applying to the Pioneer ACO Model? Yes**

**1A. Why or why not?** Provider organizations are looking for guidance in order to transition to population-based health care models; the Pioneer ACO program is a clear opportunity to move away from fee for service.

**2. If additional applicants were solicited for the Pioneer ACO model, should CMS limit the number of selected organizations or accept all organizations that meet the qualifying criteria? Limit the number of selected organizations**

**2A. What are the advantages and/or disadvantages of either approach?** The major disadvantage to limiting organizations is the risk of discouraging potentially positive groups from applying and/or dismissing groups that appear less attractive but are in fact in a position to succeed. Balancing the risk of blocking good groups, however, is setting a selection process that ensures some moderate level of success of all selected groups. While qualifying criteria will vet most candidates, a further review/limiting of applicants would allow CMS to better define a target cohort for a second round of Pioneer ACOs. Perhaps this cohort would not consist entirely of large health systems, but could instead be independent physician-led groups as well.

**3. Other than the options for refining population-based payments outlined in Section B below, should any additional refinements be made to the Pioneer ACO Model that would increase the number of applicants to the Pioneer ACO model? Some start-up capital, similar to the Advance Payment model, would be vital for physician-led initiatives.**

**1. Would being able to choose different FFS reduction amounts for Part A and Part B services be of significant importance when deciding to participate in the PBP? Yes**

**1A. Why or why not?** Certain communities and provider mixes have more control over a service line and would therefore be able to take more risk for the cost.

**2. Should CMS allow suppliers of DME equipment to be included on the list of participating Pioneer providers/suppliers that will receive reduced FFS payments? No**

**2A. Why or why not?** There is still a lot of work that needs to be done around community-based primary care services and the program should avoid "watering down" these efforts.

**3. Should CMS reconsider the requirement that a Pioneer ACO generate a specified level of savings in previous years in order to be eligible to elect to receive PBPs, and instead establish clear requirements for financial reserves? Yes**

**3A. Why or why not?** Either option should be a viable way for an organization to demonstrate its ability to participate

**4. Should any additional refinements be made to the current Pioneer ACO PBP policy? Yes**

**4A. Why or why not?** Additional input and potential changes should always be part of evolving policy.

**1. Should CMS offer ACOs capitation with insurance risk, similar to Medicare Advantage organizations? Yes**

**1A. What are the potential benefits and risks to the Medicare program and beneficiaries?** The greatest potential is allowing ACOs to work creatively to improve quality with access to the fully captivated amount, rather than trying to affect care base on the margins of a fee for service system.

**2. What categories of spending should ACOs at full insurance risk be responsible for? (For example: Medicare Parts A and B, Medicare Parts A, B, and D, or Medicare Parts A, B, and D and Medicaid for Medicare-Medicaid beneficiaries)** Potentially all parts, depending on the community and abilities of the ACO.

**3. Are there services that should be carved out of ACO capitation? Why?** No; options and flexibility should be provided, but ultimately the way to control against poor quality and cost shifting is to make one group responsible for health care in its entirety.

**4. What type of agreements with non-ACO providers would the ACO need to adopt to take on full insurance risk for a beneficiary population?** Again, it depends on the ACO and community. At a minimum an ACO would have to build a referral network, including data use agreements. Ideally an ACO would also incentivize non-ACO providers on quality metrics.

**5. What key elements of the regulatory and compliance framework for Medicare Advantage should be adopted for ACOs assuming full insurance risk? What regulatory and compliance elements in Medicare Advantage would NOT be appropriate for ACOs assuming full insurance risk?** There likely are no elements in Medicare Advantage that are not appropriate for ACOs. Full regulatory neutrality would allow ACOs to use the same creative, evidence-based solutions that certain MA plans use, without the risk of losing payment all together

**6. What challenges would ACOs encounter in meeting state licensure requirements for risk-bearing entities? What types of waivers to current regulations and/or fraud and abuse laws, if any, would be necessary for ACOs to take on full insurance risk for a beneficiary population?** State-by-state research would have to be conducted to adequately answer this question.

**Medicare Advantage Organizations have significant infrastructure that ACOs do not currently have such as member services. 7. What additional infrastructure would ACOs need to develop to be able to manage full insurance risk?** Member service is a key component, along with utilization review (assuming the ACO is making direct payments)

**The Pioneer ACO program currently uses a national expenditure growth trend for benchmarking. 8. What are approaches for setting appropriate capitation rates?** Likely some combination between national growth trends, local cost benchmarks, and realistic discussions with the ACO entities. Ultimately, the capitation rates must adequately reflect cost and certain risks to care for a specific community.

**8A. What are the advantages and disadvantages of using national expenditure growth trends?** It is a clear and transparent method, but does not account for geographic nuance

**8B. What about for using a local reference expenditure growth trend instead?** Accounts for local factors and cost of living, but must be careful not to choose a sub-community that is not an accurate reference (for example, using the immediate area of a bedroom community for a city with higher expenditures).

**9. What are the advantages or disadvantages of different strategies for risk-adjustment? (Examples include demographic risk adjustment only and/or any of the Medicare Advantage risk adjustment methodologies.)** Any adjustment methodology runs the risk of being inaccurate. It would be best to choose one with as few other consequences as possible (for example, groups spending more time on coding rather than providing direct patient care).

**10. What benefit enhancements (e.g. reducing co-pays for services delivered by ACO providers) would be appropriate for ACOs at full insurance risk to offer to their patients and how would these benefit enhancements improve care outcomes?** Both reducing out-of-pocket costs and adding robust wraparound services would support patients. Better outcomes would come from one less barrier to seeking treatment (patient costs) and overall enhanced relationships with community-based health resources.

**10A. How would benefit enhancements differ depending on integration across Medicare Parts A, B, D, and/or Medicaid?** Ideally they would differ very little. Certain patients will have different incentives based on their primary place of treatment, but all patients want better provider relationships and customized health services.

**11. What are potential program integrity issues that ACOs transitioning to full insurance risk may encounter and what are appropriate preventative safeguards?** The largest risk is cost shifting and service denials. The way to avoid both is to make the ACO responsible for all healthcare in a community rather than segregate care into silos.

**12. What types of precautions should be taken by ACOs assuming full insurance risk to protect beneficiaries from potential marketing abuses limiting beneficiary freedom of choice? What are additional protections beyond those in Medicare Advantage that would be important for beneficiaries aligned to ACOs with full insurance risk to avoid adverse selection?** The protections within MA are likely adequate. Again, the key is to make an ACO

responsible for ALL aspects of care in a community, thereby avoiding the ability to adversely select or cost shift.

**Currently, beneficiaries are aligned to a Pioneer ACO through claims-based attribution. Pioneer ACOs are accountable for improved quality and lower expenditures for aligned beneficiaries. 13. If Pioneer ACOs were at full insurance risk, should a beneficiary be allowed to elect alignment to a Pioneer ACO even if the beneficiary would not be aligned to the Pioneer ACO through the attribution methodology? Yes**

**13A. What are advantages/disadvantages of allowing beneficiaries to voluntarily align themselves to an ACO at full insurance risk rather than sole reliance on claims-based attribution?** Voluntary alignment may lead to marketing to beneficiaries, but it would allow patients and providers to establish known relationships rather than waiting on a alignment that happens retroactively.

**Current laws and regulations allow ACOs to establish business arrangements with Part D sponsors in order to align incentives in support of improving care coordination and outcomes. 1. What factors, if any, pose barriers to the effectiveness of such collaborations? Are there any considerations, such as marketing considerations, that are relevant to the promotion of these business arrangements?** The largest barrier is the limited funding for ACOs and conflicting priorities. Many ACOs likely want to enter into business arrangements with Part D sponsors, but have not yet been able to because of the time and resources necessary to meet other demands of the ACO (care management, reporting, opt-out management, provider engagement, etc).

**1A. What could CMS do in administering an ACO program to help ACOs and sponsors mitigate or avoid these barriers?** Sample arrangements and support connecting ACOs to Part D sponsors would be helpful.

**2. Would ACOs be interested in and prepared to accept insurance risk as Part D sponsors or through contracting with pharmacy benefits management companies? No**

**2A. Why or why not?** Not yet, only because the ACO programs are so new. In the near term they likely will be prepared to accept insurance risk

**2B. If ACOs assume accountability for Part D expenditures, what are the advantages/disadvantages of CMS requiring ACOs to be licensed under state law as a risk bearing entity and relying on the current Part D bidding process, versus creating a unified expenditure target for Part A, B, and D combined, with a unified risk adjustment method?** Licensing would be one more barrier to a program that may not have interest or the ability to accepting separate Part D insurance risk.

**3. Do ACOs currently have access to enough data to accept full risk for Part D expenditures? Yes**

**3A. What other mechanisms would allow ACOs to assume accountability for Part D outcomes?** Better, more timely data sharing with pharmacy databases such as SureScripts.

**CMS has encouraged States to explore the use of integrated care models including ACOs for the care of Medicaid populations. 1. Should ACOs caring for Medicare outcomes also assume accountability for Medicaid outcomes? Yes**

**1A. Why or why not?** The same infrastructure and care management principles apply across both populations.

**2. What populations should CMS prioritize in integrating accountability for Medicaid outcomes? (For instance, should ACOs be accountable for outcomes among all Medicare-Medicaid beneficiaries treated by the ACO historically? Or, should the ACO be accountable only for those Medicare-Medicaid beneficiaries over 65 years old or under 65? Alternatively, should the ACO be accountable for outcomes of all Medicaid beneficiaries as well as CHIP beneficiaries? Should they be accountable for all those beneficiaries residing in a specified geographic area, regardless of whether they had been cared for by the ACO?)** The first population that ACOs should focus on is Dual Eligibles - they are currently unmanaged in most markets and are too vulnerable to cost shifting from groups that are not responsible for Part A and Part B spend. Additional groups, and eventually all Medicaid beneficiaries, should be integrated into ACOs.

**3. What should the role of States be in providing appropriate incentives to foster the development of an integrated care system?** States are in a unique position to provide global payments and community-based funding, rather than work with individual care providers. States and state-specific programs such as the Innovation Programs can target specific areas in an attempt to develop population-based initiatives in ways that competing hospitals and health systems cannot otherwise accomplish.

**3A. What roles should States play in supporting model design and implementation?** Depending on the state and needs within the state, they could support geographic targeting, design, implementation, and funding.

**3B. Do States have adequate resources to support an ACO initiative in collaboration with CMS?** Some may have adequate resources, although the political desire and understanding of complicated and shifting landscapes are likely a huge challenge.

**4. What are the current capabilities of ACOs and other providers in integrating and using Medicare FFS and Medicaid FFS data to drive care improvement and performance reporting?** Many ACOs are likely very capable. The infrastructure necessary for supporting population health, analytics, and reporting is translatable to many other groups; ACOs, in a sense, may serve as an impartial community utility to supply health information to providers and quality information to payers.

**4A. What are the capabilities of providers in integrating this data with electronic health records?** Integration with EHRs is extremely limited, although many ACOs likely have workarounds until interoperability becomes more prevalent.

**4B. What are the capabilities of integrating information for care received in the community or from other non-traditional care providers?** Again, limited, because it takes significant time and investment to establish the technology and partnerships.



**5. What financial arrangements would be most appropriate for ACOs assuming risk for Medicare and Medicaid expenditures? (Should CMS and States offer separate but coordinated shared savings arrangements to ACOs? Should CMS and States offer a unified shared savings arrangement that reflects combined Medicare and Medicaid expenditures?)**

Unified arrangements would prevent further isolation of payment programs and reduce the chances of misaligned or different incentives. So long as the programs are well-coordinated, it likely does not make a significant difference

**A provider-led community ACO would be an ACO that would be held accountable for total Medicare, Medicaid and CHIP expenditures, and quality outcomes, for all Medicare, Medicaid and CHIP beneficiaries residing in the ACO's service area, regardless of those beneficiaries' historical care patterns.** 1. **What are options for accountable care models that are geared specifically for geographically aligned populations of beneficiaries?** I'm not sure that I understand this question. Today, there are very few options because physician-led groups are at the mercy of state Medicaid programs and private payors to expand their attribution base and population health programs. Further, they are under resourced because a hospital or insurance company did not fund the significant up front costs and on-going operational expenses. One would like to see community providers of all types join together under an ACO program to receive incentives based on the triple aim; a community ACO could then be funded as a utility either at risk or without risk, depending on the market.

**1A. What are the most critical design features of a provider-led community ACO model and why?** The business plan is the largest struggle to date. There is currently no clear sustainability model for physician-led ACOs because one cannot rely on commercial contracts or future savings alone.

**1B. What additional quality measures should be considered if an ACO is responsible for all covered lives in a geographic area?** It would be interesting to see measures expand beyond traditional health care - housing, happiness, even graduation rates may be effective indicators of 'population health'.

**1C. Are there models to consider that better integrate community-based services beyond the traditional medical system?** There likely are, but it may also be important not to over-model the issue. It is universally accepted that behavioral and mental health has a huge effect on traditional health outcomes; issues like that can be solved through community-wide systems.

**In certain permissible circumstances, organizations are able to pursue multiple service delivery and payment reform initiatives.** 2. **Should CMS formalize an accountable care model where various service delivery and payment reform initiatives are combined?** Yes

**2A. More specifically, would there be interest in a model that tests comprehensive primary care within an ACO context and/or an ACO that incorporates episode-based payments?** Yes

**2B. If so, what would the most critical features of such a "layered" ACO be and why?** Simplicity! Physicians are apprehensive to embrace new and ambiguous models. Make a program simple and reasonable, and ACOs will be interested.

**1. How can CMS encourage the adoption of ACO contracts among other payers of Medicare ACOs?** Recommend clear, transparent, and fair contracting guidelines so payers and ACOs are in discussions on a fair playing field.

**2. How can CMS and other payers focus reporting of quality measures on the most important priorities while minimizing duplication and excess burden?** The reporting should not be a critical issue. Any IT system that can aggregate data should be able to report any measure desired. The bigger focus must be on supporting physicians to develop workflows that support data integrity and better patient health.

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**Please select the option that best describes you.:** Part of both a Medicare ACO and a Commercial ACO

**1. Would additional health care organizations be interested in applying to the Pioneer ACO Model? Yes**

**2. If additional applicants were solicited for the Pioneer ACO model, should CMS limit the number of selected organizations or accept all organizations that meet the qualifying criteria? Accept all organizations that meet the qualifying criteria**

**1. Would being able to choose different FFS reduction amounts for Part A and Part B services be of significant importance when deciding to participate in the PBP? No**

**2. Should CMS allow suppliers of DME equipment to be included on the list of participating Pioneer providers/suppliers that will receive reduced FFS payments? Yes**

**3. Should CMS reconsider the requirement that a Pioneer ACO generate a specified level of savings in previous years in order to be eligible to elect to receive PBPs, and instead establish clear requirements for financial reserves? No**

**4. Should any additional refinements be made to the current Pioneer ACO PBP policy? No**

**1. Should CMS offer ACOs capitation with insurance risk, similar to Medicare Advantage organizations? No**

**Currently, beneficiaries are aligned to a Pioneer ACO through claims-based attribution. Pioneer ACOs are accountable for improved quality and lower expenditures for aligned beneficiaries. 13. If Pioneer ACOs were at full insurance risk, should a beneficiary be allowed to elect alignment to a Pioneer ACO even if the beneficiary would not be aligned to the Pioneer ACO through the attribution methodology? Yes**

**2. Would ACOs be interested in and prepared to accept insurance risk as Part D sponsors or through contracting with pharmacy benefits management companies? No**

**3. Do ACOs currently have access to enough data to accept full risk for Part D expenditures? No**

**CMS has encouraged States to explore the use of integrated care models including ACOs for the care of Medicaid populations. 1. Should ACOs caring for Medicare outcomes also assume accountability for Medicaid outcomes? Yes**

**Organization Name:** National Rural ACO

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**Please select the option that best describes you.:** Part of a Medicare ACO

**Currently, beneficiaries are aligned to a Pioneer ACO through claims-based attribution. Pioneer ACOs are accountable for improved quality and lower expenditures for aligned beneficiaries. 13. If Pioneer ACOs were at full insurance risk, should a beneficiary be allowed to elect alignment to a Pioneer ACO even if the beneficiary would not be aligned to the Pioneer ACO through the attribution methodology?** Yes

**13A. What are advantages/disadvantages of allowing beneficiaries to voluntarily align themselves to an ACO at full insurance risk rather than sole reliance on claims-based attribution?** promotes beneficiary choice and encourages great customer service

**2B. If ACOs assume accountability for Part D expenditures, what are the advantages/disadvantages of CMS requiring ACOs to be licensed under state law as a risk bearing entity and relying on the current Part D bidding process, versus creating a unified expenditure target for Part A, B, and D combined, with a unified risk adjustment method?** a unified risk adjustment method allows small and rural providers to be accountable for part D

**3. Do ACOs currently have access to enough data to accept full risk for Part D expenditures?** No

**CMS has encouraged States to explore the use of integrated care models including ACOs for the care of Medicaid populations. 1. Should ACOs caring for Medicare outcomes also assume accountability for Medicaid outcomes?** Yes

**1A. Why or why not?** ACO infrastructure costs are largely fixed. Including more payors helps small ACOs and rural providers justify the expense. It also avoids creating health disparities between Medicare and Medicaid patients and potentially reduces the burden of duals.

**2. What populations should CMS prioritize in integrating accountability for Medicaid outcomes? (For instance, should ACOs be accountable for outcomes among all Medicare-Medicaid beneficiaries treated by the ACO historically? Or, should the ACO be accountable only for those Medicare-Medicaid beneficiaries over 65 years old or under 65? Alternatively, should the ACO be accountable for outcomes of all Medicaid beneficiaries as well as CHIP beneficiaries? Should they be accountable for all those beneficiaries residing in a specified geographic area, regardless of whether they had been cared for by the ACO?)** For populations served by small community health systems, such as rural, critical access and sole community hospitals with primary care services, it is ideal to assign as much of the population that is served by the system to the community health system as a "health home" to coordinate and manage care for its population.

**3. What should the role of States be in providing appropriate incentives to foster the development of an integrated care system?** Provide \$10 PMPM for care coordination activities and pay shared savings based on total costs. Support the community health system's ability to provide insurance for its community by providing data, technical support and simplifying cost and regulations.

**3A. What roles should States play in supporting model design and implementation?** Provide data and tools to analyze the data.

**4. What are the current capabilities of ACOs and other providers in integrating and using Medicare FFS and Medicaid FFS data to drive care improvement and performance reporting?** Many tools are available. They are expensive and out of reach for small providers. This is why providing a \$10PMPM for rural providers is so important, to offset some of the costs of the program. Cost-based reimbursement lags 18-24 months from expenditure, and is only partial reimbursement. If a rural provider buys these systems for the MSSP, and gets the typical 50% Medicare cost-based reimbursement based on share of discharges, they are still out of pocket the other 50%, even though the tools are only used for Medicare patients. The PMPM will be included in the total spend, so it is really a loan from CMS.

**4A. What are the capabilities of providers in integrating this data with electronic health records?** almost none. Interoperability is not real yet, and may never be.

**4B. What are the capabilities of integrating information for care received in the community or from other non-traditional care providers?** none

**5. What financial arrangements would be most appropriate for ACOs assuming risk for Medicare and Medicaid expenditures? (Should CMS and States offer separate but coordinated shared savings arrangements to ACOs? Should CMS and States offer a unified shared savings arrangement that reflects combined Medicare and Medicaid expenditures?)** please unify payments and harmonize quality measures

**A provider-led community ACO would be an ACO that would be held accountable for total Medicare, Medicaid and CHIP expenditures, and quality outcomes, for all Medicare, Medicaid and CHIP beneficiaries residing in the ACO's service area, regardless of those beneficiaries' historical care patterns.** **1. What are options for accountable care models that are geared specifically for geographically aligned populations of beneficiaries?** If a community health system provides >50% of primary care for a zip code, it should be designated as the "health home" for that zip code and be able to participate in a program similar to the MSSP. Other patients should be allowed to opt in. The ultimate goal would be for that community health system to be able to take risk for all payors and all residents of the community.

**1A. What are the most critical design features of a provider-led community ACO model and why?** \$10 PMPM to support infrastructure costs

**1B. What additional quality measures should be considered if an ACO is responsible for all covered lives in a geographic area?** Pediatric, generic drugs, neonatal, ED utilization

**1C. Are there models to consider that better integrate community-based services beyond the traditional medical system?** Additional \$2 PMPM earmarked for community services

**In certain permissible circumstances, organizations are able to pursue multiple service delivery and payment reform initiatives. 2. Should CMS formalize an accountable care model where various service delivery and payment reform initiatives are combined?** Yes

**2A. More specifically, would there be interest in a model that tests comprehensive primary care within an ACO context and/or an ACO that incorporates episode-based payments?**

Yes

**1. How can CMS encourage the adoption of ACO contracts among other payers of Medicare ACOs?** unify claims databases, require ACO participation for the safety net

**2. How can CMS and other payers focus reporting of quality measures on the most important priorities while minimizing duplication and excess burden?** send out for comment

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**Please select the option that best describes you.:** Part of a Medicare ACO

**A provider-led community ACO would be an ACO that would be held accountable for total Medicare, Medicaid and CHIP expenditures, and quality outcomes, for all Medicare, Medicaid and CHIP beneficiaries residing in the ACO's service area, regardless of those beneficiaries' historical care patterns. 1. What are options for accountable care models that are geared specifically for geographically aligned populations of beneficiaries?**

Community health systems that provide more than 50% of the primary care for a given zip code should be assigned all of the beneficiaries in that zip code.

**1A. What are the most critical design features of a provider-led community ACO model and why?** The community ACO should agree to act as the Medical Home for its community, coordinate care outside the community and provide comprehensive support for patients with 6 or more chronic diseases. This will provide the highest level of care for the community

**1B. What additional quality measures should be considered if an ACO is responsible for all covered lives in a geographic area?** Pediatric measures, generic drug utilization and ED utilization measures should be added.

**1C. Are there models to consider that better integrate community-based services beyond the traditional medical system?** The PCMH integrates community-based services, but does not pay for them. Community ACO's should be required to share up to 10% of the \$10 PMPM payment and shared savings with community resources that provide social support/food/transportation/behavioral

**In certain permissible circumstances, organizations are able to pursue multiple service delivery and payment reform initiatives. 2. Should CMS formalize an accountable care model where various service delivery and payment reform initiatives are combined? Yes**

**2A. More specifically, would there be interest in a model that tests comprehensive primary care within an ACO context and/or an ACO that incorporates episode-based payments? Yes**



**Organization Name: New York City Department of Health and Mental Hygiene**

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**12. What types of precautions should be taken by ACOs assuming full insurance risk to protect beneficiaries from potential marketing abuses limiting beneficiary freedom of choice? What are additional protections beyond those in Medicare Advantage that would be important for beneficiaries aligned to ACOs with full insurance risk to avoid adverse selection?** RESPONSE TO SECTION A QUESTION 13A: a. The impact of allowing a beneficiary to elect alignment to the Pioneer ACO even if the beneficiary would not be aligned to the Pioneer ACO through the attribution methodology would vary according to the attribution model selected by the ACO. The advantages and disadvantages of attribution methodologies have been much discussed as Pioneer ACO and other accountable care organizations are implemented. Adding the option of patient self-attribution would create additional complexity, though the overall impact of such a change in policy would depend on the actual numbers of patients who chose to self-attribute. For ACOs using a prospective attribution model, the addition of new beneficiaries after the start of the performance period could negatively affect strategies or initiatives developed by the ACO's providers to target their known panel composition. If the ACO has chosen a retrospective attribution period, the impact would depend on the criteria being used. If the beneficiary joined early in the performance period and met the standard attribution criteria, the impact would likely be minimal. However, if beneficiaries were not required to also meet certain utilization requirements, the impact might be greater. In either circumstance, we see the need for a balance between freedom of choice for beneficiaries and the need for ACOs to manage their care quality and costs.

**Currently, beneficiaries are aligned to a Pioneer ACO through claims-based attribution. Pioneer ACOs are accountable for improved quality and lower expenditures for aligned beneficiaries. 13. If Pioneer ACOs were at full insurance risk, should a beneficiary be allowed to elect alignment to a Pioneer ACO even if the beneficiary would not be aligned to the Pioneer ACO through the attribution methodology? Yes**

**Current laws and regulations allow ACOs to establish business arrangements with Part D sponsors in order to align incentives in support of improving care coordination and outcomes. 1. What factors, if any, pose barriers to the effectiveness of such collaborations? Are there any considerations, such as marketing considerations, that are relevant to the promotion of these business arrangements?** RESPONSE TO SECTION B QUESTION 3A: a. Accepting full risk for Part D expenditures requires timely and sufficient access to Part D data as

well as sufficient support for data management and processing. In order to effectively utilize Part D data to improve care quality and outcomes, ACOs must have access to reasonably complete data with minimal lag time. The currently monthly delivery may be sufficient for clinical use, however the lag time between the event and the delivery of the Part D data must fall within clinically relevant thresholds to fully support ACO activities. The ACO must then have sufficient staff resources and expertise to analyze the data, integrate the information gained with the Electronic Health Record (EHR), and ensure that relevant quality improvement programs have access to the information. Each of these may present barriers to use of such data; the technical process of integrating claims data with EHR data for quality improvement use is in itself a significant challenge. b. We agree that ensuring ACOs have access to Part D data and working to improve the timeframe for data delivery would support the overall goals of the organization; prescription drug utilization is well documented to affect ambulatory care-sensitive hospitalizations and other key health outcomes. However, we note that ACOs may not yet have routine, reliable access to Part D plan drug formularies. Access to formularies within the EHR would enable an ACO to develop best practices guidelines and educate providers on opportunities to reduce costs and improve care, as well as facilitating each provider's efforts to adhere to guidelines. Checking drug formularies within the EHR is currently a menu measure for eligible professionals working towards Meaningful Use attestation. We therefore suggest CMS explore opportunities to ensure that Part D plans provide updated, accessible formularies to ACO participants.

**3. Do ACOs currently have access to enough data to accept full risk for Part D expenditures? Yes**

**CMS has encouraged States to explore the use of integrated care models including ACOs for the care of Medicaid populations. 1. Should ACOs caring for Medicare outcomes also assume accountability for Medicaid outcomes? Yes**

**2. What populations should CMS prioritize in integrating accountability for Medicaid outcomes? (For instance, should ACOs be accountable for outcomes among all Medicare-Medicaid beneficiaries treated by the ACO historically? Or, should the ACO be accountable only for those Medicare-Medicaid beneficiaries over 65 years old or under 65? Alternatively, should the ACO be accountable for outcomes of all Medicaid beneficiaries as well as CHIP beneficiaries? Should they be accountable for all those beneficiaries residing in a specified geographic area, regardless of whether they had been cared for by the ACO?)**

RESPONSE TO SECTION C QUESTION 1A: a. We support the proposal to encourage ACOs to assume responsibility for Medicaid outcomes, but request clarification on the specific details of such an expansion of ACO responsibility. By using the infrastructure that Medicare ACOs have developed, CMS could expand access to the coordinated care delivered by ACOs to Medicaid beneficiaries in an efficient manner: now that ACOs are up and running, the additional effort required to expand services to additional populations will be much less than that required to stand up new ACO systems. However, an expanded ACO model would require support to develop expertise in newly targeted populations. We request clarification on the following aspects of a Medicaid ACO model: 1. Model Structure: Medicaid populations may have significantly different needs and present a different case mix, and ACOs may therefore need to develop new strategies, programs, and relationships to manage Medicaid outcomes. One option may be to use a staged model, mirroring the existing Shared Savings Models, which would allow

ACOs to shift from a one-sided to two-sided model after an initial period, thereby allowing time for the development of new expertise and resources. 2. Administrative structure: We also request clarification on the intended reimbursement and attribution processes, as Medicaid is a state-by-state program and includes both Fee-For-Service and Managed Care. Would ACOs be required to work with their State Medicaid office to determine the specifics for their state, or would CMS manage the reimbursement and attribution processes centrally? We are particularly interested in the planned administrative structure, as New York State Medicaid includes at least 15 managed care plans alongside Fee-For-Service, creating a potentially complicated landscape. If Medicare ACOs expand to include accountability for Medicaid outcomes, consistency in the model structure and administration will be important to minimize burden and maximize the ACO's ability to incorporate additional populations. 3. Relationship to existing programs: Would this proposal replace or build upon the Financial Alignment Initiatives currently underway in certain states? An integrated care model incorporating accountability for Medicaid outcomes would benefit from the lessons and experiences of the Financial Alignment Initiatives models currently being tested, however these demonstrations run through 2017. Many State Medicaid programs and Medicaid managed care organizations already have contracts with providers for related programs; we would appreciate insight into CMS's proposed approach to developing a coordinated Medicaid ACO program. Similarly, several states are currently exploring or implementing Medicaid ACO-type models, including New York State's Health Home model; would this proposed new model aim to incorporate or replace the existing programs? 4. Contract structure: We are unclear as to whether the goal is to create a combination Medicaid + Medicare ACO model in which the same ACO has accepted responsibility for all Medicaid and Medicare outcome, versus a model in which an ACO could choose Medicare only, Medicaid only, or both.

RESPONSE TO SECTION C QUESTION 2: a. We support the suggestion to prioritize dual-eligible beneficiaries treated by the ACO historically. Initially, prioritizing beneficiaries already treated by the ACO seems likely to ensure that the ACO is already familiar with the specific needs of the Medicaid beneficiaries being integrated into the ACO. Accepting accountability for all Medicaid beneficiaries as well as CHIP beneficiaries would represent a significant expansion of the ACO's overall risk and responsibility, and we suggest such an expansion may benefit from an initial 'pilot' period during which reimbursement, attribution, data access, and other administrative components can be tested and refined. Experiences from the existing Financial Alignment Initiative Demonstrations may be useful in facilitating the data access and other specific needs related to dual-eligible beneficiaries. The proposal to create accountability for all beneficiaries residing in a specified geographic area appears better suited to certain areas in which all or nearly all of the providers in a given region are members of the same ACO; we are not aware of a potential benefit to such an arrangement in geographic areas in which there are multiple ACOs and/or many non-ACO providers.

**3. What should the role of States be in providing appropriate incentives to foster the development of an integrated care system?** a. In considering the role of States in providing support, incentives, and other resources for ACO initiatives, we note that certain other organizations may be able to provide significant support to ACOs in coordination with both CMS and States. These include the Regional Extension Centers established to support the Meaningful Use EHR Incentive Program, which have developed expertise in providing support to practices and providers seeking to utilize Health Information Technology (HIT) to improve care; Regional Health Information Organizations, which can support ACO data needs through health information exchange; and, potentially, organizations under the new Quality

Improvement-specific QIO model recently proposed by CMS. While there will be substantial state-by-state variation, the integration of these existing resources with any additional resources, including multi-payer databases, can provide support to new ACO initiatives. These organizations may additionally be able to support efforts to integrate and streamline reporting requirements to ease the burden on individual practices and ensure high quality data and reporting. However, given the existence of Medicaid ACO and ACO-type models already underway in a number of states, the resources available to support new models may depend on the degree of integration with existing programs.

**4. What are the current capabilities of ACOs and other providers in integrating and using Medicare FFS and Medicaid FFS data to drive care improvement and performance reporting?** a. Integrating and using data from additional sources is a challenge for providers.

Community-based ACOs that include providers on multiple different EHRs face additional difficulties in sharing data across vendors. Integrating claims data received from external sources with EHR data for use in driving care improvement and performance reporting requires extensive technological capacity and knowledge, and may not be possible for most ACOs at this point in time. Promoting drivers of interoperability between vendors and across data sources will be of particular importance to ACOs as they seek to utilize claims and other data for quality improvement. Integrating information on care received in the community or from other non-traditional care providers is similarly difficult, particularly if the care provider in question does not use an EHR or, just as vital, Health Information Exchange (HIE). The process of patient matching remains a challenge even if data from multiple sources is available; without consistently effective and reliable patient matching methods, ACOs will not be able to meaningfully use FFS or other data in conjunction with EHR data. We suggest that CMS could play a role in promoting HIT overall, including EHR, and data analytics vendor capabilities regarding integrating multiple sources of data in addition to driving provider interest. Through the EHR Certification requirements and other programs, CMS has the opportunity to drive vendors to focus on interoperability over the longer term. However, as the EHR market matures, many providers will continue to use existing products and may not update to the latest versions within the timeframe needed to support the proposed new models. We therefore see a role for CMS in the shorter term in developing and promoting best practices for gathering and exchanging data from non-interoperable EHRs. Finally, in addition to the baseline technological capabilities required, we see a role for Regional Extension Centers or other quality-focused organizations to support ACOs in developing efficient, useful data management processes to support care improvement and quality reporting.

**A provider-led community ACO would be an ACO that would be held accountable for total Medicare, Medicaid and CHIP expenditures, and quality outcomes, for all Medicare, Medicaid and CHIP beneficiaries residing in the ACO's service area, regardless of those beneficiaries' historical care patterns. 1. What are options for accountable care models that are geared specifically for geographically aligned populations of beneficiaries?**

RESPONSE TO SECTION D QUESTION 2: a. In the experience of the New York City Regional Extension Center, providers are frequently interested in pursuing multiple quality improvement, quality reporting, service delivery, and payment reform initiatives. We therefore suggest that CMS should consider formalizing one or more models that explicitly combine various service delivery and payment reform initiatives. We would suggest that considering the financial, reporting, and other interactions among federal programs, e.g. Meaningful Use, ACO,

PQRS, State programs, e.g. Medicaid advanced primary care models, and non-governmental programs, e.g. Patient-Centered Medical Home, would be helpful for both CMS and for all stakeholders as these programs achieve wider adoption among providers. b. Key features for such a “layered” ACO would include alignment of program reporting requirements. One existing mechanism for such alignment is the inclusion of attainment of Meaningful Use as a measure for an ACO model. Broadly speaking, assessing whether reporting on a specified set of measures could be used for multiple programs as well as whether participation in one program could ‘count’ towards another would inform the most critical aspects of such programs. An existing example of such an effort is the 2013 PQRS-Medicare EHR Incentive Program Pilot, which would allow eligible professionals to meet the clinical quality measure requirement for the Medicare EHR Incentive Program and simultaneously meet the requirements for the PQRS program. Such formal integration further promotes provider engagement and clarifies the integral relationships among the various programs. RESPONSE TO SECTION E QUESTION 2: a. We strongly support overall efforts to focus quality reporting on top priorities, including focusing on areas of highest healthcare burden and addressing top causes of morbidity and mortality as well as of cost, while working to minimize duplication and excess burden. We see three inter-related areas in which CMS and other payers could focus to move these efforts forward. -Work with industry partners, e.g. America’s Health Insurance Plans, as well as State Medicaid to coordinate across plans on specific quality measures, thereby streamlining reporting requirements at the highest level. -Work with vendors to encourage development of HIT tools for easier reporting, e.g. by incorporating key measures into care coordination documents and focusing on interoperability among EHRs, to facilitate the actual calculation and reporting process both within ACO models and across Federal, State, and payer programs. -Working internally to expand the use of unified reporting systems like the Group Practice Reporting Option, to minimize duplication across various programs.

**In certain permissible circumstances, organizations are able to pursue multiple service delivery and payment reform initiatives. 2. Should CMS formalize an accountable care model where various service delivery and payment reform initiatives are combined? Yes**

**2A. More specifically, would there be interest in a model that tests comprehensive primary care within an ACO context and/or an ACO that incorporates episode-based payments?**

Yes

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**Please select the option that best describes you.:** Part of a Commercial ACO

**In certain permissible circumstances, organizations are able to pursue multiple service delivery and payment reform initiatives. 2. Should CMS formalize an accountable care model where various service delivery and payment reform initiatives are combined? Yes**

**2A. More specifically, would there be interest in a model that tests comprehensive primary care within an ACO context and/or an ACO that incorporates episode-based payments? Yes**

**2B. If so, what would the most critical features of such a “layered” ACO be and why?**  
Attribution/alignment methodology to specialty physicians, population-based cost reduction targets, defining the episode trigger to align with high risk patients, gainsharing to incentivize physicians to coordinate care, and timely data.

**Organization Name:** RUPRI Center for Rural Health Policy Analysis, U of Iowa

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**Please select the option that best describes you.:** Not part of a Medicare ACO or a Commercial ACO

**2. If additional applicants were solicited for the Pioneer ACO model, should CMS limit the number of selected organizations or accept all organizations that meet the qualifying criteria?** Accept all organizations that meet the qualifying criteria

**2A. What are the advantages and/or disadvantages of either approach?** CMS should accept all qualified applicants to be included in the Pioneer ACO demonstration. This approach will help CMS avoid bias toward large integrated organizations in the Pioneer ACO program. Further, CMS should solicit and carefully evaluate applications from organizations that are not traditional integrated systems, but have adopted innovative approaches for care coordination and demonstrated capacities for delivering accountable care. For example, smaller organizations may employ successful strategies, such as building clinical integration through contractual arrangements. There also may be advantages to unique local connections (such as integration with human services) that deserve evaluation in an ACO demonstration.

**1A. What are the potential benefits and risks to the Medicare program and beneficiaries?** We believe there would be few rural organizations willing to assume the risks involved. At this time, many rural providers do not have the volume, infrastructure, and reserves necessary for significant risk assumption.

**3. Are there services that should be carved out of ACO capitation? Why?** CMS may wish to carve out from cost calculation essential community services in particularly vulnerable places (e.g., remote rural or frontier areas) to assure continued access to those essential services.

**Medicare Advantage Organizations have significant infrastructure that ACOs do not currently have such as member services. 7. What additional infrastructure would ACOs need to develop to be able to manage full insurance risk?** CMS assistance analyzing and managing the data and insurance aspects of ACO initiatives (given CMS' economy of scale and data analytic capacity) will more efficiently advance the initiatives and ensure that resources efficiently improve local health care

**The Pioneer ACO program currently uses a national expenditure growth trend for benchmarking. 8. What are approaches for setting appropriate capitation rates?** The use of national expenditure growth trends for benchmarking may inadequately reflect costs (or savings) that are out of the ACO's control. More important than the growth trend is the method used to determine the unadjusted cost benchmark. Establishing the benchmark using historic

(local) cost data discriminates against historically efficient providers and may dissuade those providers from ACO participation. A better system would establish a blending of two financial performance goals: 1) an improvement goal (i.e., how well the ACO performs compared to the ACO beneficiaries' historic costs and cost growth), and 2) an achievement goal (i.e., how well the ACO performs compared to national costs and cost growth). With this blended method, ACOs remain accountable for continuously reducing costs, yet may be rewarded for historic efficiency.

**CMS has encouraged States to explore the use of integrated care models including ACOs for the care of Medicaid populations. 1. Should ACOs caring for Medicare outcomes also assume accountability for Medicaid outcomes? Yes**

**1A. Why or why not?** State variation in approaches to ACOs may preclude a single program developed from federal rules. Additionally, dual-eligible beneficiaries deserve attention. CMS may wish to offer up to 60% shared savings for these high-cost beneficiaries.

**2. What populations should CMS prioritize in integrating accountability for Medicaid outcomes? (For instance, should ACOs be accountable for outcomes among all Medicare-Medicaid beneficiaries treated by the ACO historically? Or, should the ACO be accountable only for those Medicare-Medicaid beneficiaries over 65 years old or under 65? Alternatively, should the ACO be accountable for outcomes of all Medicaid beneficiaries as well as CHIP beneficiaries? Should they be accountable for all those beneficiaries residing in a specified geographic area, regardless of whether they had been cared for by the ACO?)**

It is appropriate to consider care and accountability for a defined geographic area. However, the Pioneer Demonstration and the Medicare Shared Savings Program specifically require patient choice of providers. Furthermore, current beneficiary attribution methods make it difficult for rural ACOs to establish adequate beneficiary numbers. Therefore, without an opportunity to establish provider panels and expanded beneficiary inclusion; ACOs may be unable to assume risk for an entire geographically-defined population. However, an exception may exist if an ACO already cares for a significant proportion of a small geographically-defined area. Please see Section II, D, 1 below.

**3. What should the role of States be in providing appropriate incentives to foster the development of an integrated care system?** The State Innovation Models (SIMs) initiative should help answer the question of incentives to develop integrated care systems.

**4. What are the current capabilities of ACOs and other providers in integrating and using Medicare FFS and Medicaid FFS data to drive care improvement and performance reporting?** Accurate and timely performance data are critical for ACO success. However, even if sophisticated data are available, rural systems may not have the data analytic capacity necessary for advanced population health and cost management. Questions from ACOs regarding data analysis challenges should initiate CMS technical assistance and tool development to assist ACOs translate data into insight that improves care and lowers cost. Furthermore, ACOs require complete data for those they care for. Beneficiaries who “opt out” of data sharing should have their data blinded.



**A provider-led community ACO would be an ACO that would be held accountable for total Medicare, Medicaid and CHIP expenditures, and quality outcomes, for all Medicare, Medicaid and CHIP beneficiaries residing in the ACO's service area, regardless of those beneficiaries' historical care patterns.**

**1. What are options for accountable care models that are geared specifically for geographically aligned populations of beneficiaries?** It makes sense that an ACO be accountable for beneficiaries of additional health plans (e.g., Medicaid and CHIP). In fact, latitude within Medicaid's more comprehensive benefits (e.g., transportation) may allow testing of additional care management strategies. Review of Community Care Organizations, such as the Oregon Medicaid CCO program, would inform this discussion.

**Options for accountable care models:** As noted above, it may make sense for an ACO to be accountable for a defined geographic area. Rural provider-led ACOs (hospitals, physicians, and associated services) that provide the plurality of primary care to more than 75% of the population of a given ZIP Code Tabulation Area (ZCTA) should have the opportunity to be accountable for the entire ZCTA population. We also envision a situation in which a beneficiary received time- or episode-limited care at a distant location or provider. Yet that beneficiary identifies a local provider as his/her primary "medical home." In that situation, the beneficiary should have the opportunity to "opt in" to the local ACO. Thus, CMS should consider three options for beneficiary attribution to an ACO: 1) plurality of primary care service allowed charges (as currently), 2) beneficiary "opt in," and 3) an entire ZCTA population if the ACO already cares for greater than 75% of the ZCTA population attributed by either of the prior two methods.

**Critical provider-led ACO design features:** Many consider the patient centered medical home (PCMH) as fundamental for ACO success. However, we do not yet know which of the PCMH characteristics directly improve clinical quality, community health and control costs. Therefore, CMS should continue to include (and eventually expand) clinical quality, patient experience, population health, care coordination, and cost control in its ACO initiatives outcome measures.

**Additional quality measures:** Additional measures to consider include pediatric clinical care, obstetric clinical care, hospital care, generic drug utilization, expanded care coordination, readmissions, and emergency department utilization. However, proper "field" testing of new measures and harmonization with multiple other measurement requirements (e.g., value-based modifier, Hospital Compare, Joint Commission, etc.) is essential.

**Models that better integrate community-based services:** The PCMH integrates community-based services, but does not pay for them. The ACO program could be combined with the Care Coordination demonstration to provide additional per capita financial support for care coordination activities. CMS should allow ACOs to share a portion of the Care Coordination payment with human services providers to provide social support, food, transportation, and/or behavioral and mental health services for the most vulnerable patients. To integrate community-based services and the traditional medical care, rural communities need the ability to move funding across the care continuum that includes both health and human services. As the ACO program matures, more robust human services performance metrics are needed. Lessons from PACE program could inform this issue.

**In certain permissible circumstances, organizations are able to pursue multiple service delivery and payment reform initiatives.**

**2. Should CMS formalize an accountable care model where various service delivery and payment reform initiatives are combined?** Yes

**2A. More specifically, would there be interest in a model that tests comprehensive primary care within an ACO context and/or an ACO that incorporates episode-based payments?**

Yes

**2B. If so, what would the most critical features of such a “layered” ACO be and why?** CMS should encourage inclusive governance structures to include providers not engaged in primary ambulatory care. Examples are critical access hospitals (CAHs), skilled nursing care facilities, and home health providers.

## Organization Name: St. Louis Physician Alliance

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Please select the option that best describes you.: Not part of a Medicare ACO or a Commercial ACO

**1. Would additional health care organizations be interested in applying to the Pioneer ACO Model? No**

**1A. Why or why not?** The patient attribution is of concern and the lack of the need to stay within the ACO network

**2. If additional applicants were solicited for the Pioneer ACO model, should CMS limit the number of selected organizations or accept all organizations that meet the qualifying criteria? Accept all organizations that meet the qualifying criteria**

**2A. What are the advantages and/or disadvantages of either approach?** The disadvantage would be to have too many in a single market and patients moving from ACO to ACO. The advantage would be to have a larger sample size for cost savings.

**3. Other than the options for refining population-based payments outlined in Section B below, should any additional refinements be made to the Pioneer ACO Model that would increase the number of applicants to the Pioneer ACO model? Informing the patients they are in the ACO and requiring them to stay within the provider network**

**1. Would being able to choose different FFS reduction amounts for Part A and Part B services be of significant importance when deciding to participate in the PBP? Yes**

**2. Should CMS allow suppliers of DME equipment to be included on the list of participating Pioneer providers/suppliers that will receive reduced FFS payments? Yes**

**2A. Why or why not?** The alignment with a large portion of the MSK spend would be important

**3. Should CMS reconsider the requirement that a Pioneer ACO generate a specified level of savings in previous years in order to be eligible to elect to receive PBPs, and instead establish clear requirements for financial reserves? Yes**

**3A. Why or why not?** There should be immediate upside for the providers

**4. Should any additional refinements be made to the current Pioneer ACO PBP policy? No**

**1. Should CMS offer ACOs capitation with insurance risk, similar to Medicare Advantage organizations? Yes**

**1A. What are the potential benefits and risks to the Medicare program and beneficiaries?** The capitated model creates patient advocates as the physicians engage to a deeper level in the patients care

**2. What categories of spending should ACOs at full insurance risk be responsible for? (For example: Medicare Parts A and B, Medicare Parts A, B, and D, or Medicare Parts A, B, and D and Medicaid for Medicare-Medicaid beneficiaries)** Medicare Parts A and B

**3. Are there services that should be carved out of ACO capitation? Why?** Emergency room visits due to the difficulty in managing

**4. What type of agreements with non-ACO providers would the ACO need to adopt to take on full insurance risk for a beneficiary population?** Fee for service

**6. What challenges would ACOs encounter in meeting state licensure requirements for risk-bearing entities? What types of waivers to current regulations and/or fraud and abuse laws, if any, would be necessary for ACOs to take on full insurance risk for a beneficiary population?** The rules around integration should be revisited given that the providers are under risk. Coordination and alignment among separate legal entities is essential

**Medicare Advantage Organizations have significant infrastructure that ACOs do not currently have such as member services. 7. What additional infrastructure would ACOs need to develop to be able to manage full insurance risk?** Large scale IT infrastructure that is expensive

**The Pioneer ACO program currently uses a national expenditure growth trend for benchmarking. 8. What are approaches for setting appropriate capitation rates?** an approach that accounts for the market

**8A. What are the advantages and disadvantages of using national expenditure growth trends?** it is not specific to the population

**8B. What about for using a local reference expenditure growth trend instead?** That would be more appropriate

**10. What benefit enhancements (e.g. reducing co-pays for services delivered by ACO providers) would be appropriate for ACOs at full insurance risk to offer to their patients and how would these benefit enhancements improve care outcomes?** Zero co-pays for network providers and penalties for out of network visits

**11. What are potential program integrity issues that ACOs transitioning to full insurance risk may encounter and what are appropriate preventative safeguards?** denial of care. Patient satisfaction and health outcome measurements are essential

**Currently, beneficiaries are aligned to a Pioneer ACO through claims-based attribution. Pioneer ACOs are accountable for improved quality and lower expenditures for aligned beneficiaries. 13. If Pioneer ACOs were at full insurance risk, should a beneficiary be**

**allowed to elect alignment to a Pioneer ACO even if the beneficiary would not be aligned to the Pioneer ACO through the attribution methodology? No**

**13A. What are advantages/disadvantages of allowing beneficiaries to voluntarily align themselves to an ACO at full insurance risk rather than sole reliance on claims-based attribution?** the patient is aware of the network and the providers

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**Please select the option that best describes you.:** Not part of a Medicare ACO or a Commercial ACO

**1. Would additional health care organizations be interested in applying to the Pioneer ACO Model? Yes**

**1A. Why or why not?** Please see response below

**2. If additional applicants were solicited for the Pioneer ACO model, should CMS limit the number of selected organizations or accept all organizations that meet the qualifying criteria?** Accept all organizations that meet the qualifying criteria

**2A. What are the advantages and/or disadvantages of either approach?** Our work with providers indicates that there are currently few organizations that are interested in participating as a Pioneer ACO outside of those who expressed interest in the initial round of the program. Generally, providers who are interested in moving more aggressively towards assuming risk find the Medicare Advantage (MA) program to be a more attractive option than the MSSP or Pioneer ACO programs. However, our experience also indicates that there are some circumstances where an organization's market may not offer a good opportunity for creation of an MA plan or where participation as a Pioneer better aligns with a provider's overall market strategy. As such, we do believe that there may be a small number of providers with new interest in joining the program. With regard to organizations who may be more inclined to pursue an MA plan, providers typically find creation of an MA plan more appealing because that model provides a number of additional program benefits. For instance, a provider pursuing an MA plan can lock patients into its own network and has more flexibility in strategically developing its benefit design. Establishing an MA plan also gives providers a stronger financial incentive for closely managing their beneficiary population. Finally, by using the open enrollment period and the ability to market to beneficiaries, MA plans build a more specific infrastructure around clinical needs of a community or targeted population. We see little risk or downside to allowing unlimited growth in the Pioneer ACO program. In fact, as noted in the previous response, we anticipate that the number of new providers interested in participating in the program may be relatively small so the risk of enrolling too many providers is slim to none.

**3. Other than the options for refining population-based payments outlined in Section B below, should any additional refinements be made to the Pioneer ACO Model that would increase the number of applicants to the Pioneer ACO model?** Improved attribution, targeted care models, enhanced financial incentives and multipayer alignment

**1A. Why or why not?** CMS should identify as many opportunities as possible for offering flexibility to providers considering participation in a shared savings or capitation model in order to make the program appealing and effective.

**2. Should CMS allow suppliers of DME equipment to be included on the list of participating Pioneer providers/suppliers that will receive reduced FFS payments? Yes**

**2A. Why or why not?** While we believe that some providers may encounter challenges in contracting with a DME supplier, and the degree of savings potential from such contracts will vary, we cannot identify any reason why CMS would refrain from offering this option to an ACO.

**3. Should CMS reconsider the requirement that a Pioneer ACO generate a specified level of savings in previous years in order to be eligible to elect to receive PBPs, and instead establish clear requirements for financial reserves? Yes**

**3A. Why or why not?** Given the complexity of establishing an effective care model and aligning providers, it may take time to generate significant savings even if an ACO is performing well. This option affords an ACO multiple options for moving forward.

**1. Should CMS offer ACOs capitation with insurance risk, similar to Medicare Advantage organizations? Yes**

**1A. What are the potential benefits and risks to the Medicare program and beneficiaries?** Our research and experience with providers indicates that in order to sustain a long term shift to population health and risk-based contracting, providers must have an overwhelming majority of its patient population in a risk-based payment contract.

**2. What categories of spending should ACOs at full insurance risk be responsible for? (For example: Medicare Parts A and B, Medicare Parts A, B, and D, or Medicare Parts A, B, and D and Medicaid for Medicare-Medicaid beneficiaries)** Offering providers the greatest amount of flexibility in assuming risk will create the best chance for success, and our experience indicates that most providers would be comfortable with assuming risk in Medicare Parts A, B and D.

**3. Are there services that should be carved out of ACO capitation? Why?** CMS may consider exempting highly specialized or expensive procedures, such as transplantation and dialysis, from capitation where attributing primary care physicians have little ability to deflect the cost of care.

**4. What type of agreements with non-ACO providers would the ACO need to adopt to take on full insurance risk for a beneficiary population?** An ACO would need a comprehensive contracting strategy with providers outside of the organization to ensure that beneficiaries participating in its insurance model have access to an adequate network of services.

**Medicare Advantage Organizations have significant infrastructure that ACOs do not currently have such as member services. 7. What additional infrastructure would ACOs need to develop to be able to manage full insurance risk?** An ACO that chooses to assume

full insurance risk would need to make significant investments in additional organizational capabilities such as network contracting, claims processing, plan marketing and enrollment, member customer service and management an

**The Pioneer ACO program currently uses a national expenditure growth trend for benchmarking.** 8. **What are approaches for setting appropriate capitation rates?** The advantages of setting capitation rates with a national expenditure growth trend, like the one currently employed in the Medicare Shared Savings Program, include encouraging care providers in areas with already low spending and cost growth to participate in ACOs. For these providers, generating savings is easier with a national benchmark because they only need to maintain their current level of efficiency to keep spending below the benchmark. Nonetheless, it also important to recognize two caveats though: (1) if national health care spending growth is too slow or even negative, providers with historically low spending would find realization of benchmark-level growth more difficult because it would represent a larger percentage of per beneficiary spending, and (2) some providers in regions with low health care spending may benefit from a national benchmark solely by virtue of local market trends. Employing a national expenditure trend may to a smaller degree have the opposite effect on providers with high cost growth, discouraging participation (relative to a local expenditure benchmark) as these providers would face a more difficult challenge slowing growth enough to generate sufficient savings to earn a bonus. By using local expenditure growth as reference for setting benchmarks, CMS would encourage providers in markets with high cost growth to participate in ACOs. These providers would be more likely to participate under this approach because the benchmark would be higher than the national average in markets with historically higher cost growth, making it easier to generate savings sufficient to yield a bonus payment. Conversely, with this approach, providers in markets with low cost growth will be more hesitant to participate because their performance will be measured against a relatively lower benchmark. To some extent, using a local benchmark would generate more savings for the Medicare program (by giving less efficient providers more incentive to participate in ACOs) while using a national benchmark rewards and supports those providers who have already developed highly efficient care models. Allowing ACOs to select either a national or local benchmark would maximize participation in the ACO program, providing a path to shared savings for both high- and low-efficiency providers.

**8A. What are the advantages and disadvantages of using national expenditure growth trends?** See question above

**8B. What about for using a local reference expenditure growth trend instead?** See question above

**Currently, beneficiaries are aligned to a Pioneer ACO through claims-based attribution. Pioneer ACOs are accountable for improved quality and lower expenditures for aligned beneficiaries.** 13. **If Pioneer ACOs were at full insurance risk, should a beneficiary be allowed to elect alignment to a Pioneer ACO even if the beneficiary would not be aligned to the Pioneer ACO through the attribution methodology?** Yes

**13A. What are advantages/disadvantages of allowing beneficiaries to voluntarily align themselves to an ACO at full insurance risk rather than sole reliance on claims-based attribution?** By allowing this voluntary alignment, CMS empowers a patient to ensure his or her



affiliation with a selected organization and provides an incentive to the providers to actively seek and manage beneficiaries in their communities.

**2. Would ACOs be interested in and prepared to accept insurance risk as Part D sponsors or through contracting with pharmacy benefits management companies? Yes**

**2A. Why or why not?** Including Medicare Part D in a capitated payment rate for a MSSP ACO could provide a significant cost savings by allowing providers to aggressively manage drug utilization using tools like generic substitution and medication therapy management

**3. Do ACOs currently have access to enough data to accept full risk for Part D expenditures? No**

**3A. What other mechanisms would allow ACOs to assume accountability for Part D outcomes?** While providers currently have some patient prescription data available, it is not a reliable and comprehensive resource. A PBM relationship or plan sponsor arrangement is needed to gain a full picture of the patient's needs and utilization.

**CMS has encouraged States to explore the use of integrated care models including ACOs for the care of Medicaid populations. 1. Should ACOs caring for Medicare outcomes also assume accountability for Medicaid outcomes? Yes**

**1A. Why or why not?** There is a significant opportunity to drive quality improvements and cost savings including Medicaid. By aligning quality metrics and coordinating Medicare and Medicaid beneficiaries, providers will be able to better able to use meaningful interventions.

**2. What populations should CMS prioritize in integrating accountability for Medicaid outcomes? (For instance, should ACOs be accountable for outcomes among all Medicare-Medicaid beneficiaries treated by the ACO historically? Or, should the ACO be accountable only for those Medicare-Medicaid beneficiaries over 65 years old or under 65? Alternatively, should the ACO be accountable for outcomes of all Medicaid beneficiaries as well as CHIP beneficiaries? Should they be accountable for all those beneficiaries residing in a specified geographic area, regardless of whether they had been cared for by the ACO?)**

We believe that the dual-eligible population and individuals with disabilities covered by Medicaid will have the most opportunity for improved quality and reduced inappropriate care utilization through improved coordination and alignment of providers.

**3. What should the role of States be in providing appropriate incentives to foster the development of an integrated care system?** We believe states have tremendous capacity to drive market behavior but there will be challenges to incorporating the Medicaid program in a shared savings model given the individual state program requirements and dynamics that inherent in the program. CMS will need a process to facilitate coordination with the states to ensure stability of the funding levels and rate structures within Medicaid for providers taking on risk for this population. CMS should consider an MSSP program design that allows states the ability to either formally cooperate with the MSSP program or yield some of the Medicaid operations to the program to ensure a functional shared savings model. Such a program should also incorporate a program design that contemplates the incorporation of community health resources as part of the ACO infrastructure.

**3B. Do States have adequate resources to support an ACO initiative in collaboration with CMS?** This will be a complex undertaking in terms of data sharing and claims processing so states will need additional resources to effectively manage this collaboration between the state and federal government and providers.

**1. How can CMS encourage the adoption of ACO contracts among other payers of Medicare ACOs?** In order to drive availability of aligned commercial risk-based contracts, CMS should partner to offer incentives to plans offered through programs such as the federal health insurance exchanges, MA, FEHB and Medicaid.

**2. How can CMS and other payers focus reporting of quality measures on the most important priorities while minimizing duplication and excess burden?** CMS should start by convening commercial payers, Medicaid, MA, and FEHB to standardize metrics, how they are measured, how they are reported, etc. and push for adoption so that providers can quickly align multiple programs based upon a reliable framework

## Organization Name: UnityPoint Health

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**Please select the option that best describes you.:** Part of both a Medicare ACO and a Commercial ACO

### **1. Would additional health care organizations be interested in applying to the Pioneer ACO Model? Yes**

**1A. Why or why not?** It is clear that health care payment is moving toward capitated or risk bearing incentive payments. The SGR policy agreement of Congress has made this abundantly clear. The Pioneer program gives providers a chance to pilot new delivery and payment optio

### **2. If additional applicants were solicited for the Pioneer ACO model, should CMS limit the number of selected organizations or accept all organizations that meet the qualifying criteria? Limit the number of selected organizations**

**2A. What are the advantages and/or disadvantages of either approach?** Our Pioneer program has benefited from the TLC it has received from CMS. Smaller programs allow CMS to nurture the models and ensure success. Ultimately, if the programs are successful other providers will be willing to engage in similar models of care in and out of the Pioneer program. Receiving timely and meaningful data has been a limiting factor in the Pioneer program. Current Pioneers are concerned that this problem will be exaceberated with the addition of more Pioneers.

### **3. Other than the options for refining population-based payments outlined in Section B below, should any additional refinements be made to the Pioneer ACO Model that would increase the number of applicants to the Pioneer ACO model? Yes, we have written extensive comments on this and sent them to MedPAC. They include improvements to data sharing and analyses, permanance of fraud and abuse waivers, improvement in communication with beneficiaries, change in attribution model, and more**

### **1. Would being able to choose different FFS reduction amounts for Part A and Part B services be of significant importance when deciding to participate in the PBP? Yes**

### **2. Should CMS allow suppliers of DME equipment to be included on the list of participating Pioneer providers/suppliers that will receive reduced FFS payments? Yes**

**2A. Why or why not?** We need payment incentives that encourage all providers/suppliers in the care continuum to participate in the ACO

**3. Should CMS reconsider the requirement that a Pioneer ACO generate a specified level of savings in previous years in order to be eligible to elect to receive PBPs, and instead establish clear requirements for financial reserves? Yes**

**3A. Why or why not?** low cost states are not experiencing high levels of savings because of the current methodology, if the methodology were changed it would be fine to maintain the requirement

**4. Should any additional refinements be made to the current Pioneer ACO PBP policy? Yes**

**4A. Why or why not?** please reference our comments submitted to Mark Miller, Executive Director of MedPac

**1. Should CMS offer ACOs capitation with insurance risk, similar to Medicare Advantage organizations? Yes**

**1A. What are the potential benefits and risks to the Medicare program and beneficiaries?** Providers would be excellent at operating programs directly under a MA structure; beneficiaries would benefit through a more direct relationship with their provider and heightened engagement in their health status

**2. What categories of spending should ACOs at full insurance risk be responsible for? (For example: Medicare Parts A and B, Medicare Parts A, B, and D, or Medicare Parts A, B, and D and Medicaid for Medicare-Medicaid beneficiaries) A, B and D**

**3. Are there services that should be carved out of ACO capitation? Why?** No, carving out services maintains silos and fights against care coordination principles

**4. What type of agreements with non-ACO providers would the ACO need to adopt to take on full insurance risk for a beneficiary population?** joint ventures, partnership, employment relationship, independent contractor and vendor relationship, utilization of insurance license potentially

**5. What key elements of the regulatory and compliance framework for Medicare Advantage should be adopted for ACOs assuming full insurance risk? What regulatory and compliance elements in Medicare Advantage would NOT be appropriate for ACOs assuming full insurance risk?** Provider led ACOs need to have the same freedom MA plans have in controlling network/incenting patients to stay in network; voluntary attribution; ability to negotiate with government on pricing; direct and free communication with beneficiaries  
Separate set of metrics on reserves; quality metrics need to be defined directly with providers; data sharing needs to be upgraded; attributes of ACO programs need to be integrated into a new hybrid model combining the best of MA and best of ACO

**6. What challenges would ACOs encounter in meeting state licensure requirements for risk-bearing entities? What types of waivers to current regulations and/or fraud and abuse laws, if any, would be necessary for ACOs to take on full insurance risk for a beneficiary population?** FRAUD AND ABUSE WAIVERS 1. Application of MSSP Waivers to Value-

Based Payor Arrangements with Commercial Payors Under the “Final Waivers in Connection With the Shared Savings Program” (the “Waivers”), certain fraud and abuse laws are only waived in connection with an MSSP accountable care organization and to the extent a legal entity is both an MSSP accountable care organization and participates in value-based payor arrangements with commercial payors, the waiver protections only expressly apply to the MSSP-related activities of the accountable care organization (see, e.g., 76 Fed. Reg. 67992, 68006 (Nov. 2, 2011)). The Interim Final Rules states: We recognize that ACOs participating in the Shared Savings Program may also receive similar performance-based payments from commercial plans and that those payments may reflect care coordination, quality improvement, and cost effectiveness activities similar to those promoted by the Shared Savings Program. However, at this time, we are not persuaded that a specific waiver for such payments is necessary ... [and] we lack adequate basis for identifying comparable private payer arrangements of ACOs that would be subject [to waiver protections.] UPH providers, like many other health care providers, apply one evidence-based standard of care to all of their patients regardless of a patient’s payor (or lack thereof). The absence of waivers expressly applicable to arrangements with commercial payors places a substantial potential obstacle to providing better care for patients and populations. Similarly, efforts to implement evidence-based clinical protocols that result lower growth in expenditures are needed for all health care costs regardless of payors. According to the Congressional Budget Office (“CBO”), spending on health care in the United States has grown on average faster than the nation’s economic output per person by almost two percentage points per year for the past several decades. In addition, the CBO has identified growth in spending on health care programs as “one of the central fiscal challenges facing the federal government.” Costs cannot be most effectively contained if the waivers do not expressly apply to value-based payor arrangements with commercial payors. For example, some beneficiaries may have both coverage through a Federal health care program, but also have other coverage or supplemental coverage through a commercial payor. In fact, the language of the Interim Final Rule implicitly acknowledges this situation when it states: Shared savings or similar performance-based payments received from a commercial plan do not necessarily implicate the fraud and abuse laws; however, in some circumstances, funds are calculated or used in downstream arrangements in ways that influence the referring of, or ordering for, Medicare or other Federal health care program patients. Because of this frequently commingling of Federal health care programs and commercial payor coverage for all or part of a beneficiaries’ care, the lack of clear application of waivers to value-based payor arrangements with commercial payors is an important obstacle to achieving the Triple Aim. Accordingly, we would recommend the express application of the Waivers to commercial payor arrangements.

2. State Fraud and Abuse Laws and the Waivers In addition to federal regulations protecting against fraud and abuse in the health care system, many states also have similar fraud and abuse regulations (see, e.g., Iowa False Claims Act, Iowa Code Section 685; Illinois Insurance Claims Fraud Prevention Act, 740 ILCS 92/1). The Waivers only apply to federal regulations. Thus, activities that might further the Triple Aim and be permitted under a Waiver may still subject an accountable care organizations and/or participants in an accountable care organization to state regulatory scrutiny. To enable accountable care organizations to undertake the type of actions that will move health care toward the Triple Aim, we recommend adoption of regulations under which the Waivers also preempt any state fraud and abuse regulations for accountable care organizations and their participants who are in good standing with the MSSP. In the event an accountable care organization either left the MSSP or was no longer in good standing, that entity

would once again be subject to any of the federal or state laws waived by the Waivers. 3. Additional IRS Guidance on Tax Treatment of Activities Undertaken Pursuant to Waivers The Interim Final Rule clearly states that “nothing in this IFC affects the obligations of individuals or entities, including tax-exempt organizations, to comply with the [Internal Revenue Code] or other Federal or State laws or regulations.” The Internal Revenue Service (“IRS”) has provided some guidance regarding the tax treatment of activities taken in connection with the MSSP (see, e.g., IRS Notice 2011-20). Establishing a successful accountable care organization will require partnership of a number of different health care providers, some of which will be tax-exempt organizations and some which will not be. In addition, many accountable care organizations may be limited liability companies to enable for-profit and tax-exempt organizations to work together more easily. We agree that it is important that an accountable care organization not become a vehicle by which tax-exempt entities attempt to circumvent protections against private inurement and private benefit. Accordingly, additional guidance from the IRS on the tax treatment of accountable care organizations (both governmental and commercial) and earnings of participants in accountable care organizations would be welcomed. For example clarification on the following matters would be valuable: • What activities of an accountable care organization further a tax-exempt accountable care organization participants’ charitable purpose, particularly in light of the fact that to achieve the Triple Aim it may be necessary to engage non-traditional participants in health care (e.g., transportation companies, food industry, employers, for-profit and tax-exempt health care providers) • What non-MSSP activities conducted by or through an accountable care organization may constitute unrelated business income, particularly in light of our position above that Waivers should apply to both governmental and commercial accountable care organizations if we are to achieve the Triple Aim. • Whether activities in which benefits are provided pursuant to a Waiver to either: (1) Medicare beneficiaries; or (2) entities providing services to an accountable care organization (e.g., hospitals, nursing homes, pharmacies, physicians), are subject to any “rebuttable presumption”-like protections when reviewed by the IRS. 4. Patient Incentive Waiver The activities of health care providers encouraged under MSSP transforms the role of providers from merely delivery of health care services to more actively managing a patient’s well-being. This new role for health care providers demands that they take steps to encourage changes in behavior by patients that will result in improved health for patients and lower health care expenditures. Currently, the MSSP restricts an accountable care organization’s ability to engage in these types of activities to only in-kind incentive. In contrast, a managed care organization can utilize a much broader array of tools to incentivize changes in behavior of patients, in particular patients with chronic conditions. Similarly, managed care organizations can utilize a myriad of preventive actions that would not be permitted for an accountable care organization or a health care provider who provides services to beneficiaries of an accountable care organization. For example, immunizations which may have a co-pay or deductible likely cannot be provided to MSSP beneficiaries, whereas they likely could be provided by a managed care organization. Accordingly, we recommend the MSSP reconsider its limitations on the ability to provide patient incentives that could transform care to achieve the Triple Aim so that Medicare beneficiaries are not at a disadvantage compared to other patients, both whom need preventative care and better management of chronic conditions.

**Medicare Advantage Organizations have significant infrastructure that ACOs do not currently have such as member services. 7. What additional infrastructure would ACOs need to develop to be able to manage full insurance risk? Data analytic capacity**

**The Pioneer ACO program currently uses a national expenditure growth trend for benchmarking. 8. What are approaches for setting appropriate capitation rates?** Using national expenditure for bench marking makes sense to us when comparing reimbursement rates; regional growth trends should be used in measuring updates

**8A. What are the advantages and disadvantages of using national expenditure growth trends?** As a low cost state we do not want to engage in a model that continues the geographic disparity of Medicare payments that currently exists between states like Iowa and Florida or New York; the formula eventually agreed upon should not perpetuate this

**8B. What about for using a local reference expenditure growth trend instead?** As stated, that makes sense for growth trend but not for base rates of reimbursement

**10. What benefit enhancements (e.g. reducing co-pays for services delivered by ACO providers) would be appropriate for ACOs at full insurance risk to offer to their patients and how would these benefit enhancements improve care outcomes?** lower co-pays; premiums for staying in network; better care coordination

**10A. How would benefit enhancements differ depending on integration across Medicare Parts A, B, D, and/or Medicaid?** The more services included the more seamless care delivery will become

**11. What are potential program integrity issues that ACOs transitioning to full insurance risk may encounter and what are appropriate preventative safeguards?** a new regulatory structure needs to be developed to ensure that patients are not cherry picked into ACO full risk programs

**12. What types of precautions should be taken by ACOs assuming full insurance risk to protect beneficiaries from potential marketing abuses limiting beneficiary freedom of choice? What are additional protections beyond those in Medicare Advantage that would be important for beneficiaries aligned to ACOs with full insurance risk to avoid adverse selection?** a beneficiary appeals process which is quick and accessible should be developed

**Currently, beneficiaries are aligned to a Pioneer ACO through claims-based attribution. Pioneer ACOs are accountable for improved quality and lower expenditures for aligned beneficiaries. 13. If Pioneer ACOs were at full insurance risk, should a beneficiary be allowed to elect alignment to a Pioneer ACO even if the beneficiary would not be aligned to the Pioneer ACO through the attribution methodology?** Yes

**13A. What are advantages/disadvantages of allowing beneficiaries to voluntarily align themselves to an ACO at full insurance risk rather than sole reliance on claims-based attribution?** Beneficiaries are more engaged, providers can communicate with beneficiaries better, care is more coordinated, beneficiaries maintain "choice", providers better able to contain cost

**2. Would ACOs be interested in and prepared to accept insurance risk as Part D sponsors or through contracting with pharmacy benefits management companies?** Yes

**3. Do ACOs currently have access to enough data to accept full risk for Part D expenditures?** No

**3A. What other mechanisms would allow ACOs to assume accountability for Part D outcomes?** 340B pricing for all populations

**CMS has encouraged States to explore the use of integrated care models including ACOs for the care of Medicaid populations. 1. Should ACOs caring for Medicare outcomes also assume accountability for Medicaid outcomes?** Yes

**1A. Why or why not?** The models should be aligned in payment structure and incentive, and in quality metrics, this creates an ease of health care delivery for providers when separate infrastructures do not need to be created for different governmental payors

**2. What populations should CMS prioritize in integrating accountability for Medicaid outcomes? (For instance, should ACOs be accountable for outcomes among all Medicare-Medicaid beneficiaries treated by the ACO historically? Or, should the ACO be accountable only for those Medicare-Medicaid beneficiaries over 65 years old or under 65? Alternatively, should the ACO be accountable for outcomes of all Medicaid beneficiaries as well as CHIP beneficiaries? Should they be accountable for all those beneficiaries residing in a specified geographic area, regardless of whether they had been cared for by the ACO?)**  
It matters less what the assigned population is as long as the providers have a prospective idea of who is in the population and meaningful data on the previous cost of care for that specific population; also meaningful if the provider has a sufficient network to meet the care needs of the defined population

**3. What should the role of States be in providing appropriate incentives to foster the development of an integrated care system?** Yes, Medicaid and Medicare programs need to move in tandem

**3A. What roles should States play in supporting model design and implementation?** Large

**3B. Do States have adequate resources to support an ACO initiative in collaboration with CMS?** No, not currently

**4. What are the current capabilities of ACOs and other providers in integrating and using Medicare FFS and Medicaid FFS data to drive care improvement and performance reporting?** capabilities are very low, not just of providers but of insurers and of CMS; this is a new capability being developed in the country; insurers have traditionally had the largest data analytic capacity but have used it only to look at claims cost and set premiums to make a profit; no entity has been using analytic capability to expertly perform population health initiatives

**4A. What are the capabilities of providers in integrating this data with electronic health records?** low but increasing quickly

**4B. What are the capabilities of integrating information for care received in the community or from other non-traditional care providers?** low but increasing quickly



**5. What financial arrangements would be most appropriate for ACOs assuming risk for Medicare and Medicaid expenditures? (Should CMS and States offer separate but coordinated shared savings arrangements to ACOs? Should CMS and States offer a unified shared savings arrangement that reflects combined Medicare and Medicaid expenditures?)**

No, programs care for very different populations; while programs move in concert separate contractual relationships for the populations should be maintained

**A provider-led community ACO would be an ACO that would be held accountable for total Medicare, Medicaid and CHIP expenditures, and quality outcomes, for all Medicare, Medicaid and CHIP beneficiaries residing in the ACO's service area, regardless of those beneficiaries' historical care patterns.** 1. **What are options for accountable care models that are geared specifically for geographically aligned populations of beneficiaries?** We will again emphasize that we believe the best approach for both Medicare and Medicaid is a new ACO regulatory structure which maintains the best attributes of the MSSP and Pioneer programs (provider led, patient centeredness, Triple Aim, quality metrics) with attributes of an MA program (voluntary attribution, embellished ability to incent patients, have relationships with other providers and vendors that are not hampered by regulations of the old world medical structure, capitated payments)

**1A. What are the most critical design features of a provider-led community ACO model and why?** alignment of the full continuum of care and inclusion of community public health services; social determinants of health need to be considered and factored into care plans

**1B. What additional quality measures should be considered if an ACO is responsible for all covered lives in a geographic area?** partnership with community public health entities

**1C. Are there models to consider that better integrate community-based services beyond the traditional medical system?** the ACO model is not traditional and could integrate community-based services

**In certain permissible circumstances, organizations are able to pursue multiple service delivery and payment reform initiatives.** 2. **Should CMS formalize an accountable care model where various service delivery and payment reform initiatives are combined?** Yes

**2A. More specifically, would there be interest in a model that tests comprehensive primary care within an ACO context and/or an ACO that incorporates episode-based payments?**  
Yes

**2B. If so, what would the most critical features of such a "layered" ACO be and why?** a reimbursement structure that incents all specialists to participate

**1. How can CMS encourage the adoption of ACO contracts among other payers of Medicare ACOs?** creating competition between risk bearing provider led ACOs and traditional insurance products

**2. How can CMS and other payers focus reporting of quality measures on the most important priorities while minimizing duplication and excess burden?** private insurance

plans should be required to adhere to the same quality metrics as the Medicare and Medicaid programs

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**Please select the option that best describes you.:** Part of both a Medicare ACO and a Commercial ACO

**1. Would additional health care organizations be interested in applying to the Pioneer ACO Model? Yes**

**1A. Why or why not?** Because the MSSP, with new baselines set every 3 years, is not sustainable model, we need to have additional options to move toward more population-based payments.

**2. If additional applicants were solicited for the Pioneer ACO model, should CMS limit the number of selected organizations or accept all organizations that meet the qualifying criteria? Accept all organizations that meet the qualifying criteria**

**1. Would being able to choose different FFS reduction amounts for Part A and Part B services be of significant importance when deciding to participate in the PBP? Yes**

**1A. Why or why not?** Different organizations will have varying levels of comfort with PBPs, so maximizing flexibility may alleviate some concerns.

**1. Should CMS offer ACOs capitation with insurance risk, similar to Medicare Advantage organizations? Yes**

**1A. What are the potential benefits and risks to the Medicare program and beneficiaries?** The inability to directly encourage local use of providers continues to limit providers willingness to move toward higher levels of risk. CMS should seriously consider how to preserve beneficiary choice that lets individuals choose how they align with ACOs

**Medicare Advantage Organizations have significant infrastructure that ACOs do not currently have such as member services. 7. What additional infrastructure would ACOs need to develop to be able to manage full insurance risk?** Many ACOs will need to engage with a TPA. Additionally, actuarial risk assessment is likely a new capability for most ACOs, and may be an opportunity for the insurance industry to create services to enhance the capabilities of ACOs.

**Currently, beneficiaries are aligned to a Pioneer ACO through claims-based attribution. Pioneer ACOs are accountable for improved quality and lower expenditures for aligned beneficiaries. 13. If Pioneer ACOs were at full insurance risk, should a beneficiary be allowed to elect alignment to a Pioneer ACO even if the beneficiary would not be aligned to the Pioneer ACO through the attribution methodology? Yes**

**13A. What are advantages/disadvantages of allowing beneficiaries to voluntarily align themselves to an ACO at full insurance risk rather than sole reliance on claims-based attribution?** This would require that beneficiaries self-limit their freedom to use services outside their chosen ACO network, at least for the period of enrollment (e.g., calendar year).

**2. Would ACOs be interested in and prepared to accept insurance risk as Part D sponsors or through contracting with pharmacy benefits management companies? Yes**

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**Please select the option that best describes you.:** Part of a Commercial ACO

**2A. What are the advantages and/or disadvantages of either approach?** I am writing on behalf of URAC, a nationally recognized accrediting entity, to offer suggestions in response to a Request for Information (RFI) posted on the Centers for Medicare and Medicaid Innovation webpage, entitled “Evolution of ACO Initiatives at CMS.” URAC’s accreditation programs span the health care spectrum and include a Clinical Integration Accreditation program which may provide insight into the path toward greater clinical and financial integration. CMS RFI seeks responses on how the ACO model can be enhanced through greater participation in the Pioneer ACO Model. In addition, the RFI solicits new ACO models that would transition to greater insurance risk; integrate accountability for Medicare Part D expenditures; integrate accountability for care outcomes for Medicare populations; increase accountability and encourage the formation of multi-payer ACOs. Unfortunately, Medicare risk contracts with both health plans and provider groups over the past few decades have produced, at best, variable results. In fact, while quality scores are improving across participants bearing risk, many organizations have struggled with the financial aspects of risk arrangements. A more comprehensive review of Medicare’s experience in promoting risk sharing would seem to argue for policymakers to investigate ways to assure that greater clinical and financial integration is established before entities enter into risk arrangements. A recent article published in Health Affairs by David Auerbach, et al., titled “Accountable Care Organization Formation is Associated with Integrated System but Not High Medical Spending” offers interesting insights into the formation of ACOs which may also prove useful. Key factors associated with successful ACO formation are: a higher degree of hospital risk sharing, the presence of larger integrated hospital systems, and a higher percentage of primary care physicians practicing in large integrated groups. The study states, “In the thirty-one regions with at least 20 percent of Medicare fee-for-service beneficiaries in an ACO, more than half of hospitals had a joint venture with physicians or physician groups and were affiliated with a health system. In low-ACO areas, the rates of physician joint ventures and health system affiliations were only 30-40 percent.” The study notes that ACOs are highly concentrated in some regions of the U.S, while nearly none exist in other regions. The authors further point out that if ACOs deliver on the promise of better care coordination, improved patient experience, and lower total costs of care then policymakers will be particularly concerned about Medicare beneficiaries’ access to them. The question of whether provider integration actively facilitates ACO formation will need to be studied over time but early indications point to a positive correlation. Therefore, the study concludes that policies that encourage clinical integration could also encourage ACO development. As a result, CMS should also consider the creation of policies that encourage clinical integration in areas of the country where ACOs have been slow to form. URAC’s Clinical Integration Accreditation

program may serve as a resource. These standards represent the first set of industry best practices, created in consultation with industry experts and health system leaders. They serve to validate that clinical integration efforts are quality and outcomes-based, structurally sound and patient centered. These attributes (along with others) are central to the ability to accept insurance risk. The standards are designed to educate and independently validate that primary care, specialty care and health systems are integrating in a way that ensures they are establishing a high degree of interdependence and cooperation, while avoiding anti-trust complications that could erode a payer's ability to successfully negotiate risk-based contracts. URAC appreciates the opportunity to offer comment in response to this RFI, and hopes this information is helpful. Please do not hesitate to contact Michele Johnson, Director of Government Relations and Public Policy at (202) 962-8835 or [mjohnson@urac.org](mailto:mjohnson@urac.org), if URAC can be of further assistance.

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**Please select the option that best describes you.:** Not part of a Medicare ACO or a Commercial ACO

**1. Would additional health care organizations be interested in applying to the Pioneer ACO Model? Yes**

**1A. Why or why not?** ACOs bring together primary care providers and acute care providers to achieve better outcomes, better patient experiences and better manage health care costs through new healthcare delivery systems.

**2. If additional applicants were solicited for the Pioneer ACO model, should CMS limit the number of selected organizations or accept all organizations that meet the qualifying criteria? Accept all organizations that meet the qualifying criteria**

**2A. What are the advantages and/or disadvantages of either approach?** ACOs bring together primary care providers and acute care providers to achieve better outcomes, better patient experiences and better manage health care costs through new healthcare delivery systems. ACOs share in both savings and risk based on benchmarks for outcomes, quality and cost effectiveness. The management of care, particularly of post-acute care and chronic conditions, is critical to the success of ACOs and to the Medicare and Medicaid programs as a whole. The home health model closely aligns with the goals of ACOs to: 1) provide beneficiary choice by providing care in home settings; 2) dramatically improve care coordination for beneficiaries, particularly high-risk patients; 3) ensure high quality and 4) deliver cost-effective care. Home health and hospice agencies provide unique expertise to ACOs to ensure better outcomes for post-acute and chronically ill patients at risk of hospitalization. VNAA supports the opportunity for additional health care organizations to apply to the Pioneer ACO model. VNAA believes that there is no “one size fits all” model and those communities with varied needs, demographics and resources require different approaches to achieve improved care coordination and health outcomes. VNAA believes that CMS should accept all organizations that apply for and meet the qualifying criteria. Advantages to such an approach include the ability for varied communities to develop partnerships and health teams that best meet the needs of the communities and utilize available, skilled health care delivery resources. VNAA believes that a key refinement to the current Pioneer ACO Population Based Payment Policy (PBP) is the addition of home health care providers as recognized Pioneer providers to receive payments on submitted and payable claims for the services furnished to align Pioneer beneficiaries. A November 2013 Evaluation of CMMI Accountable Care Organization Initiatives by L&M Policy Research, which focused on Pioneer ACOs, noted that spending for home health may reflect efforts by organizations to substitute home health episodes for acute care stays. The report notes that several ACOs, located

in the Boston area, anticipate that improved coordination or formalization of their collaboration with home health agencies will improve cost control in later performance years.

**5. What key elements of the regulatory and compliance framework for Medicare Advantage should be adopted for ACOs assuming full insurance risk? What regulatory and compliance elements in Medicare Advantage would NOT be appropriate for ACOs assuming full insurance risk?** VNAA strongly supports expansion of ACO opportunities, especially for home health and hospice agencies. VNAA makes the following recommendations to achieve that goal:

1. The Department of Health and Human Services should formally recognize home health and hospice agencies as safety-net providers in ensuring access to care in underserved rural and urban areas and for low-income beneficiaries as it has done with FQHCs and RHCs. While FQHC and RHC play an important role, only home health and hospice providers can deliver critical care to homebound and terminal patients.
2. Allow home health and hospice agencies to establish and lead their own ACOs. Federal guidance should establish the inclusion of home health and hospice agencies, either at the formation of an ACO or during an ACO performance year. The Affordable Care Act specifies that certain groups of providers of services and suppliers (including physicians and hospitals) may form their own ACO as long as they meet the eligibility criteria, including minimum beneficiary assignment. The statute permits the Secretary to use discretion to permit other Medicare providers of services and suppliers to form their own ACO. The Secretary should facilitate the leadership and engagement of home health and hospices in ACOs.
3. ACOs should receive an increased percentage of savings based on the percentage of their beneficiaries who visit a home health or hospice agency during the performance year. Shared-savings only models should receive an additional two percentage points and shared-risk-savings models should receive up to an additional five percentage points. ACOs receive an increased percentage of savings based on the percentage of their beneficiaries who visit a FQHC at least once during the performance year. Models based on shared savings only receive an additional two percentage points during the first year of agreement while shared savings-risk models receive up to an additional five percentage points.
4. Consider waivers of certain Medicare regulations to facilitate inclusion of home health and hospice agencies in ACOs. ACOs provide waivers for certain federal regulations to allow for demonstration of models that would not otherwise be possible. Consideration of waivers should include waiving the homebound requirement for home health services and the required three-day hospital stay prior to admission to a skilled nursing facility. ACOs should also consider a waiver for Outcome and Assessment Information Set (OASIS) or if use of an abbreviated version is appropriate.
5. Provide funding and incentives to home health and hospice agencies to participate in ACOs to facilitate the use of health information technology. In addition, CMS should consider paying for certain services not allowable under the current Medicare benefit such as an initial assessment visit. Provide funding and incentives to home health and hospice agencies to participate in ACOs to facilitate the use of health information technology (HIT). Physicians and hospitals already receive incentive funding for HIT, which is essential in care coordination. In addition, CMS should consider paying for certain services not allowable under the current Medicare benefit such as an initial assessment visit.
6. CMMI should provide additional funding to address issues related to interoperability of health information systems in ACO models. The ability to provide coordinated care across a system is limited and vulnerable to fragmentation when ACO participants cannot share information. For example, home health agencies could upload quality measure data into the medical home EMR so that it "counts" for ACO quality measure collection. Providing funding to ensure interoperability would



significantly reduce duplication of effort and enhance timely care coordination. 7. Quarterly performance reports should break out individual organization performance accurately so that participants in an ACO are able to monitor progress. CMS quarterly reports to ACOs provide data in the aggregate form with no data for individual providers. Financial shared savings models require analysis of several elements, such as risk scoring, that individual providers may not receive until end of year reconciliation. Without detailed quarterly data, individual providers have a difficult time tracking and predicting performance. Quarterly performance reports should break out individual organization performance accurately so that participants in an ACO are able to monitor progress and make necessary adjustments. 8. CMMI should provide additional guidance and templates for data use agreements to fast track adoption by ACOs. These templates could then be used by ACOs meet the needs of their individual organization. Data Use Agreements (DUA) between ACOs and providers are new territory. Independently, ACOs are purchasing legal assistance to construct agreements that allow for appropriate sharing of information. CMMI could eliminate duplication of effort by providing guidance and templates on data use agreements that individual ACOs could customize to meet their needs. Development of the guidance and templates should occur as part of a consensus process with ACOs. 9. Conduct a study on clinical risk adjustment with input from stakeholders, to address both clinical and socio-economic factors not previously considered in ACO models. Consider factors identified by VNAA's study on vulnerable patients. There is currently significant variation regarding how ACOs view clinical risk adjustments or stratification. For example, some ACOs may incorporate socio-economic factors while others do not. CMMI should convene a stakeholders group and devote time and attention to fully addressing clinical risk adjustment for beneficiaries enrolled in an ACO. VNAA's Vulnerable Patient Study identified clinical and socio-economic characteristics of high-cost home health patients. This needs further examination as part of the ACO model. 10. CMMI should sponsor national meetings and educational conference calls that foster exchange of "lessons learned" and "best practices" across different ACOs and demonstration models. Programs should include targeted discussions on the unique role of home health and hospice. CMS should provide resources and regular meeting opportunities to allow for information sharing that will provide benefit to both current and new ACOs. 11. CMMI should convene a meeting of stakeholders currently participating in multiple ACOs or other CMMI payment reform demonstrations to provide input on problems and solutions related to healthcare delivery and distribution of shared savings. After receiving input, CMMI should provide opportunity for additional comments before publishing ACO guidance designed to assist providers who participate in multiple ACOs and other potentially intersecting demonstrations.

**12. What types of precautions should be taken by ACOs assuming full insurance risk to protect beneficiaries from potential marketing abuses limiting beneficiary freedom of choice? What are additional protections beyond those in Medicare Advantage that would be important for beneficiaries aligned to ACOs with full insurance risk to avoid adverse selection?** • VNA Health Care in Connecticut played an active role in Hartford HealthCare (HHC)'s application to become an ACO in 2013. HHC is a five-hospital system which employees 300 physicians, has a post-acute network of home health, hospice and skilled nursing facilities and a behavioral health network. HHC, which collaborated with Integrated Care Partners to engage both employed and community physicians in providing primary care for patients, is a Medicare Shared-Savings Program (MSSP). The ACO targeted a population of about 9,500 Medicare fee-for-service patients and is reporting and improving on 33 quality

metrics. It created a designated care-management team with six care-manager RNs, two care-coordinator assistants and one social worker to follow to support the top ten percent high-risk patients with histories of frequent admissions and emergency department visits. ICP is also actively seeking risk contracts from commercial payers and currently manages another 10,000 Medicare advantage lives. VNA Health Care “lessons learned” include improved ways to identify high-risk patients, importance of care coordinators and the need for resources to address behavioral, social, functional and pharmaceutical needs of patients.

- Concord Regional VNA in New Hampshire partnered with the Dartmouth Hitchcock Medical Center pioneer ACO in February of 2012 to conduct an in home medication reconciliation visit by a home health nurse to assess a hospitalized patient with chronic illness medications. An analysis of DHMC Patients in their Concord NH clinic site showed that 45% of patients were re-hospitalized within five days of discharge due to medication related issues. During the first year of implementation of this medication reconciliation visit 204 patients received a home visit identifying 161 medication discrepancy related to the patient and 182 discrepancies due to other provider related issues. Over the pilot year the provider related issues frequently were due to the primary care provider not having an accurate updated medication profile for the patient due to the number of providers (specialist and hospitalist) who had cared for the patient, along with lack of interoperability between the physician electronic medical records. In addition Concord Regional VNA is an active member of the Concord/Elliott Medicare Shared Savings ACO providing a wide array of essential services to beneficiaries and expanding a palliative care program into the community, skilled nursing facilities and into patient’s home for those with life limiting illness.
- VNA Care Network Foundation (VNACNF) in Massachusetts, including its subsidiaries VNA Care Network & Hospice and VNA of Boston & Affiliates, is a member of Atrius Health. Atrius Health was designated as a Pioneer ACO in 2011 and has about 35,000 aligned Medicare beneficiaries in the Pioneer model. Formed in 2004, Atrius Health is a non-profit alliance of six community-based medical groups and a home health care, private duty nursing, and hospice agency. In addition to VNA Care Network Foundation, Atrius Health includes Dedham Medical Associates, Granite Medical Group, Harvard Vanguard Medical Associates, Reliant Medical Group, South Shore Medical Center and Southboro Medical Group. The organization represents more than 1,000 physicians and over 3,000 other health professionals, serving over one million patients across Eastern and Central Massachusetts. Shortly after being named an ACO, Atrius Health, recognizing the key role of home health care for a successful ACO and its own goal of improving health among populations, developed a strategic alignment with VNA Care Network & Hospice. The home health and hospice care organization became a formal member of Atrius Health in February 2013. VNACNF works closely with the Atrius Health ACO including participating in ACO workgroups, embedding case managers into the physician practices, developing standards for referrals to and communication with VNACNF, and co-developing clinical programs. In the first phase of work, the ACO and VNACNF have developed expectations for communicating care plans including patients’ care preferences along the life continuum, facilitating follow up appointments with PCP within seven days of hospital discharge and collecting key ACO quality metrics including fall risk assessment, medication review and depression screen. The ACO saw outstanding results in quality measures during this phase and overall is seeing positive trends regarding key indicators for cost efficiencies, including reducing preventable re-hospitalizations for ACO patients with home health care services with telehealth.
- The Visiting Nurse Service of New York (VNSNY) is the largest not-for-profit home- and community-based health care organization in the United States. VNSNY currently provides

home care services in seven counties in New York State and specific health plan services in as many as 33 counties. On any given day, VNSNY provides more than 70,000 patients and health plan members with direct and coordinated care. VNSNY continues to build a network of strategic partnerships with ACOs throughout the greater New York area to improve quality, reduce avoidable costs and enable people to function as independently as possible in the community. In 2013, VNSNY received over 2,000 referrals from hospital and physician-based ACOs, including one Pioneer ACO. In one such partnership with a hospital-based MSSP ACO, VNSNY staff, including a certified population care coordinator and geriatric nurse practitioner, regularly collaborates with the ACO on in-depth multi-disciplinary evaluations of high-risk patients to determine care gaps and system-based improvement opportunities, in addition home care oriented training and education to ACO Care Coordinators. VNSNY is also exploring opportunities to provide population care coordination services to several physician-based ACO groups and engage in shared savings arrangements. In addition to ACO partnerships, VNSNY is also active in other CMMI demonstration initiatives, including Bundled Payment for Care Improvement (BPCI). In the case of a hospital-based Model 2 BPCI program, VNSNY has been an integral partner in the redesign of enhanced post-acute care pathways and the deployment of new health information exchange mechanisms created to facilitate sharing of clinical data across the care continuum. VNSNY is also the lead episode-initiating provider in a BPCI Model 3 post-acute bundled payment program aimed at enhancing care coordination and reducing re-hospitalization rates during 90-day period following a hospitalization for congestive heart failure.

**Alignment of Incentives** A key component to success of ACOs is the alignment of incentives for providers and patients. VNAA proposes CMMI improve incentives for inclusion of home health and hospice care in networks, along with risk adjusting payments for certain population characteristics, to achieve lower-cost care and better health outcomes. Realigning the ACO structure and payment model to more effectively incorporate home health and hospice care will ensure patients are receiving the right care, in the right setting at the lowest cost to the health care system. According to the Clinically Appropriate and Cost-Effective Placement Project study conducted by the Alliance for Home Health Quality and Innovation, average Medicare episode payments vary significantly by care setting. ACOs are quickly discovering that home health can be very cost-effective where such care is clinically appropriate for the patient. For example, in the context of a 60-day post-acute care episode, the average Medicare payments for providing care to patients after a major joint replacement under Diagnosis Related Group (MS-DRG) 470 vary considerably by the post-acute care-setting placement. For all MS-DRG 470 episodes, the overall average episode payment is \$23,479 per patient. Where home health care is the first setting post-discharge, Medicare episode payments are \$5,411 less than the overall average. By contrast, discharge of patients to SNFs, IRFs and LTCHs, resulted in Medicare episode payments more than the overall average. LTCH first setting episodes are \$34,417 more than the overall average .

**Current laws and regulations allow ACOs to establish business arrangements with Part D sponsors in order to align incentives in support of improving care coordination and outcomes. 1. What factors, if any, pose barriers to the effectiveness of such collaborations? Are there any considerations, such as marketing considerations, that are relevant to the promotion of these business arrangements?** • VNA Health Care in Connecticut played an active role in Hartford HealthCare (HHC)'s application to become an ACO in 2013. HHC is a five-hospital system which employs 300 physicians, has a post-acute network of home health, hospice and skilled nursing facilities and a behavioral health network. HHC, which collaborated

with Integrated Care Partners to engage both employed and community physicians in providing primary care for patients, is a Medicare Shared-Savings Program (MSSP). The ACO targeted a population of about 9,500 Medicare fee-for-service patients and is reporting and improving on 33 quality metrics. It created a designated care-management team with six care-manager RNs, two care-coordinator assistants and one social worker to follow to support the top ten percent high-risk patients with histories of frequent admissions and emergency department visits. ICP is also actively seeking risk contracts from commercial payers and currently manages another 10,000 Medicare advantage lives. VNA Health Care “lessons learned” include improved ways to identify high-risk patients, importance of care coordinators and the need for resources to address behavioral, social, functional and pharmaceutical needs of patients.

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