CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

Center for Medicare and Medicaid Innovation
Request for Information: Evolution of ACO Initiatives at CMS

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Request for Information (RFI)

SUMMARY

The Centers for Medicare & Medicaid Services (CMS) are seeking input on the following areas related to the evolution of Accountable Care Organization (ACO) initiatives.

1. A second round of applications for the current Pioneer ACO Model
2. New ACO models that encourage greater care integration and financial accountability

DATES: *Comment Date:* To be assured consideration, comments must be received by March 1, 2014.

ADDRESSES: Comments should be submitted electronically through the CMS Innovation Center's web page at: http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/

FOR FURTHER INFORMATION CONTACT: PioneerACO@cms.hhs.gov with "RFI" in the subject line.

BACKGROUND

Section 1115A of the Social Security Act, as enacted by section 3021 of the Affordable Care Act, authorizes the Center for Medicare and Medicaid Innovation (hereafter, the Innovation Center) to test innovative models of payment and service delivery that have the potential to reduce program expenditures while preserving or enhancing the quality of care for Medicare, Medicaid and CHIP beneficiaries.

The Innovation Center's Pioneer ACO Model was designed to complement the Shared Savings Program, established under Section 3022, by offering participating ACOs a distinct set of payment arrangements and different methodologies for performing beneficiary alignment and expenditure calculations. The Pioneer ACO Model was also designed as a testing ground, where certain design elements could be developed and tested before being considered for incorporation into either the Shared Savings Program or another CMS program.

CMS is issuing this Request for Information (RFI) to obtain input on policy considerations for the next generation of CMS ACO initiatives. Topics of particular interest include (1) approaches for increasing

participation in the current Pioneer ACO Model through a second round of applications, and/or (2) suggestions for new ACO models that encourage greater care integration and financial accountability.

SECTION I: Additional Applicants to the Pioneer ACO Model and Feedback on Current Model Design Parameters

A. The Pioneer ACO Model was designed for health care organizations and providers that are already experienced in coordinating care for patients across care settings as well as engaging in outcomes based contracting. The Model is now entering its third performance year with 23 organizations. In addition to increasingly aggressive risk arrangements, CMS offers eligible Pioneer ACOs the opportunity to transition from fee-for-service payments to monthly population-based payments to give these organizations more revenue flexibility in determining how to best motivate providers to improve quality of care and reduce costs for their patient populations. As more and more health care organizations begin to hone their skills in care coordination and engage in outcomes-based contracting, CMS is considering giving additional organizations the opportunity to become Pioneer ACOs. To that end, CMS seeks input on the level of interest in the field for CMS to open a second Request for Applications for the Pioneer ACO Model.

   1. Would additional health care organizations be interested in applying to the Pioneer ACO Model? Why or why not?
   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? What are the advantages and/or disadvantages of either approach?
   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?

B. **Population-Based Payments:** CMS allows Pioneer ACOs to transition to population -based payments (PBP) that offer revenue flexibility to provide furnish services not currently paid for under Medicare fee-for-service (FFS), and to invest in care coordination infrastructure. In lieu of explicit requirements that Pioneer ACOs maintain adequate financial reserves to pay the claims of their participant Pioneer providers/suppliers, CMS currently requires Pioneer ACOs to demonstrate a specified level of savings in previous performance years to become eligible for PBPs. Selection of PBPs does not affect the risk profile of the Pioneer ACO's payment arrangement.

   Eligible Pioneer ACOs may elect to receive PBPs that represent a selected percentage (e.g., 40%) percent) of their expected Medicare Part A and Part B FFS revenues or their expected Part B FFS

revenues, based on historical claims of participating Pioneer providers/suppliers that agree to accept reduced FFS payments. (The current PBP policy does not allow for ACOs to request a different reduction amount on Part A and Part B services, and does not affect the payments of non-Pioneer providers/suppliers caring for the Pioneer ACO's aligned beneficiaries) In turn, participating Pioneer providers/suppliers will receive FFS payments on submitted and payable claims for the services furnished to aligned Pioneer beneficiaries, reduced by the same selected percentage (that is, selection of PBPs representing 40% of expected Pioneer ACO revenues would be coupled with a 40% reduction in FFS reimbursements to participating Pioneer providers/suppliers for services furnished to aligned Pioneer beneficiaries). CMS does not currently allow suppliers of durable medical equipment to be included on the list of Pioneer providers/suppliers to receive reduced FFS payments upon which the amount of PBPs paid to the ACO is based. At the end of the year, CMS will include the amount paid to the Pioneer ACO in PBPs and the amount by which FFS payments to participating Pioneer providers/suppliers were reduced as part of the financial settlement of shared savings/shared losses.

1. Would being able to choose different FFS reduction amounts for Part A and Part B services be of significant import when deciding to participate in the PBP? Why or why not?
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? Why or why not?
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? Why or why not?
4. Should any additional refinements be made to the current Pioneer ACO PBP policy?

Section II: Evolution of the ACO Model

The Innovation Center intends to continue testing new approaches of accountable care to support the future refinement of the Shared Savings Program and/or to lay the foundation for other CMS ACO initiatives with three major goals:

- 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.

CMS is seeking input on models that (1) transition ACOs to full insurance risk, (2) hold ACOs accountable for total Medicare expenditures (Parts A, B, and D), (3) integrate accountability for Medicaid outcomes, and/or (4) offer ACOs payment arrangements with multiple accountability components (such as shared savings/losses, episode-based payments, and/or care management fees). CMS recognizes that these strategies are not necessarily mutually exclusive, such that a new initiative could incorporate several of these strategies. CMS also believes that the adoption of the ACO model by private payers offers an opportunity to strengthen the incentives in the model while reducing burdens on providers and is interested in opportunities to advance that alignment.

A. **Transition to greater insurance risk** –ACOs assuming full insurance risk would face issues similar to current organizations participating in the Medicare Advantage program. At the same time they would encounter unique challenges because beneficiaries would retain their traditional Medicare benefits and freedom to select providers and services of their choice. The questions that follow attempt to better understand these issues.

    1. Should CMS offer ACOs capitation with insurance risk, similar to Medicare Advantage organizations? What are the potential benefits and risks to the Medicare program and 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)
    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?
    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?
    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?
    7. Medicare Advantage Organizations have significant infrastructure that ACOs do not currently have such as member services. What additional infrastructure would ACOs need to develop to be able to manage full insurance risk?

8. What are approaches for setting appropriate capitation rates? The Pioneer ACO program currently uses a national expenditure growth trend for benchmarking. What are the advantages and disadvantages of using national expenditure growth trends? What about for using a local reference expenditure growth trend instead?
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.)
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? How would benefit enhancements differ depending on integration across Medicare Parts A, B, D, and/or Medicaid?
11. What are potential program integrity issues that ACOs transitioning to full insurance risk may encounter and what are appropriate preventative safeguards?
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?
13. 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. 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? 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?

B. **Integrating accountability for Medicare Part D Expenditures**– An approach for increasing Medicare accountability is for ACOs to integrate Part D expenditures as part of their approach to care delivery and health care transformation.

1. 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. 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? What could CMS do in administering an ACO program to help ACOs and sponsors mitigate or avoid these barriers?

2. Would ACOs be interested in and prepared to accept insurance risk as Part D sponsors or through contracting with pharmacy benefits management companies? 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?
3. Do ACOs currently have access to enough data to accept full risk for Part D expenditures? What other mechanisms would allow ACOs to assume accountability for Part D outcomes?

C. **Integrating accountability for Medicaid Care Outcomes** – As part of the State Innovations Model CMS is working with States to tailor payment reforms that reflect health care priorities identified by States and local stakeholders. CMS seeks input on approaches for ACOs to assume increasing accountability for Medicaid outcomes.

1. CMS has encouraged States to explore the use of integrated care models including ACOs for the care of Medicaid populations. Should ACOs caring for Medicare outcomes also assume accountability for Medicaid outcomes?
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?
3. What should the role of States be in providing appropriate incentives to foster the development of an integrated care system? What roles should States play in supporting model design and implementation? Do States have adequate resources to support an ACO initiative in collaboration with CMS?
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? What are the capabilities of providers in integrating this data with electronic

health records? What are the capabilities of integrating information for care received in the community or 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?

D. **Other Approaches for Increasing Accountability** – CMS seeks input on other potential accountable care models not specifically addressed in Approaches A through C.

1. 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. What are options for accountable care models that are geared specifically for geographically aligned populations of beneficiaries? What are the most critical design features of a provider-led community ACO model and why? What additional quality measures should be considered if an ACO is responsible for all covered lives in a geographic area? Are there models to consider that better integrate community-based services beyond the traditional medical system?
2. In certain permissible circumstances, organizations are able to pursue multiple service delivery and payment reform initiatives. Should CMS formalize an accountable care model where various service delivery and payment reform initiatives are combined? 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. If so, what would the most critical features of such a "layered" ACO be and why?

E. **Multi-Payer ACOs** – CMS has required that Pioneer ACOs demonstrate experience with risk-based contracts as a pre-condition for assuming such contracts with CMS as well as to encourage multi-payer alignment of incentives. CMS is seeking input on how best to promote multi-payer alignment of payment incentives and quality measurement.

1. How can CMS encourage the adoption of ACO contracts among other payers of Medicare ACOs?
2. How can CMS and other payers focus reporting of quality measures on the most important priorities while minimizing duplication and excess burden?