

Medicare Slowdown at Risk: The Imperative of Fixing ACOs



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Executive Summary

In September 2014, Dartmouth College, The Dartmouth Institute, Dartmouth-Hitchcock Health, and the Campaign to Fix the Debt convened “*The Dartmouth Summit on Medicare Reform: Strategies to Create a Sustainable Health System.*” The summit brought together a wide array of health care stakeholders, top policy experts, and lawmakers to discuss ways to reform the country’s largest health care program and surmount barriers to moving away from fee-for-service (FFS) payment.

The recent slowdown in per-beneficiary costs has been most welcome for taxpayers and beneficiaries (through lower premiums and cost sharing), but the extent to which it will persist remains uncertain.¹ Moreover, the primary driver of rising federal health care costs in the coming decades is demographic changes as the Baby Boom generation ages into Medicare.²

Thankfully, growing evidence suggests some of the payment reforms enacted in the Affordable Care Act (ACA) may be having an effect, directly or indirectly, on the way health care is being delivered. As Peter Orszag, former director of the Office of Management and Budget and the Congressional Budget Office, has emphasized (including during his presentation at the Dartmouth Summit), provider changes made in anticipation of further delivery system reforms are likely playing a role in the slowdown.³ To the extent this is occurring, though, further policy changes to bolster payment and delivery system reform efforts will be critical to reinforce this trend.

The ambitious goals laid out recently by Secretary of Health and Human Services (HHS) Sylvia Mathews Burwell, therefore, are vitally important. HHS is seeking to tie 85 percent of traditional

1 See Levine M, Buntin, M. Why Has Growth in Spending for Fee-for-Service Medicare Slowed?: Working Paper 2013-06. Congressional Budget Office. 2013. Dranove D, Garthwaite C, Ody C. Health Spending Slowdown Is Mostly Due To Economic Factors, Not Structural Change In The Health Care Sector. *Health Affairs*. 2014; 33 (8):1399-1406.

2 The 2014 Long-Term Budget Outlook. Congressional Budget Office. 2014 (see <http://www.cbo.gov/publication/49759>)

3 Orszag, Peter. The Cost-Cutting Power of Medicare. Jan 26, 2015. (see <http://www.bloombergvew.com/articles/2015-01-26/medicare-s-power-to-keep-health-care-affordable>)

Medicare’s payments to quality or value by the end of 2016, and 90 percent by the end of 2018; and having 30 percent of Medicare payments in alternative payment models – such as Accountable Care Organizations (ACOs) – by the end of 2016, and over 50 percent by 2018.⁴

The current fee-for-service model encourages excessive, and often unnecessary, utilization of health care services, can lead to fragmented decision-making among various providers with little coordination between them, and provides little incentive to deliver higher quality or more efficient care. Fee-for-service leaves providers unaccountable for the health of their patients and the effectiveness of interventions; further, it diffuses responsibility for such outcomes, making it more difficult to achieve public health goals.

Moving away from fee-for-service payment and meeting such audacious goals, however, will require significant improvements to alternative payment models and continued delivery reforms. The early results of the Medicare ACO programs are in many ways promising, but also highlight the need for more changes. Specifically, to be successful, reforms are needed to 1) improve the financial model facing ACOs and 2) increase patient engagement. Changes need to be patient-centric, not health system-centric.

The potential solutions identified in this paper aim to surmount these formidable barriers. In doing so, they hold the promise of creating a better, more affordable and sustainable health care system for its beneficiaries, taxpayers, and the Medicare Trust Fund. While data are still scarce, to the extent that such reforms increase the tools available to ACOs to steer care to more efficient providers and encourage patients to be more engaged in their care decisions, they have the potential to achieve very significant savings.

Improve Financial Model

Accountable Care Organizations (ACOs) in Medicare continue to grow in number, with 424 ACOs

4 ACOs are organizations of providers that have agreed to become “accountable” for the total cost and quality of care for a defined population.



now serving roughly 7.8 million beneficiaries, almost entirely within the Medicare Shared Savings Program (MSSP).⁵ However, initial data on financial performance indicates that only about one-quarter saved enough money to generate shared savings.

Many factors contribute to the need for a better financial model; this paper focuses on several key challenges that can plausibly be addressed in the near term.

First, ACO programs need a better methodology for determining initial benchmarks that would allow providers to see a prospective cost target ahead of time, instead of well into the period over which they are being measured (as is currently the case). CMS should also reform its process for resetting, or “rebasin,” the benchmark for the next contract period to allow for a certain proportion of shared savings to be incorporated into the new benchmark, while at the same time gradually transitioning benchmarks toward a model based on regional per-beneficiary costs. These proposals can greatly mitigate the current perverse incentives that effectively penalize successful ACOs with commensurately lower subsequent benchmarks.

Second, to further encourage providers from all geographic areas to form ACOs, policymakers should consider adopting alternatives to induce and maintain participation from low-cost providers. Some low-cost provider systems empirically appear to be at a disadvantage in generating shared savings, at least partially due to their low starting point.⁶

Finally, we should identify tools to incentivize ACOs to accept two-sided risk, which puts providers at risk of loss in addition to sharing in savings. Through waiving certain regulatory restrictions built for the fee-for-service world, ACOs may be able to improve care and lower costs for beneficiaries in less intensive settings or through higher

quality referrals. Network strategies, though restrictive, should also be considered.

Increase Patient Engagement

The other area that must be addressed to make ACOs impactful is to increase patient engagement. This paper identifies three areas of reform that can serve this goal. The first is to reform the attribution methodology – how people living in a region are assigned to an ACO. This can be accomplished by using data to more accurately reflect where patients receive their primary care-related services, improving the timeliness and usability of data on assigned (attributed) patients, and shifting all programs to prospective attribution with reconciliation modifying a patient panel only downward to reflect where ACOs cannot reasonably be held to account for the outcomes of certain patients.

Secondly, CMS should allow beneficiaries to choose, or to “attest,” that they want to belong to an ACO, and this mechanism should trump any post-hoc reconciliation. Alongside such attestation, ACOs should ideally be permitted to provide differential cost-sharing and other incentives for in-network ACO care.

To make such patient engagement possible, supplemental Medicare coverage – both Medigap and that provided by employers – should be restricted from covering first-dollar beneficiary cost sharing, which would also save taxpayers approximately \$100 billion over 10 years by discouraging overutilization of care, according to the Congressional Budget Office.⁷

5 Cavanaugh, Sean. ACOs moving ahead. Centers for Medicare and Medicaid Services. Dec 22, 2014. (See: <http://blog.cms.gov/2014/12/22/acos-moving-ahead/>)

6 Heiser S, Colla C, Fisher E. Unpacking The Medicare Shared Savings Proposed Rule: Geography And Policy. Jan 22, 2015. (See <http://healthaffairs.org/blog/2015/01/22/unpacking-the-medicare-shared-savings-proposed-rule-geography-and-policy/>)

7 Committee for a Responsible Federal Budget. Implications of Medicare Benefit Redesign. Feb 25, 2015. (see: <http://crfb.org/blogs/implications-medicare-benefit-redesign>)



Potential Approaches – A Brief Summary

I. Improve Financial Model for Accountable Care Organizations (ACOs)

A. *Reformat ACO Benchmarks.* Transition to prospective, regionally set benchmarks.

B. *Pursue Alternatives to Induce and Maintain Participation from Low-Cost Providers.* Introduce graduated savings distributions so that ACOs keep more early savings but less as savings per beneficiary increase, with higher rewards for historically-efficient ACOs. Consider offering performance-based incentives to ACOs with sustained excellence.

C. *Offer Incentives to Take on Two-Sided Risk.*

- 1) Increased opportunities for shared savings;
- 2) Regulatory relief; and
- 3) Tools to improve patient engagement, including greater communication and other incentives outlined below.

D. *Incentivize Multi-Payer Alignment.* Increase shared savings opportunities for provider groups with significant non-Medicare patient revenues aligned in value-based arrangements, and offer temporary financial incentives to insurers and purchasers to enter into such arrangements.

II. Increase Patient Engagement

A. *Improve the Existing Attribution Model.* Shift to prospective attribution with limited financial reconciliation, and use more data on patient care patterns to determine an ACO's patient population.

B. *Promote Attestation.* Allow ACOs taking two-sided risk to offer lower in-network cost sharing and shared savings with beneficiaries who acknowledge, or attest, their participation in that ACO.

C. *Restrict First-Dollar Supplemental Coverage.* Remove barriers to patient engagement and discourage over-utilization of care by restricting supplemental insurance (including employer-based plans) from covering first-dollar beneficiary costs in Medicare.



Introduction

In September 2014, Dartmouth College, The Dartmouth Institute, Dartmouth-Hitchcock Health, and the Campaign to Fix the Debt convened “*The Dartmouth Summit on Medicare Reform: Strategies to Create a Sustainable Health System.*” The summit brought together a wide array of health care stakeholders, top policy experts, and lawmakers to discuss how best to reform Medicare and surmount barriers to moving away from fee-for-service (FFS) payment.

The conference focused on Medicare due to its central role both to the federal budget and to the entire health care system, as its largest payer. Medicare payment levels and policies can have spillover effects on private insurance, and Medicare policies can be a powerful tool for shaping provider behavior.

Medicare is also central to the budget outlook. It represented 14 percent of all federal spending in 2013, totaling \$492 billion (3 percent of GDP) and is the second-biggest single program in the country (behind Social Security).⁸ The recent relatively slow growth of Medicare spending and payment reductions in the Affordable Care Act will keep spending as a share of GDP from growing much this decade according to Congressional Budget Office (CBO) projections, but it is expected to begin rising more rapidly after that, reaching nearly 5 percent of GDP by 2040.

Although the recent slowdown in Medicare spending growth is promising, fast growth in health care costs is only part of the story. The primary driver of rising federal health care spending in the coming decades is demographic changes as the Baby Boomer generation ages into Medicare. In addition, as Peter Orszag, former director of the Office of Management and Budget and the Congressional Budget Office, has emphasized (including during his presentation at the Dartmouth Summit), some part of the explanation for the slowdown has likely been provider changes made in anticipation of further delivery system reforms.

The summit also included presentations from former U.S. Sen. Judd Gregg (R-NH), the former chairman of the Senate Committee on Health, Education, Labor, and Pensions and the Senate Committee on the Budget; former Centers for Medicare and Medicaid Services Deputy Director Jon Blum; and a panel of practitioners each with experience managing an Accountable Care Organization (ACO).

After hearing from the ACO practitioners, participants broke into smaller groups to brainstorm ideas for reform, with each reporting results to the broader group afterward. The diversity of perspectives allowed for a robust dialogue about recent developments in Medicare and the merits of reform options. The results of these breakout sessions shed light on what top policy experts and practitioners view as potential solutions and areas for improvement within Medicare. The most popular recommendations included the promotion of shared decision-making, an increase in patient engagement and value-based care, and policies to encourage ACOs to take on more risk and to provide them with stronger tools to succeed.

The discussions primarily centered on transitioning Medicare away from a fee-for-service payment system. The current FFS model encourages excessive, and often unnecessary, utilization of health care services, leads to fragmented decision-making among various providers with little coordination between them, and overall provides little incentive to deliver higher quality or more efficient care. FFS leaves providers unaccountable for the health of their patients and diffuses responsibility, making it more difficult to achieve public health goals.

Moving away from FFS to more integrated payment models holds the potential to make providers more accountable for their patients’ well-being and to make care delivery more efficient. To that end, Secretary of Health and Human Services Sylvia Mathews Burwell recently laid out ambitious goals to tie 85 percent of all traditional Medicare payments to quality or value by 2016, and 90 percent by 2018.⁹

⁸ Monthly Budget Review: Summary for Fiscal Year 2014. Congressional Budget Office. 2014.

⁹ Burwell, Sylvia. Setting Value-Based Payment Goals – HHS Efforts to Improve U.S. Health Care. *New England Journal of Medicine*. January 2015.



For such efforts to succeed, however, significant changes are needed to both improve the financial model for Accountable Care Organizations and increase patient engagement. Pursuing these two objectives can help smooth the way for a more efficient and effective Medicare program, and a more sustainable health care system that better serves its patients.

While data are still scarce, to the extent that such reforms increase the tools available to ACOs to steer care to more efficient providers and encourage patients to be more engaged in their care decisions, they have the potential to achieve very significant savings.

This paper builds on some of the ideas discussed at the conference. However, it is not a summary of the conference and neither the conference sponsors nor attendees endorse all of the ideas included. The proposals discussed below represent a wide range of views expressed at the conference as well as additional work undertaken by the sponsors.

Accountable Care Organizations: A Background

Section 3022 of the Affordable Care Act of 2010 authorized the creation of “accountable care organizations” (ACOs). These entities were directed to “[promote] accountability for a patient population and [coordinate] items and services under Medicare parts A and B, and [encourage] investment in infrastructure and redesigned care processes for high quality and efficient service delivery.”

Medicare’s ACO programs – the Medicare Shared Savings Program (MSSP) and the Pioneer program – are judged against spending benchmarks that take into account the past three years of fee-for-service spending for their attributed beneficiaries. The Pioneer program also uses the cost experience of a reference population as an additional factor in the benchmark calculation. ACOs are able to earn shared savings if their attributed beneficiaries spend less than the risk-adjusted benchmark and this amount exceeds “minimum savings rates,” while also meeting quality goals.

In the MSSP, ACOs may elect either one-sided risk (only upside) or two-sided risk (both upside and downside). Recent proposed regulations released by the Centers for Medicare and Medicaid Services (CMS) for the MSSP would allow one-sided risk ACOs to remain in the program with no downside risk for a second agreement period, but with reduced opportunities for shared savings, or to move forward to two-sided risk as previously planned under the current shared savings arrangement. Additionally, the proposed rule would introduce a third participation track with a new model of patient attribution at a higher rate of shared savings/loss.¹⁰ Pioneer ACOs must accept two-sided risk by the second year of the first three-year contract. In both ACO programs, there are limits to upside gains and downside losses.

The requirement for ACOs to take on financial risk for their populations is based on the theory that properly aligned incentives can drive improvements in both cost and quality of the care delivered. This in turn should produce savings for the Medicare Trust Fund, taxpayers, and beneficiaries.

Roughly one-quarter of Medicare Shared Savings Program ACOs and one-third of Pioneer ACOs have been able to successfully generate shared savings in the first period of performance.¹¹ While these early results illustrate the promise of the ACO model, they also reveal several key challenges faced by Medicare ACOs.

Improve the Financial Model for Accountable Care Organizations

Key Challenges

Benchmark System Leaves ACOs Chasing Their Own Tail

Benchmarks against which to judge an ACO’s spending in the Medicare Shared Savings Program (MSSP) are currently based solely on historical

¹⁰ Proposed Regulation 2014-28388. Centers for Medicare and Medicaid Services. 2014. (See <https://www.federalregister.gov/articles/2014/12/08/2014-28388/medicare-program-medicare-shared-savings-program-accountable-care-organizations>)

¹¹ Medicare ACOs continue to succeed in improving care, lowering cost growth. Centers for Medicare and Medicaid Services. 2014. (see <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-09-16.html>)



spending for that ACO's attributed beneficiaries. Then, after each contract period, their benchmarks are "rebased," or reset, based on an ACO's most recent three years of per-beneficiary spending. Such a model effectively requires ACOs to continually improve their efficiency in order to keep achieving savings. Not only is this difficult, but the rebasing mechanism also provides a disincentive to achieving significant savings, since ACOs are effectively penalized with a lower subsequent benchmark if they do so.

Saving Money in Low-Cost Regions

ACOs in areas with higher fee-for-service spending generally begin with a larger benchmark against which to manage per-beneficiary spending, and therefore have a greater ability to earn shared savings (although pegging the annual growth of the benchmark to national FFS spending mitigates this to some degree).^{12,13} For the same reason, ACOs in areas with lower benchmark targets will have a more difficult time earning shared savings, and may be less likely to stay in the ACO programs.

Inadequate Rewards to Compensate for High Start-up Costs

ACOs incur significant costs in both the startup and operational phases, which may make it unattractive to accept the possibility of financial losses, or continue within the program. During the startup phase, ACOs must make initial investments in building infrastructure and staffing necessary to manage populations. Additional capacities must be built in performance measurement and reporting, and care redesign. These costs decrease over time, but the financial rewards may not be of sufficient magnitude to pay for these new investments, or to spur providers to accept further risk.

If the model is to be successful in the long term, however, ACOs must eventually transition to accept two-sided (both upside and downside) risk.

¹² Report to Congress. Medicare Payment Advisory Commission. 2014.

¹³ Heiser S, Colla C, Fisher E. Unpacking The Medicare Shared Savings Proposed Rule: Geography And Policy. Health Affairs. Jan 22, 2015. (see <http://healthaffairs.org/blog/2015/01/22/unpacking-the-medicare-shared-savings-proposed-rule-geography-and-policy/>)

Certain tools and regulatory workarounds, for instance, are only tenable if an ACO is assuming some downside risk to avoid conflicts of interest.

Additionally, while Medicare is the nation's largest payer, many of the program's ACOs are still being paid on a fee-for-service basis in the private market. These conflicting incentives restrict their ability to reap the full rewards of the care delivery transformations needed to be successful as a Medicare ACO. At the Dartmouth Summit, Jim Barr, Chief Medical Officer at Optimus Healthcare Partners, which successfully earned over \$8.3 million in shared savings from the MSSP, suggested the concept of multi-payer alignment was critical to his organization's success. Barr noted that they were only able to get the entire clinical organization responding to the new incentives after they achieved payer alignment with a vast majority of total patient revenues tied to ACO-like arrangements, instead of fee-for-service.

Solutions

Benchmarks Should Be Prospective

The current benchmark methodology in the Medicare ACO programs represents a sincere attempt to encourage participation for organizations at the beginning of the transformation process. Yet, earning shared savings has proved difficult, and the returns on the clinical investments may not be sufficient for ACOs, at least in the near term. Therefore, CMS should consider several reforms to improve the financial structure and retain participation in the programs. In calculating shared savings, ACOs argue that they are at a disadvantage in that their target benchmark is unknown until it has been reconciled with actual expenditures.

In its recent proposed rulemaking, CMS presents several possible alternatives and/or improvements to the financial model, especially for future contract periods. These include: 1) equal weighting of the three benchmark years for future contracting; 2) accounting for shared savings in future benchmark calculations; 3) using regional fee-for-service spending growth, rather than national, to trend forward historical beneficiary spending to



set the new benchmark, and for annual benchmark updates within a contract period; 4) updating an ACO's benchmark for future agreements based on regional FFS per beneficiary spending growth, to avoid penalizing ACOs that performed well relative to their region; and 5) gradually transitioning benchmark methodology to rely only on regional fee-for-service spending.

Option 5, which would establish a prospective target benchmark, is a reform MedPAC has endorsed too.¹⁴ CMS could do so by calculating the average fee-for-service expenditures at some appropriate unit of analysis – MedPAC suggests a county-level average – which would be derived from a comparison group of beneficiaries who were not receiving care in an MSSP ACO. Particularly in markets where a single provider organization is dominant, which may or may not be an ACO, the sample size of the comparison group may need to be enlarged to ensure reliability. There should be appropriate prospective actuarial adjustments for anticipated demographic changes in the upcoming year, as well as for new technology and other factors. The adjustments should use standard and accepted risk-adjusting tools, such as Hierarchical Condition Categories (HCC).

Many of these potential reforms are intended to alleviate the concerns of ACOs that feel the current model forces them to “compete against themselves,” and eventually pay back their savings to CMS in future contracts. Such a system may make it difficult to sustain participation in the program.

One reform not mentioned in the proposed regulation is the potential of lengthening the contract period beyond 3 years, which could amortize the initial investments over a longer period and give ACOs a longer window over which to drive improvement and generate savings.

Make Shared Savings More Attractive

Another way to make the financial model more attractive would be to modify the potential for shared savings. Specifically, CMS could introduce a graduated shared savings distribution along sev-

¹⁴ MedPAC Comment Letter to CMS on ACOs. Medicare Payment Advisory Commission. 2014. (see <http://www.medpac.gov/documents/comment-letters/comment-letter-to-cms-on-accountable-care-organizations-%28june-16-2014%29.pdf>)

eral dimensions.

Adjustment for the magnitude of savings: To help cover start-up costs, ACOs could receive a higher percentage of their first savings (beyond the minimum levels) with a gradually lower percentage as the magnitude of savings achieved increases. Most of the first dollars saved would go to the ACO, but if high levels of savings are achieved, the Medicare Trust Fund would then receive most of the savings (analogous to a progressive income tax). By increasing the early rewards for delivering quality care below benchmark spending thresholds, such a model could increase participation and help address concerns that the required investments outweigh the potential gains.

It is also possible that ACOs achieving remarkably high levels of savings are simply taking advantage of pre-existing inefficiencies. For example, the sharing rate – the proportion an ACO could keep – could be much larger for the first 5 percent of per beneficiary savings achieved (perhaps 75-85 percent staying with the ACO) and smaller as per beneficiary savings climbed past 15 percent (perhaps declining to only 30 percent going to the ACO).

A graduated shared savings distribution may also help alleviate concerns of historically efficient providers, who begin with lower spending benchmarks, and therefore may have less “low hanging fruit” to cut when they enter into an accountable care arrangement. In these cases, only a smaller amount of further efficiencies may be achievable in the near term, for which they would now receive a higher reward, increasing the chances of keeping historically-efficient providers in the ACO program. Similarly, the larger savings potentially achievable in high-spending areas would recoup less of a reward to the ACO.

Adjusting the sharing rate for baseline risk-adjusted spending: Going further, the rates of shared savings could also be determined by the size of the starting spending level. A historically-efficient ACO could therefore be appropriately rewarded by receiving more of their savings than one with less efficiency. For example, while all ACOs might receive a high share of the first 5 percent of savings below their benchmark, ACOs with higher baseline spending levels (e.g., those in McAllen,



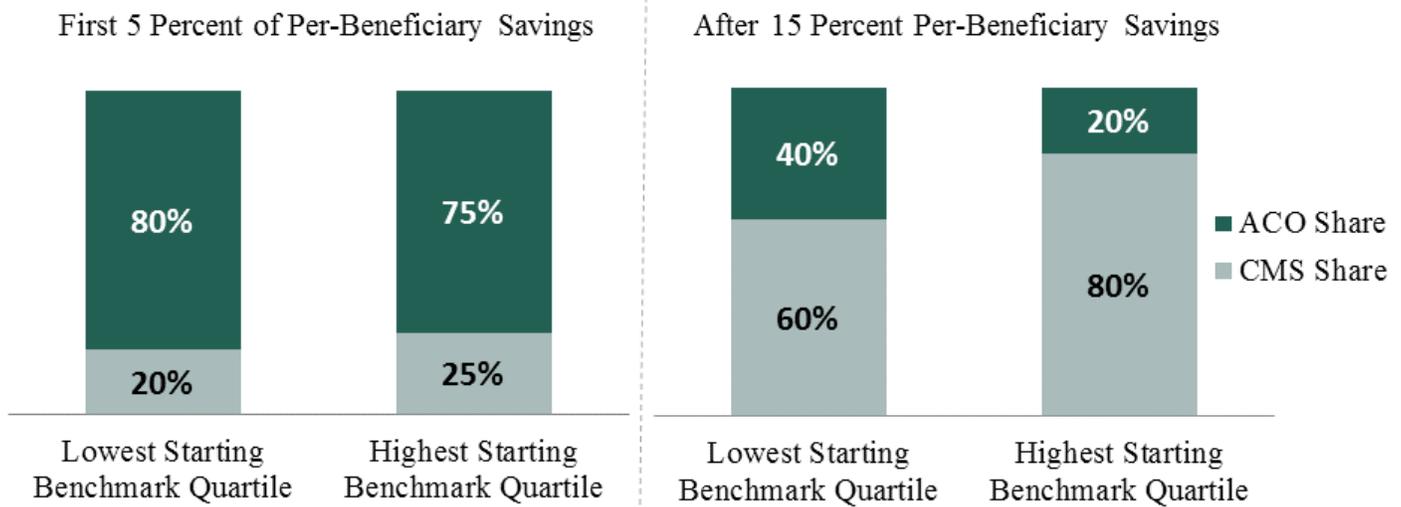
TX or Miami, FL) might have a lower sharing rate for savings achieved above the first 5 percent compared to those starting at lower levels of spending. Perhaps those with the lowest baseline spending would receive 40 percent of the savings above 15 percent per-beneficiary spending reductions, while those with the highest levels might receive only 20 percent.

Create performance bonuses for sustained excellence: One potential additional strategy that CMS might consider adopting is the creation of a performance-based bonus for ACOs that save money per beneficiary over the course of several years,

but may not achieve savings beyond the minimum savings thresholds in any single year. These bonus payments should be substantial enough to persuade ACOs to continue participating in the program, though perhaps not equivalent to what might have been paid out in the absence of a minimum savings rate requirement.

Taken together, these three changes might address some of the initial disparities between historically inefficient and -efficient ACOs and allow ACOs to keep more of their initial savings, while still providing substantial budgetary upside for Medicare.

Graduated Savings Model Offers Greater Rewards for Initial Savings and in Low-Spending Regions





Incentivize Moving to Two-Sided Risk

Providing ACOs with greater incentives to accept a portion of downside risk is an important policy goal if the alternative payment model is likely to reduce Medicare cost growth over the long term.

To this end, CMS proposes including an additional track within the MSSP (Track 3), which would prospectively attribute beneficiaries to ACOs and allow for additional potential for savings (up to 75 percent based on quality performance, capped at of 20 percent of the total benchmark) and losses (as little as 40 percent based on quality performance, capped at 15 percent of the benchmark).¹⁵ This reform may make it more attractive to take on additional risk, though the rate of uptake is as yet unclear.

MedPAC has endorsed several possible reform strategies to entice ACOs to shift toward taking risk, many of which were also included in CMS' proposed rulemaking and are only tenable for ACOs bearing both upside and downside risk.

Specifically, MedPAC recommends, as enticement to take two-sided risk: 1) allowing ACOs to shape referral recommendations to high-quality, efficient providers while preserving beneficiary choice to go elsewhere; 2) waiving current regulations that restrict referrals such as the prior three-day hospitalization requirement for skilled nursing facilities or the "homebound" definition for home health care, and 3) relief from "recovery audit contracting" for services ordered by an ACO professional for an attributed ACO beneficiary. CMS is already testing the three-day hospitalization waiver within its Pioneer ACO program.

Further, CMS could offer greater patient engagement tools to ACOs taking two-sided risk, including allowing them to offer financial incentives to their beneficiaries to use affiliated providers. Such reforms are discussed in more detail in the next section.

Recently in the MSSP rulemaking, CMS proposed

providing waivers for two-sided risk ACOs on referrals to high quality providers, the three-day hospitalization rule, inclusion of tele-health services, and the homebound requirement.

Another potential way to increase ACOs' ability to take on greater risk could be to encourage further alignment with other payers besides Medicare. Multi-payer alignment can increase the rewards for taking on risk by tying more reimbursement to similar payment mechanisms. However, there are entrenched obstacles standing in the way of ACOs contracting more with private payers.

One possible solution could be to increase the shared savings opportunities for ACOs earning a certain minimum percentage of their non-Medicare revenue from value-based contracts. In conjunction, insurers contracting with ACO-like entities could be offered a small, temporary financial incentive, such as a tax credit. An additional proposal that might merit study is a tax credit for employer-sponsored plans to encourage the purchase of ACO-like plans for their beneficiaries.

¹⁵ Proposed Regulation 2014-28388. Centers for Medicare and Medicaid Services. 2014. (See <https://www.federalregister.gov/articles/2014/12/08/2014-28388/medicare-program-medicare-shared-savings-program-accountable-care-organizations>)



Potential Solutions to Improve the Financial Model for ACOs:¹⁶

A. Reformat Pioneer and MSSP ACO Benchmarks

1. Move to prospective benchmarks within the MSSP using the county-level average fee-for-service expenditure derived from a meaningful comparison group of non-ACO beneficiaries.
2. Incorporate shared savings into the benchmark rebase.

B. Pursue Alternatives to Induce and Maintain Participation from Low-Cost Providers

1. Graduate savings distributions: ACOs keep more early savings, keep less as savings per beneficiary increase.
2. Increase opportunities for shared savings for historically efficient ACOs: condition shared savings levels in part on which quartile of spending per beneficiary an ACO's benchmark is in.
3. Consider creating performance bonuses for sustained excellence.

C. Provide Incentives to Move to Two-Sided Risk:

1. Increase shared savings opportunities.
2. Permit ACOs that accept two-sided risk to increase patient engagement, including greater communication and other incentives outlined in the next section.
3. Direct the Secretary of Health and Human Services to issue waivers to ACOs bearing two-sided risk for:
 - Shaping beneficiary referrals to high-quality, efficient providers while maintaining beneficiary choice;
 - The three-day prior hospitalization before skilled nursing facility admission under Medicare reimbursement rules;
 - The requirement that a beneficiary be declared "homebound" before Medicare will reimburse for home health care; and
 - Relief from Recovery Audit Contractor (RAC) hospital audits for services ordered by an ACO professional for attributed ACO beneficiaries.
4. Consider appropriate strategies to achieve multi-payer alignment
 - Potential for increased savings opportunities as more systemwide patient revenues are aligned in value-based arrangements.
 - Temporary financial incentives to insurers and purchasers to encourage them to move away from FFS-based contracts.

¹⁶ An additional suggestion Congress and CMS should consider would be to include Part D costs in the benchmark calculation for ACOs, which are currently excluded. ACOs have the opportunity to help beneficiaries more efficiently use medications, and make other investments to help prevent adverse drug interactions and improve medication adherence.



Increase Patient Engagement

One of the greatest difficulties facing ACOs is to manage and coordinate the care of their beneficiaries, most of whom have no idea they have been attributed to an ACO; complicating this, there are few tools to identify the highest quality or most efficient providers, much less steer patients to them.

In the Medicare ACO programs, beneficiaries are attributed to an ACO based on where they seek a plurality of their primary care; this process is reconciled at the end of the performance period, so neither patients nor providers may have any idea who is a patient of the ACO until after the fact. No financial incentives are provided to seek care with ACO providers, nor are there any disincentives to seeing out-of-ACO providers. Beneficiaries maintain unfettered access to any willing provider accepting Medicare patients, regardless of quality, efficiency, or affiliation with the ACO. Further, ACOs are limited in how they may pursue patient engagement strategies to communicate with and educate beneficiaries about the benefits of the ACO's network.

It is no surprise, then, that research has found that two-thirds of ACO assignees' visits to specialist offices occurred outside of their ACO.¹⁷ Such leakage of care presents major hurdles for ACOs attempting to coordinate patient care, and makes it significantly more difficult to hold ACOs accountable for the quality and cost of the care provided for their patients.

Additionally, ACOs report frustration about receiving timely, actionable data from CMS on which patients remain attributed to their organization over the course of the performance year.

Improve Attribution Process

Attribution methodologies have marked impacts on the ACO's overall performance and ability to

engage patients in their own care.^{18,19} The preliminary prospective and retrospective reconciliation model could be improved by adding additional data points for attribution among ACO-affiliated providers (e.g., evaluation & management visits, visits to non-physician primary care providers, prescription drugs) *and* more timely, actionable data from CMS to the participating ACOs. Currently, this is done on a quarterly basis, but should be done more frequently to allow more coordination and management of ACO beneficiaries.

Alternatively or in conjunction, CMS could pursue the proposal in its recent rulemaking to offer prospective attribution with financial reconciliation as an incentive to moving two-sided risk with higher levels of shared savings/losses (Track 3).²⁰ This proposal might be further reformed to help ACO financial performance by using the reconciliation process only to remove prospectively assigned beneficiaries who have clearly transitioned away from the ACO (e.g., by moving or seeing a new primary care provider multiple times), not add new ones. This would relieve the ACO of responsibility for those over whom they are likely to have limited influence.

Promote Attestation

CMS should consider allowing active patient attestation to an ACO, which would permit ACOs to engage patients and explain the benefits of seeking care within the ACO network. The MSSP proposed rule discusses whether attestation should be allowed for ACOs that accept two-sided risk, and proposes to improve data sharing by including more data elements that may add valuable intelligence to an ACO's care management strategy.

The CMS Innovation Center is also about to begin testing attestation in the Pioneer ACO program.²¹

18 Lewis VA, McClurg AB, Smith J, Fisher ES, Bynum JPW. Attributing Patients To Accountable Care Organizations: Performance Year Approach Aligns Stakeholders' Interests. *Health Affairs*. 2013;32(3):587-595.

19 Mehrotra A, Adams JL, Thomas JW, McGlynn EA. The Effect of Different Attribution Rules on Individual Physician Cost Profiles. *Annals of internal medicine*. 2010;152(10):649-654.

20 Proposed Regulation 2014-28388. Centers for Medicare and Medicaid Services. 2014. (see <https://www.federalregister.gov/articles/2014/12/08/2014-28388/medicare-program-medicare-shared-savings-program-accountable-care-organizations>)

21 Evans, M. Pioneer ACOs can recruit seniors under new CMS

17 McWilliams JM, Chernew ME, Dalton JB, Landon BE. Outpatient care patterns and organizational accountability in Medicare. *JAMA internal medicine*. 2014;174(6):938-945. (see <http://www.ncbi.nlm.nih.gov/pubmed/24756690>)



Beneficiary attestation in this effort will not connote any explicit financial benefits, such as lower in-network cost-sharing or a share of the ACOs savings. However, it will help test whether the simple knowledge that one is part of the ACO and understanding its mission can reduce the percentage of care sought through non-ACO providers. This form of attestation can be provided even to one-sided ACOs.

Allow Patient Engagement Outreach & Lower Cost-Sharing for Within-ACO Care

To further increase incentives for beneficiaries to seek care within an ACO, Medicare ACOs taking two-sided risk could be allowed to offer lower in-network cost sharing and shared savings with beneficiaries who acknowledge, or attest, their participation in that ACO. Due to the prevalence of first-dollar supplemental coverage in Medicare, financial rewards also could be offered in place of lower in-network cost-sharing. Legislative changes may be required to make these proposed changes feasible, and a limited version was recently proposed in the President's Fiscal Year 2016 Budget.

The proposal discussed in this paper is similar to one from MedPAC, in which Medicare ACOs would be permitted to engage directly with ACO beneficiaries with marketing materials and other incentives, including differential benefits/cost sharing for seeking in-network ACO care as opposed to out-of-network care. Importantly, these beneficiaries would maintain access to all other Medicare providers at no additional cost.

Restrict First-Dollar Medicare Supplemental Coverage

The prevalence of near first-dollar supplemental coverage, however, effectively neuters any efforts to increase patient engagement and better coordinate care through allowing ACOs to offer lower cost-sharing for seeing in-ACO providers.

The large majority of Medicare beneficiaries (90 percent as of 2010) have some form of supplemental insurance to help with cost sharing and protect

test. Modern Healthcare. 2014. (see <http://www.modernhealthcare.com/article/20141111/NEWS/31119931>)

against high out-of-pocket costs.²² Roughly half either purchase a private Medigap supplemental plan or receive supplemental coverage through their employer (including the government), much of which takes the form of near-first dollar coverage that insulates enrollees from cost-sharing incentives. Multiple studies have shown that beneficiaries with supplemental coverage use significantly more Medicare services without necessarily achieving better outcomes.^{23,24}

At a minimum, beneficiaries who attest their participation in an ACO – and thus receive lower in-ACO cost-sharing – should be restricted from purchasing Medigap plans that fully cover their out-of-ACO cost-sharing requirements. The National Association of Insurance Commissioners could be tasked with creating new Medigap plan designs to fit such requirements.

Medigap plans are also expensive for their enrollees – the most popular Plan F costs more than \$2,000 per year for first-dollar Medicare cost-sharing coverage, while each plan is only required to maintain a medical loss ratio of 65 percent, compared to the 80 percent required in the under-65 individual insurance market (that is, a plan only must spend 65 percent of enrollee's premiums on health care coverage).^{25,26} Inadequate competition, with just two insurers controlling three-quarters of the Medigap market, likely adds to high Medigap premium costs.²⁷

22 Section 3xa: Medicare beneficiary and other payer financial liability. MedPAC. 2014 (see <http://www.medpac.gov/documents/publications/june-2014-data-book-section-3-medicare-beneficiary-and-other-payer-financial-liability.pdf>)

23 Hogan, C. Exploring the effects of secondary insurance on Medicare spending for the elderly. A study conducted by staff from Direct Research, LLC, for MedPAC. Medicare Payment Advisory Commission. 2009.

24 Golberstein E, Walsh K, He Y, Chernew M. Supplemental Coverage Associated With More Rapid Spending Growth For Medicare Beneficiaries. Health Affairs. 2013; 32(5):873-881. (see <http://content.healthaffairs.org/content/32/5/873.full.pdf+html>)

25 Jacobson G, Huang J, Neuman T. Medigap Reform: Setting the Context for Understanding Recent Proposals. Kaiser Family Foundation. 2014. (see <http://kff.org/medicare/issue-brief/medigap-reform-setting-the-context/>)

26 Medigap: Spotlight on Enrollment, Premiums, and Recent Trends. Kaiser Family Foundation. 2013. (see <http://kaiserfamilyfoundation.files.wordpress.com/2013/04/8412-2.pdf>)

27 Starc, Amanda. Insurer pricing and consumer welfare: Evidence from Medigap. Feb 22, 2012.



Ideally, therefore, to remove barriers to patient engagement and discourage overutilization of care, Medicare supplemental insurance (including employer-based plans) should altogether be restricted from covering first-dollar beneficiary cost-sharing.

Such a reform could save taxpayers approximately \$100 billion over the next ten years.²⁸ The tools discussed in this section, combined, would further the goal of patient engagement, and the resulting reduced leakage would make it easier and fairer to hold ACOs accountable for their quality and costs.

Potential Solutions to Increase Patient Engagement:

A. Improve Attribution Process

1. Use more data on patient care patterns to better determine attribution
2. Improve the timeliness and usability of data feeds for ACOs to use in care management efforts.
3. Move to prospective attribution, in which financial reconciliation can only remove attributed beneficiaries, not add them.

B. Allow Patient Attestation for ACOs

1. Consider embracing an alternative attribution methodology to allow active patient attestation to an ACO.
2. For ACOs taking two-sided risk, for attested beneficiaries, allow ACOs to offer lower in-network cost-sharing and shared savings with beneficiaries (financial rewards also could be offered in place of lower in-network cost-sharing).

C. Restrict First-Dollar Supplemental Medicare Coverage²⁹

1. For attested beneficiaries in ACOs taking two-sided risk, restrict Medigap plans from fully covering patient cost-sharing for out-of-ACO providers.
2. Remove barriers to patient engagement and discourage overutilization of care by restricting supplemental insurance (including employer-based plans) from covering first-dollar beneficiary costs in Medicare.

²⁹ With restrictions placed on supplemental Medicare coverage, it becomes critical to also reform Medicare's benefit design to offer a more rational insurance product with fair cost-sharing requirements and a limit on annual out-of-pocket expenditures. Additional subsidies to help beneficiaries with lower incomes may also make sense as part of such a package. Examples have been offered by the Committee for a Responsible Federal Budget, the Bipartisan Policy Center, and MedPAC. See, for example: Committee for a Responsible Federal Budget. Implications of Medicare Benefit Redesign. Feb 25, 2015. (see: <http://crfb.org/blogs/implications-medicare-benefit-redesign>)

²⁸ According to estimates from the Congressional Budget Office, such restrictions could save roughly \$60 billion over ten years if applied to private Medigap plans, \$30 billion if applied to TRICARE-for-Life, and \$10 billion from the Federal Health Benefits Program. Applying these restrictions (or an excise tax) to employer-sponsored Medicare supplemental insurance plans could save in the range of an additional \$25 billion over ten years. For a further discussion, including how such proposals interact with benefit redesign, please see: "Committee for a Responsible Federal Budget. Implications of Medicare Benefit Redesign. Feb 25, 2015. (see: <http://crfb.org/blogs/implications-medicare-benefit-redesign>)



Ideas for Further Exploration

In addition to the reforms addressed in this paper, conference participants also discussed other levers to surmount barriers to moving away from fee-for-service payment. Shared decision-making can help match care with patient preferences. Reforming the community benefit required of non-profit hospitals holds the potential to better target investments in the health of local populations, furthering one of the key goals of ACOs. Incentivizing states to take on increased global budgeting can similarly align the incentives of private actors with the health of local populations. Such ideas merit further research and could be pursued in subsequent white papers.

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