MEDPAC Medicare Payment Advisory Commission

FACT SHEET

Comment Letter on the Proposed Rule for ACOs • June 2011

Section 3022 of the Patient Protection and Affordable Care Act (PPACA) created a shared savings program for Accountable Care Organizations (ACOs) in Medicare. The proposed rule implementing the program was released on March 31, 2011. In its comment letter dated June 6, 2011, MedPAC specifically comments on several elements of the proposed program. The comment letter is summarized in the table below.

If structured carefully, a shared savings program for ACOs could present an opportunity to correct some of the undesirable incentives in fee-for-service (FFS) Medicare payment and reward providers who are doing their part to control costs and improve quality. However, creating a well-functioning ACO will require a significant investment of money, effort, and time, and the traditional FFS program will still be an attractive alternative – particularly for providers who are accustomed to being rewarded for the volume of services they provide.

Therefore, it would be a mistake to assess the success of the shared savings program by counting how many ACOs participate in the initial agreement period. A program that builds gradually and is carefully designed to meet the goals of high quality care and slower spending growth is likely to succeed and contribute to the long-term sustainability of the Medicare program.

Issue	Comment
Use Prospective Assignment	Beneficiaries should be prospectively assigned to ACO providers and informed of their assignment prior to the measurement year. This will allow beneficiaries to become fully engaged with their health care provider in managing their care, or to choose to opt out of the program.
Benchmarks Based on Assigned Beneficiaries	To encourage ACOs to treat patients that would benefit most from the ACO (costly patients or those that received inefficient care in the past), benchmark spending should be based on the historical costs of assigned beneficiaries in the ACO. New patients, those assigned in years two or three of the performance period, would bring their historical spending and risk scores with them. Also, additional coding of conditions over the three years will not affect payment. ACOs would not be rewarded with a higher benchmark if their patients grow sicker faster than expected but will not be penalized if they keep their patients healthier than expected.
Simplify Quality Measurement	CMS should simplify quality reporting by focusing on a narrower set of quality measures that reflect the outcomes ACOs are designed to achieve. CMS should reduce uncertainty regarding the scoring of quality measures to calculate shared savings by annually establishing a clear performance threshold for each measure.
Standardize Benchmarks and Spending	CMS should standardize benchmarks to account for wages and special payments (e.g. rural add-ons, payments to teaching hospitals). Standardizing the benchmark and spending is more equitable, removing any advantages or disadvantages beyond the ACO's control.
Expand Settings For Beneficiary Assignment	CMS should allow beneficiaries to be assigned to all types of primary care providers, including non-physician practitioners and specialists under certain circumstances. CMS should also allow beneficiaries to be assigned to an FQHC or RHC, recognizing their role as a source for primary care.
Encourage Participation by Easing Requirements	To encourage participation, CMS could extend the single-sided shared savings model to give organizations more time to transition to sharing risk. In addition, CMS could reduce quality measurement and reporting requirements, reduce regulatory requirements (like HIT infrastructure), and increase the shared-savings percentages. In addition, the savings thresholds proposed by CMS should be maintained to avoid rewarding random variation.