The Voice of Accountable Physician Groups

May 3, 2016

Patrick Conway, MD
Deputy Administrator for Innovation & Quality
CMS Chief Medical Officer
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS policy for treating overlaps between bundled payment initiatives and accountable care organization programs

Dear Deputy Administrator Conway,

I write to bring your attention to policy considerations in CMS/CMMI's treatment of the interplay between the bundled payment initiatives (bundled payments for care improvement, BPCI, and the comprehensive care for joint replacement, CJR) and the accountable care organization programs (Medicare Shared Savings Program, MSSP, Pioneer, and Next Gen). While we believe that there is great opportunity for these programs to support one another, we believe that current policy may disrupt and undermine the accountable care organization (ACO) programs. This is occurring at the very time when CMS is trying to encourage participation in Advanced Alternative Payment Models, like Next Gen and Tracks 2 and 3 of MSSP.

This letter is also submitted in support of the comment letter recently submitted by Atrius and a number of other organizations on April 26.

In particular, we are concerned in cases where the ACO operates independently from the hospital participating in the bundled payment model. This is the case for many CAPG members. To illustrate the overlap issue, we will use the CMS guidance for such situations between Next Gen ACOs and BPCI participants. In the example in the guidance, the bundled target price is $10,000. The hospital participating in the bundled payment initiative achieves an actual expenditure of $8,000. The expenditure that is included in the ACO's reconciliation is $10,000. CMS pays the $2,000 in savings to the hospital, the ACO does not receive any of those savings. Because that $2,000 in savings is credited only to the bundled hospital, the savings opportunity is taken from the ACO.

We see two problems with this treatment of overlap situations. First, this approach makes it increasingly difficult for ACOs to achieve savings as compared to an historical benchmark. Second, this approach treats the care associated with the bundled payment episode as separate

and distinct from the activities of the ACO, rewarding only the hospital bundler for the savings associated with a bundled payment patient. Each issue is described in greater detail below.

This approach to overlap illustrates the problems with using historical expenditure benchmarking in the Medicare ACO programs. We believe that historical expenditure benchmarks provide a barrier to success in the ACO program. Particularly for efficient organizations, continuing to try to improve against their own historical performance is increasingly difficult. The overlap policy makes it even more difficult, eliminating savings associated with the bundled payment patients, and therefore eliminating a source of savings for ACO participants. It thus becomes even harder to generate savings as compared to the historical benchmark. As we wrote in our recent comments on the agency's proposed changes to the Medicare Shared Savings Program benchmarking methodology, we encourage CMS to adopt an approach to benchmarking that does not rely on historical performance and looks instead at national or regional comparisons. The ACO should have the option to select the benchmarking comparison (regional or national) that best meets its circumstances. We believe that the issue described above would be substantially mitigated and might disappear altogether if the ACO benchmarks were based on regional or national comparisons rather than historical expenditures.

With this overlap policy, we believe that CMS is inadvertently making a policy judgment that it is solely the work of the hospital that contributes to the lower actual episode expenditures for patients involved in bundled episodes. We believe that this is a flawed assumption and skews toward hospitals and against physician organizations. As you know, CAPG members are engaged in robust efforts to manage the care of patients discharged from the hospital. These care management programs are well-document to have led to lower readmission rates and higher quality for Medicare seniors. All of these interventions undoubtedly contribute to lower expenditures. Therefore, assuming that all of the savings achieved in a bundled payment episode are attributable only to the efforts of the hospital bundler discounts the important work of physician organizations in managing care outside of the hospital, improving the quality and lowering the cost. It is an unjustified and misdirected policy precedent to subordinate ACOs to bundlers.

We are committed to the future of risk-based coordinated care models. We think there is tremendous opportunity to improve the quality of care and reduce costs by moving from fee-for-service to APMs. However, we believe that the APM options must be attractive to physician organizations to facilitate the transition. This requires certain modifications to existing policy. Perhaps most importantly, this requires a shift away from historical expenditure benchmarking in the ACO program.

Finally, we reiterate our call for the agency to devise advanced APM models that reward organizations sophisticated in care coordination and managing risk. We continue to believe that there has been a substantial amount of focus on organizations that are looking for the "on ramp" to risk but not enough focus on those that have been engaged in care coordination for decades. We reiterate our call for CMS to continue to develop models on both ends of the risk

spectrum. For efficient organizations, historical benchmarking is particularly problematic and the design of new payment models for these organizations should include different benchmarking methodologies with regional or national, rather than historical, comparisons.

Please do not hesitate to contact me if you have any questions.

Sincerely,

DONALD H. CRANE
President & CEO