BACKGROUND

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

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

Part A: Interest in Additional Pioneer ACOs

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

   A. Why or why not?

   About CHE Trinity Health
   CHE Trinity Health appreciates the opportunity to submit feedback to the Center for Medicare & Medicaid Innovation (CMMI) and the Centers for Medicare & Medicaid Services (CMS) on the evolution of Accountable Care Organization (ACO) Initiatives. CHE Trinity Health is the second-largest Catholic healthcare delivery system in the nation, serving people and communities in 20 states from coast to coast with 82 hospitals, 88 continuing care facilities, and home health and hospice programs that have more than 2.3 million visits annually. It was formed in May 2013, when Trinity Health and Catholic Health East completed their consolidation to strengthen their shared mission, increase excellence in care, and advance transformative efforts with their unified voice. With annual operating revenues of about $13.3 billion and assets of over $19 billion, the new organization returns more than $800 million to its communities annually in the form of charity care and other community benefit programs. CHE Trinity Health employs nearly 86,000 people, including nearly 4,000 physicians. CHE Trinity Health is currently participating in 5 Shared Savings Plan (SSP) ACOs and was part of one Pioneer ACO that withdrew from the Program. We are committed to developing more ACOs over this year, but have significant concerns as described in these comments.

   Specific response to Part A
   Organizations are not gravitating toward the Pioneer ACO model because the downside risk is not outweighed by the opportunity for economic gain – the business case is not compelling. Contributing factors to this include patient turnover, floating benchmarks, and inconsistency in data timing, and accuracy. In particular, concerns about decedent adjustment methodology have made this model highly unpredictable, thus resulting in inappropriate risk.

   If CMS developed a different methodology, there may be interest from other organizations in participating in the Pioneer model. An example of an alternative methodology would be as follows:
Option A: A model that offers a larger share of savings in the first three periods in exchange for a predetermined trend rate that is lower than historical trend. For example, 80% of savings from historical average in exchange for a guaranteed trend rate of -1% for three years. Alternatively, the model could include downside risk but with a cap of 1% or something similarly low.

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

A. What are the advantages and/or disadvantages of either approach?

CMS should accept all qualified applicants. Seeking as many participants as possible will increase experience, improve analytic results, encourage more transformation, and create more savings for CMS. Also, testing these models with as many organizations as are willing and able will ensure the results are as broadly generalizable as possible.

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

As the Pioneer benchmark and target methodologies evolve, there is great uncertainty about the model. There is extreme volatility in the calculations driven by changes in mortality rates. Even a small number of differences in deaths in the population from year to year triggers results that call into question the very validity of the benchmark and target methodologies.

We believe that it is necessary to find a simpler methodology for establishing benchmarks for both programs. In particular, participating Pioneer ACOs should have a defined benchmark and target at the beginning of the year that is fixed. This will afford the ACO the opportunity to track its performance and project ultimate success with accuracy.

Part B: Population-Based Payments for Pioneer ACOs

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

A. Why or why not?

CHE Trinity Health believes that organizations will need to gradually transition from FFS payments to PBP. Such a transition process is essential. Many organizations will test their financial risk management capabilities and a large initial reduction could discourage many of these organizations from participating. Already, providers are dividing into two camps—those still reliant on FFS and those testing out alternative payment models, and as such, it is vital that CMMI continue to support and engage with those in the first camp to
prove the success of these new payment and delivery models. The success (or failure) of already high-performing organizations does not prove the effectiveness of any one model. Rather, CMMI should work to ensure that a support structure and gradual phase-in process exists for all organizations as they become accountable for the care and cost of their patient population.

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

   A. Why or why not?

   For delivery reform to be impactful, all facets of the healthcare system should be part of value-based payment. In addition, DME is a significant expenditure and is often a target of fraudulent activity, a potential for huge savings exists in this area. ACOs are already responsible for the Part B spending of their aligned population, and allowing for a DME supplier to become a partner that works hand-in-hand with the ACO will further encourage value-based relationships and a shift the mindset of suppliers towards an accountable model.

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

   A. Why or why not?

   CHE Trinity recommends that CMS and CMMI reconsider the requirement that Pioneer ACOs meet a specific threshold of savings to be eligible for PBPs. We recommend that, instead, CMS and CMMI establish clear requirements for financial reserves or a robust reinsurance policy or develop alternative approaches that recognize the capital reserves already present in some health care providers balance sheets.

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

   Yes

   A. Why or why not?

   The policy would be improved if CMS established an alternative reconciliation methodology that converts the current PBP approach – which is really a cash flow mechanism – to a true capitation approach.
SECTION II: Evolution of the ACO Model

Part A: Transition to Greater Insurance Risk

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

Yes

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

General Recommendations

The SSP Program and the Pioneer Model have attracted almost 400 participants who are committed to producing better health, better care and reduced costs for Medicare beneficiaries. Experience to date has demonstrated that ACOs can improve quality and decrease costs, even in one-sided risk models. CHE Trinity Health is currently participating in 5 SSP ACOs and was part of one Pioneer ACO that withdrew from the Program. We are committed to developing more ACOs over this year. However, we also believe that there are significant current and potential problems that need to be addressed to ensure ongoing viability of ACOs.

It is critical that CMS/CMMI continue to evolve the ACO model to ensure existing participants stay involved and to entice new participants to join. It was to be expected that the first two years of operation of both ACO initiatives would reveal many uncertainties, surprises and need for significant adjustments. The most significant immediate adjustment we believe is to recognize that the original expectation that all ACOs move to two-sided risk after three years is not a viable policy. We believe that given the many current issues with the program, insisting on movement to two-sided risk is premature and will result in the exit of most ACOs from the programs.

Similarly, lack of clarity from CMS about whether movement to downside risk will be required, or requiring it after two years will limit participation in the next three year period. Therefore we recommend that CMS eliminate the requirement to move to downside risk following three years of no risk. At the same time we believe that CMS must address the following critical current concerns to ensure ongoing robust participation in the program:

1. Year to year instability of the aligned population;
2. Uncertainty about a clear payback model and the impact on the investment in care coordination;
3. Trend calculations using national trend numbers;
4. Lack of understanding of benchmark and target methodologies;
5. Uncertainty about whether CMS will continually decrease targets based on achieved savings through rebasing;
6. Changing quality metric specifications and benchmark methodologies; and
7. **Uncertainty about which interventions are effective.**

In short, the program from both CMS and ACO’s perspectives is too immature at this time to expect providers to accept significant risk. **However, it is in everyone’s interest to allow the program to continue to evolve and grow.** We believe these issues must be addressed to achieve that end, and offer respective approaches for each area of concern below. Some of these issues could be addressed through revised regulations. We also understand that the statutory language of Section 3022 (ACO section) may limit CMS’ ability to adjust significant parameters through regulations. However, CMS has demonstrated appropriate use of Section 3021 authority to test alternative approaches within the SSP program in the Advance Payment ACO Model Test. **We believe that many of the alternative approaches described below could be similarly tested using the 3021 authority, thus bringing significant flexibility to the SSP.** We also believe that the very nature of the SSP program as an entirely new approach to financing and delivering care makes it a most appropriate place to use 3021 authority to rapidly test models. These successful models could then be scaled nationally as part of a refined SSP program.

1. **Year-to-year instability of the aligned population**

A stable population is essential to the actuarial risk management that CMS expects ACOs to demonstrate. We recommend ACO models be adjusted such that Medicare beneficiaries be permitted to "opt in" to an ACO. This could be done by creating a simple mechanism to allow patients to attest to their interest in being eligible for advanced care management services within the ACO.

CHE Trinity Health recommends that future ACO models use a corridor approach to the plurality algorithm used to assign beneficiaries to an ACO. Currently, attribution is determined by the preponderance of Medicare claims with a given ACO provider using a bright line test. Minor changes in the distribution of services from year to year result in patients being aligned or disaligned from an ACO. We suggest that a 10% corridor be established so that if a patient’s claims are within 10% of the plurality of claims then the patient would continue to be aligned with the prior ACO. Allowing patients to opt into another ACO could ensure that patients ultimately control where they have their care coordinated.

2. **Uncertainty that there is a clear payback model:**

ACOs are uncertain about the magnitude of the payback opportunity for many reasons including the seemingly black box benchmark and target setting methodology, frequent changes in the financial targets and ongoing changes in the definition of quality benchmarks. One solution would be to establish a definitive target for the ACO using a fixed trend number, not necessarily related to the actual Medicare trend. (This might require a test using 3021 authority) Another improvement that we recommend is to reduce the Minimum Savings Rate (MSR). We recognize the need to use the MSR symmetrically to keep the ACO programs budget neutral. However, we think that CMMI Section 3021 authority could be utilized to establish a “reinsurance mechanism” to make up for potential shortfalls for CMS that could occur as a result of the asymmetry in financial results that might follow decreasing the sharing threshold to 1%. As an example, if the MSR could be reduced to 1% maximum the CMMI reinsurance model would reimburse the trust fund for any payments that are made to ACOs between the 1% and calculated MSR or a 2% standard MSR.
Because of this uncertainty about earning savings, many ACOs are not investing sufficiently in care coordination to drive significant savings. We encourage CMS to build upon the success it has already achieved in the Advance Payment ACO model where you used the CMMI Section 3021 authority" to test prepayment of savings to ACOs in the MSSP ACO models. CMS could extend this approach to prepay all ACOs care management fees of $10 PMPM. This approach would also be consistent with and a test of the approach of CMS to move toward care management fees for high risk enrollees in 2015.

3. Trend calculations using national trend numbers:

Using national trend numbers without regard to regional variation could be producing results that lead to unrealistic targets in many regions. An example of such influencing factors could be the impact of localized DME bidding, or re-pricing of home care services that have much greater impact in high utilization areas. CMS should move to regional trends in setting the benchmark. They should also reconsider the use of a fixed dollar amount trend factor as we enter an era of potential negative trends. Negative trends could result in perverse lower % trend factors in low cost areas – thereby missing the original intent of Congress to give low cost areas higher annual increases.

4. Lack of understanding of benchmark and target methodologies:

On top of all the other uncertainty regarding payment in the program there is great uncertainty about the benchmark and target setting process for both programs. This has been most evident in the Pioneer model where the impact of the decedent factor on benchmark volatility has only gradually been understood by all parties. The reality is that this same volatility underlies the benchmark and target relationships in the SSP program. CMS should explore the possibility of an alternative approach to establishing benchmarks and targets that is simpler and provides fixed, not fluctuating targets, for ACOs in both programs.

5. Uncertainty about decreased targets through rebasing:

Many critics of the shared savings approach have noted that it is not a stable approach because shared savings may be entirely recouped through rebasing at the end of a defined period. CMS should explicitly recognize that their intent is to not recoup shared savings but rather to be comfortable with gradually decreasing the trend in medical expenses. As an example CMS could establish a policy that leaves 75% of the savings achieved by the ACO in the rebased target. This delivers real savings to CMS but also leaves sufficient opportunity in the target for ACOs to continue reinvesting in care coordination in expectation of achieving a positive financial result.

6. Changing quality metric specifications and benchmark methodologies:

Because of the lack of real experience with quality metrics in the FFS population, the evaluation of quality outcomes for the FFS population is in a very early stage of understanding. Specifications are just now being made available and a fair understanding of the performance expectations for ACOs is just beginning to emerge. Quality performance has a major impact on financial results. There is also widespread regional variation in quality results. CMS should establish a methodology that allows achievement of success, and payment of earned savings on either an absolute achievement or improvement basis. Providing many pathways to achieve the quality targets would be consistent with the overall intent of CMS to create a program that involves as many organizations as possible, allows as many to
be successful as possible and encourages ongoing investments by making it easier in early years to earn sufficient funds for reinvestment in care improvement.

7. Uncertainty about what interventions are effective:

While there has been a great deal of investment in new care methodologies, most ACOs are continuing to test new approaches. This is another reason that ACOs will be unwilling to take two-sided risk. CMS could help improve the discovery of new approaches that work and improve cost and quality by rapidly developing and investing more in the ACO Learning 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)

CHE Trinity Health believes that ACOs at full insurance risk can be responsible for Medicare Parts A, B, and D. It is not logical or appropriate to exclude Part D from a risk arrangement as it fundamentally affects the rest of the care provided and overall outcomes.

We would also like to suggest a model that – while not full capitation – provides many of the benefits of capitation without requiring ACOs to develop the full operational infrastructure of an insurance company or be subject to the extensive regulatory oversight of insurance companies. We call this the “Full Capitation-Equivalent Model.”

Full Capitation-Equivalent Track

- An ACO contracts with CMS for the opportunity to collect 95% of the savings compared to a fixed projected claims expense based on the prior three year population experience trended forward using regional trend factors. Targets are set at 98% of the FFS expense providing CMS with some upfront savings. The contract specifies expected quality performance as described previously.
- CMS pays the ACO a monthly payment of $50 PMPM to use to make investments in care coordination and alternative payment arrangements with participating ACO providers.
- CMS pays all claims per usual rates with all participating providers.
- ACO negotiates alternative payment arrangements with ACO providers which may result in increased payments made by the ACO or agreed upon discounts from Medicare FFS rates
- ACO is allowed to collect discounted amount from provider each month – based on claims expense documented in their monthly claims reports and negotiated discounts.
- CMS provides running quarterly reconciliations of ACO performance with payments back to CMS or from CMS to the ACO.
- ACO is required to make CMS whole for the advance payments in any event – this is the limit of their downside exposure.

Advantages – Maintains low cost structure of the ACO, no need to build processing, member service infrastructure and very limited need to hold reserves. The only downside risk to ACO initially would be the need to pay back the advance. It allows ACO to establish the alternative payment agreements with other providers deemed essential to achieve alignment across the network. It eliminates need for both parties to pay claims and the likely complexity associated
with that approach. It provides the full return to ACO of full capitation with positioning them to be regulated as insurers.

We believe that safety-net organizations should receive special consideration for this Alternative model.

Absent an approach like this, the difference between a fully-capitated ACO entity and an MA insurer with regard to reserves, operational capabilities, administrative expenses and regulatory oversight/burden seems minimal. It then becomes just an MA approach where alignment takes the place of enrollment, there is no network limitation and no referrals. While it may be a way to get more FFS beneficiaries the benefit of care coordination it inflicts an unfortunate burden of administrative expenses and complexity for all concerned, including beneficiaries.

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

   NO RESPONSE

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?**

   NO RESPONSE

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?**

   CHE Trinity agrees that ACOs will need increased flexibility in the regulatory and compliance framework if they assume full insurance risk. We recommend that CMS and CMMI:
   - Utilize a risk adjusting methodology that provides ACOS with a level playing field with MA plans;
   - Evaluate beneficiary access to ACO providers;
   - Eliminate the 3-day stay requirement for skilled nursing facility admission; and
   - Require ACOs to demonstrate financial reserves or a robust ACO reinsurance policy or develop alternative approaches that recognize the capital reserves already present in some health care providers balance sheets.

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?**

   One major attraction of ACOs that should be preserved is the limited administrative overhead. ACOs are provider-based, closer to their patient and have a long history of actually providing care directly. When considering issues of regulatory oversight or requirements we should be mindful of only adding regulatory burdens, and its resulting administrative expenses, when absolutely necessary.
State licensure for risk bearing entities can be very onerous and costly, and varies dramatically across states. Given that many ACOs operate across state lines, CMS and CMMI should work with states to limit the number of state-specific requirements that ACOs would need to comply with to serve beneficiaries. In addition, we recommend that CMS and CMMI work with states to ease requirements that risk-bearing entities file with the state on an annual basis, given the potential for fluctuation in ACO agreement periods. States that have a less stringent requirement for organized delivery systems should be used as a model.

We believe that all of the waivers that apply to MA plans should apply to a risk-bearing ACO model. There are some key waivers that are not present in the MSSP program that should be added at minimum, a waiver of the skilled nursing facility three day stay requirement, waiver of the home health homebound requirements, an allowance for sharing of internal ACO savings (as opposed to shared savings), in home safety checks prior to procedures, all of the site of service coverage policies that are rooted in the fee-for service system (IRF 60% rule, LTCH 25% rule etc).

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?

See comments above. If ACO’s become a second claims payer they will need many of the same additional patient services capabilities.

8. The Pioneer ACO program currently uses a national expenditure growth trend for benchmarking. What are approaches for setting appropriate capitation rates?

CMS should use regional trends in setting the capitation rates. Using national numbers without regard to regional variation could produce results that may not represent real costs in many regions. An example of such influencing factors could be the impact of localized DME bidding, or re-pricing of home care services that have much greater impact in high utilization areas.

A. What are the advantages and disadvantages of using national expenditure growth trends?

NO RESPONSE

B. What about for using a local reference expenditure growth trend instead?

As noted above we believe this is more appropriate.

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.)

CHE Trinity Health believes that risk adjustment should be handled in the same manner for MA and ACOs. Both should have HCC coding increases capped at the underlying rate of change in the FFS population. We believe a chosen methodology should put MA plans and ACOs on a level playing field.
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?**

As it stands the underlying fee-for-service benefit structure applies to ACOs without exception. This precludes ACOs from steering beneficiaries to “in-network” providers, encouraging compliance with physician orders, or selecting lower-cost treatments. To optimize results, ACOs should have the ability to vary copays depending on services and providers is critical to both improving the quality of care and reducing spending. Such flexibility would allow the ACOs to structure the benefits in a way that encourages beneficiaries to seek care that is evidenced-based and at providers of higher value services that will lead to better outcomes. This would generally result in reduced patient responsibility when following ACO referrals etc.

It would also serve beneficiaries for the ACOs to receive more legal waivers for providing items and services free of charge that might otherwise be considered an inducement. The ACOs need the flexibility to invest in items or services that do not necessarily have current billing codes, but could have a long-term positive impact on the beneficiaries care. PACE is a model for this where, for example, a program can pay to have a wheel chair ramp installed in the person’s home so that they can get out of the house for medical visits, adult day care etc.

A. **How would benefit enhancements differ depending on integration across Medicare Parts A, B, D, and/or Medicaid?**

NO RESPONSE

11. **What are potential program integrity issues that ACOs transitioning to full insurance risk may encounter and what are appropriate preventative safeguards?**

NO RESPONSE

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?**

CHE Trinity recommends that ACO marketing material requirements should be “file and use.” ACOs whose material is consistently found to be inappropriate or who do not comply should be penalized or removed from the program.

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?**

YES

A. **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 beneficiaries to voluntarily align with the ACO it will be clear to the ACO who their focus population is and to the beneficiary where they should first be seeking care. The expectation is that the closer relationship will engender a greater loyalty that will then reduce turnover from year to year in the population. A more stable population allows providers to better know and understand the needs of the beneficiaries and use this information to improve care.

We also believe that ACOs should be able to give members cards that they can carry that provide information about their ACO and coordinating physician office.

Very broadly, CHE Trinity Health believes that alignment of members (which can be advanced through opt-in) transforms practice for everyone, given that real investment needs to be made for a defined population. This is a person-centered practice – allowing a member to say "this is where I am getting care" – and moves the system away from a claims-based approach which was always intended to be a proxy for patient choice. We now have the ability to allow members to choose their care coordinator we should allow them to control the process.

**Part B: Integrating Accountability for Medicare Part D Expenditures**

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 strongly believe that reliance on PDPs will be an insufficient way for ACOs to integrate Part D spending into their accountability models. The distinction between medical benefits and pharmaceutical benefits is an historical artifact that unfortunately creates misalignment between the goals of PDPs and ACOs. In models like the ACO, encouraging medication adherence becomes an important tool in containing overall health costs, even as it increases drug spending. Conversely, PDPs are naturally encouraged to reduce drug spending. As a result, to make such a collaboration work successfully, ACOs and PDPs would need to carve out or make special allowances for adherence-dependent therapies.

   Integration of Part D expenditures also illustrates some of the challenges ACOs have with data timeliness. Since medication adherence is such an integral part of population health management, ACOs need to know about non-adherence quickly—far faster than a PDP could reasonably get such data to an ACO. Further, the high barriers for PDPs and ACOs in even identifying beneficiaries limit their ability to collaborate. We recommend that CMS and CMMI ease such barriers.

   Lastly, pharmacy risk assessment models differ from other risk models in that they do not distinguish between different levels of severity among enrollees who are prescribed drugs in the same therapy class. We recommend that these differences be taken into consideration so that risk adjustment methodologies used by PDPs are more accurate and aligned with those used by ACOs.

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

   One stumbling block to considering strategies in this area is the inadequacies of the Part D data. There are challenges with the Part D data and how, or even if, it can be used given
that the paid amount is blank wherever it was provided through a Medicare Advantage plan. Given this limitation, ACOs would be at a disadvantage in approaching a Part D plan to establish a formal contractual relationship.

In addition, CHE Trinity Health recommends that CMS and CMMI facilitate meetings between representative PDPs and ACOs to develop solutions and best practices to sharing data and leveraging strengths for the most optimal patient outcomes.

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

A. Why or why not?

Given the wide range of activities that an ACO, especially a fully capitated ACO, would be responsible for, we recommend that ACOs collaborate with PBMs rather than becoming a Part D sponsor or contracting directly with a PBM.

B. 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?

The MSSP providers do not have experience with the Part D bidding process and thus would be at a distinct disadvantage. Moreover, meeting the state licensure requirements can be both costly and onerous, but it varies dramatically by state. In addition, it would be simpler for both CMS and the providers to have a unified MSSP program with a combined target for Parts A, B and D combined.

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

No

A. What other mechanisms would allow ACOs to assume accountability for Part D outcomes?

For ACOs to assume accountability for Part D outcomes they would need to be able to obtain timely data on medication adherence, generic use rates, specialty drug use, refill rates, and drug costs. They would then need to be able to apply that information to a standing attributed beneficiary listing to be able to perform analysis on where savings could be realized and outcomes improved.

Part C: Integrating Accountability for Medicaid Care Outcomes

1. Should ACOs caring for Medicare outcomes also assume accountability for Medicaid outcomes?

Yes
A. Why or why not?

To the extent that ACOs can enter into similar arrangements across payers, the transformation will be faster and more effective. It is in the best interest of providers, CMS, states and beneficiaries to bring more populations into similar arrangements. However, this should not be compulsory as there is varying readiness among providers and states to move to such a model. Members report that even in states with state law authorizing Medicaid ACOs and state staff who are knowledgeable, the programs are very complex and getting buy in from the stakeholders and CMS challenging. There cannot be a one size fits all approach applied, so the implementation of joint Medicare/Medicaid ACOs will need to be state by state on a voluntary basis.

In addition, given that the State Innovation Models are currently underway, we recommend that CMS and CMMI look to successful models as guides.

2. What populations should CMS prioritize in integrating accountability for Medicaid outcomes?

We believe the natural extension of the SSP ACO program and the dual demonstration models is to allow ACOs to become participants within the duals demonstrations. This is the population that would benefit the most from care coordination and coordination of the Medicaid and Medicare benefits.

While the aspiration of ACOs taking on a whole geographic area is admirable, we are very far removed from the possibility of doing that successfully in most markets. This would require unprecedented cooperation across providers, payers, the public health agencies, schools (depending on the population) and community-based organizations. We note that the population that may be the easiest to move to this even more comprehensive model is the disabled, but even with that population there is extensive ground work that would need to be completed with strong leadership from CMS before such a move. We think this is best pursued in the context of the State Innovation Models.

3. What should the role of States be in providing appropriate incentives to foster the development of an integrated care system?

The states must play an integral role in aligning providers and payers. Firstly, the states must ensure state law supports the models, which may not only require adding new authority under the Medicaid program, but also removing barriers in existing insurance and privacy laws as an example. In addition, the states must gain CMS approval through state plan amendments or other waivers. As part of these efforts, the states will be playing an active part in the design of the programs and what incentives are built in (as well as barriers removed) to encourage providers to enter into new payment models. This will not only benefit the Medicaid program, but the healthcare system more broadly. If CMS provides assistance to the states, it will serve to strengthen the Medicare program as well by allowing providers to more fully commit to the model and care transformation. Providing more SIM grants should facilitate the ability of more states to take this approach.

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

While we believe that States should be involved in model design to reflect the unique population served and care patterns in the area, the states are often ill equipped in terms of
expertise and capacity. To the extent that CMS could facilitate, the process might move faster. This could be in funds as well as technical assistance. For instance, the State Innovation Model grants have greatly facilitated states in developing alternative payment models that are advancing delivery system reform.

B. Do states have adequate resources to support an ACO initiative in collaboration with CMS?

Each state has a different level of expertise and resources to apply to such initiatives and this can be variable across time. Some states are moving ahead with very ambitious programs that we expect will be very successful. However, to ensure that pockets of the country are not left out of this transformation, CMS will need to provide significant assistance and resources to those that have not yet made significant progress.

In addition to providing states with grants and technical assistance to design new programs, CMS could also allow the Medicaid ACOs that may not be part of MSSP join the ACO Learning Network. CMS could also include a learning track geared to those ACOs that have taken responsibility for this population (whether in addition to Medicare or not). Another service CMS could provide to reduce the burden on states is to provide the data extracts to the providers. This would also ensure that the files are similarly constructed to the Medicare data making it easier for the ACOs to make use of the information. Finally CMS could also create a more extensive SIM learning system to accelerate the development of these capabilities at the state level. Ultimately the States have greater leverage to transform care delivery, particularly if CMS is an active partner.

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?

CHE Trinity Health believes that CMS should work to standardize Medicaid data sets across states and develop a national Medicaid claims data system rapidly.

We also believe that the ACO programs should be changed such that all aligned Medicare and Medicaid beneficiary data is automatically provided to their aligned ACO and then simply provide an "opt out" option for beneficiaries who do not want their data to be shared.

A. What are the capabilities of providers in integrating this data with electronic health records?

NO RESPONSE

B. What are the capabilities of integrating information for care received in the community or from other non-traditional care providers?

NO RESPONSE

5. What financial arrangements would be most appropriate for ACOs assuming risk for Medicare and Medicaid expenditures?

NO RESPONSE
Part D: Other Approaches for Increasing Accountability

1. What are options for accountable care models that are geared specifically for geographically aligned populations of beneficiaries?

While we support the vision suggested by this question, we have such fundamental operational questions and concerns that it is difficult to comment concretely on this option. While there is merit in unifying the payment and quality policies for these currently distinct populations, this would fundamentally change the face of healthcare. Such a model would require not only health systems and community-based organizations to work together in a far more meaningful way, it would also require competing health systems to work with each other. While this is a laudable goal, it is difficult to conceive of upending the fundamental market dynamics in such a way in the near term.

One particular population that has been discussed that could benefit from such an approach in the future is the disabled. Because this population receives such significant public funding from many different state and federal agencies, the need/urgency to move to such a model is greater. While the operational challenges would remain, there is an increased likelihood of getting disparate providers and other organizations coalesced around similar goals in the near term. We believe that the SIM pathway is the best way to move forward on this initiative.

A. What are the most critical design features of a provider-led community ACO model and why?

The return on investment would need to be clear through the structure of the model especially if the model includes risk. It would need to include protections to ensure that the providers/organizations that are contributing the most resources and achieving the most savings get commensurate shared savings.

CHE Trinity Health believes that Medicare and Medicaid payment rates need to provide enough of a compelling reason to entice participants into the program. We think this can be accomplished by a greater share of the savings up front.

B. What additional quality measures should be considered if an ACO is responsible for all covered lives in a geographic area?

NO RESPONSE

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

Yes

A. 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
B. If so, what would the most critical features of such a “layered” ACO be and why?

We have encouraged CMS to include various service delivery and payment reform initiatives within the ACO program since its inception. While basing ACO payment on the fee-for-service system was necessary at the start of the program we believe it needs to evolve to further overcome the perverse incentives built into the existing system and shift compensation to supporting the Triple Aim™. For example, we think that medical home payments can serve to appropriately compensate primary care physicians for an increasingly prominent role in the continuum of care while still resulting in overall decreases in program expenditures. We also believe that bundled payment can play a critical role within an ACO and in fact a number of our members are in both the Medicare Shared Savings Program and the Bundled Payment for Care Improvement. Including bundled payments can, in particular, help to engage physician specialists who otherwise do not have enough return on investment to participate in ACOs.

Part E: Multi-Payer ACOs

1. How can CMS encourage the adoption of ACO contracts among other payers of Medicare ACOs?

Conforming other payer contracts away from fee-for-service and toward models similar to the MSSP program is critical to the long-term success of the program. Consistency across contracts will result in faster and bolder results. Two stumbling blocks in this area include an unwillingness of some payers to share data, or only limited data, and the proliferation of quality measures. To the extent that CMS can assist in either of these areas, it would benefit not only Medicare but the healthcare system as a whole.

In particular, CMS could develop a competitive program similar to the Comprehensive Primary Care Initiative where providers and payers apply together to enter into a coordinated effort to transform care with the government. However, this should also include grant funds that would be used on a local basis to work out agreements across all of the parties, including Medicare and potentially Medicaid, to implement a singular model of payment and quality measurement.

In addition, CHE Trinity Health recommends a multi-payor model to be considered for integrated health systems with significant market contracting capabilities. To qualify, an integrated health system would need to have contracts with a large percentage of payors (approximately 80%). In this instance, CMS could initially share a large portion of the savings with the ACO partner (say 85%). This opportunity for large up-front savings could entice an integrated health system to participate more readily than a smaller savings sharing opportunity. The “Full Captitation- Equivalent Program” previously described could be used for these opportunities.

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 work to consolidate measures in areas where many payers are willing to come together and agree to common methods.