

June 6, 2011

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1345-P
PO Box 8013
Baltimore, MD 21244-8013



On behalf of Medicaid Health Plans of America (MHPA), I am pleased to submit the following comments regarding the proposed rule for the Medicare Shared Savings Program.

About MHPA

MHPA is a national nonprofit organization and the leading trade association solely focused on representing Medicaid health plans. MHPA's 27 member plans range from large multi-state plans to small community-based plans and partner with 35 states for the delivery of Medicaid benefits and services. MHPA's mission is to develop and advance public policy that controls costs and improves access and delivery of quality health care to Medicaid members.

Approach to Comments

MHPA member plans have longstanding relationships with state Medicaid agencies. As managed care and risk-based capitation has become a more popular model for Medicaid programs, health plans have developed sophisticated care management and care coordination structures and have participated in state-run delivery system reforms and pilots.

MHPA recognizes that the proposed rule is specific to Medicare fee-for-service. Given the popularity and attention of ACOs, the number of states considering whether ACOs are appropriate for the Medicaid population, the dual eligible beneficiaries Medicaid health plans serve, and upcoming federal programs to implement ACO in Medicaid (i.e., the Pediatric ACO demonstration authorized by the Affordable Care Act) **MHPA submits the following comments as considerations for the applicability of this proposed shared savings program to Medicaid and Medicaid managed care programs.**

Overview

One of the foundations of an ACO is a patient centered medical home (PCMH) primary care practice. Care coordination is the hallmark of PCMHs and has also been so for successful Medicaid health plans. For many years, Medicaid health plans have been managing care transitions; providing patient-centered care; maintaining quality while controlling costs, fraud, waste, and abuse; and reducing dependence on inpatient care. Because of Medicaid MCOs' long and successful history with coordinating the care of their members, MHPA is keenly interested in assuring that Medicaid ACO rules foster the continuation of the role Medicaid MCOs have had. To that end, MHPA's comments will address the following key areas.

- Implementation Concerns for ACOs in Medicaid
- Structure and Governance – payers should have a stronger role, especially in Medicaid
- Beneficiary Attribution and Opt-out – Medicaid ACOs need to know who their patients are
- Quality Measurement and Reporting Requirements – Maintain consistency with existing Medicaid reporting requirements
- Risk Models and Determining Shared Savings

Implementation Concerns for Medicaid ACOs

The proposed rule estimates that the upfront capital costs to establish an ACO are approximately \$1.8 million. However, this number may significantly underestimate the costs to establish an ACO. According to a study commissioned by The American Hospital Association (AHA) to accurately determine ACO start-up costs, actual figures range from \$5 million to \$12 million, with the potential for even greater annual costs. Because of these costs, physician- and hospital-led ACOs will need capital partners. The projected shared savings will never cover either the start-up or the ongoing annual costs; therefore, there is no incentive for providers to create an ACO.

MHPA recommends that the shared savings earned by the ACO be paid earlier than year three with a return if the savings are not met within this timeframe. This will help offset the start-up and annual ongoing costs.

Structure and Governance

In the Medicaid program, health plans are likely to play a significant and meaningful role in facilitating the successful launch of Medicaid ACOs by developing robust information exchanges and standardized reports that can provide ACOs and ACO participants with timely feedback on comparative clinical results to support improved quality of care and better cost performance. Medicaid health plans will also add value to ACOs and increase their success by leveraging proven clinical interventions that drive down cost and increase quality.

MHPA has strong concerns that 75 percent provider control in a Medicaid ACO, as proposed, would inhibit health plan participation. This may also limit availability of capital necessary to create ACOs by creating a disincentive for other stakeholders who have the ability to fund the infrastructure to develop an ACO if they do not foresee a proportional decision-making role in the ACO.

MHPA recommends that Medicaid ACOs should align the percentage of control with the percentage of stakeholder risk distribution.

Beneficiary Assignment and Opt-Out

Many Medicaid enrollees require complex case management, and the population in general can be very transient. Understanding the health and history of enrollees has been tantamount to

the success Medicaid health plans have experienced in providing high quality, coordinated care to their enrollees. Prospective attribution will allow ACOs to conduct a thorough examination of a patient's health care history, which will then be used to assign members to the appropriate providers and practitioners.

While Medicare statutes require the Medicare beneficiaries have choice of provider and may change providers at will, CMS has allowed states to limit provider networks through waivers. Limiting the network will help prevent "leakage" of a member going to a provider that is not part of the incentive structure of the ACO and therefore may reduce the potential for performance-based incentives. Without limiting the network providers, the savings will not be realized and the ACO program will fail.

MHPA recommends that CMS consider prospective attribution of patients into ACOs and allow limited networks to control "leakage." MHPA also recommends that after a member has declined to opt out of an ACO, that the member is locked into that provider network unless there is good cause for disenrolling.

Quality Measures and Reporting Requirements

In addition to savings targets, the proposed rule requires ACOs to meet 65 measures to qualify for the full shared savings. Additionally, the quality measures fall into 5 domains with a minimum attainment level of 30% for each domain - if one item within a domain does not meet the minimum attainment level, the entire domain fails.

Types of Measures - MHPA recommends the following:

- Lowering the number of measures to a core set and giving the ACO the ability to select from a list of additional quality metrics.
- Phasing in additional measures over time
- For the core set, MHPA would encourage CMS to require states to coordinate ACO measures with other measure reporting efforts endorsed by CMS such as the Electronic Health Record Incentive Program, the Adult and Pediatric Measurement Core Measures, and existing reporting requirements for Medicaid health plans.

MHPA supports the use of standardized measures that can be used across the Medicaid program and measures that are already in use and specified for the Medicaid population.

Scoring – MHPA additionally recommends increasing the minimum attainment level to 50% for each domain but altering the threshold for a domain to pass or fail. Currently, if one item within a domain does not meet the minimum attainment level, the entire domain will fail. Instead, we support using a minimum attainment level on each domain, but the minimum attainment level should roll up to the total score for the aggregate.

Timeperiod - MHPA recommends that mandatory quality measures should be released at least 12 months in advance of the measurement year when performance against the measure will be used to determine savings. Mandatory measures added to ACO programs should have a “reporting only” status for the first year.

Risk Models and Determining Shared Savings

MHPA would propose an option for ACOs to transition from the one sided model to the two sided model within the initial 3 year agreement. Many ACOs will be steered towards the one sided model due to the retrospective attribution of beneficiaries. Physicians will be hesitant to take on risk for an unknown population. The Shared Savings Programs will see the most quality and savings in the two-sided model, so allowing the transition prior to the three-year agreement ending will benefit the program and its beneficiaries.

The CMMI is providing funding to test various payment reform models. Future rules on ACOs should not limit ACOs to shared savings models as they may not align all incentives in the most appropriate way.

Thank you for the opportunity to comment on the proposed rule. Please contact me at 202-857-5725 or tjohnson@mhpa.org with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Thomas L. Johnson". The signature is fluid and cursive, with a large initial 'T' and 'J'.

Thomas L. Johnson
President & CEO