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June 6, 2011

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**VIA ELECTRONIC SUBMISSION**

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1345-P  
P.O. Box 8013  
Baltimore, MD 21244-8013

**Re: Comments on CMS' Proposed Rule for Medicare Shared Savings Program: Accountable Care Organization, Docket No. CMS-1345-P**

Dear Sir or Madam:

The law firm of Wiley Rein, LLP ("Wiley Rein") submits these comments on the Center for Medicare & Medicaid Services' proposed rule for its Share Savings Plan as an interested party in the sustainability of the Medicare program and the success of any of its programs as a stimulus for change to the entire healthcare regime.

Congress, through the Affordable Healthcare for America Act, has charged CMS with the daunting task of establishing a program that "promotes accountability for a patient population and coordinates items and services under parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery." 42 U.S.C. § 1899(a)(1). The overarching goal of the program is to foster Accountable Care Organizations ("ACOs") in order to reduce Medicare care expenditures each year on a national level. CMS proposes to control Medicare cost growth through increased coordination, efficiency, and technology. Without a net savings, the program will have failed. Without a well-received Shared Savings Program for Medicare, the spread of ACO efficiencies into privately-funded health care is likely to be foreclosed or substantially delayed.

While important to Medicare, the concept of ACOs and the Shared Savings Program has potential benefit to the entire healthcare industry. In concept, the Medicare Shared Savings Program should serve as a stimulus to change how all healthcare, however funded, is delivered. But, as currently drafted, the proposed rule has few, if any supporters. This is not merely unfortunate for CMS' implementation of the program under statutory mandate, but it is a wasted opportunity to create a realistic, workable program that could set the foundation for changing the way healthcare is provided and decreasing its overall costs. Thus, ensuring that the ACO concept is given a meaningful chance to succeed is, literally, in everyone's best interest.

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Wiley Rein is a law firm in Washington, DC employing over 500 attorneys and support staff. Wiley Rein offers health insurance benefits to its employees (and their families) who elect to use them. Healthcare costs represent a substantial cost of doing business for any organization. As such, the firm would like to see that ACOs are properly incentivized in Medicare. Unless the ACO concept is widely accepted, it will not make a significant contribution to resolving the health care cost problem.

The adverse reactions to date of pilot program participants, other health care providers, and key legislators to the proposed ACO rules make clear that fundamental change is required if providers are to be induced to make the substantial investments in electronic health records and coordinated administration necessary to operate an effective ACO. We agree that ACOs should be voluntary and thus advance two suggestions which, in our view, will simplify the ACO incentive program and increase the likelihood of substantial participation. The first is to provide ACOs a tool for controlling, within the scope of their capabilities, the total Medicare expenditures on which incentives are based. The second is a more equitable means of establishing the base against which ongoing Medicare costs are assessed.

**I. ACOs Should Be Given The Ability To Control, Within The Scope Of Their Capabilities, The Total Cost Borne By Medicare For Treating Their Assigned Populations**

The proposed rule attempts to honor two inherently inconsistent principles. First, ACO efficiency is assessed on the basis of total fee-for-service costs borne by Medicare for treating an ACO's assigned patients (those beneficiaries to whom providers in the ACO provided a "plurality" of care). Second, an assigned patient is assured of "free choice in determining where to receive health care services," a choice which can be diminished or restricted "in no way." 76 Fed. Reg. 19528, 19645 (April 7, 2011)(proposed 42 C.F.R. § 425.6). Thus, ACOs would be put at risk for costs arising from fee-for-service payments outside their control (and known to them only *ex post facto*). It is difficult to believe that many potential ACO participants would, or should, accept the investment responsibilities and fee forfeiture risks of Medicare accreditation under this uncertainty.

While freedom of choice for Medicare beneficiaries is a principle we endorse, we believe that the scope of that choice is a different issue. ACOs, in our view, should

be permitted and incentivized to offer ACO participation agreements to Medicare beneficiaries. An ACO participation agreement would obligate the beneficiary for the duration of the ACO evaluation period to look to the ACO as the exclusive provider of his/her health care services within the limits of the ACO's capabilities. If the ACO determined that it could not provide a requisite element of care consistent with ACO quality evaluation standards, it would provide a referral to an outside provider who would then be permitted to collect a Medicare fee-for-service reimbursement notwithstanding the patient's ACO participation. Payment for non-referred outside services would be a patient responsibility.

To provide consideration for patients to accept an ACO participation agreement, ACOs should be permitted to offer preferred access or reduced co-payments where applicable to participating patients. Based on experience, Medicare could consider adjusting Part B premiums to provide incentives for ACO enrollment. The concept of voluntary *programmatically* choice is common in private insurance programs and a reasonable way to marry choice with meaningful expenditure control. It would encourage ACOs to bring as much capability as possible within their structures, particularly if ACO evaluation took into account Medicare fee-for-service payments to outside providers acting under referral from ACOs. It could and should be safeguarded against adverse-to-Medicare patient selection by ACOs by requiring that an ACO participation agreement be offered, on a non-discriminatory basis, to each patient treated by an ACO primary care physician.

## **II. An ACO's Efficiency Benchmark Should Be Determined By The Historic Adjusted Cost of Treating Patients Accepting Its ACO Participation Contract**

A reasonable benchmark standard must accommodate both CMS' interest in accurately determining whether real efficiencies and overall cost reductions are being realized in an ACO and the ACO's interest in having a fair opportunity to benefit from its own actual performance. In its Notice, CMS identifies two basic options for benchmarking. Under the first, CMS bases the benchmark on its total three-year historic expenditures for patients then treated by an ACO's primary care physicians. In this option, particularly in physician-rich areas, there may be significant differences between the benchmark patient population and the patient population to be treated during the performance period used for shared savings evaluation. In different situations, the benchmark may be set at an unreasonably high level – *e.g.*, when the benchmark population includes an above average number

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of terminal patients requiring intensive fee-for-service care – or at unreasonably low levels – *e.g.*, where the benchmark population is skewed toward a below average Medicare demographic. In any case, the perceived randomness of the benchmark population related to the treatment population may in itself, as reflected in many health care provider and expert comments, deter ACO participation.

Under the second option, CMS bases the benchmark on its total three-year historic expenditures for patients then treated by an ACO's primary care physicians who are actually assigned to and treated by an ACO. This so-called "prospective assignment" alleviates some of the problems associated with the first option and provides CMS with a benchmark that accurately represents what it would have paid in the absence of the ACO. If an ACO cannot treat the same patients for less, it has failed to implement the requisite efficiency.

Under prospective assignment, CMS may use several methods to account for beneficiaries that die during an agreement year. 76 Fed. Reg. at 19605. Under the first method, CMS would simply exclude the deceased's expenditures from the ACO's actual expenditures for an agreement term. The second method proposes to compare the average expenditures for the deceased during a year to the average expenditures of beneficiaries included in the benchmark. If the deceased's expenditures were within 5% of the average expenditures, CMS would make no adjustment. However, if the deceased's expenditures were more than 5% above the average expenditures, an adjustment would have to be made and a method for determining that adjustment would have to be developed.

Because Medicare expenditures are generally higher in the last year of life than the preceding years, we believe these expenditures should be excluded from the ACO's actual expenditures. CMS' proposal of comparing average annual expenditures for each deceased beneficiary against the average benchmark expenditures and possibly adjusting the expenditures to be in line with the average expenditures in the benchmark creates more complexity, uncertainty, and administrative burden where none is needed.

Unlike retrospective assignment, prospective assignment also allows CMS to account for newly eligible Medicare beneficiaries, who, because of their younger age and better health, often incur fewer Medicare expenditures. Again, CMS proposes several options to account for this population. 76 Fed. Reg. at 19605. For beneficiaries with less than one year of Medicare expenditures, CMS would either

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use the average expenditures for all Medicare beneficiaries during the first year they are assigned to an ACO, or exclude their limited expenditures. For beneficiaries with more than one year but less than three years of Medicare expenditures, CMS would either compute a weighted average based on a combination of their actual expenditures and the average expenditures of all Medicare beneficiaries during the year prior to the year they were assigned to an ACO, or use the expenditures they have accrued.

CMS should exclude expenditures for beneficiaries with less than one year of Medicare expenditures and use actual expenditures for beneficiaries with more than one but less than three years of Medicare expenditures. People are continually becoming eligible for Medicare benefits such that this exclusion will be constant and not inappropriately skew the actual expenditures. Furthermore, by not using averages, this administratively simpler method enables the benchmark to accurately reflect the fewer expenditures, on average, generated by the younger population of Medicare recipients.

However, under both prospective and retrospective assignment, efficient providers have no incentive to join an ACO even though they are exactly the providers CMS aims to have treating its Medicare patients. These providers will not be able to meet their own benchmarks and receive shared savings unless their benchmarks are further adjusted. Adjusting benchmarks to reflect each ACO's expenditures in relation to the nation average for Medicare expenditures would reward efficient providers and incentivize them to participate in the program instead of rewarding inefficient providers.

The fairness of prospective assignment and an adjustment toward average national Medicare expenditures, would properly incentivize enough providers to join an ACO such that CMS could recognize an overall reduction in Medicare expenditures.

### **III. Conclusion**

The basic premise of effective regulation is reasonable implementation and incentive to comply, especially for a voluntary program aimed at efficiency and cost-savings. These comments suggest changes to streamline implementation of the Shared Savings Program, incentivize providers to join ACOs, and increase the chance that Medicare expenditures will drop and ACOs will recover their savings.

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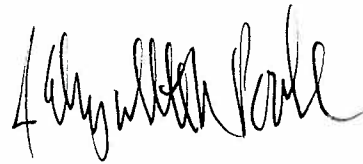
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With the deadline for implementing the Shared Savings Program quickly approaching, CMS is under pressure to move forward with the status quo. However, without changes, this program that has been touted as a real healthcare reform is likely to fail. We hope that the desire to create a workable program will drive CMS to carefully review and consider these proposed amendments.

Sincerely,



Bert W. Rein



J. Elizabeth Poole