Episode Payments and ACOs:
NAACOS Position Statement

Both bundled payment and population health models, including ACOs, have increased in popularity in recent years. While these programs are often considered in isolation, beneficiaries can fall into both types of programs in the same year, which leads to complex program overlap policies that favor bundled payment programs over ACOs. Under current CMS policy, a bundled payment participant maintains financial responsibility for the bundled payment episode of care. Any gains or losses during that episode are linked to the bundled payment participant and are removed from ACO results during year-end financial reconciliation. In the case of the Bundled Payments for Care Improvement (BPCI), when CMS calculates an ACO's shared savings, the spending for ACO patients with an episode of care provided by a bundled payment participant is set to that bundler's target price, regardless of actual spending. Target prices based on higher cost baselines arbitrarily raises an ACO's performance cost and removes their saving opportunity. At the same time, certain ACOs can benefit from bundled payment program overlap if a bundle target price is lower than the ACO's actual spending. While this impact may be favorable or unfavorable for an ACO depending on their costs relative to those of the bundlers in their market, the net effect skews accountability for population-based models and in general undermines ACOs' opportunity for savings through care redesign since any savings would automatically go to the bundler.

At the same time, for the Comprehensive Care for Joint Replacement (CJR) model as well as the cardiac episode payment models (EPMs), CMS will attribute savings achieved during an EPM episode to the EPM participant, and it will include EPM reconciliation payments for ACO-assigned beneficiaries as ACO expenditures. NAACOS continues to oppose this approach as it unfairly penalizes ACOs. CMS will make an adjustment to the reconciliation amount to account for any of the applicable discount for an episode resulting in Medicare savings that is paid back through shared savings under the MSSP or any other ACO model, but only when an EPM hospital also participates in the ACO and the beneficiary in the EPM episode is also assigned to that ACO. In these cases, CMS will reclaim from the EPM participant any discount percentage paid out as shared savings for ACOs when the hospital is an ACO participant and the beneficiary is aligned with that ACO. The agency explains that this adjustment is necessary to ensure that the applicable discount under the EPM is not reduced because a portion of that discount is paid out in shared savings to the ACO and thus, indirectly, back to the hospital. This overlap policy puts ACOs at a disadvantage and unfairly penalizes the ACO who is also invested in coordinating EPM patients' care.

The problem is further exacerbated by the fact that the 60 to 90-day patient episode of care is carved out of the ACO's provider network and there are no requirements for the bundler to transition the patient or their medical records back to the ACO to which they are assigned. CMS argues that prioritizing bundled payment programs helps assure adequate sample size for bundlers. However, much of the variation in per-episode spending is a result of utilization of post-acute care or readmissions, both of which ACOs are often instrumental in managing or preventing. ACOs focus on, and make considerable investments in care coordination and improving care transitions to manage post-acute care effectively. Many successful ACOs credit these efforts for allowing them to achieve shared savings. What's more, bundled payment models focus solely on per-unit costs rather than total cost thereby leaving the very important issue of volume unaddressed.

CMS reversed its previous decision to prohibit ACOs from gainsharing arrangements with bundlers in the final EPM rule published in December of 2016. However, this policy does not apply to all CMS bundled payment initiatives, nor does the agency properly incentivize ACOs and bundlers to partner in

coordinating beneficiary care. In fact, the rules guiding shared savings in the bundled payment programs such as Bundled Payments for Care Improvement (BPCI) specifically preclude an ACO from receiving payments for savings achieved in the bundled payment programs. While the agency claims to encourage collaboration, it has not required nor given proper incentives for bundled payment participants to enter into agreements with ACOs. Many ACOs report significant challenges negotiating arrangements with bundled payment participants, who have little incentive to do so. Unless bundled payment participants and ACOs sign collaborative agreements, ACO patients' care should not be included in bundles. Further, when appropriate based on the bundle and care provided by the ACO, we urge CMS to allow ACOs to participate directly as bundlers in such payment models so they are afforded the opportunity to benefit from the care coordination activities they are already engaged in.

CMS policy should promote the growth of population-based payment models that take responsibility for the entirety of patients' care needs and invest in care coordination throughout the year, thus reducing costly care such as avoidable hospitalizations. We urge CMS to take immediate action to give priority to population-focused health care and exclude ACO beneficiaries from bundled payment programs unless a collaborative agreement exists between the bundler and the ACO. ACOs and bundled payment participants must coordinate care and medical information of the patients they serve. While bundled payments may be able to deliver savings over the short term, placing an emphasis on programs that do not address volume or total cost of care could undermine the success of ACOs in the long term. Additionally, bundled payment models do nothing to incentivize clinicians to focus on preventing the condition or procedure. ACOs help to prevent adverse health conditions and therefore can eliminate the need for a procedure or prevent a patient from developing a condition that an episode model may address. Importantly, these models also fail to address the issue of controlling the volume of services provided. By holding episode participants responsible only for a single episode of care, CMS leaves the Medicare Trust Fund susceptible to aggregate overspending resulting from increased volume. In contrast, ACOs are responsible for total cost of care and therefore have a large incentive to address unnecessary spending and utilization of procedures being performed.

Due to the problems detailed above, we believe CMS should refrain from implementing any new voluntary or mandatory bundled payment programs until and unless the aforementioned issues can be resolved. Specifically, we believe CMS should not move forward with any new bundled payment models until CMS releases their comprehensive analysis of the BPCI experiment. For bundled payment programs currently underway, we urge CMS to exclude ACO beneficiaries from bundles. These beneficiaries could be identified in the HIPAA Eligibility Transaction System (HETS) as being prospectively or preliminarily assigned to an ACO, which would indicate to a bundler that these beneficiaries would not be participants in the bundled payment program. Additionally, we call on CMS to conduct a rigorous analysis to determine the effect of overlapping value-based programs, including the interplay between bundled payment programs and ACOs before moving forward with additional programs. CMS must refrain from implementing new voluntary or mandatory bundled payment programs unless the issues related to overlap with ACOs are addressed in a way that does not harm the ACO model.

ACOs are at a critical turning point. With the implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) accelerating the proliferation of new and innovative payment models, CMS must take action to avoid competing priorities and problems that exist when multiple programs overlap. We urge CMS to prioritize population-based payment models like the Medicare Shared Savings Program (MSSP) and Next Generation ACO (NGACO) Models, as this is the greatest opportunity to focus on total cost of care and truly transform how health care is delivered.