**Medicare Red Tape Relief Project**

Submissions accepted by the Committee on Ways and Means, Subcommittee on Health

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Name of Submitting Organization: Physicians Advocacy Institute

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Statutory

Regulatory ✓

**Please describe the submitting organization’s interaction with the Medicare program**: PAI is a not-for-profit advocacy organization focused on securing fair and transparent payment for physicians. PAI’s Board is comprised of CEOs/former CEOs of state medical associations from California, Connecticut, Georgia, Nebraska, New York, North Carolina, South Carolina, Tennessee and Texas and a Kentucky physician. A significant portion of the members of these and other states’ medical societies treat Medicare patients and submit claims to Medicare.

**Short Description**: The Centers for Medicare and Medicaid Services’ (CMS) current Accountable Care Organization (ACO) regulations result in serious and significant errors with ACOs’ beneficiary attributions and the shared savings calculations for physicians.

**Summary**: The beneficiary attribution methodology established by CMS for the ACO program creates significant transparency issues for providers, hinders care coordination, and fails to recognize/reward major care improvements undertaken by providers. The ACO attribution regulations should be revised to give providers a clearer and more predictable way of understanding which beneficiaries will “count” toward their ACO’s yearly performance.

With CMS using a retrospective attribution model for ACO Track 1, providers are unaware which beneficiaries will be factored into their ACO shared savings score until after the performance year has ended. As such, ACOs have devoted considerable time and resources improving the care of older and sicker beneficiaries, only to find out at the end of the performance year that the beneficiaries are not attributable to the ACO. In the cases, the ACOs are not rewarded for efforts such as improved medication adherence and enhanced beneficiary engagement, even when these efforts result in significant savings for the Medicare program. In other instances, particularly when patients temporarily receive care in one state before returning home, ACOs can unexpectedly be penalized for the high costs/poor outcomes of beneficiaries that they did not anticipate accounting for in the ACO. New regulatory measures are therefore needed to give physicians with greater clarity about which patients have been assigned to their ACO, which would allow physicians to engage in more targeted and effective outreach and ensure physicians are rewarded for these efforts.

As a related matter, greater transparency is needed with respect to when CMS will “reopen” its initial determination regarding an ACO’s shared savings amount, such as when CMS erroneously attributed/failed to attribute beneficiaries to the ACO. Although CMS is authorized to reopen its initial determination when evidence indicates that a calculation error was made, CMS has declined to use its reopening authority in several instances, even when an ACO has presented evidence of error. New and clearer regulatory guidance is needed to ensure that physicians can receive a reopening from CMS regarding its shared savings determination when data indicates a beneficiary attribution or other error was made.

**Related Statute/Regulation**: 42 CFR Part 425

**Proposed Solutions:**

* Improve the attribution process so that physicians are more aware of which beneficiaries will be attributed to their ACO during the performance year
* Require CMS to clarify its reopening authority and grant physicians with a meaningful avenue for beneficiary attribution review