



December 3, 2010

Donald M. Berwick, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-1850

RE: CMS-1345-NC - Request for Information Regarding Accountable Care Organizations and the Medicare Shared Savings Programs

Dear Dr. Berwick:

The Alliance of Community Health Plans (ACHP) is pleased to respond to the Centers for Medicare & Medicaid Services (CMS) Request for Information regarding Accountable Care Organizations and the Medicare Shared Savings Programs (*Federal Register*, November 17, 2010, pp. 70165-70166).

ACHP is a national leadership organization representing community-based and regional health plans and provider organizations that collectively provide health care and coverage for approximately 18 million Americans. Our members are delivery-system aligned health plans that are not-for-profit or subsidiaries of not-for-profit health systems. Member plans share ongoing dedication to their communities, close partnerships with providers, and substantial investments in the innovative approaches and infrastructure necessary to provide health care that is coordinated, affordable and high quality. ACHP members have a long-standing commitment to Medicare, serving 1.6 million Medicare Advantage enrollees as well as beneficiaries in the traditional fee-for-service program.

ACHP and its members are strongly committed to the delivery reforms called for under the Affordable Care Act (ACA). ACHP applauds the agency for its extraordinary work in implementing the Act, and for seeking information through this RFI as it proceeds with rulemaking on the shared savings model and other Accountable Care Organization (ACO) approaches that can be developed through the Centers for Medicare and Medicaid Innovation (CMMI).

Guidelines

In developing policy for the ACO model, CMS must reflect the diversity in the health care delivery system in communities around the country and achieve a careful balance: encouraging provider participation despite a lack of experience with accountability for the total costs or quality for a population, while simultaneously setting standards to assure that these entities actually have the capacity to succeed. For the long-term, the focus

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should be on transitioning to the high value delivery approach that is essential for Medicare and the entire health care system. The "triple aim" should frame both the short- and long-term direction: improved population health, a better patient experience, and lower growth in total cost of care per capita. ACHP suggests several summary guidelines as a framework for policy development in response to the questions posed in the RFI.

- CMS should encourage the more traditional fee-for-service providers to begin to work together through the shared savings approaches set out in Section 3022 of the ACA. At the same time it must use the options available through the statute and the new CMMI to identify and reward those delivery systems that are already more integrated and seek to do an even better job of providing value, so that they can continue to advance and set the future standard for performance improvement, and provide the learning laboratories that are envisioned by the CMMI structure.
- The ACO model is a population-based approach, so policy should require that the ACO, its providers, and the beneficiaries that they serve know in advance about the model they are a part of, so that providers and patients can work together to improve care and lower cost growth.
- The quality and patient experience measures should be standardized and align with current measurement systems. Standards for performance should recognize attainment of high performance thresholds as well as substantial progress toward those thresholds. From the very beginning, CMS should signal clearly that it will continually raise those performance standards.
- Every new ACO does not need to "reinvent" the infrastructure of systems, actionable information and management approaches required for success. They can collaborate with systems that serve a broader range of providers and ACOs. Organized delivery systems and the health plans that are aligned with them can, in many communities, play a valuable role in the implementation of ACO models. CMS should clarify the potential for involvement by such plans, including co-op models, as "other eligible entities" in ACO models.

ACHP offers the following comments and recommendations on the questions raised in the RFI.

Small practice issues

The RFI poses two questions related to how to bring small practices into the shared savings model. What policies or standards should be adopted to ensure that groups of solo practitioners and small practices have the opportunity to participate? And, what payment models, financing mechanisms or other systems would address the problem that many small practices may have limited access to capital to fund efforts from which shared savings could be generated?

This reflects the balancing act between the need for standards to assure that ACOs have the capacity to be successful in assuming accountability for the total costs and quality of a beneficiary population, and the desire to open a pathway to this model for smaller primary care practices.

ACHP members' experience suggests that it not is just access to financial capital and the need for investments in information technology and other systems that will be barriers to implementing an ACO in this environment. Equally if not more critical is the human capital that can manage and use the resulting clinical and cost information to work with providers and patients to change and improve health care delivery, which is the core of what the statute calls for in all of its delivery reforms, including the ACO provisions. The reality is that a certain scale is required to implement that capacity.

CMS should consider several approaches to maintaining the necessary standards to assure success, while bringing smaller practices into these models. Financial incentives could be considered. For example, smaller practices whose beneficiary population is near the minimum number of 5,000 beneficiaries (which is a small base for population-based care) could be encouraged through a variant of an "outlier" policy in determining whether they have met the savings target.

Further, each of the new small practice ACOs envisioned does not need to buy or reinvent systems or care management capacity. CMS should encourage these new entities to collectively use systems that can serve a broader population of providers, ACOs and beneficiaries. One example approach would be for these groups and networks of small practices to work in conjunction with experienced health plans and integrated delivery systems in implementing ACOs. This could be done in several ways, ranging from partnership within the ACO to more arms length contracting arrangements with more experienced organizations that can provide the human and technological capacity to help these providers achieve the objectives set out for successful ACOs.

Quality and Service Measures

The RFI poses three questions related to quality and service measures.

- How to assess beneficiary and, where practicable, caregiver experience with care;
- What aspects of patient-centeredness are important, and how to evaluate them;
- What quality measures should the Secretary use to determine performance, and what should the performance standard be?

ACHP offers the following cross-cutting comments on these questions.

Measurement approaches: Measurement should be standardized and aligned with existing measurement systems and approaches. That is necessary to provide consistent measures and incentives for all providers, allow comparisons among systems, including the new ACOs, and minimize burden. This is not a time for yet another and different set of measures for providers participating in ACOs. Since ACOs are to be measured on and

accountable for total costs and quality for a population of beneficiaries, ACHP recommends aligning with the Medicare Advantage rating system, as that is Medicare's existing population-based model. Where additional measures are needed, such as for patient-engagement issues noted below, CMS should incorporate into ACOs the appropriate measures being adopted more broadly for Medicare.

Comprehensiveness: The statute requires that ACOs be "... willing to become accountable for the quality, cost and overall care of the ... beneficiaries assigned to it." That requires that they report on and be accountable for a comprehensive set of measures for the population that they serve. They should not be able to pick and choose a small subset of measures, as that would diffuse accountability for the quality of care and prevent the national and community level comparisons that are essential. Measures should be collected across the entire eligible population, not just across those who received access to care, or had a minimum level of contact with the ACO, because population health is not just health care.

Standards: In addition to defining the measurement systems, CMS has to set the standards that it will use to assess performance, and in particular, whether an ACO that meets its financial targets qualifies for a share of savings based on its performance on the quality measurements.

There is a great deal of variability in current performance among providers and communities. As a result, it is necessary, at least in the short-term, to set standards that accommodate both ACOs that attain targeted standards for beneficiaries (such as achieving four or five star ratings) as well as those that show substantial improvement (such as by closing the gap between prior performance and the goal by 1/3 each year). While this is a logical starting point, CMS should also consider phasing to an all-attainment goal over time.

Further, ACHP strongly encourages CMS to pursue as aggressively as practical the statutory directive to improve quality over time "... by specifying higher standards, new measures, or both..." Implementation of the ACA, including these ACO models, provides a unique opportunity to set the clear expectation that standards for care for beneficiaries can and should be raised over time.

Patient-centeredness: The statute requires that ACOs meet "patient-centeredness criteria" set by the Secretary. As noted above, ACHP believes that it is best to align with existing and evolving measures used by Medicare rather than setting up another new metric. For example, the CAHPS[®] measures include components that address patient needs, such as getting care when needed and would be a viable starting point for patient-centeredness. Additional measures that are being developed for Medicare can also be valuable metrics for assessing patient-centeredness, including measures of health care acquired conditions, readmissions, and safety measures. Further, CMS needs to begin to adopt consistent standards of evidence-based practice across Medicare, FFS, MA and in the new delivery models like ACOs.

Attribution of Patients to ACOs

The RFI poses a question related to attribution of patients to ACOs, and in particular, whether attribution should be prospective or retrospective.

This is one of the most critical issues to consider in converting the ACO approach from a policy concept into reality, and ACHP strongly recommends prior attribution. ACHP members' decades of experience in population-based care tells us that it is essential that a delivery organization and its patients know in advance about the approach. The ACO must be able to reach out to the entire population of its beneficiaries, those who seek care and those who don't, to initiate preventive benefits, identify and begin to care for beneficiaries with potential health risks, and better serve and coordinate care for those who need it. Defining a population retrospectively, by definition, only captures those who sought care, missing accountability for those who needed care but did not receive it. Equally important, beneficiaries need to know about the ACO. At the heart of patient engagement is a system in which caregivers and patients work together to achieve the desired results. And a system that is not completely transparent to beneficiaries will simply not be sustainable.

We recognize that CMS will have to deal with additional and difficult issues of patient notification, and questions about whether and how patients may be able to "opt out," as well as developing statistical adjustments in any final reconciliation for patients who enter the community and exit. But any system, prior or retrospective, will require difficult adjustment and reconciliation issues, and we believe that the success and long-term viability of the ACO model calls for prior attribution.

Payment models

The RFI asks what additional payment models CMS should consider beyond the shared savings model, and what are their relative advantages and disadvantages.

The shared savings model, within traditional fee-for-service Medicare, provides potential rewards for those lowering costs and improving quality, but no consequence for those with excess costs and/or poorer quality. That is a starting point for encouraging participation by some providers and communities, but many organized delivery systems are prepared to move well beyond that model. ACHP believes that CMS, through CMMI, should encourage innovation in payment that will continually push the envelope on transformation of delivery.

CMMI should consider a range of alternatives for health care organizations that can continue to serve as a benchmark for the rest of health care. Beyond partial capitation and other forms of shared risk, these can include tests of approaches such as care coordination fees and bundled payments, as well as medical homes within an ACO model. As the statute notes, these approaches are likely limited at first to highly integrated systems and organizations capable of bearing risk. ACHP believes that testing

and rapid feedback about such approaches, along with shared savings models, will allow CMMI to pursue its long-term mission to foster testing, learning, dissemination and further innovation.

Finally, with shared savings as the starting point for many providers and communities, CMMI should begin now to think through potential transition approaches, testing how these shared savings models can transition into more integrated and truly accountable models of care.

Thank you for your consideration of our comments and recommendations. We would be happy to answer any questions and would be pleased to provide additional information and work with the agency as it implements the shared savings and Accountable Care Organization models.

Sincerely,

A handwritten signature in black ink that reads "Patricia P. Smith". The signature is written in a cursive style with a large initial "P" and "S".

Patricia P. Smith
President and CEO