Consumer-Purchaser
DISCLOSURE
PROJECT Improving Health Care Quality through Public Reporting of Performance

December 3, 2010

Donald Berwick, MD, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

File code: CMS-1345-NC

RE: Request for Information Regarding Accountable Care Organizations (ACOs) and the Medicare Shared Saving Program

Dear Dr. Berwick:

The Consumer-Purchaser Disclosure Project is a collaboration of leading national and local consumer, labor, and employer organizations committed to improving quality and affordability of health care through the use of performance information to inform consumer choice, payment, and quality improvement. We support the efforts of the Centers for Medicare & Medicaid Services (CMS) to implement the Medicare Shared Savings Program and test innovative models that complement the Savings Program.

Consumers and purchasers want an affordable health care system that works for them. We believe that ACOs, if done "right," can be a tool that increases quality and affordability of care. Given the current climate – both market and political – it is imperative that CMS hold ACOs to a standard that makes certain they can deliver on goals of improving health, improving patient experience, and reducing costs. We believe these standards will also set the stage for assessment of other new models of care that will be implemented under the Patient Protection and Affordable Care Act.

Below we offer responses to the questions posed in the Federal Register. We have combined our response to the first two questions since they are related. At the end of the document, we attach the Consumer-Purchaser Disclosure Project Principles on ACOs. These principles served as a guide post for our comments.

What policies or standards should we consider adopting to ensure that groups of solo and small practice providers have the opportunity to actively participate in the Medicare Shared Savings Program and the ACO models tested by the CMMI?

What payment models, financing mechanisms, or other systems should CMS consider assisting small practices that may lack access to capital necessary to participate in the ACO program?

There is a natural and productive tension between being inclusive and encouraging participation on the one hand and setting standards high enough to actually improve the quality and efficiency of care delivery on the other. It is critical that CMS not set a lower bar for solo and small practice participation in ACOs. The standards and accountability metrics need to be robust enough to

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generate meaningful improvements in quality of care and lower costs. Regardless of size or network composition, all ACOs and their providers should be required to meet and report on their performance against a core set of quality and cost standards.

However, it is clear that solo and small practices are likely to need technical assistance and support to facilitate the kind of practice change that will help them succeed in ACOs. First and foremost, small primary care practices should be targeted for such help. Second, a glide path for small primary care practices to be a part of ACOs should be explored: steps along the way could, for example, include meeting EHR meaningful use requirements and becoming a patient-centered medical home. Importantly, ACOs themselves should play a role in providing technical assistance and resources to small practices. They could make use of already available resources, like meaningful use money and Regional Extension Centers from the American Recovery and Reinvestment Act or private sector collaboratives. CMS should consider how ACO criteria and standards could incentivize ACOs to aggregate resources in a way that effectively supports practice transformation among solo and small practices.

For small primary care practices that meet a robust set of criteria more capital could be made available, using a model such as that of the Small Business Administration, via reduced interest rate loans. In addition, for those that meet the robust criteria, CMS could also make extra PMPM payments to the primary care practices directly, and then "deduct" the extra payment from the savings before sharing it with the practices.

How should we assess beneficiary and caregiver experience of care as part of our assessment of ACO performance?

We strongly support CMS including assessment of patient/caregiver experiences of care as one of the "core capabilities" of an ACO. ACOs should be accountable for measuring, reporting, and improving patient experience (including those domains for which we particularly expect ACOs to drive improvement, such as care coordination, patient engagement, and communication with patient). What follows are recommendations on how to make that happen:

- Use standard instruments to get reliable measures and permit comparisons
    - Domains of interest include, but are not limited to, care coordination, patient engagement, and communication with patient
    - Examine Clinician & Group CAHPS to determine whether existing content and methodology meets post-Affordable Care Act needs
    - Create new ACO CAHPS module, similar to that being developed for the medical home.
- Require reporting at the individual provider-level, if feasible
- Develop a data collection, analysis, scoring and reporting methodology that addresses emerging decision-making needs of patients, providers, purchasers and policymakers
    - Provide for "nested" layers of reporting, including ACO, practice site, and individual provider
    - Evaluate the impact of new cost-sharing arrangements and plan type in reports of patient experience
    - Take advantage of the contemporary information environment (i.e., web and mobile applications) for data collection and reporting results
    - Ensure that patient experience data is available in a timely way for all decision makers, with adequate tools for drill-down, comparison, and benchmarking

- Also require qualitative activities – like patient/family advisory councils and focus groups – as another means of gauging patient and caregiver experience of care and providing real-time feedback that providers can use to improve care practices.

The Affordable Care Act requires us to develop patient-centeredness criteria for assessment of ACOs participating in the Medicare Shared Savings Program. What aspects of patient-centeredness are particularly important for us to consider and how should we evaluate them?

Several aspects of patient-centeredness are important for CMS to consider in the development of criteria, including.

- Extent to which the provider understands the patient and caregivers' needs and preferences (including life circumstances) and the extent to which care delivered is concordant with those preferences;
- The level of patient engagement, including patient activation and self-management;
- The routine and comprehensive assessment of patients' experience of care, and the use of results to improve care;
- How well a patient's care is coordinated, both within an acute episode, as well as throughout the treatment for a chronic condition(s);
- How well a patient's care is managed by a primary care provider or relevant specialist, especially for patients with multiple chronic conditions who may have upwards of 10 providers, and dozens of medications;
- The use of shared decision-making tools for preference-sensitive conditions and treatments;
- The availability and use of a shared care plan that is electronically accessible to the patient, her family caregiver, and all members of the care team, including non-physician members that provide community-based support;
- Patients' access to their health information in their preferred format, and in a way that is portable and timely;
- Inclusion of qualified health professionals who can deliver coordinated patient education, and support self-care, self-management, health maintenance and risk reduction;
- Connections to community resources; and
- Comprehensive inclusion of the patient in all aspects of the care process.

Many of these aspects can be evaluated by tpatients and select indicators that provide evidence of patient-centeredness (e.g., absence of duplicative tests is good indicator of care management, electronic access to health information; improvements in patient-reported functional status are a good indicator of patient engagement).

In order for an ACO to share in savings under the Medicare Shared Savings Program, it must meet a quality performance standard determined by the Secretary. What quality measures should the Secretary use to determine performance in the Shared Savings Program?

To be able to better assess and compare across ACOs, a core set of measures should be monitored and reported on by all ACOs. To adequately capture the range of care needed to be assessed, thirty-five is a reasonable starting number of measures to consider for the core set. This recommendation is also based on the number of measures being used in current ACOs and pay-for-performance programs. The core set should capture preventive care and a portfolio of measures that address the breadth of care for at least three chronic conditions (which should

include measures that address multiple chronic conditions). Additionally, there must be sufficient measures in the areas of patient engagement, patient safety, care coordination, outcomes (including clinical, patient-reported and population-based outcomes), functional status, episodes of care, resource use, appropriateness, and patient experience. Measures collected and reported should be stratified and reported by race, ethnicity, primary language, gender and disability to facilitate reductions in health disparities.

ACOs should also be required to annually publicly report performance information to the public as well as providers. The information for patients should be at the doctor level and clearly presented, with explanations for how to interpret the information. Materials should be provided electronically and hard copies should be made easily available to patients/caregivers without access to the internet.

Places to look for measures to comprise the core set include:

Measures from current ACO programs:

- Blue Cross Blue Shield of Massachusetts Alternative Quality Contract
- Brookings-Dartmouth ACO Learning Collaborative
- Premier ACO Collaboratives

Measures from National Quality Forum Projects:

- National Voluntary Consensus Standards For Ambulatory Care Using Clinically Enriched Administrative Data
- National Voluntary Consensus Standards for Ambulatory Care: Additional Outpatient Measures 2010
- National Voluntary Consensus Standards For Hospital Care: Outcomes and Efficiency Phase I & II
- National Voluntary Consensus Standards for Medication Management
- National Voluntary Consensus Standards for Patient Outcomes
- National Voluntary Consensus Standards for Patient Safety Measures
- Endorsing Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination
- National Voluntary Consensus Standards for Serious Reportable Events in Healthcare

Measures from PROMETHEUS Evidence-Based Case Rates™ (ECRs™)

What additional payment models should CMS consider in addition to the model laid out in Section 1899(d), either under the authority provided in 1899(i) or the authority under the CMMI? What are the relative advantages and disadvantages of any such alternative payment models?

We strongly support models that reduce payment for units of service and increase the proportion of payment tied to quality outcomes and efficient resource use. The proposed shared savings arrangement is essentially a “bonus only” model. ACOs can achieve shared savings but there is little disincentive if costs are not lowered or quality does not improve. We suggest implementing the kind of two-way risk model that is being advocated by both MedPAC and independent payment experts such as Robert Berenson. Providers and CMS should take responsibility for both the risk

and reward of the shared savings program. For very sophisticated ACOs, CMS may want to consider full capitation programs that provide greater rewards for the higher risk.

Additionally multi-payer payment pilots, including Medicaid and major private payers, in specific communities are extremely important to develop. Patient centered medical homes, bundled payments, and FFS with quality adjustments (defined to include clinical quality, patient experience, plus overall resource use) are additional payment strategies to consider. Communities should propose the variants of models they would like to implement. Testing multiple models will be far more valuable than testing a single version of ACOs and then waiting years to test other strategies.

For any of the models, a majority of the savings should be returned to beneficiaries and CMS (or other purchasers of care if there is a public-private partnership). A target would be for 66% of the savings to be passed on to beneficiaries and Medicare (or other purchasers), with 33% going to providers.

Thank you for the opportunity to comment on this important initiative. If you have any questions, please contact either of the Disclosure Project's co-chairs, Debra Ness, President of the National Partnership for Women & Families or David Lansky, PhD President & CEO for the Pacific Business Group on Health.

Sincerely,

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President
National Partnership for Women & Families
Co-Chair, Consumer-Purchaser Disclosure Project

David Lansky
President & CEO
Pacific Business Group on Health
Co-Chair, Consumer-Purchaser Disclosure Project

Consumer-Purchaser Disclosure Project Principles for Accountable Care Organizations

In order to be successful, ACOs should:

- **Result in significant improvements in quality and care coordination and decreased cost.** This will require creating a robust dashboard of measures that reflect areas that matter to consumers, including clinical outcomes, functional status, appropriateness, patient experience, care coordination, cost and resource use and setting minimum benchmarks that providers must meet in order to reach performance goals. We do not believe that providers should receive rewards for providing marginally effective care or care that is already routinely furnished.

- **Realize meaningful cost savings.** This can be accomplished by 1) starting with having meaningful measures of cost, efficiency, and resource use; 2) setting minimum benchmarks that encourage innovations in care; and 3) once shared savings programs have demonstrated success, moving to models of shared risk and capitation.

- **Align the public and private payers.** To represent a substantial cross-section of the market, ACO/shared-savings models should include public and private sector payers, including Medicare, Medicaid, and private payers. Medicare should consider multi-payer initiatives as an important criterion for assessing which pilots to select.

- **Return a majority of the savings to beneficiaries and purchasers of care.** A target would be for 66% of the savings to be passed on to beneficiaries and the purchasers, with 33% going to providers.

- **Risk adjust payments to reflect the complexity of patients.** This is necessary in order to achieve appropriate levels of care coordination and transition activity, as well as for ensuring proper care around rare events (e.g., organ transplants and other very high-cost procedures).

- **Continually monitor the health care marketplace** to ensure that ACOs are not resulting in market consolidation and higher costs. As we learn more, there may be specific regulations that we need to help assure access to high-quality and affordable care through ACOs.

- **Reduce disparities in care.** High quality care should, by definition, reduce disparities. To achieve this data on race, ethnicity, language and gender (RELG) must be collected for all patients, and performance measures must be stratified according to this data so that disparities can be identified and addressed.

- **Protect consumers in the "attribution" process.** Attribution policies must allow patients the choice of going outside of their ACO for care, provide for adequate access to specialists, and make transparent the financial incentives available to providers.