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Donald M. Berwick, M.D.
Administrator
Centers for Medicare and 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 Pacific Business Group on Health (PBGH) appreciates the opportunity to comment on the RFI regarding Accountable Care Organizations and the Medicare Shared Saving Program. PBGH is a business coalition of 50 purchasers that seeks to improve the quality and availability of health care while moderating cost. Since 1989, PBGH has played a leading role both nationally and statewide in health care measurement, trend moderation, and provider accountability through public reporting. PBGH previously collaborated with the Centers for Medicare and Medicaid Services (CMS) Better Quality Information pilot program and is pleased to contribute learnings from that effort in these comments. We believe that public and private sector alignment is critical to the success of CMS' efforts to implement the Medicare Shared Saving Program and the Center for Medicare and Medicaid Innovation (CMMI) in ways that produce sustainable and significant effects on health system performance.

As the nation's largest purchaser of health care, CMS is in a critical position to advance health care transformation through payment reform and delivery system redesign. We urge CMS to set ambitious clinical and financial performance goals for the proposed ACOs and other innovative models of care. "Accountable for what?" is a question PBGH has raised often in discussions with diverse stakeholders. The public should expect that health care reform will deliver better health outcomes and high quality care that is affordable for all Americans.

Below we offer responses to the questions posed in the *Federal Register*. At the end of the document, we include Purchaser Principles on ACOs that reflect our expectations and aspirations for these vital new programs. Purchasers believe plan and provider organizations will achieve improvements in quality and care coordination only if performance is measured based on outcomes rather than process and structure. To deliver cost savings and trend moderation, new delivery models must also incorporate payment reform that rewards quality and not quantity. PBGH's comments on the RFI questions reflect the following principles:

- Enhance quality and cost transparency
- Focus on outcomes measurement
- Support patient-centeredness in care delivery and measurement
- Promote pay for performance
- Improve affordability and access
- Support a competitive marketplace
- Demonstrate meaningful use of health information technology.

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 CMMI?

What payment models, financing mechanisms or other systems might we consider, either for the Shared Savings Program or as models under CMMI to address this issue? In addition to payment models, what other mechanisms could be created to provide access to capital?

Groups of solo and small practice providers should be held to a common set of quality and resource management objectives. There are ample examples by small group practices and organizations that have used basic clinical registries to leverage information to deliver integrated care and improve quality. Elements of HITECH and investments in state or regional information exchanges may be leveraged to support solo and small practice providers. While shared or full risk models support incentive alignment among providers, care should be taken to address financial solvency requirements and limit downside risk for smaller organizations and provider groups.

How should we balance these two points of view in developing the patient attribution models for the Medicare Shared Savings Program and ACO models tested by CMMI?

A broad, inclusive approach to attribution would serve the larger goal of population health improvement. We believe it would be reasonable to use a plurality of E&M procedure codes to attribute members to physicians, with appropriate designation of provider specialty and subspecialty. We recommend active provider engagement in review of attributed patient lists and patient notification with an opt-out provision to assure consumer-level choice. In general, large purchaser experience with disease management programs has been that opt-in strategies do not elicit high levels of participation.

This E&M recommendation is based on PBGH's experience through the California Physician Performance Initiative in which commercial PPO data was pooled to measure and report physician-level performance for 15 quality measures. This program followed an earlier pilot through CMS' Better Quality Information program. Additional information about the technical specifications and methodology is available at http://www.cchri.org/programs/programs_CPPI.html. A potential refinement could be applied such as the inclusion of cost parameters as reported by the CMS Physician Feedback/Value Modifier Program. However, in using retroactive claims analysis, care must be taken to address changes in billing patterns based on elimination of consultative E&M codes.

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

ACOs should be accountable for measuring, reporting, and improving patient experience, including care coordination, patient engagement, interaction with providers and office staff (e.g., being treated with respect), accessibility and responsiveness. Standard survey instruments should be used to obtain reliable measures and permit comparisons. The methodology should also support drill-down analysis by users to specific domains of interest and permit comparisons of provider-level performance. The cost of survey administration needs to be addressed by leveraging mobile, Web and interactive voice communication tools.

What aspects of patient-centeredness are particularly important for us to consider and how should we evaluate them?

Key elements should include:

- Understanding patient/caregiver needs/preferences
- Patient engagement
- Assessment of patient experience
- Care coordination
- Care management
- Shared care plan electronically accessible to all members of the care team and patient/caregiver
- Use of shared decision making
- Use of qualified health professionals to deliver coordinated patient education and health maintenance support,
- Inclusion of the patient in the care process,
- Support for self-care, self-management and risk reduction
- Patient access to their health information.

What quality measures should the Secretary use to determine performance in the Shared Savings Program?

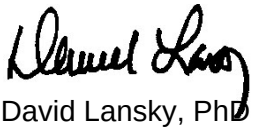
We encourage CMS to focus on clinical outcomes and measures of functional status to help drive quality measurement beyond current process measures that primarily leverage claims data. With the expansion of clinical registries and improved data interchange and integration, we hope that these systems can form the backbone of future generations of metrics that capture the overall impact of health care services. We also believe that appropriate use and measures of overuse and underuse are important elements in assessing the performance of the Shared Savings Program.

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?

Risk-sharing, bundled payments and pay-for-performance are important elements for aligning incentives among providers and advancing investments in delivery system re-engineering. Examples from the California managed care experience also warn us to exercise appropriate cautions for assuring that organizations have the capacity and reporting infrastructure to manage financial risk, and that there may need to be a minimum patient volume threshold before downside risk provisions can apply. We believe that gain-sharing provisions need to integrate both cost savings and quality performance metrics to assure appropriate management of overuse and underuse.

We hope you will find our comments useful and that CMS will take a strong leadership role in defining ACO criteria that will help achieve the triple aim of affordability, quality care and improved population health. We look forward to the opportunity to provide additional input on the forthcoming regulations.

Sincerely,



David Lansky, PhD
President & CEO

Enclosures

cc: PBGH Board of Directors
Andrew Webber, President, National Business Coalition on Health
Jonathan Blum, Director, Center for Medicare Management, Centers for Medicare & Medicaid Services
Richard Gilfillan, MD, Acting Director, Center for Medicare & Medicaid Innovation
Peter V. Lee, Director of Delivery System Reform, US Department of Health & Human Services

Pacific Business Group on Health
Purchaser Principles for Accountable Care Organizations

Introduction:
The promise of an Accountable Care Organization (ACO) is to deliver improved quality care while moderating costs. Purchasers believe plan and provider organizations will achieve improvements in quality and care coordination only if performance is measured based on outcomes rather than process and structure, and if payment is based on quality rather than quantity. The composition and definition of ACOs may vary, but regardless of the model, a set of consistent principles should guide organizational goals and processes.

ACOs should be transparent. Sharing information about clinical performance and financial arrangements is critical to performance accountability. Participation in collaborative measurement and reporting performance at the level that matters for individual decisionmaking is essential to helping consumers access the right care at the right price based on their needs.

ACOs should be outcomes-focused. ACOs must apply metrics that hold providers accountable for evidence-based care that improves health outcomes and reward results rather than rely on measures of structure and process.

ACOs should be patient-centered. ACOs must use a patient-centered, team-based approach to care delivery and member engagement that supports shared decision-making between patients and providers. ACO performance measures must be relevant for and available to patients, and include cost and patient-experience.

ACOs should pay providers for quality, not quantity. ACOs should pay for quality and efficiency by using strategies like bundled payment, shared risk and gain-sharing to align incentives among physicians, medical groups and hospitals.

ACOs should address affordability and contain costs. ACOs must hold providers accountable for stewardship of health care resources by having specific objectives such as managing the cost trend increase to Consumer Price Index (CPI) plus one percent.

ACOs must support a competitive marketplace. ACOs must support competition and transparency, providing consumers with information about the relative performance, cost and efficiency of providers. ACOs should not be allowed to achieve the scale or market dominance that would permit price-setting or other anti-competitive practices.

ACOs must demonstrate meaningful use of health information technology. ACOs must require their providers to use health information technology for clinical decision support, clinical integration, and information exchange among providers and with members.