June 6, 2011

Donald Berwick, MD, Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services, Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW.
Washington, DC 20201.

Dear Dr. Berwick:

On behalf of the multi-specialty groups and delivery systems and associations that are members of the Healthcare Quality Coalition, we are writing to you today regarding Section 3022 of the Affordable Care Act's notice of proposed rule-making (NPRM) for the Medicare Shared Savings Program/Accountable Care Organizations (ACOs).

The Healthcare Quality Coalition (HQC) represents healthcare providers throughout the nation who are dedicated to the concept of value-based care. This philosophy focuses on healthcare practices that promote measurable, high quality care. We believe healthcare entities should be held accountable for the quality and value provided to the patients and communities we serve. We are united in our view that healthcare reform should address more than just government payment systems and health insurance. Reform should change the way health care entities are financed. Currently, too much money is wasted on unnecessary procedures because payment is driven by the amount of care provided, not the quality of that care. Providers should be reimbursed for keeping patients healthy and coordinating their overall care. An essential part of healthcare reform, and our ability to leverage value, is to correct current regional disparities in Medicare reimbursement. Current unmerited regional disparities in reimbursement stifle overall quality and hinder incentives to promote more efficient care. We believe competition and transparency are healthy. Hospitals and physician groups that provide higher quality care, underscored by national measurement indices, should be provided financial incentives. The outcome saves patients, employers and communities precious healthcare dollars – making our nation's healthcare more affordable. http://www.qualitycoalition.net/default.aspx

We understand and appreciate the complexity of the task which the Centers for Medicare and Medicaid Services ("CMS"), along with the Federal Trade Commission ("FTC"), the Department of Justice ("DOJ"), and the Internal Revenue Service faced in drafting the proposed rule and the related guidance. As leaders in providing integrated care, we are strong supporters of the Accountable Care Organization ("ACO") concept as envisioned in the Patient Protection and Affordable Care Act ("PPACA"). Further, we are committed to a partnership with CMS to provide care coordination involving collaboration among providers and suppliers and the sharing of information across the continuum of care directed toward the three-part aim: (1) better care for individuals; (2) better health for populations; and (3) lower growth in expenditures.

We support the concept of ACOs as envisioned in the Affordable care Act because of the need to ensure that patients, over time, receive the best and most efficient care possible. To do so, requires more coordination and collaboration among providers and suppliers than is the case in much of our healthcare system today. We believe that it will be important to develop alternative payment systems

that properly reflect the emerging realities of delivering health care in the US. Some of the emerging ideas, including the concepts for Accountable Care Organizations and Patient Centered Medical Homes will require fundamentally different payment arrangements and therefore fundamentally different data collection systems to ensure equity in payments for Medicare services and control over global Medicare expenditures. In our view, it is not too early to begin the process of identifying payment options and the data systems that are available and/or needed to support such options.

As presently drafted the proposed rule insufficiently advances the dual goals of cost reduction and improved patient outcomes because of excessive focus on shifting risk to providers. In the spirit of constructive suggestions, we believe that health systems will be much more likely to participate in the Medicare ACO program if CMS focuses on changes to the following aspects of the policy proposals:

Quality Measures and Reporting for Shared Savings and Pioneer ACOs: Many of our members have demonstrated their ability to provide high quality care through measurable, comparison-based projects. For example, some of our members have participated in the Physician Group Practice Demonstration and the Hospital Quality Incentive Demonstration. Other HQC organizations have been recognized for the high quality of care they provide in their communities as well. We believe that ensuring high quality care is a critical component to restructuring Medicare's payment methodology, through ACOs and other initiatives. Our members believe that robust quality measurement will be critical to the success of the ACO program and to ensuring that patients are receiving high value healthcare. However, we have concerns about the quality proposals for the Shared Savings Program.

In the proposed rule, CMS states that it would require reporting on 65 quality measures to establish the quality performance standard ACOs must meet in order to share in savings, provided they also meet the program's cost savings requirement. These 65 measures span five quality domains: Patient Experience of Care, Care Coordination, Patient Safety, Preventive Health, and At-Risk Population/Frail Elderly Health. We believe that quality metrics are important for patients, CMS and providers. However, instituting 65 measures in year one is a substantial practical constraint. We recommend that CMS phase in quality measures over time. We encourage CMS to focus on a limited number of high-impact quality measures during the first years of the Shared Savings Program. Many of the 65 proposed measures are not currently collected by all providers. According to a recent Health Affairs article, only 11 of the 65 measures can be met with claims data, while 54 require potentially expensive data collection from medical records or surveys. Ultimately, CMS should select measures that not only are clearly linked to improving quality outcomes, but also do not require providers to create and/or invest in new data collection and monitoring systems that are unrelated to those already in place, such as ARRA Stage 1 meaningful use requirements.

In the rule CMS sets the quality performance standard at quality measures submission for year one and based on quality measures scores in subsequent years. CMS indicates that ACOs must attain a minimum performance level to be eligible for shared savings. We believe that such an approach, provided that it incorporates the appropriate number and type of measures, will drive quality improvement among ACOs.

Limits placed on accounting for beneficiary acuity levels that are documented and appropriate will dilute true savings realized by the ACO and will be a disincentive for management of patients with complex care needs. We support CMS' proposal to employ a methodology that incorporates diagnostic information, specifically the CMS-HCC prospective risk adjustment model that has been used under the MA program. We view the concept of coding intensely to be synonymous with

coding accurately for quality. We recommend that CMS begin programs to educate physicians and other providers about the importance of coding accuracy. Using diagnostic information will likely lead to some degree of increased identification of higher-cost conditions, but some degree of increased diagnostic coding is desirable in order to correct for inaccurate or undercoding that would prevent proper management of these affected populations. We respect CMS' need to hold spending to a budget neutral amount, but CMS should not be in the position of perpetuating disparities in care for patients, disparities in reimbursements for providers, or shortcomings in the integrity of CMS' knowledge of the presence of disease in the population.

Potential costs of ACO program participation. The proposed rule estimates that the average cost of starting an ACO will be $1,755,251 with the expectation that total startup costs may vary by a factor of two. A recent study by the American Hospital Association estimated start-up costs of as considerably higher: $11.6 – $26.1 million. Even for organizations like ours, that have already made substantial investments in care coordination, implementing the types of changes required to achieve further program savings will require the investment of substantial resources.

Another dilemma for an organization contemplating a transition to an alternative reimbursement strategy resides in the allocation of fee-for-service revenue to activities that are desirable but currently uncompensated. Care must be coordinated; electronic medical records must be configured and implemented; disease management strategies must be established and disseminated among caregivers; patients must be educated and supported in healthy lifestyles.

Alternative payment arrangements. We are concerned that the proposed shared savings payment methodologies may not fully incentivize the participation of organizations, like our members, that have achieved per capita health expenditures below the national average. In addition, we are concerned about the potential longevity of the ACO program for all provider organizations, regardless of their experience with coordinated care. For example, it is unclear to us whether ACOs will be able to achieve shared savings over multiple agreement periods in a shared savings model. Therefore, we recommend that CMS consider alternative payment arrangements in localities where per capita health expenditures are at or below the national average.

In addition, we encourage the Center for Medicare & Medicaid Innovation to use the flexibility in the request for applications for Pioneer ACOs to test and implement alternative payment methodologies for ACOs. We believe that in addition to population-based payments, Pioneer ACOs could test global capitation, episode of care and bundled payment models, among others. We believe that such models have the potential to align the necessary incentives for high quality, low cost systems to participate in ACOs.

Retrospective attribution places limits on the ACO's ability to bend the cost curve. It impedes optimal patient engagement, timely program planning and course correction, and compounds underlying issues of claims lag and financial settlement. We encourage CMS to consider implementing prospective attribution in the final rule. We understand that CMS is concerned that a prospective attribution system will lead to ACOs improving care for some patients but not others. We believe from our experiences with care coordination and process improvements, that this will not be the case. The care improvements and systems that are put in place to benefit patients assigned to the ACO will benefit all of our patient populations. We encourage the agency to offer options for prospective or retrospective enrollment similar to the alternatives it has proposed in the Pioneer ACO model.

The logistics associated with Medicare beneficiaries' opt-out of data sharing in the ACO program are simply not practical. We believe this would lead to beneficiary and physician confusion on the terms of engagement. We ask: how can any provider practically agree to this and yet still manage care; and how can patients hope to have their care properly managed if their conditions are not known? HIPAA allows providers and payors to share PHI without patient/subscriber consent for purposes of treatment, payment, and healthcare operations. We believe that timely access to accurate and complete data is essential to fulfilling the missions of providing better care at a lower cost and encourage the agency to consider ways in which it can provide more complete data to providers.

There are a number of other organizational and operational issues that our coalition organizations will address separately in our own individual comments. However, these broad categories reflect our most serious concerns related to our support for the ACO program as an avenue to promote value in health care delivery.

We look forward to working with you and other federal policymakers on this matter for improving the proposed rule and achieving our shared goals for patients and providers alike.

Sincerely,

Healthcare Quality Coalition

Aspirus, Inc.
Gundersen Lutheran Health System
Mayo Clinic
Cleveland Clinic
Wisconsin Hospital Association
Aurora Health Care
North Dakota Healthcare Association
Essentia Health
Marshfield Clinic
Prevea Health
McFarland Clinic
Dean Clinic
Rural Wisconsin Health Cooperative
Allina Hospital and Clinics
Park Nicollet Health Services
Minnesota Hospital Association
The Everett Clinic
ThedaCare
South Dakota Association of Health Care Organizations