



December 3, 2010

Donald M. Berwick, MD, Administrator  
Centers for Medicare and Medicaid Services  
200 Independence Avenue, SW, Ste. 314-G  
Washington, DC 20201

Re: CMS-1345-NC, Request for Information Regarding Accountable Care Organizations

Dear Dr. Berwick:

When Congress passed the Patient Protection and Affordable Care Act (PPACA), it created an historic opportunity to address the fragmented health care delivery system. Section 3022 of PPACA creates Accountable Care Organizations (ACOs), a clear recognition by the legislators that the health care system needed restructuring and reordering to move it toward greater integration with coordination of care; to rendering evidence-based, high quality services, delivered in an efficient manner; and placing the patient's interests and preferences at the center of the process (patient-centeredness).

AMGA's members have long delivered on ACO precepts. We applaud Congress for this legislation and extend an offer of eager willingness to work with CMS to make the shared savings program successful.

In addition to creating ACOs, PPACA created the Center for Medicare and Medicaid Innovation (CMMI). CMMI represents an opportunity for CMS to move well beyond its customary demonstration projects. CMMI is a means to devise, test, and shepherd the processes and changes necessary to move Medicare and Medicaid from being purchasers of volumes of services to those that provide value and improved outcomes for beneficiaries.

Congress crafted the shared savings program as a voluntary effort built upon the existing foundation of Federal health care programs. As such, this model, if successful, will influence the private sector as well.

As is most often the case with law, much is left to the interpretive authority of the rulemaking process. In addition to offering comments on the specifics CMS asks about, we take the liberty of proposing a general approach to the matter of ACOs: Align incentives to attract participants of various sizes and configurations. Make the requirements to entry as reasonable as possible, while keeping performance standards high.

**CMS Question: 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?**

**AMGA Answer:** We believe that CMS should foster the integration of health care delivery and incorporate solo, duo and small group medical practices best by supporting their integration into larger existing multispecialty medical group practices and other organized systems of care.

The statutory minimum number of beneficiaries for ACO participation is 5,000. This population size of 5,000 is most likely too small to have the scale of resources necessary to support a viable ACO. Participants in the Physician Group Practice Demonstration (PGP), the “field test” for the conceptual precursor to the ACO idea, had an average of 20,000 Medicare beneficiaries assigned. Also, the entities involved in the PGP project were large entities, with around 200 or more participating doctors in each.

Integration of small practices into larger ones is happening now through acquisition of practices by hospitals, foundations (in some parts of the country), and by large medical groups as well. There are existing integrators in place and integration by acquisition is happening now, in large parts of the country.

To carry out the intent of the Congress to craft greater effectiveness and efficiency in health care delivery by greater integration of care, CMS should offer incentives to multispecialty groups and other organized systems of care to incorporate small medical practices either by merger, acquisition or under contractual arrangements. The most effective means to do this is to offer incentives to larger groups to integrate and/or partner with smaller practices. National policy objectives should target efforts to include underserved or disadvantaged populations, those with special needs and circumstances, such as dual eligibles, or others deemed to warrant inclusion.

Incentives might take the form of fees, payments designed to cover recruitment, legal costs, administrative expenses, etc., involved in reaching out to smaller practices; and/or subsidies (supplemental or enhanced reimbursements, grants, special tax treatments, etc.) to make recruitment of practices serving targeted populations attractive to the integrator.

We suggest that payment incentives be offered to multispecialty medical groups and other organized systems of care. Physicians, given their training, experience, and role in health care delivery, are best equipped to diagnose and treat patients. ACOs should be physician-led for these reasons and the principle extended to the process of incentivizing integrators to act—integrators do matter.

**CMS Question: Many small practices may have limited access to capital or other resources to fund efforts from which "shared savings" could be generated. 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?**

**AMGA Answer:** This is addressed in commentary in answer 1—provide incentives to integrators directly and/or indirectly to achieve public policy goals to expand ACO coverage on a targeted basis.

**CMS Question: The process of attributing beneficiaries to an ACO is important to ensure that expenditures, as well as any savings achieved by the ACO, are appropriately calculated and that quality performance is accurately measured. Having a seamless attribution process will also help ACO's focus their efforts to deliver better care and promote better health. Some argue it is necessary to attribute beneficiaries before the start of a performance**

**period, so the ACO can target care coordination strategies to those beneficiaries whose cost and quality information will be used to assess the ACO's performance; others argue the attribution should occur at the end of the performance period to ensure the ACO is held accountable for care provided to beneficiaries who are aligned to it based upon services they receive from the ACO during the performance period. 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?**

**AMGA Answer:** The process of attribution should be prospective, i.e., that beneficiaries and the ACO should know in advance who is assigned to the ACO. ACOs are an advanced model of health care delivery, different in many ways from traditional care. Open channels of communication are critical to successful clinical exchanges and to create a patient-centered environment. This is true on a system-wide basis and also in tailored, targeted ways.

Echoing MedPAC's comments on this matter, here are extracts from its letter that make the case well: "Beneficiaries should know if their health care providers are operating under a new incentive structure. ...beneficiaries will need to have greater engagement in their own care management (for example, medication adherence). Properly structuring how the beneficiary is informed of ...assignment to an ACO provider could help accomplish both of these goals."

While AMGA supports prospective attribution, we are concerned that may lead to the imposition of administratively burdensome marketing and reporting requirements on ACOs. In the Medicare Advantage program, CMS imposes very strict and burdensome limitations on communications between the plans and beneficiaries, primarily designed to prohibit highly aggressive, even abusive sales and marketing approaches. We urge CMS not to impose similar Draconian communications controls, prohibitions and limitations on ACO communications to patients. These requirements are typically imposed upon insurance companies that have past experience and adequate staff to comply with these requirements. However, if applied to potential ACOs with neither past experience, nor staff, we fear that ACO provider participation would be strongly inhibited. Such burdensome communications rules would get in the way of the many, necessary communications between caregivers in the ACO and their patients.

Related to patient attribution, but also a function of the ACO advanced model of medical practice, there is an indispensable need for patient information as well as other clinical and administrative data. ACOs will rely on such information to assess patients, monitor operations, and make systems changes of many kinds. ACOs need virtually 'real time' claims data, i.e., monthly data related to the cost and quality performance standards ACOs will need to meet, in a format that is easily handled at the provider level; and, failing that, any significant data lags should not result in any penalties or loss to the participating ACOs, since this is beyond their control.

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

**AMGA Answer:** The answer is quite simple, ask them. However, practically speaking, existing tools to evaluate the caregiver and patient experiences are inadequate for the purpose of assessing the full spectrum of care along the continuum as offered by ACOs. The CAHPS and other surveys are episode-of-care focused. The care model of ACOs is bigger, broader, and far more comprehensive. New instruments must be developed to measure the scope of ACO care experience. Realizing that, and recognizing that need for its members, AMGA is currently working in a "fast track" mode with a national survey vendor, to create just such an instrument.

**CMS Question: 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?**

**AMGA Answer:** Assessing patient-centeredness is a reflection of medical practice quality. The term “patient-centeredness,” however, is not well defined in the Affordable Care Act of 2010 (ACA) and can have a variety of meanings. We would like to offer some examples of patient-centeredness concepts that distinguish care in ACOs.

Characteristics that demonstrate patient-centeredness should include the extent to which patients are involved in diagnostic and treatment decisions; the extent to which patient values and preferences are explicitly incorporated into decision-making about their care; whether patient preferences for end-of-life care are formally assessed, recorded, shared among health care providers, and honored at the end-of-life; whether written or verbal communications to patients are available in the patients’ preferred language and with consideration of patients’ ethnic, cultural, or religious background; whether same-day appointments are available for patients who need them; whether after-hours visits are available to patients who need them; and whether patient preferences for communication, whether by e-mail or by phone, are recognized and accommodated.

To assess the above patient-centeredness elements and their application in ACOs, AMGA believes the best approach is to ask the patients themselves. Potential “patient centeredness” survey instruments should allow medical groups to track what is most important to their patients; identify key drivers of overall patient satisfaction and retention; access benchmarks so that groups know how they compare internally and compared to other ACOs nationally; and identify areas in need of improvement using valid and reliable information. Only through systematic surveying of patient populations assigned to ACOs about their experiences, can CMS assess the goal of providing patient-centered care. We stand ready to work cooperatively with the agency and to make available our expertise and experience in surveying patients, on this and related matters.

**CMS Question: 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?**

**AMGA Answer:** Since the overwhelming percentage of Medicare expenditures, more than 75%, is related to treatment of patients with chronic diseases, we believe that that ACO quality performance measures should focus on high cost/high volume disease states. The measures should also reflect that which is important to Medicare beneficiaries: Access to care, effective coordination of care, staying healthy and active. CMS should consult with specialists and other stakeholders with clinical expertise in the relevant disease states to determine the best metrics to apply.

Utilizing another “lesson learned” from the PGP demonstration, AMGA recommends that CMS phase in the submission of quality metrics for ACOs over the 3-year performance period. Requiring ACOs to submit data on all quality metrics in year 1 (which will presumably number over 30 metrics) will represent a significant technological and administrative burden. We strongly urge that this phased approach be maintained in the model employed for ACO roll-outs.

**CMS Question: 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?**

**AMGA Answer:** We believe that Congress wanted to make the ACO idea broadly attractive and accessible to interested provider parties. The law is clear on defining those groups eligible to participate, but allows the Secretary considerable interpretive latitude in that regard. Specifically, we believe that Section 1899(d) should be interpreted to allow participation of Rural Health Clinics, Federally Qualified Health Centers, and others paid under Medicare Part B as ACOs. These entities make up a vital part of the primary care component for Medicare beneficiaries and play a significant role in reducing overall costs and improving quality in the Medicare program. Moreover, these entities provides care to patients in areas that may not see significant ACO developments. If anything, CMS should encourage these entities to become ACOs. Performance standards for these entities would mirror standards for all ACOs.

Thank you again for the opportunity to provide comments on ACOs. We look forward to other opportunities, such as the forthcoming notice of proposed rulemaking, to provide additional and more detailed perspectives and ideas. We would welcome the opportunity to be of assistance to CMS in its information gathering processes in any way that would be helpful. We believe in ACOs and the potential they have to make health care delivery better for Americans. Do not hesitate to call me if AMGA may be of further assistance.

Sincerely,

A handwritten signature in black ink, appearing to read "Donald W. Fisher".

Donald W. Fisher, Ph.D.  
President and CEO