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Office of the President and CEO

Robert Wood Johnson Foundation

June 6, 2011

Don Berwick, MD
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1345–P
P.O. Box 8013
Baltimore, MD 21244–8013

Submitted electronically to: http://www.regulations.gov

RE: Robert Wood Johnson Foundation comments on Medicare Shared Savings Program–Accountable Care Organizations–File No. CMS–1345–P

Dear Dr. Berwick:

The Robert Wood Johnson Foundation (RWJF) respectfully offers these comments and recommendations on the proposed rule for a new Medicare Shared Savings Program for Accountable Care Organizations (ACO)–File No. CMS-1345–P. RWJF congratulates you and the Centers for Medicare and Medicaid Services (CMS) on the thoughtful proposed rule that outlines this new ACO program.

The vision of accountable care embodied in the ACO idea is promising. We agree with the premise that health professionals, working together with patients in the delivery of care, should be accountable for the quality and cost of that care as well as their patients' full experience with that care and, importantly, also for the health of the relevant population. That accountability may seem obvious; unfortunately, it's almost certainly a departure for American care in too many settings. Accountability, nevertheless, is an idea whose time has come. We believe that systems of accountable care should have, at a minimum, the following characteristics:

- Focus on Patient and Consumer. Health professionals will be accountable for delivering high quality, efficient and safe care to their primary customers: patients, consumers and Medicare beneficiaries–whether those primary customers are in the role of patient, consumer, beneficiary or some combination of the three. Accountable professionals will keep their patients and consumers informed, and they will promote good health and health care decision making.

- Data. Timely, widely available, maximally transparent data and information must play a pivotal and critical role in the success of accountable care. ACOs must broadly incorporate and meaningfully use electronic health records and registries.

- Collaborative Teams, Primary Care and Workforce. Accountable health professionals must work in collaborative teams. Further, all members of that team will practice to the top of their training and their education. Primary care in accountable systems should be robust. Specialty connections with primary care and among other specialists will be seamless, strong and accountable for high quality, safe and efficient care. Health professionals, including physicians, nurses, pharmacists, social workers and other professionals, will engage patients fully in their care. They will coordinate that care across the entire continuum, from prevention to post-acute care.

- Payment Reform. Since accountable systems' teams will work to keep people out of the hospital, professionals on those collaborative teams must be paid for creating higher-value care outcomes for patients and consumers rather than high volumes of care such as procedures, hospital admissions, clinical visits, lab tests and imaging.

- Population Health. Accountable systems that are delivering truly patient-centered care will look beyond clinic or hospital walls and get to know the communities they serve. Success of accountable systems will depend as much on the promotion of healthy behaviors and addressing the social determinants of health as it will depend on treating people who are sick.

- Racial, Ethnic and Language (REL) Health and Health Care Disparities. Accountable systems will monitor carefully and routinely for racial, ethnic and language-related health and health care disparities in the populations they serve. That means they will proactively identify disparities in their patient population and work iteratively and assertively to close disparity gaps.

Recommended adjustments to the proposed rule to match this vision:

Given our framing of what accountable care should be, we have the following specific recommendations that would strengthen and improve the proposed rule:

1. General Comments.

    - Regional alliances. We agree fundamentally with your reminders that efforts to transform health care will play out at the community level. Specifically, as you noted in a speech in Washington, D.C. on September 13, 2010, health care transformation "will not yield to a massive top-down national project . . . . The successful redesign of health care is a community by community task . . . because, in the end, each local community, and only each local community has the

knowledge and the skills to define and deliver what is locally right." Our foundation's work has shown, time and again, that the opportunities for, and barriers to, improving quality and reducing cost are very different in different market contexts. Specifically, the foundation's long term initiative, Aligning Forces for Quality, helps sixteen (16) communities across the nation do just that. Each of those communities is making dramatic progress in that transformation. Each also has been able to make that progress by working with and through a regional alliance of key health care employer, physician, nursing, consumer, hospital, health plan and business leaders–those who give, get and pay for care. Those regional alliances have made significant progress in constructing measures and public reporting those measures. Those alliances have established a strong, nation-leading track record and wide spread credibility by establishing the important data relationships for measurement, aggregating the data for measures, and constructing measures. They have also learned a tremendous amount about the public display of that information in their respective markets. We strongly urge CMS to look to these regional alliances, where they exist, as key partners in any delivery and payment reform for a given care market. While pursuing new delivery and payment models, CMS should ensure that it promotes rather than subverts the enormous potential of those alliances. Unfortunately, the proposed rule could potentially undermine the role of key regional alliances. For instance, under the proposed rule, ACOs would presumably collect data internally, construct measures internally and then directly submit those measures to CMS. That internal measurement construction and direct submission to CMS would circumvent regional alliances' market role in measurement and reporting and undermine alliance credibility. Instead, the final rule should direct or allow ACOs to utilize existing, suitable market measurement and reporting infrastructure in its reporting requirements to CMS. The final rule should where possible help CMS leverage the hard work, expertise and successes of regional alliances.

- Voluntary ACO Program–Engendering Trust with Health Professionals. We strongly support, in general, the notion of ACOs taking on risk for quality and cost as soon as possible. Nevertheless, this approach is new and this proposed new ACO program is voluntary. Given the potentially radical change in the way many health professionals provide care, CMS should make every effort to foster participation and build trust and confidence in the new approach. The final rule, for instance, should seek to build trust with and among health professionals who take initial, voluntary steps to participate in this new program. CMS should make every effort to be fair, establish reliable, stable rules and allow participating health professionals to adjust and adapt in a reasonable manner.

    - For instance, under the proposed rule an ACO may drop health professionals from the ACO during the three years; however, the ACO may not add health professionals. That prohibition and resulting one-way professional turn-over, arguably, hurts rather than helps address America's many health care workforce challenges.

- CMS can change the rules during the shared savings period, which could present problems for entities trying to make this major adjustment. In this ACO voluntary effort, entities will be exposed to new financial risk. The final rule should give pioneering ACO efforts comfort that the rules will not suddenly change.

- Under the proposed rule, there is a significant risk with a voluntary but failed ACO trial. ACOs that fail to perform will be excluded from "trying again" anytime in the future. CMS clearly has a strong rationale for ensuring that an ACO that has caused real harm to patients or whose health professionals have acted in nefarious ways should not be eligible for a subsequent attempt. On the other hand, this effort to establish ACOs is new, voluntary and with many unknown aspects and features. Perhaps, a more flexible approach in the final rule that fosters voluntary participation rather than penalizing well-meaning, otherwise acceptable initiators who might have had understandable difficulties might be appropriate.

- Public-Private Alignment. Accountable care must span both the public and private health care sectors to be successful at transforming care.

  - The proposed rule provides little guidance on how CMS will foster ACO alignment with private sector payers. We strongly encourage CMS on its own and in the final rule to identify and implement explicitly focused efforts to align and link with the private sector in building accountable systems of care.

2. Patient and Consumer Focus. We strongly support a fundamental, explicit focus of accountable care on the patient and health care consumer. The proposed rule goes a long way toward that end. CMS proposes a robust definition of patient-centeredness using: surveys of patient experience; including a beneficiary on the ACO governing board; evaluation of patient population needs; individualized care plans for high-risk patients; electronic exchange of information to support care coordination; shared decision-making; beneficiary access to medical records; and processes for measuring and improving care. We applaud these strong patient and consumer focused efforts in the proposed rule. It also, however, leaves some key openings for improvement.

   - The proposed rule fails to leverage beneficiary choice to help drive high quality and lower cost. Beneficiaries will be assigned to an ACO if they receive a plurality of primary care services from a primary care professional in the ACO, based on allowed charges. Assignment for purposes of calculating shared savings would be retrospective, but providers and patients would be informed prospectively that they are receiving care in an ACO. The rule therefore acknowledges that it is important to inform patients about their participation in an ACO but ultimately only holds ACOs accountable for the patients who stay in the ACO. Under the final rule, the

assignment for calculating shared savings and monitoring accountability should be prospective, not retrospective.

- The proposed rule deals with beneficiary choice as if it's a problem rather than a potentially powerful lever for quality and value. The final rule should ensure that beneficiaries have a range of quality and cost information about ACOs, and the rule should facilitate and promote beneficiary decision-making around choice of providers. ACOs should also be required to educate beneficiaries about the availability of quality and cost information.

- Under the proposed rule, ACOs may not be able to encourage patients to use the ACO's health professionals and hospitals. Instead, the proposed rule requires that CMS approve all "marketing materials". The rule should allow ACOs to inform patients, consumers and beneficiaries about the quality and cost of care the ACO provides without unreasonable interference from CMS.

3. Data. We strongly support transparency imperatives for accountable care. That means that CMS should make every effort to ensure that ACOs, health professionals, beneficiaries, patients, consumers, employers and others have timely, readily available access to the best information about the quality and cost of care possible. The proposed rule includes key provisions that pursue those transparency goals. For instance, certain information regarding the operations of the ACO would be reported publicly–including information on 1) providers and suppliers for participating ACOs, 2) parties sharing in the governance, 3) shared savings information, and 4) quality performance scores.

    - However, the amount of transparency on quality performance is minimal and problematic, especially if reporting is only at the ACO level. One could argue that the rule would move the field backwards by not requiring individual-level health professional reporting. Patients, consumers, beneficiaries and others need information about the quality of ACO care, but they also need to understand the quality and experience of the individual health professionals working within the ACOs. The final rule should ensure that public reporting of performance measures, shared savings and other relevant information is, as much as feasible, at both the ACO and the individual health professional level.

    - Under the proposed rule, CMS will not provide data on patients or costs until after the ACO is in the program. CMS likely has sound reasons for proposing that data maneuver. However, in general timely, helpful, usable data is critical to the success of delivery transformation efforts like this one. Under the final rule, CMS should make broad, timely, helpful release of cost and quality data an immediate imperative.

    - We strongly encourage CMS to promote longitudinal measurement of ACO care. The shared savings program will last for at least three (3) years; its goal is to manage a patient population over that time frame. Under the final rule, ACOs and CMS

should measure progress to understand what is working and what is not in terms of process and outcomes of care for those populations during that period.

- Similarly, the final rule should include attention to comparing care provided by ACOs as envisioned by this rule with care, ACO or otherwise, provided outside that defined mode of care.

4. Collaborative Teams, Primary Care and Workforce.

    - Nurse led center.

        - Under the proposed rule, ACOs will not share in savings for patients who did not receive a plurality of primary care from the ACO's primary care physicians. That means beneficiaries who see independent nurse practitioners at a nurse led center, for instance, cannot be included in the draft shared savings program. We urge CMS under the final rule to foster rather than exclude nurse led centers, which are, themselves, a potentially significant delivery model transformation. As the Institute of Medicine (IOM) recommended in its October 2010 consensus report on *The Future of Nursing*, CMS ". . . should support the development and evaluation of models of payment and care delivery that use nurses in an expanded and leadership capacity to improve health outcomes and reduce costs." The IOM report further recommends that "[h]ealth care organizations should support and help nurses in taking the lead in developing and adopting innovative, patient-centered care models."

    - Federally Qualified Health Centers/Rural Health Center. The proposed rule does not allow for FQHC and RHC oriented ACOs. FQHCs and RHCs in many areas are beacons of improvement and backbones of the safety net. The final rule should foster and allow for accountable systems of care that build from FQHCs and RHCs rather than exclude them.

5. Population Health. In several instances, the proposed rule misses key opportunities to address determinants of good health.

    - The final rule should set a high bar with respect to population health improvement without excessive fiscal or administrative burden. Given that, the rule should require ACOs to:

        - Acquire and apply data about local population health status from an array of sources such as the *County Health Rankings*.

        - Negotiate memoranda of understanding about data sharing, referrals and coordination with community organizations that provide services that address determinants of health other than care.

- Convene groups of patients, consumers and health professionals to discuss the social determinants of health in their communities and how to address them.

- Collaborate with other organizations about evidence-based interventions that address multiple determinants of health; and

- Devote a part of shared savings to local population health improvement activities.

- Relationship between population health focus and ACO metrics.

  - The proposed measures for assessing what ACOs do and how they report about "better health for populations" do not adequately address broad health determinants. For example, of 39 proposed performance measures that might pertain to health determinants, 29 assess process, mainly in clinical preventive services. Only 6 of them measure patient behaviors that are risk factors for chronic disease. Only a single measure–of preventing falls–acknowledges the effects of patients' physical environment on their health. The final rule measure set should include additional measures that address health determinants.

6. REL Health and Health Care Disparities. The proposed rule misses some key opportunities to help close REL disparities and risks making them worse.

   - As written, the proposed rule could establish ACOs among hospitals or groups of health professionals that are not motivated to address REL disparities. Instead, such an ACO arguably could systematically attempt to avoid care for groups of patients impacted by disparities. The final rule should include strong safeguards against and monitoring for such detrimental "cherry picking" behavior.

- The proposed rule could leave lower-income patients, who are less likely to be white, more concentrated in systems that are less able to form ACOs. That problem is exacerbated by the exclusion of FQHCs and RHCs as noted in section 4 above. The final rule should establish mechanisms to monitor for that undesirable impact and guard against it.

- The final rule should include requirements for strong and explicit monitoring, by the ACO, of the impact of ACO restructuring and delivery of care on REL disparities.

- Measurement of disparities is a key step in addressing disparities. The final rule should require that ACOs stratify reported quality measures by patient race, ethnicity and primary language and then publicly report those stratified metrics in a timely, iterative, usable manner.

Thank you for this opportunity to comment. We appreciate your leadership of this critically important national endeavor to foster greater accountability in health and health care across the nation. Please feel free to contact Dr. Michael Painter at 609-627-7659, with any comments, questions or concerns.

Sincerely,

Risa Lavizzo-Mourey
President and CEO
Robert Wood Johnson Foundation