Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

December 3, 2010

Dr. Donald M. Berwick
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Suite 314-G
Washington, DC 20201

Re: File code CMS-1345-NC

Dear Dr. Berwick:

On behalf of the Catholic Health Association of the United States, thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) Request for Information Regarding Accountable Care Organizations (ACOs) and the Medicare Shared Savings Program, published in the Federal Register on Wednesday, November 17, 2010. In response to the Request for Information, we offer here some first thoughts on ACOs and look forward to commenting in greater detail when CMS releases a proposed ACO regulation.

The Catholic Health Association of the United States (CHA) is the national leadership organization of the Catholic health ministry, representing the largest group of not-for-profit providers of health care services in the nation:

- 1 in 6 patients in the United States is cared for in a Catholic hospital each year.
- All 50 states and the District of Columbia are served by Catholic health care organizations.
- Over 600 hundred hospitals and more than 800 post-acute care organizations provide the full continuum of health care.

CHA and its members - more than 2,000 Catholic health care sponsors, systems, hospitals, long-term care facilities, and related organizations – are committed to creating a health care system that ensures everyone will get the health care they need, when they need it. CHA's *Vision for U.S. Health Care* lays out the Catholic health ministry's principles for reforming the health care system. As a central component of our vision, we believe that health care should be patient-centered, addressing health needs at all stages of life through services that are coordinated and

integrated all along the continuum of care, with accountability for health outcomes. We also call for safe, effective health care delivered with the highest possible quality to achieve the best outcomes for patients.

CHA believes ACOs offer a promising opportunity to achieve those goals, through improved integration of inpatient and outpatient care and joint accountability for care delivery across providers and over time. Especially important is the working relationship between hospitals and physicians, as well as other post-acute and community-based agencies. At the same time, implementation of the ACO option under Medicare presents a number of challenges and must be undertaken with great care lest beneficiary access to care or the quality of that care suffer.

As CMS develops regulations for ACOs in the Medicare Shared Savings program and designs models though the Center for Medicare and Medicaid Innovations, CHA advises the agency to allow the maximum degree of flexibility possible. There must of course be guidelines by which CMS will designate and enter into agreements with ACOs, determine and pay out shared savings, and ensure that the quality of care and the outcomes experienced by beneficiaries improve. But the regulations must also allow diverse types of providers and provider organizations, operating under different market conditions and in different geographical locations, to come together and participate under the shared savings model. We are particularly concerned about the ability of providers in rural areas to be able to participate in ACOs, given, for example, the requirement that ACOs be accountable to a minimum of 5,000 Medicare beneficiaries. In areas where CMS believes the regulations must be more restrictive to meet statutory requirements, we urge CMS to give guidance on how more flexible models may be tested through the Innovation Center.

Patient-centeredness

Among the core values underlying CHA's vision for health care is the principle that every person is invested with inherent dignity and therefore fostering the well-being of each individual patient throughout the life span must be the goal of our health care system. This principle must be at the center of every health care related decision that is made, whether by care providers or by CMS as it develops rules for ACOs.

Patient-centered care implies the coordination of a person's health care through time and across care settings. ACOs can provide a new structure to allow health care providers – doctors and other health professionals, hospitals and nursing homes, and others – to coordinate the care they provide and to accept joint accountability for outcomes.

It also refers to how a patient is treated while receiving care. Patient-centered care makes sure that care is designed to meet the needs of the patient, rather than the patient being subjected to the needs of the care regimen and the care givers. It focuses on whether the patient is fully informed and involved in the decision making process.

Among the factors CMS should consider when developing criteria for patient-centeredness in this sense are:

- Is the patient given information about his condition and treatment options in a form and manner that is understandable?
- Is the patient actively involved in the decision making process?
- Are transitions between care settings or from a health care facility to the home conducted so that the patient fully understands her part in her ongoing treatment, what to do, and whom to contact with questions?
- Is care delivered in a manner that respects and accounts for linguistic and cultural differences, so that all patients understand the information they receive and are able to make choices that accord with their preferences?
- Are the patient's wishes concerning the involvement of family members or friends respected?
- Is patient pain managed appropriately, and do patients have access to palliative care?
- Do patients have clearly defined care plans?
- Do ACO participants have access to personalized information and education on prevention measures?

A patient-centered focus can also contribute to improving population health. For example, an ACO should do a comprehensive assessment of a beneficiary's social, cultural, literacy and mental health status in addition to medical status. This information can assist in efforts to reduce disparities in health care.

Beneficiary Participation in ACOs

Whether CMS proposes prospective or retrospective beneficiary assignment to ACOs for quality measuring and cost savings calculation purposes, two factors should be considered. First, given the principle of patient-centeredness just discussed, ideally beneficiaries should be informed of their participation in an ACO even where definitive beneficiary assignment is retrospective. For example, beneficiaries could be informed that they have been preliminarily assigned to an ACO based on past utilization of health care services, but that a final assignment would be made later. Whether assignment is prospective or retrospective, beneficiaries should be given information about what an ACO means, the providers participating in the ACO from which they have received or are receiving care, and what care coordination services are available to them. They should be encouraged and empowered to take a greater role in their own care management. Beneficiaries should also be informed of the benefits of receiving care from an ACO and that they are not under an obligation to receive care from an ACO or a given ACO professional. In addition, the attribution policy must not create incentives for delivering care to patients differently based on whether or not they are attributed beneficiaries.

Quality Measurement and Data Issues

ACOs will be required to meet quality performance standards in order to receive a share of any savings achieved. In choosing the quality measures to apply to ACOs, CMS should ensure that the ACO quality program is aligned with other quality programs in Medicare, including the Hospital Inpatient Quality Reporting Program, formerly known as RHQDAPU; the Meaningful Use Program; Physician Quality Reporting System; and the new Value Based Purchasing Program. In addition, there should be alignment of the quality measures for hospitals and physicians. Measures should relate to the "triple aim" goals of better care, better population health and lower cost of care, and should be approved by the National Quality Forum.

The success of the ACO program's ability to improve care and outcomes and lower cost will depend on ACOs having access to data in a timely manner. For example, ACOs must receive prompt notification when beneficiaries access care from non-ACO providers so they can address care coordination needs and make sure care transitions occur in a smooth manner with appropriate follow up care and, where needed, patient education.

Payment Models

Some groups of providers already operating in ACO-like structures may be ready to assume a degree of risk, and CMS may want to include a risk-bearing model in the program to allow these ACOs to move forward in their development. However, many providers interested in participating in the ACO program are at the beginning stages and are not ready for shared risk. There should be adequate opportunities for providers to participate in ACO models involving traditional fee-for-service payments and no assumption of risk.

Establishing an ACO requires significant up-front investment by the participants. The opportunity for shared savings should allow recoupment of some of those costs. To address this, CMS should consider steps to support these investments. For example, ACOs could share in a very large percentage of the savings, at least in the early years. If CMS decides to set a threshold that must be met before savings are shared, to account for random variation concerns, it should consider using those threshold savings to assist ACOs with infrastructure investments.

In closing, I would like to return to the concept of patient-centeredness. While lowering the cost of care (and thus the cost of the Medicare program) is an important component of the Medicare Shared Savings Program, the central goal must be improving the quality of care and the health status of individual patients. If we are able to do that, then we will also be able to improve population health and rein in cost.

Thank you again for this opportunity for input as CMS develops its proposed rule. We look forward to working with you and CMS as you implement this and other important provisions of the Patient Protection and Affordable Care Act. Implementing health care reform and reshaping our delivery system to provide quality, affordable care to everyone is a daunting task. It will

require the hard work of you and your colleagues at CMS and coordination and collaboration within the agency, and the commitment of the health care community to be active partners in shaping and implementing the regulations. If CHA can be of any assistance, please do not hesitate to contact me.

Sincerely,

Sr. Carol Keehan, DC
President and CEO