December 3, 2010

The Honorable Don Berwick
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CCD Comments on ACO and the Medicare Shared Savings Program: [CMS-1345-NC] Aspects of CMS Policies and Standards for Accountable Care Organizations (ACOs)

Dear Administrator Berwick:

The co-chairs of the Consortium for Citizens with Disabilities (CCD) Health Task Force appreciate the opportunity to comment on the request for information from CMS on the development of Accountable Care Organizations (ACOs). CCD is a coalition of approximately 100 national disability organizations working together to advocate for national public policy that ensures the self determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society.

As an initial matter, the CCD believes that better integration of health care providers and the services they provide can lead to reductions in unnecessary cost, inefficiency, and duplication of effort in the health care delivery system. We also believe that quality improvement can be the end result of such an environment, if ACOs are structured and regulated appropriately.

But the fact remains that in an environment where health care providers are financially rewarded for keeping costs down, anyone who has a disability or chronic condition or anyone who requires specialized or complex care is at risk of losing access to appropriate technology, medical devices, rehabilitation care and other specialized services. This includes rehabilitation care at the appropriate level of intensity of services to meet the needs of the individual patient. Simply put, providers in ACOs should not be permitted to share in savings achieved through the denial of

high quality patient care. This is largely the dynamic that soured Americans on capitated HMOs and we urge CMS to not repeat the private market's mistakes of the past.

CCD believes that provider participation in *any* shared savings under *any* new delivery model should be explicitly conditional upon the achievement of quality and outcome measures. Any new delivery model developed by the Centers for Medicare and Medicaid Services (CMS) or the Center for Medicare and Medicaid Innovation (CMMI) should have at its foundation the achievement of patient-centered outcomes. Primary and acute care outcome measures are necessary in this regard, but they are not sufficient, at least for the population of people with disabilities and chronic conditions. Outcome measures for this population must include measures based on function, not simply primary health care status.

For instance, a person who experiences a traumatic injury or surgical operation may achieve completely acceptable primary care outcomes (e.g., blood pressure, blood sugar, heart rate, and cholesterol) six months later, but the real indicator of a successful outcome is the level or independence the person enjoys. Is the person not only "healthy," but living at home as independently as possible, having returned to work and normal activities, or is that person significantly compromised in terms of their function, living in a nursing home, unemployed, and out of the mainstream of normal activities? Measures to assess functional status of this kind will need to be employed if ACOs are truly going to improve quality and outcomes while saving money.

With that in mind, CCD offers the following responses to the questions posed by CMS:

1) **What policies or standards should be adopted to ensure groups of solo and small practice providers have the opportunity to participate in the Medicare Shared Savings Program and the ACO models tested by CMMI?**

   CMS can level the playing field for small providers by creating strict standards to ensure that patients have access to a wide variety of providers within any specific network. CMS should link network adequacy criteria to an assessment of the size of the local population, as well as an assessment of the needs of a wide variety of patients. The criteria should:

   - Ensure an adequate number and variety of practitioners and specialists within the networks to provide comprehensive health care services to ACO enrollees;

   - Ensure that the ACO regulations permit patients to access out-of-network providers if their needs are not being met within the existing network;

   - Establish an explicit right of choice of provider (both inside and outside a network) so that patients who believe the ACO is more interested in cost savings than in good outcomes can access the care they need in a timely manner;

   - Ensure that providers accept all patients assigned to them by any payer using an ACO and be subject to severe penalties (financial and otherwise) if ACOs participate in any efforts to skim patient populations for the youngest and healthiest participants;

- Include guidance as to the categories of specialists an ACO is required to include in its network in order to provide the full spectrum of plan or program benefits and to meet the wide range of needs of its patients, including people with disabilities and chronic conditions; and

- Ensure that patients have been fully informed and consent to participating in an ACO.

- As a mechanism to ensure compliance with network adequacy requirements, CMS should consider utilizing third party, independent bodies to accredit ACO's that meet such requirements.

2) **What payment models, financing mechanisms or other systems should be considered to address funding efforts for small practices? Which mechanisms could be created to provide access to capital?**

CCD has no relevant comments to this question.

3) **How should CMS balance the two points of view – attribute beneficiaries before the start of a performance period versus at the end of a performance period – in developing the patient attribution models for the Medicare Shared Savings Program and ACO models tested by CMMI?**

Regardless of when patients are attributed to an ACO, CMS should require ACOs to inextricably link costs savings to patient outcome measures. That is, providers and payers should only be able to share savings when they can demonstrate maintenance or improvement in outcome standards that measure the quality of care provided. Such measures would ensure the system provides incentives to both improve the quality of care and patient outcomes while working toward better efficiencies. CCD believes that ACOs should have an understanding of their patient population if they are to be held accountable for their care, and therefore, we are more inclined to favor the attribution of patients to ACOs before the start of a performance period rather than after that period.

4) **How should CMS assess beneficiary and caregiver experience of care as part of the assessment of ACO performance?**

CMS should strongly recommend that ACOs use consumer feedback tools to measure quality from the perspective of the consumer of services. These tools can gather data on a large scale that can be used to develop benchmarks. CMS can use these benchmarks to compare the experiences of many consumers across ACOs, while detailing the experiences of patients within a specific ACO. A variety of psychometrically-validated consumer reporting systems are already available for this purpose, including one such proprietary tool known as "uSPEQ" (pronounced "You Speak"), a consumer survey tool developed by the Commission on Accreditation for Rehabilitation Facilities (CARF). While CCD does not endorse such products, uSPEQ is a good example of a consumer

feedback tool currently used to measure the quality of health services from the perspective of the consumer of services.

Patient outcome measures must reflect the experience of *all* patients over their lifetimes. Each person may be relatively healthy and a low-user of healthcare services at one point in their life and, at another point, be consumed with treatment of an acute injury or a chronic condition that requires intense services and access to an array of providers. In order to reflect a range of experience and accurately capture the quality of care a patient receives, we strongly recommend the development of patient centered outcome measures focused on the functional capabilities and outcomes of patient care.

Simply measuring a person's primary care or acute care health status is not enough. ACOs should be required to measure the *functional status of their patients*, including their ability to perform independent activities of daily living, whether medical rehabilitation services are necessary and effective, quality of life, degree of independent living, and degree of community participation. These and other measures are inextricably linked to the receipt of appropriate health care services and should be considered relevant outcomes along with more acute and primary care measures. The measurement of functional status disproportionately affects people with disabilities and chronic conditions and is a critical set of indicators of successful outcomes for this population.

In addition, CMS should implement protections to prevent providers from "cherry-picking" healthy patients to boost outcome measures while appearing to save money from the aggregate baseline of forecasted costs for a given population. These protections are particularly important for patients with disabilities and chronic conditions, as their needs often translate into more extensive treatment, more specialized treatment, and potentially more nuanced outcomes.

For instance, a good outcome for a patient with Multiple Sclerosis may be a slowing of the progression of neurological impairment, rather than complete restoration of function after an MS relapse. Likewise, the performance measurement system should not punish providers that specialize in the treatment of individuals with disabilities and chronic conditions and, thereby, have a disproportionate number of patients where cure is no longer an option and improved functionality is the more appropriate measure of a successful outcome.

5) <u>What aspects of patient-centeredness are particularly important for CMS to consider and how should CMS evaluate them?</u>

The issue of consumer choice and participation has particular importance for persons with disabilities and chronic conditions. An appropriate health care system is one that ensures:

- services are patient-centered and consumer-directed to the maximum extent possible;
- informed consumer choice in relation to providers and services;
- an appropriate amount, duration and scope of services, devices and related benefits;
- access to trained, qualified, and appropriately credentialed health care personnel;

- the designation of physicians who understand disability and function to help plan and coordinate care with the rehabilitation team as an alternative to gatekeeper case managers with no experience with disability; and that
- all patients are responsible for making good individual health care choices.

CMS should evaluate these criteria through a feedback loop with consumers, particularly a survey of consumers/patients that is conducted on routine basis.

6) <u>What quality measures should the Secretary use to determine performance in the Shared Savings Program?</u>

As already stated, a strict condition of participation in shared savings under ACOs or any CMS delivery model should be the achievement of quality and outcome measures, specifically function-based outcome measures. Most current outcome measures in our healthcare system tend to reflect the benefits of primary and acute care and do not tend to reflect the experience of patients seeking care for conditions that last for an extended period or for a lifetime. The focus of health care for many people with disabilities and chronic conditions is to improve health, for sure, but also to improve the quality of life by improving, maintaining or preventing deterioration of a patient's ability to function.

It is, therefore, critical that ACOs use a multi-dimensional health measure as the basis for health systems performance measurement. For example, the International Classification of Functioning, Disability and Health (ICF), which belongs to the World Health Organizations' family of international classifications, classifies functioning and disability associated with health conditions. The use of these and other relevant measures will help ensure that ACOs are not just focused on saving money and redistributing those savings to providers, but also focused on achievements in quality and functional outcomes.

For example, quality care measures for ACOs should focus on answering questions that get to the heart of a patient's healthcare experience and the practical side of healthcare treatments, such as:

1. Can the individual or patient live independently, i.e., live in a relatively unstructured environment with a minimum of hands-on supervision or care?
2. Can the individual live actively and productively, not only in terms of gainful employment, but also in terms of contributions to community and family life?
3. Can the individual remain free of medical complications, especially those that result in downstream health care utilization and hospitalization?

Each of these questions resonate with core American values and each includes a substantial economic component, i.e., they have economic consequences for society in terms of cost of care, supervision, hospitalization, etc. The following are a list of metrics that could operationalize the concepts contained in the questions above:

1. A measure of functional status, such as the AM-PAC (Activity Measure for Post-Acute Care)
2. Living arrangement or discharge location
3. Onset of sentinel health conditions, e.g., urinary tract infections, pressure sores, bloodclots, etc.
4. Unplanned ER visits
5. Unplanned hospital admission
6. Mortality
7. Patient satisfaction with care (the "care experience")
8. Self-report or proxy-report of health-related quality of life
9. Some measure of societal participation

The timing of these measures is critically important. For instance, if a patient prior to treatment has functional limitations, these limitations should be accounted for in the intake examination. The treatment's impact on the limitation should then be quantified based on the quality measures – including the treatment's ability to prevent further limitations. Equally important is how measures are risk-adjusted, reported and vetted (e.g., by quality accreditation organizations such as NQF and CARF, the Accreditation Commission).

7) <u>What additional payment models should CMS consider? What are the relative advantages and disadvantages of any such alternative payment models?</u>

Condition-Specific ACOs: Some conditions are well suited for specialized, condition-specific ACOs, particularly conditions where there is active and ongoing use of the health care system, the costs of treatment are relatively high, and the complexity of care is such that integration among providers serving these subpopulations of patients has already developed over the years to best serve patients. For instance, the kidney care community has a proposal to implement a renal-specific ACO that could take advantage of the existing integrated network of chronic kidney and end stage renal disease (ESRD) providers to further integrate care, improve efficiency, reduce cost, and improve patient outcomes for this vulnerable and relatively expensive Medicare population.

Other condition-specific ACOs might include delivery models focused on traumatic brain injury or spinal cord injury. These are complex conditions that often require extensive rehabilitation and related care to achieve good patient outcomes. Patients with these types of conditions are at risk under typical ACOs of being underserved because these are the types of patients that will counter any savings achieved on primary and acute care patients. In the end, ACOs must be prohibited in sharing in savings if quality outcomes are not met, including functional outcomes, for all patients within an ACO. But condition-specific ACOs may be a more effective mechanism for treating the health care needs of these populations while still achieving savings for the Medicare program.

Continuing Care Hospital Concept: In fact, limiting an ACO to a specific medical condition may not be necessary, considering the existence of alternative delivery models that CMS must test in the new Center for Medicaid and Medicaid Innovation. Known as

the Continuing Care Hospital (CCH), this new delivery model would act as an integrated system for care delivery after the acute onset of an illness or injury. A bundled payment would be made to a new entity, the Continuing Care Hospital, which would be responsible for matching the intensity and breadth of medical rehabilitation and related services to the needs of each patient, while being held accountable for function-based patient outcomes. For many populations of people with disabilities and chronic conditions, this model appears promising and is worthy of robust testing to CCD is hopeful that this model may

Exemptions for Certain At-Risk Populations: Until CMS can demonstrate that ACOs work effectively without negative consequences for patient outcomes, certain conditions should be exempt from ACOs. In particular, patients should be exempt from traditional ACOs where there health conditions require costly, complex, or specialized care on an ongoing basis and where the patient would be at-risk for under-service in a delivery model that shares savings with participating providers. Until specialized ACOs or the CCH model can be implemented successfully, CCD believes that conditions such as traumatic brain injury, spinal cord injury, severe stroke, and multiple trauma should be subject to an exemption from the ACO model.

Thank you for your consideration of our comments. Please contact any of the co-chairs below if you have any questions or comments.

Sincerely,

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