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December 3, 2010

Donald M. Berwick, MD  
Administrator  
Centers for Medicare and Medicaid Services  
Room 314G  
Hubert H. Humphrey Building  
200 Independence Avenue SW  
Washington, DC 20201

RE: Request for Information Regarding Accountable Care  
Organizations and the Medicare Shared Savings Program;  
75 Federal Register 70165 (November 17, 2010) [CMS-1345-NC]

Dear Dr. Berwick:

The Network for Regional Healthcare Improvement (NRHI) appreciates the opportunity to make recommendations on several of the issues in the November 17 Request for Information regarding Accountable Care Organizations and the Medicare Shared Savings Program.

NRHI is the national membership organization for Regional Health Improvement Collaboratives – non-profit, multi-stakeholder, community-based organizations that are working to improve the quality and reduce the costs of health care in metropolitan regions and states across the country. Many NRHI members are also designated as Chartered Value Exchanges (CVEs) by HHS and AHRQ. Attached is a list of the 31 member Collaboratives in NRHI and a map showing their locations.

**1. *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?***

We believe that CMS can significantly increase the willingness of small physician practices and other providers to participate in new payment and delivery models and their ability to succeed under such models by taking the following actions:

**1. Provide access to Medicare claims data to Regional Health Improvement Collaboratives that do quality/cost measurement**

and reporting. Most Collaboratives have sophisticated programs to assemble and analyze data from health insurance claims to help providers identify where there are opportunities to improve the quality and cost of care and to help patients choose the highest-value providers. However, in most cases, Collaboratives have been unable to obtain timely access to Medicare fee-for-service claims data in a usable format. We urge that CMS make Medicare claims data available to Regional Health Improvement Collaboratives as soon as possible so that they can help providers in their community identify successful strategies for forming ACOs and also to develop other innovative payment and delivery reforms that CMMI can support.

2. Provide financial support to Regional Health Improvement Collaboratives so that they can provide technical assistance to help small physician practices, hospitals, and other providers redesign their care processes and organizational structures to more effectively coordinate care. Payment reforms and electronic health records will not result in more coordinated, higher quality, lower cost care unless frontline healthcare workers develop the skills needed to change the way care is delivered and unless physician practices, hospitals, and other providers build more collaborative relationships. A number of Regional Health Improvement Collaboratives, such as the Pittsburgh Regional Health Initiative ([www.prhi.org](http://www.prhi.org)), the Institute for Clinical Systems Improvement ([www.icsi.org](http://www.icsi.org)), and HealthInsight ([www.healthinsight.org](http://www.healthinsight.org)), have extensive experience in helping healthcare providers transform the way they deliver care.
  3. Establish an explicit priority at CMMI for payment and delivery system demonstration projects developed by or in coordination with Regional Health Improvement Collaboratives. We believe that the most successful, high-impact demonstration projects will be those that address the most important quality issues in a particular community, that have support from both consumers and a broad range of healthcare providers, that have participation by payers other than Medicare, and that have effective local mechanisms for monitoring implementation and resolving problems. Several Regional Health Improvement Collaboratives, such as the Maine Health Management Coalition ([www.mehmc.org](http://www.mehmc.org)) and the Pittsburgh Regional Health Initiative ([www.prhi.org](http://www.prhi.org)), are actively working with physicians, hospitals, health plans, employers, consumers and others to develop Accountable Care Organizations that truly result in better health, better care, and lower costs. Announcing an explicit priority at CMMI for projects developed by or in coordination with Regional Health Improvement Collaboratives would ensure that CMMI is building on the extensive work that these and other Collaboratives have already done to build consensus on healthcare improvement strategies and multi-payer payment reforms in their communities, and would also encourage additional communities to pursue similar consensus-building efforts.
2. ***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?***

Small practices not only need financial resources to improve care, they need information and technical assistance. Even with access to capital, many providers, particularly small providers, will need information on current utilization patterns and analyses of the likely impact of interventions in order to construct a feasible business case for the investment of that capital, and many will likely need technical assistance in implementing interventions and monitoring their performance. As described in more detail in the previous section, we recommend that CMS provide both data and financial support to Regional Health Improvement Collaboratives so that they can assist physician practices, hospitals, and other healthcare providers to carry out analyses of care improvement opportunities and then design and successfully implement changes in care that will improve quality and reduce costs. We further recommend that wherever possible, other federal funding programs designed to support local quality improvement initiatives should give priority to applications from Regional Health Improvement Collaboratives or to applications which have been endorsed by such Collaboratives as being consistent with the priorities and goals established in those communities.

In many cases, an appropriate payment model could provide the capital that practices need to transform their care. For example, the Puget Sound Health Alliance and the Washington State Health Care Authority have coordinated efforts among commercial payers and Medicaid plans to develop a method of giving primary care physician practices the upfront resources needed to restructure the way care is delivered to their patients in return for a commitment to reduce the rate at which those patients use emergency rooms for non-urgent visits and the rate at which patients are admitted and readmitted to the hospital for ambulatory care sensitive conditions. We recommend that CMS make a similar payment model available under Medicare, either as part of the Shared Savings Program or through the Center for Medicare and Medicaid Innovation, so that physician practices can improve care for Medicare beneficiaries and achieve savings for the Medicare program in areas that they can influence without being penalized for the costs of other services they are not in a position to control.

3. **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?**

The accuracy of any attribution methodology will be improved if it is accompanied by proactive efforts to encourage patients to use a consistent medical home and a coordinated network of specialists. Active patient engagement dramatically increases the ability of physicians to help patients improve their health, avoid unnecessary hospitalizations, and reduce the use of unnecessary and duplicative services. We recommend that CMS provide support for Regional Health Improvement Collaboratives so that they can undertake proactive efforts to educate Medicare beneficiaries and encourage them to take actions that will help make ACOs successful, e.g., to choose and consistently use a primary care physician as a medical home, to select specialty physicians, hospitals, and other providers who coordinate effectively with their primary care medical home and with each other, to engage in shared decision-making processes with their physicians about appropriate treatments for their conditions, and to participate in other types of programs developed by their physicians that can maintain and improve their health at an affordable cost.

### **4. *How should we assess beneficiary and caregiver experience of care as part of our assessment of ACO performance?***

Measurement of patient and caregiver experience is very important, but it is also very challenging. Because data on experience cannot be collected through standard claims data or electronic health records, they require the use of special surveys of patients. We believe that surveying patients and caregivers and reporting results should be done through independent, multi-stakeholder Regional Health Improvement Collaboratives (RHICs) for several reasons: (1) RHICs actively work to involve consumers in the design and dissemination of measures, helping to ensure they are responsive to consumer concerns and usable for consumers; (2) RHICs involve not only consumers, but healthcare providers, purchasers, and payers, thereby ensuring that measurement is objective and balanced; (3) RHICs which measure and report on clinical quality can combine those measures with patient experience measures in order to provide a comprehensive picture of the value of care for patients. Several Collaboratives, including Massachusetts Health Quality Partners ([www.mhqp.org](http://www.mhqp.org)) and Minnesota Community Measurement ([www.mnhealthscores.org](http://www.mnhealthscores.org)), already collect and report measures of patient experience along with quality of care measures based on claims and/or clinical data.

The lack of resources available to conduct patient experience surveys has been a principal barrier slowing their implementation. We urge that CMS provide financial support to enable more Regional Health Improvement Collaboratives to collect and report data on patient experience.

Although the Consumer Assessment of Healthcare Providers and Systems (CAHPS) should be the foundation for experience of care measures, additional survey questions may be needed to measure patient experience issues that will be affected by ACOs. Particularly in the near term, different measures may be needed in different

communities because the areas where ACOs will focus their cost reduction efforts will likely vary significantly from region to region. We recommend that CMS and AHRQ provide support to multi-stakeholder Regional Health Improvement Collaboratives to develop and test new patient experience measures working in collaboration with the physicians and ACOs in their communities.

**5. *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?***

One of the biggest challenges to delivering patient-centered care is the fragmentation within the existing delivery system and lack of coordination among providers. With appropriate payment reforms, ACOs will have both the ability and incentive to achieve greater coordination of care. CMS should allow providers to define their own pathways to better coordination, and should avoid establishing arbitrary requirements that could force undesirable consolidation of providers; the goal should be *clinical* integration, not necessarily corporate integration. We recommend that CMS provide support to Regional Health Improvement Collaboratives so that they can both assist providers to coordinate without consolidating and so they can provide a mechanism for helping CMS determine whether improved coordination is occurring.

An ACO's ultimate success in being "patient-centered" is something that can best be evaluated by patients' experience with the care provided by the ACO, not by whether the ACO meets specific standards established by CMS. As described in more detail in the previous section, we recommend that CMS support the creation of effective mechanisms for assessing patients' experience of care through Regional Health Improvement Collaboratives.

**6. *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?***

In developing quality measures and performance standards for Accountable Care Organizations, we urge CMS to build on the extensive quality measurement and reporting infrastructure which has already been developed in many regions around the country by Regional Health Improvement Collaboratives such as the Albuquerque Coalition for Healthcare Quality ([www.abqhealthcarequality.org](http://www.abqhealthcarequality.org)), Aligning Forces for Quality – South Central Pennsylvania ([www.aligning4healthpa.org](http://www.aligning4healthpa.org)), Better Health Greater Cleveland ([www.betterhealthcleveland.org](http://www.betterhealthcleveland.org)), the California Cooperative Healthcare Reporting Initiative ([www.cchri.org](http://www.cchri.org)), the Greater Detroit Area Health Council ([www.gdahc.org](http://www.gdahc.org)), the Health Improvement Collaborative of Greater Cincinnati ([www.the-collaborative.org](http://www.the-collaborative.org)), Healthy Memphis Common Table ([www.healthymemphis.org](http://www.healthymemphis.org)), HealthInsight ([www.healthinsight.org](http://www.healthinsight.org)), the Integrated Healthcare Association ([www.ihc.org](http://www.ihc.org)), the Iowa Healthcare Collaborative ([www.ihconline.org](http://www.ihconline.org)), the Kansas City Quality Improvement Consortium ([www.kcqic.org](http://www.kcqic.org)),

the Louisiana Health Care Quality Forum ([www.lhcqf.org](http://www.lhcqf.org)), the Maine Health Management Coalition ([www.mehmc.org](http://www.mehmc.org)), Massachusetts Health Quality Partners ([www.mhqp.org](http://www.mhqp.org)), the Midwest Health Initiative ([www.mhi.org](http://www.mhi.org)), Minnesota Community Measurement ([www.mncommunitymeasurement.org](http://www.mncommunitymeasurement.org)), the Oregon Healthcare Quality Corporation ([www.q-corp.org](http://www.q-corp.org)), the Puget Sound Health Alliance ([www.pugetsoundhealthalliance.org](http://www.pugetsoundhealthalliance.org)), and the Wisconsin Collaborative for Healthcare Quality ([www.wchq.org](http://www.wchq.org)).

The measurement systems these Collaboratives have developed are non-proprietary and the methodologies are publicly available. Indeed, Regional Health Improvement Collaboratives proactively encourage providers, consumers, purchasers, and other interested parties to participate in the development of the systems and to ensure the accuracy of the measures, so that the results will be trusted by all parties.

Of particular note is the methodology developed by the Wisconsin Collaborative for Healthcare Quality ([www.wchq.org](http://www.wchq.org)) for collecting and reporting data on the quality of care. This methodology overcomes the major limitations of claims-based data systems and enables intermediate outcomes to be measured accurately regardless of whether physicians have electronic health records systems or not. This same methodology is now being used by Minnesota Community Measurement ([www.mncommunitymeasurement.org](http://www.mncommunitymeasurement.org)) and the Health Improvement Collaborative of Greater Cincinnati ([www.the-collaborative.org](http://www.the-collaborative.org)). We recommend that CMS provide support to other communities which wish to implement the kind of robust measurement and reporting methodology developed by the Wisconsin Collaborative for Healthcare Quality.

Not only are Regional Health Improvement Collaboratives already collecting and publicly reporting an extensive array of quality measures, they are also actively using them to encourage improvements in the quality of healthcare in their communities. Indeed, in many cases, the measures have been developed specifically to support a local quality improvement initiative, rather than the other way around. This type of synergy between measurement/reporting initiatives and quality improvement initiatives at the local level is precisely what will help Accountable Care Organizations be successful. The practical reality is that healthcare providers can only implement a limited number of quality measurement and improvement initiatives while still keeping up with patient care responsibilities, so inconsistencies or conflicts between national and regional priorities and requirements may force providers to shift resources and attention away from an important local quality improvement initiative they have worked hard to develop in order to improve on national measures, even though the local initiative could achieve greater impacts on the ultimate goal of improved healthcare quality and lower costs. Consequently, in regions where Regional Health Improvement Collaboratives have already established quality measurement and reporting programs and/or quality improvement goals and initiatives, we urge CMS to require that these same measures and goals be used to measure the performance of Accountable Care Organizations.

In addition to quality measures, communities will need measures of cost and resource utilization and measures of population health, functional outcomes, and patient experience in order to ensure that Accountable Care Organizations and other payment and delivery reforms are truly achieving all three goals of health reform, i.e., better health and lower costs as well as better care. Several Regional Health Improvement Collaboratives are already working to develop such measures, but much more effort is needed. Moreover, since we know that the types of problems with quality, utilization, coordination, etc. vary significantly across the country, these measures need to be developed in the context of the specific types of cost and quality improvement that individual communities are pursuing. Consequently, we recommend that CMS provide financial support to Regional Health Improvement Collaboratives to help develop and test measures of cost and resource utilization and measures of population health, functional outcomes, and patient experience in conjunction with ACO implementation in their communities.

7. ***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?***

We urge CMS to create mechanisms so that it can participate as an equal partner in multi-payer payment reforms that are being developed at the local level, such as those coordinated by Regional Health Improvement Collaboratives. Physicians, hospitals, and other healthcare providers need to be paid by all payers in consistent ways, and trying to implement a new payment model from CMS at the same time they are trying to implement a different payment model with local commercial payers could cause providers to spend more time on trying to administer different payment systems than to actually improve care for patients. In addition to CMS creating the flexibility to customize payment models to unique local circumstances, we recommend that there be no arbitrary limits on the number of geographic areas which can participate in innovative payment models, and that regions and providers not be precluded from participating because other CMS demonstrations are implemented in the same geographic area.

We appreciate the opportunity to submit these comments, and we would be happy to provide any additional information regarding them or to assist you in implementing them.

Sincerely,



Harold D. Miller  
President and CEO

cc: Jonathan Blum  
Richard Gilfillan, MD

Attachment

## Regional Health Improvement Collaboratives in the Network for Regional Health Care Improvement

- Albuquerque Coalition for Healthcare Quality ([www.abqhealthcarequality.org](http://www.abqhealthcarequality.org))
- Aligning Forces for Quality – South Central PA ([www.aligning4healthpa.org](http://www.aligning4healthpa.org))
- Alliance for Health (West Michigan) ([www.afh.org](http://www.afh.org))
- Better Health Greater Cleveland ([www.betterhealthcleveland.org](http://www.betterhealthcleveland.org))
- California Cooperative Healthcare Reporting Initiative ([www.cchri.org](http://www.cchri.org))
- California Quality Collaborative ([www.calquality.org](http://www.calquality.org))
- Finger Lakes Health Systems Agency ([www.flhsa.org](http://www.flhsa.org))
- Greater Detroit Area Health Council ([www.gdahc.org](http://www.gdahc.org))
- Health Improvement Collaborative of Greater Cincinnati ([www.the-collaborative.org](http://www.the-collaborative.org))
- Healthy Memphis Common Table ([www.healthymemphis.org](http://www.healthymemphis.org))
- Institute for Clinical Systems Improvement (Minnesota) ([www.icsi.org](http://www.icsi.org))
- Integrated Healthcare Association (California) ([www.iha.org](http://www.iha.org))
- Iowa Healthcare Collaborative ([www.ihconline.org](http://www.ihconline.org))
- Kansas City Quality Improvement Consortium ([www.kcqi.org](http://www.kcqi.org))
- Louisiana Health Care Quality Forum ([www.lhccf.org](http://www.lhccf.org))
- Maine Health Management Coalition ([www.mehmc.org](http://www.mehmc.org))
- Massachusetts Health Quality Partners ([www.mhqp.org](http://www.mhqp.org))
- Midwest Health Initiative (St. Louis) ([www.midwesthealthinitiative.org](http://www.midwesthealthinitiative.org))
- Minnesota Community Measurement ([www.mncm.org](http://www.mncm.org))
- Minnesota Healthcare Value Exchange
- Nevada Partnership for Value-Driven Healthcare (HealthInsight) ([www.healthinsight.org](http://www.healthinsight.org))
- New York Quality Alliance ([www.nyqa.org](http://www.nyqa.org))
- Oregon Health Care Quality Corporation ([www.q-corp.org](http://www.q-corp.org))
- P2 Collaborative of Western New York ([www.p2wny.org](http://www.p2wny.org))
- Pittsburgh Regional Health Initiative ([www.prhi.org](http://www.prhi.org))
- Puget Sound Health Alliance ([www.pugetsoundhealthalliance.org](http://www.pugetsoundhealthalliance.org))
- Quality Counts (Maine) ([www.mainequalitycounts.org](http://www.mainequalitycounts.org))
- Quality Quest for Health of Illinois ([www.qualityquest.org](http://www.qualityquest.org))
- Utah Partnership for Value-Driven Healthcare (HealthInsight) ([www.healthinsight.org](http://www.healthinsight.org))
- Wisconsin Collaborative for Healthcare Quality ([www.wchq.org](http://www.wchq.org))
- Wisconsin Healthcare Value Exchange

