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June 6, 2011

Donald M. Berwick, MD
Administrator
Centers for Medicare and Medicaid Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

RE: Proposed Rule for the Medicare Shared Savings Program:
Accountable Care Organizations; 76 Federal Register 19528
(April 7, 2011) [CMS-1345-P]

Dear Dr. Berwick:

The Network for Regional Healthcare Improvement (NRHI) appreciates the opportunity to submit comments on the Proposed Rule for the Medicare Shared Savings Program and to respond to a number of the specific issues you raised in the Preamble to the rule.

As you know, 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 dozens of metropolitan regions and states across the country. Many NRHI members are also designated as Chartered Value Exchanges (CVEs) by HHS and AHRQ.

Summary of Recommendations

Accountable Care Organizations could be a very important mechanism for improving quality and controlling the costs of health care in communities across the nation, but only if they are implemented efficiently and effectively and in ways that complement community-wide quality improvement and cost containment initiatives. We recommend that CMS make the following changes in the Proposed Rule in order to support this:

1. We recommend that CMS explicitly encourage and require ACOs to support and work with local multi-stakeholder

Regional Health Improvement Collaboratives in the communities where such Collaboratives exist.

2. We recommend that CMS provide funding to Regional Health Improvement Collaboratives so that they can assist CMS in proactively educating the Medicare beneficiaries in their communities about things such as (a) the quality of care delivered by the physicians and hospitals participating in the ACOs in the community as well as providers who are not part of an ACO, and (b) the types of actions beneficiaries can take to support efforts by an ACO to improve their health and the quality of the healthcare services they receive.
3. Instead of requiring that all ACO marketing materials be approved in advance by CMS, we recommend that CMS permit ACOs to use materials that have been approved by, or developed and issued jointly with, the Regional Health Improvement Collaborative in the community where the ACO operates.
4. We urge CMS to permit and encourage ACOs to assess patients' experience of care through community-wide patient experience surveys conducted by Regional Health Improvement Collaboratives.
5. We urge that CMS draw on the experience and expertise of the Regional Health Improvement Collaboratives that are currently collecting and reporting patient experience measures as CMS refines its requirements for ACOs to collect such measures.
6. We recommend that CMS provide financial support for programs by Regional Health Improvement Collaboratives to collect and report data on patient experience, so that ACOs, particularly ACOs composed of small providers, can utilize such programs to comply with requirements under the Shared Savings Program.
7. We urge that CMS and AHRQ work with Regional Health Improvement Collaboratives to develop and test new patient experience measures that specifically address the care delivery issues associated with ACOs.
8. We recommend that CMS give priority to using quality measures that are already successfully being used for public reporting by one or more Regional Health Improvement Collaboratives.
9. We recommend that ACOs be allowed to report on and be held accountable for quality measures that are being collected and publicly reported by a Regional Health Improvement Collaborative in their community, in place of some of the measures proposed by CMS.
10. We recommend that ACOs be consistently required to calculate quality measures on all patients seen by the ACO to whom the measure is applicable, not just Medicare patients or attributed patients.
11. We urge that CMS provide Regional Health Improvement Collaboratives with Medicare claims data for all of the beneficiaries in the community, so that the Collaboratives can calculate claims-based quality measures on the full populations served by ACOs and by other healthcare providers in the community.

12. We urge that any reports issued by CMS on the quality of care delivered by ACOs should clearly and visibly explain any differences between the measures CMS reports and the measures that are being publicly reported by Regional Health Improvement Collaboratives in the ACOs' communities.
13. We recommend that CMS replace Measure 35 with the Optimal Diabetes Care Composite that was recently endorsed by the National Quality Forum (#0729), and that CMS use the specifications for the individual elements of NQF Measure #0729 for the proposed measures 36-41.
14. We recommend that instead of Measure 52, CMS should use the Optimal Vascular Care Composite that has been endorsed by the National Quality Forum (#0076), since it focuses on outcome measures rather than process measures.
15. Instead of or in addition to Measure 34 (Depression Screening), we recommend measuring (1) the use of the Patient Health Questionnaire 9 (PHQ-9) for patients with depression, and (2) the remission rate for patients with depression, either at 6 months or 12 months or both, which are measures that have been endorsed by the National Quality Forum (#0710, #0711, and #0712).
16. In states and regions where a Regional Health Improvement Collaborative is already collecting and publicly reporting on the quality of care in physician practices and/or hospitals and has the capability to collect and report the quality measures required by CMS, we urge that CMS allow the ACO to use the Collaborative's data to meet its reporting obligations under the Shared Savings program, rather than requiring ACOs to collect and submit data separately.
17. We urge that before developing its own data submission tool, CMS should consider using existing reporting tools, such as the RBS system that was developed in Wisconsin and is being used in several other communities.
18. We recommend that, in addition to any mechanisms CMS establishes for making claims data available directly to providers, CMS should make Medicare claims data available to Regional Health Improvement Collaboratives on all of the Medicare beneficiaries living in and/or receiving care in the region or state that the Collaborative serves.
19. We urge that CMS begin making Medicare claims data available to Regional Health Improvement Collaboratives immediately so that the Collaboratives can help providers in their communities identify successful strategies for forming ACOs.
20. We recommend that in states and regions where a Regional Health Improvement Collaborative has an active quality measurement and reporting program, ACOs should be required to submit the information required under §425.23 to the Collaborative.

The rationale for these recommendations and specific language to include in the regulations to implement them are described in detail below.

Partnerships with Community Stakeholders

We strongly endorse the proposed requirement in §425.5(d)(3)(v) that an Accountable Care Organization (ACO) “must establish partnerships with community stakeholders in order to advance the three-part aim of better care for individuals, better health for populations, and lower growth in expenditures.” We believe that ACOs will be far more successful if they can draw on community resources to help them (1) measure the quality and cost of their care and compare it to other providers, (2) redesign their care processes and organizational structures to improve care coordination and eliminate inefficiencies; (3) educate and encourage patients to improve their health, select high-value providers and services, and support coordination of their healthcare services; and (4) obtain changes in healthcare payment from commercial health plans and state Medicaid programs as well as Medicare.

The core mission of all Regional Health Improvement Collaboratives is to help transform their community’s current health promotion and healthcare delivery systems to meet the Triple Aim goals of better health, better care, and affordable costs. Collaboratives are doing that in four key ways:

1. **Performance Measurement.** Most Regional Health Improvement Collaboratives serve as a neutral, trusted source of actionable information about the cost and quality of healthcare services, the health of the population, and/or the extent to which state-of-the-art methods of delivery, payment, and health promotion are being used in their community. This enables the community to identify opportunities for reducing costs and improving quality and for monitoring whether those opportunities are being successfully addressed.
2. **Payment and Delivery System Reform.** A growing number of Regional Health Improvement Collaboratives are serving as a neutral planning and problem-solving forum where win-win multi-payer, multi-provider payment and delivery reforms can be designed and where the inevitable implementation problems can be discussed and resolved jointly by the affected stakeholders.
3. **Training and Assistance in Performance Improvement.** Many Regional Health Improvement Collaboratives operate programs through which physician practices, hospitals, and other healthcare providers can obtain affordable training, coaching, and technical assistance to enable them to analyze problems in care delivery and to design and successfully implement solutions.
4. **Consumer Education and Engagement.** Regional Health Improvement Collaboratives have developed a variety of creative, proactive efforts to help citizens in their communities (a) understand and actively engage in activities that will maintain and improve their health, (b) choose providers and services based on their cost and quality, and (c) support the delivery of higher quality, more coordinated care.

(More information and examples of these activities are available on the Network for Regional Healthcare Improvement’s website, www.NRHI.org.)

Clearly, the activities in which Regional Health Improvement Collaboratives are engaged are completely aligned with what ACOs will need to do to successfully control healthcare costs while maintaining or improving quality. Moreover, because of the multi-stakeholder nature of Collaboratives, with active involvement of providers, payers, employers, and consumers, Collaboratives are an ideal mechanism for helping ACOs obtain the broad range of community support they need to be successful. Most ACOs will likely be in communities where Collaboratives exist, since Collaboratives are now operating in states and regions containing more than 40% of the U.S. population.

We urge that CMS explicitly encourage ACOs to support and work with local multi-stakeholder Regional Health Improvement Collaboratives in the communities where such Collaboratives exist, and we recommend the following change to the language in §425.5(d)(3)(v) to support this:

(v) The ACO must establish partnerships with community stakeholders in order to advance the three-part aim of better care for individuals, better health for populations, and lower growth in expenditures. In states and regions where Regional Health Improvement Collaboratives or other multi-stakeholder health improvement organizations exist, ACOs must demonstrate that they will support and coordinate with those entities.

We also recommend that the language in §425.5(d)(9)(ix) (which defines the supporting materials ACOs must include in their applications) should be changed to read:

(H) A description of how the ACO will partner with community stakeholders, including a Regional Health Improvement Collaborative if one exists in the state or region where the ACO is located.

Finally, to support these amendments and other recommendations below, we recommend that you add a definition of “Regional Health Improvement Collaborative” in §425.4:

Regional Health Improvement Collaborative. A non-profit organization whose mission is to improve the health of citizens and the quality and efficiency of healthcare in a metropolitan region or state and whose governing body is composed of healthcare providers, health plans, employers, and citizens from that region or state. This shall include, but not be limited to, organizations designated as Chartered Value Exchanges by the Agency for Healthcare Research and Quality.

Communications with Beneficiaries

§425.5(d)(4) of the proposed rule would require that “Any ACO marketing materials or activities, as defined in §425.4, must be approved by CMS before use,” and §425.4 would define “marketing materials” as including “general audience materials...used to educate...Medicare beneficiaries ... regarding the Shared Savings Program.”

Although this provision may help protect Medicare beneficiaries from inaccurate or inappropriate marketing efforts, it does nothing to proactively ensure that they get accurate information about the advantages that the ACO provides. The success of ACOs will depend heavily on having patients (1) actively work to maintain and improve their health; (2) choose and consistently use a primary care physician as a medical home; (3) select specialty physicians, hospitals, and other providers who coordinate effectively with their primary care medical home and with each other; (4) engage in shared decision-making processes with their physicians about appropriate treatments for their conditions; and (5) participate in other types of programs developed by their physicians that can help them maintain and improve their health at an affordable cost. Requiring all marketing materials to be pre-approved by CMS will have several undesirable effects, including:

- It will likely cause significant delays and increase the costs for ACOs to communicate with their patients;
- It may deter ACOs from producing educational materials for beneficiaries designed to encourage desirable patient behaviors; and
- CMS may unknowingly approve materials that are inaccurate or misleading in the context of a particular community.

Many Regional Health Improvement Collaboratives have extensive programs designed to help citizens in their communities understand and actively engage in healthy lifestyles, choose providers and services based on their cost and quality, and support the delivery of higher quality, more coordinated care. For example:

- the Oregon Health Care Quality Corporation has developed patient-friendly materials to help people select quality healthcare providers and work with them to develop appropriate treatment plans. Publications include *Making the Most of Your Medical Appointments* and *Getting the Kind of Care That Works Best*.
- Minnesota Community Measurement has established "The D5: 5 Goals for Living with Diabetes" to make it easier for people with diabetes to manage their condition and to find the healthcare providers who can most effectively help them.
- The Wisconsin Collaborative for Healthcare Quality created *Wisconsin Health Reports*, a patient-friendly website designed to help patients learn about their healthcare conditions, compare providers, and take action to improve their health.
- Massachusetts Health Quality Partners launched the *Expect the Best* campaign to help patients know what they should expect when they have an office visit with a physician so they are more likely to get high quality care. For example, patients are urged to "Expect that your doctor takes the time to give you clear instructions on what to do to take care of your medical problem, including what to do if your symptoms get worse or come back," and patients are given specific suggestions as to what they and their doctor can do to make this happen.

We recommend that CMS provide funding to Regional Health Improvement Collaboratives so that they can assist CMS in proactively educating the Medicare beneficiaries in their communities about things such as (a) the quality of care delivered

by the physicians and hospitals participating in the ACOs in the community as well as providers who are not part of an ACO, and (b) the types of actions beneficiaries can take to support efforts by an ACO to improve their health and the quality of the healthcare services they receive.

In addition, instead of requiring that all ACO marketing materials be approved in advance by CMS, we recommend that CMS permit ACOs to use materials that have been approved by, or developed and issued jointly with, the Regional Health Improvement Collaborative in the community where the ACO operates. To accomplish this, we recommend modifying the language in §425.5(d)(4) as follows:

(4) Marketing Materials. (i) Any ACO marketing materials or activities, as defined in §425.4, must be approved by CMS before use, unless the marketing materials are approved by a Regional Health Improvement Collaborative or are developed and issued jointly with a Regional Health Improvement Collaborative.

Assessing Experience of Care

§425.5(d)(15)(ii)(B)(1) requires an ACO to “have a beneficiary experience of care survey in place (using the Clinician and Group CAHPS survey, including an appropriate functional status survey module) and describe how the ACO will use the results to improve care over time.”

Measuring patient and caregiver experience is very important, but also very challenging, because data on experience cannot be collected through standard claims data or electronic health records and therefore requires the use of special surveys of patients. We believe it is preferable that both the surveying of patients and caregivers and the reporting of the results of those surveys be done by or under the supervision of independent, multi-stakeholder Regional Health Improvement Collaboratives (RHICs) whenever possible, for several reasons: (1) conducting patient experience surveys is more cost-effective if it is done jointly for multiple ACOs and other provider organizations by an RHIC, rather than separately by each ACO; (2) having comparable patient experience data available on providers in the community other than ACOs through RHICs will allow consumers to compare ACOs and non-ACO providers; (3) patient experience data developed by RHICs are more responsive to consumer concerns and more usable for consumers, because RHICs actively work to involve consumers in the design and dissemination of experience measures; (4) RHICs involve not only consumers, but physicians and other healthcare providers, in the design, collection, and reporting of experience measures, thereby ensuring that the measures are actionable; and (5) RHICs which measure and report on clinical quality can combine those measures with patient experience measures in order to provide a more comprehensive picture of the value of care for patients. Consequently, we urge CMS to permit and encourage ACOs to assess patients’ experience of care through community-wide patient experience surveys conducted by Regional Health Improvement Collaboratives.

In addition, although we agree that it is reasonable to use all or part of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) as a foundation for experience of care measures in order to enable comparability across ACOs in different parts of the country, additional survey questions may be needed to measure patient experience issues that will be affected by ACOs. Moreover, 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 from region to region.

To implement the above points, we recommend modifying §425.5(d)(15)(ii)B)(1) as follows:

(1) Have a beneficiary experience of care survey in place (using including, but not limited to, items included in the Clinician and Group CAHPS survey, including an appropriate functional status survey module) and describe how the ACO will use the results to improve care over time. If a Regional Health Improvement Collaborative in the community has a program to measure patient experience of care, the ACO will be permitted to utilize that program to the maximum extent possible to comply with this requirement and with the measurement requirements in §425.9.

Several Collaboratives, including Massachusetts Health Quality Partners (www.mhqp.org) and Minnesota Community Measurement (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 biggest barrier to conducting patient experience surveys in other communities has been a lack of resources, and this cost may also discourage small providers from forming ACOs under the Shared Savings Program. Consequently:

- We urge that CMS draw on the experience and expertise of the Regional Health Improvement Collaboratives that are currently collecting and reporting patient experience measures as it refines its requirements for ACOs to collect such measures.
- We urge that CMS provide financial support for programs by Regional Health Improvement Collaboratives to collect and report data on patient experience, so that ACOs, particularly ACOs composed of small providers, can utilize such programs to comply with requirements under the Shared Savings Program.
- We urge that CMS and AHRQ work with Regional Health Improvement Collaboratives to develop and test new patient experience measures that specifically address the care delivery issues associated with ACOs.

Quality Measures

According to Section II.E of the Preamble, CMS is proposing to have ACOs report on 65 separate quality measures in five domains in their first year, and the preamble

indicates that ACOs may be required to report on additional measures in subsequent years.

We strongly support the importance of having ACOs measuring and reporting on the quality of their care. Indeed, Regional Health Improvement Collaboratives have the most extensive experience in the nation regarding how to successfully implement healthcare quality measurement and public reporting efforts for a wide range of measures and for patients associated with multiple payers, and in how to ensure the reports are used to actually improve the quality of care in a community. A number of Collaboratives have been collecting and publicly disseminating measures of the quality of care provided by physician practices and/or hospitals in their communities for multiple years, and a growing number of them also measure and report on patient experience and the cost of care. Examples include the Albuquerque Coalition for Healthcare Quality (www.abqhealthcarequality.org), Aligning Forces for Quality – South Central Pennsylvania (www.aligning4healthpa.org), Better Health Greater Cleveland (www.betterhealthcleveland.org), the California Cooperative Healthcare Reporting Initiative (www.cchri.org), the Greater Detroit Area Health Council (www.gdahc.org), the Health Improvement Collaborative of Greater Cincinnati (www.the-collaborative.org), Healthy Memphis Common Table (www.healthymemphis.org), HealthInsight (www.healthinsight.org), the Integrated Healthcare Association (www.iha.org), the Iowa Healthcare Collaborative (www.ihconline.org), the Kansas City Quality Improvement Consortium (www.kcqic.org), the Louisiana Health Care Quality Forum (www.lhccf.org), the Maine Health Management Coalition (www.mehmc.org), Massachusetts Health Quality Partners (www.mhqp.org), the Midwest Health Initiative (www.mhi.org), Minnesota Community Measurement (www.mncommunitymeasurement.org), the Oregon Healthcare Quality Corporation (www.o-q-corp.org), the Puget Sound Health Alliance (www.pugetsoundhealthalliance.org), and the Wisconsin Collaborative for Healthcare Quality (www.wchq.org).

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.

We believe it will be very difficult for many ACOs, particularly smaller ACOs, to report on the large number of measures that CMS is proposing to require in the first year, particularly given the one-size-fits-all nature of the proposed requirements and the fact that many of the measures have never been publicly reported before or have not been reported at the level of an “ACO.” We believe that having CMS rigidly defining a large number of quality measures, including new measures, for which ACOs will be accountable will have several undesirable effects:

- The major drivers of costs differ from community to community, and so ACOs in different parts of the country may need to change different aspects of care for different patient subgroups. Any single set of quality measures selected by CMS

may bear little relationship to the specific types of patients or types of care on which a particular ACO is focusing its efforts. This means that (a) the quality measures may not actually protect consumers from any undesirable impacts of the changes in care the ACO makes, and (b) the ACO will have to divert attention from efforts to reduce costs in areas where there are significant opportunities for cost reduction in order to focus attention on the quality measures required by CMS in other areas.

- Requiring ACOs to focus on the quality measures required by CMS may also force them to divert resources and attention away from existing quality improvement initiatives in the community which are focused on issues not covered by or emphasized in the ACO measures. The practical reality is that healthcare providers can only implement a limited number of quality measurement and improvement initiatives at an one time 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.
- Requiring ACOs to collect and report on measures required by CMS that differ from measures used in local quality measurement and reporting initiatives may undercut the local initiatives and also confuse consumers. For example, if a consumer sees a quality score in their Regional Health Improvement Collaborative's quality report for a particular physician practice, but sees a different score for the same physician practice for what appears to be the same measure as part of the ACO, it could cause that consumer to doubt the validity of both sources of information. Similarly, the motivation of physicians, hospitals, and other healthcare providers to improve their performance will likely be lower if they are getting different performance information from local sources and CMS.
- Requiring ACOs to collect and report on measures that have not previously been collected, publicly reported, or reported at the level of the ACO will likely result in significant administrative problems and measurement errors that will distract ACOs from their primary goal – improving patient care – and potentially penalize them financially through reductions in their shared savings payments.

In addition, although CMS acknowledges in the Preamble the importance of aligning measures in the ACO program with those in other programs, the emphasis is on alignment with *Medicare and Medicaid* programs, not with patients covered by commercial insurance. For example, in Section II.E.7 of the Preamble, CMS invites comments on “the best and most appropriate way to align quality domains, categories, specific measures, and rewards across ... Federal healthcare programs,” but it does not explicitly invite comments on how they should be aligned with non-Federal programs. In a number of communities, Regional Health Improvement Collaboratives have already developed coordinated efforts to report on quality performance including a broad range of patients who are associated with multiple commercial payers and Medicaid and to

have the pay-for-performance programs of those payers aligned with those measures, and it would be unfortunate if national requirements established under the Medicare Shared Savings Programs undercut these hard-won local successes.

Consequently, we urge that CMS ensure that the quality measures and related rules under the Shared Savings Program are designed and implemented in ways that will support the ability of ACOs to improve care for patients and reduce costs for the Medicare program, support community efforts to inform citizens about the quality of care they receive, and support multi-payer payment reform initiatives that have been developed in many communities. In particular, we recommend that:

- CMS should give priority to using quality measures that are already successfully being used for public reporting by one or more Regional Health Improvement Collaboratives. This will achieve several important goals: (1) it will enable CMS to use measures which have already been extensively field-tested for public reporting, significantly reducing the chances of unintended consequences from using them in the Shared Savings Program; (2) it will reduce the likelihood that measures reported as part of the ACO program will confuse consumers through inconsistencies with local measures of performance or divert physician attention away from local quality improvement priorities being pursued by Regional Health Improvement Collaboratives; and (3) it will help support the efforts of Regional Health Improvement Collaboratives to collect and report on additional measures.
- ACOs should be allowed to report on and be held accountable for quality measures that are being collected and publicly reported by a Regional Health Improvement Collaborative in their community, in place of some of the measures proposed by CMS. For example, CMS could allow an ACO to substitute locally collected and reported measures for a subset of the default CMS measures in the same measurement domain. CMS could still compare an ACO's quality to other ACOs nationally based on a smaller, minimum set of measures, but it could base shared savings payments on the ACO's performance on a combination of nationally and regionally-defined quality issues, thereby better supporting local quality improvement priorities.
- ACOs should be consistently required to calculate quality measures on all patients seen by the ACO to whom the measure is applicable, not just Medicare patients or attributed patients. In some cases, CMS is proposing that ACOs calculate measures based solely on attributed patients (such as Measure 8); in some cases, the proposed measure would apply to all patients 65 and older (such as Measure 10), and in other cases, the proposed measure would apply to patients of a wide range of ages, not just individuals eligible for Medicare. Regional Health Improvement Collaboratives use either multi-payer claims data or direct data submission from physicians on *all* appropriate patients in order to compute the quality measures they report; this is done for two important reasons: First, the more patients used to calculate a measure, the more reliable the performance score will be; second, physicians need a single performance score with which to analyze and monitor improvement for all of their patients, not separate

performance scores for each payer. The Shared Savings program should use measures based on all patients for similar reasons.

- CMS should provide Regional Health Improvement Collaboratives with Medicare claims data for all of the beneficiaries in the community, so that the Collaboratives can calculate claims-based quality measures on the full populations served by ACOs and by other healthcare providers in the community. Even if CMS provides claims on attributed beneficiaries to the ACO as it proposes to do, this would not include all Medicare beneficiaries served by the ACO, since some beneficiaries may not meet the statistical thresholds for attribution, and some attributed beneficiaries might opt out of having their data provided to the ACO. Moreover, although the proposed rule allows ACOs to participate in the Shared Savings program even if hospitals are not part of the ACO, the only way that such an ACO could report quality measures based on hospitalizations (such as Measures 8, 9, 10, 12, etc.) would be to have access to hospital claims for all Medicare beneficiaries. Providing claims data on all Medicare beneficiaries to Regional Health Improvement Collaboratives would allow them to compute quality measures accurately for all of an ACO's patients, thereby meeting CMS's standards for complete and accurate reporting. It would also enable the ACO, the local community, and Medicare to know how the ACO is performing on quality measures compared to other healthcare providers in the community, not just compared to other ACOs in the community or in other parts of the country.
- Any reports issued by CMS on the quality of care delivered by ACOs should clearly and visibly explain any differences between the measures it reports and the measures that are being publicly reported by Regional Health Improvement Collaboratives in the ACOs' communities. For example, if CMS reports measures based only on Medicare patients, it should visibly highlight the fact that performance reported on those patients may differ significantly from performance reported by a Regional Health Improvement Collaborative using a broader, multi-payer dataset.

In terms of the specific measures proposed by CMS, we have the following comments:

- We recommend that CMS replace Measure 35 with the Optimal Diabetes Care Composite that was recently endorsed by the National Quality Forum (#0729). This measure is being successfully collected from physician groups in Minnesota and publicly reported by Minnesota Community Measurement. CMS should also use the specifications for the individual elements of NQF Measure #0729 for the proposed measures 36-41. If CMS chooses to reduce the number of quality measures included for diabetics, it should retain the composite and drop the individual measures (proposed Measures 36-41).
- We endorse the use of a Coronary Artery Disease Composite, but recommend that instead of Measure 52, CMS should use the Optimal Vascular Care Composite that has been endorsed by the National Quality Forum (#0076), since it focuses on outcome measures rather than process measures. This measure is

being successfully collected from physician groups in Minnesota and publicly reported by Minnesota Community Measurement.

- Instead of or in addition to Measure 34 (Depression Screening), we recommend measuring (1) the use of the Patient Health Questionnaire 9 (PHQ-9) for patients with depression, and (2) the remission rate for patients with depression, either at 6 months or 12 months or both. These measures have been endorsed by the National Quality Forum (#0710, #0711, and #0712) and are being successfully collected from physician groups in Minnesota and reported by Minnesota Community Measurement.

Collection and Submission of Quality Measures

Section II.E.3 of the Preamble indicates that CMS is planning to enhance its Group Practice Reporting Tool in order for ACOs to submit data for quality measures that cannot be derived from claims data. CMS invited comment on whether alternative data submission methods should be required or considered.

Some communities have already established methods of doing exactly what CMS is proposing to do. For example, the Wisconsin Collaborative for Healthcare Quality developed a methodology for collecting and reporting data on the quality of care that 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. A similar methodology is now being used by Minnesota Community Measurement, Quality Quest for Health of Illinois, and the Health Improvement Collaborative of Greater Cincinnati.

Regional Health Improvement Collaboratives in many other communities have established systems for measuring and reporting on the quality of care using data from private health plans and state Medicaid agencies, and a number of them are considering expanding those systems to include clinical data. These Collaboratives and the stakeholders in their communities have invested considerable time and money in creating mechanisms for validating quality measures, communicating the results to both consumers and providers, and helping providers use the results to improve care.

All of these efforts could be harmed if CMS requires a completely separate system for submitting data by ACOs. For example, there is growing evidence of the value of multi-provider patient registries in helping physicians and hospitals improve the quality of care they deliver and to support research on the relationship between process and outcome measures. The value of such registries is enhanced by having the maximum number of patients and providers included. CMS should be seeking to support the creation of such registries, but if it creates a separate data submission mechanism for providers focused on the specific set of measures required of ACOs, it could undermine these local registries. There are already indications that CMS's initial use of the GPRO tool has caused some providers to withdraw from submitting data to local quality data collection systems.

Consequently, in states and regions where a Regional Health Improvement Collaborative is already collecting and publicly reporting on the quality of care in physician practices and/or hospitals and where the Collaborative has the capability to collect and report the quality measures required by CMS, we urge that CMS allow the ACO to use the Collaborative's data to meet its reporting obligations under the Shared Savings program, rather than requiring ACOs to collect and submit data separately. This will reduce the cost of reporting for the ACOs, reduce the cost for CMS to obtain all-patient data, strengthen local data registries, and avoid having CMS reporting on different performance measures than a local Collaborative's own public reporting program. For example, the Repository Based Data Submission (RBS) system in Wisconsin is a CMS approved registry for Physician Quality Reporting System reporting, and it could be similarly designated as an approved registry for ACO quality reporting.

To implement this, we recommend that §425.9(b)(2) be modified as follows:

(2) ACOs must submit data on the measures determined under this paragraph (b) according to the method of submission established by CMS. In communities where a Regional Health Improvement Collaborative has a quality measurement and reporting program that can obtain the necessary data and create the measures required by CMS, CMS will allow the Regional Health Improvement Collaborative to submit the data to CMS on the ACO's behalf.

We also urge that before developing its own data submission tool, CMS should consider using existing reporting tools, such as the RBS system that was developed in Wisconsin (<http://www.wchq.org/measures/>) and is being used in several other communities. This would save CMS money compared to the costs of developing an entirely new tool; it would also allow ACOs to use the same system for submitting data to CMS as they and other providers could use for submitting data to local quality measurement and reporting systems.

Data Sharing with ACOs

We believe it is essential for CMS to share data on Medicare beneficiaries in order to help ACOs and other providers to improve the quality of care they deliver. Lack of access to Medicare claims data has been a major barrier for quality improvement initiatives across the country. Most Regional Health Improvement 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. This has meant that quality and cost measures published by these Collaboratives have had to be based on fewer patients than would be desirable or necessary for reliability, that the quality and cost of care for senior citizens cannot be accurately measured at all, and that disparities in care between seniors and others cannot be identified. In the few communities where Medicare data has been made available, it has typically been several years old. Providers need access to timely

information so that they can measure progress towards improvement, and consumers need timely information so they can choose providers wisely and fairly.

Although §425.19 of the proposed rule authorizes sharing data with ACOs, the rule proposes only to release data *after* an agreement is already in place. However, physicians and hospitals need these data well before even applying to participate in the Shared Savings Program, in order to determine whether it makes sense for them to become an ACO and how to structure the ACO. This is particularly true since both of the payment tracks in the proposed rule place ACOs at risk for increases in costs. It is unreasonable to expect a group of providers to accept such risk blindly, without access to the data necessary to make an assessment of the magnitude of the risk and the ACO's ability to control costs. Some of the biggest concerns that prospective ACOs will have about their ability to control costs relate to the extent to which patients attributed to them receive expensive care from providers outside of the ACO, and no matter how sophisticated a physician's or hospital's data systems are, it cannot obtain a total picture of the services its patients are receiving from other providers, particularly providers in other states, by itself.

Similarly, the prospective ACO will need to know how the providers it is proposing to include as part of the ACO are performing on the quality measures that CMS will be using to determine the ACO's payments, since including poor-quality providers in the ACO would undermine the financial viability of the ACO. But few providers will have the ability to assess this unless the providers they are considering partnering with to form an ACO have access to Medicare data and can show how they are performing on those measures.

Also, even if an ACO already exists or has decided to form, it needs to know this information well before the beginning of the first performance period so it can take the necessary planning steps and be ready to implement the necessary changes in care as soon as the Shared Savings agreement with CMS is in place.

An obvious challenge CMS faces is determining which providers should receive data during this exploratory phase, what types of data to provide, and how to provide it. We recommend that, in addition to any mechanisms CMS establishes for making such data available directly to providers, CMS should make Medicare claims data available to Regional Health Improvement Collaboratives on all of the Medicare beneficiaries living in and/or receiving care in the region or state that the Collaborative serves. The Collaborative can then help providers in the community use the data to assess their current level of quality, identify opportunities for quality improvement and cost reduction that could enable the ACO to be successful, identify risks for increased costs, etc. The Collaboratives which do public reporting today already have sophisticated systems in place to protect against disclosure of patient-specific information, and CMS should use them as trusted partners to help in the development of ACOs in their community.

We also recommend that, in addition to making such data available to help providers explore the formation of ACOs, CMS should continue to make Medicare claims data available to Regional Health Improvement Collaboratives on an ongoing basis. This

will enable the Collaborative to help the ACO assess its performance on cost and quality relative to other providers in the community and help Medicare beneficiaries assess whether the ACO and its providers are delivering higher quality care than non-ACO providers.

Finally, we urge that CMS begin making these data available to Regional Health Improvement Collaboratives immediately so that the Collaboratives can help providers in their communities identify successful strategies for forming ACOs. Since the Affordable Care Act requires ACOs to begin operation on January 1, 2012, which is less than 7 months away, delays in accessing data could significantly limit the number of providers willing to form ACOs and jeopardize the initial success of those which do form ACOs.

To implement these points, we recommend the following addition to §425.19:

(h) CMS will share beneficiary identifiable data with a Regional Health Improvement Collaborative for all beneficiaries residing in or receiving care in the region or state served by the Collaborative, if the Collaborative has systems in place to ensure the appropriate use of the data and the confidentiality and privacy of individually identifiable health information. Collaboratives may use these data to (1) measure and publicly report on the quality and cost of care in their communities, (2) help physicians, hospitals, and other providers improve the quality and reduce the cost of care they deliver; (3) help physicians, hospitals, and other healthcare providers assess whether and how to form an ACO, and (4) help Medicare beneficiaries determine whether an ACO is providing higher quality care than other healthcare providers in the community. If a beneficiary opts out of sharing identifiable claims data with the ACO pursuant to paragraph (g) of this section, CMS will still provide identifiable data on the beneficiary to the Regional Health Improvement Collaborative where the beneficiary resides or receives care in order to support the Collaborative's measurement and reporting programs, but the Collaborative will be prohibited from sharing those data with the ACO in an identifiable form.

Public Reporting and Transparency

We support requiring ACOs to publicly report information about the quality of care they deliver. However, we believe that the provisions of §425.23 are too narrowly defined; ACOs should be required to publicly report their performance on individual quality measures, not just "quality performance standard scores," as the proposed rule would require. We recommend the following change to §425.23(c)(5):

(5) Quality performance standard scores, and the ACO's reported performance on each of the individual measures required under §425.9.

Section II.E.6 of the Preamble asks for comment on "whether ACOs themselves should be required to make this information publicly available or whether ACOs should report this information to us [CMS], and we [CMS] would then make this information

publicly available.” We believe that neither of these options is ideal. We believe that the biggest impact of public reporting occurs (a) when it is done by an independent, neutral body, not a provider or payer; (b) when it is done at the local level with the active support and engagement of the physicians, hospitals, and other providers who are being measured, (c) when it includes data from all payers, not just a single payer, even one the size of Medicare, (d) when it is supported by efforts to educate consumers about how to properly use the information, and (e) when it is connected to training, payment reform, and other initiatives designed to help physicians overcome barriers to improvement.

Consequently, we recommend that in states and regions where a Regional Health Improvement Collaborative has an active quality measurement and reporting program, ACOs should be required to submit the information required under §425.23 to the Collaborative. To implement this, we recommend adding the following additional language at the end of §425.23:

If the ACO is located in a community where a Regional Health Improvement Collaborative has an active program of public reporting on the quality of healthcare services, the ACO will be required to submit the information defined in this section to the Regional Health Improvement Collaborative, and the Collaborative will be permitted to publicly report that information in addition to any public reports made by CMS or by the ACO itself.

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
John Pilotte
Terri Postma
Elizabeth Richter