RUPRI Health Panel
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Centers for Medicare 7 Medicaid Services
7500 Security Boulevard
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Comments responding to Request for Information Regarding Accountable Care Organizations and the Medicare Shared Saving Program:
CMS-1345-NC

Rural Policy Research Institute (RUPRI) Health Panel: The Panel is an expert group supported by RUPRI for the purpose of providing objective policy analysis. Members include Keith Mueller, Ph.D. (Chair), Andrew Coburn, Ph.D. Jennifer Lundblad, Ph.D., A. Clinton MacKinney, M.D., Timothy McBride, Ph.D., and Sidney Watson, J.D.

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Question 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?
Response:

- Access to primary care services for Medicare beneficiaries participating in ACOs should be a primary consideration. For that reason, ACOs should be held to the standard used in the Medicare Advantage program, that beneficiaries should be able to maintain their usual patterns of care seeking. Such a standard would assure that ACOs, regardless of where they are based (e.g., in an urban system), would need to secure participation by rural primary care providers (professionals and hospitals) if they want to incorporate beneficiaries into their plan who historically seek care from small rural practices.
- Soliciting participation in ACOs from solo/small physician practices may require affiliation arrangements that retain as much local autonomy as possible for those physicians. While they should accept requirements related to care management for the ACO to be effective, they should retain independent physician-patient relationships outside of participating in ACO policies for care management.
- Federal policies should promote and disseminate health management processes and resources that enable providers, including solo and small providers, to re-design their care delivery to maximize quality and minimize costs. This includes resources such as disease registry software, quality improvement techniques, lean processes, and technical assistance.

- Health care systems, based either in physician groups or in hospitals, should be allowed to share their decision tools with small physician practices who wish to participate in an ACO involving their patients. The ACO may finance the use of technology that facilitates that participation.
- Small physician practices should be allowed to participate in multiple ACOs, opening up opportunities for their patients in a competitive environment.
- Payment incentives should reward improved performance among already high-performing practices and hospitals through comparison to national benchmarks. Benchmarks should not be based exclusively on the particular organization's historic performance.
- Anti-trust laws may require modification to allow provider collaborations (for the purpose of improved quality and/or cost control) while still protecting patient and tax payer interests.
- A plan to disseminate best ACO models that include rural providers should be implemented.

Question 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 CMNMI to address this issue? In addition to payment models, what other mechanisms could be created to provide access to capital?

Response:

- Resources available to small practices would be increased through programs bringing multiple payers to the same ACO, with bonus payments as a support mechanism to encourage initial participation, followed by shared savings over time.
- Since gain-sharing necessarily implies bonus payment (if eligible) after services have been provided, small practices/hospitals with fewer resources will need upfront capital assistance to implement processes necessary for health management. Capital will be required not only to establish electronic health records in small practices and hospitals, but to support personnel training and system maintenance/upgrades. Access to some funding may be available through the Meaningful Use Medicare and Medicaid incentives, but small and rural providers are generally further behind in adoption and effective use of EHRs so won't be realizing these incentive payments in as much or as timely a way as their larger and health system counterparts.
- Federal support is required, through funding and regulation, for health information system interoperability. Without interoperability, optimal care coordination will not be realized.
- Capital is required to establish Regional Health Information Organizations with links between inexpensive remote desktop equipment and central servers to facilitate participation by small rural practices.

Question 3: 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; other 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?
Response:

- Medicare should attribute ACO beneficiaries prior to the performance period so they can proactively provide prevention and other interventions for patients.
- Although rural providers may participate in multiple ACOs, ideally the quality performance metrics should be the same. Thus, Medicare ACO quality metrics should be standard and consistent. Furthermore, consistent standards should be strongly encouraged across private ACOs.

Question 4: How should we assess beneficiary and caregiver experience of care as part of our assessment of ACO performance.
Response:

- Care should be patient-centered (see response to question below).
- Care should be accessible (see response to first question).
- Thus, both patient-centeredness and access (particularly utilization of preventive services) should be measured. Measures must well-tested, statistically valid and reliable, and rural relevant.
- The H-CAHPS (hospital) and CG-CAHPS (clinic/group) patient experience of care survey tools can be used, or adapted, to assess beneficiary experience in an ACO.

Question 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?
Response:

- The criteria should include patient satisfaction with the entire experience of care, including timeliness and access to primary care. Patient (and caregiver) satisfaction assessments (e.g. surveys) should be well-tested, statistically valid and reliable, and rural relevant.
- Patient-centeredness assessment should include indicators of cultural sensitivity, informed consent, and patient education.
- In addition to how patients assess their experience in receiving care delivered via an ACO model, there are other criteria that reflect the patient-centeredness of an ACO, for example, effective medication reconciliation between providers, consistent use of electronic health information exchange, rates of achieving evidence-based preventive and screening care.

Question 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?
Response:

- Measures must be established and tested prior to use for performance evaluation. Hospital Compare, PQRI, and HEDIS measures will likely be appropriate. Measures should be vetted through the National Quality Forum.

- Measures should be critically evaluated to determine resources required for compliance/reporting and for rural relevance.
- Measures of ACO performance should align with other related national measure sets, such as Meaningful Use and PQRI measures, whenever possible to reduce data collection burden and align quality goals and activities.

Question 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?
Response:

- The Medicare ACO payment model (gain sharing) is appropriate for program start, especially for ACOs with limited risk-bearing experience.
- HHS may wish to later consider tiered risk-bearing, based on ACO experience.
- Benchmarks for performance comparison (and gain-sharing) should not be exclusively based on past organizational performance. Regional (or national) benchmarks should be used. In addition or alternately, organizations should be assessed on performance improvement, recognizing that performance improvement is more challenging when baseline performance is already good.
- "Allowing" rural provider participation in ACO is inadequate. Initiatives should be developed that facilitate rural provider participation, including initial hold-harmless policies, active dissemination of rural ACO models, and flexibility regarding anti-trust laws that might hamper rural provider collaboration.

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