June 06, 2011

Donald M. Berwick, MD
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services
Attention: CMS–1345–P; Mail Stop C4–26–05
7500 Security Boulevard, Baltimore, MD 21244–1850

RE: CMS-1345-P; Medicare Program; Medicare Shared
Savings Program: Accountable Care Organizations; Proposed Rule

Dear Administrator Berwick:

URAC appreciates the opportunity to comment on CMS’s Medicare Shared Savings Program proposed rule, and commends the proposed rule’s overall goal of bringing higher quality, value-based, coordinated, patient centered care to Medicare beneficiaries through Accountable Care Organizations (ACOs).

As a nationally recognized health care accreditation organization that puts patients first in terms of care quality and timely and appropriate access, and with deep expertise in accrediting utilization management programs, URAC well understands the unintended consequences that could befall a savings-driven model of care. These include: avoidance of high risk/multiple chronic condition beneficiaries; skimping on or delaying needed services; and providing less than optimal, evidence-based care.

URAC commends CMS for acknowledging and addressing these potentially sensitive areas in the proposed rule, which indicates CMS will be intimately involved in reviewing ACO marketing materials, holding ACOs accountable against nationally vetted quality measures, and performing ongoing monitoring of ACO performance (including site visits, follow-up on beneficiary and provider complaints, and audits).

The proposed rule is also forthright in providing CMS with the oversight and enforcement authority it may need to: intensify its monitoring; impose potential sanctions; or, if necessary, terminate an ACO’s 3-year agreement with CMS, for avoiding at-risk beneficiaries, and/or failing to meet CMS’s proposed quality standards. URAC believes these quality-based ACO performance requirements will help protect Medicare beneficiaries participating in the program, and the Medicare Trust Funds at large.
Implementation Challenges

URAC is aware of the challenges of implementing such sweeping innovation on a national scale, and creating new organizational and care delivery models under very tight timelines. Our concern is that the proposed rule’s extensive requirements may collectively prove so burdensome as to discourage participation in the program and undermine its potential impact. Taken together, the proposed rule’s exacting ACO qualification requirements, steep projected start-up costs, lack of guaranteed shared savings and potential downside risk exposure, extensive performance measurement reporting requirements, and fast approaching January 1, 2012 implementation date, may produce an impact (in terms of number of ACOs able to participate, beneficiaries covered, and program savings) which falls short of CMS’s Office of the Actuary’s projections.

URAC also believes that the large volume and range of public comment being generated by the proposed rule will take a substantial amount of time for CMS to process, and likely push back the timeline for issuing a final rule substantially.

**URAC Recommendation #1: Initially Focus on Building Program Participation and Infrastructure.**

For the program’s first three years, URAC would recommend that CMS focus on maximizing provider participation and incentivizing the building of robust ACO infrastructures, recognizing that program savings may take longer to develop and validate. In terms of managing the care of high risk Medicare beneficiaries with multiple chronic conditions, we believe ACOs should adopt a building block approach, drawing on the best practices of existing health care/medical home, care coordination, case management, and disease management programs.

URAC also believes that reducing financial barriers and risks for participation will be critical for encouraging organizations to become ACOs. CMS’s recently announced “Medicare Shared Savings Program Advanced Payment Initiative” is a step in the right direction, recognizing “many providers do not have access to the capital needed to invest in infrastructure and staff for care coordination.” CMS assistance with startup costs could be pivotal in whether or not eligible providers pursue participation; however, URAC would propose that such funds not be contingent on future (and uncertain) ACO earned shared savings. In addition, to increase participation of smaller and/or rural providers, CMS might offer small startup grants to help them form their own ACO. CMS could also consider offering incentives to encourage integration of smaller and mid-size practices into larger multi-specialty groups.

In addition, CMS might consider phasing in its requirement for ACO reporting on the program’s 65 quality measures, perhaps prioritizing a smaller set of measures to report on initially (see related URAC recommendation below concerning new measures related to provider care hand-offs).
URAC Support for ACO Patient-Centeredness Requirements

URAC commends CMS for adopting a patient-centered, population health-based approach to coordinating and delivering care to Medicare beneficiaries, including actively engaging patients/families/caregivers in culturally sensitive shared decision-making, and requiring individualized care plans for high-risk beneficiaries, with strong linkages to community resources. URAC is also pleased that CMS’s nine patient-centeredness criteria for ACOs align closely with the Joint Principles of a Patient Centered Medical Home, issued in 2007 by four leading national primary care medical societies: the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association. The Joint Principles are also supported by the Patient Centered Primary Care Collaborative, of which URAC is a member. In addition, URAC has incorporated the Joint Principles in its Patient Centered Health Care Home Program, which also includes a set of Guiding Principles and detailed standards which have a high degree of alignment with CMS’s nine ACO patient-centeredness criteria.

**URAC Recommendation #2: Centralize Care Coordination Responsibilities within an ACO, Building on or Replicating a Health Care/Medical Home Model.**

URAC believes it is vital that care coordination responsibilities within an ACO be centralized, to ensure patients’ needs are constantly anticipated and proactively addressed, including ensuring that care transition hand-offs occur smoothly, with full clinical information transference between the sending and receiving providers/care settings.

Given the fact that Medicare beneficiaries are assigned to an ACO based on where “the beneficiary has received a plurality of his or her primary care services…from primary care physicians…who are an ACO participant,” it makes good sense to have this physician’s practice serve as the ACO’s locus of responsibility for coordinating each assigned patient’s care.

URAC’s Patient Centered Health Care Home (PCHCH) Program’s standards address virtually all the proposed rule’s patient-centeredness criteria. We believe an ACO which includes primary care practices that have received formal recognition as a health care/medical home, should be able to demonstrate compliance with CMS’s nine patient-centeredness criteria, as long as these criteria are adopted and subscribed to throughout the ACO.

Given CMS’s strong support for health care/medical home initiatives, we believe the final rule should explicitly support and encourage participation of accredited health care/medical homes (which meet CMS’s patient-centeredness criteria), serving as care coordination hubs within an ACO. This would have two major effects: (1) help align the quality, care coordination, and cost savings goals of CMS’s Medicare Shared Savings Program and its Multi-Payer and FQHC
Advanced Primary Care Practice demonstrations, and Medicaid Health Care Home State Plan option and; (2) encourage health care/medical home practices’ participation in more than one of these CMS initiatives, ensuring they are held to a consistent and compatible set of standards.

**URAC Support for Proposed Rule’s Beneficiary Protection and Satisfaction Provisions**

URAC is pleased that the proposed rule clearly puts Medicare beneficiaries’ well being and interests first, by including several provisions that protect this important constituency. This includes a CMS communications plan to fully and clearly inform beneficiaries about the Shared Savings Program in general, about the possibility of their being assigned to an ACO for quality and shared savings purposes, and about the potential that their protected health information may be shared with the ACO, and that they have the ability to opt-out of that data sharing.

Another major beneficiary protection which URAC supports is the maintenance of free choice of Medicare provider: allowing an ACO assigned beneficiary to see any Medicare fee-for-service provider they choose, whether aligned with the ACO or not. In fact, the proposed rule explicitly prohibits an ACO from imposing any policies or procedures which would impede a beneficiary from seeking care from providers not participating in the ACO, or exchanging a beneficiary’s medical information with providers who are not part of the ACO. In addition, if a beneficiary is not happy with the care he or she is receiving from the ACO, all he or she has to do is find a new primary care provider outside of the ACO—effectively terminating his/her ACO assignment.

To assure beneficiaries’ needs are being met, URAC also supports the proposed rule’s requirement for an ACO to obtain and utilize the results of beneficiary experience of care surveys, specifically the Clinician and Group CAHPS survey (as is employed in URAC’s Patient Centered Health Care Home Program), including an appropriate functional status survey module.

The proposed rule has many valuable beneficiary protections, reflecting CMS’s Medicare Advantage and Medicare Part D Drug Plan program integrity and oversight experience. URAC supports the proposed rule’s CMS oversight and enforcement provisions aimed at deterring ACOs from avoiding high-risk patients and/or providing subpar care access or quality. These provisions include:

**Monitoring and Oversight:**

- Review and approve all ACO marketing materials.
- Analysis of specific financial and quality data as well as aggregated annual and quarterly reports.
- Site visits.
- Assessment and following up investigation of beneficiary and provider complaints.
Audits (including, for example, analysis of claims, chart review, beneficiary surveys, coding audits).

Enforcement:

The proposed rule also specifies CMS may, at its discretion, terminate an ACO from participation in the Shared Savings Program for questionable performance and/or excessive care expenditures, though it may also impose lesser ACO intermediate sanctions, such as a warning notice, requirement for a corrective action plan, or placement of the ACO on a special monitoring plan.

**URAC Recommendation #3:** URAC believes the proposed rule should add a new mandatory requirement for a formalized ACO internal and external review process to address and resolve beneficiary complaints regarding access to, and quality of, care and customer service they receive under the coordinative responsibility of their ACO. Beneficiaries should be fully informed of their rights to file complaints and the process for filing and having such complaints heard and resolved.

URAC also believes a higher level of beneficiary protection and confidence in their ACOs could be achieved by adopting accreditation standards employed in URAC’s Core Organization, Provider Performance Measurement and Public Reporting, and Health Utilization Management Accreditation Programs. These include standards which ensure continuous quality improvement via action on poor performance, as well as standards which ensure timely action on beneficiary complaints.

The legislative precedent for utilizing national accreditation standards to protect beneficiaries and provide transparent and comparable provider performance data has already been established by Section 1311(c)(1)(D)(i) of the Patient Protection and Affordable Care Act, which requires such accreditation for qualified health plans to participate on state health insurance exchanges.

A number of federal health programs already have acknowledged the value of URAC’s accreditation programs in protecting the interests, rights, and quality of care delivered to consumers: Tricare and the Office of Personnel Management formally recognize URAC’s Case Management, Disease Management, and Health Network Accreditation Programs. In addition, the Department of Veterans Affairs Health Call Center has received URAC’s Health Call Center Accreditation, assuring veterans receive timely access to care. Given the volume of beneficiary health information that will be exchanged by providers within and outside an ACO, we believe URAC’s HIPAA Privacy and Security Accreditation Program would be of great value in assuring beneficiary personal health data is properly handled and protected.
Strengthening Care Coordination and Care Transitions Accountability and Measures

Given the fact that beneficiaries aligned with an ACO will be transitioning between providers and care settings both within and outside the ACO, the importance of having explicit accountability requirements for sending and receiving providers cannot be understated. It is precisely at these critical patient “hand-offs” that the greatest risk exists for needed care to “fall through the cracks,” as well as the greatest opportunity to optimize patient care outcomes, and avoid medication mishaps, rehospitalizations, and other untoward and costly events.

While the proposed rule’s patient-centeredness criteria requires that an ACO describe and have in place a mechanism for coordination of care, including a plan for exchanging patient information electronically with other sites of care during patient care transitions, the related CMS care coordination/transitions quality measures do NOT directly address MEASUREMENT OF ACCOUNTABILITY OF THE SENDING AND RECEIVING PROVIDERS. The proposed rule needs to be more prescriptive about what the specific responsibilities of the sending and receiving providers are, so that their care hand-off performance (or lack thereof) can be measured, tracked, and corrected if necessary.

This is especially critical for high risk/multiple chronic condition beneficiaries. While the proposed rule calls for an individualized care plan for this population, it is left for the ACO to decide how comprehensive and inclusive this plan is, in terms of identifying shared patient care goals and needs, the spectrum of providers who will participate in the patient’s care, the community resources which will be needed to support the patient’s achievement of care goals, and the timeline over which the care plan is established.

In short, URAC believes CMS needs to be much more prescriptive in defining the critical components of an effective care plan for beneficiaries, and add quality measures which truly assess the accountability and performance of sending and receiving providers.

URAC Recommendation #4: URAC would suggest the following enhancements to the proposed rule:

- **CMS should require that ACOs provide training in care coordination skills to all of its providers; this is a unique skill set that is not usually taught as part of professional curriculums.** Having ACO professionals fully understand their care coordination roles and responsibilities would go a long way to helping achieve the Shared Savings Program’s goals.
- **CMS should require that individualized care plans for high risk/multiple chronic condition beneficiaries be extremely detailed and comprehensive and have a longitudinal time horizon.** The care plan should fully identify all short and long term shared patient care goals, a complete and up to date medication list with strategies for tracking and encouraging compliance, and identification of all key providers and supportive community services.
• **CMS should add new quality measures under the “Care Coordination/Transitions” category that explicitly define responsibilities of a sending and receiving provider, to help ensure and measure accountability and performance of these providers during patient care hand-offs and transitions of care settings.** URAC would urge this particular measure set be prioritized if CMS decides to phase in reporting on its current set of 65 measures.

• **Specifically, in responding to the preceding two bullet points, URAC would strongly recommend the guidance of the excellent resources and references offered by the National Transitions of Care Coalition (NTOCC), of which it is a member. In particular, for developing the new measures suggested above, URAC recommends the detailed guidance provided in the attached “Care Transition Bundle: Seven Essential Intervention Categories.”** The full spectrum of NTOCC resources can be accessed at: [www.ntocc.org](http://www.ntocc.org).

**Summary**

The Patient Protection and Affordable Care Act offers CMS and its Center for Medicare and Medicaid Innovation several opportunities to test new approaches to delivering high quality, patient centered, coordinated care which has the potential to rein in spiraling health care costs and bring a new sense of order to our currently fragmented health care delivery system. URAC supports these efforts at both the national and local level, recognizing that change can be challenging and painful, and that pioneering efforts such as the Medicare Shared Savings Program require the patient support, guidance, and good will of every stakeholder in our industry. Success in implementing this program should be measured not just in dollars saved, but in the inestimable knowledge, experience, and lessons to be learned—hopefully moving us all a few steps up the ladder to a saner, better organized, value-based system of care that puts quality and patients first.

URAC hopes our foregoing comments and recommendations will be helpful to CMS in crafting a final rule for the Medicare Shared Savings Program which can achieve the level of provider support and participation, and well as positive impact on Medicare beneficiaries and the Medicare program at large, envisioned by its congressional authors.

Please feel free to contact me if we can provide any further clarity or assistance related to this correspondence.

Sincerely,

[Signature]

Alan P. Spielman
President and CEO

Attachment