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December 3, 2010

Donald Berwick, M.D., M.P.P.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-1345-NC
Medicare Program; Request for Information Regarding Accountable Care
Organizations and the Medicare Shared Savings Program

Dear Dr. Berwick:

The Illinois Hospital Association (IHA), on behalf of its 200 members, welcomes this opportunity to submit comments in response to the Centers for Medicare & Medicaid Services request for input on regulations that will create a framework for the development for accountable care organizations (ACOs) under the Affordable Care Act (ACA). The ACA, with ACOs as a key element, holds promise for increased access to care, greater quality, and better value for health care expenditures. While this change presents challenges, it also presents opportunities, especially the opportunity for hospital leaders, in partnership with state and federal officials and other stakeholders, to transform the health delivery system.

Most of our comments will focus on the specific questions you have posed in your November 17, 2010 request for comments that was published in the *Federal Register*. However, we do have some preliminary general comments for your consideration:

- Hospitals are eager to see the regulations, particularly as they relate to patient attribution to the ACO and how risk adjustment will be done. Those who are contemplating this model need as much time as possible to assess their readiness for participation.
- Joint agency direction to include the Federal Trade Commission (FTC) and other relevant agencies regarding safe harbors for providers implementing ACO pilots will be helpful to ensure consistency among the various agencies that will play a role.
- The regulations or safe harbors should promote creative approaches to improve coordination of care along the entire continuum and to reduce readmissions. Hospitals should be able to provide services and products for patients who are

discharged to nursing homes, home health, other post acute providers, or home without the fear of violating Medicare prohibitions. Hospitals are seeking to prevent readmissions and are not seeking to provide Medicare beneficiaries with unnecessary services or to inappropriately provide inducements to use hospital services.

- In a new environment where reimbursement incentives move from volume to value, ACOs will require physicians to change their practice patterns to maximize cost savings. A key barrier in Illinois is the practice of defensive medicine. Medical liability protections for ACO providers who practice evidence based medicine and conform to best practices should be included in any government framework for successful ACO development.
- The Stark regulations, rules for imposition of civil monetary penalties, anti-kickback prohibitions, antitrust law, and IRS restrictions on payment to physicians should allow for qualified providers to participate in the ACO pilot.
- Providers will need to have access to as much near real time data as possible on claims, pharmacy, and other services utilized. In addition, providers will benefit from baseline data for several years prior to the ACO start date so that they can measure their progress.

The following points are intended to address your specific questions. Note that while the first two questions address the challenges that small practices will face, and therefore will benefit our small and rural hospitals, IHA's comments will also apply to all hospitals since even large academic medical centers will have medical staff members who are in small practices. A successful ACO will need to maximize physician participation.

What policies and standards will ensure that groups of solo and small practice providers will have the opportunity to participate?

- A low threshold after which shared savings can be realized would benefit small and large providers alike. The Group Practice Demonstration Project (PGP) set the cost reduction target at 2% before shared savings could be realized. Reducing the 2% threshold would create a greater incentive for participation. In addition, shared savings should be reconciled regularly. The program will be most successful if rewards are realized well before a year-end accounting.
- Several levels of ACO, with the higher levels taking on more risk in return for the potential to achieve greater rewards, will allow participating ACOs to learn from their participation and move to higher levels. Small providers will likely find participation at the "entry level" more attractive at the beginning.
- The regulations should be flexible regarding whether providers are exclusive to one ACO or participate in more than one. In addition, if there are specific requirements for medical specialty coverage, these should be crafted to allow the ACO to develop their own physician arrangements based on the needs of their patient populations and the availability of specialists.

What payment models, financing mechanisms or other systems should be considered to address the fact that many small practices may have limited access to capital or other resources to fund efforts from which shared savings could be generated?

- Regardless of the size or capital resources of providers who seek to participate, it should be recognized that financial support is required for the infrastructure that will be needed to create ACOs. CMS should consider contributing to the start-up costs. Hospitals are committed to improving quality and decreasing costs despite the knowledge that, if their ACOs are successful, their utilization will fall. Among the financial investments that ACOs will require are:
 - legal support to develop the required ACO structure;
 - infrastructure commitments such as information tools that span the entire continuum of care;
 - analytic tools; and
 - workforce investment, to support patient care and enhanced IT infrastructures.
- Primary care needs to be strengthened in both rural and urban settings. Non-physician providers should be recognized as an important clinical resource.
- To the extent that ACOs can participate in medical home demonstrations, this may provide some initial capital to invest in needed infrastructure.

How should patient attribution models balance the perspectives that providers need to know up-front which beneficiaries they are responsible for and that others believe that attribution should be determined retrospectively at the end of the performance period to ensure ACO accountability?

- ACOs need to know which beneficiaries are assigned to them to continually monitor both quality improvement and cost reduction. They should have information about patient transitions from the ACO. For example, a patient may transition from the ACO to a Medicare Advantage plan. They should also have information on patients who seek a significant amount of care outside their area. Many patients will likely spend a significant part of the year in another location. Consideration should also be given to patients' use of services in determining whether they were actually in the ACO for purposes of calculating shared savings.
- ACOs should be able to promote the benefits of the ACO to patients so that the ACO can improve care coordination across the continuum. Patients will still have choice of providers, but the ACO should have an opportunity to educate their patients about how seeking health care services within the ACO will benefit them.
- ACOs should be allowed to incentivize patients to participate in their own care, to stay within the ACO, and to use continuum of care providers who have formal relationships with the ACO. This is essential to the ACA goals to improve population health and to prevent hospital readmissions.

How should the beneficiary and caregiver ACO experience be assessed?

- The same measurements currently being used in the various CMS facility comparisons for hospitals, nursing homes, home health, and others should be carried over and reported for an ACO. Additional measurements on care coordination and outcomes outside of the hospital setting should be available so patients can determine where they want to receive care – within an ACO or outside of an ACO.
- The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) tool should be expanded to capture the patient experience as the patient navigates through the ACO. This is despite problems with the HCAHPS methodology for reporting results.
- Measurements should be included, similar to measures for hospitals and other care settings, on complications and infections incurred during care throughout the ACO experience.
- Measurements should shift from a disease perspective to a wellness perspective. For example, wellness measures important for the patient should include preventive screenings, the annual physical checkup, etc.
- New measurements should go through the National Quality Forum (NQF) and only NQF approved measurements should be publicly reported. Work is underway at NQF on expanded disease and clinical care conditions, which should be timely and helpful.

What metrics should we use to assess patient-centeredness?

- CMS should consider measures that NQF is working on to assess patient care along the continuum of care. Other measures could include daily living activity, functional status, and others that will increase our understanding of the condition and functional status of patients.
- Culture of safety survey results for internal improvement are helpful in understanding the level of support for patient centered care delivery as well as patient satisfaction measurement tools, which would need to be modified for an ACO.
- Measurements being utilized in the various facility comparisons by CMS would help patients select their care providers. Physician performance measurements and patient satisfaction with physicians and other care givers are being discussed. These would benefit both patients and care givers, who would know their gaps in performance and who could work toward improvement.
- Patients want to know the expected outcome of any hospital care provided and the expected follow up treatment plan in terms of interventions, patient time, and any additional costs. While this is not usually provided, it is a goal to strive for in

light of the continuum of care services that will be available through an ACO and the increasing use of electronic health records (EHRs).

- Measurements focused on wellness should be incorporated into the ACO set of patient-centered metrics, since an ACO is not just about disease care but wellness.
- IHA supports AHA's recommendation, specifically citing the Institute of Medicine (IOM) recommendations to use the definition of patient-centeredness below to develop metrics:
 - "Providers should have a process for engaging with the patient and family at each step of care to understand that patient's physical, emotional, mental and spiritual needs, and allow the patient's values to drive the care provided to the greatest extent possible.
 - Providers should deliver care that is culturally and linguistically sensitive.
 - Providers should have processes in place to enable smooth transitions in care as patients move from one part of the delivery system to the next, ensuring that information about their diagnoses, treatment plans, and personal preferences are communicated to other providers as well as to the patient and family.
 - Clinicians should provide information, education and counseling to ensure maximum patient engagement and enhance shared-decision making to achieve a patient's sense of empowerment and self-responsibility."

What quality measures should the Secretary use to determine performance in the Shared Savings Program?

- Quality measures should reflect the many metrics that hospitals and other health care providers are already accountable for measuring and reporting. If new measures are required, they should be nationally recognized standards based on evidence-based best practices and expert consensus using the NQF.
- Individual ACOs should have some flexibility to select their own metrics so that they can be tailored to the needs of the patient population that they serve. Some metrics could also be selected to support targeted areas for improvement that the ACO has identified. Physician support of an ACO will require that physicians have input into the selection of the metrics that they will be accountable for.

What additional payment models should CMS consider?

- ACOs should not be precluded from participation in the other financing initiatives under the ACA. For example, an ACO may choose to participate in the voluntary pilot program to bundle payments for 10 conditions for inpatient, outpatient, physician, and post-acute services provided up to three days prior to the admission and within 30 days after discharge. In addition, ACOs may choose

to improve the care they provide via primary care case management, disease management programs, or establishing medical homes, for some or all of their patients. Payment systems should support these models.

- In Illinois, and perhaps in other states, behavioral health resources have been decimated. This leaves hospital emergency departments as a last resort for patients, many of whom are dual eligibles, who have no access to community based resources. Particularly in rural areas, hospitals do not have the resources to provide the best care for these patients as there are few psychiatrists and other mental health professionals. An ACO may serve as an excellent platform to facilitate regional systems of behavioral health care, which are also needed in urban settings. The regulations should be crafted to allow for an ACO model that will integrate primary and behavioral health care and allow for payment for services delivered via telemedicine.

The Illinois Hospital Association appreciates the opportunity to provide comments and suggestions in advance of the publication of regulations to implement accountable care organizations. Illinois hospitals recognize and support the need to move away from health care delivery that is often uncoordinated and fragmented to a true system of care – one that is coordinated, collaborative and accountable. Towards this end, we hope you find our comments constructive. If you have questions, please feel free to Ann Guild at 630-276-5496 or via e-mail at AGuild@ihastaff.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Howard A. Peters III". The signature is fluid and cursive, with the first name "Howard" being the most prominent.

Howard A. Peters III
Executive Vice President
Illinois Hospital Association