



December 3, 2010

The Honorable Donald M. Berwick, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1345-NC
P.O. Box 8013
Baltimore, MD 21244-1850

Dear Administrator Berwick:

AARP is pleased to respond to the Centers for Medicare & Medicaid Services (CMS) Request for Information (RFI) regarding Accountable Care Organizations and the Medicare Shared Savings Program (*Federal Register*, November 17, 2010, pp. 70165-70166). AARP supported the delivery reforms in the Patient Protection and Affordable Care Act (ACA), including the shared savings and accountable care organization models that are the subject of the RFI, as well as the establishment of the Center for Medicare and Medicaid Innovation (CMMI) that will test these models. We believe new and innovative service delivery approaches have the potential to improve the quality of care people on Medicare receive, as well as contribute to cost control. We hope that the planned pilots will inform CMS' policies to improve service delivery in the Medicare program. Below, we delineate principles that should undergird and guide the policies applicable to the Medicare Shared Savings Program and also respond to the specific questions posed in the RFI.

- **Anchor delivery reforms to the underlying purposes of Medicare.** Medicare was created to assure aged and disabled beneficiaries health protection and economic security. It is critical that ACO policies reflect these fundamental precepts to ensure that Medicare provides affordable quality health care for future generations.
- **Provide clear communication about the overall purpose and direction of the Shared Savings Program:** Given widespread misunderstanding about the ACA among Medicare beneficiaries and other segments of the population, it is critically important that CMS be fully transparent with respect to the goals and implementation of new delivery models in Medicare. The transformative changes envisioned in the ACA will be successful only if beneficiaries and the general public are fully informed about the rationale for change, the nature of new initiatives, and have clarity about the expected impact of new programs. Equally important will be a willingness on the part of CMS to discontinue tests of models where the beneficiary is not well served or

the spending expectations are not met. AARP is committed to continue educating our members about the provisions of the ACA and its implications for them. However, our efforts cannot substitute for substantial Medicare outreach to beneficiaries and the related advocacy and provider communities to assure general understanding of the purposes and processes that relate to the implementation of ACOs.

- **Ensure patient engagement in all aspects of program development and implementation.** AARP believes that complete information and transparency for beneficiaries about any changes in the arrangements for their physicians' and hospitals' participation in Medicare is essential to achieve understanding, acceptance, and participation. Further, as the statute envisions, patient engagement in these new models will be critical for successful implementation of any delivery reform and enhancements in the value of care. It will be essential for patients to be fully informed of their rights and responsibilities as patients receiving care in an ACO before they decide to remain with a clinician who participates in an ACO; as well as their right to change providers at will.
- **Ensure effective oversight through standardized measurement, performance expectations and monitoring.** Measurement and monitoring are especially critical as CMS develops, tests, and implements the far-reaching changes set out in the ACA. It will be important to have robust, standardized measurement to achieve the "Triple Aim" in the Medicare program: better care, affordable care, and healthy communities.

Responses to the Specific Questions in the RFI

Small practice issues

The RFI poses two questions related to small practices concerning the policies or standards CMS should adopt to ensure that groups of solo practitioners and small practices have the opportunity to participate; and the payment models, financing mechanisms or other systems to address the problem that many small practices may have limited access to capital to fund efforts from which shared savings could be generated.

These are critical questions, and AARP agrees it is important to receive the input from smaller practices and their representatives. Since the vast majority of patients receive services from small practices, it is critically important for CMS to support small practices with technical assistance so that they can meet the standards for quality, patient experience, patient engagement, and cost savings set out in the statute and implementing regulations. AARP also suggests that CMS adopt the Institute of Medicine's definition of primary care so that advanced practice registered nurse-led practices and Nurse Managed Health Clinics are included as eligible participants.

Quality and Service Measures: The RFI poses three questions related to quality and service measures: how to assess beneficiary and, where practicable, caregiver experience with care; which aspects of patient-centeredness are important, and how to evaluate them;

and which quality measures should the Secretary use to assess performance, and what should the performance standard be?

Measures: AARP has consistently advocated for robust measurement of quality and patient experience across the Medicare program. In developing the measures of the areas identified in the RFI (experience with care, clinical quality, and patient-centeredness), it will be important to define a comprehensive and standardized set of measures for all ACO models. Further, the ACO measures should be aligned with other measures used in Medicare to create common incentives, actionable comparative information, and to avoid unnecessary burden on providers. Performance should be assessed across several dimensions, including structure, process (when the process has a recognized proximal relationship to an outcome), clinical outcomes, patient-reported outcomes, and patient experience. Measures to assess important practices, such as care coordination and care transitions, pain mitigation, infection avoidance, and the like, should be included in the measurement set. Measurements should include type of clinician so that accurate data could be available to determine the level of care provided by all models of ACOs and types of clinicians including physicians, advanced practice registered nurses, and physician assistants. Performance should be stratified by race, ethnicity, gender, disability status, and preferred language to identify and address detected disparities in care.

Performance standards: Nationwide, there is great geographic variability in quality among hospitals and providers. As CMS implements ACOs and other delivery innovations, it should recognize both quality improvement and the attainment of high levels of performance. ACOs that attain a targeted goal (such as achieving four or five stars) as well as those that cannot perform at that level, but show substantial improvement (such as improving by "x" percentage points, or closing the gap between prior performance and the target by a certain percent each year) should be eligible to share savings. This approach will encourage providers throughout the country to participate in ACOs, and, if rewards are properly established, incent quality improvement.

In addition, AARP urges the Secretary to pursue aggressively the statutory directive to improve quality over time "... by specifying higher standards, new measures, or both..." This is a very unique opportunity to set different expectations going forward about continuing improvement and innovation in health care. The Secretary, in proposed and final rules, should articulate clearly the pathway under which ACO standards and performance benchmarks for quality and patient experience will be raised over time.

Patient-centeredness: The Institute of Medicine (IOM) defines patient-centered care as care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions. The IOM identifies six dimensions of patient centeredness: respect for patients' values, preferences and expressed needs; coordination and integration of care; information, communication and education; physical comfort; emotional support - relieving fear and anxiety; and involvement of family and friends. To ensure that these dimensions are properly

integrated into ACO operations and care delivery within the ACO, patients and ACO clinicians must work in partnership to ensure that patient preferences and individual circumstances are addressed. CMS should measure how well the ACO accomplishes a range of patient-centered activities. For example, to determine whether care has been effectively coordinated, measures of the patient's experience should be implemented, as should assessment of avoidable hospital readmissions. Finally, a key determinant of patient-centeredness is decision quality. Did patients have the knowledge to make informed decisions; were they prepared to make required decisions; were their preferences honored, and did they report being part of the decision making process?

Attribution of Patients to ACOs. The RFI poses a question related to attribution of patients to ACOs. The question sets out two approaches, describes briefly their advantages, and asks how CMS should balance between attribution prior to the start of a performance period and attribution at the end of the performance period. AARP recognizes that this is one of the most difficult technical and practical issues confronting CMS. From a beneficiary perspective, AARP strongly favors attribution of patients prior to the performance period. Beneficiaries need clear and consistent information before they decide to receive care from a clinician or institution participating in an ACO. As noted earlier, we believe full disclosure about the providers' participation in the ACO and the impact of such participation on patients is necessary to ensure a patient understands and can actively engage in her care. (Similarly, being able to identify the population for whom an ACO is responsible will ensure that an ACO most effectively targets its resources and addresses the health of the population it is expected to serve.) AARP believes delivery reform will not succeed without beneficiary acceptance of new care models and active patient engagement in their care. During the health care reform debate, many Medicare beneficiaries expressed misunderstanding and mistrust about the changes occurring under the new law. Therefore, we believe transparency and patient engagement are essential elements for patients to accept new models of delivery.

Payment models. The RFI asks whether CMS should consider other payment models beyond the shared savings model, and to identify their relative advantages and disadvantages.

The statute identifies one alternative -- partial capitation -- and authorizes CMS to develop others as well, recognizing that approaches such as partial capitation might be limited at first to highly integrated systems and organizations capable of bearing risk. AARP supports exploring different models, with different payment approaches and degrees of risk. CMS may want to test risk corridors that allow sharing savings and losses, as suggested by the Medicare Payment Advisory Commission. Considering the effect of different payment models on beneficiaries is essential, and we urge CMS to apply the previously noted policies about transparency, with standardized measures and performance standards to determine the quality and cost of care provided. Different approaches and payment models can only be tested and assessed if the agency uses standardized measurement and holds the models to the same performance expectations.

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Patient information and engagement also are needed in any model. In addition, monitoring is essential if the program is to succeed and retain support over time.

AARP appreciates this opportunity to comment and will be pleased to continue to work with CMS in implementing these and other reforms called for in the ACA. If you have any questions, please feel free to contact Nora Super of our Government Relations staff at (202) 434-3770.

Sincerely,

A handwritten signature in black ink, appearing to read "David Certner". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

David Certner
Legislative Counsel and Legislative Policy Director
Government Relations and Advocacy