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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201
Re: CMS-1345-NC

Dear Mr. Carey:

Thank you for the opportunity to provide input in response to the Medicare Program; Request for Information Regarding Accountable Care Organizations and the Medicare Shared Saving Program. Below are comments and suggestions from the Massachusetts Executive Office of Health and Human Services in response to the feedback questions in the request for input published on November 17, 2010.

Feedback 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?

We recommend that standards include the consideration of virtual ACOs and geographic differences in practice locations. We also recommend that ACOs be considered in multiple levels or models allowing for flexibility in practices, including specialty care. There should be different levels of ACOs. Some might have PCPs only, or PCPs and hospitals, or PCPs/ Hospitals/ Ranges of Specialty Care.

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

We recommend that considerations include identifying types of new payment methodologies best suited to different types of ACOs and provider organizations, to



promote cost savings and maintain and improve quality of care for different types of ACOs. We also recommend maintaining flexibility for an ACO to allocate funds among individual providers and services based on the cost of the services, and the care needed through an integrated care model, and that ACOs, particularly those smaller practices, not be required to take on the risk of loss. In the redesign of the payment system flexibility is needed for ACOs to pay providers in a fee for service method or to use other allowable mechanisms, such as risk sharing, which limit small practices' exposure to financial losses.

Feedback Question #3: The process of attributing beneficiaries to an ACO is important to ensure that expenditures, as well as any savings achieved by the ACO, are appropriately calculated and that quality performance is accurately measured. Having a seamless attribution process will also help ACOs focus their efforts to deliver better care and promote better health. 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; others 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?

We recommend a flexibly patient-centered approach to the process of attributing beneficiaries to an ACO. Patient engagement in ACO membership is a critical component to a successful model. Whether this is accomplished through patient choice or attribution, patient affiliation with an ACO should be transparent. We think that patients should be attributed to PCPs, that PCPs should be in only one ACO (but can choose to change ACOs) and that patients are associated with the ACO for whatever period of time the PCP is part of that ACO.

Feedback Question #4: How should we assess beneficiary and caregiver experience of care as part of our assessment of ACO performance?

We recommend that satisfaction surveys about patient and provider satisfaction and experience of care be done at various intervals, and set up in a way such that appropriate action is taken to make changes to the program as needed based on the information received. We also recommend the alignment of payment incentives with health outcome goals of patients.

Feedback 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?

We recommend tools, such as PACIS, which retrospectively assess patient centeredness using measures of patient involvement in the practice and their own care. However, because practices and their patient populations differ so much, practices should be required to involve patients prospectively in defining what patient-centeredness means at the practice level

Feedback 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?

Measures endorsed by the National Quality Forum as well as measures in the HEDIS measure set should be used. HEDIS measures are particularly valuable because of the benchmarks provided by the National Committee on Quality Assurance (NCQA).

Feedback 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

We recommend payment and delivery reform efforts move forward in multiple ways by implementing the following:

- (1) patient centered medical homes moving towards ACOs: Patient centered medical homes ("PCMH") will form the foundation for the development of integrated, coordinated systems of health care delivery. It is through PCMHs that ACOs will develop and become the future of medical care delivery.
- (2) All-payer global payment projects-it is important that all payers be involved
- (3) Medicaid/Medicare dual eligible pilot projects
- (4) bundled payment pilots for chronic conditions

We also recommend that the following issue be considered: Many Medicaid members have complex Behavioral Health (BH) and Long Term Care (LTC) needs that aren't addressed by Medicare and most commercial health insurance plans and managed care benefit packages. ACOs that aren't accountable for coverage and coordination of BH and LTC services wouldn't address the full range of medical needs for Medicaid-eligible members (including members dually eligible for Medicare and Medicaid, disabled members, and elderly members). CMS should consider how payment models and ACOs would function in commercial insurance and Medicaid contexts, as well as within the Medicare program. We also recommend that ACOs be encouraged to cover a

broad range of services. In particular, if Behavioral Health and Long Term Care services are not included in ACO service packages, the full range of medical needs for Medicaid-eligible members (including members dually eligible for Medicare and Medicaid, disabled members, and elderly members) will not be addressed.

We appreciate the opportunity to provide input in response to the Medicare Program; Request for Information Regarding Accountable Care Organizations and the Medicare Shared Saving Program.

Sincerely,



JudyAnn Bigby, M.D.