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December 3, 2010

Dr. Donald Berwick

Administrator

Centers for Medicare and Medicaid Services

200 Independence Avenue, SW

Suite 314-G

Washington, DC 20201

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

Dear Dr. Berwick:

National Patient Advocate Foundation (NPAF) would like to thank you for the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Request for Information Regarding Accountable Care Organizations (ACOs) and the Medicare Shared Savings Program Measures. NPAF is a non-profit organization dedicated to improving access to healthcare services through both federal and state policy reform. Our mission is to be the voice for patients who have sought care after a diagnosis of a chronic, debilitating or life-threatening illness. The advocacy activities of NPAF are informed and influenced by the experience of patients who receive direct, sustained case management services from our companion organization, Patient Advocate Foundation (PAF). In fiscal year 2009 (July 1, 2009 – June 30, 2010), PAF resolved 64,188 patient cases and received more than four million additional inquires from patients nationally.

The Patient Protection and Affordable Care Act (PPACA) provides numerous innovative mechanisms to better coordinate affordable, quality patient care, such as the formation of ACOs. ACOs could take various forms, but they have generally been conceived of as groups of primary care physicians, specialists, and sometimes hospitals, joined together in either vertically integrated systems or networks that are accountable for improving the quality and affordability of care for a defined patient population and that are eligible for financial bonuses if performance goals are met.¹ NPAF sees ACOs as having the potential to provide increased provider accountability, a renewed focus on managed primary care and improved coordination of services throughout the continuum of care. As a result, we expect successful ACOs to benefit Medicare patients, especially those who suffer from multiple, often interrelated chronic conditions. That said, NPAF believes that achievement of the quality and cost-containment benefits expected of ACOs requires individuals to have the ability to select the ACO in which they will participate. Providing choice allows individuals to select care based on their own needs and research and should foster heightened willingness to assume personal responsibility for health care decisions. We also believe that individuals should be given the opportunity to

participate in ACO-related savings through reduced costs of services rendered, reduced out-of-pocket requirements and/or other mechanisms defined by CMS.

As CMS continues to engage stakeholders, including patient advocates, regarding the structure and administration of ACOs, we urge the agency to carefully examine the impact that ACO structure will have on patients. In many ACO-like models, including Medicare's Physician Group Practice Demonstration project, patients who received the majority of their care from participating providers were assigned to an ACO through "invisible enrollment," with no prospective notification and sometimes no awareness by the patients that they were associated with an ACOⁱⁱ. Consistent with the numerous provisions in the PPACA which strengthen patient protections and encourage transparency, we believe that patients must have the right to choose the ACO in which they prefer to participate, rather than being assigned. Patients who are unknowingly assigned to a particular ACO without their consent or notification may feel disenfranchised, particularly if the result of their ACO assignment is lack of access to a specific hospital or specialist group that they deem most appropriate for their needs.

Geographical differences will pose a unique challenge for ACO model development. Managing the care of patients has been, and continues to be, difficult in rural areas. Enrollment options may not be as variable in these areas, making it all the more important to consider ways to make patients feel that they are part of their own health care team and not just a revenue-generating source for the ACO. ACOs that form in rural areas are likely to experience greater challenges than their urban counterparts in a variety of care-related issues. For example, how will an ACO manage patients requiring expert consultation that is not available in a rural community? We are concerned that if patients are assigned to a particular ACO, little consideration will be given to the burden of geography. The geography of an ACO may incent or disincent patient participation, given that some patients may be forced to travel long distances in order to receive care from an in-network provider or hospital.

If CMS moves forward with assigning patients to a particular ACO, we would counsel that patients be assigned prospectively. NPAF concurs with the following position taken by the Medicare Payment Advisory Commission's (MEDPAC):

"Beneficiaries will have to be assigned prospectively if they are to be informed of their assignment to an ACO before care is delivered to them under that model. Prospective assignment uses claims data from a prior year to make the assignment. An ACO would first identify its primary care provider members to Medicare. Medicare would then assign beneficiaries to the ACO whose primary care had been provided in prior years by those members. Some have argued that retrospective assignment is superior to prospective. Retrospective assignment would use data from the performance year to make the assignment. However, if retrospective assignment were used, neither the ACO nor the beneficiary would know at the beginning of that year who was assigned to the ACO and prior notification would be impossible."ⁱⁱⁱ

It is imperative that patients have a clear understanding of all aspects of the ACO to which they are assigned before any care is administered. One way this can be achieved is through the counsel of primary care physicians. "Involving the primary care provider in beneficiary notification would contribute to the beneficiary understanding what is different under an ACO, how the new approach to care could benefit them, and what their new responsibilities would be."^{iv} In order for ACOs to reach their greatest potential, patient acceptance, awareness and support is crucial.

NPAF further agrees that "in any new Medicare program the rights and responsibilities of Medicare beneficiaries should be a primary consideration. Beneficiaries should know if their

health care providers are operating under a new incentive structure.”^v Patients should never have the feeling that they are constrained to a particular group of health care providers and, historically, patients have been hesitant to accept closed provider networks. Unless beneficiaries thoroughly understand and agree with an ACO’s philosophy and operational parameters, they may feel that restrictions associated with participation in that ACO are rooted in a desire to save money rather than provide high quality, patient-centric care.

Conversely, patients who are able to choose their health care providers will have more confidence in the quality of care they are receiving. As well, they may conform to protocol more routinely, thus saving the health care system the substantial costs believed to be associated with non-compliance. In the 15 years that NPAF has served the interests of patients, it has become abundantly clear to us that patients want the ability to exercise free choice when selecting their health care providers and when they have such choice, they invest effort in adherence to a higher level of care.

We thank you for the opportunity to comment. We would be pleased to respond to any questions about our recommendations that may arise regarding ACOs in the future.

Respectfully submitted,



Nancy Davenport-Ennis
Chief Executive Officer and President

ⁱ Anna D. Sinaiko, Ph.D., and Meredith B. Rosenthal, Ph.D. “Patients’ Role in Accountable Care Organizations.” *New England Journal of Medicine*, November 10 2010.

ⁱⁱ *Ibid.*

ⁱⁱⁱ Medicare Payment Advisory Commission (MEDPAC). Comments on the Request for Information Regarding Accountable Care Organizations and the Medicare Shared Savings Program, November 22, 2010.

^{iv} *Ibid.*

^v *Ibid.*