

June 2, 2011

Donald Berwick, MD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW.
Washington, DC 20201

RE: File code CMS-1345-P. Medicare Program; Proposed rule to implement section 3022 of the Affordable Care Act, the Medicare Shared Savings Program; *Federal Register/* Vol. 76, No. 67 / Thursday, April 7, 2011, pages 19528-19654.

Dear Dr. Berwick:

The Washington State Medical Association (WSMA), on behalf of our more than 9,800 physician members in Washington state, appreciates this opportunity to provide input regarding the Centers for Medicare and Medicaid Services' (CMS) request for comments on the proposed rules for implementing accountable care organizations (ACOs) in the Medicare Shared Savings Program.

Overall, we are extremely disappointed in both the tone and substance of the proposed rules. We believe they will require substantive revision in order to attract physician participation and make the Shared Savings program viable. Rather than include an extensive list of recommendations covering every possible technical issue, we are instead focusing our comments on just a few key areas.

In this letter, we make seven major recommendations for changes to the final regulations, which we believe will make the Shared Savings program stronger, more effective, and more appealing to physicians and physician groups who are being asked to participate in this program on a voluntary basis. Without these changes, we believe the program will be largely ignored and thus an opportunity to improve the quality of health care in America will be lost.

The WSMA is completely supportive of achieving the three-part aim identified in the preamble: 1) better care for individuals; 2) better health for populations; and 3) lower growth in health care expenditures. We strongly believe that efforts to achieve these goals must involve a cooperative, trust-based partnership between CMS and physicians. The overall tone of the proposed regulations, and many of the specific alternatives selected for the draft regulations, give very little evidence that CMS views the Medicare Shared Savings program as a partnership with physicians.

Our first overall recommendation, therefore, is that the final rules do a much better job of making the actual regulations reflect the important goals and aspirations of the preamble by treating physicians as partners rather than recalcitrant opportunists.

Second, we encourage CMS to create an additional ACO option that will allow newly formed groups a longer, more gradual transition period. This third option (or, potentially the fourth ACO option, given your recent introduction of “Pioneer ACOs”), would allow medical groups new to care coordination more time to build the infrastructure needed to function successfully as an accountable care organization. We disagree with the CMS statement (at the top of page 19618 of the April 7 *Federal Register*) that “... it is important that all Shared Savings Program participants quickly move to taking on downside risk.” We believe what is important is that medical groups begin the transition to accountable care provision, and not be discouraged from this transition by unrealistic financial requirements. Downside risk sharing is definitely appropriate at some point, but requiring it of all applicants by the third year of the contract is counterproductive to the goal of achieving the three-part aim.

CMS cannot expect the bulk of the American medical system to leap the quality chasm in a single bound. To be successful in the long run, the Shared Savings program must be acceptable to and financially viable for mature organizations. It is our opinion that CMS may have badly misjudged the current state-of-the-art in care integration for most medical practices. We strongly recommend the creation of a new “Gradual ACO” option that allows organizations to take on risk when they are confident they can do so successfully. Specific recommendations for this Gradual ACO option are:

- Do not require down-side risk sharing in the third year of the contract. Retain that as an option, but do not require ACOs to do this in their first three-year contract. This would also eliminate the need for the 25% withhold of savings from the first two years.
- Allow an extended initial contract period for rural and small organizations; a five year contract period, with only upside risk sharing, would make this program much more attractive to start-up ACOs with a fragile business base.
- For the second contract period (beginning in year 4, or potentially in year 6 for rural and small ACOs), CMS can require downside risk sharing.
- Create a less cumbersome application process and reduced administrative requirements for new, small and/or rural ACOs. Give these fragile organizations technical assistance to help them get up and running. One-day technical conferences are hardly sufficient.
- Allow these Gradual ACOs to add new participants during their contract period if they can clearly demonstrate their market share for core services will remain under 30%.
- Phase-in the quality reporting requirements. Require reporting of at least half the quality metrics in each domain in Year 1 of the contract, at least 75% of the metrics in each domain in Year 2, and all metrics in all domains for the third year. Provide small bonuses if they can exceed those requirements.

- Allow more time to come up to speed on quality performance. Give some small credit in Year 2 and Year 3 toward shared savings even if the ACO is under the 30th percentile.
- Allow a more gradual ramp-up for EHR meaningful use. For example, require at least 25% use at the end of Year 1, 50% at the end of Year 2, and 75% for Year 3.
- The net effect of these more gradual requirements is that few of these Gradual ACOs are likely to be eligible for large amounts of shared savings, so there is not a significant financial risk to CMS in creating this program. Nor is there a large financial incentive for medical groups to form Gradual ACOs. By offering this option, however, CMS would send a clear message that it wants to encourage broader participation in the Shared Savings program over time, and has created a true “on-ramp” to encourage participation.

Third, make the benchmark amount a blend of regional and national expenditures; do not base it on the ACO’s own performance. The proposed approach is a Catch-22: only experienced organizations with effective care coordination are encouraged to apply, but they will be judged against their own performance so “savings” are likely to be minimal. This is the single most objectionable technical feature of the proposed rules: virtually all medical groups believe they can do better than “the other guys” but few see much value in competing against themselves. Our recommended change also solves two other difficulties with the proposed regulations:

- The approach begins to narrow the payment gap between different regions of the country, resulting in more equitable payments for efficient providers and reducing payments for higher-cost areas over time.
- It eliminates the problem of how to create true “savings” beyond the initial three-year contract, by constructing a benchmark that is not based on the ACO’s own performance.

Fourth, assign patients to ACOs using a prospective attribution method, and if necessary confirm the assignment with retrospective verification. This will result in smaller numbers of patients assigned to an ACO than under the proposed method. However, this approach will be far more acceptable and understandable to the physicians treating these patients. To ask medical groups to take on financial risk for patients that will not be assigned until at least six months after the end of a contract year is, in our opinion, unworkable. Physicians simply will not do this. In addition, in using the proposed method assignment for prospective assignment or retrospective verification, there must be a floor to the plurality of primary care charges used for that assignment. We recommend that the floor be set at 20% -- meaning that unless the ACO is responsible for at least 20% of a patient’s primary care charges, that patient would not be assigned to any ACO.

Fifth, adopt meaningful risk adjustment between the baseline period and each of the contract years. This is absolutely essential if you adopt our third recommendation above, and is still needed even if the benchmark remains defined by the ACO’s own patients. We believe the arguments made in the proposed rules’ preamble about the potential for up-coding are weak, especially given the impending adoption of ICD-10 in the middle of the second contract year (October 2013). Comparisons of case-mix severity between the baseline period and each of the contract years can be closely monitored, and aberrant behaviors investigated and corrected. Finding valid methods for risk adjustment, given the ICD-10 coding change, will be a challenge, but that should not be used as an excuse for ignoring this important adjustment.

Sixth, make the sharing of savings and losses parallel. The proposed regulations assign the ACO a share of the savings between 0% to 65% (the theoretical maximum under the two-sided model with large FQHC/RHC involvement) – but require the ACO to pay back between 35% and 100% of the losses (the theoretical minimum for the same ACO). This seems inequitable. Change the formula so that the maximum gain percentage is used -- instead of “1” -- in the case of a loss. For example, in the example given above, make it “0.65 minus the quality score” rather than “1 minus the quality score”. If the ACO’s theoretical maximum is only 60% of shared savings, then the formula would be “0.60 minus the quality score.”

Seventh, give added financial incentives to ACOs with significant RHC and FQHC participation. The added points listed in the tables on page 19647 of the April 7 *Federal Register* are too small to be considered as significant financial incentives for including patients from these providers. This is particularly true since the challenges of delivering care in the settings where these providers are frequent make care integration even more challenging. We strongly recommend doubling the points in the right-hand column of each table on page 19647: to a maximum of 5 points in the one-sided model and a maximum of 10 points in the two-sided model.

In addition to these seven major recommendations for improvement, we also have a number of additional suggestions and recommendations which we believe will greatly improve the clarity and acceptability of the final rules. These are:

- Simplify wherever possible. The administrative and application requirements, as identified in the preamble to the proposed regulations, will present a real barrier to entry for many smaller and non-hospital-based applicants. Streamline the application process wherever possible; do not reinforce the stereotype that a government-run program requires overwhelming paperwork, delays, and red-tape. This is a voluntary program – make physicians want to participate, and make it as easy as possible for them to participate.
- Be more explicit on timing – Give specific dates for the baseline data (for example CY 2008-CY 2010), when payments will occur following claims run-outs, the timing of required quality and other reporting, and when the application deadlines will be. Include a timeline chart with dates of all significant events and requirements for the three year contract.
- Release of patient data – We have a concern about patients opting-out of personal data release, although we agree they must be given this option. These data are necessary for ACOs to effectively manage care, especially data about health services provided outside the participants of an ACO. We recommend that if a patient refuses to release his/her data, that patient should be excluded from ACO assignment for that year. This requirement can be revisited in future years, if large numbers of patients opt-out of allowing their data to be released. As a starting provision, however, we believe such patients should be excluded.
- Future contracts – Please make it explicit that the one-sided model (and the “Gradual ACO” model recommended above) will continue to be available for first time participants in future years. Ambiguity about this point is widespread. The transition to accountable care is a journey, and we want to encourage all medical groups to start down this path.

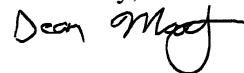
- At-risk patients – The definition of “at-risk” patients (as described on page 19625 and defined on page 19641 of the April 7 *Federal Register*) seems exceptionally broad. We fully support monitoring the care of such patients, but are concerned that this definition may be so broad that it would encompass virtually all Medicare beneficiaries treated by an ACO. In particular, “patients with multiple chronic conditions” are likely to be a very large percentage of this population. The final rules should be explicit about what percentage “at-risk” patients are likely to be of the total beneficiaries, and the definition made more explicit so that it keeps the at-risk population to be monitored manageable (under 50% of the total, for example).
- Compliance with quality performance standards – The proposed requirement to terminate ACOs which score under the 30th percentile in any domain appears to us to be counter-productive. A financial penalty (a further-reduced shared savings percentage, for example) seems more appropriate, and would continue the ACO’s participation in the program. We also caution that the world of ACOs cannot be like Lake Wobegone – all the participants cannot be above average. The goal should be to improve quality, not banish low performers.

In addition to these recommendations, we also encourage CMS to retain in the final rules the many positive features of the Shared Savings program that would encourage wide-spread physician participation. These include:

- Keeping primary care physicians at the core of the program;
- Requiring at least 75% of an ACO Board be clinical participants in the ACO;
- The strong emphasis on quality improvement in order to share in the savings;
- The strong emphasis on patient-centered care;
- Setting a high bar for quality of care and meaningful use (yet allow a more gradual entry);
- Using a flat national dollar amount for adjusting baseline data forward to the benchmark; and
- Allowing a fast-track to ACO participation, for those who are ready, through Pioneer ACOs.

We appreciate the opportunity to provide our input on CMS’ request for comments on the proposed rules for ACOs and the Medicare Shared Savings Program. We look forward to working with CMS to implement this program in a manner that addresses the concerns above and which encourages participation by a wide range of physician practices.

Sincerely,



Dean Martz, MD
President

cc: Susan Johnson, Region X HHS Regional Administrator
Washington State Congressional Delegation
WSMA Board of Trustees
WSMA Senior Staff