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June 3, 2011

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 Ave., S.W.

Washington, DC 20201

Re: CMS-1345-P
Medicare Program; Medicare Shared Savings Program; Accountable Care
Organizations

Dear Dr. Berwick:

The Illinois Hospital Association (IHA), on behalf of its 200 members, welcomes the opportunity to submit comments on the proposed regulation to implement the Accountable Care Organization (ACO) Medicare Shared Savings Program (MSSP). Illinois hospitals are already working to transform the care they provide consistent with the principles of the Triple Aim – better care for individuals, better health for populations, and reduced per capita costs. They are implementing changes to respond to an environment that demands greater accountability and care coordination.

However, Illinois hospitals are also viewing the proposed rule, in its current form, with considerable caution. The upfront investment required is too high to encourage participation for most hospitals given the limited potential to recoup shared savings and the risk for repayment of losses. Illinois hospitals also recognize that the final rule will be different and look forward to a rule that resolves their concerns and encourages diverse participation in the MSSP.

The costs for health care providers to make the investments to transform themselves into accountable care organizations are high. To be successful, an ACO needs to invest in information technology and analytic capabilities. An ACO also needs human resources to improve primary care including both primary care physicians and mid-level practitioners. Increased use of hospitalists will be needed. And other investments to support care coordination and process improvements will be key.

The proposed rule estimated an average \$1.7 million investment per ACO. An April 2011 study released by the American Hospital Association (AHA) estimated that the costs would be substantially higher. For a 200-bed hospital, the start-up costs are estimated to be \$5.3 million with \$6.3 million in annual operating costs. For a 1,200-bed, 5-hospital system, start-up costs would be \$12 million with \$14.1 million in annual operating costs.

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Regardless of whether a hospital or health system contemplates participating in the MSSP, investments are needed. Hospitals are committed to improving quality and decreasing costs despite the knowledge that, if their ACOs are successful, their utilization will fall.

Because of this, it would be helpful for the Centers for Medicare and Medicaid Services (CMS) to provide advance payments to help fund the needed infrastructure. Advance payments would be particularly helpful for smaller hospitals and health systems. However, whether they would jump start participation in the MSSP would depend on the conditions attached to the payments.

There are additional **financial incentives** that would increase the rewards and reduce the risks for those who choose to participate. Few in the Medicare Physician Group Practice Demonstration were able to achieve shared savings despite the fact that there were lower hurdles in that demonstration. Even high performing ACO-like groups will find it hard to achieve savings because their baseline will be set using their current performance and improvements will be harder to achieve. For those that do qualify for savings, the reward will be delayed. ACO participation requires physician support. This will be easier to achieve if there are shared savings that can be distributed in a timely manner.

The rule should be revised to make it financially feasible for ACOs to participate. We understand that it is important to demonstrate savings to the Medicare program. But that won't happen if organizations don't step up and participate. The proposed financial model is slanted too far towards protecting CMS rather than creating an environment that will encourage accountable care. **The following changes could enhance participation and give CMS a more robust laboratory to analyze the attributes of ACOs that best meet the needs of Medicare beneficiaries, providers, and CMS.**

1. Allow all ACOs to share in first dollar savings. This can help fund appropriate infrastructure and overhead expenses. In addition, the 2% savings threshold in the proposed regulation may not be authorized under the Affordable Care Act.
2. Remove the 25% withhold of shared savings payments. The rules already require a mechanism to repay losses.
3. Standardize the Minimum Savings Rate (MSR) at 1% or 2% for all ACOs, regardless of the number of attributed beneficiaries. The 3.9% MSR for those ACOs with fewer beneficiaries will likely make it impossible for them to qualify for shared savings.
4. Establish a minimum sharing rate of 50% for Track 1 and 60% for Track 2. Then use the quality score to increase the minimum rate to 80% for Track 1 and 90% for Track 2.
5. Expedite shared savings payments by using a three-month claims run out period rather than a six-month period.

6. Change the methodology for both benchmark and performance year expenditures so that they reflect actual resource use. Payment adjustments such as those to compensate for improved “coding practices,” Disproportionate Share Hospital, Indirect Medical Education, the Area Wage index, the Low Cost County Payment Adjustment and the Geographic Practice Cost Index should not be included in the calculation. These payment adjustments reflect policy decisions that are not under an ACO’s control. If they are included they will also disadvantage some ACOs more than others.
7. Risk adjust for the severity of an ACO’s population on an annual basis, not just at the beginning of the three performance years.
8. Consider a separate incentive for early adopters of ACOs to reward those who choose to participate early in the program. They have already made substantial investments. This incentive could be reduced over time.

The models themselves should be reconsidered if the goal is to attract participants and spur providers to transform the care that they provide.

1. Change Track 1 so that participants do not need to bear financial risk for losses in the third year. There is no real risk for CMS because the FFS payments will be made regardless of whether providers are in an ACO or not. A model that does not put the ACO at risk for losses will encourage more providers to move down the path of improving care coordination, quality, population health, and efficiency.
2. Consider an additional Track that allows for partial capitation. This is consistent with the move from Fee-For-Service volume based payments to payment for care that provides the best value. This model would provide an option for clinically integrated high performing ACO-like organizations to innovate further.

The final rule should increase the opportunity for ACOs to succeed by **changing the model for beneficiary attribution** and by clarifying the acceptability of providing value added services to attributed beneficiaries. It should also create a system that provides **timely and complete data** on the attributed beneficiaries.

1. The proposed rule calls for attribution tied to the primary care physicians who provided most of the Medicare beneficiaries’ care. Primary care physicians are narrowly defined to include internal medicine, general practice, family practice, and geriatric medicine. Since it is common for seniors to receive most of their primary care services from specialists, they should be included in the attribution model. A strong primary care foundation is critical, but some specialists should also be recognized. In addition, CMS should consider including nurse practitioners, physician assistants, and clinical nurse specialists. The recognition of the types of professionals that deliver primary care services is particularly important in light of the primary care physician shortage.

2. CMS should attribute beneficiaries prospectively. Beneficiaries should know that they are attributed so that they can be engaged in the processes that are intended to improve their care. The need for patient engagement is supported by the 2011 Commonwealth Fund study, “High Performance Accountable Care: Building on Success and Learning From Experience.” Prospective attribution will give ACOs more timely information so they can better monitor their performance. Additionally, beneficiaries should be given the opportunity to opt in.
3. Exclude Medicare beneficiaries who spend a substantial amount of time in a different geographic location. An ACO will not be able to impact the quality or cost of their care.
4. Likewise, exclude Medicare beneficiaries if they transition to a Medicare Advantage plan during a performance period.
5. The final rule should clearly allow ACOs to provide incentives and value added services to attributed beneficiaries to motivate them to improve their health status. This should not be viewed as a beneficiary inducement but as an important tool for ACOs to engage their patients, improve population health, and prevent readmissions.
6. Make beneficiary-identified data available on a monthly basis. Beneficiaries should not be able to opt out of data sharing. The law already has comprehensive confidentiality protections in place to protect beneficiaries. Because beneficiaries will be able to seek care from any provider, either inside or outside of the ACO, the ACO will be better able to coordinate care for its assigned beneficiaries if it can monitor service use and pharmaceutical claims.

Reduce the operational barriers to ACO development.

1. Allow ACOs to use their current governance structures rather than requiring them to create a separate legal entity if none currently exists. The goal should be to support governance structures that enhance clinical integration and accountability. That should not require a separate legal structure, which will require additional resources to create.
2. Eliminate the requirement for 75% of the governing body to be representative of ACO participants. This may conflict with IRS policy that requires boards to be comprised of a broad spectrum of community members. Boards should not be representing their own interests, but those of the ACO. In addition, if an ACO has many small physician practices, it could be difficult to achieve 75% representation.
3. Allow physician Tax Identification Numbers (TINs) to be updated regularly to facilitate independent physician practices to join or leave an ACO or form different group arrangements.

4. Eliminate the meaningful use requirements. Providers are moving as quickly as possible to meet the meaningful use standards and understand that health information technology is critical to develop integrated systems of care. Clearly, some providers and systems are ahead of the curve, but the capital requirements are significant, there is great demand, and the supply may not be sufficient. Other tools can support the goals of the MSSP initially, such as disease registries.
5. Consider allowing for a development period in 2012, with a program start in 2013. Hospitals cannot decide whether they want to participate until they know what the final rules are. Then, it will take them time to analyze their own data to assess the potential benefits and risks before making a decision. While many hospitals are prepared to accept risk, they want it to be predictable and manageable.
6. Establish guidelines for marketing materials. However, do not require approval prior to their use.

Quality measurement and improvement is key to improving patient outcomes. It is also key to any ACO achieving meaningful shared savings. However, accountability for 65 quality measures is excessive at the beginning of the program. **The focus should be on fewer high impact measures.** In crafting revised measures, strong consideration should be given to the AHA's recommended quality metrics.

1. Scale back the 65 quality measures to a more reasonable number. Additional measures can always be included over time, with the caveat that new measures should be nationally recognized standards based on evidence-based best practices and expert consensus using the National Quality Forum (NQF).
2. For new measures that hospitals are not already capturing and reporting, allow a two-year time period for pay for reporting.
3. Minimize measures that require ACOs to retrospectively pull patient charts to abstract data.
4. Only count readmissions for heart failure, pneumonia, and acute myocardial infarction if they are related to the original admission. For example, an ACO should not be penalized if a patient is readmitted after a discharge with a diagnosis of pneumonia when the readmission is due to a fall resulting in a hip fracture.
5. Eliminate the care transition measure for medication reconciliation as it is a self-reported unidirectional measure. Instead, consider the care coordination measures of the Physician Consortium for Performance Improvement developed through the American Medical Association.
6. Re-consider the group practice reporting option (GPRO) as there is insufficient experience with it and data needs to be extracted from the medical record.

7. The patient experience of care is an important component of the quality measures. However, there are concerns about the consumer assessment of healthcare providers and systems (CAHPS) tool and its methodology for reporting results. The Clinician and Group CAHPS survey tool should be used, but CMS should consider using the results to calculate a bonus to the quality scores in the other four quality domains.

Minimize the **administrative burdens** to participate. They add costs and distract organizations from focusing on improving care coordination and quality.

1. Simplify the application process. Much of the documentation that an organization must submit with its application can be streamlined. For example, does CMS really need a list of ACO committees, names of committee members, and job descriptions for senior administrative and clinical leaders?
2. Eliminate the requirement for physician practices to report on their primary service areas. This creates an administrative burden for them, particularly for smaller practices. Hospitals are concerned because as they strive to care for populations rather than only their patients, physician group participation in ACOs is essential.
3. Don't require ACOs to verify CMS' shared savings calculations before payments are made. ACOs may not even have sufficient information to verify them. Instead, CMS should make shared savings payments and offer ACOs the opportunity to appeal.

Finally, in an environment where reimbursement incentives are moving from volume to value, ACOs will require physicians to change their practice patterns. A key barrier to this 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 framework for successful ACO development.

The Illinois Hospital Association appreciates the opportunity to comment on this proposed regulation. The Association is excited about the potential for ACOs to lead to new partnerships that will transform the health care delivery system. We hope you find our comments constructive as we all share the same goals for the MSSP. If you have questions, please feel free to contact Ann Guild, Vice President, Health Policy and Regulation, at 630-276-5496 or at AGuild@ihastaff.org.

Sincerely,

Maryjane A. Wurth
President
Illinois Hospital Association