American Society of Anesthesiologists

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June 3, 2011

Donald Berwick, MD, MPP
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1345-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1345-P, Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations; Proposed Rule, March 31, 2011

Dear Dr. Berwick:

The American Society of Anesthesiologists (ASA), on behalf of its over 46,000 members, appreciates the opportunity to comment on several of the issues addressed in the proposed rule with comment period issued on March 31, 2011.

EXECUTIVE SUMMARY OF KEY ISSUES

ASA has provided below comprehensive comments on many of the issues identified and requested in the proposed rule. Our more significant issues are briefly identified here in this executive summary.

1. **Patient accountability** - the proposed rule does not hold patients accountable for their part in their own healthcare and helping to achieve the healthy population goal of the Triple Aim. Without active patient support and participation, the ability of physicians to help patients improve their health, avoid unnecessary hospitalizations, and reduce the use of unnecessary and duplicative services is inherently limited.

2. **Role of anesthesiologists** - ASA believes that anesthesiologists are critical to achieving the goals of reducing health care costs and improving quality of care. To that effect, ASA strongly promotes the concept of a coordinated perioperative or surgical home model in order to achieve better value for beneficiaries through care coordination and process improvements led by anesthesiologists.

3. **Assignment of beneficiaries -** retrospective assignment of beneficiaries is problematic because the statistical-based attribution does not account for care provided to those Medicare and non-Medicare patients that are not attributed to the ACO but who nonetheless benefit from systematic quality and efficiency improvements. For this group of beneficiaries, ACOs will produce savings for the Medicare program, but those savings will not be shared with those responsible. We believe that this inequity should be addressed by implementing models such as the surgical home and increasing the sharing rate from the proposed 50% to 80%.

I. **Eligibility**

While primary care physicians are proposed to serve as the core of an ACO, anesthesiologists are concerned that CMS does not envision much of a role for those, like anesthesiologists, involved in surgical or specialty care within an ACO. **ASA, however, believes that anesthesiologist engagement is critical to achieving the goals of reducing health care costs and improving quality of care. To that end, ASA strongly promotes the concept of a coordinated perioperative or surgical home model in order to achieve better value for beneficiaries through care coordination and process improvements led by anesthesiologists.** This model is the surgical counterpart to the medical home model and would assist hospitals and facilities in effectively managing health care expenses. Approximately 60-70% of a traditional hospital's expenses are associated with surgical and procedural (perioperative) care. The opportunity to reduce overall health care costs through improved coordination and efficiency of surgical and procedural care is arguably better than the opportunity to reduce those care costs through a medical home model.

Why should anesthesiologists play a leadership role in a surgical home? Anesthesiologists routinely interact with providers from virtually all care settings and assess and monitor the patient from an overall perioperative perspective; thus, anesthesiologists are ideally suited to effectively assess and manage risk across the full continuum of the perioperative setting. Anesthesiologists partner with hospitals, proceduralists, and surgeons in selecting cost-effective implants and pharmaceuticals to provide better quality of care at a lower cost. In addition, anesthesiologists serve as physician managers and coordinators of operating and procedure rooms. In addition to managing patient flow and triage through the surgical experience, anesthesiologists evaluate and help optimize patients for proposed operative procedures. For those situations where multiple pathways of care are available, anesthesiologists play a central role in helping patients determine the most appropriate course of care. Evidence-based Cost Utility Analysis can play a role in informing the patient's decision-making. Some patients may elect to have less expensive conservative management after such counseling, creating shared savings for Medicare and the ACO. These savings are directly attributable to the anesthesiologist's participation. Additional shared savings would be derived from decreased testing and consultations, through pre-operative evaluations performed in anesthesiologist-run Pre-Anesthesia Testing (PAT) clinics, as well as reduced hospital lengths of stay and hospital readmissions arising from 1) selection of appropriate candidates for surgery, including interventions with those who are highly unlikely to benefit, 2) identification of optimal timing for surgical interventions, to avoid rescheduling, 3) reduction of complications such as surgical or catheter-related infections, poor perioperative glycemic control, and postoperative nausea and vomiting that increase length of stay or necessitate admission following outpatient surgery, and 4) improved perioperative management of pain and anxiety to ensure the best possible patient care experience.

A decidedly chronic disease management focus, a primary care centered model and a lack of any attention to improving costly acute inpatient surgical management, combine to inhibit surgical specialists and anesthesiologists from actively participating in ACOs. ASA believes that a medical home is primarily responsible for chronic care management while a perioperative or surgical home is responsible for acute care management, focused specifically on anesthetic and sedation-based surgeries and procedures. Given the benefits, both financially and in patient experience arising from the active participation of anesthesiologists in surgical care, payment methodologies should promote anesthesiologists' involvement with and oversight over perioperative care management.

Anesthesiology has a storied history of promoting patient safety and improving outcomes, including trailblazing initiatives such as our development of numerous and rigorous standards and guidelines long before this was in vogue, creation of a closed claim study of liability cases that has led to documented practice improvement, and mandating basic monitoring standards. In combination, these efforts have led to dramatic reductions in anesthesiology mortality and morbidity, leading to recognition from the Institute of Medicine in "To Err is Human" for these accomplishments. The ACO model, as proposed, fails completely to engage our specialty and leverage our experience in process and outcome improvement.

More broadly, while ASA commends CMS for including Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) as ACO participants, we recommend that CMS risk adjust the ACO benchmark for the socioeconomic and health status of the patients that are assigned to each ACO, taking into account income/poverty level, insurance status prior to Medicare enrollment, race, ethnicity, and health status. Some studies have shown that patients with these factors generally have experienced barriers to care and are much more costly to serve once they reach Medicare eligibility. A recent press release from the U.S. Department of Health and Human Services (HHS) stated that, "the Medicaid spending per Medicare-Medicaid enrollee was $15,459 in 2007, over six times higher than the comparable cost of a non-disabled adult Medicaid-only enrollee ($2,541)."[1] This underscores the importance of targeting dual beneficiaries in the ACO program and a need for robust risk adjustment methods to ensure performance measurement is accurate and fair.

In addition, CMS should more aggressively promote participation of smaller and mid-sized practices in ACOs, since much of the care delivered takes place in these settings, and the opportunities for quality and efficiency improvement are substantial. One example of a useful incentive would be a start-up grant to help smaller practices create an ACO. As proposed by the Center for Medicare and Medicaid Innovation (CMMI) on May 17, 2011, the grant could be considered an advance, subject to recoupment later from projected or actual shared savings.

II. Legal Structure and Governance

ASA strongly agrees that broad involvement and strong communication among all ACO participants is necessary and essential to achieve cost savings and quality improvement. However, the leadership and ultimate decision-making authority for ACOs should lie with physicians. We applaud the proposed requirement that an ACO have a board-certified physician serve as medical director who provides clinical management and oversight. Physicians are far and away the best qualified to serve in this role and will assure that health care delivered under the ACO model is patient-centric and that a physician's medical decisions are based on professional medical judgment that puts patients' interests first. As stated by CMS in the proposed rule, participants in the Physician Group Practice demonstration identified dedicated physician leadership as a critical factor to improving quality and recognizing savings. Clearly, physician leadership of ACOs is necessary for these organizations to achieve their overarching goals. We believe that the ACO's physician leaders, including the medical directors, should be licensed in the state in which the ACO operates and in the active practice of medicine. To ensure local accountability and oversight, any medical director(s) must report to the physician governing board who will be actively engaged in the development and oversight of the ACO's medical policy, utilization review, quality improvement, and performance measurement.

[1] http://www.hhs.gov/news/press/2011pres/05/20110511a.html

Further, we believe that legal entities in existence prior to enactment of the Patient Protection and Affordable Care Act should be permitted to participate in the Shared Savings Program, as long as the existing entities meet the same regulations and requirements as newly-formed entities created for the purpose of forming an ACO. Requiring formation of a separate and distinct legal entity raises substantial economic and operational barriers which will be very difficult for small and medium-sized physician practices to surmount. Such a burden will likely discourage the formation of ACOs and ultimately limit widespread engagement in this program.

In addition, retrospective assignment of beneficiaries is troublesome to ASA, because, just as there is clinical diversity among beneficiaries, there is also significant diversity in what patients value and how they define "patient-centered care." Not being able to identify the expectations and values of the patients within an ACO is a direct consequence of retrospective assignment. It creates massive barriers to the delivery of beneficiary-centered care.

Also, ASA is concerned about the limitations imposed by CMS with respect to an ACO's ability to add providers during the 3-year agreement period. Anesthesiology practices are mobile by nature, typically offer anesthesia services in multiple settings owned by different entities and may potentially undergo mergers and acquisitions. As these practices grow and change in response to patient and population needs and a changing economic environment, they will want to have the flexibility add new providers. If they are participating in a Medicare ACO, the practice will also want to include the new providers as participants in the ACO. **We encourage CMS to avoid implementing barriers that fail to reflect normal and expected changes in staffing needs and to be flexible in governance requirements to promote integration of practices and further coordination of care.**

III. Application Process

Given the limited opportunity for organizations to learn and understand the proposed regulations regarding Medicare ACOs, let alone the final regulations CMS will issue later this year, we do not believe most organizations will be sufficiently prepared to meet the anticipated start date of January 1, 2012. Thus, we recommend delaying the proposed start date to afford adequate time for organizations, contemplating to become ACOs, to perform financial and quality modeling, complete their applications, enroll, and perform other due diligence as required.

We understand that a certain level of commitment from the ACO to the program is necessary for the program to be fully implemented and to identify areas of benefit and risk. However, given the hurdles involved in starting an ACO and the potential risks associated with participation, it may be too burdensome for a group to commit to a time frame longer than the proposed 3-year agreement period. A longer time commitment is especially concerning given that CMS has proposed the option for the agency to change terms and conditions of the ACO contract before the end of the 3-year agreement period, notably without giving the ACO a chance to renegotiate terms. This proposal will prevent ACOs from being able to adequately prepare and plan for changing regulatory requirements; furthermore, given the proposal for fairly remote retrospective data reports from CMS, it is unlikely that an ACO can effectively implement timely improvements in care based on quality measurement collection and quality and cost improvement activities during the agreement period. This is especially of concern due to the recent CMS track record of delaying distribution of timely data reports and incentive payments to eligible participants

in the Physician Quality Reporting System (PQRS). We recognize the enormous administrative burden placed upon CMS in implementing all of the current and future ACO program initiatives; however, we believe that the totality of these administrative requirements may exceed CMS' ability to deliver in a timely fashion, thus severely hampering success for programs such as the shared savings program. With all of the confounding factors stacked against them, we are struggling to determine how ACOs will ultimately succeed in improving care, reducing costs, remaining financially sound and meeting the extensive proposed regulatory requirements.

CMS has proposed screening ACOs during the application process, to include any history of program exclusions or other sanctions and affiliations with individuals or entities that have a history of program integrity issues. ACOs, whose screening reveals a history of program integrity issues and/or affiliations with individuals or entities that have a history of program integrity issues, may be subject to rejection of their application or the imposition of additional safeguards or assurances against program integrity risks. We believe that the proposed screening requirements by CMS are too broad and thus should be narrowed, based on the nature of the relationship of an ACO applicant with an entity with a history of program integrity issues. Perhaps CMS should consider parameters so that potential rejection or exclusion by CMS is not so broad as to prevent reasonable and appropriate participation by organizations with only passing contact with potentially problematic providers. ASA has concerns that recent increased attention to program integrity is also leading to increased reports of unfounded and inaccurate allegations being made by CMS and its contractors against Medicare providers. Program integrity allegations should not be held against aspiring or approved ACOs until the claims have been fully adjudicated.

While ASA appreciates CMS recognition that an ACO may need to discontinue participation prior to the end of the 3-year period and must provide 60 days notice of any intention to do so, we strongly believe that the ACO should not have to forfeit its share of any shared savings recognized for services provided during its participation period. If the goal is to encourage the formation and participation of ACOs, we view this forfeiture requirement as an additional obstacle to achieving that goal. ACOs will incur considerable financial costs in their formative years for which they will not receive compensation. This reality will likely deter those organizations from seriously considering the formation of an ACO. Thus, ASA recommends that CMS should allow withdrawal from the Shared Savings program without penalty and with sharing of savings under specified circumstances. One example would be to limit this option to those in a two-sided model and only in the first year of the agreement.

IV. **Distribution of Savings**

While CMS does not stipulate how an ACO is to distribute shared savings payments among its participants, CMS is requiring the ACO to describe how it will distribute payments in the application process. We believe that this may lead to recoupment of funds from individual participants who are enrolled in the Medicare program rather than from an ACO that may not be enrolled in Medicare. ASA asserts that recoupment from individual fee for service (FFS) payments that participants receive for care provided to ACO beneficiaries is not acceptable.

CMS is proposing a 6 month claims run-out period to evaluate whether an ACO is eligible for shared savings, and anticipates it will take even longer for CMS to calculate and process the shared savings. **We believe that the additional 1% accuracy rate for a 6 month claims run-out period as compared to a 3 month claims run out period is not worth the extra 3 months (or more) an ACO would have to wait to receive potential shared savings.** While participating ACOs will, by definition, be supportive of

the effort to reduce health care expenditures, the reality is that such a reduction means reduced revenue for the ACO in the form of Medicare and commercial insurance payments. After investing heavily in infrastructure and organizational changes, ACOs will apply their care processes across all patients, not just Medicare ACO beneficiaries. Reduced payments from fee-for-service activities (both public and private), the delay in calculating and distributing shared savings, and the withhold of earned shared savings are likely to cause cash flow challenges for the ACO and its participating practices and organizations as they continue to incur costs to introduce ACO related infrastructure and re-engineer care delivery. Delays in and withholds of payments should be kept to an absolute minimum to ensure the greatest opportunity for ACOs to succeed.

V. **Minimum Size of Organization**

ASA agrees that 5,000 beneficiaries will generally infer an adequate number of participating primary care providers. **While we acknowledge that CMS focused much of the ACO proposed rule on primary care, we recommend that CMS identify criteria to determine whether the ACO has an adequate number of specialists available to meet Medicare beneficiaries' needs for patient-centered, acute care treatment and management.** We believe that a focus on both primary and specialty care, including anesthesia, will ensure adequate ACO infrastructure to meet all of the health and medical care needs of Medicare beneficiaries.

VI. **Planning and Organization Development**

ASA appreciates the flexibility CMS has allowed in plans to promote evidence-based medicine, encourage beneficiary engagement, facilitate internal reporting of quality and cost metrics, and enhance coordination of care. As the program matures and the agency identifies successful organizations, CMS should share successful strategies with other ACOs so they can incorporate relevant approaches to help them meet the goals of shared savings consistent with program requirements. ASA also believes that a standardized and uniformly applied tool should be adopted to measure quality, beneficiary satisfaction, and other metrics if these criteria are to be consistently measured and applied to all ACOs.

While we recognize and appreciate the intent of CMS to protect Medicare beneficiaries, we do not believe that CMS should require advance approval of ACO marketing materials. We are concerned that CMS may not have sufficient resources to review materials in a timely fashion. Further, we believe that review of marketing materials is significantly far removed from the core mission of the Centers for Medicare and Medicaid Services: "To ensure up-to-date health care coverage and to promote quality care for beneficiaries." The various regulatory and quality reporting requirements imposed on ACOs will sufficiently address the CMS mission without requiring review of marketing materials.

ASA is also concerned about the beneficiary notification requirements. The proposed retrospective assignment of beneficiaries is problematic since ACOs may not be aware of and thus not be able to provide required notice to all relevant beneficiaries. We would appreciate clarification from CMS on how often a beneficiary should be notified (i.e., annually, at each visit, etc.). **We also encourage CMS to issue model notification forms that would work for a variety of ACOs, or to consider CMS directly notifying the beneficiaries to lessen the ACO's administrative burden.**

VII. Assuming and Managing Risk

ACOs seeking to participate in the Medicare Shared Savings program will incur significant financial costs and requirements in order to demonstrate compliance with the proposed regulations. While CMS estimates that ACOs will initially need to invest $1.7 million to develop the organization and infrastructure required, a study released by the American Hospital Association (AHA) on May 13, 2011, estimates that cost to be $11.6 to $26.1 million.[2] **In addition to these significant start-up costs, CMS proposes that ACOs withhold 25% of any shared savings to offset losses. Under the proposed rule, ACOs forfeit this withhold if they withdraw from the program or are terminated by CMS. This does not seem reflective of other CMS programs, especially the PGP Demonstration on which this proposed rule is largely based, and presents a burden for the ACO, particularly small practices that may not have ample capital and those ACOs in markets currently demonstrating relative high quality and low costs.** CMS also requires ACOs to assure repayment of shared losses, including establishing lines of credit, recoupment of losses from future fee-for-service payments, and obtaining reinsurance. These provisions must, at a minimum, be sufficient to account for 1 percent of per capita expenditures for the assigned beneficiaries. We are concerned about potential overlap between these requirements and state insurance requirements and would appreciate a statement of federal law primacy in this area confirming that ACOs will not be subject to state insurance requirements.

CMS has proposed two tracks for shared savings: the shared savings model (one-sided model) with no risk in years one and two of the agreement, and the shared savings/losses model (two-sided model) with risk assumed in the first year of the agreement. Both tracks do carry downside risk, in year 3 for the one-sided model and from inception for the two-sided model. **ASA fears that including downside risk in the one-sided model will diminish interest in the ACO program, particularly in markets lacking a history of effective clinical integration. ASA believes that CMS should propose another risk model that does not include any downside risk, and allow organizations to undertake downside risk at their own pace.** We also recommend that CMS consider including other models, such as partial capitation, in the ACO program with potential testing through the CMMI, as proposed on May 17, 2011.

In the proposed rule, ACOs will not recognize any shared savings until the minimum savings rate (MSR) reaches a specified threshold (e.g., 2%-3.9%). We believe that the proposed 2%-3.9% MSR is too high a threshold to entice organizations to form ACOs and recommend that CMS allow ACOs to share in first dollar savings without requiring an MSR. As a comparison, with the 2% MSR required in the CMS Physician Group Practice (PGP) Demonstration, only 6 out of the 10 participants achieved the minimum 2% threshold after three years, excluding start-up costs that averaged $1.7 million.

We believe the success rate of ACOs will be even less if the proposed MSR is retained. **If CMS determines that some MSR must be preserved in the program, we recommend that CMS establish a common 2% threshold for the ACO program, especially in the early years to encourage providers to participate in the program.**

[2] http://www.aha.org/aha/issues/Clinical-Integration/casestudies.html

In addition to the minimum threshold of savings an ACO must achieve to begin sharing in the savings, CMS is also proposing to cap the maximum shared savings an ACO may recognize at 7.5% for the one-sided risk model and 10% for the two-sided risk model. These caps, again, limit the opportunity for ACOs to achieve the maximum success possible and help the Administration achieve the goals of improved quality and reduced costs. An additional concern is that based on the proposed rule, ACOs will be eligible to share in only 0-65% of the savings depending on whether they meet quality metrics but will be responsible for 35-100% of the losses (after surpassing the proposed thresholds). The lower reward for a higher downside risk may lead some providers to decide not to participate in the Shared Savings program.

Finally, according to the proposed rule, one-sided ACOs will be limited to a 50% sharing rate and two-sided ACOs to a 60% sharing rate. If the ACO includes a FQHC and RHC, the sharing rates are increased to 52.5% and 65% for one-sided and two-sided models, respectively. While we applaud the concept of increased sharing rates for ACOs that include a FQHC and RHC, we also note that practices in the PGP Demonstration had a sharing rate of 80%. The lower sharing rates in the proposed rule may lessen the attractiveness of the ACO program to providers who also have to consider the investment costs. **We propose that CMS change the sharing rate to 80%, especially in the beginning of the program to encourage formation of ACOs, as this sharing rate proved reasonably successful in the PGP demonstration program.**

VIII. Benchmark Determination and Adjustments

CMS is proposing to base savings benchmarks, used to calculate the shared savings an ACO can recognize, on local historic performance. ASA believes that this methodology provides a substantial advantage for poorer performing organizations in high cost areas. This may discourage high performers, who often practice in historically less costly areas, from participating in the ACO program as they would be forced to compete against their own effective performance. Thus, national benchmarking may be more appropriate instead of historical benchmarking for Medicare regions with a history of efficient care delivery. Alternatively, we would recommend CMS identify a different payment structure for those ACOs formed in regions already achieving high quality care and low costs. **ASA contends that sustaining performance marked by high quality and low costs is just as important as demonstrating measurable improvement in areas with historically poor performance, just as CMS demonstrated in the recently published IPPS rule.**

In addition, under the proposed rule, ACOs are provided an economic incentive to discourage beneficiaries from receiving care in teaching hospitals even when that may be the optimal setting for the patient. This is because these hospitals receive direct graduate medical education (DGME),[3] indirect medical education (IME), and disproportionate share hospital (DSH) payments which means that a Medicare admission to a teaching hospital will incur higher Medicare payments than an admission to a nonteaching hospital. Including these policy payments in ACO benchmarks and performance expenditures could induce ACOs to recommend that patients receive care in hospitals less equipped to care for them rather than in teaching hospitals. This result also would negatively impact Medicare beneficiaries by decreasing support for societal goods including the training of health professionals, discovery of advanced treatments, and ensuring the presence of the highest level of clinical care in a community.

[3] While DGME payments are not addressed in the proposed rule, because these payments are made under both Parts A and B we will treat them like IME and DSH payments for purposes of this comment.

For these reasons, we urge CMS to remove DGME, IME, and DSH payments from the final rule ACO benchmark and performance calculations, as well as from subsequent determinations of shared savings. Such action, statutorily permitted by the Affordable Care Act, will create an equal playing field and ensure that beneficiaries have access to teaching hospitals and the critical services they provide.

IX. Quality Measures

CMS proposes that ACOs report 65 quality measures as part of the Shared Savings program. Failure to report even one of the measures prohibits the ACOs from recognizing any shared savings in one of the five defined domains, even if the ACO created savings for the system. ASA is concerned that the quality measure requirement is too burdensome for organizations new to practicing as an ACO. **ASA recommends that CMS reduce the overall number of quality measures for the first year of participation and tier the measures over the 3-year agreement period. Further, we recommend that CMS adopt a menu approach for quality measures reported by ACOs to afford flexibility to the ACO to determine which measures are most relevant to their practice, patients and Medicare beneficiaries. Incorporating a one-size-fits-all approach could stifle innovation and unnecessarily increase compliance and health system costs.**

While we encourage CMS to reduce the overall quality measurement reporting burden, ASA also recommends that CMS add measures to the menu that are relevant to the perioperative setting, including anesthesia-specific measures, to recognize care excellence or improvement in this setting. We proudly assert that anesthesiologists provide high quality care based on our specialty's performance in PQRS. In the setting of an ACO, we want to demonstrate our contributions to CMS and Medicare beneficiaries, thus allowing a mechanism for recognizing our contributions to the ACOs success. Some suggestions for anesthesia-specific measures include Measures 30 (timely administration of prophylactic antibiotics) and 193 (perioperative temperature management) from the CMS Physician Quality Reporting System (PQRS).

With respect to patient experience, we encourage the collection of appropriate survey data, such as the Agency for Healthcare Research and Quality (AHRQ) approved Consumer Assessment of Healthcare Providers and Systems (CAHPS). We would also recommend that CMS incorporate or encourage the use of the equivalent instrument for the surgical setting, i.e., the Surgical CAHPS[4].

Quality improvement efforts depend on solid and reliable data. An organization requires accurate data to identify root causes for quality problems, to focus resources and to eliminate or explain outliers that do not necessitate a system modification. **Due to the importance of data in quality improvement efforts, ASA recommends that CMS provide near real-time claims data to ACOs to allow them to track quality by ACO beneficiary in real time.** Further, practices that are interested in becoming ACOs should be provided with sample data to allow them to examine the format of the data set and to determine whether and how they will be able to meet the requirements based on their data infrastructure.

[4] https://www.cahps.ahrq.gov/content/products/sc/PROD_SC_Surgical_Care.asp

These recommendations will assist ACOs in their efforts to succeed and are consistent with the Administration's transparency initiatives.

While we believe that CMS' efforts to align the meaningful use electronic health record (EHR) program with the ACO program are laudable, the proposal to require 50% of the ACO primary care physicians to be meaningful EHR users by the end of year one of the agreement may be too burdensome. This requirement will potentially discourage small and mid-size provider practices with limited resources to become part of an ACO, having the downstream effect that willing specialists, including anesthesiologists, will not be able to participate in ACO driven quality and efficiency improvements for Medicare beneficiaries.

The reduction in administrative burden allowed by incorporating the Physician Quality Reporting System (PQRS) into ACO quality reporting seems advantageous; however, it is unclear how, or if PQRS incentives will be allotted to eligible professionals working in ACOs for whom one or more of the 65 listed quality measures are not applicable to their practice. Further, the methodology for monitoring and evaluating quality measures that may track rare events (i.e., inpatient safety events) is not clearly defined in the proposed rule, specifically at the individual practitioner level. **ASA requests further information on changes to the PQRS program that will be implicit in ACO quality reporting plans, and for clarification as to how these changes will impact the participation of non-primary care professionals.**

X. **Beneficiary Assignment Issues**

ASA believes that retrospective attribution of beneficiaries will be a disadvantage to ACOs as they will be unaware of which patients they are caring for, and consequently, what strategies they could be using for patient-centered care improvement. This strategy makes it particularly difficult for the ACO to actively engage patients in their care delivery choices. In addition, since attribution is based on a plurality of primary care services, it will lead to many ACO patients being only loosely aligned to the ACO. For example, a patient may have relatively limited contact with an ACO primary care physician and yet be considered as an ACO patient for whom the ACO is accountable. Conversely, an ACO specialist may provide numerous services to a patient, particularly if the patient has a complex medical history, and the patient's care would not be attributed to the ACO. As an example, consider the diabetic patient with poor glucose control and renal insufficiency. The plurality of this patient's visits may be with an endocrinologist or nephrologist. While this patient may benefit most from an effective ACO and Medicare may benefit from the savings attendant to coordinated care, the attribution methodology may prevent these beneficial effects from being attributed to the ACO. This has the potential to skew the quality and cost metrics of an ACO. **One suggestion is to modify the methodology for beneficiary assignment from plurality of allowed charges to number of encounters by a provider. If one of the goals of the Shared Savings Program is to achieve a healthier population, the greater the number of encounters, regardless of the allowed charges or the physician's specialty, provides increased opportunities to educate and impact the patient and influence his/her behavior.**

Another issue with retrospective assignment is that the proposed statistical attribution does not take into account care provided to those beneficiaries that are not attributed to the ACO. Organizations participating in this program will inevitably care for Medicare as well as non-Medicare patients, but will not receive any benefit for improving the care of non-Medicare patients and non-attributed Medicare

patients. We believe that this inequity should be addressed through modifications to the ACO proposed rule, CMMI demonstration programs and models such as the surgical home discussed in Section I of this letter.

Further, the proposed rule does not hold patients accountable for their role in improving their own health. This is contrary to the healthy population goal of the Triple Aim. Without active patient support and participation, the ability of physicians to help patients improve their health, avoid unnecessary hospitalizations, and reduce the use of unnecessary and duplicative services is inherently limited. If a Medicare beneficiary is unwilling or unable to participate in efforts to better coordinate and manage their care, then an ACO should not be held accountable for the overall costs of services associated with a beneficiary simply because a physician in that ACO provided the beneficiary with a needed primary care service (and as a result had the beneficiary "attributed" to the ACO). Conversely, if a beneficiary and a physician mutually agree to work together to provide optimal care for the beneficiary's most critical needs, the ACO with which the physician is associated should not have any savings resulting from that care attributed to providers in other ACOs based on an arbitrary statistical rule.

We support the CMS proposal to share quality, clinical and population health claims data for potentially assigned beneficiaries. As previously stated, data is the foundation for improving the quality of care in any setting. Under the proposed rule, however, Medicare beneficiaries have the option of opting out of such data sharing. Further, ACOs are required to notify beneficiaries of that option. While we recognize and believe that patient health care data must be rigorously protected and secured, we believe this beneficiary opt-out would result in incomplete data sets and skewed results and will further create barriers to coordinated care. One simple example of the negative consequences of this proposed requirement is that an ACO may order duplicative tests previously performed on a Medicare beneficiary because the ACO was not provided access to the beneficiary's clinical data. Further, prohibiting the sharing of alcohol and substance abuse data to health care providers within the ACO without patient consent, while affording patient privacy, completely ignores the impact on population health of such conditions and restricts the ability of an ACO to successfully assist the beneficiary in managing the challenging health conditions associated with drug and alcohol abuse. These requirements will potentially increase costs to the system, result in inappropriate blemishes on the ACO's quality metrics, and further challenge ACOs in their efforts to successfully participate in the Shared Savings program. **We believe the ability of Medicare beneficiaries to seek care outside of an ACO coupled with the ACO notification requirements provide sufficient patient protections; however, if a beneficiary agrees to seek care and treatment in an ACO, part of that agreement should include sharing of necessary health care data with relevant and appropriate providers within that ACO. All of the stakeholders in the Medicare system must participate and be accountable to achieve the goals of health system reform.**

In accordance with the surgical home model discussed in Section I, ASA firmly believes that the shared saving program should recognize all physicians who provide care coordination and achieve process changes leading to efficiency and quality improvements. This includes anesthesiologists who do this by providing perioperative management of care, including pre-operative assessment or post-procedure management, such as pain or ICU care. In addition, anesthesiologists should receive recognition for helping patients use tools such as Cost Utility Analysis (CUA), Health Related Quality of Life (HRQoL) or Quality Adjusted Life Years (QALY) in making decisions to proceed to surgery. ASA believes that anesthesiologists, including those in rural areas, are in a unique position to apply these tools to help patients determine if they are best served by proceeding to a surgical intervention. Therefore, ASA urges

CMS to provide a mechanism to attribute credit to anesthesiologists for whom they provide essential perioperative care management.

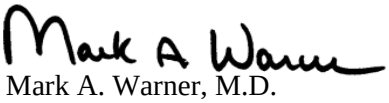
CONCLUSION

ASA believes that ACOs have the potential to reduce health care costs and improve quality if they are administered in a way that is not overly prescriptive. We believe the recommendations provided in this letter will help achieve such a vision. We know that we are not alone in our concerns about the proposed ACO structure, as we support many of the observations in the recent comment letter from the American Medical Group Association (AMGA), an organization that represents some very highly integrated health care systems with a proven track record in coordinated care delivery, such as the Mayo Clinic, the Cleveland Clinic, Intermountain Healthcare, and the Geisinger Health System. In its letter, AGMA cited a survey of members that found that 93% would not enroll as an ACO as the rule is currently written.[5]

This survey finding does not surprise us; it is yet another reason we hope that CMS seriously considers our recommendations in making the many necessary changes to the ACO proposed rule suggested in this comment letter.

Anesthesiologists wish to continue our legacy of delivering high quality, patient-centered care and fervently want CMS to make the necessary changes to assure that the Medicare ACO program will both encourage and recognize our specialty's contributions to achieving this goal. Please feel free to contact Jason Byrd, J.D., Director of Practice Management, Quality and Regulatory Affairs at J.Byrd@asawash.org or Loveleen Singh, M.P.H., Health Policy Analyst at L.Singh@asawash.org or via phone (202-289-2222) with any questions or issues.

Sincerely,



Mark A. Warner, M.D.
President
American Society of Anesthesiologists

[5] http://www.amga.org/Advocacy/MGAC/Letters/05112011.pdf