June 1, 2011

The Honorable Donald M. Berwick, M.D.
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: CMS-1345-P Medicare Shared Savings Program: Accountable Care Organizations

Dear Dr. Berwick:

As the nation’s principal voice for medical group practices with 22,500 members who lead 13,600 organizations in which some 280,000 physicians provide more than 40 percent of the nation’s healthcare services, the Medical Group Management Association (MGMA) is pleased to submit these comments in response to the April 7, 2011 notice of proposed rulemaking (Notice) establishing the Medicare shared savings program for accountable care organizations (ACOs).

BACKGROUND

Medical group practices are potential participants in ACOs in multiple ways. A large multi-specialty group that is part of an even larger integrated health system might be the core of an ACO, as was the case with many of the physician group practice (“PGP”) demonstration projects. A single-specialty, primary care practice might be an essential element or part owner of an ACO developed in cooperation with hospitals and other groups. Single-specialty groups in other specialties (not primary care) might be integral parts of an ACO, as either full participants or indispensable contractors, or alternatively might simply furnish some of the specialty care for which the ACO is accountable without having a formal relationship to the ACO. Some groups might be aligned
principally with only one ACO, while others might be community providers serving patients assigned to more than one ACO. Whatever the precise role of medical group practices in a particular ACO, it is difficult if not impossible to imagine a successful ACO without significant participation from medical groups.

The medical group practice model of delivering physician services is in many respects the forerunner of the ACO concept. By joining one another and professional practice management, physicians are better able to coordinate and manage patient care, often across specialties. As the group model evolved, groups added ancillary services and non-physician practitioners to seamlessly coordinate a much broader spectrum of services than just physician care. Some combined with hospitals and other institutional providers to form integrated delivery systems, with the scale and administrative and technological infrastructure necessary to care for large groups of patients in a geographic service area. Without this evolution in group practice, an ACO, as we think of it today, would be virtually impossible. That groups were at the heart of most of the PGP demonstrations speaks to this fact.

GENERAL COMMENTS
If the large majority of medical groups were to conclude that the shared savings models proposed by CMS in the Notice are unworkable, then there will not be a sufficient number of ACOs to accomplish the program’s stated goals. Those that do form may be so “hospital-centric” that the playing field will almost exclusively include those relatively mature integrated systems with large numbers of employed physicians at the expense of more loosely affiliated collaborations between hospitals and medical groups. Even if the agency favored a bias towards large, highly-integrated systems, there are simply not enough of those systems to ensure widespread geographic penetration of the ACO concept. Further, many of these systems may prefer other models where they are more fully at risk for utilization.

Based on feedback received from our members, including those who participated in the PGP demonstrations, as well as similar private sector contractual arrangements, MGMA believes the ACO shared savings model may not be viable as a national
strategy unless significant program policies are modified when final rules are promulgated.

The perceived defects in the Notice are many, and can best be summarized as follows:

- The complexity of the program has already established a bias against participation
- The cost of both ACO development and ongoing operation will be too high relative to the potential financial benefits
- The financial benefits are not only too small, but they are also too uncertain
- The regulatory risks under related joint notices from CMS and the Office of Inspector General (OIG), and the Federal Trade Commission (FTC) and the Department of Justice (DOJ) are substantial or at least so uncertain as to add another disincentive to participation.

MGMA believes that many of the defects which create these interrelated obstacles can be addressed by relatively straightforward changes in program design. Below, we submit our detailed recommendations with respect to the principle design features proposed in the Notice. At the same time we feel compelled to note that part of the problem with the program may be more fundamental. ACOs are a hybrid business model between the traditional fee for service model at one end of the payment and delivery spectrum, and capitation or similar “all risk” models at the other. The organizations purport to offer many of the advantages of the latter from the government’s perspective as a payer, but preserve much of the patient and provider freedom of choice that has traditionally characterized the former. It remains to be seen if it is possible for Medicare (and each of its stakeholders) to “have its cake and eat it too” regarding ACOs.

MGMA also submitted recommendations with respect to the CMS/OIG notice of April 7th and the FTC/DOJ notice of April 19th. We urge reviewers to consider our comments on all three notices in concert, since it is the totality of the policies
proposed that need to be addressed. The type and scope changes MGMA recommends would inevitably make the program more attractive to medical groups, and increase the number and geographic dispersion of ACOs likely to be formed.

COMMENTS ON SPECIFIC PROGRAM DESIGN ELEMENTS

Patient Assignment
MGMA believes that retrospective assignment of patients to contracted ACOs is a major design flaw, and recommends patient assignment on a prospective basis prior to finalization of the contract. At the most basic level, it is very difficult to coordinate and manage care for a patient population which you can identify only in hindsight. It is equally difficult to assess the financial risk/reward equation for an unknown group of patients. Even with prospective patient assignment, accountability may not always be possible, and MGMA recommends the following ancillary assignment policies:

- CMS should give serious consideration to fixing the assigned population upfront for the full three year period. Population-based care management is more difficult if the population being managed is constantly evolving. Long-term savings to the government are likely to be more substantial in a program that emphasizes long-term results for the same patients as opposed to short term results for different patients.

- ACOs should have the option of excluding patients from upfront assignment who, based on the most recent historical claims data, are expected to get a significant percentage of their health care from outside the geographic service area of the ACO (the “snowbird” factor).

- ACOs should have the option of excluding from assignment those patients expected, based on the most recent historical claims data, to get a very high percentage of their care from non-primary care physicians (the “specialty-managed patient” factor). Where chronic disease patients look to their specialist(s) as their “routine” care provider, opportunities for savings in a primary care model are limited unless the specialists are also active participants in the ACO.
• Patients permanently relocating away from the ACO’s service area early in the contract period, e.g. before the six-month mark each year, should be automatically excluded (the “former patient” factor).

• Beneficiaries should not have the ability to “opt-out” of data sharing as it will make it difficult if not impossible to coordinate care.

Minimum Savings Rate
The proposed scaling of the minimum savings rate is a good example, MGMA believes, of counter-productive complexity. Patient assignment rates are likely to be smaller, particularly in the early years of the program, for newly emerging ACOs than for larger, established systems. Yet visible potential savings in the early years is the most important inducement for the smaller systems to participate. MGMA recommends that the minimum sharing rate be set at 2 percent for all participants, which proved to be difficult enough in the PGP demonstrations, and that if there is to be a two-track system, that it be the same for both tracks.

Benchmarks
The ACA states that the shared savings benchmark “shall be adjusted for beneficiary characteristics and such other factors as the Secretary determines appropriate....” As CMS observes, several factors in the Medicare fee-for-service payment systems – including the indirect medical education (IME) adjustment and the disproportionate share hospital (DSH) adjustment – could provide ACOs with an incentive to avoid referring patients to hospitals that receive IME and DSH patients due to the increased Medicare cost associated with these adjustments. However, CMS proposed not to remove IME and DSH payments from the per-capita costs included in the benchmark for an ACO. MGMA believes that IME, direct graduate medical education (DGME) payments and DSH payments should be excluded from the benchmark. Inclusion of these payments in the benchmark is likely to distort shared savings. The benchmark must be adequately risk-adjusted to reflect the costs of treating more complex and economically disadvantaged patients such as those treated at academic centers.
**Shared Savings Percentage**

The sharing of savings in the PGP demonstrations was 80 percent to the ACO and 20 percent to Medicare as payer. MGMA believes it should be similar in the new program, at least for the first three-year contract cycle. The development and initial operating costs for ACOs will be substantial. Some estimates put them at large multiples of the official CMS estimates. To take on these financial burdens, potential participants need a much clearer and more compelling financial “upside.” For the same reason, savings should be shared on a gross basis, and not, as proposed, only on those savings net of the minimum shared savings rate. All sharing policies should be the same for both tracks.

**Incentives for FQHC and RHC Inclusion**

While MGMA applauds the policy goal of including these provider categories, the patient populations served by them may differ substantially from those seen by community physician practices in the same service area. Unless the Federally Qualified Health Center (FQHC) or Rural Health Center (RHC) provides the primary case base for the whole, or most of the whole, ACO, we think the incentives need to be larger than those proposed. We recommend a 10 percent increase in the sharing rate on both tracks.

**Loss Sharing and the Two Tracks**

Loss sharing was not a feature of the PGP demonstrations, and MGMA questions both the policy rationale and legal authority for including this feature in a more permanent ACO program. We think that Congress intended only a shared savings program, and urge CMS, at a minimum, to eliminate the third year loss sharing requirement from the “one-sided” model. An alternative would be to provide for contract termination by the government at the end of the second year, if the ACO is not performing in a way that either generates, or makes a good faith effort to generate, savings for both the payer and the ACO.

We think CMS would be well advised to seriously consider elimination of the “two-sided” model entirely. If current Medicare Advantage offerings do not provide
enough risk-based payment options, CMS could use its long-standing
demonstration authorities to explore one or more “two-sided” models without
imbedding this additional complexity, and we believe disincentive to participate, in
the permanent ACO program.

Quality Measures and Impact on Shared Savings
MGMA supports reasonable quality measures but believes the proposed approach is
unduly burdensome in several respects. Given that virtually all medical groups are
already actively involved in other quality enhancement activities, either self-
generated or imposed by private and public payers, it is simply not necessary to
overlay another complicated reporting and performance system as an adjunct of the
shared savings program. While CMS needs certain basic assurances that shared
savings will not be produced by diminished quality of care, MGMA believes this can
be accomplished:

- With significantly fewer measures than the 65 proposed for year one
- With stability in the quality metrics used for ACO purposes through a full
  three-year contract term, rather than the prospect of new or changed
  requirements year-by-year
- Without holding medical groups responsible for hospital quality measures if
  the ACO is designed without formal hospital participation
- Without making any aspect of the quality metrics an “all or nothing”
criterion for sharing in savings achieved

Quality measures do not come without cost, both clinical and administrative. With
this in mind, it is vital that quality measures are aligned across measure domains
and across programs (ACO, EHR, and PQRS). Reducing shared savings based on
quality metrics is more of a stick than a carrot, and serves to increase the
uncertainty associated with ACO participation. Both factors argue for restraint in
this aspect of the program’s design. Contract termination provisions based on
minimally acceptable quality thresholds, where they can be fairly identified and
accurately measured, should be sufficient to protect beneficiaries. Indeed, for “failed
ACOs,” earlier termination is more protective of beneficiaries than a system that perpetuates the contract while reserving to the government a higher share of whatever savings are achieved, possibly, at least in part, by lowering quality of care.

Electronic Health Records
As is the case with quality metrics, the Notice tries to use the new ACO program as a means to serve other program ends, this time in the technology arena. Medical groups already face a number of incentives or penalties associated with decisions to deploy or not to deploy health care information technology. MGMA has urged the government in multiple forums to be realistic about the pace of EHR deployment, given the significant upfront and ongoing costs of those systems, and the very real risks of “false starts” with technology that may not be sustainable because of rapid product innovation and market dynamics.

While aggressive use of health information technology will likely be an ingredient of success for most ACOs, arbitrary benchmarks are not the answer. To tie ACO program eligibility to any particular threshold percentage or timeframe for primary care physicians becoming “meaningful users” of EHR is more likely to deter ACO participation than speed EHR adoption. MGMA urges strongly CMS to simply eliminate this aspect of the proposal.

On behalf of the medical group practice professionals we represent, and the physician group practices they serve, MGMA is pleased to submit these comments for your consideration. Should you have any questions regarding these comments, please contact Miranda Franco, MGMA Government Affairs Associate, at 202.293.3450 or mfranco@mgma.org.

Sincerely,

William F. Jessee, MD, FACMPE
President and Chief Executive Officer