

**President**

Jeff Wiese, MD, SFHM  
New Orleans, LA

**President-Elect**

Joseph Ming Wah Li, MD, SFHM  
Boston, MA

**Treasurer**

Shaun D. Frost, MD, SFHM  
Saint Paul, MN

**Secretary**

Burke T. Kealey, MD, SFHM  
Minneapolis, MN

**Immediate Past President**

Scott Flanders, MD, SFHM  
Ann Arbor, MI

**Board of Directors**

Daniel D. Dressler, MD, MSc, SFHM  
Atlanta, GA

Lakshmi K. Halasyamani, MD, SFHM  
Ann Arbor, MI

Eric Howell, MD, SFHM  
Baltimore, MD

Sylvia McKean, MD, SFHM  
Boston, MA

Janet Nagamine, RN, MD, SFHM  
Aptos, CA

Jack M. Percelay, MD, MPH, SFHM  
New York, NY

Eric M. Siegal, MD, SFHM  
Madison, WI

**Editors**

**Journal of Hospital Medicine**

Mark V. Williams, MD, FHM  
Chicago, IL

**The Hospitalist**

Jeffrey J. Glasheen, MD, SFHM  
Denver, CO

**Chief Executive Officer**

Laurence D. Wellikson, MD, SFHM  
Dana Point, CA

December 3, 2010

Donald Berwick, M.D.  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1345-NC  
P.O. Box 8013  
Baltimore, MD 21244-8013

**RE: CMS-1345-NC, Medicare Program; Request for Information  
Regarding Accountable  
Care Organizations and the Medicare Shared Saving Program;  
Request for Information, November 17, 2010 (Volume 75, Number  
221)**

Dear Dr. Berwick:

The Society of Hospital Medicine (SHM), representing over 10,000 hospitalists nationwide, appreciates the opportunity to provide information on the development of Accountable Care Organizations (ACOs) and the Medicare Shared Savings Program. SHM supports CMS's efforts to develop these programs in a transparent manner and respects the significant effort that has been put into gathering stakeholder input. I particularly appreciated the opportunity to attend the November 15 briefing on delivery system reform, hear your vision for ACOs, and participate in the discussion and dialogue that followed.

Your effort will hopefully be rewarded with widespread success as providers begin to implement ACOs, but it will be important for CMS to maintain a position of flexibility and remain willing to revise requirements when the need arises. An ability to build upon lessons learned as the ACO environment begins to unfold will be critical to long term success. SHM fully supports CMS' view that "one size will not fit all" when it comes to ACOs, making it essential to extend this flexibility from the national level down to the local level. Hospitalists will bring significant value to the success of the ACO model due to the central role that many hospitalists play in promoting team-based care, care coordination, and improving transitions of care. SHM's response to the agency's request for information is as follows:

## **Policies or Standards to Ensure Participation of Groups of Solo and Small Practice Providers**

Many solo and small practices are not prepared to implement the level of integration often envisioned in the ideal ACO model. While these providers desire to join or form various ACO models, they fear their level of preparedness may prevent them from taking such action. It is for this reason that it will be important for CMS to recognize that “one size does not fit all” and set different standards according to the specific situation of the ACO in question. Such standards should be made in relation to the level of preparation at the beginning of ACO formation, which would form the baseline for an individual ACO’s growth. For example, a group of small or solo practices wishing to form an ACO should not be held to the same HIT requirements as an existing large integrated delivery system. Small and solo practices may be provided a reasonable timeline that would define their different stages of development thereby enabling an ever increasing, yet achievable, level of integration and coordination.

Another concern for small practices is their ability to participate within an ACO while maintaining independence. They are concerned about ever increasing pressure to become employed by larger health care systems and challenged to maintain viability under these pressures. Although it will be important to allow for flexibility when enforcing antitrust and anti-kickback laws, great care must be taken to avoid situations where ACOs are set up to exclude smaller groups. Without monitoring, an ACO could pressure small and independent practices into merging with an already dominant medical system. If this phenomenon becomes widespread it would not only reduce competition, but also restrict both physician and patient choice. Future ACO models must allow an even playing field for participation. A provider’s willingness to work in concert with other providers to improve patient care needs to be the key qualifier for ACO and Shared Savings participation. SHM recommends that CMS work closely with the FTC and DOJ to ensure that control over employment models and increasing market share do not become the driving forces behind ACO formation.

### **Access to Capital**

Access to capital will be the largest hurdle that most small practices face when attempting to implement an ACO model. The necessary HIT infrastructure alone will prove to be cost prohibitive for some practices. To assist with funding, ACO HIT requirements should be tied to the EHR Meaningful Use program. ACO participants could be provided with a subsidy above and beyond what will be provided through achieving meaningful use. In the case of shared systems, ACO participants who would not normally be considered Eligible Providers could be granted eligibility provided they use the incentive payments to enhance their ACO’s HIT capabilities. Another option would be to provide ACO grants to small practices wishing to form ACOs.

CMS should remain flexible regardless of the financial ability of an ACO to finance and implement costly systems such as HIT. The focus of an ACO should be on improving

health and providing better care at a lower cost. CMS should focus on these goals as well. If an ACO finds ways to achieve these goals without costly system upgrades, it should be granted the ability to carry on without regulatory constraints or interference.

### **Attribution of Beneficiaries**

It may be necessary to attribute beneficiaries before the start of a performance period in the early stages of the Medicare Shared Savings Program and ACO models, but SHM believes attribution occurring at the end of the performance period should be the eventual goal. The ACO model should not remain exclusively focused on Medicare beneficiaries but should strive to achieve system wide changes that benefit the overall population. Early attribution may encourage providers to focus only on attributed beneficiaries and slow the implementation of wider scale changes.

Early in the program, it will be useful to have attribution at the start of the performance period so that ACOs are aware of who their beneficiaries are for the purpose of testing coordination strategies. This awareness will allow an ACO to refine strategies within a smaller, target beneficiary population and will save the cost of immediate system wide changes that post performance period attribution will require. Once an ACO determines that its strategies work within the beneficiary population, it can then expand to the overall population and better facilitate post performance period attribution. At this point, attribution at the end of the performance period will be most appropriate to ensure that an ACO is held accountable for care provided. This hybrid approach for balancing two points of view on attribution can be phased in over the course of several years. For example, at the beginning of the program in 2012, 100% of beneficiaries may be attributed at the beginning of the performance period. This percentage can be scaled back 25% for each subsequent performance period until 100 percent of beneficiaries are attributed at the end of the performance period ( e.g. in the second performance period 75% would be attributed at the beginning and 25% at the end). Instituting this mechanism not only balances the differing points of view regarding attribution, but also allows CMS the opportunity to measure for discrepancies between the two methods since they will be used concurrently during parts of the phase in period.

### **Assessment of Experience of Care and Patient Centeredness**

SHM believes that assessment of experience of care and patient centeredness can be done through the use of nationally accepted surveys such as the Patient Satisfaction Survey. A second option would be to use the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys that have been developed by AHRQ. CAHPS is a well known and respected survey instrument for measuring satisfaction. Access to subspecialists and interaction with subspecialists should also be considered when assessing an ACO for patient centeredness. These assessment criteria will be important to prevent beneficiary suspicions that they are limited in their care options and help to ensure continued access to specialties. To encourage the collection and reporting of this data, CMS could financially reward providers who establish HIT infrastructures that support collecting patient satisfaction data. Such a program would

not only encourage patient satisfaction assessment, but would also help finance further development of HIT capabilities.

### **Quality Measures**

SHM believes the Secretary should use National Quality Forum (NQF) endorsed measures in determining quality performance standards for the Shared Savings Program and ACOs. NQF measures are derived from both healthcare experts and patients and would provide a uniform set of standards and measures that are widely accepted by the medical community. The NQF has also endorsed SHM developed care transitions measures, which will be important to include since one of the stated purposes of an ACO is to improve care coordination. Regardless of whether CMS chooses to use NQF endorsed measures, another set of quality measures or a combination of measures, readmissions data is a significant quality indicator, and should be included with any measure sets that are selected.

### **System Performance and Attribution**

As opposed to many physician groups that raise major concerns about physician attribution and being measured as “part of the system”, hospitalists are organized into groups whose focus is typically overall system and hospital performance. Therefore, hospitalists have the potential to be central to high performing ACO’s involving hospital systems. Hospitalists are essential to both coordinating care for hospitalized patients within the hospital and as these patients transition out of the hospital. We encourage CMS to recognize the likely importance of hospitalists in successful ACO’s.

### **Additional Payment Models**

SHM strongly supports the notion that successful payment models will vary depending on the individual characteristics of each ACO. For this reason CMS should remain flexible in allowing additional payment models, which are based on the needs of the ACO in question.

SHM appreciates the opportunity to participate in this Request for Information Regarding Accountable Care Organizations and the Medicare Shared Saving Program. If we may be of further assistance or provide any additional information, please contact Joshua Boswell, Health Policy Analyst, at JBoswell@hospitalmedicine.org or 267-702-2632.

Sincerely,



Jeffrey Wiese, MD, SFHM  
President