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Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Baltimore, MD 21244-8013

Dear Dr. Berwick:

The American Thoracic Society (ATS), an international education and scientific multi-disciplinary society of 15,000 members focused on respiratory, critical care and sleep medicine, appreciates the opportunity to comment on the creation of Accountable Care Organizations (ACO)'s through the Medicare Shared Savings Program (SSP).

The ATS has played an active role in working with CMS to implement evidence-based measures to improve quality in the field of respiratory, critical care, and sleep medicine. ACO's have the potential to be an important mechanism for the delivery of quality, coordinated care for patients and reduced system costs. We are hopeful that ACO's will ensure better management of chronic diseases such as COPD and lung cancer. Because a new Medicare payment and delivery model is being proposed, the ATS recommends that CMS issue an interim final rule, rather than a final rule, to allow the agency to adapt and improve the ACO regulations as both the agency and healthcare organizations learn more about this new model.

Risk Structure

Both of the payment models proposed require ACOs to pay a penalty to Medicare if costs for patients increase beyond the levels projected by CMS. The ATS is concerned that the shared savings approach will make it difficult to recoup the substantial up-front investments that physician practice must make in information systems and other infrastructure costs, which have been estimated at up to $11 million by the American Hospital Association. There is also the risk that an ACO will not achieve necessary savings, particularly in the first few transition years. We urge CMS to work with physician organizations to minimize the down-side risk of ACO's. The ATS recommends that CMS consider including a payment option that includes shared savings only ("onesided risk") without the mandatory shared loss provision. We believe an option allowing ACOs to receive shared savings, without the down-side risk, will encourage wider participation by physician practices.

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Lack of Risk Adjustment During the Performance Period
The ATS is concerned that the proposed regulations do not include any flexibility in the expenditure benchmark during the performance years of the agreement based on the health status of ACO patients. This could be a problem for smaller ACOs, especially. If patient's become sicker during the performance period, they will inherently incur greater costs, even if the ACO is working to keep costs lower. This is especially relevant to patients with expensive chronic respiratory diseases such as COPD. Additionally, if an ACO demonstrates that it can provide better care coordination for patients with multiple health conditions, they may attract a disproportionate share of such Medicare beneficiaries. Overall, even if an ACO reduces costs, the substantially higher costs of these patients may make the ACO's total expenditures end up being higher, resulting in lost savings and potential losses for the ACO. The ATS recommends that CMS adjust benchmark calculations to account for these higher cost patients.

Payment Flexibility
In order to begin to change the underlying fee-for-service structure to support better, more efficient care for patients, CMS should permit reimbursement for some non face-to-face services, such as telephone consultations. Such consultations have the potential for reducing costs while providing quality patient care and improving patient satisfaction. Although CPT codes for telephone consultations and other non-face-to-face services exist, these codes are not currently authorized for payment by Medicare. The ATS recommends that CMS authorize payment for telemedicine codes for ACO's. This change may assist small physician-only ACOs since they will be the least likely to have access to capital reserves to cover short-term losses incurred by shifting care from currently billable to currently unbillable procedure codes. Data collected on utilization of these services could be used to evaluate if these reimbursement policies should be expanded to fee-for-service Medicare.

Quality Measurement & Reporting
Linking payment to patient outcomes is an opportunity to align payor and provider incentives and improve the structure, process, and outcome of health care for patients, if implemented appropriately. However, the ATS believes that ongoing research will be necessary to measure the effectiveness of ACO's and other programs on patient care quality and the organizational, structural, and patient-cultural factors that may influence program success. In order to avoid adversely impacting quality of care, CMS should ensure that the SSP rewards multiple measurable domains of quality (including structure, process, and outcome), and rewards both relative quality improvement as well as absolute performance.

In order for ACO's to ensure the highest quality patient care and appropriately compensate providers, CMS must continue to work with health professionals societies to develop valid, reliable quality measures for quality programs. Additionally, ongoing evaluation of program effectiveness to ensure the success of pay for performance initiatives and avoid unintended negative consequences will be necessary.

COPD Quality Measure
The ATS is pleased that the SSP proposes to utilize the Prevention Quality Indicator #5 on screening and early detection of COPD, developed by the AHRQ. Selected indicators identify smoking as a major root cause of COPD and focus on the application of targeted

evaluation, intervention, and management criteria in clinical practice that will improve health. Utilization of this measure will ensure early identification of COPD that will reduce costs enable appropriate care coordination and ultimately improve outcomes for patients with COPD. We encourage CMS to implement this quality measure throughout other quality programs.

Appropriate Quality Measurement of Hospital-Acquired Conditions

The ATS shares a common goal with the Secretary to reduce the incidence of hospital-acquired conditions (HACs). We are currently involved in an ongoing dialogue with the Department in developing research questions and defining key HACs, including ventilator-acquired pneumonia. While some HACs are preventable, there are some acute and complex syndromes within pulmonary and critical care, such as ventilator-associated pneumonia, that can be reduced but not eliminated entirely. Programs that expect elimination of such events may provide incentives for providers to avoid caring for high-risk, vulnerable patients. CMS will give ACOs that fail to meet minimum attainment level for one or more quality domains a warning, but continued underperformance can lead to termination of ACO agreement. The ATS is concerned that the number and scope of the measures will be difficult for many physician groups to report and be measured on. The ATS seeks additional clarification on how physician-led ACO's can effectively meet quality measures on hospital-acquired conditions.

CMS should work with societies to identify evidence-based exceptions to specific quality measures and rational thresholds in incentive programs, particularly those involving penalties rather than rewards. The ATS recommends that the Department develop 1) alternative systems to encourage providers to adopt processes to reduce HACs; and 2) systems to measure whether process steps are being taken. Further, we believe that research will play a key role in how to detect and prevent HACs and we urge the Secretary to continue efforts to solicit research proposals on the effectiveness and implementation of HAC prevention strategies.

We look forward to working with CMS as it develops the final rule on ACO's. Please contact Nuala S. Moore, Sr. Legislative Representative in our Washington Office at 202.296.9770 or via e-mail at Nmoore@thoracic.org if you have any questions.

Sincerely,

Nicholas Hill, M.D.
President
American Thoracic Society