



# American College of Surgeons

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June 3, 2011

Donald M. Berwick, MD, MPP  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1345-P  
Room 445-G, Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

Re: Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations; Proposed Rule

Dear Administrator Berwick:

On behalf of the more than 75,000 members of the American College of Surgeons (ACS), we appreciate the opportunity to submit comments to the proposed rule: *Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations* that was published in the *Federal Register* on April 7, 2011. The ACS is a scientific and educational association of surgeons, founded in 1913, to improve the quality of care for the surgical patient by setting high standards for surgical education and practice.

The ACS is supportive of the Centers for Medicare & Medicaid Services' (CMS) stated goals of the Shared Savings Program, namely to provide better care to Medicare patients, to provide better health to populations, and to decrease the cost of health care by reducing waste in the system. We are also generally supportive of the concept of a properly implemented accountable care organization (ACO) as a mechanism to improve quality, delivery, and coordination of patient-centered care for surgical patients; however, we have concerns that the ACO concept, as currently proposed, will be extremely difficult to operationalize. We also believe that the proposed rule does not adequately acknowledge and account for the importance of specialists in the implementation of ACOs. The success of an ACO depends not only on the participation of qualified primary care physicians, but also on specialists, who will be crucial to the improvement of quality of care. Additionally, lack of coordination between primary care physicians and specialists can result in duplication of efforts (for example, lab tests) and poor support for preventing complications, thereby reducing potential shared savings. As such, for an ACO to be successful, it will be necessary to promote coordination with specialists, even specialists who are not ACO participants.

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The ACO concept of coordinated multiple levels of care with a regionalized structure is not new to surgery. Surgical care has been organized into regional coordinated systems integrated into clinical institutions by way of trauma care networks since the 1970s. Other surgeon-led care coordination teams, such as burn care and cancer care teams, coordinate services within institutions across diverse disciplines and levels of care. In addition, surgery has developed data systems to track outcomes and quality for accountability such as the American College of Surgeons National Surgical Quality Improvement Program, the American College of Surgeons National Trauma Data Bank, and the American College of Surgeons National Cancer Database. The experiences and lessons learned by surgeons are an example for the development of the current and future stages of ACOs. Trauma systems and other surgeon-led care coordination teams provide a model for surgeon-led organized care delivery that includes complex inter-institutional relationships on multiple levels, the maintenance of control and government structures, and public input and feedback, all of which are core components of successfully implemented ACOs. For many years, the American College of Surgeons has worked with both the government and private sector to make care better, safer, and more accountable. Our comments below are intended to improve the Shared Savings Program and remove barriers to participation so that patients will receive improved care and have access to the full range of services necessary for the improvement of their quality of care. Our comments are presented in the order in which the relevant issues appear in the proposed rule and are intended to complement the separate set of comments we submitted in response to the *Waiver Designs in Connection with the Medicare Shared Savings Program and the Innovation Center* notice with comment period.

## **ELIGIBILITY AND GOVERNANCE**

CMS proposes that in order to be eligible for participation in the Shared Savings Program, the ACO participants must have at least 75 percent control of the ACO's governing body. In addition, each of the ACO participants must choose an appropriate representative from within its organization to represent them on the governing body. We support CMS' proposal to require that ACO participants have at least 75 percent control of the ACO's governing body. However, we request that CMS clarify the requirement that "each of the ACO participants must choose an appropriate representative from within its organization to represent them on the governing board." It is unclear whether the governing board will be required to include a representative from "each of the ACO participants" or whether each of the ACO participants will choose a representative "from within its organization," referring to the ACO as an organization rather than the individual participants' organizations. Requiring each ACO participant to have representation on the governing board could lead to an overly large and unmanageable governing board, but having a board of a workable size should also be balanced by appropriate representation of specialists and others providing episodic or acute care in addition to those providing chronic or longitudinal focused care.



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CMS proposes that the ACO meet several criteria consistent with a requirement of the Patient Protection and Affordable Care Act (ACA) that the ACO have a leadership and management structure that includes clinical and administrative systems. One of these criteria is the requirement that the ACO develop and implement evidence-based medical practice or clinical guidelines and processes for delivering care. The ACS supports the use of evidence-based guidelines developed by appropriate medical specialty organizations and based on non-biased, well-designed, prospective, randomized studies. Evidence-based guidelines must also be shown to meaningfully improve care, and we are concerned that some evidence-based guidelines, such as many of the Surgical Care Improvement Project (SCIP) measures, may not show a meaningful improvement in the gap or variance in care. Implementation of such evidence-based guidelines can vary dramatically from one hospital to another and can consume substantial financial and staffing resources. If there is no evidence of an improvement in care, implementation of such evidence-based guidelines could potentially even cause harm. Other evidence-based guidelines, however, have in fact been shown to meaningfully improve care. For example, the ACS has been instrumental in the development of effective evidence-based guidelines related to bariatric surgery in conjunction with the American Society for Metabolic and Bariatric Surgery, breast cancer surgery in conjunction with the Commission on Cancer, and trauma surgery in conjunction with the Advanced Trauma Life Support course. We support the inclusion of only evidence-based guidelines that can be shown to meaningfully improve care.

### **ESTABLISHING THE 3-YEAR AGREEMENT WITH THE SECRETARY**

CMS proposes to establish an application process with an annual application period during which a cohort of ACOs would be evaluated for eligibility to participate in the Shared Savings Program. We agree with CMS that in light of the short time frame for implementing the Shared Savings Program in the first year of the program, a January 1 start date might not provide the flexibility necessary to allow all interested ACOs to complete their applications. As a result, we support CMS' suggested alternative of adding an additional start date of July 1 for the first year of the Shared Savings Program and to allow the agreement period for ACOs with a July 1 start date to be increased to 3.5 years so that the first performance period would be defined as 18 months in order for all of the agreement periods to synchronize with ACOs entering the program on January 1 of the following year. CMS states that it envisions such an alternative only being available in the first year of the program, but we recommend that a July 1 start date be allowed for the first two years of the program. The regulations related to ACOs are complex and the process of completing the application will require extensive analysis, planning, time, and resources. Some potential ACOs might not even be able to meet the deadlines for a January 1, 2013 start date. Accordingly, we believe that a July 1 start date for the first two years of the program would enable additional qualified ACOs to participate in the early stages of the Shared Savings Program.



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## **ASSIGNMENT OF MEDICARE FEE-FOR-SERVICE BENEFICIARIES**

### ***Operational Identification of an ACO***

CMS proposes that primary care physicians upon whom assignment of beneficiaries is dependent would be committed to the ACO for a three-year period and be exclusive to that ACO. Conversely, to ensure that specialists and other entities upon which assignment of beneficiaries is not dependent can participate in more than one ACO, and thereby facilitate the creation of competing ACOs, these providers and suppliers would be required to commit to the three-year agreement to participate in an ACO. This agreement, however, would not be exclusive, and the specialist would have the flexibility to join another ACO. We support CMS' proposal to not require specialists to be exclusive to one particular ACO. We agree that competition in the marketplace and patient access to a variety of providers can promote quality of care. Limiting specialists to one ACO, especially in areas of the country where there are shortages of particular specialists, could encourage the formation of ACOs with undue market power, which, in turn, could reduce or eliminate the benefits to Medicare beneficiaries of what should have been the positive influence of market competition.

### ***Definition of Primary Care Services***

Section 1899(c) of the ACA requires the Secretary to assign beneficiaries to an ACO based on their utilization of primary care services, but does not specify how to identify the appropriate primary care services on which to base the assignment. CMS proposes to implement this requirement by assigning beneficiaries to physicians designated as primary care providers (defined as internal medicine, general practice, family practice, and geriatric medicine) who are providing certain primary care services to beneficiaries. These "primary care services" would be defined as Healthcare Common Procedure and Coding System (HCPCS) codes 99201 through 99215; 99304 through 99340; and 99341 through 99350, the Welcome to Medicare visit (GO402) and the annual wellness visits (GO438 and GO439). This definition of primary care services is set forth in section 5501 of the ACA. This proposed method of assignment was the second of three possible options that CMS considered.

The first option proposed by CMS would assign beneficiaries based on a predefined set of "primary care services," namely, the evaluation and management (E&M) services defined as "primary care services" in section 5501 of the ACA (listed above). The third option would assign beneficiaries by first identifying primary care physicians (internal medicine, family practice, general practice, geriatric medicine) who are providing primary care services, and then identifying specialists who are providing these same services for patients who are not seeing any primary care professional.



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We do not support CMS' proposal to use the second option for beneficiary assignment. Rather, we recommend use of the administratively straightforward first option, assignment based on the predefined set of primary care services. We believe that the resulting increase of potential beneficiaries assigned to the ACO in areas with primary care shortages (where specialists would be providing more primary care services as defined by the code set) is a necessary and appropriate consequence of the use of the first option. CMS expresses concern that assigning beneficiaries to ACOs based solely on primary care services without distinction of caregiver specialty increases the likelihood of assigning beneficiaries to a specialist over a primary care provider. Although we recognize CMS' concern that this could possibly diminish the emphasis on primary care in the Shared Savings Program, we urge CMS to focus the program on the services that the patients will receive rather than on the providers providing the services. In addition, using the first option would increase the number of patients assigned to ACOs in rural areas because patients would be included who otherwise would not be attributed to an ACO due to the fact that they receive their primary care from cardiologists, oncologists, surgeons, or other specialists. This, in turn, would make it easier for ACOs to form in some geographic areas with primary care specialty shortages, thereby enhancing the viability of the Shared Savings Program generally. We also firmly believe that assignment of beneficiaries based on provision of primary care services should be voluntary for the specialists. We see value in the implementation of the first option, and if CMS elects to move forward with the first option, we urge CMS to allow specialists to elect whether to participate in an ACO in this capacity.

#### ***Prospective vs. Retrospective Beneficiary Assignment to Calculate Eligibility for Shared Savings***

CMS states that there are two basic options for assigning beneficiaries to an ACO to calculate eligibility for shared savings for a performance year: prospective or retrospective assignment. CMS proposes retrospective beneficiary assignment for purposes of determining eligibility for shared savings, but also proposes to provide aggregate data to the ACO for its assigned population of Medicare patients during the benchmark period. In addition, for this same beneficiary population, CMS proposes to provide an ACO with the following data elements: beneficiary name, date of birth, sex, and health insurance claim (HIC) number. This combined approach (retrospective attribution plus the provision of some beneficiary data) is an attempt to balance retrospective assignment, which CMS believes is preferable to prospective, given the benefit to the ACO of having meaningful information about its expected assigned population before the performance period begins.

While we appreciate CMS' use of the combined approach to attempt to provide information about the ACO's patient profile prior to the performance year, we support prospective rather than retrospective assignment of beneficiaries. Retrospective assignment is problematic because neither the patient nor the physician knows that CMS is assigning accountability to the physician for the costs of all of the patient's care until after the care has already been delivered. It is also uncertain



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how an ACO would be able to track its performance quarterly if it does not know who the enrolled beneficiaries are and where the ACO should direct its limited resources for improvement, if the focus for the improvement is not known.

We agree with other commenters whom CMS has referenced in the proposed rule that it is fundamental to population management for the ACO participants to be able to profile a population, identify individuals at high risk, develop outreach programs, and proactively work with patients and their families to establish care plans. In addition, we believe it is essential to inform patients of their assignment to an ACO in advance of the period in which they may seek services from the ACO so that the patient has the freedom of choice to see a different physician. However, in the case of retrospective assignment, neither the patient nor the provider will know until after the performance year whether the patient was assigned to the ACO. While we understand there are operational issues associated with prospective assignment, we recommend that CMS support policies that structure ACOs from the perspective of the patient in a way that preserves the patient's individual choice. Prospective assignment would not only create a model under which systems could more efficiently organize and coordinate patient care while managing costs, but it would also allow beneficiaries a greater degree of certainty and clarity as to what it is that they are opting into when a physician discloses participation in an ACO. For these reasons, we can only support prospective rather than retrospective attribution of beneficiaries.

### ***Beneficiary Information and Notification***

CMS proposes to develop a communications plan, including educational materials and other forms of outreach, to provide Medicare patients with accurate, clear, and understandable information about the Shared Savings Program; the patient's utilization of services furnished by a provider participating in an ACO; the possibility of the patient being assigned to an ACO for quality and shared savings purposes; the potential that the patient's health information may be shared with the ACO; and the patient's ability to opt out of that data sharing. CMS also proposes to require ACOs to post signs in the facilities of participating ACO providers/suppliers indicating their participation in the Shared Savings Program and to make available standard written information to Medicare patients whom they serve.

We commend CMS for these proposals to develop a communications plan, and we firmly believe that patients should be adequately informed about the Shared Savings Program, its possible ramifications, and patients' available options. We agree with CMS that patients' freedom of choice to go to different physicians can be undermined or even nullified if the patient does not have the appropriate information about the Shared Savings Program. We also urge CMS to allow for stakeholder input regarding how the educational materials present the ACOs and the patients'



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options to the patients. We agree with CMS that transparency must be a central feature of the Shared Savings Program, and we consider this need for transparency to apply also to the terms CMS uses to describe ACOs to a provider's patients. Among other things, we believe that any beneficiary educational or handout materials must be balanced, describing the potential benefits of the ACO model as well as its potential risks for beneficiaries, and we believe that stakeholder input on draft educational/handout materials, even if only on an informal basis, would help achieve this goal. We also recommend that CMS provide more clarity and guidance as to what standardized written information Medicare beneficiaries should receive so that the beneficiaries have a clear understanding of the Shared Savings Program as it relates to their care.

We also believe that the proposed requirement of posting signs in the facilities of participating ACO providers indicating their participation in the Shared Savings Program might be a practical approach for notifying patients of primary care providers, but this requirement would be more complex for specialists who could have fewer patients assigned to an ACO. Additionally, because the specialist's relationship with the patient will not affect whether the patient is attributed to the participating specialist's ACO (if CMS' proposed assignment methodology is largely retained in the final rule), the specialist will have little to no information about the patient's likelihood of being assigned to the specialist's ACO or any other ACO. In addition, given that specialists can participate in multiple ACOs, the signage might convey information that is of little value to patients. If a signage requirement is retained in the case of specialists and others with a non-exclusive relationship with one or more ACOs, CMS should ensure that the wording of any such signage is carefully crafted so as not to mislead beneficiaries into thinking that mere receipt of services from such specialists or other providers will automatically assign them to a given ACO.

#### **QUALITY AND OTHER REPORTING REQUIREMENTS**

CMS proposes to use 65 performance measures in five domains (patient/caregiver experience, care coordination, patient safety, preventive health, and at-risk population/frail elderly health) in the first year of the ACO program, with ACOs required to report full and accurate data for those measures, but not meet any specific performance target. For subsequent performance periods, ACOs will be expected to exceed certain minimum performance levels for each ACO performance measure then in use. The ACS supports this process of reporting in the first year with performance targets set for following program years. This is consistent with past recommendations for other CMS programs.

While the ACS understands this is an initial start for reporting of quality measures, we have a number of suggestions for improving the ACO measure set and related policies. First, we urge CMS to consider inclusion of surgery-related measures in the first year of this program. In an effort to



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align the Shared Savings Program with the other CMS quality programs, ACS recommends that the Physician Quality Reporting Initiative (PQRI) perioperative measures be included:

- NQF #0268: Selection of Prophylactic Antibiotic: First OR Second Generation Cephalosporin
- NQF #0270: Timing of Antibiotic Prophylaxis: Ordering Physician
- NQF # 0271: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)
- NQF #0239: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)

Second, in collaboration with CMS, the ACS National Surgical Quality Improvement Program (NSQIP) staff has developed five surgery-related, outcomes-based quality measures that we recommend for inclusion:

1. A risk adjusted vascular surgery lower extremity bypass measure;
2. A risk and procedure mix adjusted surgical site infection (SSI) measure;
3. A risk and procedure mix adjusted urinary tract infection (UTI) measure;
4. A colon resection outcomes measure; and
5. A risk and procedure mix adjusted elderly surgery measure, which evaluates the outcomes of all procedures performed in a facility for persons 65 years and older.

To the extent practicable, CMS proposes that measures used be nationally endorsed by a multi-stakeholder organization and aligned with best practices among other payers and the needs of the end users of the measures. CMS proposes to align the quality measures specifications for the Shared Savings Program with the measures specifications used in existing quality programs to the extent possible and appropriate for purposes of the Shared Savings Program. The ACS supports the proposal that measures have multi-stakeholder endorsement, and we believe measures should be developed through a rigorous and stringent process that is transparent, physician-led, and consensus-based. However, the ACS urges CMS to not limit measure selection to National Quality Forum (NQF) endorsed measures. The NQF endorsement process is relatively slow and expensive, and other multi-stakeholder endorsement pathways exist or might come into existence that provide a standardized, consistent, and open process that requires relevant stakeholder input based on clinical evidence.

In addition to our suggestions above for improving the ACO measure set and related policies, we urge CMS to also permit ACOs flexibility to report on a set of measures that are most relevant to their unique practice and patient population, rather than taking a one-size-fits-all approach to quality measurement. We ask CMS to offer ACOs greater flexibility in selecting from a menu of appropriate measures with minimum reporting standards instead of requiring the ACO to achieve 100 percent compliance with all ACO measures.



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In regard to the patient/caregiver experience domain, CMS proposes to include measures from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinical & Group Survey. In 2010, the CAHPS Consortium adopted and trademarked the CAHPS Surgical Care Survey. This survey was developed by the ACS and the Surgical Quality Alliance (SQA) to assess patients' experiences with surgical care, and more specifically, to encompass the domains of care for the surgical patient that the CAHPS Clinician & Group survey lacks, including: informed consent, shared decision making, anesthesia care, and post-op follow-up. Like the CAHPS Clinician & Group survey, the CAHPS Surgical Care Survey focuses on aspects of surgical quality that are important to patients and for which patients are the best source of information. The ACS recommends that the CAHPS Surgical Care Survey measures be included as a patient/caregiver experience domain.

In regard to the care coordination domain, CMS proposes to include percentages of physicians meeting Stage 1 Health Information Technology for Economic and Clinical Health (HITECH) Act Meaningful Use (MU) requirements. The ACS is concerned that many of the measures are primary care focused and the lack of exclusions makes it difficult for specialists to comply. For example, eight of the 15 Stage 1 core measures and three of the 10 Stage 1 menu options do not include an exclusion category. Furthermore, many of the exclusions for measures under both the core and menu sets do not allow an exemption for specialists who do not routinely perform the activity described. In addition to the overwhelming task of implementation, we feel that specialists should not also be required to report on those measures that are not relevant to their scope of practice or the services that they routinely provide to their patients. We are concerned that specialists may be placed into an inclusive category that will automatically penalize them in a way that is patently unfair, not unlike the application of electronic-prescribing penalties to surgeons who do not meet the minimum prescription requirements. In order to achieve the main goal of widespread implementation and use of health information technology to improve health care, we believe that there should be greater flexibility to allow providers to successfully meet the criteria of meaningful use. In the absence of such flexibility, we recommend that measure #19, % All Physicians Meeting Stage 1 HITECH Meaningful Use Requirements, be dropped from the list of initial ACO performance measures.

In regard to the patient safety domain, CMS proposes to include the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicator (PSI) 90 Complication/Patient Safety for Selected Indicators composite, which includes the accidental puncture or laceration PSI. ACS supports the inclusion of patient safety measures in general, but we are concerned about measure implementation. For example, hospitals are now publicly reporting several AHRQ measures including PSI 15 ("Accidental Puncture or Laceration"). This is reported on hospital billing forms via ICD-9 code 998.2 and, as such, it is associated with the provider (including a surgeon or other physician) of that



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service. While exclusion criteria exist, the only instructions are “with principal diagnosis denoting technical difficulty.” ACS has identified circumstances where the code might be incorrectly included on patient bills because of ambiguous coding guidelines that do not take into account the circumstance of inadvertent laceration or puncture *not* considered to be accidental (e.g. serosal tears). Given this reliability and validity problem, we recommend that CMS field test such patient safety measures prior to their inclusion in the ACO measure set, either individually or as part of a composite measure. Additionally, we encourage CMS to provide further education and outreach to ensure the patient safety indicators are coded correctly. The ACS is willing to partner with CMS and AHRQ in such education efforts.

Lastly, we also make two recommendations regarding the safety of the Medicare population and their access to specialty care. First, we recommend that CMS include a requirement, either in the form of a measure or other criterion, that the ACO ensure appropriate patient access to specialists, in accordance with professional society guidelines and criteria. We are concerned that ACOs could have an incentive to reduce costs by reducing primary care physicians’ referrals to specialists, so we urge CMS to include a requirement that ACOs ensure patients’ referrals for medically necessary specialist care. We also request that CMS monitor the health status of the ACO population against comparable populations of Medicare beneficiaries. The quality measures that CMS has proposed would not prevent ACOs from discouraging patients from receiving needed specialty care, so we view this additional safeguard as necessary to protect the ACO patient population.

## **SHARED SAVINGS DETERMINATION**

### ***Technical Adjustments to the Benchmark: Impact of IME and DSH***

ACOs that meet the quality standards established by the Secretary and that achieve savings compared to a benchmark of expected average per capita Medicare fee-for-service expenditures will share in a portion of the Medicare savings. Part of establishing an expenditure benchmark involves determining whether adjustments are warranted to avoid potentially disadvantaging various types of providers, for example, teaching hospitals that receive indirect medical education (IME) payments or hospitals that receive Medicare disproportionate share hospital payments (DSH hospitals). Many hospitals, especially academic medical centers, receive both adjustments, which can provide substantial increases in their Medicare payments compared to hospitals that do not qualify for these adjustments. The higher payments provided to these types of hospitals could provide ACOs with a strong incentive to realize savings by avoiding referrals to hospitals that receive IME and DSH payments. CMS does not propose to remove IME and DSH payments from the per capita costs included in the benchmark and the calculation of actual expenditures for an ACO because CMS believes that while it has the authority to adjust the benchmark by removing IME and DSH



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payments, it does not have the authority to do so in its calculation of performance year expenditures, which would set the benchmark artificially lower relative to the performance period.

We have grave concerns about CMS' proposed treatment of IME and DSH payments. We also note that the proposed rule does not appear to address how direct graduate medical education (GME) payments would be handled in establishing ACO benchmarks and determining shared savings and losses. The ACS has a longstanding commitment to graduate medical education, the practice of academic medicine, and the successful training of surgical residents. Both GME and IME Medicare payments are a crucial component of ensuring a strong general surgery workforce, which is currently experiencing a growing shortage. In April 2008, the *Archives of Surgery* published an analysis showing that the number of general surgeons per U.S. population declined by almost 26 percent between 1981 and 2005, and data from the Dartmouth Atlas have shown a 16.3 percent decline in the number of general surgeons per population between 1996 and 2006. Unfortunately, this disturbing trend appears to continue as the Bureau of Health Professions (BHP) projects a 7 percent decline in the actual number of practicing general surgeons between 2005 and 2020. Similarly, GME and IME payments provide critical support to other surgical and medical residency programs and the teaching hospitals that offer them.

The IME adjustment has long been viewed by policy makers as necessary for two reasons: (1) teaching hospitals tend to offer a wider variety of technologically sophisticated services than is typically available at other hospitals; and (2) because of these services, the hospitals attract sicker patients who require complex and costly treatments. Failure to remove the IME and DSH payments from the per capita costs included in the benchmark and the calculation of actual ACO expenditures and the resulting pressure on ACOs to realize savings by avoiding referrals to hospitals that receive IME and DSH payments is a serious and potentially damaging consequence to teaching hospitals and the generally sicker patients for whom they provide care. We strongly urge CMS to work with our organization and others to find a solution.

Since section 3022 of the ACA explicitly gives the Secretary the authority to adjust ACO benchmarks for "such other factors as the Secretary determines appropriate," and since fair "apples to apples" comparisons of benchmark and actual expenditures would only be possible if any adjustments made to the benchmarks are also made to actual ACO expenditure data, we believe it is logical to assume that the Congress at least implicitly gave the Secretary the authority to make adjustments to actual ACO expenditures that permit such "apples to apples" comparisons. Otherwise, the Congress could be viewed as giving the Secretary authority to make adjustments to the benchmarks that would produce an unfair or unjustified outcome.



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We also ask that the final rule explicitly acknowledge that GME payments would not be taken into account in determining ACO benchmarks and actual spending, which we presume is the case given CMS' silence about the matter in the proposed rule. If this is not the case, the arguments noted above for IME and DSH payments would also apply to the treatment of GME payments.

### ***Withholding Performance Payments to Offset Future Losses***

CMS proposes that a flat 25 percent withholding rate be applied annually to any earned performance payment in order to encourage ACOs to participate for all three years of their agreements, to protect the Medicare program against losses, and to ensure ACOs have an adequate repayment mechanism in the event they incur losses under either the one-sided or two-sided payment models. While we understand CMS' rationale for the 25 percent withhold, we are concerned about the impact of this withhold on the ability of the ACO to meet its operating costs. A withhold would reduce the available cash flow that the ACO would otherwise apply to the additional operating expenses attributable to the ACO. As a result, we urge CMS to not apply a flat 25 percent annual withhold to any earned performance payment. We note, also, that the proposed rule already requires that each ACO have a self-executing mechanism for paying any shared losses that it might incur, making the proposed withhold both unnecessary and redundant.

We appreciate the opportunity to provide comments regarding this proposed rule. The ACS looks forward to continuing dialogue with CMS on these important issues. If you have any questions about our comments, please contact Bob Jasak in our Washington office. He can be reached at [bjasak@facs.org](mailto:bjasak@facs.org) or at (202) 672-1508.

Sincerely,

A handwritten signature in black ink that reads "David B. Hoyt".

David B. Hoyt, MD, FACS  
Executive Director