



December 3, 2010

Donald Berwick, MD
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: Medicare Program; Request for Information Regarding Accountable Care Organizations and the Medicare Shared Savings Program; 75 *Fed. Reg.* 70,165 (November 17, 2010); CMS-1345-NC.

Dear Dr. Berwick:

The American College of Rheumatology, the leading professional society for rheumatology providers, appreciates the opportunity to provide comments on accountable care organizations and the Medicare Shared Savings Program. The ACR has been discussing this issue as well as other payment reform issues with great concern regarding quality of care and patient safety.

The ACR supports the Centers for Medicare and Medicaid Services' decision to request feedback on how to ensure that small and solo physician practices will have an opportunity to participate in these programs. The ACR has a number of small and solo physician practices who are concerned that they will be forced to merge with a larger group practice in order to survive. One of the main obstacles is the various laws and regulations that surround small practices collaborating together. CMS must create safe harbors that will protect physicians from the Civil Monetary Penalty statute, Anti-kickback Statute, and STARK laws. The most effective way to encourage small and solo practices to remain in business and continue to collaborate, is to enable the practices to work independently without pressure to integrate into a hospital or large health system.

A major concern for practices would be the capital needed for shared savings. Most small and solo practices run efficiently without extra capital. CMS should consider creating loan assistance programs and grants, so practices could obtain financing assistance from lenders. CMS should avoid creating burdensome requirements that require unnecessary administrative paperwork and upfront capital. Requiring early capital will effectively price small and solo practices out-of-the market, likely forcing them to merge with a hospital or large practice.

Beyond the current legal restrictions and capital issues, the ACR has other concerns about the current law. There are approximately 6,000 rheumatologists in the United States. Of these rheumatologists, many work in less densely populated states, such as North Dakota (10), South Dakota (8), Wyoming (4), Montana (18), and Alaska (5). Requiring rheumatologists in small population states to have large numbers of Medicare beneficiaries reduces the ability for small practices in rural communities to participate. It would also decrease choice and competition that could result in increased costs. The converse could also pose a problem. Requiring physicians in densely physician populated areas to have a large number of Medicare beneficiaries could result in increased competition for patients.

Rheumatologists generally treat patients with multiple chronic co-morbidities. We are concerned that ACOs would “cherry pick” healthier patients to demonstrate that they are providing optimal care. Additionally, rheumatoid arthritis, lupus and other rheumatic diseases are difficult to diagnose and treat. Physicians should be measured on overall patient care in the practice and how the health problems are being managed. Complex care must be recognized when developing payment models, so physicians who care for complex patients who require expensive treatments, are not penalized for treating a more difficult patient set. This is particularly true for rheumatologists who utilize expensive treatments.

This leads to the issue of how beneficiaries will be attributed to the ACO. The ACR recognizes the importance of measuring the appropriate number of patients to the ACO. It is difficult to address this issue as the patient-physician relationship is unique, and decisions should be jointly made between the patient and the physician. It is important that patients with rheumatic diseases follow physician orders and make required follow-up visits. If a patient is unable or unwilling to follow the physician’s orders, who will be held accountable? How will this be documented? CMS should allow beneficiaries to voluntarily participate in the ACO or shared savings program. Voluntary participation would encourage the patient to take responsibility for their actions and to follow their physicians instructions. Additionally, it would be easier to measure the quality of physician care with the patient’s support.

If physicians participate in an ACO or shared savings program, they should receive feedback throughout the year on their progress. This would allow physicians to modify their behavior as necessary. There have been past concerns with some CMS programs, such as the physician quality reporting systems that the feedback is not helpful or is hard to obtain. CMS must improve access to information so physicians can easily access and obtain feedback. In order for quality programs to work effectively, the individual must understand his or her performance. The most effective way to know if the physician is performing well is to provide feedback.

Measuring beneficiary and caregiver experience is an interesting issue to tackle. The only way to truly measure experience is through special surveys. Surveys would have to be administered through a neutral party, and outliers should be discarded or weighted

differently. Patients can become emotional when receiving unsettling prognoses or negative feedback. Any experience surveys should not be used to determine financial incentives, but should be used to improve physician or ACO performance.

The queries in the Federal Register notice include a request for defining patient-centeredness. This is a term that has been thrown around for a number of years in different contexts. How is "patient-centered" different among individual patients? This falls back to the patient-physician relationship and how the two individuals work together. We believe that by addressing some of the issues above, such as allowing the patient to volunteer for the ACO/shared savings program, the unique patient-physician relationship will improve. Patients should be encouraged to closely follow physician instructions. Additionally, physicians should not be penalized for treating more difficult patients. Patient-centered means that the physician and patient should work in harmony. Physicians must have the opportunity to treat the patient at 100% and be reimbursed for providing optimal care. Optimal care would include answering telephone calls and/or emails while physicians are appropriately reimbursed for this care.

The only quality measures that are available and have been used on this scale are the measures reported under the CMS PQRS program. CMS will need to develop additional measures. We highly stress that CMS continue to work with specialty societies to appropriately create new measures. The ACR looks forward to working with CMS on new measures.

Thank you for the opportunity to provide comments on the queries from the Federal Register. We would also like to mention that the ACR has some concerns about hospital based ACOs and large practice ACOs. We are concerned that specialists, such as rheumatologists, could be swallowed by hospitals and forgotten because they admit and treat few patients as in-patients. The ACR encourages CMS to recognize that there are many physicians who treat chronic conditions outside of the hospital and large practice environment.

Please feel free to contact me if you have additional questions directly at (805) 925-8899.

Sincerely,



Karen S. Kolba, MD
Chair, Committee on Rheumatologic Care
American College of Rheumatology