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THE STUDY OF LIVER DISEASES



June 6, 2011

Donald Berwick, MD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

Re: CMS-1345-P

Dear Dr. Berwick:

The American Association for the Study of Liver Diseases (AASLD) appreciates the opportunity to submit comments on the Medicare Shared Savings Program: Accountable Care Organizations (ACO) proposed rule, as published in the Federal Register. AASLD is the leading organization of healthcare professionals and scientists committed to preventing and curing liver disease. While we support the goal of providing coordinated care to improve the health of patients, we are writing to share our concerns about the program as proposed.

Protecting Patient Access to Specialty Care

We support the goal of increasing coordination and communication between all of a patient's physicians; this is critically important to a high quality healthcare system. However, we are concerned that the ACO proposal as written could limit a patient's access to specialty care.

Patients may be confused and their referral to a hepatologist may be hindered because the referring primary care physician and the hepatologist are either not in the same ACO or the specialist is not participating in an ACO. The potential for primary care physicians to limit referrals to hepatologists and other specialists outside of the ACO is a real one that CMS must address. How patients can transition between ACOs or in and out of ACOs must be clearly outlined for both patients and providers prior to the commencement of the program, allowing providers and patients to familiarize themselves with them. These transitions must be seamless to guarantee timely access to needed specialty care.

We believe that patient education is key to ensuring continued access to patients' preferred specialists. We applaud CMS for requiring that ACO providers notify their patients that the provider is participating in an ACO, specifically how the ACO will improve their care. However, we are concerned that this information will not be detailed enough. It must be clear to all patients that they have the right to see physicians outside of the ACO. This is of critical importance for patients being treated by hepatologists.

Governance and Leadership

AASLD supports CMS' efforts to provide for flexibility in establishing shared governance mechanisms and leadership structures that best suit the ACO. It is critically important that specialists be represented on the governing board in order to ensure that patient access to specialty care is preserved and that specialists receive fair distribution of payments and operational support.

We support the inclusion of a Medicare beneficiary on the ACO governing body. However, the beneficiary representative must have a strong voice, independent from that of ACO leadership. Procedures should be put in place to guarantee that the beneficiary will not merely be a friend of leadership. Perhaps each ACO should have a patient council from which the governing board representative would be chosen. ACO providers could nominate beneficiaries for the council. While we understand this would add another layer of bureaucracy to the process, it is vitally important that patients are active participants in ACOs and that their rights as patients are protected.

Risk Models

CMS outlines two risk models in the proposed rule. In one model, ACOs will not be responsible for repaying any losses until year three; in the other, the ACO will share in the losses for the duration of the agreement in exchange for a higher percentage of the savings generated. We are concerned that the potential for sharing the losses will discourage participation by groups that are not already operating in a method similar to that of the ACO.

AASLD asks CMS to consider adding a model where the losses will not be shared at any point during the three year agreement in exchange for a lower share of the savings. We believe that this approach will encourage providers in a wider variety of specialties and settings to participate in this program. Hepatologists treat very ill patients who tend to have high health care costs, and not sharing losses would prevent ACOs from attempting to cherry pick their patients.

Quality Measurement and Reporting Requirements

AASLD understands that quality measurement is integral to accomplishing the goals of a shared savings program, but believes that the quality measurement

requirements as proposed are unrealistic. Withholding shared savings from an ACO that does not successfully report on all 65 measures is a strong disincentive to participation. It is likely that an ACO could generate savings and improve the quality of care and not meet that requirement. Statistically, it is almost impossible that an ACO would meet this requirement. Furthermore, CMS recently lowered the reporting threshold in the Physician Quality Reporting System (PQRS) from 80 to 50 percent for its claims-based reporting option and the threshold remains 80 percent for registry reporting. When formulating the requirements for PQRS, CMS is attempting to set an achievable standard, something not done in this proposed rule.

We are recommending that CMS consider alternatives to the proposal as written. One alternative would be for CMS to prioritize the quality measures. For example, 20 measures could be designated as “critical.” For those measures, CMS would require that ACOs report successfully to be eligible for the bonus. However, for the balance of the measures, CMS should require a success rate similar to that for the PQRS. This method would still require ACOs to meet rigorous quality measurement standards, but the requirement would not be so high as to discourage participation. By focusing on quality improvement rather than only meeting specified quality targets, participants would be less likely to engage in the cherry picking of patients.

We are also concerned that there are no hepatology specific measures included in the program. CMS should broaden the list of measures included in this program, and we recommend using the hepatitis measures currently included in the PQRS program. Including these measures will provide hepatologists an active way to participate in the quality measurement portion of the shared savings program.

Standardization of Requirements

CMS currently administers the PQRS, the Medicare and Medicaid EHR Incentive Program and the ePrescribing Incentive Program; with each of them having its own reporting requirements. The ACO program will be added with its own set of requirements. These programs provide a variety of incentives and penalties that physicians must track. We applaud CMS for beginning to standardize the PQRS and the ACO program. However, this does not go far enough. It would behoove CMS to standardize the requirements for these programs to the extent possible to reduce the confusion already experienced by physicians and their office staff. Their success and that of these CMS programs depends on having standardized requirements that are easily digestible by participants.

Costs of Establishing an ACO

Based on the Physician Group Practice Demonstration experience, it is estimated that it will cost approximately \$1.7 million to establish an ACO. Those deciding to participate will spend these funds upfront without any guarantee that they will see any shared savings. If no savings are generated, this would be a serious financial blow for many practices. We are recommending that CMS provides funds upfront to

defer the cost of establishing an ACO if needed. These funds could come either from the Innovation Center in the form of a grant and/or can be paid back through a reduction in shared savings. We believe that this type of change would help incentivize physicians to participate.

Thank you for the opportunity to submit comments on the Medicare Shared Savings Program as proposed. AASLD is committed to providing high quality care to patients and believes that a program of this nature could have significant benefits for patients and reduce health care costs if implemented correctly. If you have any questions about these comments, please contact Erika Miller at emiller@dc-crd.com or (202) 484-1100.

Sincerely,

A handwritten signature in black ink, appearing to read "Jake Liang", with a large, stylized flourish at the end.

Jake Liang, MD
President

