



June 6, 2011

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Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

Attn: CMS-1345-P; Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations

Dear Dr. Berwick:

The American College of Gastroenterology (ACG) and the American Society for Gastrointestinal Endoscopy (ASGE) appreciate the opportunity to provide comments in response to the Centers for Medicare and Medicaid Services' (CMS) proposed rule for implementation of a Medicare Shared Savings Program (Proposed Rule), also referred to as Accountable Care Organizations (ACOs).

The ACG is a physician organization representing gastroenterologists and other gastrointestinal specialists. Founded in 1932, the College currently counts 12,000 physicians among its membership of health care providers of gastroenterology specialty care. Although the vast majority of these physicians are gastroenterologists, the College's membership also includes surgeons, pathologists, hepatologists, and other specialists involved in various aspects of the overall treatment of digestive diseases and conditions. The College has chosen to focus its activities on clinical gastroenterology – the issues confronting the gastrointestinal specialist during the treatment of patients.

Since its founding in 1941, ASGE has been dedicated to advancing patient care and digestive health by promoting excellence in gastrointestinal endoscopy. ASGE, with more than 11,000 members worldwide, promotes the highest standards for endoscopic training and practice, fosters endoscopic research, recognizes distinguished contributions to endoscopy, and is the foremost resource for endoscopic education.

Our societies understand the complexity associated with health care delivery reform. We therefore recognize the enormous effort that was required by CMS, under your leadership, to draft this Proposed Rule. In attempting to reach the "Triple Aim" of better care, improved health, and reduced cost, we

appreciate the difficulty in achieving the delicate balance of policies that will allow for continual and concurrent pursuit of all three goals.

We believe that the current Part A and B payment silos lead to a fragmented system of care for Medicare beneficiaries and fail to account for savings to the Medicare program generated by physicians who are keeping patients out of the hospital and streamline inpatient stays through effective care management. ACOs should encourage care coordination across payment silos and allow physicians to share in both Part A and Part B savings that are generated as a result of efficient resource use and high quality care.

We believe that ACOs have the potential to lead to better care coordination and quality of care. However, we do not believe that the Proposed Rule creates an attractive or viable opportunity for gastroenterologists to participate in an effort that was intended to reward physicians for improving the quality and cost efficiency of health care services. The challenge of achieving ACO objectives with few incentives and excessive risk will create a missed opportunity. Our recommendations that follow will promote the ACO concept from bench to bedside, incorporating accountability and value into our health care delivery system.

Our comments focus on two areas: 1) Preserving access to high-quality gastroenterologists and the endoscopy services they provide; and 2) Incentivizing voluntary participation of gastroenterologists in ACOs. Within these areas, we appreciate the opportunity to discuss several specific aspects of the Proposed Rule that we find particularly pertinent to the practice of gastroenterology.

PRESERVING ACCESS TO HIGH-QUALITY GASTROENTEROLOGISTS AND THE ENDOSCOPY SERVICES THEY PROVIDE

- Definition of primary care services
- Use of the colorectal cancer screening measure in quality measure reporting requirements
- Medicare beneficiary education and written notices
- Medicare beneficiary choice of physician

INCENTIVIZING VOLUNTARY PARTICIPATION OF GASTROENTEROLOGISTS IN ACOS

- ACO assignment of Medicare beneficiaries
- Patient accountability and incentives
- Increasing financial incentives for physicians to join ACOs
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- Integration of the Physician Quality Reporting System (PQRS) in ACO quality reporting requirements.
- Electronic Health Record (EHR) requirements

PRESERVING ACCESS TO HIGH-QUALITY ENDOSCOPY SERVICES

Definition of Primary Care Services

Under the Proposed Rule, Medicare beneficiaries will be assigned to an approved ACO based on the plurality of appropriate primary services provided by primary care providers, defined as those providers with a designation of internal medicine, general practice, family practice, and/or geriatric medicine. We disagree with this restrictive assignment methodology. We believe that specialists who provide the principal care for the patient's primary chronic conditions should be included in the definition of primary

care providers for ACO assignment purposes. The risk of not including a specialist who provides a plurality of a beneficiary's principal care services is that the beneficiary may be assigned to an ACO based upon a primary care provider who has little-to-no involvement in the patient's routine medical care. We believe that not including specialists who provide a plurality of a patient's principal care service will actually inhibit the ability of ACOs to effectively manage the care of chronically ill patients.

Gastroenterologists are trained, and typically maintain board certification, in internal medicine and are able to look at the whole patient. Medicare beneficiaries with chronic digestive diseases routinely see gastrointestinal specialists who provide ongoing care and primary management of these digestive conditions. These conditions include chronic inflammatory bowel diseases, such as Crohn's disease and ulcerative colitis, chronic viral hepatitis and other liver diseases, esophageal disorders, chronic pancreatitis, celiac disease, and irritable bowel syndrome.

We ask that CMS strongly consider using one of the two other assignment methodologies explored by CMS in the drafting of the Proposed Rule: 1) Assignment of beneficiaries based upon a predefined set of primary care services, regardless of physician specialty; or 2) A step-wise assignment of beneficiaries that would allow a beneficiary to be assigned based upon primary services provided by a specialist in cases where the beneficiary is not receiving care from a primary care provider.

We also wish to point out that should the assignment methodology be revised to include assignment of beneficiaries based upon the plurality of principal care services provided by specialists, additional guidance will be necessary to ensure that specialists can continue to participate in more than one ACO, as well as on the assignment of beneficiaries. This flexibility will be especially important if a considerable portion of a specialist's patient population is assigned to another ACO because the plurality of primary care services of those patients are being delivered by a primary care physician and not the specialist.

Use of the Colorectal Cancer Measure in Quality Measure Reporting Requirements

Our organizations strongly support the proposed inclusion of the colorectal cancer screening measure (PQRS measure No. 113) among the measures that will be used for establishing quality performance standards for ACOs.

The U.S. Preventive Services Task Force (USPSTF) has given an "A" recommendation for colorectal cancer screening using fecal occult blood testing (FOBT), sigmoidoscopy or colonoscopy, in adults beginning at age 50 and continuing until age 75. We believe that it is critically important that patients, in consultation with their physicians, be allowed to choose the most appropriate screening tool based on clinical guidance and personal preference.

The primary goal of colorectal cancer screening should be prevention. Thus, we are concerned that in an effort to generate cost savings, primary care physicians will "steer" patients toward FOBT. However, FOBT is not a test for *preventing* cancer; it is a test for *detecting* cancer. We want to underscore that FOBT is an important screening option; however, we want to make sure that patients also have full access to colonoscopy, which allows for the detection and removal of polyps, thus allowing for the *prevention* of colorectal cancer.

Our sensitivity to the use of FOBT by primary care physicians for colorectal cancer screening was heightened following the release of a recent Centers for Disease Control and Prevention study, which found that three-quarters of primary care physicians who recommend FOBT employ in-office tests, but that in-office FOBT often is *not* done appropriately. The study noted "in-office FOBT may be worse than no screening at all because it misses 95% of cases with advanced neoplasia, giving many patients a false

sense of reassurance.”¹ We believe that efforts must continue to educate providers about colorectal screening options and how they can increase patient compliance without having to resort to in-office FOBT.

A National Quality Forum (NQF)-commissioned report by RAND released in February 2011 examined the measures that will be needed to support innovative payment reforms. The report noted that measurement of inappropriate use may be important to assure clinically effective use of the population-based payment to the ACO. The report further suggests that longitudinal measurement is an effective way to assess whether providers are optimally applying services within the ACO. **We believe that longitudinal study of ACO patients will be needed to ensure that inclusion of the colorectal cancer screening measure actually meets the intended goal of both early detection and reduced incidence of colorectal cancer.**

Medicare Beneficiary Education and Written Notices

Among the key elements of the ACO program as proposed are that it is voluntary for providers, Medicare beneficiaries have the option to seek health care services from any provider outside the ACO, and ACO providers must notify their patients of their participation in an ACO. We understand that these elements should provide some level of assurance to Medicare beneficiaries that ACOs are not a thin-veiled attempt at a closed-network, HMO-style delivery system. We acknowledge the importance of providing beneficiaries the ability to exercise their right to participate in an ACO. Even with this statutorily required flexibility, we support CMS’ intention to develop a communications plan that will educate beneficiaries about what assignment to an ACO means for their care. **We believe that any communications plan should clearly relay that assignment to an ACO does not limit, restrict or diminish the freedom of beneficiaries to choose physicians or other health care professionals from whom they will receive services.** We strongly urge CMS to develop the wording of these communications in conjunction with organized medicine representatives, because experience has shown that failure to do so results in confusing or misleading information reaching beneficiaries about program benefits and rules.

Furthermore, **we believe that all written notices used by ACOs to inform beneficiaries of their participation in the Shared Savings Program should clearly indicate that patients have the right to access physicians of their choosing, regardless of whether those physicians participate in the ACO.** We believe that this right should be made as clear as possible and could include requiring patients to initial next to a specific line on the notice acknowledging that they have received a notice of their rights to access physicians of their choice. We believe that this extra step will ensure that this important right does not get lost among the other notices and forms that are routinely provided to patients.

Medicare Beneficiary Choice of Physician

Emphasized throughout the Proposed Rule is the right for Medicare beneficiaries to exercise freedom of choice in the physicians and other health care practitioners from whom they receive their services. However, CMS states in the Proposed Rule, “...if a beneficiary’s physician becomes part of an ACO and the beneficiary does not wish to receive health care services under the ACO care coordination and management efforts, the beneficiary has freedom of choice to go to a different physician.” **We believe that for true freedom of choice to exist, a beneficiary should be able to choose a physician participating in an ACO even if that beneficiary has affirmatively opted out of an ACO.**

¹ Nadel M, Berkowitz, Z, Klabunde, C, et al. Fecal Occult Blood Testing Beliefs and Practices of U.S. Primary Care Physicians: Serious Deviations from Evidence-Based Recommendations. J Gen Intern Med. 2010

INCENTIVIZING VOLUNTARY PARTICIPATION OF GASTROENTEROLOGISTS IN ACOs

ACO assignment of Medicare beneficiaries

CMS proposes a retrospective assignment of beneficiaries after a one-year performance period. Under this approach, although CMS would provide upfront data on a set of beneficiaries who might ultimately be assigned to the ACO, the beneficiaries for whom the ACO would actually be accountable would only be determined one to two years after services are actually delivered. **We therefore believe that beneficiaries should be assigned prospectively to an ACO.** We believe that prospective assignment, when coupled with making assignment voluntary for the beneficiary, will allow ACOs to implement other mechanisms that will increase active patient support and participation in their care. Additionally, voluntary, prospective assignment would allow CMS to hold ACOs accountable only for those patients who voluntarily choose their physicians to provide or manage their care and who are willing to allow the ACO to access data about the services they have received.

Patient Accountability and Incentives

We believe that the success of ACOs to improve quality and lower costs are dependent upon both provider and patient involvement. As proposed, there are no tangible incentives for beneficiaries assigned to an ACO to seek care from the panel of physicians and other health care providers who are participating in the ACO. We believe it will be important for ACOs to incorporate incentives to encourage beneficiary involvement in their care and to seek care from ACO providers. Stronger incentives and rewards, including financial incentives, will likely be necessary, such as a tiered cost-sharing structure. **We request that CMS clarify in the Final Rule whether it has the authority to allow ACOs to use a tiered cost-sharing structure designed to incentivize beneficiaries to seek care from ACO providers. A tiered cost-sharing structure could be financed through Medicare's portion of program savings.**

Included in the Patient/Caregiver Experience domain are measures assessing the communication between the patient and overall patient experience. However, the ACO is still responsible for the costs and services provided to the beneficiary from non-participating physicians. We believe that the ACO can only be held accountable for the quality outcomes that are within their control. Therefore, some allowance needs to be established for when a beneficiary chooses to obtain much of their care outside the ACO.

We recommend the development of measures for inclusion in the Patient/Caregiver Experience domain that would assess the caregiver's experience with the patient. Such measures could include "patient follow-up to care" and "patient services outside the ACO."

Increasing Financial Incentives for Physicians to Join ACOs

Higher Shares of Savings for ACOs

CMS estimates in the proposed regulation that start-up and first-year operating costs for each newly-formed ACO will be roughly \$1.75 million. The amount of shared-savings payment an ACO would receive depends on the size of the ACO, the model selected (one-sided model or two-sided model), and the achievement of quality performance standards that have yet to be defined. We believe that the proposed shared savings structure will make it difficult for ACOs to obtain the funding to cover the costs incurred to improve care.

- First, the ACO must achieve a minimum percentage savings (2-3.9%) in order to prove that the savings are not "random."
- Second, except for the smallest ACOs, CMS keeps the first 2 percent of any savings that are generated before the ACO is eligible for any share of the savings.
- Third, CMS only shares 50-60 percent of the savings beyond that 2 percent.

- Fourth, the savings percentage is reduced based on an ACO's performance against quality standards.
- Fifth, the savings that an ACO can receive is capped at 7.5 percent to 10 percent of the baseline expenditure.
- Sixth, if an ACO achieves savings, CMS proposes to keep 25 of those savings to hedge against cost increases incurred by the ACO in future years.
- Seventh, the savings share is not paid for a year after the end of the year in which the savings are actually achieved.

The Physician Group Practice Demonstration (PGP) was the precursor to the current CMS-proposed Shared Savings Program and many health experts have used this demonstration as a comparison when reviewing the current proposal. Health policy experts have concluded that all 10 ACOs participating in the PGP lost money in the first three years when accounting for this \$1.75 million in start-up costs. These PGP participants were also better suited for the ACO model as they were already highly integrated, involved large entities and had EHR infrastructures in place prior to the demonstration program. We concur with many other organizations responding to this Proposed Rule that the likely startup costs for less-organized delivery systems will be many-fold the \$1.75 million.

We believe that CMS should increase the percentage of savings that ACOs can receive, particularly in the initial years.

Implementing a Pure Shared Savings Model

The Proposed Rule has been met with confusion and trepidation among our memberships. One of the primary reasons physicians choose to be a solo practitioner or belong to a small practice is the freedom of practice autonomy and being held accountable to the person that matters most – the patient. Significant financial risk, including the costs over which ACO members have no control, when coupled with the fear of loss of practice autonomy, serves as a significant disincentive for solo and small group practices from joining an ACO. CMS proposes two shared savings models for ACOs.

Under Track 1, shared savings would be reconciled annually for the first two years of the three-year agreement using a one-sided shared savings approach, with ACOs not being responsible for any portion of the losses above the expenditure target. For the third year, CMS will establish a two-sided payment model under which an ACO would be required to agree to share any losses that may be generated, as well as savings. Under Track 2, ACOs would be under a two-sided model for all three years of the agreement period. Consequently, an ACO that pursues Track 2 would be eligible for higher sharing rates than would be available under the one-sided model.

We believe that, at least initially, CMS should offer an additional shared savings model that would implement a one-sided shared savings approach for all three years of the first agreement period.

We believe that there are four fundamental reasons why CMS should implement a pure shared savings model:

1. Prospective ACOs do not have access to Medicare claims data that would enable them to evaluate the nature or magnitude of the down-side risks they would be accepting.
2. Because of the retrospective assignment of patients, ACOs would not know which beneficiaries would be assigned to them until after the fact, and those beneficiaries have no obligation or incentive to cooperate with an ACO's efforts to control expenditures.
3. In the Proposed Rule, there is no adjustment of the benchmark based on changes in health status of the patients attributed to the ACO.

4. ACOs and their participating providers are responsible for costs that result from actions taken by providers outside the ACO.

Availability of Beneficiary Data

CMS proposes to provide aggregated data reports for potentially assigned beneficiaries. These data reports are intended to allow the ACO to better monitor, understand, and manage its utilization and expenditure patterns, as well as to develop, target and implement quality improvement programs and initiatives. These data will include the beneficiary's name, date of birth, sex and health insurance claim number. Additionally, CMS is proposing to give ACOs the opportunity to request certain identifiable claims data on a monthly basis for beneficiaries being served by the ACO. **We strongly support having CMS provide detailed data to ACOs on their patients as frequently as possible.** However, we believe that the usefulness of the data is somewhat diminished because of the retrospective assignment of Medicare beneficiaries to the ACO. Under the regulations as proposed, CMS would be providing ACOs data on some beneficiaries who ultimately would not be assigned to them.

Because timely data will be important for ACOs to manage care and risk, **we propose that if timely and accurate data in a useable format are not provided to ACOs by CMS, an ACO will be exempt from shared losses for the relevant performance year.** Additionally, **our organizations do not support providing claims data to ACOs with provider or supplier identification information if that provider/supplier is not an ACO participant.** We believe that absent quality data, assumptions will be made about providers based simply on resource use and could result in steering of patients to providers who may be low cost, but not necessarily high quality.

Consistency of Clinical Practice Guidelines

The Proposed Rule states "the ACO would develop and implement evidence-based medical practice or clinical guidelines and processes for delivering care consistent with the goals of better care for individuals, better health for populations, and lower growth in expenditures." The Proposed Rule further states "ACO participants and ACO providers/suppliers would have to agree to comply with these guidelines and processes and to be subject to performance evaluations and potential remedial actions." We believe that consistency of clinical practice guidelines used by ACOs located in the same geographical area will be important, particularly since specialists are permitted to participate in more than one ACO. Without some level of consistency, specialty physicians may be forced to adhere to different guidelines for various subsets of their patient population, which could have negative consequences on practice workflow. **Lack of consistency of medical practice or clinical guidelines serves as a disincentive to ACO participation by specialists and is exacerbated by the fact that beneficiaries will be retrospectively assigned to an ACO, leaving physicians in the dark as to which guidelines should be applied to which patients.** Furthermore, an ACO may choose to implement guidelines from proprietary commercial sources that are in conflict with guidelines accepted and promoted by physicians' specialty organizations.

Quality Measure Reporting Requirements

Quality Measure Reporting Flexibility

CMS is proposing 65 measures across five "domains," or areas, of quality of care for use in calculating an ACO's quality performance standard. In the ACO's first year of operation, in order to receive shared savings, the ACO must achieve 100 percent "complete and accurate" reporting on all 65 quality measures. In subsequent years, a performance threshold will be calculated based on an ACO's measurement scores.

We believe that a broad scope of measures will enable flexibility and experimentation in the structure and scope of ACOs. However, we believe that requiring reporting on all 65 quality measures diminishes an ACO's ability to select and build a portfolio of measures that best reflects their patient populations while also enabling regional and national benchmarking. **Like Stage One of the EHR Incentive Program, CMS should offer ACOs a menu of measures from which they could select a subset of the 65 measures in each of the five domains.**

Additionally, we believe that consideration should be given to granting ACOs more flexibility in selecting quality measures that are in use in other quality incentive and reporting programs, such as PQRS, thereby allowing ACOs to report on both national and local measures that are related to their patient population.

We also ask that CMS allow ACOs more flexibility in reporting thresholds for the first year. We believe that ACOs that achieve savings should be allowed to share in some percentage of the savings even if the ACO has not successfully achieved 100 percent reporting on all 65 measures. Based on the experience from PQRS, errors can occur with the capture, transmission and evaluation of quality measurement data. Furthermore, to the extent beneficiaries receive care outside the ACO and claims data for those services or results of specific tests are not made available to the ACO, significant data elements needed will not be available.

Use of Colorectal Cancer Measures

As previously stated, our organizations support the proposed inclusion of the colorectal cancer screening measure (PQRS measure No.113) among the measures that will be used for establishing quality performance standards for ACOs. However, this measure only assesses whether the Medicare beneficiary has received a colon cancer screening and does not assess the quality of the screening itself or any necessary follow-up care. **We recommend that CMS consider adding to the Preventive Health domain the following measure: Endoscopy & Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use (PQRS measure No. 185).** This measure is reported by the physician performing the surveillance colonoscopy, which is most often a gastroenterologist. When coupled with PQRS measure No. 113, the measure will examine whether high-risk beneficiaries are receiving the appropriate follow-up services, thus demonstrating whether the ACO is being effective at enhancing provider communication and collaboration.

Use of Registries for Reporting Data

We believe that if ACOs are given the flexibility to select measures other than the measures prescribed in the Proposed Rule, it will afford ACOs the opportunity to take advantage of quality data collection efforts occurring through established clinical registries on a wider range of process and outcomes measures. ACOs could select measures used in clinical registries and could rely on the quality reports generated by those programs to meet CMS' requirements.

ACG and ASGE have been instrumental in forming the GI Quality Improvement Consortium (GIQuIC), an educational and scientific organization that allows gastrointestinal specialists to submit measures and receive outcome data on procedures in order to increase quality of care for their patients. The GIQuIC is a clinical registry that allows gastrointestinal specialists to collect and submit to a data repository patient data that is then translated into key quality measures, including measures that have been endorsed by the NQF and adopted by the AQA Alliance.

In July 2010, GIQuIC launched its national benchmarking effort and began collecting quality indicators for colonoscopy. This effort will be followed by the collection of quality indicators for other gastrointestinal-related measures. As of June 2011, more than 200 physicians were participating in GIQuIC, resulting in more than 13,000 cases being entered into the database. Allowing ACOs the

flexibility to use clinical registries for quality measurement will allow for a robust assessment of ACO providers and will enable CMS to ensure that ACOs are not performing the minimum standard of care in order to achieve greater cost savings.

Facilitating Formation of Physician-Centered ACOs

The Patient Protection and Affordable Care Act (ACA) specifies that the following groups of providers and suppliers can participate as ACOs under the Shared Savings Program:

- ACO professionals in group practice arrangements
- Networks of individual practices of ACO professionals
- Partnerships or joint venture arrangements between hospitals and ACO professionals
- Hospitals employing ACO professionals
- Other groups of providers as the Secretary determines appropriate

We believe that the quality measures proposed by CMS make participation of a hospital in an ACO a requirement to achieve any shared savings if CMS is to require reporting on all 65 measures. For example, included in the Patient Safety domain is a measure that is comprised of hospital-acquired conditions currently included in the Medicare Inpatient Hospital Acquired Conditions Non-Payment Program. If the hospital is not part of an ACO it may not be possible to easily obtain the information from which an ACO is required to report. **We, therefore, underscore our previous recommendation that CMS offer ACOs a menu of measures from which they could select a subset of the 65 measures in each of the five domains, which will facilitate the formation of ACOs that do not include a hospital.**

Integration of PQRS in ACO Quality Reporting Requirements

In the Proposed Rule, CMS proposes to incorporate a PQRS group practice reporting option (GPRO) under the shared Savings Program and further proposes that the eligible professionals that are ACO participation providers would constitute a group practice for purposes of qualifying for a PQRS incentive under the Shared Savings Program. CMS states that the goal of aligning the PQRS requirements with the Shared Savings Program reporting requirements is to eliminate the need for extra reporting in order for eligible professionals or the ACO to earn the PQRS incentive under the Shared Savings Program. Thus, PQRS-eligible professionals within an ACO will be considered eligible for the PQRS incentive under the Shared Savings Program if the ACO reports on all measures proposed in this Proposed Rule. The Proposed Rule clarifies that an eligible professional could not qualify for the PQRS incentive as both a group that is part of an ACO and as an individual. We believe that CMS' proposed alignment of PQRS and the Shared Savings Program raises several questions that are not addressed in the Proposed Rule.

1. Because the measures being proposed for the Shared Savings Program would be out of the control of a gastroenterologist, if the ACO fails to meet future quality performance standards beginning in 2015 when PQRS turns punitive, would physician specialists be penalized because of the failure of the ACO to meet quality performance standards?
2. Even though an eligible professional cannot receive incentive payments both as a group that is part of an ACO and as individual, does participation in an ACO exempt eligible professionals from PQRS reporting requirements?
3. If an eligible professional participates in more than one ACO but only *one* meets quality performance standards, would the professional be eligible for an incentive payment and, when the program turns punitive, would the eligible professional still be at risk of a negative payment adjustment?

Finally, we also wish to point out that due to the lack of specialty measures, it appears that some specialists, like gastroenterologists, may be compelled to report quality metrics that have no pertinence to a gastroenterology practice. Clarity is needed from CMS on expectations of physicians reporting on measures through the ACO for the purpose of receiving a PQRS incentive payment. Specifically, the Final Rule should provide clarification on how incentive payments will be distributed to PQRS-eligible professionals who participate in an ACO that meets quality performance standards. Will the ACO distribute the payments, and, if so, will the ACO be required to distribute the incentive payments equally across all participating eligible professionals, even in cases where an eligible professional has no relevant quality measures on which to report?

Electronic Health Record Requirements

We believe that requiring 50 percent of an ACO's primary care physicians to be an EHR "meaningful user" by year two of a three-year agreement is unrealistically high and required very early. An ACO by its nature will have strong incentives to promote EHR use, but communities with many solo or small group primary care providers can't realistically be held to the standard proposed. Furthermore, we believe the real gain comes less from having an EHR within an individual practice but primarily from the interchange of data among all of the ACO providers (physicians, ancillary services, hospital(s), etc.). Health data interchange is still rudimentary in many communities and not well supported financially. We believe there should be more emphasis on milestones for Regional Health Information Organizations and less pressure on the specific threshold of meeting EHR meaningful use criteria.

Conclusion

Given the importance of the issues and concerns we have summarized above, we strongly urge CMS to restructure the proposed ACO rules to address and remedy the problems outlined, otherwise it will be difficult for our societies to promote to our members this ACO initiative as a feasible alternative Medicare payment and delivery model. If these issues are not addressed, we will feel obliged to recommend to our memberships that they not participate in ACOs where possible.

We welcome the opportunity to work with you and other policymakers in an effort to improve these proposed rules in order to achieve our shared goals for better patient care. Thank you for the opportunity to offer these comments. If we may provide any additional information, please contact Camille Bonta, consultant to ASGE at 202-320-3658 or cbonta@asge.org, or Brad Conway, Vice President of Public Policy, ACG, at 301-263-9000, or bconway@acg.gi.org.

Sincerely,



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