



AMERICAN COLLEGE OF GASTROENTEROLOGY

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December 27, 2010

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Director, Centers for Medicare and Medicaid Services
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Washington, DC

Re: Follow-up of outreach meeting, December 17, 2010

Dear Dr. Berwick and Dr. Emanuel:

The American College of Gastroenterology (ACG) appreciates the opportunity to participate in the "health care system delivery reforms" physician outreach meeting on December 17, 2010 in Washington DC. The College thanks you for the invitation and hopes to meet with you again in the near future to discuss our thoughts on how to improve quality of patient care.

ACG is a physician organization representing gastroenterologists and other gastrointestinal specialists. Founded in 1932, the College currently numbers nearly 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 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 in treatment of patients.

The Obama Administration and ACG share the common goal of increasing efforts to ensure the quality of care our members provide patients.

Patient Safety

ACG is very encouraged that a major initiative will be launched to promote safety, especially in the hospital setting. Systemic risks to patients must be minimized to the extent possible. To achieve this goal, the College advocates for funding fewer projects that aim for comprehensive, revolutionary redesign of care delivery systems. Instead the College recommends consideration of grant programs for hospitals, hospital systems or other entities that provide coordinated outpatient care. Emphasis should be placed on those projects that envision better and more timely information sharing, which the College believes is the biggest risk in today's fragmented system. Grant funds should be available to support transitions among institutions as well as referring practices to way that support for use of EMR has been structured to maximize buy-in from across the provider community. This should involve creation of a personal medical record that attaches to the patient, not the organization providing care. With today's technology and privacy

protections, this is not out of reach. Concerns about the protection of personal information can be met with appropriate encryption and keys that would limit access to providers specified by the patient.

Accountable Care Organizations

The College has reservations about the accountable care organization (ACO) model as the vehicle to improve quality while lowering health care system costs. ACG fears there is insufficient emphasis placed on the initial capital investment required to produce the safety, quality, and cost-savings goals shared by both the medical organizations and the federal government. Even if the “shared savings” bonuses entice the initial capital investment, the College is less optimistic that subsequent “shared savings” targets will continue to make participating in the ACO worthwhile after the initial ACO roll-out campaign ends.

While the College understands that the ACO model is mandated by law under the Patient Protection and Affordable care Act (or the Affordable Care Act “ACA”) and the regulations governing ACOs have yet to be released, the initial reaction from our membership is that the risks of the ACO model likely outweigh the potential benefits of both improved patient care and higher provider reimbursement.

The cost savings from the ACO will come from coordinating care but may also come from an appearance of restricting patient services. Ethically, ACOs pose great challenges for physician/providers due to a fundamental conflict of interest: physicians will be placed in the role of profiting from limiting patient choices rather than being patient advocates. Of course, the patient will not benefit from unnecessary or duplicative services, but patients may not always see it that way especially when there is a disagreement between the treating physician and ACO leadership in regard to the proper course of treatment. The College fears that once Medicare beneficiaries learn that they have been “assigned” to an ACO that provides provider-bonuses for limiting costs, allegations of “health care rationing” and “profiteering,” whether or not these allegations have any merit, could lead to an increase in the fragmented care that the ACO model was designed to eliminate.

Providers must also already carefully allot time participating in various quality improvement initiatives versus the time actually spent treating patients. This becomes more of a dilemma when the physician quality reporting system (PQRS) and “meaningful use” of health information technology program becomes mandatory in 2015. These overhead costs and increased time *away from patients* are not small issues for most practices and grow with time due to increases in staff salaries and expenses. Since our members already face ever-present pressure on and uncertainty of Medicare reimbursement, the anticipated “savings” may not be sufficient to fund the capital needed to provide true “coordinated care.”

Also, the College fears that providers in an ACO may put themselves in risk of medical malpractice lawsuits because they are members of an ACO responsible for coordinating care of a patient, whether or not the patient was treated by providers outside the ACO.

Another concern is the asymmetry in negotiating positions between physicians and hospitals in setting up ACOs. Hospital systems have easier access to capital and restrictions on physician ownership of healthcare resources and antitrust considerations put doctor-organized ACOs at a disadvantage. Hospitals can, and in our view will, stiff-arm physician groups which will produce an adversarial rather than a cooperative interaction if it is in their financial interest to do so.

A final point has to do with the development of ACOs in teaching environments. Because some cost “savings” might be realized by shifting care to physicians-in-training, provisions for adequate supervision of trainees by the billing physician is mandatory.

Quality Improvement

Unfortunately, improved outcomes initially require higher administrative costs. The College believes, however, that quality reporting is the integral component to quality improvement and providers must recognize the importance of quality reporting.

The College hopes to work with CMS and the Administration to better streamline quality reporting to achieve improved outcomes without sacrificing time spent treating patients. ACG recommends that HHS and the Administration consider incorporating into the quality improvement specifications of ACOs, as well as into PQRS and the “meaningful use” program, those quality improvement initiatives that providers already participate in and have a demonstrated history of improving patient care and outcomes.

One such quality of care initiative, which we mentioned to Dr. Emanuel at the meeting, is called the “GI Quality Improvement Consortium” or GIQuIC. GIQuIC is a clinical registry and collaborative effort by ACG and ASGE that allows gastrointestinal specialists to collect and submit actual patient data that is translated into key quality measures, including measures endorsed by the National Quality Forum (NQF) and adopted by the AQA alliance, to a data repository. These providers receive outcome data on thousands of procedures enabling them to increase the quality of patient care they deliver. Comparable feedback reports, which are based on actual cases submitted rather than less reliable claims data, are provided on a group practice level or at the individual physician level, per the choice of the participants. Unlike issues associated with PQRS, GIQuIC allows gastrointestinal specialists to submit data that is specific to their specialty and provides them with the means to receive apples-to-apples comparative data based on other participants reporting the same measures.

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 procedures as well as non-procedural physician/patient interactions. Providers submit data through an electronic data collection form but there is an option for those who do not have an endwriter or an electronic health record system to participate; a computer with Internet access is sufficient. All data that comes to GIQuIC is stripped of personally identifiable information and is also encrypted.

There is evidence that scientific measurement of the quality of endoscopic procedures will improve the quality of the medical care being provided to patients throughout the United States and abroad. There is no reason to believe this will not hold true for non-procedure interactions in GI as well. Over time, the project will help determine which indicators are good measures for improving patient treatment and outcomes.

GIQuIC plans to share the scientific results of its benchmarking with the general public by releasing data to medical colleges and universities through presentations at scientific meetings, as well as by publishing scientific papers on how to improve gastrointestinal procedures and treatments. In addition, we believe that sharing GIQuIC results with medical colleges and universities will help shape the curriculum and training of future gastrointestinal specialists.

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Conclusion

Thank you again for the invitation to participate in the December 17, 2010 meeting. The College would also appreciate the opportunity to meet with you for a follow-up discussion on quality measures in gastroenterology and provide more information on quality improvement initiatives such as GIQuIC.

Very truly yours,

A handwritten signature in black ink, appearing to read "D L Chumley". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Delbert L. Chumley, M.D., FACG
President

A handwritten signature in black ink, appearing to read "Lawrence R. Schiller". The signature is cursive and elegant, with a large initial "L" and a long horizontal flourish.

Lawrence R. Schiller, M.D., FACG
President-elect

Cc Bradley C. Stillman, ACG Executive Director