



September 30, 2011

The Honorable Patty Murray, Co-Chair
Joint Select Committee on Deficit Reduction
United States Congress
448 Russell Senate Office Building
Washington, DC 20510

The Honorable Jeb Hensarling, Co-Chair
Joint Select Committee on Deficit Reduction
United States Congress
129 Cannon House Office Building
Washington, DC 20515

Dear Co-Chairs Murray and Hensarling:

On behalf of the Board of Directors of the American Medical Group Association (AMGA), an organization representing multi-specialty medical groups and other organized systems of care, including some of the nation's largest, most prestigious integrated health care delivery systems, I am writing to urge your support and recommendation of a cost saving measure for the Medicare program. AMGA urges the members of the Joint Select Committee of Congress to support strengthening the shared savings program, popularly known as Accountable Care Organizations (ACOs). The steps we suggest will help assure that this model of delivery, due for implementation on January 1, 2012, is best able to maximize its cost saving potential over time.

Congress created the shared savings program, ACOs (section 3022 of the Affordable Care Act), to allow health care delivery organizations to share in savings from their provision of high quality medical care while lowering the costs. We support accountable care and want this concept to succeed.

The Physician Group Practice Demonstration (PGP) project, the "field test" for the ACO concept, conducted by the Centers for Medicare and Medicaid Services (CMS), from April 2005 through March 2010, saved the Medicare program \$134.1 million. Steady improvements in quality were attained by all of the 10 participating groups. In the final year, all participants achieved benchmark quality performance measures on heart failure, coronary artery disease, and preventive care metrics, a stellar demonstration of value, the delivery of effective care supplied efficiently.

CMS has not fully heeded the lessons learned from its PGP project. It has created a regulatory framework which is overly prescriptive, operationally burdensome and the incentives too difficult to achieve. This will not succeed in attracting ample participation to allow this voluntary program to realize its long term cost saving, quality improvement promise. Nor will it be the foundation for health care delivery transformation from volume-based to value-based care. Nine of the ten participating entities in the PGP were AMGA members and much of what we propose here is based on their experiences and perspectives.

While the regulatory framework has not yet been finalized, the level of dramatic change necessary to make the program viable and successful is not likely to be forthcoming in the final rule. We therefore urge that your committee incorporate in its recommendations the following key legislative measures. These are not the only changes which would be beneficial, but they would assure that ACOs are structured to best advantage to achieve their goals, and emerge as strong, cost saving and quality enhancing health care delivery improvements, as was the intent of Congress.



Prospective Alignment of Patients

Knowing who the patients are is essential to managing their care and knowing for whom the ACO will be held accountable. Thus, aligning patients (attributing their care to the ACO for accounting purposes) and sharing their demographic and clinical information with the ACO must be prospective, not after-the-fact as proposed.

Too Much Risk Assumption will Discourage ACO Participation

ACO risk sharing is proposed as two-sided, risk of upside (shared savings) and downside performance (shared losses). In the PGP, risk sharing was one-sided (shared savings) only. The risk-reward structure must be attractive in the context of voluntary participation. Too much risk will discourage participation, thus one-sided risk should pertain.

Sicker Patients Require Costlier Care than do Healthier Patients: Risk Adjustment

Risk adjustment is a commonly used tool in medical care delivery and is a weighting methodology used to account for disease severity of the patient population. In Medicare, ACOs included, patients can seek care anywhere. Thus patient populations change quite a bit, as much as 25% according to CMS' own estimates. To factor that in equitably, risk adjustment must be *recalculated* yearly, not once in three years, as proposed.

Minimum Savings Rate (MSR)

The MSR is designed to assure that ACOs financial results are based on clinical interventions and operations efficiencies, not as a result of statistical data fluctuations. The proposed framework sets the bar too high at 2% and those dollars go back to the Medicare program—they are not included in the basis of shared savings calculations. The MSR should be set at 1% and if attained, those monies should remain as the shared savings calculation base—they should not be “taken off the top,” as is proposed.

Quality Data Reporting—Too Much too Fast

In the PGP demonstration, 32 quality measures were reported on a phased-in basis: 8 measures in year one, 16 in the second year, and 32 in years three and beyond. The data gathering and reporting was extensive and expensive, but manageable. The proposed framework calls for 65 measures to be reported immediately the first year. This is excessive. Keep the number of measures attainable, as in the PGP.



Antitrust Issues/ Stark Law/Anti-kickback Statute/Civil Monetary Penalties

The “protections” and assurances offered are not sufficient to convince many that they are adequately shielded from antitrust problems. ACOs should be given a clear safe harbor if they meet clinical integration criteria such as those already used by the Federal Trade Commission. Similarly, the Congress should grant authority to the Secretary of the Department of Health and Human Services and the HHS Office of Inspector General to deem ACOs accepted into the program to be in presumptive compliance with Stark, anti-kickback and civil monetary penalty laws, given the extensive application and vetting procedures, documentation, and attestations necessary to form an ACO.

As you face the challenges of working to meet your committee objectives, AMGA stands ready to assist you in any way it can. Please contact George Roman of my staff at groman@amga.org or (703) 842-0772 if you have questions about our proposal or need more information.

Sincerely,

A handwritten signature in black ink, appearing to read "Donald W. Fisher", is positioned below the word "Sincerely,".

Donald W. Fisher, PhD, President and CEO

cc: Members of the Joint Select Committee on Deficit Reduction