AGS | THE AMERICAN GERIATRICS SOCIETY
Geriatrics Health Professionals.
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Submitted Electronically via
http://www.regulations.gov

Dr. Donald Berwick
Administrator
Centers for Medicare & Medicaid Services
Mail Stop C4-26-05
Attention: CMS-1503-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations Proposed Rule (CMS-1345-P)

Dear Dr. Berwick:

The American Geriatrics Society (AGS) greatly appreciates the opportunity to comment on a number of the proposals in the Medicare Shared Savings Program: Accountable Care Organization (ACO) Proposed Rule to implement Section 3022 of the Patient Protection and Affordable Care Act (Affordable Care Act, or "ACA").

The AGS is a not-for-profit organization comprised of close to 6,000 geriatrics healthcare professionals who are devoted to improving the health, independence and quality of life of all older people. The Society provides leadership to healthcare professionals, policy makers and the public by implementing and advocating for programs in patient care, research, professional and public education and public policy.

As a specialty society with a mission of advancing efforts that promote high quality of care, quality improvement, and increased payment accuracy, we support efforts to improve care coordination and improve efficiency and quality of care provided to Medicare beneficiaries. AGS members are the geriatricians and other health professionals specializing in the care of older adults, including advanced practice nurses and physician assistants, who are responsible for furnishing and directing care for our nation's growing number of elderly patients with multiple and complex conditions. The population of Americans aged 65 and older is expected to nearly double, to more than 70 million, by 2030. Of added significance is the phenomenal growth of the population of adults aged 85 and over. This segment is growing at four times the rate of the rest of the population and encounters greater overall disability, as well as need for medical and other support services. In fact, frail elders and those with multiple chronic conditions account for the highest percent of Medicare expenditures.

As CMS implements new and innovative payment methodologies, it is imperative for the agency to recognize that the frail elderly with multiple chronic illnesses are the patients who will benefit the most from the transformation of Medicare into a patient-centered system focused on primary geriatric

care, chronic care management and coordination of care across settings. We are very pleased that CMS has recognized in this proposed rule that geriatricians and other geriatrics professionals will be key players in a reformed payment system; and we urge CMS to continue to consider the issues that are unique to geriatrics as the agency continues to test and phase in new payment and care delivery models.

As we discuss in greater detail below, geriatricians are unique in that they care for patients, many of whom are Medicare beneficiaries, as primary care physicians and as specialists. Geriatricians are perhaps the most likely physician specialty to be able to contribute to the success of the Accountable Care Organization (ACO) model; and our patients are the most likely to benefit from ACOs. Therefore it is crucial that the physician incentives for participating in such a system ensure that geriatricians and other geriatrics professionals can participate in ACOs. In fact, we strongly urge CMS to require that all ACOs be structured in such a way that beneficiaries have access to the expertise of geriatricians. The AGS is committed to addressing the nation's eldercare workforce by building a caring and competent workforce. As co-conveners of the Eldercare Workforce Alliance, we have signed on to the workforce principles that the group recently submitted to CMS. We believe that care models such as ACOs should provide well-coordinated, person-directed and family-focused services across settings. A competent workforce should include the promotion of quality care and recognition of the complexity of caring for older adults with multiple chronic conditions.

Below please find our high level comments, followed by more detailed comments on specific issues.

High Level Comments

In general, we are concerned about the complexity of the proposed regulation, and it is unclear whether many physician practices, other than very large multi-disciplinary practices that already have many of the processes in place, will be able to form an ACO or achieve success under the model as currently proposed. The substantial up-front investment costs needed to develop the infrastructure, data systems and quality reporting functions that will be necessary to form an ACO, combined with the downside risk in the third year of the initial 3-year agreement period, will make it less attractive for physicians and physician practices to want to test this model.

Because geriatricians tend to care for the oldest and frailest Medicare beneficiaries, who often are living with multiple chronic illnesses or conditions, we are concerned that the limitations on the ability to account for a beneficiary's acuity level could reduce an ACOs ability to realize savings, and potentially create a disincentive toward the management of patients with complex care needs; and the safeguards that are proposed to prevent "cherry-picking" may not be strong enough to avoid this result.

We are very concerned about the beneficiary opt-out process, particularly as it relates to the vulnerable beneficiary population that geriatricians care for. Our patients are typically very elderly and very sick, and we are concerned that the processes proposed for informing beneficiaries of their option to opt-out of data sharing within the ACO is burdensome in terms of the time it will take to explain the opt-out option to this population and will certainly cause confusion on the part of both beneficiaries and physicians. Further, if patients do not want to participate in the ACO at all, yet their primary care physician is an ACO participant, the patient will have to find a new primary care physician outside of the ACO. The doctor-patient relationship is always important, but it is especially significant to older, sicker

patients who are perhaps the most vulnerable, and discontinuing a relationship with a physician could have a considerable and detrimental impact on members of this beneficiary group.

Geriatricians are unique in that they practice as either primary care physicians, or consultants/specialists, and in many cases as both. This characteristic distinguishes geriatricians from most other primary care physicians, but also raises questions about the geriatricians' role and ability to participate as a geriatric consultant to multiple ACOs. As discussed in more detail below, we believe geriatricians should be able to participate with more than one ACO when acting as a specialist or consulting physician. Further, we believe that given the current and growing shortage of geriatricians, this will likely be the best way for multiple ACOs to tap into the unique expertise of geriatrics health professionals.

The large number of quality measures that each ACO must report beginning in the first year of the program is overwhelming and burdensome. Many of the quality measures are new or are currently not being used, so providers have little or no experience with their use and potential results. Implementing the programs associated with reporting new quality measures is extremely costly, and many of the proposed measures are not claims-based, adding to the expense.

Finally, we have very strong concerns about the transparency requirements that CMS has proposed. In theory, transparency should facilitate an ACO's ability to improve performance and to inform consumers about its providers, governance and performance scores, in addition to other information. However, given the very little experience providers and CMS have in this area, we feel strongly that CMS should allow an adequate period for gaining better knowledge and understanding of how ACOs will work in practice. To that end, we recommend that the transparency requirements be phased in over time, rather than being required at the start of the program.

In short, as currently proposed, the shared-savings program design is complex and the potential for incurring losses rather than achieving savings in the first three-years is very real. We have significant concerns that, unless CMS is able to reduce the burden or to provide substantial additional ramp-up time, many geriatricians, even those in large multispecialty practices that already have quality measurement and efficiency processes in place, may not be able to participate in ACOs.

Our specific comments follow.

I. <u>Beneficiary Assignment to ACOs</u>

Under the proposed rule, Medicare beneficiaries would be retrospectively assigned to ACOs on the basis of receipt of primary care services from an ACO-participating physician specializing in general practice, family practice, internal medicine, and geriatric medicine. We have several specific comments under this heading.

A. <u>*Physician Designation as a Primary Care Physician*</u>

The primary care physicians defined in the proposed rule will be required to be exclusive to a single ACO, while specialists would have flexibility to participate in more than one. In the proposed rule, CMS expressed concern that this proposal may not adequately account for primary care services delivered by specialists, especially in certain areas with shortages of primary care physicians. CMS also

stated that this could create difficulty in an ACO obtaining the minimum number of beneficiaries to form an ACO in geographic regions with primary care shortages.

The AGS has particular concerns with this rule that are unique to geriatricians. Geriatricians typically practice as both primary care physicians and specialists (e.g., furnishing geriatric consultations). Some geriatricians may focus on the provision of primary care services, and others may focus on providing consultation services as specialists, but virtually all practices do both. This characteristic may distinguish geriatricians from other primary care physicians and, at the same time, it raises additional unique questions about the geriatricians' role and ability to participate as a geriatric consultant to multiple ACOs.

We appreciate that CMS has included geriatricians in the definition of primary care physicians for purposes of the proposed ACO rule. However, we also recommend that the final rule address the "dual" nature of geriatrics and clarify that a geriatrician may participate in multiple ACOs when the physician is acting in his or her role as a consultant, while still serving as the primary care provider for the purpose of assigning beneficiaries for which that geriatrician is the physician of record to an ACO. While beneficiaries may be attributed to a particular ACO based on their utilization of the primary care health care services of the geriatrician, this should not bar the same physician from serving as a specialist to multiple ACOs.

<u>Comment:</u> We are pleased with the recognition of geriatricians as primary care physicians; however, we also recommend that CMS modify its proposal to allow geriatricians to participate in multiple ACOs for the purpose of providing consulting services. For example, CMS could designate the ACO to which the geriatricians' primary care patients are attributed as their "base" for the purposes of calculating quality performance and savings, but allow geriatricians to participate with other ACOs when providing services as a specialist.

B. *<u>Beneficiary Assignment and the Patient/Physician Relationship</u>*

CMS clearly did not intend for beneficiary assignment to an ACO based on historical utilization to restrict the ability of a beneficiary to seek care from providers outside of the ACO. CMS states in the proposed rule that a beneficiary must be notified of, "and have meaningful control over who has access to his/her personal health information for purposes of the Shared Savings Program." Once notified by the provider that (1) the provider is an ACO participant, and (2) that the provider may request claims data about the beneficiary, the beneficiary may "opt-out," i.e., may choose not to have his or her protected health information shared amongst the health care providers in the ACO.

The "opt-out" proposal raises two issues. First, a beneficiary may opt-out of having his or her health information shared with other providers. In this case, a beneficiary can continue to receive care from his or her primary care provider, although explaining what this means to vulnerable, older and very sick Medicare beneficiaries will be extremely burdensome, time-consuming and will cause great confusion for beneficiaries.

Second, irrespective of the data-sharing opt-out, the proposal could have the unintended consequence of significantly disrupting the physician-patient relationship. When a primary care physician decides to become an ACO participant, those Medicare beneficiaries who received the plurality of their primary care services from that physician will be assigned retrospectively to that ACO,

and the physician will be responsible for explaining what this means to the beneficiary. Separate and distinct from the data-sharing opt-out, a beneficiary may decide, for a variety of reasons including misinformation or lack of understanding of the purpose of the ACO, to opt-out entirely; that is the beneficiary may desire not to participate in the ACO at all.

We believe it is very likely that some beneficiaries would discontinue their current physician relationship when the physician is an ACO participant, even though this is not what CMS intended. CMS does not specifically address this situation in the proposed rule, but it is clear that the beneficiary who does not want to participate in the ACO, for any reason, and for whom opting out of the data sharing is not a satisfactory option, effectively will have to seek care from a provider that is not participating in an ACO. As geriatrics health professionals, we have a number of significant concerns about this provision.

Notifying the beneficiary at the point of care about the physician's participation in an ACO and what that means for the beneficiary is an admirable idea, but in our experience with an older, more frail patient population, the process of notifying and explaining this complex information to this cohort of Medicare beneficiaries will be extremely difficult. ACO participants will be required to post signs in their facilities indicating the provider's participation, and to make available standardized written information to the Medicare beneficiaries whom they serve. Additionally, all Medicare patients treated by participating providers must receive a standardized written notice of the provider's ACO participation and a data use opt-out form. All of these activities will no doubt take time and verbal explanation, in addition to the written information, particularly for this patient population.

Because an ACO is essentially defined by its primary care providers, we are very concerned about the disproportionate burden this requirement will place on primary care physicians' offices. Medicare, not the provider, should have to shoulder the burden of explaining ACOs to beneficiaries. Medicare should reach out to beneficiaries through mailings and other means, and develop materials, including posters, brochures and other standardized materials that can be used by primary care offices to provide details about the ACO program and clarify any questions beneficiaries might have.

Comment: We are very concerned that patients will not understand or may be skeptical of this opt-out provision, and for this reason, could opt to seek care from ACO non-participants, even if the beneficiary has an established relationship with a physician or other eligible primary care professional. The doctor-patient relationship is very important to the population that we care for. In addition, it is unclear how CMS will be able to implement this provision. In theory, the beneficiary would only opt out of having his or her personal information shared with the ACO by other providers. The proposed rule states that this decision would not affect use of the beneficiary's data or assignment to the ACO for purposes of determining calculations such as ACO benchmarks, per capita costs, quality performance or per-capita expenditures in the performance year. Again, we have significant concerns about how CMS intends to implement this proposal.

C. ***Beneficiary Attribution to ACO Based on Nurse Practitioner Services***

CMS interprets the statute as defining the term "ACO professional" to include both physicians and other clinicians, such as advance practice nurses, physician assistants, and nurse practitioners. However, for purposes of beneficiary assignment to an ACO, the statute requires that CMS consider only the beneficiaries' utilization of primary care services rendered by physicians, even though non-physician

practitioners are included as a factor in determining entities that are eligible to participate in the Shared Savings/ACO program.

Comment: We understand that the statute requires CMS to determine a method for assigning Medicare fee-for-service beneficiaries to an ACO based on beneficiaries' utilization of primary care services furnished by physicians. However, we are concerned that interpreting this language to mean that CMS may consider only the services furnished by physicians could be limiting, and potentially result in the incorrect attribution of many beneficiaries to ACOs where the beneficiary did not receive a plurality of primary care services, because their primary care services were actually provided by a non-physician practitioner, such as a nurse practitioner. In other words, the beneficiaries that are assigned to an ACO may not represent the full picture of that ACO's patients, when the attribution model does not include all primary care providers, such as nurse practitioners.

Elsewhere in the statute CMS clearly gave CMS discretion in designing the ACO program. We believe that the statute affords CMS some discretion under the statute to include certain non-physician practitioners, in addition to physicians, for the purpose of assigning Medicare fee-for-service beneficiaries to an ACO.

Comment: CMS should carefully re-examine the statute to determine if it has discretion, given the discrepancy between the definition of the term "ACO professional" and the statutory language regarding primary care services furnished by physicians. We are concerned that not including practitioners such as nurse practitioners and physician assistants as providers of primary care services for the purpose of assigning beneficiaries to ACOs could materially affect the success of the ACO program.

CMS should also consider how to devise a more reliable methodology for determining a practitioner's specialty, including non-physician practitioners such as nurse practitioners and physician assistants. The current self-designation process may not be enough to accomplish what is necessary to truly define primary care. With a more granular system, CMS could determine whether an advance practice nurse, e.g., an NP, was a geriatric NP and not a surgical NP.

Finally, regardless of whether there are geriatrics providers who are participating in an ACO (given the acute and growing shortage of geriatrics health professionals), AGS believes that all ACOS should have geriatrics expertise on their Board of Governors so that they have access to the unique knowledge base and training of geriatrics health professionals related to care of older adults. It is critical for the governing body of the ACO to have access to adequate geriatric competency for the patients of the ACO.

D. Beneficiary Assignment and Community Health Centers

Another challenge with respect to beneficiary assignment to ACOs involves beneficiaries who receive the bulk of their care from community health centers, or Federally-Qualified Health Centers (FQHCs). Under the proposed rule, FQHCs can participate with an ACO, but due to data collection and reporting limitations at these providers, and the fact that many beneficiaries receive their primary care from non-physician practitioners in this setting, CMS will not assign beneficiaries to an ACO based on the care a beneficiary received at an FQHC. While the proposed rule does include some incentives for ACOs to include FQHCs as participants, the FQHC's typical patients will not be assigned to the ACO (because

CMS cannot identify the primary care services furnished by physicians in that setting), and the savings attributable to those patients will not be realized by the ACO. The incentives included in the rule may not be great enough to overcome the disincentives for ACOs to include these providers as participants.

Comment: CMS should continue working to find a way to identify patients who receive their primary care services at an FQHC, in order to attribute FQHC patients to an ACO. The services provided at an FQHC are primary care services, and they are typically furnished by a team of providers that includes physicians. We believe that CMS has the discretion to include these beneficiaries and assign them to ACOs based on their utilization of FQHC services.

II. Maintaining 5,000 Beneficiaries in the ACO

CMS has proposed that ACOs that fall below the 5,000 beneficiary threshold in a year must follow a corrective action plan and will be terminated if they do not meet the threshold by the end of the following performance year. The statute clearly requires that ACOs meet a 5,000 beneficiary minimum; however, the law does not go as far as the proposed regulation by requiring termination if the number of beneficiaries falls below 5,000. Some normal fluctuation should be expected in the number of beneficiaries that are receiving care through an ACO. The proposed rule does not make clear what amount of fluctuation will be considered acceptable. While we understand the statutory requirement, and agree that a corrective action plan may be necessary, particularly if the ACO continually falls below and remains below the minimum number of beneficiaries in a performance year; however, we do not agree that termination is necessarily the answer, particularly in the first three-year agreement period when ACOs are just getting up and running.

Comment: We recommend that CMS allow for a longer "ramp-up" period or a grace period during the first three-year agreement period, during which time, an ACO should not be terminated for falling below the 5,000 beneficiary minimum. While CMS should monitor ACOs for compliance with the rules and regulations, CMS also has recognized that because this is a brand new program, there will almost certainly be issues that will require adjusting as the agency gains experience with ACOs. In addition, because beneficiaries will be assigned retrospectively to the ACO, an ACO may not be fully aware, or even have any control over the number of beneficiaries at a given time, and therefore, an ACO should not be terminated based on something that is beyond its control.

Further, ACOs will be investing significant amounts of money to develop an infrastructure under the assumption they will qualify as an ACO. If they do not qualify retrospectively, those investments will not be recoverable, as there will be no potential for shared savings.

We do not believe that ACOs should be terminated based on failure at certain times to comply with the minimum threshold, particularly during the first three-year agreement period. In the future, we believe that ACOs should only be terminated for falling below the minimum number of beneficiaries when the failure to comply is ongoing and cannot be resolved through any corrective action.

III. Requirement for a "Full-Time" Medical Director

The proposed rule includes other governance requirements, including the establishment of various committees and requirements for "dedicated physician leadership." Under the proposed rule, ACOs would be required to have a full-time, senior level medical director for clinical management and oversight, who is board-certified, licensed in the state in which the ACO is located, and physically

present in the state. The regulatory text at proposed 42 CFR 425.5(d)(9) (Leadership and Management Structure) requires clinical management and oversight by a licensed and board-certified "full-time senior-level medical director who is physically present on a regular basis in an established ACO location." The preamble language does not elaborate on this requirement.

Comment: We agree that physician leadership will be one of the keys to an ACO's success and that this requirement is important. It is important that the medical director be involved in direct patient care in order to gain better knowledge and understanding of what is going on in the ACO. However, CMS should clarify in the final rule what is meant by "full time" and should clarify that the duties of a "full time medical director" could include the provision of direct clinical care to patients. If CMS does not include such a clarification in the final rule, then the agency should consider allowing an ACO to have a part-time medical director.

IV. Patient-Centeredness Criteria

The proposed rule outlines criteria that an ACO must meet in order to demonstrate that it is patient-centered, as required by the law. CMS proposes to require ACOs to address each of eight different criteria, from beneficiary experience of care and patient involvement in ACO governance, to having systems in place to identify high-risk individuals and processes for developing individualized care plans for target populations and a process for communicating information to beneficiaries in ways that are understandable for them and that allow for patient engagement and shared decision-making.

Comment: While patient-centeredness is critical to the furnishing of care to older, sicker populations, and while these are excellent goals, we believe that requiring an ACO to meet each of these criteria in the initial years of ACO development will be burdensome to providers. We believe it will be difficult for ACOs to demonstrate compliance with all of these criteria, at least initially. Again, CMS should consider a longer ramp-up time, or grace period, during which compliance with some or most of these requirements, or "other documentation that demonstrates patient-centeredness" would be sufficient in the first three-year agreement period. The eight criteria outlined in the proposed rule could be set forth as illustrative examples of patient-centeredness.

V. Quality Measures and Performance

Clearly, ACOs must achieve and maintain good quality care in order to earn incentive payments under the Shared Savings Program and we applaud CMS' inclusion of two PCPI geriatrics measures (falls assessment and medication reconciliation), as well as the fact that CMS has recognized the importance of frail elder measures. The law required CMS to determine which measures might be appropriate for assessing the quality of care furnished by an ACO, including measures of clinical processes and outcomes, patient experience of care (and where practicable, caregiver experience of care) and utilization (such as rates of hospital admission for ambulatory sensitive conditions).

CMS has therefore proposed 65 quality measures, across five domains -- patient/caregiver experience of care, care coordination, patient safety, preventive health, and at-risk population/frail elderly health, and has sought to align measures across Medicare and Medicaid's public reporting and payment systems, in an effort ultimately to achieve a core set of measures appropriate to each provider category that reflect the level of care and the most important areas of service and measures for that provider.

Comments: The main issue for AGS is the burden of these measures, which we believe could prevent some provider groups from participating. While we agree with the goals of aligning measures across public reporting and payment systems, and efforts to minimize provider burden, the requirement that ACOs submit quality data on all 65 measures for each year of the three-year agreement period is unduly burdensome. Many of the measures that CMS has proposed have not been used before and do not have specifications of stakeholder endorsement. While many of the measures come from claims, others, such as the patient experience of care measures (Measures 1-7), do not and will need to be collected via surveys, which will be time consuming, expensive for ACOs to collect, and may not provide reliable results, given providers' lack of experience with these measures. We were pleased to see that the patient experience of care and coordination of care measures included, but we are concerned that these measures will need improvement, and the AGS is happy to work with CMS on such a project.

Decreasing the burden, for example by phasing in measures, or by requiring those measures that are as of yet untested to be reported only, rather than be scored on performance (such as admission rates for ambulatory care sensitive conditions (ACSCs)) for the first three years of the program may encourage some providers or provider groups to participate. Such changes could also allow providers and policymakers to understand how different population groups, such as frail elders, were affected by being in an ACO. They would also reveal any unintended consequences, such as "cherry picking," and may improve quality for many more patients, because more provider or provider groups would participate.

CMS' proposal to require the reporting of measures during the first year of the agreement period, which will determine the performance standard for the next two years, does not give providers enough time to gain enough experience with those measures. This is particularly important, given the requirement that in the first year, CMS intends to base the receipt of shared savings on 100 percent complete and accurate reporting on all quality measures; and ACOs that fail to report quality measures are subject to immediate termination. Finally, we have significant concerns about the use of composite measures in the program, as such measures are not appropriate for patients with multiple comorbidities. Prioritization of multiple care measures is more appropriate for this population in order to achieve patient-centered care that is consistent with patient preferences, to decrease patient burden, and to avoid multiple measures where evidence for efficacy in frail elders is lacking.

Below are comments on several specific measures that are of particular interest to AGS:

Patient/Caregiver Experience Domain

Clinician/Group (C/G) CAHPS (Measures 1-6) - As discussed above, these measures have not been used before and are not well understood. AGS recommends reducing the number of measures, either until better measures are available for measuring patient experience, or until providers have more experience with these measures. In addition to lack of experience with the measures, they are expensive to administer because the information does not come from claims, which is a significant concern to our members.

Care Coordination/Transitions of Care Domain

Measures of care coordination and care transitions will be critical in an ACO; and we applaud CMS for including these measures in the program (Measures 9-11). However, as stated above, providers have limited experience with these measures and the current measures are not optimal for their

intended purpose. Until providers are able to gain more experience with these measure, or new and better care measures for this domain are developed (e.g., 30-day readmission rate for all conditions, or 30-day post-discharge physician visit), AGS recommends that only the reporting of, and not performance on these measures in the last two years of the agreement should be counted toward an ACOs compliance with measures reporting. Other measures, such as the care transitions measures endorsed by the NQF and the ambulatory care sensitive conditions (ACSC) measures (also NQF-endorsed), are either not used for quality reporting in Medicare or it is not clear whether they are ever used. With respect to these measures, AGS recommends basing compliance on reporting only during the first three-year agreement period.

Comment: CMS should consider reducing the number of measures until new and better care measures for this domain are developed and requiring reporting only (not performance) on all measures for the first three-year agreement period. AGS would be pleased to work with CMS in this area.

VI. Transparency and Public Reporting

Under the proposed rule, ACOs would be required to report publicly on both their shared savings and, if applicable, on their amount of losses under the two-sided model. CMS states in the proposed rule that, while the law did not include a specific requirement for public reporting and transparency related to the Shared Savings Program, improved transparency would support many of the program requirements, and allow beneficiaries to make informed health care choices. Additionally, CMS proposed a number of transparency requirements as a way to facilitate an ACO's ability to improve the quality and efficiency of its care by making available information that enables ACO professionals to compare their performance to that of their peers, creating incentives to improve performance. CMS proposes to require ACOs to publicly report information regarding:

- Providers and suppliers participating in the ACO;
- Parties sharing in the governance of the ACO;
- Quality performance standard scores; and
- General information on how an ACO shares savings with its members (e.g., proportion of shared savings reinvested in infrastructure or system/process redesign; proportion distributed among ACO participants, etc.)

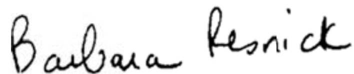
Comment: AGS has strong concerns about these transparency requirements. While in theory, transparency should allow ACO's ability to improve performance by comparing their performance to that of their peers, and to inform consumers about the ACO's providers, governance, performance scores, and other information that may assist consumers in choosing providers. However, given the very little experience that providers and CMS have in this area, we feel strongly that the transparency requirements should be implemented in a phased-in manner over time, rather than being required at the start of the program, until there is better knowledge and understanding of how the ACO will work in practice. Physicians may choose not to participate in an ACO or have their name associated with an ACO until they are more comfortable with the type of information that will be made publicly available about them and their quality or performance in comparison with other physicians. Also, it is unknown what types of information are desired by, or useful to, consumers (e.g., internal distribution of savings). CMS should seek to obtain more data on this before making public large amounts of information that may not be useful or actionable.

Summary

In summary, the AGS believes that the Shared Savings Program, as proposed, is overly complex and burdensome, and while we agree with many of the concepts related to care coordination and quality improvement, it will be difficult for most physician groups to meet all of the requirements to participate, much less be successful, under the program. However, with greater flexibility, reduced regulatory burden and additional ramp-up time, it is possible that greater participation could be achieved. This is obviously a new program, and the chances for success may be improved as physicians gain experience with the new processes and systems that will be required.

We appreciate this opportunity to comment on this proposed rule. Please do not hesitate to contact Alanna Goldstein, Assistant Director of Public Affairs and Advocacy at agoldstein@americangeriatrics.org or 212-308-1414, if you have any questions or need any additional information.

Sincerely,



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