February 6, 2015

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244
Submitted electronically via www.regulations.gov

RE: Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations

Administrator Tavenner,

The Coalition of State Rheumatology Organizations, or CSRO, is a group of state or regional professional rheumatology societies formed in order to advocate for excellence in rheumatologic disease care and to ensure access to the highest quality care for the management of rheumatologic and musculoskeletal diseases. Our coalition serves the practicing rheumatologist. CSRO and the undersigned members of the coalition appreciate the opportunity to comment on policies outlined in the Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACO) proposed rule.

General MSSP ACO Program Concerns

Interest in the MSSP ACO program is growing among rheumatologists as a way to improve quality and resource use, as well as better coordinate care for patients with complex health conditions, such as rheumatoid arthritis. This is fostered by some of the ACO program's noteworthy attributes, including expanded access to meaningful and actionable patient data, and a robust infrastructure that fosters improved communication among multiple providers.

Despite the positive role ACO's can play in their assigned populations health, unfavorable behaviors are possible given the financial incentives (or potential for financial penalties) at stake. As a result, ACOs may employ "gatekeeper" tactics, limiting referrals to "expensive" specialists, particularly if there are no specialists in the ACO's network. While CMS previously finalized that ACOs are prohibited from requiring that beneficiaries be referred only to ACO participants or ACO providers/suppliers within the ACO that does not mean a certain level of "intra-ACO steering" won't occur, or that referrals will be made "too late."

At present, CMS monitors beneficiary access to specialty medicine providers by requiring the ACO to report beneficiary reported data collected via the CG-CAHPS Survey module, "Access to Specialists." However, this measure reflects subjective beneficiary perceptions and is not based on any actual data, meaning it will not be enough to demonstrate whether beneficiaries are being referred for specialty care at the most clinically appropriate point in their disease progression. In fact, data collected through the survey could be unreliable as beneficiaries may be unaware that specialty medical care is necessary in order to properly manage a diagnosed health condition. For patients with conditions such as rheumatoid arthritis (RA), early intervention by a rheumatologist drastically limits the development and progression of the disease.

In addition, despite CMS' clarification that fee-for-service Medicare beneficiaries assigned to an ACO maintain all of their Medicare rights including the right to see any doctor or provider that accept Medicare regardless of the providers participation or affiliation with the ACO, this may not be evident to the assigned beneficiary population. This misconception may cause beneficiaries to delay seeking access to a specialty care provider, even if that level of expertise is warranted.

We have heard anecdotally that some ACOs are of the mindset that specialty care is not essential to improving the care of their assigned population, and their focus will be exclusively on managing chronic health conditions, including RA, at the level of the primary care physician and other health care professionals. The aforementioned issues are of great concern, therefore, we offer the following recommendations to monitor and improve access to specialists, including rheumatologists:

1. **To ensure beneficiaries receive important specialty care at the most clinically appropriate time, we urge CMS to closely examine the referral patterns of ACOs and establish benchmarks that will foster an appropriate level of access to and care coordination with rheumatologists, and particularly for beneficiaries with conditions where rheumatology care has demonstrated improved outcomes.**
2. **To ensure beneficiaries are made aware of their rights under the Medicare fee-for-service program, we urge CMS to require that ACOs inform beneficiaries of their right to receive care outside of the ACO as part of the ACO's "standardized written information" to Medicare fee for service beneficiaries, including on the ACO's posted office signs.**

Assignment of Medicare FFS Beneficiaries: *Consideration of Physician Specialties and Non-Physician Practitioners in the Assignment Process*

CMS' current beneficiary assignment process requires ACO participants billing for "primary care services" (i.e., office visits) to remain exclusive to a single ACO. This "exclusivity requirement" is of concern to CSRO, particularly in areas where there are multiple ACOs, but few rheumatologists.

We appreciate that CMS listened to many specialty medicine organizations and is proposing to exclude primary care services provided by certain physician specialties from the beneficiary assignment process. Unfortunately, rheumatology was not included on the list of specialties proposed for exclusion.

Given rheumatologists are not primary care physicians, and the type and level of primary care we provide is limited to the conditions we treat, we do not believe it is appropriate to include claims for our specialty in the beneficiary assignment process. As a result, **we strongly urge CMS to exclude rheumatology (specialty code 66) from step 2 of the beneficiary assignment process in the final rule.**

ACO Eligibility Requirements: *Agreement Requirements*

Under this section of the rule, CMS would add a new requirement permitting an MSSP ACO to take remedial action against an ACO participant and its ACO providers/suppliers *"…to address noncompliance with the requirements of the Shared Savings Program and other program integrity issue, including those identified by CMS.*" The rule explains that remedial action may include the denial of shared savings payments (that is, the ability of the ACO participant or ACO provider/supplier to receive a distribution of the ACO's shared savings). This is concerning, given CMS does not make any requirement that an ACO share its savings with ACO participants or ACO providers/suppliers.

CMS does ask ACOs to describe how they intend to share savings with ACO participants and ACO providers/suppliers, or to use the shared savings to reinvest in the ACO's infrastructure, redesigning care processes, etc., as well as explain what percentage of savings it intends to distribute to each category,

including the criteria the ACO intends to use for distributing those payments, as part of the ACO application. However, this is not a requirement, nor do we have any evidence that CMS reviews or contracts with ACOs based on the information provided.

To address the aforementioned, **CSRO urges CMS to require MSSP ACOs to share some portion of their savings with ACO participants and ACO providers/suppliers that have facilitated the ACO's success.** In addition, **CMS should develop guidance to help ACOs establish a shared savings distribution model that fosters a fair and sustainable shared savings distribution process.** We maintain that MSSP ACOs should have flexibility in determining what proportion of shared savings are appropriate for distribution among ACO participants and ACO providers/suppliers, given a portion of the savings will likely be needed to reinvest in the ACO's infrastructure. Regardless, the shared savings model should consider the contributions of each individual ACO provider/supplier and ACO participant. Furthermore, **we urge CMS to establish benchmarks to determine whether the ACOs shared savings distribution process is facilitating or limiting care coordination activities and access to specialty care.** This may require CMS to tweak the quality measures set ACOs report to include measures of specialty care, such as those developed for rheumatologic conditions, at some point in a future rulemaking.

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We recognize and appreciate CMS efforts to thoughtfully improve the MSSP ACO program. For this reason, we are confident that CMS will give our special concerns and recommendations due consideration. Should you have any questions about our comments or concerns, or require additional clarification, please contact Emily L. Graham at egraham@hhs.com or 703-975-6395.

Sincerely,

Coalition of State Rheumatology Organizations
California Rheumatology Alliance
Florida Society of Rheumatology
Kentuckiana Rheumatology Alliance
Maryland Society for Rheumatic Diseases
New York State Rheumatology Society
Oregon Rheumatology Alliance
Pennsylvania Rheumatology Society
Rheumatology Alliance of Iowa
Rheumatology Alliance of Louisiana
Rheumatology Society of Delaware
Washington Rheumatology Alliance
Wisconsin Rheumatology Association