American Academy of
Allergy Asthma & Immunology

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,

Established in 1943, the AAAAI is a professional organization with more than 6,700 members in the United States, Canada and 72 other countries. This membership includes allergist/immunologists (A/I), other medical specialists, allied health and related healthcare professionals—all with a special interest in the research and treatment of patients with allergic and immunologic diseases. We appreciate the opportunity to comment on policies outlined in the Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACO) proposed rule.

General Concerns

Not unlike former managed care models, MSSP ACOs are incentivized to reduce costs and improve quality, prompting ACO's and their "primary care" providers/suppliers to serve as "gatekeepers," limiting referrals to specialists, particularly those outside the ACO. Despite CMS' clarification that fee-for-service Medicare beneficiaries assigned to an ACO maintain all of their Medicare rights, including the right to choose any doctors and providers that accept Medicare, this may not be evident to the assigned beneficiary population.

CMS monitors access to specialty care providers through its requirement that ACOs report data collected from beneficiaries via the "Access to Specialists" module of the CG-CAHPS Survey; however, we are concerned that this measure 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.

We maintain that early intervention and referral to A/I physicians drastically limits the development and progression of certain chronic illnesses, such as asthma, allergic rhinitis, food allergy, and primary immune deficiencies.

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 A/I physicians, and particularly for beneficiaries with health conditions where A/I specialty care has demonstrated improved patient outcomes.** While not solicited in this particular rulemaking, **to the extent CMS proposes modifications to the list of ACO quality measures in a future proposed rule, CMS should consider adding measures focused on A/I conditions. This would help ACOs better assess the quality of care provided by the ACO's A/I physician participants and provider/suppliers.**

In addition, **we urge CMS to require that ACOs, as part of their "standardized written information" to Medicare fee for service beneficiaries, including their posted office signs, inform beneficiaries of their right to receive care outside of the ACO.**

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

In order to assign Medicare beneficiaries to MSSP ACOs, CMS adopted an assignment process that requires ACO participants billing for "primary care services" (i.e., office visits) to remain exclusive to a single ACO. This "exclusivity requirement" has concerned a number of specialty providers, including A/I physicians. This is particularly concerning in areas where there are multiple ACOs, but few A/I providers.

To address exclusivity concerns, CMS is proposing to exclude primary care services provided by certain physician specialties from the beneficiary assignment process; that is, CMS would exclude Medicare claims for primary care services by the "excluded" physician specialties when determining the ACO's assigned population. Unfortunately, A/I was not a specialty proposed for exclusion.

Requiring A/I physicians to remain exclusive to a single MSSP ACO is counter to the MSSP's goal of improving care coordination, and is more likely to disrupt long-standing patient–physician relationships. A/I physicians are not primary care physicians for the vast majority of patients we serve, despite our management of certain chronic conditions for certain patients with rare and/or chronic health conditions. For this reason, we do not believe it is appropriate to include claims for A/I physicians in the beneficiary assignment process. As a result, **we urge CMS to exclude A/I physicians from step 2 of the beneficiary assignment process in the final rule.**

ACO Eligibility Requirements: *Agreement Requirements*

In this rule, CMS is proposing to add a new requirement that would permit 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."* 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).

As part of the MSSP ACO application, 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. But, again, this is not a requirement to share savings with ACO participants and ACO providers/suppliers.

We are concerned that CMS is proposing a requirement that ACOs may deny payments to ACO participants and ACO providers/suppliers when there is no requirement that ACOs share any savings with ACO participants and ACO providers/suppliers.

To address this concern, **AAAAI 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.** 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 proportion of the savings will likely be needed to reinvest in the ACO's infrastructure, as noted above.

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.** AAAAI supports a shared savings model that considers the contributions of each individual ACO provider/supplier and ACO participant.

Further, **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 A/I care.**

****

We support CMS' efforts to improve cost and quality through a variety of value-based payment and delivery models, including the MSSP ACO. Given the frequency Medicare policy is repeated with private payers, we urge CMS to be especially diligent about continuously assessing the ACO model to ensure access to specialty care is not restricted, especially for patients with complex health conditions, and that innovative models do not stimulate inappropriate cost-shifting on beneficiary and patient costs.

We appreciate the opportunity to provide comments on the aforementioned issues of importance to our members. Should you have any questions, please contact Sheila Heitzig, Director of Practice and Policy, at sheitzig@aaaai.org or (414) 272-6071.

Sincerely,

James T. Li

James T. Li, MD PhD FAAAAI
AAAAI President