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December 3, 2010

Donald Berwick, MD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Via <http://www.regulations.gov>.

Re: Medicare Program; Request for Information Regarding Accountable Care Organizations and the Medicare Shared Savings Program; *75 Fed. Reg. 70,165* (November 17, 2010); **CMS-1345-NC**.

Dear Dr. Berwick:

The Medical Society of New Jersey (MSNJ) appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services' (CMS) request for information concerning Accountable Care Organizations (ACOs) and the Medicare Shared Savings Program.

The vast majority of MSNJ's members practice solo or in small groups of less than ten physicians. We are concerned that our members will not be able to participate in ACOs if CMS does not carefully consider both structural and financial barriers unique to those physicians in solo and small practices. Given our membership base, we believe that MSNJ is in a unique position to provide information and our position on the following CMS questions:

What policies or standards should we consider adopting to ensure that groups of solo and small practice providers have the opportunity to actively participate in the Medicare Shared Savings Program and the ACO models tested by CMMI?

Fund Education and Outreach: MSNJ believes that it, along with other state medical societies whose membership is dominantly solo and small practice, is in a unique position to educate small practices about different healthcare delivery and payment models that might qualify as ACOs. We, and other state medical societies, have already begun the education process with our members. Since there are any number of models that may eventually meet ACO criteria, there is a large of amount of information for solo and small practices to consider. In addition, the various models must be analyzed by each physician for their operational and financial feasibility. Current practice demands simply do not allow the time and effort required for any solo or small practice to mount this learning curve. MSNJ urges CMS to adopt policies that will fund education and outreach

on how solo and small practices can participate in ACOs. We recommend that the funds be available to state medical societies to work with their members.

Electronic Medical Records Implementation Status Should Not Be a Barrier: To ensure that solo and small physician practices can successfully participate in ACOs, CMS should ensure that the implementation status of electronic medical records is not a barrier to participation. (This will be discussed further in response to Question 2). Only a small percentage of physician practices nationwide has fully adopted electronic medical records to date. While full implementation of electronic medical records in the healthcare industry is laudable and may facilitate the successful operation of ACOs, full implementation in solo and small offices is not achievable in the near term. Therefore, we urge CMS to be mindful of this and not adopt policies that condition ACO participation on the adoption status of electronic medical records in solo and small offices.

Provide Professional Expertise: Any change in business, clinical practice or payment models, require a significant expenditure of time for start-up and implementation. (This has been painfully evident this year when the Medicare fee schedule has changed several times and practices have had to act and react to the anticipated different fee schedules.) There is always a loss in efficiency. Many solo and small practices are already operating with very slim profit margins and cannot afford to undertake a change that will result in short-term practice inefficiency and the consequent financial loss. CMS should adopt policy and fund professional expertise for small and solo practices to help them evaluate different ACO models and successfully participate in them. Expertise is needed for: data collection and management; risk analysis of financial capacity and infrastructure to invest in risk contracting; analysis of clinical integration; and staff support. CMS should provide these services to solo and small practices in partnership with organizations like state medical societies or through other non-profit entities. Consideration should be given to support through entities like the Regional Extension Centers that are facilitating the implementation of electronic medical records.

Hospital Affiliation Should Not be a Condition of Participation: Many of our members, including psychiatrists, have no hospital affiliation and have no reason to become affiliated with a hospital. The ACO criteria should not require a hospital entity in order qualify as an ACO. In addition, physicians should not be required to be affiliated with, or employed by, a hospital in order to participate in an ACO, even if a hospital is part of the ACO. We urge CMS to assist small and solo practices not affiliated with hospitals in the development of ACOs that are independent of hospitals. MSNJ believes that physicians should lead in the delivery and coordination of healthcare. We concur with the American Medical Association's comments on keeping physician leaders at the forefront of ACOs.

Clearly Defined Safe Harbors from Antitrust Enforcement and AntiKickback & Referral Laws: It is imperative that CMS and other federal agencies adopt clear and concise policies that remove the risk of antitrust, anti-kickback and referral laws. Solo and small practices do not have the resources to employ antitrust lawyers and will not assume risk of enforcement to embark on new practice models that require a three year commitment. The cloud of enforcement must be removed and replaced with clearly understood and sanctioned ACO models. MSNJ concurs with the American Medical Association and urges CMS and other federal agencies to work with the AMA to develop meaningful guidance and policies on this issue.

Many small practices may have limited access to capital or other resources to fund efforts from which "shared savings" could be generated. What payment models, financing mechanisms or other systems might we consider, either for the Shared Savings Program or as models under CMMI to address this issue? In addition to payment models, what other mechanisms could be created to provide access to capital?

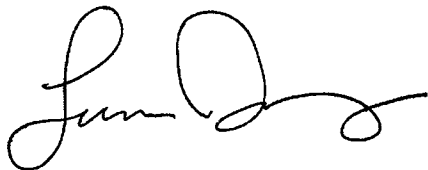
Fund Capital Expenditures: To participate in an ACO, capital expenditures may be necessary. While MSNJ believes that adoption of electronic medical records should not be a condition to participation, we believe that many solo and small practices will be endeavoring to adopt electronic medical records or not fully implemented when they may wish to participate in an ACO. To ensure that capital expenditures are not a barrier to ACO participation MSNJ urges CMS and other federal agencies to fund these expenditures in a variety of ways. We urge the federal government to make funds available through a variety of means including grants; small business, low interest, or federally guaranteed loans.

Advance and Installment Payments: Any payment methodology must allow for at least a partial or installment payment before the end of a course of treatment. Many solo and small practices operate on slim profit margins and do not have cash reserves. In New Jersey, we already have obstetrician practices that are fiscally at risk because of global billing for pregnancy. Our Legislature addressed the issue specifically with a law that requires installment payments. Bundling or payment models that pay only at the end of a specific course of treatment will be a barrier to participation by solo and small practices.

In order for an ACO to share in savings under the Medicare Shared Savings Program, it must meet a quality performance standard determined by the Secretary. What quality measures should the Secretary use to determine performance in the Shared Savings Program?

Limit Quality Reporting Measures: To ensure that solo and small practices can participate in ACOs, CMS should limit quality reporting measures to those already in place, such as the Physician Quality Reporting System (formerly PQRI). While additional quality reporting may be warranted in the future, to maximize participation by solo and small practice physicians in ACOS, CMS should consider policy that allows a phase-in period for more extensive quality measures. Since participation requires a three-year commitment, we recommend that the first three-year cycle focus on existing, nationally recognized quality measures.

Respectfully submitted,



Lawrence Downs, Esq., General Counsel

Medical Society of New Jersey