SIMED
SOUTHEASTERN INTEGRATED MEDICAL

ORIGINAL

May 9, 2011

Donald Berwick, MD, Administrator
Centers for Medicare and Medicaid Services
Attn: CMS – 1345 – P
PO Box 8013
Baltimore, MD 21244 – 8013

Re: CMS-1345-P Proposed Rule for the Medicare Shared Savings Program and FTC/DOJ Proposed Statement of Antitrust Enforcement Policy Regarding ACOs Participating in the Medicare Shared Savings Program, Matter V100017

Dear Dr. Berwick;

Our comments and questions come from the perspective of smaller to mid-size physician practices that want to participate in the Shared Savings Program as ACOs. We are submitting these comments on behalf of Southeastern Integrated Medical, PL (SIMED), a multi-specialty physician group practice serving North Central Florida since 1986. We are locally owned and operated by our physician members. We currently have 425 employees located in Gainesville and the outlying areas. This includes 63 physicians and 15 physician assistants and advanced registered nurse practitioners. SIMED includes primary care, urgent care, specialists, physical, occupational and aquatic therapy, a community pharmacy, lab, imaging, sleep studies, and a research studies department. Our 21 Primary Care Physicians care for over 8,000 Medicare beneficiaries. SIMED's goals are to provide quality care to patients by offering an integrated approach to their care, resulting in improved resource stewardship, efficiency, patient care, and to improve the health of our community. We respectfully submit these comments for consideration.

- 425.5 (8)(d)(vi)(b) states that if the ACO is comprised of a single entity that is financially and clinically integrated…the ACOs governing body may be the same as the governing body of that entity. CMS solicited comments in preamble section (2) (a) as to whether all ACOs participating in the Shared Savings Program should be required to be formed as distinct legal entities, or whether an existing legal entity could be permitted to participate in the Shared Savings Program as an ACO.

  Our recommendation is that where an existing physician group practice already has in place the infrastructure to support the financial and clinical integration to establish an ACO, they should not be required to create a separate entity. The creation of a new entity places a financial burden on the group practice for legal fees, professional liability insurance, hardware and software licensing fees, and credit worthiness for loss recoupment. This will create additional expense for the physicians without adding a cost benefit to the beneficiary or Medicare.

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- 425.5 (9) (iii) Leadership and management structure states that clinical management and oversight must be managed by a full-time senior-level medical director who is physically present on a regular basis in an established ACO location.

  For smaller ACOs, especially those that are formed from an existing physician group practice, they will not have the volume of work to require a full-time Medical Director. We recommend that these ACOs should be allowed to assign the ACO Medical Director duties to practicing physicians that are part of the ACO, for the time required to conduct the management and oversight needed.

- 425.6 (2)(b)(1)(5) Assignment of Medicare Beneficiaries based on where they receive the plurality of their primary care services based on total allowed charges for those services.

  We agree with the selection of option two, as proposed in II (D)(2) in the preamble section of the rule, as it supports the intent of the ACA for primary care practitioners to reduce the fragmentation of care and improve overall quality. Many specialists are not providing the primary, preventive services that are the building blocks for ACOs. Rather, specialists may tend to be quicker to refer patients to other specialists for problems outside the scope of their practice.

- 425.7 (4) States that an ACO with fewer than 10,000 assigned beneficiaries in the most recent year for which CMS has complete claims data, and that meets any one of (the following) criteria, is exempt from the 2 percent net savings threshold adjustment under the one-sided model.

  Smaller ACOs may select Track 1 and potentially be eligible for this exemption. It is clear that the ACO would need to meet the minimum savings rate, and then would be paid first dollar shared savings. It is silent as to what would happen if an ACO operating under these exemptions had losses above the 2% of benchmark during Performance Years one and two, while it is under the one-sided model.

  We suggest that the Final Interim Rule should be clear on the treatment of losses beyond the threshold under these exemptions, i.e., that losses are not repaid under the one-sided model, even when the exemptions apply.

- 425.11 (b)(1) Electronic health records technology states that fifty percent of an ACO's primary care physicians must be meaningful EHR users...by the start of the second performance year to continue participating in the Shared Savings Program. The preamble section II (e)(5) seeks comment on whether CMS should also specify a percentage-based requirement for hospitals, and whether ACOs that include only one hospital or no hospital should be provided an exclusion or exemption in such a circumstance.

  In an area with only one community hospital, the ability of the physicians in the ACO to direct admissions to another hospital is not feasible. While the ACO physicians would encourage the hospital to achieve meaningful use of EHR, it may not be within their control to assure that it will occur by the beginning of performance year two. We feel that an exclusion or exemption

should be given to ACOs that include only one hospital or no hospital as a provider/supplier, should CMS propose to add this percentage-based requirement for hospitals.

- 426.7 (b)(9)(e) Loss recoupment limit and Notification of savings and losses states that if an ACO has shared losses, the ACO must make payment in full to CMS within 30 days of receipt of notification.

  The cost of having funds available with such quick turnaround may be prohibitive to smaller ACOs. Allowing 90 – 120 days for repayment would be more reasonable.

- Establishing the 3-Year Agreement with the Secretary, in the preamble II (12)(C)(1), asks for comments regarding alternatives to a January 1 start date for the first year of the program; specifically, adding an additional start date of July 1, 2012. This would allow the agreement period to be for 3.5 years, with the first year being defined as 18 months to synchronize with the ACOs entering the program on January 1, 2013.

  We support CMS adding the option of starting a cohort of applicants on July 1, 2012. While we, and likely other ACOs, are fully prepared to go live January 1, 2012, we are concerned that there may not be enough time between now and the end of 2011 for the final regulations to come out, applications be made, reviewed and accepted by CMS. We would rather have a cohort of ACOs start July 1, 2012 than wait until January 1, 2013, in the event CMS does not have the resources and/or time for all of the applications to be reviewed and approved by the end of this year.

In closing, we appreciate the opportunity to offer comments on the Proposed Rule for the Medicare Shared Savings Program and ACOs and hope you find them useful. If there are any questions, or if further explanation is needed for any of our comments, please contact Connie Pegram, SIMED's Director of ACO Development at (352) 224-2234 or cpegram@simedpl.com.

Sincerely,

Oscar DePaz, MD, Chairman

Jesse Brannen, CEO

cc: Senator Bill Nelson
2370 Rayburn House Office Building
Washington, DC 20515

cc: Representative Cliff Stearns
716 Senate Hart Office Building
Washington, DC 20510

cc: Federal Trade Commission
Office of the Secretary
Room H – 113 (Annex W)
600 Pennsylvania Avenue, NW
Washington, DC 20580