



Statement of

**Lawrence P. Martinelli, MD**

Lubbock, Texas

**CMS Listening Session**

**Baltimore, Maryland**

**RE: Workshop on Issues Related to Accountable Care Organizations**

**September 27, 2010**

Ms. Bohl, Ms. Drew, Ms. Jex, and other officials, I am Dr. Lawrence Martinelli, a clinician member of the Infectious Diseases Society of America (IDSA). I live and practice infectious diseases (ID) medicine in Lubbock, Texas. IDSA represents more than 9,000 physicians and scientists and is widely recognized as the pre-eminent authority on infectious diseases in the United States. Thank you for the opportunity to speak about the legal issues associated with Accountable Care Organizations (ACOs), which were authorized by the Patient Protection and Affordable Care Act (ACA) of 2010.

In past comments<sup>1</sup>, IDSA has suggested that an exception to the physician self-referral (“Stark”) law<sup>2</sup>, drafted with sufficient flexibility, will be critical to the development and success of innovative payment models, such as ACOs and other gainsharing arrangements. This is because such an exception will remove existing impediments to hospitals’ ability to incentivize non-employed physicians who help implement and maintain payment innovations for not only patient care activities but also non-patient care activities, such as infection control and prevention strategies and procedures. **IDSA believes that many hospitals and physician groups will be unwilling to innovate and thereby risk a confrontation with the Office of Inspector General without such an exception.**

**ACOS SHOULD BE GIVEN DISCRETION IN DETERMINING WHICH ACTIVITIES TO INCENTIVIZE**

The Centers for Medicare and Medicaid Services (CMS) has previously proposed a definition of “shared savings” that includes any program offering “physicians a share of the hospitals’ variable cost savings attributable to physicians’ efforts in controlling the

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<sup>1</sup> IDSA Comments. Exception for Incentive Payment and Shared Savings Programs, 2009 PFS Final Rule. February 2010.

<sup>2</sup> 42 U.S.C. § 1395nn; 42 C.F.R. § 411 Subpart J.

costs of patient care by eliminating or reducing unnecessary services or procedures.”<sup>3</sup> Unfortunately, infection control and prevention procedures (and other non-patient care activities), which are focused on improving systems of care at the institution level, do not fit neatly into this traditional definition of gainsharing, ACOs and other shared savings arrangements. Infection control and prevention efforts attempt to avoid infectious complications before they occur, thereby avoiding the cost of treatment of these hospital-acquired conditions (HACs). Numerous inpatient quality measures and Medicare’s HAC’s non-payment policy have demonstrated the Agency’s interest in reducing the prevalence of these avoidable complications. **The fact that payments for meeting infection control targets are based on the savings achieved, or costs avoided, by the hospital should not preclude their inclusion in gainsharing arrangements.**

For example, health economists are able to calculate the healthcare related cost-savings associated with decreases in the number of bloodstream infections in medical intensive care units when ID specialists direct and implement patient-care, antimicrobial-management, and infection-control programs. In a recent study, the excess direct hospital costs per each nosocomial infection were estimated at an average of \$15,275, with collateral costs totaling an estimated \$38,600.<sup>4</sup> Accordingly, **IDSA requests that CMS establish a broad definition of ACOs and gainsharing that explicitly recognizes a wider variety of quality enhancing and cost-saving programs, including those that are focused on reducing or preventing infections and other avoidable hospital complications.**

### **CMS SHOULD ESTABLISH A NATIONAL LIST OF APPROVED ACO MEASURES**

Many performance standards and recognized indicia of quality are not included in the Physician Quality Reporting Initiative (PQRI), the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU), or other quality measures compendia that CMS uses in various settings of care. For example, the National Healthcare Safety Network (NHSN),<sup>5</sup> administered by the Centers for Diseases Control and Prevention (CDC), provides robust data for comparison of hospital infection rates that can be used at the local level to establish a performance improvement baseline for infection control programs. Likewise, the Healthcare Infection Control Practices Advisory Committee (HICPAC),<sup>6</sup> also under the auspices of CDC, provides a source of best practices for infection control and prevention, establishing protocols for standardization across the country. **IDSA urges CMS to establish a public list of permitted quality measures**

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<sup>3</sup> 73 Fed. Reg. 38502, 38549 (July 7, 2008).

<sup>4</sup> Daniel P. McQuillen et al., The Value of Infectious Disease Specialists: Non-Patient Care Activities, 47 Clin. Infect. Dis. 1052, 1052 (Oct. 15, 2008) (citing Rebecca R. Roberts et al., The Use of Economic Modeling to Determine the Hospital Costs Associated with Nosocomial Infections and Zhan, 36 Clin. Infect. Dis. 1424-32 (June 1, 2003) and Chunliu Zhan et al., Excess Length of Stay, Charges, and Mortality Attributable to Medical Injuries During Hospitalization, 290 J. of Amer. Med. Assoc. 1868-74 (Oct. 8, 2003)).

<sup>5</sup> <http://www.cdc.gov/ncidod/dhqp/nnis.html>.

<sup>6</sup> <http://www.cdc.gov/ncidod/dhqp/hicpac.html>.

**that may include the PQRI and RHQDAPU but also includes the NHSN and other nationally-recognized data sources that reflect objective, evidence-based quality outcomes or standards.**

#### **NATIONAL MEASURES SHOULD BE ADAPTED TO MEET LOCAL NEEDS**

IDSAs believe it is important to recognize that although nationally recognized quality measures provide a necessary starting point from which to measure ACOs' performance, implementation of these measures must be adapted at the local level. As an example, the NHSN database discussed above provides national comparison data for infection rates specific to particular procedures and stratified for hospital size and type. Institutions that are already below NHSN infection rates for particular procedures can use local baseline data collected as part of their own infection control and prevention programs to identify needed areas for further improvement. In order to be successful, **it is critical that ACOs be given the flexibility to adapt national measures to meet local needs.**

**Improvements can then be measured against local baselines to calculate avoided costs.**

#### **INCENTIVE PAYMENTS FOR MAINTAINING QUALITY AND EFFICIENCY GAINS**

The practice of medicine is not static—quality and efficiency targets, once achieved by the ACO, must be maintained by the participating providers. For example, infection control interventions may result in short-term improvements that revert to the baseline when attention shifts to another area of concern. This challenge is magnified by ever changing hospital patients and staff, both of which necessitate a continuous process of education and reeducation. The ACO that maintains previously achieved gains has demonstrated clear evidence of continued effort that exceeds standard practice. As such, **IDSAs urge CMS to permit ACOs to incentivize maintenance of previously achieved gains for both patient care and non-patient care activities.**

#### **INCENTIVE PAYMENTS SHOULD CORRELATE WITH PERSONAL EFFORT**

Incentive payments to physicians and other providers participating in an ACO model should correlate with their personal effort in reducing costs or increasing the quality of care. This is especially true for those physicians, such as ID physicians serving as infection control medical directors, who have additional roles and responsibilities such as the design, development or administration of procedures that result in achievement of quality or cost of care benchmarks. **IDSAs recommend that ACOs be given the flexibility to provide additional incentive payments based on the results achieved for those physician participants who are central to the design and implementation of cost saving and quality enhancing procedures.**

## **CONCLUSION**

I appreciate the opportunity to testify before you today about the issues associated with Accountable Care Organizations (ACOs) and I urge you to review IDSA's February 2009 Comment letter on a proposed exception to the "Stark" law that would allow the establishment of incentive payment programs or shared savings arrangements between physicians and hospitals. This letter can be viewed and downloaded at: <http://www.idsociety.org/WorkArea/showcontent.aspx?id=13434>.

Please feel free to use IDSA staff ([jscull@idsociety.org](mailto:jscull@idsociety.org)) and me ([pusdoc@mac.com](mailto:pusdoc@mac.com)) as resources as you develop the ACO rule. Thank you.