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November 22, 2010

Glenn M. Hackbarth, J.D.  
Chairman  
Medicare Payment Advisory Commission  
601 New Jersey Avenue, NW  
Suite 9000  
Washington, DC 20001

## Re: October 7<sup>th</sup> MedPAC Discussion—Medicare Shared Savings Programs for ACO's

Mr. Hackbarth:

I am writing on behalf of the Infectious Diseases Society of America (IDSAs) in response to the Medicare Payment Advisory Commission's (MedPAC) recent discussion concerning Section 3022 of the Patient Protection and Affordable Care Act (ACA), which authorizes the establishment of Accountable Care Organizations (ACOs) and other shared savings arrangements focused on incentivizing high quality and cost effective care.

IDSAs represents more than 9,300 physicians and scientists devoted to patient care, education, research, and community health planning in infectious diseases (ID). The Society's members focus on the epidemiology, diagnosis, investigation, prevention and treatment of infectious diseases in the United States and abroad. Our members care for patients of all ages with serious infections, including meningitis, pneumonia, tuberculosis, surgical infections, those with cancer or transplants who have life-threatening infections caused by unusual or drug-resistant microorganisms and new and emerging infections, such as severe acute respiratory syndrome (SARS) and H1N1 influenza.

At the October 7<sup>th</sup> MedPAC Meeting, Commissioners and staff began to develop a number of positions concerning how ACOs should be structured, including 1) exclusive vs. non-exclusive provider contracts, 2) two-sided risk sharing vs. partial capitation, 3) variable growth targets for efficient vs. inefficient ACOs, 4) and patient choice to opt-out. IDSAs believes that sufficient numbers of comments have been provided on these issues (and on specific waivers to the Civil Monetary Penalty statute, the Anti-Kickback statute, and the Stark law) to ensure that MedPAC's positions and the Centers for Medicare and Medicaid Services' (CMS) Proposed Rule consider all possible points of view.

However, IDSAs has serious concerns that MedPAC's focus up to this point—how ACO's should be structured to improve the quality and efficiency of *patient care activities*—overlooks many *non-patient care activities* within a hospital that also

have the potential to significantly reduce system costs and improve quality. Infection control and antimicrobial stewardship activities are two ID-specific examples of non-patient care activities, but other specialties may have their own examples. While payments for these activities currently are limited by Stark Law rules governing remuneration to medical directors, continued access to ID physicians and other cognitive specialists, who have been severely impacted by the elimination of payments for consultations<sup>1,2</sup>, will depend on the ability of ACOs and other innovative payment models to incentivize a broader spectrum of activities than those that involve direct patient care.

IDSAs offers the following comments for MedPAC to consider as it develops positions and drafts comments to CMS on the ACO Proposed Rule that will be released later this year.

**1. ACOs and other “shared savings” arrangements should be allowed to incentivize a wider variety of quality enhancing and cost-saving programs, including those that are focused on reducing or preventing infections and other avoidable systems-level complications.**

A commonly cited definition of “shared savings” is the “variable cost savings attributable to providers’ efforts in controlling the 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 definition. 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 shared savings 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> As such, IDSA believes that ACOs also should be allowed to include collaborative arrangements between physicians and hospitals, such as infection control and prevention programs, that look beyond patient care activities and focus on improving quality and reducing costs at the system (institutional or health system) level.

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<sup>1</sup> Lawrence P. Martinelli et al. Devaluing a Specialty: The Centers for Medicare and Medicaid Services Proposal to Eliminate Consultation Codes. Clin. Infect. Dis, Vol. 49 (Oct. 1, 2009): 995-996.

<sup>2</sup> Impact of the Elimination Payments for Consultations. Survey Final Report. AMA, June 2010: <http://www.ama-assn.org/ama1/pub/upload/mm/399/consultation-codes-survey.pdf>.

<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, Vol. 47 (Oct. 15, 2008): 1052-1063 (citing Rebecca R. Roberts et al. The Use of Economic Modeling to Determine the Hospital Costs Associated with Nosocomial Infections. Clin. Infect. Dis, Vol. 36 (June 1, 2003): 1424-32 and Chunliu Zhan et al. Excess Length of Stay, Charges, and Mortality Attributable to Medical Injuries During Hospitalization. J. of Amer. Med. Assoc, Vol. 290 (Oct. 8, 2008): 1868-74).

- 2. A public list of permitted quality measures should be developed that not only includes the PQRI and RHQDAPU but also the NHSN and other nationally-recognized data sources that reflect objective, evidence-based quality outcomes or standards.**

Many performance standards and recognized indices 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 measure 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.

- 3. ACOs should be given the flexibility to use local measures or benchmarks, especially when national quality and efficiency priorities have been achieved or are not applicable to local needs.**

IDSA believes 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 to meet local needs. 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.

- 4. Maintenance of previously achieved quality and efficiency targets warrant continued incentive payments that recognize the effort necessary to sustain 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. For these reasons, IDSA believes that ACOs should be allowed to reserve a portion of incentive payments for activities that are focused on sustaining previous improvements.

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

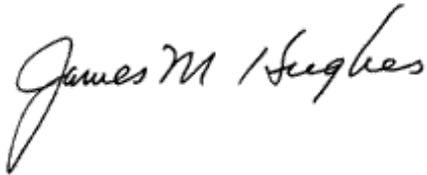
<sup>6</sup> <http://www.cdc.gov/ncidod/dhqp/hicpac.html>.

**5. Incentive payments should correlate with personal effort thereby rewarding hard work and minimizing the problem of “free riders.”**

ACO participating providers should receive incentive payments commensurate with their level of effort. While many organizations are opposed to unequal distribution of incentive payments, such a policy would not only reward personal work and innovation but also minimize the problem of “free riders” who may officially belong to an ACO but contribute little to the achievement of performance targets. Higher incentive payments are especially appropriate for those providers, 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.

For additional guidance on how to appropriately structure ACOs, please review a February 2009 comment letter that IDSA submitted to CMS in response to a proposed exception to the “Stark” law that would have allowed incentive payment programs or shared savings arrangements between physicians and hospitals. The letter can be downloaded at: <http://www.idsociety.org/WorkArea/showcontent.aspx?id=13434>. If you have any questions, please contact Jason A. Scull, IDSA’s Program Officer for Clinical Affairs, at [jscull@idsociety.org](mailto:jscull@idsociety.org) or phone at 703-299-5146.

Sincerely,

A handwritten signature in cursive script that reads "James M. Hughes".

James Hughes, MD, FIDSA  
President, IDSA

cc:  
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MedPAC

Jon Blum  
CMS

Richard Gilfillan  
CMS

Troy Barsky  
CMS

Kristin Bohl  
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