November 29, 2010

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Donald Berwick, MD
Acting Director
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1345-NC,
P.O. Box 8013,
Baltimore, MD 21244-801

Re: Medicare Program; Request for Information Regarding Accountable Care Organizations and the Medicare Shared Saving Program

Dear Dr. Berwick:

The Infectious Diseases Society of America (IDSA) appreciates the opportunity to provide comments in response to the Centers for Medicare and Medicaid Services’ (CMS) Request for Information on Accountable Care Organizations (ACOs) and other shared savings arrangements authorized by Section 3022 of the Affordable Care Act.

IDSA 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.

IDSA has repeatedly argued that ACOs and other shared savings arrangements should be structured to improve not only the quality and efficiency of patient care activities but also non-patient care activities, such as infection prevention and antimicrobial stewardship, which have the potential to achieve significant systems-level improvements within hospitals and the healthcare system at large. Continued access to ID physicians and other cognitive specialists, who have been severely impacted by the elimination of payments for consultations1,2, will depend on the

ability of ACOs and on innovative payment models to incentivize a broader spectrum of activities than strictly those that involve direct patient care. A more detailed description of IDSA positions on ACO structural issues were included in a September 27th statement to CMS officials and in a November 19th letter to the Medicare Payment Advisory Commission. These documents can be found at: http://www.idsociety.org/WorkArea/DownloadAsset.aspx?id=17023 and http://www.idsociety.org/WorkArea/DownloadAsset.aspx?id=17253.

The remainder of IDSA’s comments specifically respond to the following questions that were included in the Request for Information: What additional payment models should CMS consider in addition to the model laid out in Section 1899(d), either under the authority provided in 1899(i) or the authority under the Center for Medicare and Medicaid Innovation (CMMI)? What are the relative advantages and disadvantages of any such alternative payment models?

Fee-for-service Medicare has long resisted efforts to cover home infusion therapy services, a safe and cost effective alternative to the provision of intravenous therapies in the inpatient setting, by citing payment policy limitations and concerns over fraud and abuse. As a result, many Medicare beneficiaries experience prolonged stays in inpatient facilities (acute care hospital, long term acute care hospital or skilled nursing facility) or make daily trips to physician offices or other outpatient facilities. These seniors, particularly those that must remain in an inpatient facility, incur increased risks for healthcare-associated infections (and other complications), excess cost, slower recovery, prolonged hospital stays, and more inconvenience than if they were able to receive these treatments at home.

In contrast, the commercial healthcare industry has concluded that it is more cost effective to provide home infusion therapy rather than pay for continued hospitalization for patients who can be safely and effectively treated in the comfort of their home. This was underscored by a recent Government Accountability Office Report (GAO) which found that “all of the health insurers in this study provide comprehensive coverage of home infusion therapy for all members in their commercial health plans, and some do so in their Medicare Advantage plans as well.”

Medicare’s inability or unwillingness to cover home therapy services spurred the GAO to recommend that “the Secretary of HHS should conduct a study of home infusion therapy to inform Congress regarding potential program costs and savings, payment options, quality issues, and program integrity associated with a comprehensive benefit under Medicare.” IDSA supports the GAO recommendation and believes that such a study falls within the statutory authority of CMMI “to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care.”

In response to the GAO recommendation, IDSA and other home infusion stakeholders are developing a demonstration proposal for CMMI’s consideration. The intention is to submit the proposal once CMMI clearly explains 1) how to format proposals, 2) what types of information

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5 Section-by-Section Analysis. The Patient Protection and Affordable Care Act (H.R. 3590) as Passed. March 2010.
should be included in proposals, and 3) where to send proposals. **IDSA urges CMMI to use the federal rulemaking process, which provides an opportunity for public comment, to answer these specific questions and to more generally propose a process for submitting unsolicited proposals.**

IDSA looks forward to working with CMS as it implements ACOs and tests other innovative payment models through the newly established Center for Medicare and Medicaid Innovation. If you have any questions or comments, please feel free to contact Jason A. Scull, IDSA’s Program Officer for Clinical Affairs, at (703) 299-0200 or jscull@idsociety.org.

Sincerely,

James Hughes, MD, FIDSA
President, IDSA

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