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Via Electronic Submission (www.regulations.gov)

June 6, 2011

Donald Berwick, M.D., M.P.P.
Administrator
Centers for Medicare & Medicaid Services
ATTN: CMS-1345-P
7500 Security Blvd.
Baltimore, MD 21244-8013

Dear Dr. Berwick:

Re: Medicare Shared Savings Proposed Rule, File Code CMS-1345-P

The Association of American Medical Colleges (AAMC or the Association) welcomes this opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS' or the Agency's) Proposed Rule entitled "*Medicare Program; Medicare Shared Savings Program: Accountable Care Organization (ACOs)*" 76 Fed. Reg. 19528 (April 7, 2011). The AAMC represents all 134 accredited U.S. medical schools, nearly 400 major teaching hospitals and health systems, and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 125,000 faculty members, 75,000 medical students, and 106,000 resident physicians who deliver over one-fifth of all clinical care in the nation.

At the outset, we commend the significant effort by CMS staff in developing this proposed rule. In addition to the time and effort Agency staff spent crafting the proposed rule, they sought input on establishing and implementing ACOs from the health care community and other stakeholders prior to issuing the proposed rule. These opportunities to share input included listening sessions, open door forums, and the November 17, 2010 Request for Information (RFI). We also appreciate that CMS considered a variety of delivery and payment options and presented these for comment in the proposed rule.

OVERVIEW

This is an important time for the nation's health care system. It is critical that hospitals, physicians, and other providers find ways to improve the health of our population while constraining the growth in health care costs. Such goals will require a fundamental redesign of the current delivery and payment systems.

The AAMC and our member teaching hospitals, medical schools, and clinical faculty are committed to changing the way health care is delivered to achieve better care for patients,

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improved health status for communities, and a more efficient delivery system. Together, these entities deliver more than one-fifth of the nation's patient care services, train most physicians and many other health professionals, provide half of all continuing medical education, and carry out the majority of federally funded biomedical and health services research. They have increased their focus on work to improve quality, lower cost growth, and improve the health status of their patients and communities through their research agendas and training curricula for the next generation of health care professionals.

Many of our members look forward to the introduction of Healthcare Innovation Zones (HIZs), a model included in the Center for Medicare and Medicaid Innovation (CMMI) created by section 3021 of the Affordable Care Act (ACA), which specifically include teaching hospitals and physicians, as one important way for our members to participate meaningfully in improving quality care and reducing health care costs. At the same time, many members are considering the other health care delivery initiatives contained in the ACA, including the Medicare Shared Savings (also known as the ACO) Program authorized under section 3022 of the ACA.

As set forth in the ACA, the ACO program is not a pilot, but rather will be an option under the current Medicare program, similar to the Medicare Advantage (MA) program. Because it will be an ongoing and permanent part of Medicare, we believe the goal of this initial rulemaking should be to build a foundation that ensures Medicare beneficiaries continue to have access to high quality providers, such as teaching hospitals and teaching physicians. Additionally, ACOs should include appropriate incentives to improve the value of health care services Medicare beneficiaries receive.

Unfortunately, we believe the proposed rule falls short of these goals. Including Medicare policy payments in the ACO payment calculations, namely, direct graduate medical education (DGME)¹, indirect medical education (IME), and disproportionate share hospital (DSH) payments could encourage ACOs to recommend that patients avoid teaching hospitals, depriving beneficiaries of the breadth of options offered at these facilities which may be integral to providing appropriate care. In addition, not including physician specialists in the attribution methodology will likely mean less coordination and accountability for complex patients who regularly seek care from these physicians. We also believe that, as proposed, the risk adjustment policies, quality measures, and spending targets could unintentionally work against the stated goals for ACOs to encourage higher quality, more coordinated care—goals which we support. Finally, the administrative requirements put forth in the rule are so burdensome that they could present an insurmountable barrier to widespread provider participation.

We urge CMS to adopt the following changes in the final rule. We believe such changes will go a long way toward establishing an ACO program that meets the goals that both we and CMS

¹ While the proposed rule does not specifically address DGME payments, because they are part of Medicare Part A and Part B spending, we are including them in our discussion of this issue.

embrace: higher quality, more coordinated, and more efficient care for Medicare beneficiaries that enable system-wide improvements to benefit all patients.

DGME, IME, AND DSH PAYMENTS MUST BE REMOVED FROM THE BENCHMARK AND PERFORMANCE EXPENDITURE CALCULATIONS

While the ACO concept offers promise as a means of improving the care provided to Medicare beneficiaries, we are very concerned that the proposed rule, as written, will restrict Medicare beneficiary access to teaching hospitals, even when that is the optimal setting for the patient. If this were to happen, in addition to constrained access, Medicare beneficiaries, and in fact all patients, would be harmed by reduced support for the societal missions of teaching hospitals and their affiliated faculty physicians. These missions include the training of health professionals, discovery of advanced treatments, and ensuring access to the highest level of clinical care in a community often unavailable elsewhere.

Excluding DGME, IME, and DSH Payments Is Critical to Ensuring Access to Medically Necessary Services for Medicare Beneficiaries

The proposed rule specifically requests comments regarding how the inclusion or exclusion of DGME, IME, and DSH payments could impact the “medically necessary services provided at teaching/DSH hospitals” (76 *Fed. Reg.* at 19608). The AAMC appreciates CMS’ recognition of this issue and believes strongly that excluding these payments from benchmarks and performance updates is the only legitimate safeguard to ensuring that Medicare beneficiaries have access to necessary teaching hospital services.

The Medicare program has long recognized the higher costs associated with the important societal roles of teaching hospitals and has provided DGME, IME, and DSH payments to help offset these costs. In addition to training future physicians and other health professionals, teaching hospitals treat the sickest and most complex Medicare patients. They have higher case mix indices (which measure the complexity and severity of a hospital’s Medicare patients) and treat a disproportionate share of outlier cases (which reflects a high number of extraordinarily complex and severely ill patients).² These institutions also receive the majority of transfers from other hospitals when patients need more sophisticated diagnostic and treatment services than other providers can deliver. In 2010, approximately 406,000 Medicare patients were transferred from one acute care hospital to another. Of these patients, nearly three-quarters (300,000) were transferred to teaching hospitals. These transfers occur because of the recognition that teaching

² As a group, major teaching hospitals (defined as having an intern and resident-to-bed (IRB) ratio greater than or equal to 0.25) have the highest case mix index, (on average, 1.71 compared to 1.58 and 1.38 for other teaching and non-teaching respectively); major teaching hospitals also have the highest outlier payments: on average, \$5.74 million compared to \$2.18 million and \$845,000 for other teaching and non-teaching respectively. (Source: AAMC Analysis of IPPS Proposed Rule Impact File, FY 2012).

hospitals provide a higher level of specialized care that exceeds transferring hospitals' capabilities.³

Medicare provides DGME, IME, and DSH payments to help offset a portion of the costs related to these unique roles. Subsequently, a Medicare admission to a teaching hospital will include policy payments for these societal goods which are not included when patients are admitted to a non-teaching hospital. By including DGME, IME, and DSH payments in both the benchmark and performance expenditure calculations, the proposed rule creates an economic incentive for physicians to admit patients to non-teaching hospitals, thereby potentially limiting access to medically necessary services. If the ACO's benchmark population previously utilized the services of teaching hospitals, the ACO can generate savings merely by directing patients to non-teaching hospitals while not truly reducing the utilization of services. Similarly, if an ACO's benchmark population was relatively healthy and did not previously require many teaching hospital admissions, an ACO is incentivized *not* to send a patient to a teaching hospital during the performance period, even if the patient needs that level of care, because the higher payments will make it more difficult for an ACO to generate savings compared to its benchmark. With these incentives in place, the proposed rule potentially rewards those ACOs that might make clinical decisions which are not in the best interest of the patient or the Medicare program.

We do not believe the proposed quality measures can provide the appropriate safeguards against inappropriate admissions to non-teaching hospitals that lack the expertise and technology many Medicare beneficiaries might require, particularly aging seniors with multiple illness and complex health needs. Additionally, we do not believe that any quality measures exist at this time that would fully protect beneficiaries against the potential harm that could result from the proposed rule's economic incentives to avoid teaching hospital admissions.

Because of their advanced technologies and clinical expertise, teaching hospitals have a range of care options that are not available at most non-teaching hospitals. Particularly for complex or seriously ill patients, having these options can be the difference between good and bad outcomes. For instance, 95 percent of bone marrow transplants occur in teaching hospitals.⁴ For Medicare beneficiaries with certain blood related cancers,⁵ these transplants may be an appropriate treatment option, but that option may not be considered or available if the beneficiary is sent to a non-teaching hospital.

Excluding DGME, IME, and DSH payments from the benchmark and performance calculations will ensure that decisions by ACOs will be based on *clinical* determinations that are in the best interests of the patient and will not be influenced by financial interests. Excluding these

³ Source: Analysis of FY 2010 MedPAR File, IPPS Proposed Rule FY 2012 Version. For Medicare discharges between October 1, 2009 and September 30, 2010, and based on claims processed by December 31, 2010.

⁴ Agency for Health Care Quality and Improvement <http://hcupnet.ahrq.gov/>, 2009 Data, Retrieved 6/5/2011.

⁵ For example, allogeneic hematopoietic cell transplantation (HCT) may be an appropriate regimen for myelodysplastic syndrome, CLL, or acute myelogenous leukemia in younger Medicare patients.

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payments would be similar to CMS' action in 1997 to "carve out" DGME and IME payments from Medicare managed care payment rates and make these payments separately to teaching hospitals. This allowed managed care plans to negotiate rates based on clinical care services rather than intermingling policy payments.

Excluding DGME, IME, and DSH Payments Preserves Vital Support for the Societal Missions of Teaching Hospitals

The AAMC supports efforts to reduce unnecessary spending and to care for patients in settings that are clinically appropriate—which often includes care in non-teaching hospitals. However, policymakers have long recognized the value of care provided in teaching hospitals which may require investments in standby services or other highly specialized personnel and equipment; or support for the disproportionate level of care provided to patients who are unable to receive care elsewhere for financial or other reasons. Since its inception in the 1960s, Congress has continually re-affirmed that Medicare should support its share of societal investments in medical education, research, and the provision of the highest level of clinical care to patients who need it most. These critical societal goods are provided by the nation's teaching hospitals.

The level of teaching hospital policy payments is based on a methodology that is driven by a teaching hospital's inpatient utilization. If including DGME, IME, and DSH payments in the ACO calculations reduces teaching hospital admissions by inappropriately directing patients to non-teaching hospitals, this problematic policy will potentially endanger beneficiaries and erode important financial support for the unique societal missions of teaching hospitals that benefit all patients. We do not believe such a result was intended in 1965, when Congress determined that Medicare would pay its share of the costs associated with these missions.

We recognize that under the current inpatient-dependent methodologies, any time Medicare inpatient admissions decline in teaching hospitals, DGME, IME, and DSH payments also decline. For example, admissions are likely to be reduced under the excess readmission program mandated by the ACA. Yet many of the mission costs are not reduced, and we recognize that we must work with CMS and the Congress to identify Medicare policies that support graduate medical education and the other missions of teaching hospitals through payment methodologies that do not rely solely on inpatient hospital utilization.

However, in the case of excess readmissions, CMS made an intentional policy decision: the full DGME, IME, and DSH "savings" associated with avoided readmissions to teaching hospitals is retained by the Medicare program. This is better policy than trying to generate savings by incentivizing ACOs to "cherry pick" among hospitals rather than make true changes in health care delivery. Moreover, if an ACO does not include a teaching hospital, it will have an additional financial advantage, because it will receive these policy payments but does not bear the costs these payments are intended to offset. Such a result is bad policy, is inequitable, and should not be included in the ACO final rule.

CMS Has the Statutory Authority to Exclude DGME, IME, and DSH Payments

In the proposed rule, CMS expresses concern with the Agency's statutory authority to exclude IME and DSH payments from both the benchmark and expenditure targets, noting that section 1899(d) of the ACA gives the Secretary this authority for the benchmark calculation but is silent with regard to the expenditure target calculation. CMS clearly has the authority to remove these payments under section 1899(i) of the ACA. Moreover, applying the rules of statutory construction mandates a reading of section 1899 that permits CMS to exclude these payments from both the benchmark and expenditure calculations.

The attached legal memorandum, prepared by Katten Muchin Rosenman, LLP ("Katten"), discusses this issue in more detail. Briefly, section 1899(i), titled "Option to Use Other Payment Models" grants the Secretary the authority to use *any* payment model for shared savings payments provided that she determines it will improve the quality and efficiency of items and services furnished under the Medicare program. As the attached memorandum points out, the proposed rule recognized the broad authority of section 1899(i) to allow the Agency, if it so chooses, to deviate from specific requirements in section 1899(d), including structuring the risk models, updating the benchmark, and determining the net sharing rate. As Katten writes, section 1899(i) "is clear in granting the Secretary authority to exclude" DGME, IME, and DSH payments."

While emphasizing that the Secretary's authority under section 1899(i) clearly permits the exclusion of these payments, Katten's memorandum also points out that applying the general principles of statutory construction mandates an interpretation of section 1899(d) that also allows this result. According to the memorandum, determining shared savings requires an "apples to apples" comparison between the benchmark and expenditure calculations. Accordingly:

Reading the statute to prohibit the Secretary from adjusting the formula for the calculation of expenditures for "other factors" beyond beneficiary characteristics would render the statutory language regarding the benchmark calculation essentially meaningless. Thus, applying the principles of statutory construction...section 1899(d) should be interpreted to permit the Secretary to adjust for "other factors" for both the benchmark and the expenditure calculations.

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THE ACO BENEFICIARY ATTRIBUTION METHODOLOGY SHOULD BE MODIFIED

Beneficiary assignment is fundamental to the ACO program. It affects not only the size of the ACO, but also identifies the population upon which shared savings and quality performance will

be measured. It is essential that the attribution methodology be as accurate as possible, because it affects so many aspects of the Shared Savings Program

CMS proposes to assign beneficiaries based on a retrospective examination of utilization of primary care services. Specifically, at the end of each performance period, CMS will review the Medicare claims submitted during that year for each beneficiary and will “retrospectively” assign that beneficiary to an ACO based on the plurality of primary care services (determined by allowed charges) provided by physicians who participate in the ACO program with the primary specialty of internal medicine, general practice, family practice, and geriatric medicine. CMS uses the Primary Care Incentive Payment (PCIP) program set forth by section 5501 of the ACA as the basis for defining both primary care services and the specialties that would meet the primary care definition.

While CMS proposes a retrospective methodology based on primary care physicians, the Agency notes that it considered other options that include specialists in the assignment methodology. It also considered prospective attribution. The proposed rule specifically requested comments on these other options, as well as whether there should be a minimum visit threshold requirement.

The AAMC believes strongly that specialists should be included in the attribution methodology. We also think a prospective methodology would better promote the goal of high quality and high value care, because ACOs could target specific interventions for the patient population assigned to them. Lastly, the AAMC believes a minimum visit threshold is necessary to ensure accurate assignment.

Specialists Should be Included in the Attribution Methodology

Many Medicare beneficiaries, particularly those with multiple chronic conditions, routinely receive care from physician specialists. These physicians often also are responsible for managing the overall care of these complex patients whose predominant morbidity is related to a single organ system or disorder. ACOs that better coordinate care for these patients can improve quality and achieve substantial savings to the Medicare program. For the ACO program to meet the laudable goals of improving the quality and efficiency of care for the chronically ill, the attribution methodology should include services provided by specialists.

As CMS acknowledges, specialists are “often the principal primary care provider for elderly and chronically ill patients” (76 *Fed. Reg.* at 19564); yet the proposed methodology does not include these physicians. By definition, under the proposed rule beneficiaries who receive all of their care from specialists would be excluded from the ACO assignment. Yet, these beneficiaries could benefit most from the improved care coordination that an ACO provides. Thus, excluding these patients is counter-intuitive to the intent of the program. In addition, patients who infrequently see a primary care physician, but who receive most of their primary care from a specialist, would be assigned to a physician who in actuality is not their primary care physician.

For these reasons, the AAMC supports an assignment methodology that recognizes specialists who are responsible for ensuring that adequate primary care needs are also addressed.

CMS identified two possible ways to include specialists in the assignment methodology. The AAMC would prefer option one in the proposed rule, which assigns beneficiaries based on the plurality of primary care services regardless of specialty, or, alternately, a variation that excludes those specialties that rarely provide primary care. This model has been used in the Physician Group Practice (PGP) Demonstration and the Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO). While we do not believe it is ideal, the AAMC could also accept option three, the hybrid model, in which the beneficiary is assigned to a specialist if not otherwise assigned to a primary care physician. If option three is selected, however, it is important to ensure the primary care physician is in fact serving as the beneficiary's principal care provider. For example, the Pioneer ACO Model, recently released from the CMMI, suggests the primary care physician meets a minimum percentage of primary care services. As explained in more detail below, the AAMC believes a minimum number of visits must apply as well. Finally, the AAMC would also support an additional option of letting the ACO decide which physicians in the organization are primary care providers and should be included in the attribution methodology.

Related to the necessary inclusion of specialists, we do not believe that CMS is constrained to follow the definition of primary care physicians from the PCIP program for defining which physicians are to be included in the ACO program. Determining who should receive an incentive payment adjustment for primary care is distinct from determining who is providing primary care for a specific patient.

CMS expresses concern in the proposed rule that including specialists in the beneficiary assignment methodology could affect market competition by reducing the number of specialists who can participate in more than one ACO. If CMS is worried about specialists belonging to only one ACO, we believe the Agency could develop a series of "tie-breaker" rules to determine to which ACO the beneficiary would be assigned. The AAMC would be happy to work with CMS to develop possible rules. While this recommendation could be more complex to administer, the benefits of including specialists (and their complex patients) in the ACO program greatly outweigh any potential administrative burden.

ACO Beneficiaries Should be Assigned Prospectively

The AAMC believes the final rule should include an option for an ACO to identify its population prospectively. With prospective assignment, ACOs can create systems to actively manage and engage patients. Prospective attribution also allows providers to understand their ACO population and potentially identify specific interventions and programs based on the characteristics and health status of their ACO participants. The ACO also would have the opportunity to review the patient list and ensure the accuracy of the assignment methodology. Finally, a prospective assignment simplifies the communication with Medicare beneficiaries

about being part of an ACO. Restricting the beneficiary assignment to a retrospective methodology hampers ACOs' abilities to manage their patients proactively and effectively.

The AAMC is disappointed that CMS selected a retrospective assignment and asks the Agency to reconsider prospective assignment of beneficiaries. In its response to the November 17, 2010 RFI, CMS acknowledged that "few commenters" favored retrospective assignment. The Agency also acknowledges that there are merits to prospective assignment. In fact, the Pioneer ACO Model allows Pioneer ACOs to choose either prospective or retrospective assignment. We believe the Agency can, and should, extend the same flexibility to ACOs in the Shared Savings Program.

There Should be a Minimum Visit Threshold for Assigning Beneficiaries

The attribution methodology should ensure that physicians are accountable for the patients for whom they are actually coordinating care. Any attribution based on evaluation and management services must include some minimum threshold to avoid assigning patients based on a single visit. In the PGP Demonstration and the PQRS GPRO, beneficiaries need at least two visits with a physician in order to be assigned. The AAMC believes this two-visit threshold should be the minimum for any beneficiary attribution assignment scheme.

ACO RISK ADJUSTMENT NEEDS TO BE ROBUST AND ACCURATE FOR THE PATIENT POPULATION ACTUALLY BEING TREATED

Risk adjustment is a key component of any payment system. It ensures that providers are paid appropriately for the patient populations they treat. Standardizing for patient risk profiles also is important when making comparisons, otherwise providers with higher costs and that receive higher Medicare payments for treating complex patients may be viewed as "inefficient" and unduly penalized. Ensuring accurate risk adjustment for both benchmark and performance period expenditure calculations, as well as quality outcomes, is particularly important in the ACO program. It will be applied to all payments for services received by a beneficiary and will have a direct impact on the amount of savings, if any, that an ACO achieves.

Academic medical centers disproportionately treat the sickest and most complex patients. Without accurate risk adjustment, these providers could be unduly penalized for treating these patient populations. While the rule proposes to use the CMS-HCC risk adjuster in an attempt to account for beneficiary characteristics, the AAMC is concerned that this particular adjuster lacks the capability to account for socio-economic status (SES) which deeply impacts providers' ability to provide quality and efficient health care to a given population. Even when risk adjustment accounts for differences in underlying health status (generally worse in lower SES patients), utilization of services may be significantly higher among lower-income patients due to factors beyond the control of the provider.

Risk Adjustment Scores Should Be Recalculated For Each Performance Year

As directed by the ACA, an ACO's benchmark calculation is established using the three most recent years of per-beneficiary expenditures under Medicare Parts A and B and is adjusted for beneficiary characteristics and "other factors as the Secretary deems appropriate" (76 *Fed. Reg.* at 19604). CMS proposes using the CMS-HCC prospective risk adjustment model for the ACO program. This model incorporates diagnostic information and currently is used in the MA program. The proposed rule would apply the CMS-HCC model to the historical ACO benchmark population. The AAMC is concerned, however, that under the proposed rule the same benchmark score would then be used to adjust the performance expenditures throughout the agreement period.

CMS asserts that incorporating diagnostic information, as the CMS-HCC model does, provides an incentive for practitioners to code more fully, which increases risk scores. CMS states that this result occurred in both the PGP Demonstration and in the MA Program. The preamble text notes that "the practical effect of increasing risk scores would be to decrease the actual annual expenditure compared to the benchmark, because the benchmark would be increased to reflect changes in the ACO's risk score, while actual expenditures would not change...[allowing] an ACO to achieve apparent savings by coding changes alone" (76 *Fed. Reg.* at 19607). In support of its proposal, CMS writes that by applying the benchmark risk score throughout the agreement period, the ACO program will be protected "from costs due to greater diagnosis coding intensity" (76 *Fed. Reg.* at 19607).

We believe the concern about potential increased coding intensity is far outweighed by a concern about incentives to avoid complex patients or to penalize institutions that treat patients in their performance period who are more complex compared to their benchmark population. Applying a single risk score provides an inherent incentive to avoid complex patients: an ACO whose benchmark has a relatively high risk adjustment score due to a more complex and sicker population could achieve savings by avoiding these patients during the performance period. Correspondingly, this methodology penalizes those ACOs whose patient population in the performance period is more complex than in the benchmark period. As CMS acknowledges throughout the proposed rule, the assigned population could change up to 25 percent annually, rendering it illogical that a benchmark risk score based on historical data should be applied year after year to populations that could change significantly.

The AAMC believes an ACO's risk adjustment score should be determined by the population the ACO is actually treating; therefore, the risk adjustment score should be recalculated each year of the agreement period. If CMS remains concerned about inappropriate coding changes, the Agency should monitor ACOs for this behavior.

We believe strongly that calculating annual risk scores is more appropriate and not unduly burdensome to the Agency. If, however, CMS chooses not to make this change, we believe that the Agency should at least calculate risk adjustment scores for subpopulations in the benchmark

period (for example, elderly population, the end stage renal disease (ESRD) population, the disabled population, et cetera, as determined by the Agency) and then calculate an overall benchmark risk score using the various subpopulation weights (share of the total). During the performance period, CMS would use the subpopulation benchmark risk scores but the performance period subpopulation weights to ultimately determine the performance period risk score, should it change from the benchmark period. Such a methodology would both address CMS' documentation concerns and help to reflect shifts between benchmark and performance period populations.

Quality Measures Need Robust Risk Adjustment

It is imperative that any payment program that applies financial incentives and penalties based on quality outcomes should contain a risk adjustment that adequately accounts for differences in patient populations, such as severity of illness. In particular, it is increasingly apparent that SES is associated with patient outcomes, yet the current risk adjustment tools do not account for these factors.⁶ Inclusion of these and other indicators is critical to ensuring a level playing field for providers that treat sicker and more vulnerable patients, such as teaching hospitals and faculty physicians.

We recognize that developing risk adjustment methodologies is a difficult undertaking, and we appreciate the efforts CMS has made to date. Yet we believe more can and must be done, and with urgency. We urge CMS to bring together national experts to develop appropriate risk adjustment models and to identify mechanisms for collecting the necessary data, particularly to address the issue of adequately adjusting for patient SES.

CMS SHOULD RECONSIDER HOW TO TREND AND UPDATE ACO BENCHMARKS FOR SHARED SAVINGS DETERMINATIONS

The amount of ACO savings, if any, is determined by comparing the ACO's expenditure benchmark to the assigned beneficiary per capita Medicare expenditures in each performance year throughout the three-year agreement period. Because it is fundamental to the shared savings calculation, how CMS decides to trend forward the three years of historical data to obtain the initial benchmark, as well as how that initial benchmark will be updated during the agreement period, is key not only to determining whether an ACO is able to achieve savings and how much, but also whether providers will agree to participate in the program at all. These decisions also involve issues of fundamental fairness, particularly for institutions, like academic medical centers, that have higher costs (and sometimes cost growth rates) as a result of factors, such as location and patient populations, that are beyond their control. We urge CMS to reconsider how it will trend and update the benchmarks in light of these factors.

⁶ SES factors include income, education levels, and poverty and literacy rates.

The ACO's Historical Benchmark Data Should Be Trended Forward Using the ACO's or a Local or State Percentage Growth Rate

Under the proposed rule, an ACO's expenditure benchmark will be established using three years of historical data. These data must be trended forward to current dollars and then averaged using a proposed weighting scheme of 60 percent for the most recent year, and then 30 percent and 10 percent for the two previous years, respectively. The proposed rule lays out a number of options to trend forward the data, first debating the use of a flat dollar update or percentage growth rate; and, second, whether to use a state or local rate, or a national rate. CMS ultimately proposes to use a national percentage growth rate to trend forward each ACO's historical data to establish its initial benchmark.

The AAMC has serious concerns with this trending proposal. As the proposed rule notes, the use of a national growth rate disadvantages ACOs in historically high cost growth areas—areas where many academic medical centers are located and where complex, chronically ill patients are most often treated. The aim of establishing the initial benchmark should be to provide the most accurate portrayal of historical ACO spending, be it high or low. It should not be used to make policy decisions as to what the spending should have been by drawing comparisons to national spending levels. It is illogical to penalize providers for historical spending when they were not attempting to meet known and specified goals.

The AAMC recommends that the historical data be trended forward using the ACO's own percentage growth rate or, as the next best proxy, the local or state growth rate where the ACO is located. This would ensure the most accurate picture of the ACO's spending prior to entering into a Shared Savings Program agreement.

The ACO Benchmark Should Be Updated by a Local or State Growth Rate

The legislative language is quite prescriptive in the methodology to be used to update the benchmark during the agreement period: the benchmark shall be “updated by the projected absolute amount of growth in national per capita expenditures” (76 *Fed. Reg.* at 19610). Acknowledging this language, but also noting its flexibility under section 1899(i) (76 *Fed. Reg.* at 19610), the proposed rule debated two options before proposing to update the ACO benchmarks using an absolute flat dollar amount equivalent of the absolute amount of growth in national fee-for-service expenditures.

The AAMC believes CMS should invoke its authority under section 1899(i), as noted in the proposed rule, and use a state or local percentage growth rate to update the benchmark. As the rule states: “Incorporating more localized growth factors reflects the expenditure and growth patterns within the geographic area served by ACO participants and ACO providers/suppliers, potentially providing a more accurate estimate of the updated benchmark based on the area from which the ACO derives its patient population” (76 *Fed. Reg.* at 19610). With a flat dollar update, “ACOs in high cost high growth areas must reduce their rate of growth more to bring

their costs more in line with the national average” (76 *Fed. Reg.* at 19610), which significantly disadvantages ACOs in areas with higher costs that could result from being located in larger urban areas and areas where populations have significant SES challenges. Barring the use of a local growth rate, the application of a national growth rate must accommodate local variation in input costs rather than apply an absolute dollar amount across all areas. At the very least, it should employ a more nuanced update scheme, such as that to be used for the Pioneer ACO Model.

QUALITY REPORTING REQUIREMENTS SHOULD BE REEVALUATED

Achieving quality performance thresholds is a prerequisite for receiving shared savings under the ACO program. The AAMC supports the inclusion of quality measures in the ACO program, because they help to ensure that beneficiaries are receiving high quality health care and that any savings achieved by an ACO are not at the expense of poor or reduced quality. The AAMC also appreciates that CMS is aligning ACO quality reporting with the PQRS.⁷ We have several concerns, however, with the quantity, substance, and scoring of the proposed measures.

The Quality Measures Should be Reduced and Refocused

The proposed rule requires ACOs to submit data on 65 quality measures to be eligible for shared savings. We believe this number is excessive and that measuring the quality of care provided by ACOs can be accomplished with fewer measures. For example, the PGP Demonstration, which has been a model for many aspects of the ACO program, started with 10 measures and, only after gaining experience with the program, were more measures phased in to a maximum of 32.

The AAMC believes that, like other Medicare quality programs, all measures included in the ACO program should be endorsed by the National Quality Forum (NQF). Many measures included in the proposed list, such as the three newly-created composites (CAD, diabetes and patient safety) do not meet these criteria and, therefore, should not be considered for inclusion in the ACO program. NQF endorsement is important, because it ensures that measures have gone through a rigorous evaluation of the supporting evidence base as well as an assessment of a measure’s reliability and validity.

CMS proposes to include a patient safety composite measure comprised of nine Hospital Acquired Conditions (HACs) and an AHRQ Patient Safety Indicator (PSI) composite. The AAMC opposes the inclusion of the HACs in the ACO program, as the occurrence of these events is very rare. More importantly, the way the rates are calculated does not allow for the use of a risk adjustment model to account for the differences in patients across hospitals. Therefore, these measures are not appropriate for comparison purposes or performance payments. Lastly, to

⁷ As an aside, we support further alignment across the national quality reporting programs to reduce provider burden and encourage CMS to focus on those measures that make true improvements in care.

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the extent they occur, there is an HAC payment program already in place that withholds payment to hospitals for the occurrence of specific HACs acquired during a hospital stay. Inclusion of these measures would lead to hospitals potentially being penalized multiple times for the same performance on these measures.

The AAMC also opposes the proposed readmission measure, which is not NQF-endorsed. We are extremely concerned that CMS has not provided specifications for this measure, making it impossible to evaluate CMS' risk adjustment methodology or to review the measure exclusions, such as planned readmissions and transfers. Similar to the HAC measures, there is a readmission payment policy already required under the ACA that would potentially penalize hospitals multiple times for the same readmission.

While the AAMC supports the use of population health measures, we are concerned about the use of the AHRQ PQI measures for payment purposes. Related to our previous comments on risk-adjustment, these measures do not utilize a robust risk adjustment methodology, as the measures adjust only for age and sex. In addition, these measures are designed to evaluate large populations which typically include both healthy and sick individuals. According to the attribution methodology, ACO populations are based only on patients seeking health care services. Therefore, the AAMC recommends using these measures for monitoring purposes only, not for payment.

The AAMC supports the inclusion of patient satisfaction as a quality metric for ACOs; however, we have concerns regarding the requirement for submitting CG-CAHPS data. We recommend that CMS require the submission of CG-CAHPS data, but only for reporting purposes and not for payment in the initial agreement period. There will be a significant learning curve to become familiar with the data and to understand how to use the data to make improvements. In addition, since the data have not been collected on a national basis, there is no mechanism to determine appropriate benchmarks.

The AAMC opposes the inclusion of the Health Information Technology (HIT) and e-prescribing measures in the ACO program. These measures already are included in the EHR incentive program and should not be double-counted in performance programs. Furthermore, these measures account for the presence of a technical infrastructure to facilitate quality care but are not proximal to the delivery of that care and should not be used as a proxy for quality.

While we believe the number of measures is excessive and needs to be streamlined, we also believe CMS should focus more on outcomes measures. While we realize outcome measures with robust risk adjustment methodologies are limited, we support the rapid development of these measures as required in section 10303 of the ACA. As an additional avenue to identify appropriate measures, CMS might also consider giving ACOs the opportunity during the application process to indicate which quality measures would be most relevant or appropriate for their patient population.

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Finally, as required by statute, a measure cannot be included in the Hospital Value-Based Purchasing (VBP) program until it has been reported on the Hospital Compare website for a year. The AAMC believes a similar requirement should be in place for all new measures proposed for inclusion in the ACO program. No measure should be used until it has been reported for at least one year with no financial penalties attached.

Phase in the Quality Performance Payment Model

While the proposed rule would require ACOs to submit quality data in each of the three performance years, for the first year eligibility for shared savings will be based on reporting the quality measures only. In the second and third years, the ACO would need to meet specified performance thresholds.

The AAMC strongly supports the reporting-only requirement for the first year and appreciates CMS' recognition of this type of phased-in approach. Such a process follows the precedent established by other national reporting programs, such as the hospital inpatient quality reporting (IQR) program and the PQRS.

For the second and third year of the ACO program, CMS proposes to use a performance payment model. The proposed method is similar to the Hospital VBP program. Individual measures, in five care domains, must exceed a minimum threshold (30th percentile); performance above the minimum threshold is then scored on a sliding scale. The measures are aggregated by domain and each domain is then weighted equally to determine a total performance score. The total performance score determines the percentage of eligible savings an ACO will receive. While not proposed, CMS also notes that the Agency considered a minimum quality threshold model, which allows an ACO to achieve full savings if a minimum threshold is achieved, and hybrid models that include aspects of both the threshold and performance-based models.

The AAMC appreciates that the proposed performance model provides an opportunity to achieve greater savings based on performance. Our concern, however, is that the ACO program represents a newly formed organization and construct that has not been measured before. We recommend further consideration of a hybrid approach. Consequently, we recommend the second year of reporting should include a minimum threshold model of 30 percent—where ACOs that meet this threshold for all care domains are able to achieve full savings. CMS can then graduate to the performance model in the third year.

The proposed rule states: “ACOs that do not meet the quality performance thresholds for all proposed measures would not be eligible for shared savings” (76 *Fed. Reg.* at 19570). The AAMC believes that an ACO should not be excluded from shared savings based on the score of an individual measure, regardless of the payment model. Therefore, we strongly recommend that any minimum threshold requirement be set at the domain level.

The proposed scoring methodology requires the use of performance benchmarks to determine relative performance. It is unclear, however, whether Medicare fee-for-service data or actual ACO performance will be used to establish performance benchmarks. The AAMC believes the benchmarks should be set utilizing Medicare FFS rates, ensuring ACOs overall are being compared against traditional FFS services. In addition, the benchmark should be a fixed percentage, not percentile, providing a defined target rather than relative performance which ACOs are unable to determine prior to the performance year.

GOVERNANCE AND ADMINISTRATIVE REQUIREMENTS ARE ONEROUS AND NEED TO BE REASSESSED

Governance Requirements Need Clarification and Increased Flexibility

CMS relies on the statutory requirement that an ACO have a “mechanism for shared governance” as a means to propose a comprehensive set of governance requirements for an ACO to participate in the Medicare Shared Savings Program. The AAMC is concerned that the proposed governance requirements, when taken as a whole, go well beyond the statutory requirement and will create an additional burden on existing entities that may otherwise meet the criteria and have the structure in place to become an ACO. In addition, the AAMC seeks clarification from CMS regarding its proposed requirements that ACO participants possess at least 75 percent control of the ACO’s governing body, and have “appropriate proportionate control over governing body decision making” (76 *Fed. Reg.* at 19540).

As noted above, the basis for determining “proportionate level of control” is unclear. Specifically, would this require each individual physician practice be represented on the governing body of the ACO or rather simply representatives from each *type* of provider (e.g. representatives of the primary care physician group practices)? What is the basis for determining the proportionate level of control? Is it based on equity interest in the ACO’s legal entity, the number of ACO participants, or something else? The Association asks CMS to clarify these issues in the final rule.

The AAMC appreciates CMS’ flexibility in allowing existing entities that meet all eligibility criteria to not create a separate legal entity to participate in the ACO program. However, we think that few existing systems can meet the proposed governance requirements. The AAMC supports a model that allows existing legal entities to participate in an ACO without forming a new governing body and recommends that CMS drop its specific governing body composition and relationship requirements.

ACOs Should Have the Ability to Add ACO Participants During the Agreement Period

Under the rule as proposed, an ACO would be allowed to drop, but not add, ACO participants (identified by federal tax identification number) over the course of its three-year agreement with

CMS. The AAMC is concerned that this provision, if finalized, severely limits the ability of an ACO to maintain and expand provider networks over the course of the contract period.

While the AAMC acknowledges that CMS' intent may be to prevent ACOs from recruiting providers having patient populations with beneficial cost profiles following the initiation of the contract period, we believe this provision undermines the overall objectives of the Shared Savings Program, and it does not encourage broader provider participation and network development. We urge CMS to allow ACOs the flexibility both to add and subtract providers during the course of the three-year contract period, thus ensuring ACOs can maintain beneficiary access to the highest quality care.

Beneficiary Opt-Out of Data Sharing is Problematic for ACO Care Management

As proposed, CMS would allow beneficiaries to opt-out of having certain identifiable claims data shared with their ACO providers. If a beneficiary chooses this option, it would not affect participation in the ACO or CMS' use of their data for purposes of assessing quality or cost measures.

The AAMC has serious concerns with the beneficiary opt-out provisions in the proposed rule. We believe that ACO providers must have access to beneficiary identifiable claims data to properly manage and improve the health of the patient population. Moreover, tracking beneficiaries who have opted-out of data sharing would be needlessly burdensome for ACO providers. Beneficiaries who choose not to have their data shared should seek a non-ACO provider for care.

Aggregate Data Should be Shared with Prospective ACOs

CMS proposes to share aggregate data of historically assigned beneficiaries with ACOs accepted into the Medicare Shared Savings Program prior to the first performance period. The AAMC appreciates this provision, as data access is integral for an ACO to assess and effect change in the health of its population. However, the AAMC requests that CMS also share aggregate data with *prospective* ACO participants, before they are required to commit to the formation of an ACO. Prospective ACOs could use these data to determine the feasibility and practicality of entering into the Shared Savings Program, without incurring additional costs.

CMS Should Streamline and Simplify the Application Requirements

The proposed rule makes numerous mentions of ACO application requirements throughout the preamble and regulatory text. These requirements range in degree of difficulty and level of detail from perfunctory requests for copies of agreements with ACO participants establishing their liability, documents related to formation and operation of the ACO, and other specific documentation-type requirements, scaling up to the application requirements related to meeting

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patient-centeredness, which ask applicant ACOs to offer very detailed information on specific interventions, care plans, and cost sharing schemes the ACO will employ.

In a program designed to provide seamless coordinated care and achieve the three-part aim of better care for individuals, better health for populations, and lower growth in expenditures, there is certainly merit in addressing these issues. The AAMC is concerned, however, that these application requirements are burdensome and require ACOs to provide a level of detail that may not be known upon application without any information as to how these detailed plans will be used by CMS in the development of the ACO program. Furthermore, such onerous application requirements discourage organizations from participating. Lastly, the development of an ACO requires significant investment and a commitment to operating in this coordinated care environment. While CMS has offered myriad requirements for applying to be an ACO, the proposed rule does not provide specific timelines or details regarding the application process.

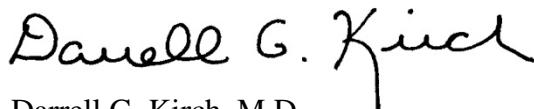
The AAMC believes CMS should not require this level of detail in the initial application. More appropriate would be a general work plan, addressing goals and overall approach, as opposed to day-to-day operations. It would allow an ACO to be flexible, agile, and not restricted to processes and plans prescribed in an application. In addition, CMS should define timelines of how and when applications will be solicited, reviewed, and approved.

SUMMARY

The AAMC very much wants to be supportive of the health care delivery reform models, programs and demonstrations under development at CMS. We believe that developing an accurate and equitable ACO program is key to ensuring that these entities achieve the goal of redesigning the delivery system without producing unintended consequences that endanger Medicare beneficiary access to quality care. Such efforts also should not undermine other important policy goals, such as helping to offset the higher costs associated with the important societal roles taken on by America's teaching hospitals and faculty physicians.

If you have any questions concerning these comments, please feel free to contact me or Karen Fisher, J.D., Senior Policy Counsel, at kfisher@aamc.org or at 202-862-6140.

Sincerely,



Darrell G. Kirch, M.D.
President and CEO

cc: Jonathan Blum, CMS
Karen Fisher, AAMC

Memorandum

TO: Karen Fisher, JD
Senior Director and Senior Policy Counsel, Healthcare Affairs
Association of American Medical Colleges

FROM: Lisa M. Ohrin, Esq.
Joseph Willey, Esq.

DATE: May 17, 2011

SUBJECT: ACO Benchmark and Expenditure Calculations: CMS's Authority under Section 1899 of the Social Security Act to Exclude IME, DGME and DSH Payments

You have asked us to review the statutory authority granted to the Secretary of the Department of Health and Human Services (the "Secretary") under section 1899 of the Social Security Act (the "Act"), as added by section 3022 of the Patient Protection and Affordable Care Act (the "Affordable Care Act"), with respect to the determination of the per capita "benchmark" and "expenditure" measures for accountable care organizations ("ACOs") participating in Medicare's new Shared Savings Program. As described more fully below, we believe that section 1899(i) of the Act is clear in granting the Secretary the authority to exclude from the calculation of the benchmark and expenditure measures indirect medical education ("IME") payments, direct graduate medical education ("DGME") payments,⁸ and payments made to hospitals that serve a disproportionate share of low-income beneficiaries ("DSH" payments).

I. Background

Section 1899 of the Act⁹ requires the Secretary to establish a Shared Savings Program that "promotes accountability for a patient population and coordinates items and services under [Medicare] parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery."¹⁰ On April 7, 2011, the Centers for Medicare & Medicaid Services ("CMS"), pursuant to its delegation of authority from the Secretary, published in the Federal Register a proposed rule to implement section 1899 entitled "Medicare Shared Savings Program: Accountable Care Organizations" (the "Proposed Rule").¹¹ Of particular relevance to this analysis is section II.F, "Shared Savings Determination."¹² Among other things, this section of the Proposed Rule describes how CMS

⁸ The proposed rule is silent about the treatment of DGME payments. However, because these payments are made under both Parts A and B we will treat them like IME and DSH payments for purposes of this memo.

⁹ All references to section 1899 herein are to the Social Security Act.

¹⁰ Section 1899(a)(1) of the Act.

¹¹ 76 Fed. Reg. 19528 (Apr. 7, 2011).

¹² 76 Fed. Reg. at 19602-19616.

will determine the benchmark of expected average per capita Medicare fee-for-service (“FFS”) expenditures against which an ACO’s actual performance year expenditures will be measured in order to identify its achieved savings, if any.

Section II.F.5 of the Proposed Rule discusses whether CMS should make “technical adjustments” to remove IME and DSH payments from the benchmark and the calculation of actual expenditures for an ACO.¹³ CMS specifically referenced language in sections 1899(d)(1)(B)(i) and (ii), which states that the Secretary has the authority to adjust the benchmark for “beneficiary characteristics and such other factors as . . . [she] determines appropriate,” and shall adjust the Parts A and B expenditure data for “beneficiary characteristics.” Although CMS acknowledged the authority granted in section 1899(d)(1)(B)(ii) to remove IME and DSH payments from the per capita costs included in the benchmark for an ACO, CMS elected not to propose removing these costs from the benchmark calculation. CMS also did not propose removing IME and DSH payments from the calculation of an ACO’s actual performance year expenditures, but for a different reason: CMS asserted that it does not have the statutory authority to remove these costs from the expenditure calculation. The Proposed Rule does not mention section 1899(i) when discussing the Secretary’s authority regarding “technical adjustments” to the shared savings calculations.

II. The Secretary’s Authority under Section 1899(i) of the Act

Section 1899(i) is titled “option to use other payment models.”¹⁴ It grants the Secretary the authority to use a partial capitation model or “any payment model that the Secretary determines will improve the quality and efficiency of items and services furnished under the [Medicare program]” for making payments under the Shared Savings Program rather than the payment model described in section 1899(d). This authority is limited only by the requirement that payments to an ACO for items and services for beneficiaries for a year shall be established in a manner that does not result in spending more for such ACO for such beneficiaries than would otherwise be expended for such ACO for such beneficiaries for such year if the model were not implemented (as estimated by the Secretary). Assuming this requirement is satisfied, the Secretary may use any payment model for shared savings payments, provided that she determines it will improve the quality and efficiency of items and services furnished under the Medicare program.

In the Proposed Rule, CMS explicitly recognizes the broad authority granted to the Secretary under section 1899(i) to deviate from specific requirements in section 1899(d) when determining shared savings payments to ACOs. As described in the Proposed Rule, such authority extends to a wide variety of options for determining shared savings, including: (1) structuring a risk model within the Shared Savings Program other than and in addition to the “value-based purchasing model” described in section 1899(d);¹⁵ (2) updating the benchmark by the lower of the national projected absolute amount of growth in per capita expenditures or the local/State projected absolute amount of growth in per capita expenditures;¹⁶ and (3)

¹³ 76 Fed. Reg. at 19608.

¹⁴ Section 1899(i) of the Act was added by section 10307 of the Affordable Care Act.

¹⁵ 76 Fed. Reg. at 19603. Noting the limitations of the one-sided approach, CMS stated that it also considered whether it should “focus on [its] authority under section 1899(i) to create a risk-based option in the Shared Savings Program.” Ultimately, CMS proposed a hybrid approach that combines many of the elements of the one-sided model described in section 1899(d) of the Act, but relied on its authority under section 1899(i) to include risk-based aspects.

¹⁶ 76 Fed. Reg. at 19610. After describing the requirement in section 1899(d)(1)(B)(ii) to update the benchmark “by the projected absolute amount of growth in national per capita expenditures,” CMS stated that it “also considered [its] authority under section 1899(i) for an alternative option.” CMS proposed a national per capita

options for a methodology to determine the net sharing rate (*i.e.*, the amount of savings) ACOs under the one-sided model could be eligible to receive.¹⁷

As described above, section 1899(i) permits the Secretary, if she determines it is appropriate, to use *any* payment models that she determines will improve the quality and efficiency of items and services furnished under the Medicare program in lieu of the model described in section 1899(d). CMS correctly recognizes that this authority extends to: (1) establishing alternative risk models different from the one described in section 1899(d); (2) selecting an update factor for the benchmark that may be different from the one implied by section 1899(d)(1)(B)(ii); and (3) utilizing a formula for determining the net sharing rate that ACOs may receive under a one-sided risk model that may be different from the one described in section 1899(d)(2). Establishing formulas other than those described in sections 1899(d)(1)(B)(i) and (ii) for calculating the benchmark and performance year actual expenditures is analogous to the types of alternative structures and calculations for which CMS recognizes authority under section 1899(i) and falls squarely within that authority.

We believe that the Secretary clearly has authority under section 1899(i) to opt for a payment model in the Shared Savings Program other than the one described in section 1899(d). This includes a model that calculates shared savings payments by removing IME, DGME and DSH payments from the per capita costs used to determine both the benchmark and the actual performance year expenditures.

III. Principles of Statutory Construction

Although the Secretary's authority to remove IME, DGME and DSH payments from the per capita costs used to determine both benchmark and actual performance year expenditures is clear, a discussion of the principles of statutory construction as applied to section 1899 is helpful.

When attempting to ascertain the meaning of a statute, courts employ general rules of construction. The starting point for any analysis of a statute's meaning is the text of the statute itself. Under the "plain meaning" rule, "the language used is given its natural, plain, ordinary, and commonly understood meaning."¹⁸ However, although "courts must presume that a legislature says in a statute what it means and means what it says there," the statute must be read as a harmonious whole, in which each part is interpreted in the context of the broader statute and in a manner that avoids futility.¹⁹ Thus, the language of the statute must be construed in way that is consistent with the statute's purpose. Once it is determined that a statute's meaning cannot be derived from the text alone, courts will employ other rules of construction, including an analysis of the legislating body's intent.

update factor, but specifically sought comments on the approach that would utilize its authority under section 1899(i).

¹⁷ 76 Fed. Reg. at 19613. In its discussion of the net sharing rate, CMS noted that a particular option is required under section 1899(d)(2). Despite this "requirement," CMS elected to propose a different option, utilizing the broad authority granted under section 1899(i). Specifically, CMS proposed that, once an ACO surpasses its minimum savings rate ("MSR"), it would share in savings beyond a certain threshold. CMS did so in order to "protect[] the program from sharing unearned savings" and "help[] to ensure that shared savings are due to enhanced care coordination and quality of care on the part of the ACO."

¹⁸ Norman J. Singer and J.D. Shambie Singer, *Sutherland Statutes and Statutory Construction*, 3A Sutherland Statutory Construction § 74:5, p. 1 (7th ed.) (2010).

¹⁹ Yule Kim, Congressional Research Services, *Statutory Interpretation: General Principles and Recent Trends* CRS-4 (2008) (available at: <http://www.fas.org/sgp/crs/misc/97-589.pdf>) (citing *Connecticut Nat'l Bank v. Germain*, 503 U.S. 249, 253-54 (1992)).

A. “Plain Meaning” Analysis

The first step in the process of statutory interpretation is to determine meaning based upon the plain meaning of the words used. Under the "plain meaning" rule, if the intention of the legislature is "so apparent from the face of the statute that there can be no question as to its meaning," the analysis is complete and the meaning derived from the text attaches.²⁰ However, the plain meaning rule should not be followed “when application would be tantamount to a formalistic disregard of congressional intent.”²¹

The language of section 1899(d)(1)(B)(i), which describes the calculation of actual performance year expenditures, does not provide expressly for adjustments for “other factors.” In contrast, the language of section 1899(d)(1)(B)(ii) explicitly includes “other factors” as permissible when calculating an ACO’s benchmark. “Where Congress includes particular language in one section of a statute but omits it in another. . . , it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion.”²² However, to accept this reading of the statute would frustrate congressional intent, because it is inconsistent with the statutory purpose of the Shared Savings Program, which is to promote higher quality of care while reducing costs.

B. “Statutory Purpose and Congressional Intent” Analysis

The construction of a statute is sometimes misaligned with respect to its purpose and legislative intent. “However well [the] rules may serve at times to aid in deciphering legislative intent, they long have been subordinated to the doctrine that courts will construe the details of an act in conformity with its dominating general purpose, will read text in the light of context and will interpret text so far as the meaning of the words fairly permits so as to carry out in particular cases the generally expressed legislative policy.”²³ Therefore, where a plain meaning analysis is insufficient, courts employ other methods of statutory construction to effectuate congressional intent and avoid rendering a statute or its provisions meaningless.

From a mathematical perspective, determining shared savings requires an “apples to apples” comparison between the benchmark and expenditure calculations. In the vast majority, if not in all cases, it neither would be appropriate nor methodologically correct to include or exclude payments from the benchmark without making corresponding changes to the expenditure calculation. Accordingly, reading the statute to prohibit the Secretary from adjusting the formula for the calculation of expenditures for “other factors” beyond beneficiary characteristics would render the statutory language regarding the benchmark calculation essentially meaningless. Thus, applying the principles of statutory construction described above, section 1899(d) should be interpreted to permit the Secretary to adjust for “other factors” for both the benchmark and the expenditure calculations.

IV. Conclusion

As described in section II, above, section 1899(i) of the Act grants the Secretary clear authority to exclude IME, DGME and DSH payments from the calculation of an ACO’s benchmark and actual performance year expenditures measures. Moreover, applying the rules of statutory construction mandates a reading of

²⁰ *Overseas Education Ass’n v. Federal Labor Relations Authority*, 876 F.2d 960 (D.C. Cir. 1989).

²¹ *Rice v. Rehner*, 463 U.S. 713, 732 (1983).

²² *Bates v. United States*, 522 U.S. 23, 29 (1997) (recognizing the inclusion of “intent to defraud” language in one provision and exclusion of the language in a parallel provision), citing *U.S. v. Wong Kim Bo*, 472 F.2d 720, 722 (5th Cir. 1972).

²³ *SEC v. Joiner*, 320 U.S. 344, 350-351 (1943).

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section 1899(d) of the Act that does not frustrate its purpose and enables the Secretary to design the Shared Savings Program to promote the improvement of health care quality while lowering health care costs—that is, it enables a reading that permits the Secretary to exclude IME, DGME and DSH payments from both the benchmark and expenditure calculations.