

Comments: Medicare Proposal for Shared Savings Program,
§III.M.2, [regulations.gov#!docketDetail:D=CMS-2014-0094](http://www.regulations.gov#!docketDetail:D=CMS-2014-0094)

Comment (1) - Medicare needs to provide automated data for the proposed documentation of current medications, by improving drug lists in MyMedicare. p.40478
[federalregister.gov/a/2014-15948/p-1156](http://www.federalregister.gov/a/2014-15948/p-1156)

Without automation, manual review at each visit will *raise* Medicare costs by lengthening doctor visits to update drugs in the electronic health records at doctors' offices. Automated data from Medicare will let data entry happen once for each prescription, with savings in time, money, and accuracy.

Patients can already create a list of their at-home drugs on MyMedicare to help them compare Part D programs. Doctors need access to a list which starts there and is augmented with Part D claims, and drugs at hospitals, nursing homes, dialysis centers, imaging centers, doctors' offices, etc. Only Medicare can access all sources. Most patients do not know what drugs they get at facilities, yet doctors need to know these to avoid interactions.

The combined list needs generic and brand names, prescribing doctor(s), start date with purposes, end date with reasons, dose, any special instructions, allergies and side effects experienced, disposal instructions.

The drug lists prepared during hospital admission and discharge should be built on this list, saving costs and improving accuracy over current manual efforts.

The list needs to be easy for patients and doctors to annotate, expand with other drugs not yet in Medicare's files, and print.

Having the list lets all the patient's doctors and Medicare see that appropriate drugs have been used (supporting quality measures), and regularly review which drugs can be dropped (saving health and money). It allows analysis of which Part D program is best for the patient. It needs to generate notices to pharmacies to end automatic refills when drugs are discontinued, again saving money and avoiding errors.

Medicare should only allow drugs to be dispensed, prescribed or reimbursed to the extent they are in this list.

Proposing a quality measure on drug documentation without leveraging Medicare's own rich ability to compile drug data, increases the length and therefore cost of doctor visits, and misses the chance for significant gains.

Comment (2) - All existing and proposed hospital admission and readmission measures for ACO quality should be dropped, since they are ineffective and if followed would be deadly to all types of ACO patients, especially those with diabetes, heart failure, multiple chronic conditions, emphysema, chronic bronchitis or asthma. Table 50
[federalregister.gov/articles/2014/07/11/2014-15948/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-clinical-laboratory#t-43](http://www.federalregister.gov/articles/2014/07/11/2014-15948/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-clinical-laboratory#t-43)

Medicare has no mandate to remove hospital care for patients.

(A) Penalizing hospital stays **does not measure quality**, since all the stays are determined medically necessary by doctors and

Medicare reviewers. No expert believes in avoiding all hospital stays of these patients.

The latest August 2014 research adds to the long list of studies which find that readmissions reduce deaths, and cutting readmissions increases deaths (Gilman et al. *Health Affairs*, 33, no.8 (2014):1314-1322, pubmed.gov/25092831) "safety-net hospitals were more likely than other hospitals to be penalized under the... Hospital Readmissions Reduction Program... [M]ortality outcomes in safety-net hospitals were better than those in other hospitals for patients with acute myocardial infarction, heart failure, or pneumonia." (More at Globe1234.info/medicare/category/research/.)

(B) Hospital quality measures are **ineffective**. They adjust rewards, but 3/4 of ACOs do not cut costs enough to get rewards, so quality measures will not work for them. Most ACOs include hospitals, so incentives to avoid hospital stays will not work for them either. They have legitimate costs to cover (such as maintaining services 24/7) and will not reduce total Medicare stays in hospitals. At most, hospitals will shift to other Medicare patients. They do not join ACOs for rewards, but for waivers on antitrust and referrals.

(C) The main effect of the new rewards is to mislabel these harmful measures as "quality," so they will eventually spread beyond ACOs. This is an underhanded approach in the guise of "quality," unworthy of a distinguished national program.

The proposals **vilify** and deter far too many hospital stays. The proposals penalize all unplanned hospital stays by patients with diabetes, heart failure or multiple chronic conditions; and all stays by these and any patients for treatment of heart failure, emphysema, chronic bronchitis or asthma; and all 30-day readmissions, with extra penalties if a patient goes to a nursing home between the hospital stays. Penalties are additive, so six penalties will apply for example to a patient with multiple chronic conditions who goes into a hospital for emphysema, then to a nursing home and back to a hospital for heart failure within 30 days.

(D) ACOs will **avoid treating** seriously sick patients. Dr. Prince, President of Beacon ACO in New York, which does earn rewards, presciently said before Beacon became an ACO, "If they're going to put the risk back onto the ACO and onto the physician, it's going to be more difficult and we could start self-selecting which patients we want to include in our ACO" (*Renal Business Today* Keith Chartier, "ACOs Beginning to Take Form" 2/8/11, RenalBusiness.com/articles/2011/02/acos-beginning-to-take-form.aspx).

Sick people long ago realized that HMOs discourage their participation by giving them poor service. Medicare is driving ACOs down the same route, so any apparent cost savings will come from shifting the population served, not from medical improvements.

Drop the hospital admission and readmission measures from the quality program because they (A) do not measure quality, (B) are ineffective at saving money, (C) endorse a reduction in hospital coverage which patients have earned and need, and (D) deter ACOs from serving sick people.