



AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

February 4, 2015

Marilyn Tavenner, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1461-P
P.O. Box 8013
Baltimore, MD 21244-8013

Dear Administrator Tavenner:

On behalf of the American Academy of Family Physicians (AAFP), which represents 115,900 family physicians and medical students across the country, I write in response to the [proposed rule](#) titled "Medicare Shared Savings Program: Accountable Care Organizations" as published by the Centers for Medicare & Medicaid Services (CMS) in the December 8, 2014 *Federal Register*.

CMS issued this proposed rule to make changes to the Medicare Shared Savings Program (MSSP), including provisions relating to the payment of Accountable Care Organizations (ACOs) participating in the MSSP. The AAFP appreciates that CMS issued this proposed rule to make changes to the regulations that were promulgated in November 2011 based on experience with the program and to respond to concerns raised by stakeholders.

Prospective Attribution as a Single-Step Assignment Process

The AAFP is a longstanding supporter of efforts that improve the quality and efficiency of care and efforts that demonstrate an increased value of healthcare expenditures. We believe properly structured ACOs have the potential to help make the delivery system more accountable and more focused on value instead of volume. The AAFP remains committed to working with CMS and the Congress to refine the MSSP to ensure its success. However, the AAFP continues to believe that the current and proposed changes to the Medicare ACO program will struggle or fail to meet the potential benefits of better care for individuals, better health for populations, lower per capita costs for Medicare beneficiaries, and improved coordination among physicians.

Our principal concern is the agency's continued reliance on the needlessly complicated retrospective claims-based attribution method for the MSSP rather than the AAFP's recommended approach to more broadly attribute Medicare beneficiaries to MSSP ACOs on a prospective basis, as is the case in the Pioneer ACO program and the proposed MSSP Track 3 option. If CMS allowed patients to prospectively choose their own Medicare ACO with a consent process similar to that of the new chronic care management code, CMS would have a significantly improved, more timely, actionable, and therefore more effective beneficiary attribution method.

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The *Affordable Care Act* requires Medicare ACOs to demonstrate patient-centeredness systems, and we believe family physician practices have taken this responsibility very seriously. For several years, the AAFP has advocated for members' practices to transform to patient-centered medical homes (PCMH), an enhanced model of primary care practice that focuses on the triple aim.

In addition, as of 2012, sixty-eight percent of family physicians have adopted (with evidence indicating that percentage is over eighty percent in 2014) health information technologies into their practices and are committed to delivering team-based care. For these reasons, family physician practices are best situated to provide coordinated care to Medicare beneficiaries, a fundamental objective of the Medicare ACO program. Participation by small- and medium-sized primary care practices is essential for the success of Medicare ACOs, and they find a retrospective attribution system particularly burdensome, since it is challenging to engage in effective population management if you do not know who that population is before the patient encounter. For these reasons, we believe CMS ought to reconsider the beneficiary's attribution method and explicitly adopt a prospective method to replace the retrospective method that CMS uses for MSSP Track 1 and Track 2.

The *Affordable Care Act* authorizes HHS to "determine an appropriate method to assign Medicare fee-for-service beneficiaries to an ACO based on their utilization of primary care services provided by an ACO professional." The AAFP recognizes that CMS currently assigns Medicare fee-for-service beneficiaries to a specific ACO based on their utilization of primary care services. Under Step 1 of the current attribution method, the primary care physician with the plurality of visits determines to which Medicare ACO the patient is assigned, and if the primary care physician participated in two Medicare ACOs, CMS would find it difficult to assign the patient to the appropriate one. The AAFP calls on CMS to identify policies so that primary care physicians are able to participate in multiple Medicare ACOs.

Through the current and proposed attribution methods, CMS would limit participation by primary care physicians to only one Medicare ACO. Limiting primary care physicians who wish to participate in the MSSP to only one Medicare ACO could compel them to simply not participate at all. Family physicians and other primary care physicians provide healthcare services to a variety of Medicare patients who often receive further care in multiple tertiary centers and various hospitals. By locking primary care physician participation into only one Medicare ACO, CMS essentially is limiting ACO participation to only a portion of the primary care practice's Medicare patient population. This proposed policy reinforces our belief that the regulation offers very little incentive for even the most sophisticated primary care practice to pursue Medicare ACO participation.

However, these problems could be avoided by creating incentives (e.g., none or reduced cost-sharing for primary care physician services) for patients to identify prospectively a primary care physician in an ACO. The patients need to be accountable as well as the participating physicians and providers. The prospective method would dramatically increase patient engagement with a usual source of primary care. Identification of a primary care physician does not have to limit patient choice in any way. It may help to get more engaged patients thinking about having a usual source of care. Also, providing physicians with a prospective list of patients for which they are responsible will facilitate proactive panel management and will lead to improved outcomes.

Another limitation of the current method of attributing patients based on a retrospective analysis of claims data is the inherent reliance on traditional fee-for-service payments to ACO participants. The AAFP

believes CMS should not confine its payment method to the current, traditional Medicare fee-for-service payments but instead employ a variety of payment approaches, such as blended fee-for-service payments, prospective payments, episode/case rate payments, and partial capitation payments. Many of these innovative, non-fee-for-service payments would require a prospective linking of Medicare ACO patients with the primary care physician of their own choice.

The AAFP greatly appreciates that CMS recognizes the complexity of the retrospective assignment methodology and requested comments on establishing a single-step assignment process. We strongly believe that the best pathway toward a simplified and single-step approach utilizes a prospective, beneficiary consent framework.

Definition of Primary Care Services

This proposed rule would update the definition of primary care services to include the transitional care management codes (CPT codes 99495 and 99496) and the chronic care management code (CPT code 99490) and to include these codes in the beneficiary assignment methodology. To whatever extent CMS intends to continue using claims data in patient attribution, the AAFP fully supports this approach, since we fully support the increased utilization of these relatively new primary care services.

Exclusion of Subspecialty Physicians in the Beneficiary Assignment Process

If CMS insists on using a retrospective, claims based attribution process, the AAFP offers the following comments on the attribution proposals within this regulation. For purposes of Step 1 in the attribution process, we fully support and applaud CMS for proposing to exclude services provided by physicians with the specialty designation as:

- 02 General surgery
- 04 Otolaryngology
- 05 Anesthesiology
- 07 Dermatology
- 09 Interventional pain management
- 12 Osteopathic manipulative therapy
- 14 Neurosurgery
- 18 Ophthalmology
- 20 Orthopedic surgery
- 21 Cardiac electrophysiology
- 22 Pathology
- 24 Plastic and reconstructive surgery
- 26 Psychiatry
- 27 Geriatric psychiatry
- 91 Surgical oncology
- 92 Radiation oncology
- 93 Emergency medicine
- 28 Colorectal surgery
- 30 Diagnostic radiology
- 33 Thoracic surgery
- 34 Urology
- 36 Nuclear medicine
- 40 Hand surgery
- 72 Pain management
- 76 Peripheral vascular disease
- 77 Vascular surgery
- 78 Cardiac surgery
- 79 Addiction medicine
- 81 Critical care (intensivists)
- 85 Maxillofacial surgery
- 86 Neuro-psychiatry
- 94 Interventional radiology
- 99 Unknown physician specialty
- C0 Sleep medicine

The AAFP fully agrees that these specialists, while occasionally submitting claims for defined “primary care” services, do not actually provide primary care. We agree that this change would increase the accuracy in beneficiary assignment based on the delivery of primary care from true primary care physicians. We urge CMS to monitor this list continually and develop a process to exclude additional

specialty and subspecialty designations as needed. As CMS considers these issues, we urge the agency to carefully consult our [policy](#) definitions of primary care.

Inclusion of Services Furnished by Nonphysician Practitioners in Step 1

The AAFP does not support policy that could assign a beneficiary to an ACO based solely on services delivered by a non-physician ACO professional, since we believe that assignment should be limited to primary care physicians. We also point out that some non-physician providers who traditionally practice primary care can practice in a specialty office, which would confuse the attribution process further.

The AAFP recognizes that there are providers of health care other than physicians who render some primary care services. Such providers may include nurse practitioners, physician assistants, and some other health care providers. We also recognize that these providers of primary care may meet the needs of specific patients. In doing so, they should provide these services in collaborative teams in which the ultimate responsibility for the patient resides with the primary care physician. However, we do not believe the Medicare claims data is sophisticated enough to distinguish such non-physicians from their colleagues who either practice independently or practice in non-primary care settings, such as the offices of the excluded subspecialists mentioned earlier. Thus, we oppose policy that could assign a beneficiary to an ACO based solely on services delivered by a non-physician ACO professional.

Medicare ACO Structure and Shared Savings Methodology

At its core, an ACO is a group of health care providers who agree to share responsibility for the quality, cost and coordination of care for a defined population of patients. An ACO can be nearly any combination of group practices, networks of practices, hospitals, hospitals employing other providers, or hospital-physician joint ventures as long as the ACO is legally capable of receiving and distributing payments. The AAFP remains concerned that only large and established integrated health systems that already possess the necessary capital and infrastructure are successful participants in the MSSP, and we believe that CMS should do more to attract small- to medium-sized practices, especially in rural settings and in urban underserved areas, to form ACOs and participate in the MSSP. The AAFP therefore applauds CMS' efforts to consider continually its Medicare ACO policies and strive to offer greater flexibility so that small- to medium-sized primary care practices will be more likely to participate. In that same spirit, the AAFP supports policies that expand the shared saving methodology in Track 2 option to make it more feasible for small- and medium-sized practices to participate in a two-sided risk arrangement.

Quality Reporting

In addition to ACO quality-measure performance information that CMS already posts on the Physician Compare website, in the spirit of increasing transparency, CMS proposes to post additional information and then requests feedback on what additional, ACO-specific information to include.

Like CMS, the AAFP is concerned with including too much information online about quality measures that an average patient does not well understand. This may negatively impact a patient's ability to make an informed medical decision. The AAFP appreciates that CMS recognizes this dilemma, and we encourage the agency to avoid that outcome by including only the most important information about the ACO and its physicians as well as including educational products targeted at patients visiting the website.

The AAFP urges CMS to adhere to our [principles](#) on physician performance reporting, which state the belief that the primary purpose of performance measurement and sharing of results should be to identify

opportunities to improve patient care. Specifically, the AAFP urges CMS to support the physician/patient relationship by providing ACO participants and patients with meaningful data. Physicians must be provided a minimum of 90 days to review, validate, and appeal their data before public reporting.

In sum, we are supportive of the Physician Compare concept. Our concern comes with ensuring that what CMS publishes is accurate and actually useful to patients. In this regard, a smaller set of composite quality and patient experience measures with statistically valid benchmarks is preferable to a myriad of individual measures required of an ACO to publicly report. Before expanding Physician Compare to include all measures required to report by an ACO, CMS should ensure that reported data is accurate and published in an easy-to-read format to assist patients with making informed medical decisions.

Conclusion

The AAFP hopes that CMS addresses our concerns so that appropriately structured Medicare ACOs can flourish and make the healthcare delivery system more accountable. We remain committed to working with CMS on efforts that focus on better healthcare, better health, and lower costs. We appreciate the opportunity to provide these comments and make ourselves available for any questions you might have. Please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org.

Sincerely,



Reid B. Blackwelder, MD, FAAFP
Board Chair