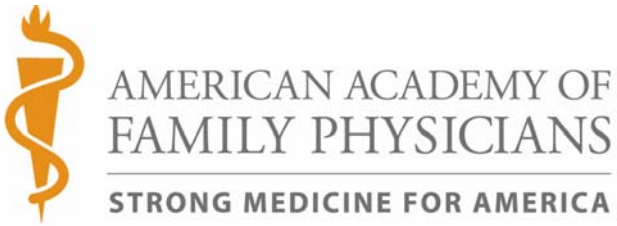

Donald Berwick, M.D.
Administrator, Centers for Medicare and Medicaid Services
Department of Health and Human Services,
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201
December 3, 2010

Dear Dr. Berwick,

The American Academy of Family Physicians (AAFP) represents over 94,700 family physicians, family medicine residents and students interested in family medicine. The AAFP has a deep and long lasting commitment to high quality patient care for all and is supportive of efforts to reform our ailing US health care system.

In response to the Request for Information on potential regulations for Accountable Care Organization and the Medicare Shared Savings Model (CMS-1345-NC) published in the Federal Register, the AAFP would like to offer the following comments for your review and action. In addition to the specific questions below, we would like to call your attention to the recently published , Joint Principles for Accountable Care Organizations that resulted from a collaboration of the American Academy of Family Physicians, the American College of Physicians, the American Academy of Pediatrics and the American Osteopathic Association.

1. **What policies or standards should we consider adopting to ensure that groups of solo and small practice providers have the opportunity to actively participate in the Medicare Shared Savings Program and the ACO models tested by CMMI?**

The policies or standards should require that the ACO provide primary care access that is distributed appropriately throughout the community it serves. This should be accomplished by engaging the community physicians who are ready, willing and able to contribute to the overall efficiency and effectiveness of the ACO enterprise. Exclusive contracts with a single provider of primary care services should be avoided, unless they can demonstrate local patient access for the entire community served.

ACO organizers should be required to provide an environment that offers information and management services that help support affiliation of solo or small practices without ownership by the ACO. We suggest that ACOs be required to have a mechanism for small practices to join as long as they meet certain reasonable participation criteria.

The key issue for small practices will be the proper flow of funds for the value added to the ACO and its overall efficiency. In addition, the ACO must provide resources to support these practices, specifically in their efforts to achieve cost efficiency through better care management and better care coordination. In most cases, this will require some “up-front” investment on the part of the ACO, to fortify the primary care infrastructure.

ACOs must have a governance model and a financial model that fosters the proper distribution of capital, fees and quality bonuses to primary care. The governance structure must include adequate

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representation from primary care physicians in small practices to assure that the unique needs and concerns are addressed. These resource allocations should recognize the proportion of cost savings that comprehensive, accessible primary care contributes to the overall ACO enterprise.

CMS should not accept conceptual models where the ACO is run by a hospital that sets up primary care solely to serve as a feeder route for expensive procedures or hospital services. Policies and standards should be established to prevent monopolistic behaviors in markets with little competition, since this will ultimately lead to higher costs.

Small practices will have difficulty participating in an ACO if it is a "Medicare only program." If Medicare is the only payer involved, the percentage of patients in a single practice will be too small to warrant the logistical changes required to participate. CMS should make efforts to align private payer and public payer incentives to provide adequate incentives for the changes required for successful ACO participation.

CMS and other Federal agencies must address the barriers to clinical and financial integration that are required for independent practices to collaborate fully with other partners in the ACO models. This may require changes to or waivers from current anti-trust laws and regulations governing such business relationships.

2. Many small practices may have limited access to capital or other resources to fund efforts from which ''shared savings'' could be generated. What payment models, financing mechanisms or other systems might we consider, either for the Shared Savings Program or as models under CMMI to address this issue? In addition to payment models, what other mechanisms could be created to provide access to capital?

The concept of shared savings implies that resources would flow at some future point in time to those who helped to earn the savings. It is critical that ACOs invest in primary care infrastructure to be able to deliver the potential savings in the first place. A mechanism should be in place to provide for pre-payment of a care management fee to primary care practices. Ideally these care management payments should be made on a "per patient per month" basis because they are intended to support ongoing fixed costs which are not related to individual visits. Up-front or monthly payments to primary care should not be funded from the shared savings calculation but should instead be recognized as a necessary and ongoing support for non-visit based services, such as patient self-management support, care management and care coordination. Although capital needs are important to upgrade and maintain the primary care infrastructure of an ACO, it is important to acknowledge that there are ongoing expenses related to patient care that are not associated with visits. In order to promote the team approach to care, the work of the team must be valued by the ACO. This can be accomplished using a pre-paid, monthly care management fee.

Individual practices in a community should not be prohibited from participating in more than one ACO. If a practice provides high quality efficient care for a panel of patients, that practice should be able to serve any ACO structure in the community.

Shared savings models have important limitations that must be addressed if CMS is considering any wide-scale implementation of this payment mechanism. Current systems or markets that are relatively efficient will be at a disadvantage because the savings to be distributed will be less from the start. In essence, the most wasteful regions will gain the most from this approach. Accounting methods should be developed to preclude organizations from showing a particularly high cost structure during the "base-year" when calculating shared savings. The shared savings model is self limiting by design. When the savings have been achieved, new incentives for high quality, cost effective care will be required to maintain the gains.

Innovative financing models might include incentives for ACO performance against efficiency benchmarks generated from community or market cost data. Per capita cost analysis is an essential part of the "triple aim" promoted by CMS. Incentives for the efficient operation of the entire ACO might be very different from the internal financial incentives used to achieve the best results. Although we believe that CMS should allow as much innovation as possible within the ACO structure, we are concerned that primary care could easily be short changed and not rewarded for the value it brings to the enterprise.

3. The process of attributing beneficiaries to an ACO is important to ensure that expenditures, as well as any savings achieved by the ACO, are appropriately calculated and that quality performance is accurately measured. Having a seamless attribution process will also help ACOs focus their efforts to deliver better care and promote better health. Some argue it is necessary to attribute beneficiaries before the start of a performance period, so the ACO can target care coordination strategies to those beneficiaries whose cost and quality information will be used to assess the ACO's performance; others argue the attribution should occur at the end of the performance period to ensure the ACO is held accountable for care provided to beneficiaries who are aligned to it based upon services they receive from the ACO during the performance period. How should we balance these two points of view in developing the patient attribution models for the Medicare Shared Savings Program and ACO models tested by CMMI?

Effective continuing and comprehensive primary care requires an ongoing healing relationship. The current attribution models are necessarily tied to claims data and sophisticated algorithms have been developed to guess at relationships in retrospect. We believe that the relationship is so important for the primary care component that patients should have incentives or inducements to select a usual source of care up front, preferably a patient centered medical home. Patient selection of a primary care practice is the best way to determine the proper recipient of a care management fee discussed above in #2. The up-front patient selection of a primary care site should serve as the attribution model for primary care, while post-facto episode algorithms could still be used for specialty care, hospital care or long term care. There would need to be interplay among the different attribution components.

Current episode based quality and efficiency metrics work extremely well for discrete, time-limited episodes such as a hip fracture. The methodology is clearly less precise and less useful for determining quality and efficiency in patients with the multiple chronic illnesses that are so common in the Medicare population. We believe that separating the attribution methodology into patient choice for primary care and retrospective attribution for specialty and hospital care makes good operational sense and focuses payment incentives on the right point in the system.

Post facto attribution may be the only way that Medicare can calculate the level of shared savings for the ACO program. This should not preclude ACOs from using internal incentives for patients to choose a medical home and practices to be aware of which patients have chosen that particular ACO. In fact, CMS should provide educational materials and incentives for patients to choose a medical home. Up-front knowledge of patient affiliation with a primary care practice allows and promotes first contact at that level and leads to continuing and comprehensive care that are at the heart of healing relationships.

4. How should we assess beneficiary and caregiver experience of care as part of our assessment of ACO performance?

Patient experience of care surveys are a well-established mechanism to assure that the patient input is solicited. Standardized surveys such as the CG-CAHPS are helpful for quality improvement efforts but generally do not differentiate individual providers with the precision needed for payment decisions unless a large number of surveys are completed. ACOs should be required to survey patients so that service levels can be determined and improved. These organizations should have systems in place to collect and act on patient experience of care data and show positive trends over time.

5. The Affordable Care Act requires us to develop patient-centeredness criteria for assessment of ACOs participating in the Medicare Shared Savings Program. What aspects of patient-centeredness are particularly important for us to consider and how should we evaluate them?

Patients want and need access to care, primary care physicians and team members that listen to their symptoms or health concerns, and evidence that they are getting better outcomes as a result of the care they receive. In addition, care should be safe and sensitive to the cultural and linguistic needs

of the patient. Access has to do with more than just visits with clinicians. Access is about having timely answers to questions and concerns, which may be through a visit, phone call, email, or internet communication. The CAHPS survey mentioned above helps to assess provider listening and communication skills. Finally, a set of patient oriented outcome measures for the common chronic illnesses and preventive services should be part of the ACO assessment process.

CMS should also seek measures to assure that the quality of care is being maintained in areas that are specifically targeted for cost cutting. There should be more investment in the development of appropriateness measures especially regarding imaging, optional procedures and long term treatment regimens such as cancer chemotherapy.

6. In order for an ACO to share in savings under the Medicare Shared Savings Program, it must meet a quality performance standard determined by the Secretary. What quality measures should the Secretary use to determine performance in the Shared Savings Program?

Patients must be assured that they are getting better health and/or evidence based care from the health system. Measures should be designed to fill that need. In addition to some of the usual outcome measures for common chronic illnesses, measures of continuity of care, functional status, comprehensiveness of care and service levels should be included. More important than just having a standard set of measures is the need for the ACO to have ongoing measurement and feedback that drives organizational learning, improves quality and assures that patients' needs are fulfilled.

The National Quality Forum has endorsed a long list of primary care oriented measures that are already in use by CMS in the PQRS program. Currently, there is a relative lack of measures in place for specialty care and surgical care when we think of patient oriented outcomes. CMS should invest in the development and implementation of measures to monitor functional status and quality of life.

7. 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 CMMI? What are the relative advantages and disadvantages of any such alternative payment models?

The CMMI must look at novel ways to redistribute the way our health care dollars are spent. We must focus on paying for what works and for the things that clearly benefit patients in measurable ways. Global payments for comprehensive primary care services that include efficient and effective care management and care coordination should be considered as part of any future payment strategy. Partial capitation for specialty and hospital care could begin to change the cost driver in the current volume-based fee for service payment system.

Blended payment systems that combine fee-for-service, care management payments and incentives for achieving quality benchmarks should be tested. If the proportions of the three incentives are properly balanced, no individual one will disproportionately drive behavior.

The language in Section 1899(i) implies that care management or care coordination services should be available only for certain groups of patients (high need, CHF patients or women). We believe that all patients will benefit from these same services although the intensity of the intervention may vary considerably. These very same services are useful in achieving higher rates of screening and immunizations in relatively healthy populations or in patients with more severe but short term illnesses.

On behalf of the American Academy of Family Physicians, I would like to thank you and the staff at CMS for the opportunity to provide these comments for your review. Please let me know if you have questions or would like more detailed comments on any of the items. The AAFP staff contact for ACOs is Bruce Bagley, M.D., the medical director for quality improvement. He can be reached at 913-906-6000 ext. 4120 or by email at bbagley@aafp.org

Sincerely,

Lori Heim

Lori Heim, M.D.
Board Chair, AAFP