



March 23, 2016

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Ave., SW
Washington, DC 20201

Dear Acting Administrator Slavitt:

On behalf of the American Academy of Family Physicians (AAFP), which represents 120,900 family physicians and medical students across the country, I am responding to the [proposed rule](#) titled, “Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations—Revised Benchmark Rebasing Methodology, Facilitating Transition to Performance-Based Risk, and Administrative Finality of Financial Calculations” as published by the Department of Health and Human Services (HHS) in the February 3, 2016, *Federal Register*.

This proposed rule makes changes to the Medicare Shared Savings Program (MSSP), including provisions relating to benchmarking and beneficiary assignment which affects payments to Accountable Care Organizations (ACOs) participating in the MSSP. The AAFP especially appreciates that the Centers for Medicare & Medicaid Services (CMS) continues to improve ACO regulations since we remain concerned that only large or established integrated health systems, which already possess the necessary capital and infrastructure, can be successful participants in the MSSP.

In 2015, the AAFP and Humana conducted a [survey](#) of family physicians to understand their perceptions and attitudes on value-based payment (VBP). **The survey showed practice sustainability was the factor family physicians felt was most important in evaluating the success of a VBP system (92 percent).** Benchmarking is one of the primary factors for gauging an ACO’s success or failure and plays a critical role in sustainability. If initial benchmarks are established in a way that provides an opportunity for organizations of different sizes and levels of sophistication to succeed, this will help maximize participation among providers. The AAFP applauds CMS’ efforts to continually reexamine its Medicare ACO policies and offer greater flexibility so that small- to medium-sized primary care practices will be more

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likely to participate and succeed. In that same spirit, the AAFP supports policies that expand the shared savings methodology so all practices could choose, if they desire, to enter two-sided risk arrangements.

Family physicians and other primary care providers are central to effective and efficient population health management. **Therefore, the AAFP believes benchmarking for primary care should be designed to account for primary care's uniqueness. Specifically, (1) primary care is relatively inexpensive in delivering high-quality care, (2) primary care is more "clinically nuanced" than other specialties, and (3) primary care has the greatest potential of generating long-term savings if there is an upfront investment for advanced primary care functions.**

On our first point, various [studies](#) have shown the United States spends four to seven percent of its total health care dollars on primary care, which is well below many highly functioning systems of care that demonstrate effective and efficient population health management. Family physicians and other primary care providers who deliver high-quality care will be asked to offer patients more services in value-based arrangements. The AAFP believes benchmarks must not deter the growth in primary care utilization if they are designed to reduce downstream costs.

Regarding the second point, the [concept](#) of "clinical nuance" illustrates two important facts about primary care. The first is that similar services rendered to various patients differ in the outcomes produced. The second is that the clinical benefit derived from a medical service depends on who is using it, who is delivering the service, and where it is being delivered. Family physicians and other primary care providers treat upwards of 2,500 patients in their panels, and each patient has varying acute conditions, chronic conditions, and adherence levels that interact in complex ways. A recent Robert Graham Center [paper](#) showed 55 percent of office-based visits made by adults with diabetes to primary care involved care for that condition in addition to at least one additional diagnosis. Overall, the complexity of the office visit, as reflected by the number of visit diagnoses reported, was found to be higher for primary care physicians than for subspecialist physicians. Primary care physicians have meaningful, continuous, and longitudinal relationships with their patients and, therefore, know best how to deliver patient-centered care. Benchmarks should not prevent family physicians and other primary care providers from delivering high-quality care. The AAFP believes primary care will require flexible and creative methodologies to ensure we account for its clinical nuance and accurately measure its value.

Finally, on our third point, the AAFP advocates that public and private payers at least double their spending on and investment in primary care in the United States for family physicians and other primary care providers to deliver more effective population health management and generate further savings through reductions in fragmentation of care delivery.

Proposals for Defining an ACO's Regional Service Area

CMS proposes to determine an ACO's regional service area by using as the geographic unit of measure the counties of residence of the ACO's assigned beneficiary population. The AAFP

believes benchmarks should address fairly the myriad of variables that could be used to establish those benchmarks. Geography should be just one of several components. Using an aggregate of counties to establish an ACO's regional service area would be a fairer method, but we urge CMS to consider:

1. The number of counties per state ranges from three in Delaware to over two hundred in Texas.
2. In central and western states, county land-area increases while population density decreases.
3. For some counties, one assigned beneficiary would add that whole county to the regional service area.

Therefore, the accuracy and precision of defining an ACO's regional service area would widely fluctuate depending on the state, thereby putting some ACOs at a distinct disadvantage.

While the AAFP would support county lines to determine an ACO's regional service area, we believe there are more robust methodologies to more accurately and precisely define geographic service areas. Furthermore, while the stability of the definition of the geographic unit of measure is important, the AAFP believes the accuracy and precision of defining the regional service area to be of equal or greater importance. Legally defined borders, such as county lines, do not change frequently and CMS uses legally defined borders in other Medicare operations.

However, simple geographic units of measure should not act as a deterrent to experiment with alternative methodologies, if such methodologies can yield more accurate and precise results. The AAFP urges CMS to further explore using Core Based Statistical Areas (CBSAs), Metropolitan Statistical Areas (MSAs), Combined Statistical Areas (CSAs), and other methodologies to better define regional service areas. The CBSA, MSA, and CSA are already defined and maintained by the Office of Management and Budget (OMB) and are the result of the application of published standards to Census Bureau data.

CMS recently issued a [proposed rule](#) titled, "Medicare Program; Part B Drug Payment Model" that discusses using Primary Care Service Areas (PCSAs) as a geographic unit for that demonstration. While PCSAs are defined based upon patterns of Medicare Part B primary care services and may not be an accurate geographic unit for benchmarking, in this case, CMS proposes to utilize a more sophisticated methodology rather than settle for legally defined borders. Specifically, PCSAs illustrate patterns linking the residence of Medicare Part B beneficiaries with the practice locations for evaluation and management visits to Medicare participating physicians in primary care specialties. CMS analyzed calendar year 2014 claims data, including provider and supplier practice locations for those delivering Part B drugs relative to PCSA boundaries using the practice location of the performing National Provider Identifier (NPI) or the billing location of the organizational NPI for hospital outpatient departments, and observed that almost all claims for an individual provider or supplier were billed within a single PCSA. A methodology, similar to PCSAs that takes into account peoples' behavior would more

correctly predict where they will seek treatment. Linking markets and communities together by utilization patterns, commuting patterns, population trends, and other variables would be more analytically challenging for CMS, but not to the level that CMS is asking physicians and ACOs to analyze clinical and claims data to manage population health. The AAFP encourages CMS to consider using a more sophisticated and granular methodology that will accurately and precisely define every ACO's geographic service area.

Proposals for Establishing the Beneficiary Population Used to Determine Expenditures for an ACO's Regional Service Area

CMS proposes to use all assignable beneficiaries, including ACO-assigned beneficiaries, in determining expenditures for the ACO's regional service area to ensure sufficiently stable regional mean expenditures. The AAFP agrees with the methodology to assign the beneficiary to an ACO based on of the patient's receiving primary care services from a primary care physician. This methodology is consistent with the patient attribution methodology proposed in the Health Care Payment Learning and Action Network's (LAN) [draft paper](#) on "Accelerating and Aligning Population-Based Payment Models: Patient Attribution." The AAFP supported the use of a single approach for attribution for performance measurement and financial accountability. According to the draft paper, "a single approach provides clarity, ties together quality and financial goals, and attributes a single group of patients to a provider group" allowing for consistency of reporting.

The AAFP strongly supports and recommends prospective attribution in assigning the beneficiary population to an ACO with a lookback period of 24 months. This patient information should be prospective to allow for appropriate planning and allocation of resources to enable high-quality care and cost-savings. In addition, the AAFP recommends assigning more weight to the number of services provided over time by a single provider, rather than a single, more recent visit to another provider. The AAFP believes the family physicians and primary care providers must know in real time for which patients they are accountable and the expected period of management. While the AAFP agrees with the proposed methodology, we suggest adding a simple process to allow a patient to change the assigned primary care physician. If the ideal attribution methodology is for the patient to select prospectively a primary care physician, the patient should be allowed to initiate a change if the primary care physician is assigned based on services provided. The AAFP strongly encourages the inclusion of a simple, transparent appeals process to allow physicians the opportunity to decline a patient based on the patient's utilization patterns.

Within the proposed rule, CMS discusses weighing county-level fee-for-service (FFS) expenditures by the ACO's proportion of assigned beneficiaries in the county. CMS would determine the number of the ACO's assigned beneficiaries residing in the county in relation to the total number of beneficiaries and adjust the FFS expenditure amount. While the AAFP supports this weighing adjustment, it illustrates our earlier concern that county-level data is not accurate or precise enough to truly reflect expenditures and needs to include weighing

adjustments. We again urge CMS to use an alternative methodology to define regional service areas, similar to those that define CBSAs, MSAs, and CSAs.

CMS also proposes to calculate expenditures separately according to the following populations of beneficiaries (identified by Medicare enrollment type): end-stage renal disease, disabled, aged/dual-eligible, and aged/non-dual eligible. The AAFP believes this approach inherently risk-adjusts, based on enrollment type, but we call on CMS to risk-adjust using a more robust methodology. Risk-adjustment should factor in a patient's medical diagnosis, socio-economic characteristics (income, education level, and health literacy) and socio-demographic characteristics (race, ethnicity, and gender), prior health care utilization (inpatient, outpatient, pharmacy, home health, and durable medical equipment), health insurance status prior to attribution, geography, and other relevant risk-adjusters.

Proposals for Applying Regional Expenditures to an ACO's Rebased Benchmark

CMS proposes to calculate an ACO's rebased benchmark using historical expenditures for the beneficiaries assigned to the ACO in the three years prior to the start of its current agreement period. In addition, CMS proposes to adjust the ACO's rebased historical benchmark to reflect risk-adjusted regional average expenditures, based on county FFS expenditures determined for the ACO's regional service area. The AAFP supports this rebasing methodology, because we believe benchmarks should be established and rebased on a blend of historical and regional data to ensure physicians are showing improvement at any level. As the MSSP evolves, we implore CMS to test whether rebasing benchmarks more on regional average expenditures and less on historical expenditures would yield a fairer methodology for measuring performance. Relying too much on historical data forces ACOs to compete against themselves and will ultimately lead to diminishing returns on quality improvement and cost savings. This creates an inherent penalty mechanism for ACOs to generate the same amount of quality improvement and cost savings overtime or lose out on gainsharing, regardless of the needs of the patient population and the environmental factors outside of their control (e.g., a flu epidemic). In other words, relying on historical data specific to the ACO rewards those who performed poorly in the past and penalizes those who have done a good job over time.

A one-size-fits-all approach for benchmarking will not lead to equitable distributed success among all types of ACOs and could penalize already high-performing ACOs. The AAFP urges CMS to consider using an incremental or tiered, rather than a single, threshold approach to assess an ACO's meaningful improvement at any level. The AAFP strongly urges CMS also to consider stratifying benchmarks based on an ACO's practice-mix and level of sophistication when measuring costs and spending. CMS should recognize high-performing ACOs that are exceeding benchmarks and provide these ACOs with the corresponding financial reward and a bonus for being in the highest level of performance. This would ensure incentives for high-performing ACOs are not diminished over the long-term, while giving incentives for lower achieving ACOs not only to improve but also to strive for a "best in class" standard. Lastly, benchmarks should not be established in a way where high-performing ACOs rest on their laurels and do nothing further to improve quality or reduce costs.

The AAFP believes similar peer groups should be used within benchmarks for ACOs to be compared to each other as fairly possible. Comparing similar ACOs would provide more accurate data related to providers' efforts to improve patient care and reduce costs. Peer groups should be structured and adjusted, along with the benchmarks, on two levels. The first level is the patient population served by the ACO. Comparability at this level is attained through risk-adjustment, which encompasses a patient's medical diagnosis, socio-economic characteristics (income, education level, and health literacy) and socio-demographic characteristics (race, ethnicity, and gender), prior health care utilization (inpatient, outpatient, pharmacy, home health, and durable medical equipment), health insurance status prior to attribution, geography, and other relevant risk-adjusters. The second level concerns the characteristics of the ACO itself: ACO type and sophistication, performance capability, number and type of providers, the full-time equivalent status of providers, geography, number of attributed patients, available resources, obtainable capital investments, practice sustainability, and other relevant factors.

Proposals for Adjusting the Reset ACO Historical Benchmark to Reflect Regional FFS Expenditures

CMS proposes to remove the adjustment to account for savings generated by the ACO under its prior agreement period. We agree with the observations that "for ACOs generating savings, an alternative rebasing methodology that accounts for regional FFS expenditures would generally leave a similar or slightly greater share of measured savings in an ACO's rebased benchmark for its ensuing agreement period. By contrast, for ACOs generating losses, an alternative rebasing methodology that accounts for regional FFS expenditures would tend to carry forward a significant portion of measured losses into their rebased benchmarks and push benchmarks lower than the current rebasing policy." Establishing and adjusting benchmarks should avoid penalizing organizations that innovate care delivery, coordination, and management strategies to generate savings and improve care. The AAFP asks CMS to avoid using benchmarks that inadvertently remove incentives for ACOs that have already done a good job in making their populations healthier by relying more on prevention and health wellness or promotion. The AAFP believes that if physicians develop innovative delivery solutions that reduce overall costs, it may be appropriate to rebase or readjust benchmarks accordingly. However, CMS and private payers must ensure providers, patients, and other stakeholders are able to share in the savings generated. This way, rebasing or readjusting benchmarks will not inadvertently reduce the benefits over time for ACOs that hired additional clinical staff, such as care managers, or for ACOs that had primary care practices transform into a Patient-Centered Medical Home (PCMH). Those types of ACOs with advance primary care practices may have already improved their performance relative to their past performance and may not be able to maintain a similar percentage improvement in subsequent years.

Proposals for Regional Growth Rate as a Benchmark Trending Factor

CMS proposes to replace the national trend factors used for evaluating an ACO's yearly expenditures in calculating its rebased historical benchmark with regional trend factors. These would be derived from a weighted average of risk-adjusted FFS expenditures in the counties

where the ACO's assigned beneficiaries reside. The AAFP agrees with using regional trend factors over national trend factors, because low-cost regions should not be compared to high-cost regions without taking into account the actual cost of providing medical services. The cost of living varies geographically and is why benchmarks should be established and rebased using regional trends. In addition, benchmarks based on smaller geographic areas may be necessary within some states to prevent unintended consequences for ACOs operating in markets that deviate materially from the national trend. It is possible and reasonable to compare similar geographic regions across the nation to established and rebased benchmarks. For example, an ACO in Kansas City should be compared to an ACO in St. Louis but not to one in New York City. We recommend CMS set targets for medical costs and for medical cost-performance expectations based on benchmarks that reflect regional patterns in spending and costs.

Adjusting Benchmarks for Changes in ACO Participant Composition

CMS proposes to replace the current approach for calculating adjusted historical benchmarks for ACOs that make changes to the ACO Participant List. The new approach would adjust an ACO's historical benchmark with a ratio that is based on expenditures for the ACO's assigned beneficiaries using lists for the new performance year and the most recent prior performance year. The AAFP welcomes this replacement, because while family physicians and other primary care providers can be responsible for the management of the total cost of care, they need access to real-time quality and cost information and resources to monitor cost. In addition, patient choice, adherence, and accountability affect the total cost of care and should be quantified and factored into benchmark calculations. Depending on the insurance product, patients are able to choose which services to utilize even if their family physician or other primary care provider may not recommend those services, like specialty consultations, chiropractic care, or cosmetic services. In addition, patients may choose to see providers outside their network or outside the ACO. As for adherence, a patient may believe he/she does not need an inexpensive cholesterol medication, and another patient may not be able to afford the expensive diabetes medication prescribed to him/her by the physician. Therefore, physicians should not be responsible for costs they cannot control, and provider accountability for costs needs to be balanced with patient accountability. Patients who leave the ACO Participant List should not adversely affect the ACO's benchmark calculations.

Facilitating Transition to Performance-Based Risk

CMS proposes to provide an additional option for ACOs participating under Track 1 to apply to renew for a second agreement period under a two-sided model (Track 2 or Track 3). The AAFP supports this option but insists that if family physicians and other primary care providers decide to take on more risk, they need more timely and actionable quality and cost information from CMS. An ACO's success depends on the timely transfer of information to manage and coordinate patient care effectively and efficiently. **The AAFP/Humana survey found 63 percent of family physicians do not receive data in a timely manner to improve care or reduce costs.** The AAFP is deeply concerned and family physicians are frustrated that the current CMS payment systems rely on a two-year lag between the performance year, when data is collected and reported, and the payment year. The AAFP continues to believe that two-year

old data is not clinically actionable or meaningful, and we implore CMS to explore ways to realistically provide actionable feedback.

We also recommend that private payers be required to share relevant and actionable data in a timely manner as well. On a related matter, **76 percent of family physicians reporting in the AAFP/Humana survey said they do not have information on costs of services for appropriate referrals**. CMS currently provides ACOs with a retrospective administrative claims dataset. While these datasets are valuable, they show services that have already been provided and do not give physicians an opportunity at the point of care to make the best care decisions at the best time while avoiding unnecessary costs. Costs for surgeries, procedures, labs, and diagnostic tests should be available to physicians, so they and their patients can make informed decisions on referring patients to specialists, and ordering diagnostic tests and labs. **The AAFP strongly urges CMS to consider ways to offer ACOs and primary care practices a point-of-service notification system that would allow physicians to view near-real-time, patient-specific information regarding a patient's eligibility, coverage, and out-of-pocket costs.** In addition, the system should provide physicians with performance data on outcomes, quality, and costs of physicians and facilities providing ancillary services. Clinical and cost information is what drives care decisions, and physicians need access to that information to improve care and mitigate risk. As family physicians and other primary care providers take on more responsibility for the management of total cost of care and as payment for primary care becomes more global and comprehensive, CMS needs to phase out prior authorizations, paperwork associated with justification of clinical decisions, and other hassles intended to control utilization, because they add administrative burden without improving patient care.

Circumstances for Reopening Initial Determinations and Final Agency Determinations of ACO Shared Savings or Shared Losses to Correct Financial Reconciliation Calculations

CMS proposes to define timeframes and other criteria for the reopening of a determination of ACO shared savings or shared losses to correct financial reconciliation calculations. Specifically, CMS proposes to limit reopenings to not later than four years after the date of the notification to the ACO of the initial determination of shared savings or shared losses for the performance year for good cause. The AAFP agrees with a four-year time period for ACOs to find and present new and material evidence that was not available or known at the time of the payment determination and which may result in a different conclusion. In addition, the AAFP urges CMS to streamline the process to initiate, complete, and evaluate errors in order to minimize disruptions and administrative burdens on physicians. Lastly, while CMS does not intend to propose an exhaustive list of potential issues that would or would not constitute good cause to reopen determinations, we call on CMS to provide comprehensive, robust, and understandable guidance.

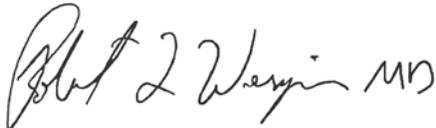
To determine whether to reopen an error for good cause, CMS is considering whether to use a materiality threshold, such as three percent of the total amount of net shared savings and shared losses for all ACOs for the applicable performance year. The AAFP asks CMS to consider a tiered materiality threshold for ACOs of varying size, practice-mix, patient population,

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and level of sophistication. A smaller or newly formed ACO or an ACO serving a high-need population may consider a 2.9-percent correction materially important to recover. While value-based care and payment constitute uncharted territory for all stakeholders, the AAFP believes family physicians and other primary care providers will take on increased risk and deliver higher performance on population health management if proposals and reforms are flexible and take into account the wide variety of practice types and levels.

The AAFP believes that appropriately structured Medicare ACOs can flourish and make the health care 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 Milack Talia, Practice Environment Manager, at (913) 906-6000 extension 4175 or mtalia@aafp.org.

Sincerely,

A handwritten signature in black ink that reads "Robert L. Wergin MD". The signature is written in a cursive style with a large initial "R" and "W".

Robert L. Wergin, MD, FAAFP
Board Chair