

June 6, 2011

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

Re: Medicare Shared Savings Program: Accountable Care Organizations (CMS-1345-P)

Dear Dr. Berwick,

On behalf of the Council of Academic Family Medicine (CAFM), which represents the membership of The Society of Teachers of Family Medicine, The Association of Departments of Family Medicine, The Association of Family Medicine Residency Directors, and The North American Primary Care Research Group, and in conjunction with The American Academy of Family Physicians (AAFP), we are pleased to submit comments in response to the proposed rule, "Medicare Shared Savings Program: Accountable Care Organizations (ACO)," (as published in the April 7, 2011, Federal Register).

The AAFP submitted comments to this proposed rule on May 20, 2011, and CAFM enthusiastically supports the AAFP comments, and would like to be associated with them. CAFM and the AAFP have some supplementary issues related to education and the success of the primary care training infrastructure that we raise in the following comments.

Protecting the Educational Infrastructure

We support the intent of the proposed program to promote affordable, evidence-based, high quality care delivered by inter-professional teams that rely on a foundation of primary care. However, we are concerned that the ACO program, as currently proposed, will have a significant negative effect on the Graduate Medical Education (GME) training infrastructure in the US. If graduate medical education payments to teaching hospitals are included in the ACO benchmark and performance expenditure calculations, we expect at least two untoward consequences.

First, this provision will provide ACOs a significant economic incentive to discourage beneficiaries from receiving care in teaching hospitals that receive GME payments. Because GME funding is tied to Medicare hospital payments, Medicare admissions to teaching hospitals incur higher Medicare payments than a similar admission to a nonteaching hospital. In the shared savings structure of an ACO, there would be an immediate financial bias against choosing a teaching hospital for care. Strategically, ACOs would be incentivized to increase their shared saving allocation in the short term by recommending that patients receive care in hospitals that do not participate in the enterprise of teaching the next generation of physicians. This will not only limit the care options for Medicare beneficiaries, but it will also decrease the exposure of trainees to an innovative health care system that is designed to improve outcomes and reduce costs. Our trainees need to experience and understand such new and improved models of care.

Secondly, a successful ACO program will result in a reduction of inpatient bed days. A reduction of Medicare inpatient bed days will result in reduced Indirect Medical Education (IME) payments.

Because GME funding is directly linked to hospital Medicare payments, the intended financial outcome for ACOs likely will have a negative effect on primary care resident physician training at a time when the US is experiencing a growing shortage of primary care physicians.

In order to avoid these two untoward effects, CAFM and AAFP recommend that graduate medical education payments to teaching hospitals be excluded from the ACO benchmark and performance expenditure calculations.

Incentivizing Educational Change

CAFM and AAFP have long supported the need for significant reform of GME funding under Medicare. We believe that the ACO model should be utilized to incent changes that would lead to a properly balanced physician work force, as recommended in the 20th report of the Council on Graduate Medical Education (COGME), *Advancing Primary Care* (December 2010). We suggest two ways in which the ACO model may be utilized to reverse the current negative incentives for training in primary care.

The first method relates to our comments regarding the exclusion of GME funding from ACO benchmark and performance expenditure calculations. Primary care training physicians tend to be underfunded already by Medicare related GME payments, due to historic deficits in counting primary care resident FTEs and **we recommend, at a minimum, that GME direct and indirect funding for primary care physician training be excluded from the baseline in savings calculations.** This would prevent ACOs from preferentially reducing spots in primary care training in order to maximize their shared savings.

However, this suggestion will not lead to significant innovations in training that are desperately needed in the United States. We are concerned that the ACO provisions do not properly incentivize the development of the primary care training in new models of care, such as patient centered medical homes, federally qualified health centers, and other ambulatory settings.

We support the Congressional intent of Medicare GME that asserts the training of physicians is a societal good, and we recommend that CMS should provide financial incentives, through its various programs, for the development of an accomplished, well-trained, and progressive physician work force – one that is suited to practice most efficiently and effectively in our new health care system. CMS, through its ACO program, should take the lead in providing payment incentives for the development of new models of care that will improve health outcomes for Medicare beneficiaries at significantly reduces costs. These models of care can only develop appropriately if medical students and resident physicians are trained in these settings, and this can only occur when there are financial incentives for proper curriculum development and faculty development programs. These incentives are needed to support the development of faculties with special expertise to champion and teach health care delivery redesign and to promote the critical changes that will lead to successful ACO implementation.

Thus, we recommend that CMS provide incentives for the development of new training models through ACOs. We support the recommendations of the Medicare Payment Advisory Commission (MEDPAC), which states, “reforming medical education will be a key component to transforming the nation’s healthcare delivery system from one that historically is focused on care of acute illness to one that values patient centered care, quality improvement, and resource conservation.” To this end, we recommend a pilot project to test an innovation in primary care graduate medical education. To accomplish this, the pilot would provide financial incentives to:

1. Support primary care training in all sites where care is delivered.
2. Provide structured GME payments for primary care residencies to directly fund the entity where education is the primary mission.

3. Increase payments for primary care training to support added costs of training in community based (nonhospital) settings, as well as to offer incentives to medical students who chose a primary care career.
4. Provide incentives for training in rural and under-served areas.

We recognize that funding for innovative educational programs is not currently part of the ACO model, but we believe that CMS should consider financial incentives for the development of innovative educational systems in all its new programs. We believe it important that all funding mechanisms in accountable care settings recognize the importance of education, both for the training of an appropriately equipped physician work force, and for the future success of the model. Payment incentives are needed to promote a more balanced educational model than the traditional model in which all CMS payment for medical education is allocated to hospitals. It is our hope that the provision of such financial incentives for new models of education by CMS would be an incentive for the development of a system of GME payments by private insurers as well.

In its May 20 letter, the AAFP made this statement: "One of the main challenges for any ACO is to modify physicians' behaviors, and the AAFP believes the best mechanism to achieve this is through immediate reinforcement in the form of payment for services provided directly in the office and indirectly through contacts like e-mail and telephone as well as a per-patient/per-month care management fee. Unless or until CMS is able to pay ACOs (and, in turn, facilitate ACOs paying their participants) in a manner more consistent with the desired outcomes (i.e., through a blend of fee-for-service, partial capitation, etc.), we do not believe the Medicare ACO program can succeed. We therefore encourage CMS and the Center for Medicare and Medicaid Innovation to further consider and experiment with payment models outside the limitations of Sec. 3022." We believe that blended payment systems are essential to the most effective health system reform, and therefore must be supported in the ACO structure. From the experience of many state Medicaid programs, such as those in North Carolina and Illinois, we know that blended payment systems that include both prospective care coordination payments and fee-for-service payments lead to impressive healthcare cost savings and improvement in quality indicators.

We enthusiastically support the recommendation of the AAFP for a blended payment structure and strongly reinforce this request for prospective care coordination (care management) payments to primary care practices operating in within the structure.

Equitable Distribution of Shared Savings

We consider the ACO shared savings program an important part of a blended payment system, a part that reflects financial reward for effective performance. We believe that CMS should specify that a reasonable amount of the shared savings generated by individual ACOs be shared with the participating primary care practices. Currently the proposed rule leaves the distribution of savings up to the separate contracts the ACOs make with CMS. It would be helpful if CMS would set a minimum standard for these contracts. **Based on the need for a balanced physician workforce to achieve optimal health outcomes and costs, as shown by the wealth of literature reviewed in the COGME 20th report, we recommend that CMS specify a minimum shared savings allocation of 33 to 50 percent to primary care physician practices.** Another option would be for CMS to require the ACO (in its application) to describe the formula it will employ to distribute any savings and that CMS formula should require such formula to demonstrate the emphasis placed on primary care, both in patient care and in compensation (reward) through the savings generated.

We further recommend, in reinforcement of the AAFP letter of May 20, 2011, that primary care physicians be defined as family physicians, general pediatricians, and general internists who function as a usual source of comprehensive, longitudinal care, and whose billing profile meets the definition of primary care already established by CMS for the primary care bonus payments under the Affordable Care Act.

Quality Reporting Burden

Our last major concern relates to the ability of most primary care practices to even participate in the proposed ACO model. In particular, the quality reporting requirements are onerous and would prevent most primary care practices from engaging in this endeavor. We believe that CMS should start with a much smaller set of quality reporting measures that have the greatest likelihood of major impact on healthcare costs and outcomes. With time, more measures might be added as participating systems establish a reporting infrastructure and as health services research defines additional effective quality reporting metrics. In order to ease the reporting burden and to encourage more systems to participate, **we recommend a small initial set of quality reporting measures and, as new contracts are written in the future, a gradual phase-in of other quality measures can be added.**

In conclusion, we support the efforts of CMS to implement the provisions of the Affordable Care Act (Sec. 3022) to establish a program that “promotes accountability for a patient population, 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.” We appreciate that this proposal will undergo changes as it becomes finalized, and we hope that CMS will incorporate our concerns into the final rule.

Sincerely,



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