AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

May 20, 2011

Donald Berwick, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
P.O. Box 8013
Baltimore, MD 21244–8013

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

Dear Dr. Berwick:

On behalf of the American Academy of Family Physicians (AAFP), which represents more than 100,300 family physicians and medical students nationwide, I am writing in response to "Medicare Shared Savings Program: Accountable Care Organizations" (CMS–1345–P) proposed rule as published in the April 7, 2011, *Federal Register*.

Sec. 3022 of the *Affordable Care Act* requires the Centers for Medicare & Medicaid Services (CMS) to establish a voluntary, three-year program "*by Jan. 1, 2012 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*." Participating entities, referred to as Medicare Accountable Care Organizations (ACOs), that meet quality and performance standards are eligible to receive payments for shared savings.

The AAFP recognizes this proposed regulation as the first major health delivery reform initiative following the passage of the *Affordable Care Act*. As 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.

However, the AAFP is concerned that the Medicare ACO program as currently proposed will fail to offer the potential benefits of better care for individuals, better health for populations, lower per capita costs for Medicare beneficiaries and improved coordination among physicians. The AAFP remains committed to working with CMS and the Congress to refine the Medicare Shared Savings ACO program to ensure its success.

To improve the final Medicare ACO regulation, the AAFP offers the following detailed recommendations related to this rule. Key recommendations include urging that CMS:

- Identify alternative policies so that primary care physicians are able to participate in multiple Medicare ACOs;

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- Not confine its payment method to the current, traditional Medicare fee-for-service payments to ACO participants 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;
- Drastically reconsider its proposed Medicare ACO policies and instead offer greater flexibility so that small- to medium-sized primary care practices will be more eligible to participate;
- Consider proposing additional tracks that are tailored for smaller medical practices less familiar with assuming financial risk;
- Specify that the Medicare ACO governance structure must utilize primary care physicians in the top leadership positions to ensure that Medicare ACOs are primary care driven; and
- Outline quality reporting requirements for the full three-year program, significantly reduce the number of required quality measures, and only require reporting on quality measures that improve population health outcomes and efficiency.

Medicare ACO Eligibility

An ACO typically refers to a group of physicians, hospitals and other suppliers of services that will work together to provide coordinated care to a specified patient population. For purposes of the Medicare Shared Savings Program, CMS defines five types of entities permitted to form Medicare ACOs:

- ACO professionals (physicians, physician assistants, nurse practitioners and clinical nurse specialists) in group practice arrangements;
- Networks of individual practices of ACO professionals;
- Partnerships or joint venture arrangements between hospitals and ACO professionals;
- Hospitals employing ACO professionals; and
- Critical Access Hospitals that bill for the facility and the professional services to their fiscal intermediary or their Medicare Part A/B Medicare Administrative Contractor.

Although only these five entities can form a Medicare ACO, other Medicare providers and suppliers may participate.

In the proposed rule, CMS anticipates aggregate start-up investment and first-year operating expenditures for Medicare ACOs will be between $131 million and $263 million. The AAFP is quite concerned that, as currently proposed, only large and established integrated health systems that already possess the capital and infrastructure would be able to qualify as a Medicare ACO. Failing to attract small- to medium-sized practices, especially in rural settings but also in urban areas, will squander this tremendous opportunity to improve the healthcare delivery system and will deny the potential benefits of the ACO model to patients throughout the country, most of whom receive care from small and medium size physician practices.

The AAFP urges CMS to drastically reconsider its proposed Medicare ACO policies and instead offer greater flexibility so that small- to medium-sized primary care practices will be more eligible to participate. This would involve eliminating all but the essential requirements included in the statute (e.g., demonstrated ability to care for at least 5,000 beneficiaries, ability to measure and report on quality of care provided) and making the “one-sided model” truly one-sided. CMS’s concern with the minutiae of ACO governance and management structure and marketing seems misplaced. If CMS focuses only on the essentials and allows ACOs to take shape in ways that make the most sense in their respective markets, then small- to medium-sized practices will have more opportunity to participate, and Medicare patients will reap the rewards of their doing so.

The AAFP, therefore, encourages CMS and the Center for Medicare and Medicaid Innovation to offer significantly different Medicare ACO participation options in the final Medicare ACO regulation and in future efforts to experiment with innovative payment methodologies.

Medicare ACO Structure

As proposed, a Medicare ACO will be a legal entity that is recognized and authorized under applicable state law and is identified by a Taxpayer Identification Number (TIN). Providers and suppliers participating in a Medicare ACO not only will continue to receive traditional fee-for-service payments under Medicare Parts A and B, but also will be eligible to receive a portion of the shared savings if successfully satisfying quality performance standards and reducing healthcare costs.

The AAFP does not believe that the Medicare ACO program can succeed if CMS confines its payment method to the current, traditional Medicare fee-for-service payments to ACO participants. Per the AAFP principles on ACOs, we urge CMS to revise the proposed policies and instead employ a variety of payment approaches, such as blended fee-for-service payments, prospective payments, episode/case rate payments, and partial capitation payments. Sec. 3022 of the *Affordable Care Act* discusses a partial capitation model, yet CMS unaccountably did not include this model in the proposed regulation. The AAFP believes continuing traditional fee-for-service payment on a day to day basis is an approach that lacks sufficient financial incentives to motivate ACO participants to improve the coordination of patient care. The incentives derived from potential shared savings, which the Medicare ACO may or may not receive many months after clinical care is provided, will be small in relation to the fee-for-service payments derived from visits or procedures, making it difficult for ACO management to effect the needed changes.

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.

The AAFP is pleased that CMS proposes a requirement that at least 75 percent of a Medicare ACO's leadership and governance structure must consist of clinicians, administrative staff, and patients. Since Congress intended the Medicare ACO program to be based on a foundation of primary medical care, we urge CMS, in the final rule, to specify that the Medicare ACO governance structure must utilize primary care physicians in the top leadership positions to ensure that Medicare ACOs are primary care driven. Significant and equitable representation from primary care and specialty physicians in a Medicare ACO's administrative structure, policy development, and decision-making processes will help to ensure the program's success.

Also commendable is the requirement that all Medicare ACOs employ a board-certified physician, licensed in the state in which the ACO operates, who is physically present in an established ACO location and who serves as a senior-level medical director responsible for clinical management and oversight. Similarly, we support the provision requiring all Medicare ACOs to employ a physician to direct the quality assurance and process-improvement committee. We concur with CMS that physicians, especially primary care physicians, serving in these leadership positions will promote continued quality improvement efforts.

Shared Savings Methodology

To the extent participating providers meet certain quality standards and savings benchmarks, such providers can receive payment for shared Medicare savings limited by benchmarks, thresholds and caps. As proposed, participating Medicare ACOs have the option to select one of two payment models, depending on the experience level of the ACO and willingness to assume a share of the risk.

- Track 1 (one-sided model): Shared savings are reconciled annually for the first two years of the three-year term using a pure shared savings approach whereby the ACO is not responsible for any portion of any losses. In the third year, the ACO is required to share in any losses generated, as well as any savings. For Track 1, the minimum savings rate ranges from 2 percent for Medicare ACOs with over 60,000 beneficiaries to 3.9 percent for Medicare ACOs with only 5,000 beneficiaries.
- Track 2 (two-sided model): A risk-based model is used for the entire three-year term. The ACO is eligible for higher sharing rates and other benefits in return for the increased risk of sharing in any losses for all three years of the agreement. Track 2 Medicare ACOs may receive to up to 60 percent of the gross savings beyond the minimum savings rate and up to the maximum sharing cap of 10 percent of the expenditure benchmark.

The AAFP appreciates CMS offering risk-based options to potential Medicare ACOs, but we urge CMS to consider proposing additional options tailored for smaller medical practices. To encourage greater participation, the AAFP recommends easing the 2 percent to 3.9 percent minimum savings rate, as these rates are too high to entice small- to medium- sized primary care practices, less familiar with assuming financial risk, to consider becoming part of a Medicare ACO. CMS should also eliminate the cap on shared savings. Doing so may increase interest and may improve participation in the program. The statute anticipates that professionals in group practice arrangements should be permitted to form Medicare ACOs. Requiring all Medicare ACOs to assume down-side risk in at least the third year will also discourage small- and medium-sized practices from forming a Medicare ACO. Mandatory risk-sharing for all Medicare ACO participants will be problematic, particularly as the Medicare ACOs will have no ability to identify their assigned beneficiaries or influence their behavior.

Despite the proposed rule's discussion of the shared savings methodology, potential Medicare ACOs are still unable to determine possible shared savings for several reasons. To measure likely Medicare expenditures in the absence of the ACO, CMS must establish each ACO's expenditure benchmark, calculated based on the most recent available three years of per-beneficiary expenditures for Medicare Parts A and B services for those beneficiaries assigned to the ACO. Without access to recent Medicare claims data or knowledge of how beneficiaries will be assigned to ACOs, potential Medicare ACOs are unable to estimate their expenditure benchmarks. This inability to determine potential Medicare shared savings will further discourage initial participation. The AAFP thus encourages CMS to provide estimated expenditure benchmarks to entities prior to the formal ACO application process so that the prospective ACO participants can make a more informed business decision.

Quality Reporting Requirements

For the first year, CMS proposes that the Medicare ACOs report 65 quality measures on patient and caregiver experiences, care coordination, patient safety, preventive health, and at-risk populations. Quality measure reporting requirements for the second and third year will be created during future rule-making. Under the current proposal, Medicare ACOs that demonstrate that they are providing high quality care are eligible for a portion of the shared savings.

The AAFP questions why CMS proposed quality reporting requirements for the first year only, while requiring potential Medicare ACOs to commit to participating for three years. Instead, the AAFP urges CMS to outline quality reporting requirements for the full three-year program. CMS must do this so that interested entities are fully aware of all Medicare ACO program requirements.

Furthermore, the AAFP believes the number of initial quality measures is, at least for the first year, onerous and operationally unrealistic. We note that the Physician Quality Reporting System only requires three measures, and the response to that program has not been overwhelming. We therefore urge CMS to specify clearer parameters pertaining to reporting on quality measures. Quality measure reporting must be handled

with great care and must yield accurate, timely, and actionable data. The value of quality measures is to provide timely and actionable feedback to the Medicare ACO and its participating physicians so that they can then modify practices, behaviors and systems. Medicare ACOs should be allowed to choose which NQF endorsed quality measures apply to that ACO's covered population. CMS should only require Medicare ACOs to report on quality measures that improve population health outcomes and efficiency.

The *Affordable Care Act* does not require a hospital to be a part of a Medicare ACO. It is therefore puzzling that CMS proposes all Medicare ACOs must report a measure that incorporates 9 hospital acquired condition measures. The measure set should be limited to a more feasible list (e.g., 10 measures) in the first year, focusing on addressing high cost/high volume disease conditions, with the remaining measures phased-in over the three-year performance period. Another option is to have reporting requirements for the first year, without targets or penalties, and phase those in after year one or two. Furthermore, the AAFP has concerns over the proposed quality measure scoring process, the overall performance score, the performance benchmarks, and the minimum attainment level for each quality measure. This is an overly complicated process that should be significantly streamlined. These types of complexities further exclude smaller and less integrated primary care practices.

CMS proposes that Medicare ACOs publicly report information on providers and suppliers participating in the ACO, parties sharing in the ACO governance, quality performance standard scores, and general information on how a Medicare ACO shares savings with its members. AAFP supports these efforts as a way to ensure transparency. Furthermore, we commend CMS for aligning the Medicare and Medicaid Electronic Health Record incentive program with the Medicare ACO quality reporting requirements and urge continued alignment in future rulemaking.

Role of Primary Care

By statutory requirement, ACOs must "*include primary care ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries assigned to the ACO*" and "*at a minimum, the ACO shall have at least 5,000 such beneficiaries assigned to it*." For purposes of the Medicare Shared Savings Program, CMS defines "primary care professionals" as physicians who have a primary specialty designation as "internal medicine, general practice, family practice, or geriatric medicine" and who are providing the appropriate primary care services to beneficiaries. For purposes of Medicare ACOs, CMS proposes to define "primary care services" as those identified by HCPCS codes 99201 through 99215, 99304 through 99340, 99341 through 99350, the Welcome to Medicare visit (G0402), and the Annual Wellness Visits (G0438 and G0439). We urge CMS to specify "general internal medicine" in the final Medicare ACO regulation to ensure that Medicare ACOs are truly based on primary care physicians. We propose that the definition of primary care professionals for purposes of the Medicare ACO program only include "general internal medicine, general practice, family medicine, or geriatric medicine" in any of their specialty designation fields, primary, secondary or otherwise.

We further recommend that rather than list "primary care services," that CMS go further to state that the primary care professionals be limited to those eligible for Primary Care Incentive Payments as a matter of consistency and specificity across CMS policy. The AAFP recognizes that some sub-specialists occasionally provide some primary care services. However, they are not providing continuing and comprehensive primary healthcare to their patients. The AAFP would strongly oppose any further expansions of the definition of "primary care professional" for purposes of the Medicare ACO program.

With respect to defining ''primary care services'' for the purposes of assigning beneficiaries under the Medicare ACO program, CMS proposes and seeks comments on three options:

1. Assignment of beneficiaries based upon a predefined set of ''primary care services;''

2. Assignment of beneficiaries based upon both a predefined set of ‘‘primary care services’’ and a predefined group of ‘‘primary care providers;’’ and
3. Assignment of beneficiaries in a stepwise fashion.

The first option assigns beneficiaries by defining ‘‘primary care services’’ on the basis of the select set of E&M services, specifically those defined as ‘‘primary care services’’ for purposes of the Primary Care Incentive Program and including G-codes associated with the Annual Wellness Visit and Welcome to Medicare benefit regardless of provider specialty. Though this option increases the number of potential beneficiaries assigned to the ACO in areas with primary care shortages and is administratively straightforward for CMS, the AAFP strongly opposes this proposed method. The AAFP believes assigning beneficiaries to Medicare ACOs based only on primary care services without distinction of physician specialty increases the likelihood of assigning beneficiaries to a specialist instead of a primary care physician. We believe this is inconsistent with the statutory requirement that Medicare ACOs rest on a foundation of primary medical care. We concur with the CMS commentary in the proposed rule that this option would diminish the appropriate level of emphasis on a primary care core in the Medicare ACO program by failing to place any priority on the services of designated primary care physicians in the assignment process.

Under the third option, beneficiary assignment would proceed by first identifying primary care physicians (internal medicine, family medicine, general practice, geriatric medicine) who are providing primary care services, and then identifying specialists who are providing these same services for patients who are not seeing any primary care professional. The AAFP opposes this option since specialists do not provide the entire range of primary care services. By failing to place any priority on primary care physicians that deliver comprehensive and continuous care for the full range of primary care services in the assignment process, we consider this option to be inconsistent with the *Affordable Care Act's* emphasis on a primary care core in the Medicare ACO program.

The second option proposed by CMS is to assign beneficiaries to physicians designated as primary care providers (internal medicine, general practice, family medicine, and geriatric medicine) who are providing the appropriate primary care services to beneficiaries. The AAFP believes this option is more closely aligned with the definition of primary care services as intended under the *Affordable Care Act,* and this approach is consistent with implementation of the Primary Care Incentive Program. As in the case of the first option, this option would be relatively straightforward administratively.

The AAFP believes the second option is the best of the three proposals; however, it limits primary care physicians to participate in only one Medicare ACO. Prior to publication of this proposed regulation, CMS conducted multiple ACO listening sessions, special conference calls, and workshops, and the agency issued a formal request for information. Throughout these opportunities to provide feedback, the AAFP and other national medical societies consistently urged CMS to allow primary care physicians as well as specialty physicians and other healthcare professionals to have the option to participate in multiple Medicare ACOs. For the Medicare ACO program to succeed, it is absolutely essential for CMS to identify alternative policies so that primary care physicians are able to participate in multiple Medicare ACOs.

Limiting primary care physicians that wish to participate in the Medicare Shared Savings Program 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 that 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.

The AAFP recognizes CMS must assign Medicare fee-for-service beneficiaries to a specific ACO based on their utilization of primary care services. As proposed, 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, confusion over to which one CMS should assign a patient may arise. However, this problem could be avoided by creating incentives (e.g., no deductibles and reduced co-insurance for primary care physician services) for patients to prospectively identify a primary care physician in an ACO. The patients need to be accountable as well as the participating physicians and providers. Identification of a primary care physician does not have to limit patient choice in any way. It simply provides an alternative method for identifying the population of patients for which the ACO is responsible while getting more engaged patients to think about having a usual source of care.

Alternatively, CMS should prospectively allow patients to choose their own Medicare ACO. This would relieve CMS from the proposed and flawed beneficiary attribution method that currently limits primary care physicians to participate in only one Medicare ACO.

The AAFP reminds CMS that the *Affordable Care Act* requires Medicare ACOs to demonstrate patient-centeredness systems. The AAFP is a longstanding advocate for concepts that provide everyone with a patient-centered medical home, an enhanced model of practice offering quality, comprehensive primary care. Family physicians—the majority of whom have adopted health information technologies into their practices—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 will be essential for the success of Medicare ACOs, and CMS ought to reconsider the beneficiary attribution method so that primary care physicians may participate in multiple Medicare ACOs.

The AAFP concurs with the CMS proposal to offer Medicare ACOs flexibility in adding or removing providers' National Provider Identifier numbers. This is especially important for small or rural Medicare ACOs to flourish over the course of the three-year agreement.

Involvement of Medicare Beneficiaries in an ACO

The AAFP supports the flexibility offered to Medicare patients receiving care in a Medicare ACO. For instance, the agency specifies that participation of Medicare beneficiaries is completely voluntary and there is no automatic enrollment or assignment of beneficiaries to the Medicare ACO. The proposed regulation also allows Medicare beneficiaries to receive care outside of the Medicare ACO at no penalty to the patient.

The AAFP concurs with the proposed requirements that Medicare ACOs notify patients at the point of care that their provider or supplier is participating as a Medicare ACO. We also agree with the proposed condition that Medicare ACOs must obtain a patient's permission to request that patient's Medicare claims data. According to our principles on ACOs, we believe patients receiving care in a Medicare ACO should be encouraged to prospectively select a primary care physician. We urge CMS to consider this as a resolution to the problem that, as currently proposed, primary care physicians could only participate in one Medicare ACO.

Participation in Rural Areas

CMS requests comments on payment mechanisms for rural primary care practices under Medicare ACO payment methodologies. The participation of small rural practices in Medicare ACOs is essential for Medicare beneficiaries, especially given the statutory requirement that Medicare ACOs have 5,000 beneficiaries.

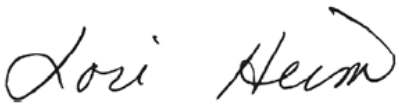
Small- and medium-sized primary care practices in rural areas will encounter additional challenges with the Medicare ACO program. If they attempt to participate, they will be compelled to align with larger entities that possess the robust financial resources needed to fund health information technology infrastructure and sufficient reserves to fund any possible losses. For purposes of the Medicare ACO, rural primary care practices likely will not band together in an independent practice association (IPA) arrangement since IPAs, especially new IPAs, typically lack the needed financial reserves. A rural primary care practice could participate with the local hospital as a Medicare ACO. This is problematic as these small hospitals are not positioned to be successful ACOs.

To address the considerable challenges individual physicians in rural areas face, the AAFP urges CMS to consider further incentives, such as an enhanced fee-for-service payment and other payment methods (e.g., partial capitation), for joining a Medicare ACO. This rural primary care provider incentive could help to fund the infrastructure requirements of a Medicare ACO, buffer risk, and stimulate further participation. CMS should consider offering start-up grants or low-cost loans to entities wishing to create an ACO in a rural area. CMS must offer different Medicare ACO participation requirements for rural areas.

Conclusion

The AAFP recognizes that this regulation is only a proposal, and we hope that CMS ultimately finalizes the Medicare ACO requirements so that appropriately structured Medicare ACOs successfully 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 or clarifications you might need. Please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org.

Sincerely,



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