



December 3, 2010

Donald Berwick, MD
Administrator
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Dr. Berwick:

The American College of Physicians, representing over 130,000 internists and medical students, is pleased to comment re: *Medicare Program; Request for Information Regarding Accountable Care Organizations and the Medicare Shared Savings Program; 75 Fed. Reg. 70,165 (November 17, 2010); CMS-1345-NC.*

The College has previously submitted to CMS a copy of the “American College of Physicians (ACP) Policy Positions on the Development of Accountable Care Organizations” and a set of general “Joint Principles for Accountable Care Organizations (ACO)” (attached) that was developed in collaboration with the American Academy of Family Physicians, the American Academy of Pediatrics and the American Osteopathic Association. Both of these documents emphasize the importance of primary care as a foundation for successful implementation of ACO programs. The comments below specifically address the questions included in the request for information.

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?

- ACP believes that the goals of ACOs—reduce, or at least control, the growth of health care costs while maintaining or improving the quality-of-care patients receive—will best be achieved when payment systems value and support patient-centered health care delivered from a robust primary care base that interacts with a neighborhood of specialty and subspecialty physicians and other health care professionals in a coordinated and integrated manner. It, therefore, is critically important that CMS create incentives for smaller *primary care practices* to participate successfully in ACO models.

- Although non-primary care physician practices often provide principal care to patients with particular disease conditions that require their expertise and this care is usually coordinated and of high quality, ACP urges CMS to ensure that that ACOs include enough primary care physician practices to effectively serve their Medicare beneficiary population. Such practices should be led by physicians who have the requisite training in comprehensive and longitudinal primary care in a recognized primary care specialty: internal medicine, geriatrics, family medicine, pediatrics, or combined pediatric-internal medicine training.
- Incentives should also be created to support participation by internal subspecialty practices and other specialty practices-- including smaller ones--that are working in collaboration with primary care physicians, but not in lieu of ensuring sufficient participation by primary care physician practices.
- Most solo and small practices will need to have a relationship with a larger entity in order to satisfy the 5,000 Medicare fee-for-service beneficiaries requirement for participation in the Medicare Shared Saving Program and likely some of the other ACO models tested by the CMMI. Nonetheless, these smaller practices should not be forced into direct integration/incorporation into a large group practice or hospital-owned physician practice network as a project requirement.
- CMS should encourage the development of ACO models that allow participation by smaller primary care practices either through the practices being accepted into an existing larger ACO structure, or through facilitating a group of solo and small practices to jointly engage in efforts to formally or virtually organize into a larger structure. In order to facilitate these activities, CMS should:
 1. Work with the Department of Justice and Federal Trade Commission to create well-defined safe harbors from existing antitrust, anti-kick, gain sharing, self referral and civil monetary penalty statues that currently interfere in practice collaboration, integration and payment sharing.
 2. Develop mechanisms to disseminate information to interested practices on models of formal and virtual practice integration and how they can be effectively operationalize and implemented. Potential mechanisms to accomplish this under Medicare include expanding the scope of work of the Quality Improvement Organizations (QIO) or providing support to offer these services through Regional Health Improvement Collaboratives or similar non-profit entities.
 3. Provide incentives to larger ACO structures to include solo and small practices within their network. Examples of how this might be accomplished are:
 - A direct approach --- provide a potential for increased payment or a larger portion of share savings to ACO entities that include a threshold percentage of solo and small practices--- particularly primary care practices. These increased payments

recognize the anticipated additional expenses related to the provision of support and infrastructure (e.g. providing health information technology (HIT) or care management capabilities) necessary to effectively integrate these solo and small practices within the ACO structure.

- An indirect approach --- require that an entity contracted as an ACO have a low population to primary care clinician ratio. Not only does this reinforce the importance of the provision of primary care within the ACO structure, but it increases the likelihood of small practice participation because these smaller practices provide a high percentage of primary care services throughout the healthcare system.
- Allow flexibility in any criteria used to qualify practices for participation in an ACO. Thus, solo and small practices that have been recognized as having the capability to provide quality and efficient care (e.g. NCQA Medical Home recognition, including practices recognized as Level One Medical Homes) should be able to participate, without necessarily having high cost HIT capabilities.

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?

- ACP agrees that many small practices—particularly primary care practices—do not readily have discretionary capital to fund efforts from which “shared savings” can be generated. This highlights the importance of having an “upside-risk only” approach within the Shared Savings Program and including such an option in future ACO programs developed through the CMMI. Practices (particularly solo and small practices) that use their limited resources to participate should not be required to assume any additional downside risk; particularly during this exploratory/experimental phase of payment model development.
- Provide incentives to larger ACO structures to include solo and small practices within their network with the understanding that these increased payments will serve as capital to help effectively integrate these small practices into the ACO structure. This approach was outlined in more detail in question 1.
- Create structures that increase access to financing to small practices to be used for forming an ACO or for preparing their practices for effective integration

into an ACO structure. These structures can take the forms of loan guarantee, low-cost loan or grant programs.

- Encourage payment methodologies that provide sustained and upfront payments to practices to offset the costs to them of participating in an ACO and to better support the value of primary care, rather than methodologies that rely solely on “shared savings” that are determined after-the-fact. The College’s ideas on potential payment models are discussed later in this letter in response to question 7.

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 ACO’s 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 assigned 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?

- While the College understands the need to test varying approaches, we believe that participation by patients/families, as well as physicians and other health professionals, within an ACO should be voluntary. This engages the patient, strengthens the doctor-patient relationship, and facilitates efforts by all parties toward improved care. A proactive attribution approach also allows for the effective implementation of risk-adjusted payment models, which would significantly reduce any incentives for the ACO toward discrimination against the treatment of the more medically-complex or difficult-to-treat patient. Implementation of this voluntary ACO participation approach will also require an extensive effort on the part of CMS to educate beneficiaries on the positive nature and goals of these ACO entities.

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

- CMS should assess beneficiary and caregiver experience of care by building on the previous work of the Agency for Healthcare Research and Quality (AHRQ) in developing the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. These current surveys provide an excellent foundation for the development of a reliable and valid ACO experience of care measure. Any

implementation of this patient survey methodology will need to recognize the added administrative burden of this approach, as opposed to more traditional data collection approaches such as through claims, registries or electronic health records.

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?

- Patient-centered care, the delivery of care that emphasizes the preferences and needs of the patient, should be a primary focus of any care delivery system. The College's refers you to the recent work by such organizations as the Commonwealth Fund (<http://www.commonwealthfund.org/Topics/Patient-Centered-Care.aspx>), NCQA (<http://www.ncqa.org/tabid/631/Default.aspx>) and the National Partnership for Woman and Families (http://www.nationalpartnership.org/site/DocServer/Advocate_Toolkit-Consumer_Principles_3-30-09.pdf?docID=4821) in developing patient-centeredness criteria. While these above efforts are focused on the PCMH, they can serve to inform your current ACO effort.
- The provision of patient-centered care is a primary requirement for practices to receive recognition as a PCMH through the NCQA recognition process. CMS should consider using the number of primary care practices recognized as a PCMH by NCQA, or similar nationally-recognized certifying entity, within an ACO as potential general indicator of patient-centered care delivery.

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?

- Rather than offer a set of specific quality measures for the Shared Savings Programs, the College offers the following approach to performance measurement selection. As much as possible, only quality measures that have been vetted and approved by a nationally-recognized, multi-stakeholder consensus-based entity, such as the National Quality Forum (NQF), should be used. The decision regarding the specific approved measures to be employed within the Medical Shared Saving Program should be informed by input from all relevant stakeholders --- as the agency is currently doing through this RFI and the subsequent regulatory rule-making process. It is also recommended that the final measurement set established be used not only for the Shared Savings Program, but also in related projects developed through the CMMI. Furthermore, the measures selected should, as much as possible, be aligned with the performance

measures currently being used by CMS under the PQRS and Meaningful Use initiatives. The goal should be to have a standard set of quality measures to facilitate appropriate performance focus and decrease unnecessary administrative burden.

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?

- CMS should require that ACOs specifically develop payment methodologies that support the value of care provided by primary care physicians, in both large and small practices, and to encourage their participation.
- The College supports the evaluation of a variety of payment approaches to align the incentives for improving quality and enhancing efficiency while having the potential to reduce overall costs, including, but not limited to, blended fee-for-service /prospective payment, shared savings, episode/case rates and partial capitation. Our principles on ACOs state that payment models used within the ACO demonstration and pilot projects should:
 - Recognize and reward performance based on a combination of the meeting of absolute and improvement-based quality and efficiency benchmarks.
 - Adequately reflect the participating practice’s contribution to increased quality and efficiency.
 - Ensure that a significant portion of any savings attributable to the ACO’s activities be shared by the participating practices.
 - Protect ACO participants from “insurance risk” (e.g. degree of illness/severity in the population).
- In addition, as noted in the Joint Principles on ACOs developed by ACP, the AAFP, AOA, and AAP, payment methodologies under ACOs or other programs authorized by the CMMI should have the following elements:
 - The payment models and incentives implemented align mutual accountability at all levels.
 - The payment models and incentives implemented adequately reflect the relative contributions of participating physicians and other health care professionals.
 - The payment models used recognize effort required to involve family, community/educational resources and other pertinent entities and activities related to care management/care coordination of patients with complex conditions.

- Recognition and rewards for the ACO's performance are based on processes that combine achievement relative to set target levels of performance.
 - Practices participating within ACOs that achieve recognition as medical homes by NCQA or other nationally accepted certification entities should receive additional financial incentives.
 - The structure adequately protects ACO physicians and other health care professional participants from "insurance risk."
 - They employ a variety of payment approaches to align the incentives for improving quality and enhancing efficiency while reducing overall costs.
- Specifically relative to small practices participating in or forming an ACO, payment approaches that provide a prospective payment and/or guarantees of regular monthly payments are preferable. They provide these practices or entities with the financial resources needed to participate within the ACO project and to implement processes to provide higher quality, more efficient care. Look back, or retroactive approaches, such as shared savings, will make it more difficult for these smaller practices to successfully participate given their significant capital limitations.
 - ACO payment models also should recognize the practice expenses and administrative costs associated with participation in an ACO model, including the costs of implementing and maintaining HIT.

ACP appreciates the opportunity to comment. Please contact Neil Kirschner, Ph.D., Senior Associate, Regulatory and Insurer Affairs, by phone at (202) 261-4535 or e-mail at nkirschner@acponline.org if you have questions.

Respectfully,



Fred Ralston, Jr. MD, FACP
President

