September 27, 2010

Secretary Donald S. Clark
The Federal Trade Commission
600 Pennsylvania Avenue, NW
Washington, DC 20580

Administrator Donald Berwick, MD
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: ACO Legal Issues, Mail Stop C5-15-12
7500 Security Boulevard
Baltimore, MD 21244-1850

Inspector General Daniel R. Levinson
Office of Inspector General
Department of Health and Human Services
330 Independence Avenue, S.W.
Washington, D.C. 20201

RE: CMS-1356-N

Dear Secretary Clark, Dr. Berwick, and Inspector General Levinson:

I am writing on behalf of the American Academy of Family Physicians (AAFP), which represents more than 94,700 family physicians and medical students nationwide. Specifically, I am writing to offer our comments on the upcoming October 5 workshop regarding Accountable Care Organizations (ACO), and implications regarding antitrust, physician self-referral, anti-kickback and civil monetary penalty laws as published in the September 17, 2010 Federal Register.

AAFP believes innovative payment policy ideas require scrutiny before they can be fully embraced by practicing family physicians. We urge the FTC, CMS, and OIG to base the foundation of ACOs on primary care and the patient-centered medical home (PCMH). The concept should be defined as a primary care-based collaboration of health care professionals and health care facilities that accept joint responsibility and accountability for the quality and cost of care provided to a defined patient population. ACO should become an extension of the PCMH, so that the ACO becomes the medical home 'neighborhood' that aligns all of the health care providers outside of the patient-centered medical home practice.

In anticipation of inclusion of the ACO concept in the Affordable Care Act, the AAFP Board of Directors adopted the following ACO Principles. I urge you to strongly consider these principles as the FTC, CMS, and OIG further develop the ACO concept.

**Structure**

- The core of an Accountable Care Organization is to provide accessible, effective, team-based primary care for the defined population it serves, which includes efforts to deliver care in a culturally competent and responsive manner.

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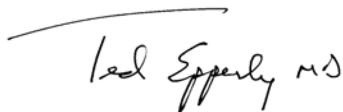
- Should include strong physician leadership, be clinically integrated and operated in a true partnership among physicians and all other participants.
- Physician and patient participation in an Accountable Care Organization should be voluntary. However, if patients are assigned to an Accountable Care Organization they should be encouraged to select a primary care physician.
- Nationally-accepted, validated clinical measures focused on ambulatory and inpatient care should be used to measure performance and augment efficiency and patient experience measures.
- Clinically integrated information systems should provide relevant information at the point of care and assist in care coordination among multiple clinicians and across transitions of care.
- Accountable Care Organization participants will support continuous innovation to identify best practices that provide value to patients.
- Organizational relationships, spending and quality benchmarks, and payment distribution mechanisms need to be clearly defined and agreed to by participants.
- Accountable Care Organization structure and payment systems should be implemented in an incremental manner and monitored to prevent "unintended consequences," such as poor access to physicians or denial of needed care.
- A sufficient number of patients in an Accountable Care Organization is necessary to statistically determine if the care provided and not mere chance resulted in the reported outcomes.
- Primary care physicians and sub-specialists should have the option to participate in multiple Accountable Care Organizations.
- Accountable Care Organizations should purposefully involve and provide incentives for patient engagement in their health and wellness.
- Changes to antitrust regulations and to Stark self-referral regulations need to be explored to allow physicians to fully participate in Accountable Care Organizations especially for physicians in small- and medium-sized practices.

**Payment**

- Payment models and incentives must align mutual accountability at all levels, fostered by transparency and focus on disease prevention, care management, and coordination.
- Recognition as an Accountable Care Organization and rewards for its performance should be based on a combination of absolute standards, relative performance, and improvement.
- Payment changes should evolve over time in ways that support the transitional changes in care processes and information systems.
- Primary care practices designated as PCMH's and participating in an Accountable Care Organization should be eligible for payments in both models of care (i.e.fee-for-service, episode/bundled payment, global payment, care management fee, bonuses, shared savings, blended payment, etc.)

Thank you for this opportunity to comment on this matter. If we may be of further assistance on this matter, please contact John Swanson at jswanson@aafp.org.

Sincerely,



Ted D. Epperly, MD, FAAFP
Board Chair