AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

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Submitted via HCP-LAN website

Dear Ms. Edgman-Levitan, Dr. Golden, and members of the LAN PCPM Work Group,

On behalf of the American Academy of Family Physicians (AAFP), which represents 124,900 family physicians and medical students across the country, this letter is in response to the draft white paper titled, "Primary Care Payment Models" released on October 19, 2016.

The AAFP applauds the Work Group for developing a draft white paper on Primary Care Payment Models (PCPM). The AAFP supports the mission of the LAN and believes it will play an integral part in consistent deployment of alternative payment models (APMs) across all payers. The model outlined in this draft white paper is consistent with AAFP APM principles of:

- APMs must provide longitudinal, comprehensive care
- APMs must improve quality, access, and health outcomes
- APMs should promote evidence-based care
- APMs should be multi-payer in design.

The AAFP is supportive of alternative payment models and believes that to be truly successful in improving care and reducing cost, APMs need a strong foundation of primary care. In addition, transformation cannot be overly complex and burdensome to operationalize. There is not a one size fits all as patient panels or populations and primary care practices vary. In keeping with the goals of the U.S. Department of Health and Human Services (HHS) regarding APMs, we urge the HCP-LAN to recognize that further work needs to be done to improve quality and patient engagement while reducing total cost of care. There is an emerging but definite consensus that strengthening primary care is imperative to improving individual and population health outcomes and restraining health care spending growth. Increasing the current primary care spend from five or six percent of total spend to at least 12 percent is an important first step in supporting and sustaining the transformation and staffing needed to meet these goals. **Value based incentives, to the greatest extent possible,**

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should reach the physician across the primary care teams that directly deliver care rather than being absorbed by intermediaries as is often the case today.

Collaborative engagement among all payers in the aggregation of data on cost and quality is paramount. The development of effective partnerships between patients, families, and caregivers can only be developed over time through personalized care plans. Improvements in EHR functionality and usability are critical to improving the health of the population and reduction of cost of care. Without the changes listed above, few primary care practices will achieve the true transformation needed to be successful as an APM.

The AAFP appreciates the commitment of the work group to propose the principles and recommendations outlined in the HCP- LAN PCPM document. The AAFP believes this is an important first step. Many of the principles and recommendations mirror various AAFP policies and the Joint Principles of the Patient Centered Medical Home which have been in place since 2007. It is the AAFP's understanding that the next step in this process will be to provide more definition to operationalize the success of these proposals. The comments and suggestions that follow summarize the thoughts and concerns related to implementation of the principles and recommendations that can assist the LAN in the next step in the process. Importantly these AAFP comments reflect input from practicing family physicians from across the country.

Principle 1: New payment models will support high value primary care that fosters health for all patients (including underserved, at risk, vulnerable, and complex patients), expands access to innovative methods of delivering effective care, and minimizes disparities in care.

> *AAFP Response:* CMS has made a commitment to improving payments for primary care through the 2017 proposed Medicare physician fee schedule (PFS). The AAFP in a response letter urged CMS to maintain these payment changes in the final rule. Private payers need to follow this lead to increase the **investment in primary care to at least 12 percent** of total spend to support higher functioning healthcare systems based in primary care. The AAFP has asked public and private payers to document and report their percent of total spend on primary care to ensure that teams are financially supported to make necessary changes at the primary care team level. The HCP-LAN should do likewise.

Recommendation 1: PCPMs will support population–focused patient centered and team based care.

> *AAFP Response:* Baseline levels of investment in primary care need to be calculated and organizations need to provide documentation that these increased payments are channeled down to the practice level to support the necessary changes. Quarterly attribution reports are necessary to accurately monitor the patient population. Primary care physicians providing comprehensive primary care across a multidisciplinary team must have interoperability within health information technology (HIT) to monitor both quality and cost and assist with successful care transitions.

Recommendation 2: PCPMs will adjust payment to account for underlying differences in the patient population served by different primary care practices.

AAFP Response: Because it may be difficult to collect socioeconomic information at the practice level due to EHR limitations, it will be ideal if census and other data can be used to help account for differences*.* **Syncing data on cost/utilization and quality/outcomes will create an opportunity to appropriately risk adjust to capture complexity in the entire patient population. It will be critical that resource use and quality measures are coupled with adequate and useful feedback reports for all members of the care team, all of whom need timely and actionable clinical claims data to make value-based care decisions for their practice as well for those to whom they refer.**

Principle 2: PCPMs should allow primary care practices to focus on work that promotes the health of patient populations and minimize work that does not contribute to high quality care.

AAFP Response: AAFP agrees with this principle. Primary care teams must be freed from administrative burdens that do not directly improve the patient centered relationship. This will allow the focus to be on transformative changes needed to improve patient outcomes, population health, reduce costs, and provide a positive quality of work life for the primary care team.

Recommendation 3: The preferred form of payment for primary care employs a risk-adjustment, comprehensive prospective payment, including some retrospective reconciliation, based on the patients empaneled or attributed to the primary care practice. This corresponds to payments in Category 4 APMs.

AAFP Response: Multi-payer participation or larger risk pools of primary care practices/patient are paramount for risk in PCPMs. Only larger independent practice associations (IPAs) and accountable care organizations will be able to take on the risk outlined in the PCPM draft white paper. In order to spread this model across the country, it will be important for practices to start with small incremental financial risk. Examples of programs that are designed for small practices include the Comprehensive Primary Care (CPC) initiative and CPC+. Small practices often have the ability to be more nimble in improving quality and reducing cost.

The AAFP recommends an APM that includes a primary care global payment per patient per month (PMPM) for direct patient care, a separate population based payment (PMPM) for patient care management and/or co-ordination, additional fee-for-service payments limited to services not otherwise included in the primary care global fee, and performance–based incentive payments that hold physicians appropriately accountable for quality and costs. These prospective, performance-

based, incentive payments would reward practices based on their performance on patient experience, clinical quality, and utilization measures.

Risk adjustments and risk protection mechanisms such as risk corridors must be in place for each of the PMPM payments described above. These mechanisms make it more feasible for primary care physicians with a smaller patient population to enroll in risk based arrangements. The AAFP strongly supports patients being prospectively assigned to a primary care physician along with a simple process for the beneficiary to change the primary care physician to whom he or she was attributed. This approach promotes patient engagement and empowers beneficiaries and their families in directing their care. PCPM category 3A or 3B should use prospective attribution in the preferred method for empanelment. The AAFP's position regarding any attribution model is that patients must be attributed based on who can control specific costs. The model must include a reconciliation process for clinicians to review, add, or remove patients from the list received and include enough time to adequately review the list. The AAFP recommends that the attribution process review and reconciliation should occur at least quarterly.

Recommendation 4: For PCPMs to be effective in incentivizing practice transformation, PCPMs should be multi-payer and cover the majority of a practice's patient population.

AAFP Response: To truly realize the value of family medicine and primary care, public and private payers cannot simply rely on delivery system reforms and APMs. CMS and private payers must make a new and increased investment in primary care as outlined in figure 3 in the paper to truly capture and realize the value proposition of family medicine and primary care.

Recommendation 5: Prospective payments will be in excess of historic primary care payment amounts to support the infrastructure of the clinical team that will be held accountable for greater coordination of service, and for bending the total health system cost curve.

AAFP Response: **AAFP appreciates that the HCP-LAN white paper draft indicates "It is not sufficient to base prospective PBP rates on current spending levels for primary care in FFS payment systems."** In order to improve preventive care, chronic care management and care coordination, an increased investment on a prospective basis will be needed to implement and sustain transformation. In order to bend the cost curve, it is imperative that the primary care physicians have access to cost and quality for referral to appropriate specialists and ancillary services.

Recommendation 6: PCPMs will use prospective payment to incentivize the necessary investments by primary care organizations in practice infrastructure to result in more efficient delivery of healthcare.

AAFP Response: Practices need to have flexibility in determining what practice changes are needed to support their patient population.

Recommendation 7: Fee-for-service payment will still play a limited role as part of a blended PCPM; it will be used to incentivize certain services that need to be performed in a face-to-face encounter and promote more efficient, comprehensive primary care.

AAFP Response: As stated earlier in this document, we agree with this statement. Both primary care physicians and payers need a transitional path for decreasing FFS and increasing PBP. It will be important for PCPM participants to count on stable payments during transition as outlined in Recommendation 3.

Close observation of outcomes from the Comprehensive Primary Care (CPC) initiative and Plus (CPC+) will allow best practices to be deployed to PCPMs.

Principle 3: PCPMs will enhance collaboration with specialists, hospitals, emergency departments, and other health care professionals to delivery timely, appropriate, and efficient care.

AAFP Response: The AAFP agrees with this principle. **It is critical that primary care teams are able to send and receive information across all settings to promote effective transitions in care**. Medical homes are the appropriate conduit to manage care transitions, as they are foundational to an efficient and effective health care delivery system.

Recommendation 8: Continued participation in PCPMs will be contingent upon primary care teams' adoption of technologies and processes that allow them to closely coordinate care with specialists and hospitals.

AAFP Response: Primary care physicians are the first point of contact for many patients' and this leads to the coordination of care with specialists and hospitals. The transformation required to support innovative processes to coordinate care is dependent on interoperability and functionality within the care team's EHR. To be successful in PCPMs, standardized functions need to be built in EHRs to provide streamline information exchange and communication sharing among all physicians and settings. Information technology infrastructure is central to coordination of care.

Principle 4: Performance measurement in PCPMs will promote excellent clinical and patient experience outcomes that reflect patient goals and whole-person care, to support healthcare professionals to partner with patients and families to achieve the outcomes they desire.

AAFP Response: The AAFP agrees with this principle. Measures must be clinically relevant, parsimonious in number, harmonized among public and private payers, minimally burdensome to report, and cost effective to gather. **It is only when a provider has**

access to timely and actionable data that they can have an impactful influence on performance.

Measuring performance provides a practice strategy for achieving quality improvements to promote patient-centered care.

Recommendation 9: Financial incentives used in all models will be transparent to care teams and the public, clearly communicated, and promote trust that these new payment models will promote better quality and appropriate costs.

*AAFP Response***:** Financial incentives should be separate from other lumped payments. Primary care physicians should receive prospective bonuses that can only be kept by meeting specific and agreed upon targets. This allows for incremental improvement rather than all-or-nothing progress to incentivize physicians who may feel they are unable to reach a target threshold.

Recommendation 10: Performance measurement will eliminate economic incentives to limit the provision of evidence-based care or deny costly or complex patients access to primary care practices and the care they need.

AAFP Response: Evidenced-based care should be team-based, and primary care-oriented to ensure it is patient-centered. Patient-centeredness requires an ongoing, active partnership with a personal primary care physician and a team of professionals dedicated to providing proactive, preventive, acute and chronic care management through all stages of life.

At times, patient characteristics may be outside of the primary care practice's control resulting in lower quality scores and higher costs. Risk-adjustment must be taken into account with regard to quality measures and expectations. Such adjustment must avoid masking health care disparities or normalizing them.

Unfortunately, high deductible plans may be working against PCPMs by creating barriers for appropriate care. The health of individuals, families, and communities may delay care due to insufficient funds for copayments and deductibles. First dollar coverage for primary care services is essential to incentivize patients to seek primary care in the outpatient setting and avoid costly ER and preventable hospitalizations.

Recommendation 11: Incentive payments in primary care will be based on an aligned set of comprehensive measures of primary care, rather than relying exclusively on a rigid set of disease –specific metrics.

AAFP Response: We agree with this recommendation but realize that such comprehensive primary care outcome measures are not currently available but must be pursued. In the interim, the cores measure sets developed by the multi-

stakeholder Core Quality Collaborative are preferred. Processes and criteria should be established to determine if a measure is evidenced-based reliable and valid. Consistency and harmonization between all payers involved in the multi-payer imitative is important.

Principle 5: PCPMs will encourage robust integration between primary care, behavioral health (including substance use treatment programs), and strong linkages with community resources to address determinants of health.

AAFP Response: AAFP agrees with this principle. Increased value-based payment for counseling and services is paramount to improving access to needed behavioral health and counseling staff. AAFP members struggle with trying to secure these services in many areas of the country. The expectation to meet all patients' mental and behavioral health issues will take time to achieve.

Recommendation 12: PCPMs will hold primary care practices accountable for the management of behavioral health and substance abuse services, because this recognizes the critical role that behavioral health plays in overall health, supports better integration between these services and primary care, and promotes shared accountability at the organization and clinical level.

AAFP Response: Behavioral health integration in a primary care practice is a way to promote accountability in PCPMs. Specific arrangements to support care coordination that integrate the patient's behavioral health and medical conditions need to meet the needs of the local market along with the circumstances within the PCPMs. **Risk adjustment in PMPMs that includes behavioral and or mental health with social determinants is critical to support these services.**

Recommendation 13: PCPMs will maximize the flexibility that primary care teams have to expend resources on coordination with community services, including direct support for community programs that demonstrably improve patient outcomes.

AAFP Response: Community resources and programs should have a single web-based application that would streamline information exchange between patients and staff for referrals. This information should be reviewed and updated at least annually. This is a necessary component to ensure that there are strong linkages with the community to improve health outcomes.

Principle 6: PCPMs will promote multifaceted efforts to make caregivers and patients partners in the delivery of their care, as well as at all levels of PCPM design, implementation, governance, and evaluation.

AAFP Response: The AAFP agrees with this principle. **To make caregiver and patients partners in their care, the functionality within EHRs to create a personalized care plan must be operational.**

Recommendation 14: PCPMs will ensure that primary care practices reflect patient goals, needs, and preferences in the care plans they develop collaboratively with the patient.

AAFP Response: A personalized care plan for each patient is essential for excellent care and outcomes. Until technology catches up with this principle, numerous work arounds will occur. This inefficiency needs to be addressed to EHR vendors to become a standard. While this standard is an expectation of 2015 certified EHRs, it will be important that the functionality is realized by practices. **Also important is that the cost to update should not be passed on to the primary care practice.**

Recommendation 15: PCPMs will ensure that primary care practices collect patient input, make patients meaningful partners on advisory councils and encourage patients to provide input about their experience.

AAFP Response: A diverse number of patients should be represented on practice advisory councils. Primary care practices should recruit council members who are willing to work constructively with each other to describe clinic experiences, propose quality improvement projects, and provide feedback.

It will be important that practices have flexibility to incorporate patient input in ways that work for that population.

Principle 7: Payers and primary care teams will collaborate in partnerships to ensure the success of PCPMs.

AAFP Response: The AAFP agrees with this principle. Sharing of data by payers, practices, and shareholders is required to manage utilization and care transitions. This will promote communication, gaps in management, and cost to drive to success in PCPMs. Again, we would stress that the acquisition of data should not require additional investment in technology or staff by the physician or practice.

To build and support the needed infrastructure necessary to implement a PCPM, primary care providers should receive a separate, risk stratified care management fee for each of their patients.

Recommendation 16: Ongoing participation in PCPMs will be conditioned on a primary care practice's ability to demonstrate success on metrics, of patient access, quality of care, comprehensive provision of services, responsiveness to patients and effective stewardship of resources as stipulated in the model design.

AAFP Response: To accommodate practices at different levels of readiness for transformation, best practice tools and resources should be developed as part of a primary care medical home multi-payer project such as CPC and CPC+.

Recommendation 17: PCPMs should foster data sharing and analysis to facilitate care coordination, patient engagement, population health management, and performance assessment.

AAFP Response: The AAFP agrees that multi-payer data on practice performance reports is critical for establishing the value of primary care delivered in PCPMs. With volumes of data available for primary care, an actionable dashboard will help identify metrics to track real-time performance. A notable finding in the AAFP Value –Based Payment Survey was that 61 percent of family physicians submitted claims to seven or more payers in the past year. Therefore, alignment of measures and analysis needs to be in a single actionable report to decrease administrative burden related to tracking performance and freeing up resources into making needed adjustments to improve care and reduce cost.

Recommendation 18: Primary care practices will need external coaching support and technical assistance to help them transition to new payment and delivery models.

AAFP Response: Collaboration among payers and other outside organizations will identify best practices such as 1) business and financial,2) practice infrastructure, 3) data collection and measurement, 4) incorporating data into workflow, 5) population health analytics; and 6) leadership development to support the success of transformation. Additional recommendations of the AAFP include: 7) identifying and recovering from burnout and 8) interfacing with payers and other member of the healthcare systems.

All payers need to provide the tools, resources, and financial support to lift up primary care so they can build and sustain improved quality and reduce the cost of care.

Recommendation 19: Although incremental progress will need to be made much more quickly, PCPMs can only be expected to deliver a return on investment over the long term. Therefore payers should develop business models that do not require investments in PCPMs to be recouped from reduction in total cost of care in the short term.

AAFP Response: The AAFP values that the HCP-LAN identified that patient outcomes take time to realize. Financial risk associated with PCPMs needs to be nominal and increase as practices and systems evolve to ensure success. To create and sustain a delivery system that values quality, cost effectiveness, and patient engagement, there are important concepts that need additional consideration on the best way to transition to APMs for primary care practices to

ensure success as they implement principles and recommendations in the white paper.

The AAFP strongly agrees with the following statement in the Work Group proposal: "Because primary care emphasizes a preventative approach and longitudinal care for the whole patient, improved patient outcomes often do not materialize immediately, and may take years (and in the case of some preventive measures, decades) to realize. Accordingly, and because primary care has traditionally been such a minor part of the total cost of care, it is unreasonable to expect PCPMs to significantly impact total cost of care in the short term. Nevertheless, taking into account the heterogeneity of practices within PCPMs, it is reasonable to expect to see other, incremental, returns on investment in the short to medium term. For example, it is reasonable to expect practices to demonstrably reduce hospitalizations and readmissions, and duplicative or unnecessary imaging; implement better medication management; and better integrate care in the first five years of a PCPM." This statement represents both the need for a greater investment in primary care while recognizing the return on investment in total cost of care will occur over a longer period of time but that primary care can in the interim achieve other measureable outcomes as mentioned.

Again, the AAFP wants to thank the work group for this important white paper that highlights the principles and recommendations that will be the structure of the Primary Care Payment Models. We thank you for the opportunity to provide input that will help define the next stage of development of this model. It is through the dedicated work of the LAN Guiding Committee with the PCPM Work Group that practical recommendations may be considered for the alignment of payment approaches across and within private and public sectors. Please do not hesitate to call upon the AAFP for assistance.

For additional information, please contact Karen Breitkreutz, Delivery System Strategist at 913-906-6000 extension, 4162 or kbreitkreutz@aafp.org.

Sincerely,

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