AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

October 12, 2016

Physician-Focused Payment Model Technical Advisory Committee (PTAC)
c/o Scott R. Smith, Director, Division of Healthcare Qualities and Outcomes
Assistant Secretary for Planning and Evaluation (ASPE)
U.S. Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

Dear Members of the PTAC and Mr. Smith:

On behalf of the American Academy of Family Physicians (AAFP), which represents 124,900 family physicians and medical students across the country, I write in response to the Characteristics of Payment Models Likely to be Recommended by the PTAC and the Request for Proposals (RFP) documents that are open for public comment on the Assistant Secretary for Planning and Evaluation website.

The AAFP appreciates that the PTAC is dedicated to establishing a transparent set of processes and operations that encourage physicians to submit Physician Focused Payment Models (PFPM) and allow for incorporation of feedback from stakeholders. We continue to believe that the PTAC will play a vital role in the development of PFPMs and the PTAC will have a strong influence on the identification of Advanced Alternative Payment Models (AAPMs), including models that are primary care focused. Primary care-based APMs are foundational to transforming our health care system by placing patients at the center, and connecting and coordinating all of their care. We strongly encourage the development of more primary care AAPMs in the future – and look forward to working with the PTAC and CMS to ensure all Medicare beneficiaries have access to continuous, coordinated, first contact, comprehensive, and patient-centered primary care

Characteristics of Payment Models Likely to be Recommended by the PTAC

In general, the AAFP supports the nine criteria outlined in the PFPM proposal requirement document, as a primary-care APM would "score" well on all dimensions. However, we are very disappointed that a characteristic of a payment model does not include a criterion that, first and foremost, PFPMs be primary care-centered. PFPM criteria should place an emphasis on being primary care centered, but if not, at a minimum, specialty focused APMs should demonstrate how they will coordinate with primary care physicians. Primary care is (and must be) a critical – and foundational – component of the system wide transformation that the U.S. health care system is undergoing as providers and public and private payers test and implement value-based payment and care delivery models that aim to improve care, improve outcomes, and reduce costs. Primary care's value to patients and payers alike is well-documented in terms of its positive effects on costs, access, and quality in the U.S. and numerous other health systems. Specifically, primary care helps prevent illness and death,

and it is associated with a more equitable distribution of health in populations.[1] Primary care is also related to enhanced access to healthcare services and better health outcomes, as well as lower costs through changes in utilization such as lower rates of hospitalization and use of emergency department visits.[2] Last, primary care is associated with positive impacts on individual and population level health and cost outcomes, because it preserves a holistic view of the patient, who is much more than a set of organ systems and disease conditions. Primary care's goal is to ensure that medicine does not lose sight of the whole patient and the patient's context, which affects a range of health outcomes. The AAFP offers a number of modifications to the proposed PTAC criteria that we believe would support the delivery of comprehensive, longitudinal care for patients - and promote quality over volume.

Patient-Centered Care Models

Moving to a value-based health care system in a sustainable way requires transitioning away from a model of symptom and illness based episodic care to a system of comprehensive coordinated primary care for children, youth and adults. The PTAC should not promote efforts to replace fragmented care under fee-for-service with fragmented care under APMs. The intent and characteristics of APMs should be to promote the delivery of comprehensive, coordinated, and patient-centered care. Therefore, we caution the PTAC to not needlessly fragment care through a plethora of condition-focused APMs. Instead, a fundamental characteristic of all APMs should be to be patient-centered, and there is ample evidence that primary care-oriented health systems are more effective, more efficient, and yield better outcomes for patients than systems that are not.

If the PTAC considers creating condition-focused APMs, then the AAFP strongly urges these APMs be required to initiate contact with the primary care physicians serving Medicare patients in that geographic area, so patients receiving care through a condition-focused APM are also connected with their primary care physician and continue to receive high-quality, coordinated, first contact, comprehensive, and patient-centered care. Similar to when a patient is admitted to the hospital and asked who their primary care physician is for purposes of the discharge summary, the condition-focused APM should ask their patients who their primary care physician is in order to facilitate proper communication. Primary care physicians are best suited to lead a team of professionals dedicated to providing proactive, preventive, and chronic care management through all stages of a patient's life.

Primary Care Focus and Orientation

Since there is ample evidence that health systems that are more primary care oriented are more effective, more efficient, and yield better outcomes than those that are not, the first characteristic for an APM or PFPM to be recommended should be "How primary care oriented or focused is the proposed model?" That is, to what extent is the proposed APM or PFPM based on first contact, comprehensive, continuous, coordinated, and connected primary care, and to what extent does it encourage treatment on an ambulatory basis rather than in a costly institutional setting? If it is physician-led and primary care-oriented, it should do both of these things.

Equally important would be to assess to what extent does the proposed PFPM use medical homes expanded under section 1115A(c) and to prioritize consideration of such proposals. The AAFP

[11] Starfield, B., Shi, L., Macinko, J. 2005. Contribution of Primary Care to Health Systems and Health. Milbank Quarterly, 83, 3, 457-502.
[2] Shi, L. 2012. The Impact of Primary Care: A Focused Review. *Scientifica.*

believes that an advanced primary care practice is one that incorporates the core functions of the Joint Principles of the Patient-Centered Medical Home and essential five functions of the Comprehensive Primary Care Plus (CPC+) initiative.

We strongly believe the PTAC should evaluate all PFPMs, including condition-focused APMs and PFPMs, using the same criteria and the PTAC must focus on and promote the development of sustainable primary care models. The criteria for any condition-focused PFPM should include its connection to and integration with a primary care model.

Prospective Attribution and Financial Risk
Another characteristic that we believe may support the PTAC recommendation of a proposed PFPM is that, where applicable, patient attribution must be prospective rather than retrospective. Prospective attribution is preferable, because it allows physicians to know up front for which patients they will be responsible under the payment model. Prospective attribution is critical for proactive care management and patient engagement – but will be especially important for those PFPMs that are risk-bearing.

Barriers in Current Payment System
We support the PTAC's intent to examine the extent to which the payment model differs from the physician fee schedule (i.e. fee-for-service) As has been observed, "Fee-for-service, the predominant physician payment scheme, has contributed to both the continuing decline in the primary care workforce and the capability to serve patients well." Fee-for-service is a significant part of the problem that APMs are designed to solve. PFPMs that continue to rely on fee-for-service have little chance of success, in our opinion. We believe the goal of APMs, especially PFPMs, should be to eliminate fee-for-service as a baseline formula. The less fee-for-service involved in the model, the better. The AAFP recommends that the PTAC expand Criterion 3 to call on proposed PFPMs to address the need for risk-adjusted payments or risk-stratified payments to ensure that provider performance is fairly assessed and patients' needs are fully met. From our perspective, the ideal primary care PFPM would involve a per-member per-month global payment for direct, face-to-face services plus a separate, capitated care management fee for care coordination, which is typically not face-to-face. Both payments should be risk-stratified based on patient complexity (e.g. comorbidities, cognitive impairment, self-care ability as measured by activities of daily living), patient demographics (e.g. age, gender), and other factors, such as sociodemographic factors that are social determinants of health.

Risk Adjustment and Stratification
In this context, we also believe the PTAC should more explicitly include criteria on appropriate risk adjustment or risk stratification of payments. We believe that payments should be risk-stratified based on patient complexity (e.g. comorbidities, cognitive impairment, self-care ability as measured by activities of daily living), patient demographics (e.g. age, gender), and other factors, such as sociodemographic factors that are social determinants of health. The AAFP recommends that the PTAC expand Criterion 3 to call on proposed PFPMs to address the need for risk adjusted payments or risk-stratified payments to ensure that provider performance is fairly assessed and patients' needs are fully met.

Clinician Performance and Patient Experience Measures
The second criterion – "Promoting Quality and Value" – is critical, and assessing clinician performance through appropriate quality and resource use measures is necessary to achieve these goals. AAFP recommends the PTAC place an emphasis on the use of the Core Measures

Collaborative's PCMH/Accountable Care Organization (ACO)/Primary Care Core Set. Key stakeholders of this Collaborative include the Centers for Medicare & Medicaid Services (CMS), America's Health Insurance Plans (AHIP), other health plans, and clinician, consumer, and employer groups. This important effort uses a multi-stakeholder process to define core measure sets and thus promotes alignment and harmonization of measure use and data collection across public and private payers. This process recognizes high-value, high-impact, evidence-based measures that promote better patient health outcomes. It also provides useful information for clinical improvements, decision-making, and payment. Additionally, it aims to reduce the burden of measurement and volume of measures by eliminating low-value metrics, redundancies, and inconsistencies in measure specifications and reporting requirements across payers. The Collaborative uses an iterative process that always seeks to include better and more desirable measures to meet these goals of the Triple Aim. The latest and most-updated version of the PCMH/ACO/Primary Care Core Set should always be used in this model.

Total Cost of Care
We support the PTAC's consideration of how a PFPM may impact the total of care. Family physicians and other primary care clinicians can be responsible for the management of the total cost of care as long as they have access to real-time quality and cost information and resources needed to monitor all cost. Data provided to primary care physicians should include information on all services provided by other physicians, hospital, post-acute care facilities, laboratory services; as well as spending on pharmaceuticals, biologics, and durable medical equipment. The PTAC should consider the ability to assess total cost of care across PFPMs given that patient attribution to multiple APMs or PFPMs could make appropriately assigning the cost of their care to those responsible more difficult.

Request for Proposals (RFP)
The AAFP reviewed the nine criteria outlined in the Proposal Information Requirements and Request for Proposals documents and find them both straightforward and supportable. The proposed timeline for reviewing proposals seems protracted, but we recognize and appreciate that the PTAC is proposing a transparent process that incorporates public input on proposed models.

We continue to support the creation of advanced APM and PFPM options being available for physicians to move out of the Merit-Based Incentive Payment System (MIPS) successfully and quickly. We continue to believe that the PTAC is in a position to assist physician groups, stakeholders, and CMS with moving physicians out of MIPS and into APMs. We see PTAC as an important part of the process and encourage CMS and stakeholders to be responsive to the committee's recommendations.

We appreciate the opportunity to comment and make ourselves available for any questions you might have. Please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org.

Sincerely,

Wanda D. Filer, MD, MBA, FAAFP
Board Chair