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Senior Vice President, Performance Measurement and Improvement
Blue Cross Blue Shield of Massachusetts

Glenn Steele, Jr., MD, PhD
Chair, xG Health Solutions, Inc.
Population-Based Payment Work Group Co-Chairs
Submitted via website

Dear Ms. Safran and Dr. Steele,

On behalf of the American Academy of Family Physicians (AAFP), which represents 120,900 family physicians and medical students across the country, I write to share the AAFP's support for and, comments about, the Accelerating and Aligning Population-Based Payment Models: Patient Attribution draft white paper created by the Population-Based Payment (PBP) Work Group. Overall, the AAFP is supportive of the white paper since clearly defined and effective models of patient attribution are essential for implementing PBP Models under which providers accept accountability for a patient population across the continuum of care.

The AAFP appreciates the workgroup's effort to summarize the benefits of patient attribution and agrees the patient-provider health care relationship is a foundational component of PBP models. We agree using claims-based data is reasonable as it is generally easy to obtain. We urge the workgroup to be mindful that for many primary care physicians (PCP), their perspective on attribution is simply asking who is my patient and who is not my patient. Physicians with this perspective may, initially, be resistant to complicated and retrospective efforts that use data for attribution purposes.

With respect to the language that primary care providers "can include traditional primary care specialties or other providers who accept accountability for coordinating the patient's overall care", the AAFP encourages the workgroup to specifically define situations where a specialty care provider can treat patients like a PCP and articulate services that define a PCP. Without clear definitions, specialists may inappropriately claim they are providing primary care services. It is the AAFP's position that the contributions of physicians who deliver some services usually found within the scope of primary care practice may be important to specific patient needs. However, the absence of a full scope of training in primary care requires that these individuals work in close consultation with fully-trained, primary care physicians. An effective system of

primary care may utilize these physicians as members of the health care team with a primary care physician maintaining responsibility for the function of the health care team and the comprehensive, ongoing health care of the patient.

Population-Based Payment Model Adoption
The AAFP shares the LAN's desire to drive payment approaches that improve the quality and safety of care, and the overall performance and sustainability of the U.S. health system. In particular, the AAFP supports the patient-centered medical home, which is a transition away from a model of symptom and illness based episodic care to a system of comprehensive coordinated primary care for children, youth and adults. Patient centeredness refers to an ongoing, active partnership with a personal primary care physician who leads a team of professionals dedicated to providing proactive, preventive and chronic care management through all stages of life. These personal physicians are responsible for the patient's coordination of care across all health care systems facilitated by registries, information technology, health information exchanges, and other means to ensure patients receive care when and where they need it. With a commitment to continuous quality improvement, care teams utilize evidence-based medicine and clinical decision support tools that guide decision making as well as ensure that patients and their families have the education and support to actively participate in their own care. Payment appropriately recognizes and incorporates the value of the care teams, non-direct patient care, and quality improvement provided in a patient-centered medical home.

The AAFP agrees with the benefits of attribution for patients, yet is concerned with a lack of current evidence to support the white paper's statement, "Patients have an increased likelihood of attaining health goals in a PBP model." One weakness of the population-based payment model is a PCP's lack of control over the inappropriate utilization of specialty and ancillary services. While patient freedom of choice is important, the model as it currently exists minimizes the accountable primary care physician's opportunity to manage overall cost of care.

Recommendations
With regard to the workgroup's recommendation that the guidelines be adopted by commercial insurers, and when possible, government programs, the AAFP supports and strongly encourages public and private payer alignment. For each of the white paper's recommended methods, the AAFP strongly encourages the inclusion of a simple, transparent appeals process to allow providers the opportunity to decline a patient based on his or her utilization patterns. The AAFP offers the following comments on particular recommendations within the white paper:

1. **Encourage patient choice of a primary care provider:** The AAFP strongly agrees the patient selection of a primary care physician is the ideal method of attribution. The AAFP encourages the workgroup to consider the need for public education regarding the value of selecting and establishing a continued relationship with a primary care physician as it relates to improved quality of care. The AAFP also recommends a process to allow the patient to change his or her physician in the event the provider leaves the medical group or accountable care organization (ACO) for another group or ACO.
2. **Use a claims/encounter based approach when patient attestation is not available:** The AAFP fully supports the workgroup's recommendation.
3. **Define providers at the beginning of the performance period**: This recommendation appears to be in support of prospective attribution rather than retrospective attribution. If so, the AAFP fully concurs with and supports this recommendation and strongly urges the workgroup be more explicit on this point – patient attribution must be prospective if at

all possible. We also recommend the inclusion of the phrase “If a primary care provider cannot be identified...” for each option presented for identifying an eligible provider. The AAFP recommends physician assistants, nurse practitioners, and other providers be listed as primary care providers only if they actively provide the same services as a primary care physician and are not restricted to urgent, retail, or specialty services. They should provide these services in collaborative teams in which the ultimate responsibility for the patient resides with the primary care physician.

4. **Provide transparent information to patients about their attribution:** The AAFP fully agrees with the workgroup’s recommendation and suggests adding a simple process to allow a patient to change his or her assigned primary care provider. If the ideal attribution methodology is to allow the patient to prospectively select his or her provider, he or she should be allowed to initiate a change in the event the primary care provider is assigned based on services provided.
5. **Prioritize primary care providers in claims / encounter-based attribution:** It is unclear in this recommendation if one E&M code for a wellness visit during a look back period would override multiple E&M codes for other primary care services. The AAFP recommends assigning more weight to a number of services provided over time by a single provider. The AAFP also recommends a 24-month look back period over an 18-month period. In addition, the AAFP cautions the Work Group to consider the impact of retail clinics, telemedicine-only practices, and urgent care clinics on claims / encounter-based attribution. Patients should not be attributed to these care settings and algorithms should be designed with these exclusions to attribution.
6. **Consider subspecialty providers if no primary care encounters are evident**: As this recommendation assumes the patient is not receiving primary care services from the subspecialty provider, the AAFP strongly recommends the patient be assigned a primary care physician or provider. The AAFP supports Figure 3: Patient Attribution Flow Chart and is encouraged to see the inclusion of patient verification for all attribution methods not initiated by the patient as this step is not included in the recommendations narrative. The AAFP requests the workgroup consider providing a simple process for the patient to change the provider to whom he or she was attributed.
7. **Use a single approach for attribution for performance measurement and financial accountability:** The AAFP supports the alignment of attribution for performance measurement and financial accountability.
8. **Use the patient attribution guideline nationally for commercial products:** The AAFP supports this recommendation in the spirit of alignment and reduced administrative burden.
9. **Alignment among commercial, Medicare, and Medicaid populations may be possible with adjustments:** The AAFP agrees with this recommendation and requests the workgroup consider including privatized Medicare and Medicaid plans such as Medicare Advantage and Medicaid Managed Care Organizations. Regarding Figure 5. Comparison of the PBP Work Group Recommendations with CMS Program Approaches to Attribution, the AAFP supports this figure as an effective method to communicate the recommendations. The figure should also include a definition for the term, “plurality of primary care.”
10. **Regardless of whether prospective or concurrent attribution is used, providers should receive clear, actionable information about patients attributed to them:** As a point of clarification, the AAFP recommends moving the definition of “prospective” and “concurrent” to the beginning of this section or earlier in the paper. The AAFP also supports the idea the provider should know in real time which patients they are accountable for and the expected time period for management. This patient information

should be prospective to allow for appropriate planning. If a concurrent attribution method is used, consideration should be given to the frequency of adding or removing patients from a provider's attribution list as well as the patient's preference of providers. While the ability to add or remove patients based on usage patterns is attractive, such potential instability could make it difficult for providers to effectively allocate resources and manage overall cost of care.

In the results of the Blue Cross Blue Shield of Massachusetts demonstration, 24.3 percent of patients were left unattributed. As the workgroup considers this topic further, we encourage the workgroup to explore recommendations to determine the proper attribution of these patients. While one may assume these patients were not engaged in their healthcare due to the absence of claims during the look back period, these patients also represent an opportunity for improved patient selection of a primary care provider. These patients represent the need for patient education on the importance of primary care and the value of a patient – primary care physician relationship. But absent such patient choice, they should be assigned to a primary care physician in a prospective manner.

We thank you for the opportunity to provide these comments and suggestions on the Patient Attribution draft white paper and we look forward to working further with the workgroup on this subject. Should you have questions please contact Kristen Stine, Practice Transformation Strategist, Center for Quality, at kstine@aafp.org or (913) 906-6000, ext. 4164.

Sincerely,

Robert L. Wergin, MD, FAAFP
Board Chair