# Advanced Primary Care:
## A Foundational Alternative Payment Model (APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care


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The U.S. health care system is undergoing an intense period of transformation as physicians, along with public and private payers, test and implement value-based payment and care delivery models that aim to improve care and outcomes, and reduce costs. Most recently, passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) has accelerated this movement to value by providing payment incentives to move physicians into alternative payment models (APMs) that aim to improve quality for patients while also reducing costs.

Primary care is (and must be) a critical and foundational component of this system-wide transformation. Its 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 associated with enhanced access to health care services and better health outcomes, as well as lower costs through changes in utilization, such as lower rates of hospitalization and emergency department visits.[2] Lastly, primary care is associated with positive impacts on individuals—as well as 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. The goal of primary care is to ensure that medicine does not lose sight of the whole patient and the patient's context, which affects a wide range of health outcomes.

There is an emerging consensus that strengthening primary care is imperative to improving individual and population health outcomes and restraining health care spending growth. The evidence supports increasing the ability of physicians to deliver primary care functions, and reorienting health systems to emphasize delivery of primary care can help accomplish these goals.[3] Accordingly, public and private payers are investing in enhanced primary care models through multiple efforts. While there are numerous efforts underway, some of the most well documented and studied include:

- Center for Medicare and Medicaid Innovation's (CMMI) Comprehensive Primary Care Plus (CPC+) and original Comprehensive Primary Care (CPC) initiatives;
- CareFirst BlueCross BlueShield's Patient-Centered Medical Home (PCMH) Program;
- Blue Cross Blue Shield of Michigan's Physician Group Incentive Program (PGIP); and
- Anthem's Enhanced Personal Health Care Program (EPHC).

These initiatives are showing a broad range of outcomes, including improved quality and/or cost savings.[4,5,6,7]

In sum, there is wide agreement on the need to reorient our health care system to one that is built on primary care. Aspirational words such as 'patient-centered' and 'whole person' care have returned to the health policy vernacular. Meanwhile, primary care physicians have begun to shift their infrastructure and workforce to achieve better coordination of care and integration of health information from a growing variety of data sources.

Primary care is comprehensive, continuous, coordinated, connected, and accessible through a patient's first contact with the health system, as well as being patient centered. In fact, among the American Academy of Family Physicians' (AAFP) clinically active members, 45 percent already work in an officially recognized PCMH. The AAFP calls this advanced primary care through the medical home model, and it is foundational to an efficient and effective health care delivery system.

In this position paper, the AAFP presents an advanced alternative payment model (APM) for primary care we believe is transformational to improving the health care system by placing patients at the center and connecting all of their care.

## Definition and Recognition of Primary Care Medical Homes

*Definition*

The AAFP defines a primary care medical home as one that is based on the Joint Principles of the Patient-Centered Medical Home (PCMH)[8] and has adopted the five key functions of the Comprehensive Primary Care Plus (CPC+) Initiative.[9] The key functions are:

**1. Access and Continuity**

Primary care medical homes optimize continuity and timely, 24/7 first contact access to care supported by the medical record. Practices track continuity of care by physician or panel.

**2. Planned Care and Population Health**

Primary care medical homes proactively assess their patients to determine their needs and provide appropriate and timely chronic and preventive care, including medication management and review. Physicians develop a personalized plan of care for high-risk patients and use team-based approaches to meet patient needs efficiently.

**3. Care Management**

Primary care medical homes empanel and risk stratify their whole practice population and implement care management for patients with high needs. Care management has benefits for all patients, but patients with serious or multiple medical conditions benefit more significantly due to their needs for extra support to ensure they are getting the medical care and/or medications they need.

**4. Patient and Caregiver Engagement**

Primary care medical homes engage patients and their families in decision-making in all aspects of care. Such practices also integrate into their usual care both culturally competent self-management support and the use of decision aids for preference sensitive conditions.

**5. Comprehensiveness and Coordination**

Primary care is the first point of contact for many patients, and therefore is the center of patients' experiences with health care. As a result, primary care is best positioned to coordinate care across settings and among physicians in most cases. Primary care medical homes work closely with patients' other health care providers to coordinate and manage care transitions, referrals, and information exchange.

The AAFP considers these five key functions equally important to delivering primary care. These functions depend on the support of enhanced and prospective accountable payments, continuous quality improvement driven by data, and optimal use of health information technology, including a certified electronic health record (EHR) with a data registry or repository capability. Annual requirements should guide the development of—and build the capability to—deliver these five functions in a primary care medical home.

*Recognition*

The AAFP supports attestation, accompanied by an evaluation process that is driven by practice performance, as the method for recognizing whether a practice meets the threshold requirements for a medical home. A practice would attest to achievement of those requirements, similar to those used in the CPC+ Initiative. The reporting would be on a quarterly to annual basis, depending on the particular requirements being reported and the evolution of the practice. Practices that are more advanced may have fewer reporting requirements than those at earlier stages on the transformation continuum. The quality, patient experience, and utilization data practices report should be harmonized across all payers, consistent with the work of the Core Quality Measure Collaborative, and serve to validate whether a practice is delivering the performance to which it attests.

The AAFP strongly believes a physician should not be required to pay a third-party accrediting body to receive recognition as a medical home. The measure of medical home status by an accrediting body may not precisely capture actual improved functionality of primary care.

## Attribution Methodology

Patient attribution methodology is critical to payment, quality and cost performance measurement, and defining accountability in a primary care medical home. A reliable, prospective, and transparent attribution method is important for the payer, the physician, and the patient. With a fine-tuned attribution process, a payer knows they are providing payment for enhanced services to the correct physician for the correct patient population. Physicians know they are receiving payment for the appropriate patients, and are assured they know who they are accountable to in terms of quality and cost. Accurate attribution may also help patients understand the importance of their relationship with their primary care physician, and the need to include the physician in the patient's decisions about anything that impacts their health care, such as when and how to seek medical care or even lifestyle choices that will affect their health.

The AAFP recommends a patient-based, prospective, four-step process that includes a 24-month look-back period for attribution. Patients attributed through this process should be the focus of payment and performance measurement under the recommended payment model. A prospective methodology allows physicians to know for whom they are responsible in advance and facilitates proactive care planning and management. Similar to the CPC+ Initiative, payers should attribute patients on a quarterly basis. For attribution purposes, a primary care physician should be defined as a physician who is in a family medicine, general internal medicine, geriatric medicine, general pediatrics, or general practice setting.

*The Four-Step Attribution Process*

**1. Patient Selection of Primary Care Physician and Team**

- This is the acknowledgement that patient selection is the best choice in attribution and should be prioritized as such.

**2. Primary Care Visit Events: Wellness Visits**

- If a patient is not attributed by self-selection of a primary care physician, payers should use well visits, including Welcome to Medicare, physicals, and Annual Wellness Visits provided by the patient's primary care physician or the practice team, as the next step in the attribution process.

**3. Primary Care Visit Events: All Other E/M Visits**

- If a patient is not attributed by a wellness visit, the next incremental step is to include all other evaluation and management (E/M) visits to a primary care physician. The payer should attribute the patient to the primary care physician who provides the plurality of E/M visits.

**4. Primary Care Prescription and Order Events**

- If the patient is not attributed by a wellness visit or any other E/M services, payers should consider claims related to medication prescriptions, durable medical equipment prescriptions, and lab and other referral orders made by primary care physicians. Payers should require a minimum of three such events before attributing a patient on this basis.

*Please see table on the next page.*

| Step in Process | Event Type | Eligible Procedure or Event | Look-back Period | Assignment Criteria | Minimum Threshold for Assignment | In Event of a Tie |
|---|---|---|---|---|---|---|
| Step 1 | Patient Selection of Primary Care Physician | N/A | N/A | N/A | N/A | N/A |
| Step 2 | Primary Care Visits: Wellness Visits | Well Visit E/M and Select G Codes Only | 24 months | Plurality | 1 visit | Most recent visit |
| Step 3 | Primary Care Visits: All Other E/M Visits | Any E/M Codes | 24 months | Plurality | 1 visit | Most recent visit |
| Step 4 | Primary Care Prescriptions and Order Events | Any Rx code; claims related to medication prescriptions, durable medical equipment, and lab and referral orders | 24 months | Plurality | 3 events | Most recent event |

*Review and Reconciliation of Attributed Patients*

No patient attribution methodology is perfect. The four-step methodology recommended above may still produce errors in assignment. Physicians should have the option to engage in a reconciliation process in which they can review, add, and remove patients from the formal list the payer supplies to them. Like the attribution process, review and reconciliation should occur quarterly and include enough time to adequately review the list.

## Payment

Fee-for-service (FFS) payment systems create impediments to medical homes achieving the Triple Aim of cost effective care that improves both the patient experience and the health of the population. One study suggests that only 55% of adult patients receive recommended care.[11] Under a FFS payment system, physicians often provide time-intensive services such as counseling, patient education, screening, and preventive medicine at a decreased level of efficiency, because total payment (i.e. revenue) is based on the overall volume of services.[10] Likewise, temporal and financial constraints of a FFS system encourage primary care physicians to order diagnostic testing or refer to sub-specialists, which often increases the cost of care without necessarily improving either patient satisfaction or the health of the population.[12] Finally, FFS payments often do not compensate key functions of a primary care medical home, such as planned care for chronic conditions and coordination of care across the medical neighborhood.

The Medicare Payment Advisory Commission (MedPAC) and others share this view of the impediments to advanced primary care posed by FFS payment. For instance, in its March 2016 report to Congress on Medicare payment policy, MedPAC stated, "The Commission remains concerned that the [Medicare physician] fee schedule and the nature of FFS payment leads to an undervaluing of primary care and overvaluing of specialty care."

MedPAC also stated, "The Commission has also become concerned that the fee schedule is an ill-suited payment mechanism for primary care."[13] Accordingly, MedPAC has recommended Congress establish a per beneficiary payment for primary care.

MedPAC further noted, "The [FFS] fee schedule is oriented toward discrete services and procedures that have a definite beginning and end. In contrast, ideally, primary care services are oriented toward ongoing, non-face-to-face care coordination for a panel of patients. Some patients in the panel will require the coordination of only preventive and maintenance services. Others will have multiple complex chronic conditions and will require extensive care coordination."[13]

MedPAC observed that FFS is not well designed to support these types of activities.[13]

As noted, the key functions of a medical home depend on enhanced, prospective, and accountable payment. Accordingly, the AAFP recommends a payment method for primary care medical homes that will compensate them for care not captured through traditional FFS billing, and empower them to commit temporal and supportive resources to their patients, particularly those of high complexity.

Specifically, the AAFP recommends an APM that includes a primary care global payment for direct patient care, a care management fee, and FFS payments limited to services not otherwise included in the primary care global fee—coupled with 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. The CPC+ performance-based incentive payment is an example of such a payment mechanism. Commercial payers are also showing the value of investing in enhanced, prospective payments that include mechanisms for accountability.

The AAFP's proposal and those put forth by others place an increased emphasis on the important role primary care plays in ensuring our health care system delivers low-cost, efficient health care. The expectations placed on modern primary care practices to transform workflows; invest in new technology; provide extended services beyond traditional face-to-face encounters; and manage populations of patients are all achievable, and primary care is positioned to deliver these objectives. However, it is unreasonable to ask primary care to do so when the overall payment structure continues to be based on a model that woefully underinvests in primary care.

The current FFS system and its payment levels for primary care are inadequate on every level. Our health care system should pay for what it truly values. As articulated by the current fee schedule, we do not value primary care. This proposal places a marker in the ground for how primary care should be paid differently and better to deliver an advanced level of care and services to every American. In return, it is essential that payment levels be dramatically increased to ensure this transformation is possible and sustainable over time. Extending current payment levels into this new delivery model would be a tragedy and disservice to our health care system and every patient.

*Primary Care Global*

Primary care practices should be able to elect one of two levels of prospective primary care global payment to allow primary care physicians to move toward a more fully capitated payment arrangement at a reasonable pace for their particular practice to eventually replace FFS for face-to-face care/visits. The two levels of primary care global payment would be defined as follows:

- Level 1: Ambulatory, office-based, face-to-face evaluation, and management (E/M) services
- Level 2: All E/M services regardless of site of service

At either level, all other services, including all non-E/M services, would continue to be billed and paid based on the current FFS payment model. Primary care global payments under both level one and level two should be risk stratified based on patient complexity (including social determinants of health) and other factors.

*Care Management Fee*

Primary care practices should receive a separate, risk-stratified care management fee for each of their patients. This capitated fee should be calculated and paid prospectively on a monthly basis (or at least quarterly), and it should be without risk to the physician and free of patient cost sharing. The care management fee should also be risk stratified based on the patient's complexity level and other factors (including social determinants of health). Assessments of quality and cost-effective care should later determine eligibility of the physician to continue receiving care compensation under this payment model, which is consistent with how the AAFP envisions the validation of attestation as a primary care medical home.

*Risk Stratification*

As noted, both the primary care global fee and the care management fee 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. Patient complexity certainly is multifactorial, but it is essential to define it as precisely as possible in order to allow for an ordered and thorough evaluation of each patient. One suggested approach that could be applied in practice would define complexity as "interference with standard care and decision making by diagnostic uncertainty, system severity, impairments, lack of social safety, lack of participation, difficulty engaging care, disorganized care, and difficult patient-clinician relationships."[14]

In practice, the Minnesota Complexity Assessment Method, (which modifies earlier work)[14] specifies certain domains for assessment of patient complexity that includes illness, readiness (to engage treatment), social, health system, and resources for care. This allows clinicians to assess patient complexity and identify areas of intervention.[14]

The AAFP believes this tool represents the best approach to assess complexity that is not captured through a review of disease burden, and it can better direct care teams in patient management. Therefore, the AAFP recommends the use of the Minnesota Complexity Assessment Method to risk stratify the primary care global payment and the care management fee on an annual basis. Under this tool, patients can be classified as being of low, medium, or high complexity, and payment under the primary care global fee and care management fee should be stratified accordingly.

The AAFP believes a risk-stratified, two-level option for the primary care global fee would allow medical homes of various capacities to participate and encourage the move to a more robust care provision. Coupled with a risk-stratified, population-based payment, this payment model empowers medical homes to manage patients efficiently, manage health care costs, and dedicate the time for adequate screening, preventive care, patient education, robust care coordination, and social services that contribute to cost-effective care that improves both the patient experience and the health of the population (i.e. the Triple Aim).

Operational dollars would alleviate the constraints imposed by the current FFS approach by providing such practices with more freedom to manage their patient panels independent of the face-to-face visit model. This approach would allow such practices

to diversify available resources to better manage ancillary care needs and provide other services that yield improved, cost-effective care. The ultimate goal of such payment reform should be a global payment, which combines the primary care global and care management payments into a single, risk-adjusted global payment for medical homes (with additional FFS payment for services outside the defined services to be included in this combined fee, along with the additional payment for quality improvement).

## Quality Measurement

*Physician Performance and Patient Experience*

Under the AAFP's recommended payment model for advanced primary care, payers should assess a physician's quality and resource utilization using selected quality measures. The physician's performance on those same quality measures will also allow a payer to validate a practice's implementation of advanced primary care functions.

Performance measures selected for evaluation should consist of the Core Quality 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), the National Quality Forum (NQF), America's Health Insurance Plans (AHIP), other health plans, and physician, 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 the goals of the Triple Aim. Ideally, payments for primary care will be based on such an aligned set of comprehensive measures of primary care, rather than relying exclusively on a rigid set of disease-specific metrics. The latest and most-updated version of the PCMH/ACO/Primary Care Core Set should always be used in this model.

The PCMH/ACO/Primary Care Core Set includes clinical quality, patient safety, patient experience, and resource use measures using the National Quality Strategy as a guide. The core set includes various types of measures including: process, intermediate outcome, outcomes, and patient-reported outcome measures.

Regarding patient experience, the core set includes use of the Clinician and Groups Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) to evaluate patient experience. However, this assessment comes with great expense and is resource intensive, especially for smaller practices. Therefore, the Core Quality Measures Collaborative effort suggests payers provide the CAHPS survey at no cost to physician offices and their patients through an online process. This approach would remove the financial burden associated with CAHPS implementation to assess patient experience. The AAFP supports this approach.

*Primary Care Impact on Total Cost of Care*

A key goal of the movement to value-base care is to control the total cost of care of patients. Evaluation of any APM should consider if, and how, it impacts total cost of care—and whether the model can help control those costs across the care continuum. It is clear that greater investments in primary care are necessary to support the delivery of continuous, longitudinal, and comprehensive care across settings and providers. Given the central role that primary care would play in this construct, it is possible to assess an advanced APM on its ability to impact total cost of care—taking into consideration the relatively low spending on primary care compared to other specialties.

However, any reductions in total cost of care from investments in an advanced primary care APM would need to be assessed over the long term across the care continuum. Experts agree investments in primary care APMs cannot be "recouped" in the short term. However, other measures of utilization of services can help assess the impact of an advanced primary care APM on patient care and costs, such as reduced admissions and readmissions, reductions in duplicative or clinically unnecessary testing, and reduced medication-related complications. In the long term, advanced primary care practices with a sufficient number of patients and well-developed care coordination and management capabilities should be able to demonstrate impact on total cost of care. This is the goal for an advanced primary care APM, along with working in concert with the development of other specialty or condition-specific models, where appropriate.

*Risk Adjustment*

Like payment, physician performance outcomes, including total cost of care, should be adjusted for risk 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 determinants of health. These factors can influence performance outcomes regardless of the care provided. Risk stratification and risk adjustment should occur annually. This process enables a physician's performance to be adjusted appropriately for factors outside of their control.

*Baseline and Benchmarking*

The baseline for performance should be a set time period prior to the performance year. A fixed baseline is needed to assess improvement, so the incentive to improve is not undermined. Frequently updating the baseline weakens movement towards improvement, and undermines investments by physicians to improve the effectiveness of care delivery. Payers should hold the benchmarks steady for at least two years (if not longer) instead of reassessing after each performance year.

## Financing

The AAFP believes spending on primary care should be increased from current levels given the evidence that access to primary care is associated with improved individual and population health outcomes, and reduced costs. Today, primary care only represents approximately 6% of total spending on health care.[15] We believe this should be increased to at least 12% of total spending.[16] The AAFP believes that such an increase can be accomplished without an increase in the overall spending on health care. In fact, the AAFP believes increased spending on primary care will lead to a decrease in overall spending on a per patient basis.[16]

This belief is rooted in the experience of other Organization for Economic Cooperation and Development (OECD) countries. Most of those countries have health care systems where primary care is foundational, and their spending per capita is well below that of the United States. Within the U.S., Rhode Island mandated an increase in primary care spending from 5.4% to 8% between 2007 and 2011.[17] The Rhode Island Insurance Commissioner reported a 23% increase in primary care spending was associated with an 18% reduction in total spending—a 15-fold return on investment.[17] Last, Portland State University completed a 2016 study of Oregon's Patient Centered Primary Care Home (PCPCH) program and found every $1 increase in primary care expenditures as part of the PCPCH model resulted in $13 in savings in other health care services, including specialty, emergency room, and inpatient care.[18]

Public and private payers are investing in the advanced primary care model through multiple efforts. Such investments demonstrate the AAFP is not alone in its belief that appropriate financing of advanced primary care can pay dividends for payers, as well as patients.

With respect to business and practice transformation, primary care physicians will require financial and technical assistance to ensure their practices remain financially viable in advanced alternative payment models. Primary care physicians will also need enhanced training in methods to partner effectively with patients. Since primary care in advanced alternative payment models is a data-driven endeavor, primary care physicians will require considerable support with the data analytics that enable them to identify high-need patients, monitor and design comprehensive care plans, and make informed decisions at the point of care. Payers and other outside organizations (e.g., professional associations) will play a prominent role in providing support and technical assistance that focuses on these areas.

Finally, primary care physicians will need time to transform their practices. Primary care, by definition, is concerned with delivering patient-centered, longitudinal, and coordinated care, and changing such care delivery does not happen quickly.

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