May 25, 2018

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Administrator Verma,

On behalf of the American Academy of Family Physicians (AAFP), which represents 131,400 family physicians and medical students across the country, I write in response to the request for information on *Direct Provider Contracting Models* as solicited by the Center for Medicare and Medicaid Innovation within the Centers for Medicare & Medicaid Services (CMS) on April 23, 2018.

The AAFP appreciates the opportunity to comment on CMS' Direct Provider Contracting Models Request for Information. The AAFP would like to applaud CMS' continued focus on strengthening primary care for beneficiaries and bringing greater value to beneficiaries and the healthcare system.

Following passage of the *Medicare Access and CHIP Reauthorization Act* of 2015 (MACRA), the AAFP began designing a multi-payer, advanced primary care alternative payment model (APC-APM) that would allow all our members – regardless of practice size, geography, or capacity – to provide high-quality care to their patients. The APC-APM has been designed to improve quality and outcomes for Medicare beneficiaries – and to reduce costs for the program.

The AAFP's market-based, physician focused model aligns with CMS' overall goals for Direct Provider Contracting models and can support the delivery of patient-centered primary care regardless of where a patient lives. The APC-APM was designed based on nearly two decades of experience and feedback of the AAFP's members – including small and independent practices that have had limited opportunities to participate in previous Innovation Center models. Major areas of alignment between the AAFP's efforts to develop the APC-APM and CMS' goals in launching Direct Provider Contracting models include:

- Increasing Access. Direct Provider Contracting Models and the APC-APM seek to increase access to high-value, comprehensive primary care for beneficiaries by enhancing the physician-patient relationship, while promoting beneficiary choice and engagement.
- Reducing Administrative Burden. The APC-APM is designed to reduce administrative burden for all participating physicians – especially small and independent practices to ensure they can continue to serve their communities and patients. The model also seeks alignment across payers and populations.
- Providing Predictable Revenue Streams. The APC-APM payment model would provide practices stable, prospective revenue streams and performance-based payments that allow

physicians to flexibly meet the unique needs of their patients and to make the investments necessary to transform their practices, while fostering accountability.

The AAFP offers a number of recommendations in response to CMS' questions on how the agency can test and implement a Direct Provider Contracting model for primary care that improves quality and outcomes for beneficiaries, that reduces costs for Federal health programs – and reduces burden for physicians. Our recommendations are based on our extensive work developing the APC-APM model with our members and stakeholders and the feedback and development that occurred in 2017 with the Physician-Focused Payment Model Technical Advisory Committee (PTAC). We also have undertaken additional technical work to prepare for working with CMS to implement the model for testing.

Lastly, the AAFP would welcome the opportunity to offer our lessons learned and experience supporting our members' participation in a range of advanced primary care and multi-specialty models including Comprehensive Primary Care (CPC) classic, CPC+, Medicare Shared Savings Program Accountable Care Organizations (MSSP ACOs) as well as those participating in direct primary care to implement the APC-APM and its features. Family physicians conduct approximately one in five of the total medical office visits in the United States per year – more than any other specialty, and they serve patients in over 90% of counties nationwide. The AAFP would be pleased to be a resource to CMS to accomplish the shared goals outlined above.

Questions Related to Provider/State Participation

1. How can a DPC model be designed to attract a wide variety of practices, including small, independent practices, and/or physicians? Specifically, is it feasible or desirable for practices to be able to participate independently or, instead, through a convening organization such as an ACO, physician network, or other arrangement?

Model Design for Wide Variety of Practices

The AAFP believes it is possible to design an APM that a wide range of practices can participate in– regardless of size, geography, or organization. In turn this will also allow for a sufficient number of beneficiaries to participate in a model that is likely to lead to improved quality – and that can support evaluation of a model for its impacts on beneficiaries and the Medicare and Medicaid programs. This was a central goal of the AAFP's APC-APM - to expand primary care physicians' access to Advanced APMs – including small, independent, and rural practices. The model would allow primary care practices of all sizes and in any location to participate. The model builds on the existing CPC classic and CPC+ programs, moves further away from fee-for-service (FFS), better supports small and independent practices, and reduces administrative burden in the healthcare system. Advancing such a model would also support CMS' goals as outlined in the current RFI.

In our experience, models designed with smaller practices as the foundation can be scaled up for larger practices to successfully participate where the reverse is often not true. Therefore, the AAFP designed the APC-APM model with small, independent physician practices in mind. The model's prospective payments provide a predictable revenue stream for smaller practices to reliably make the necessary and sustainable investments in practice transformation.

Mechanisms for Practice Participation

CMS is also considering how a new model would interact with existing efforts, such as the ACO program. Regarding the APC-APM, the AAFP envisions practices within ACOs can participate in the

program, but practices will not be required to be part of a convening organization to participate. CMS should consider a similar approach in launching a Direct Provider Contracting model.

2. What features should CMS require practices to demonstrate in order for practices to be able to participate in a DPC model (e.g., use of certified EHR technology, certain organizational structure requirements, certain safeguards to ensure beneficiaries receive high quality and necessary care, minimum percent of revenue in similar arrangements, experience with patient enrollment, staffing and staff competencies, level of risk assumption, repayment/reserve requirements)? Should these features or requirements vary for those practices that are already part of similar arrangements with other payers versus those that are new to such arrangements? If so, please provide specific examples of features or requirements CMS should include in a DPC model and, if applicable, for which practice types.

Required Primary Care Practice/Care Delivery Features for Participation

It will be important to strike a balance between requirements that participating practices must meet in a new model, while ensuring that they do not impose undue burdens or barriers for practices and beneficiaries. CMS could consider the AAFP's approach with the APC-APM to guide the development of a primary-care focused model. The APC-APM would require practices to provide the five key functions defined in the AAFP's Medical Home policy, The five principles are based on the Joint Principles of the Patient-Centered Medical Home (PCMH) and the five key functions of the CPC+ Initiative: 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 advanced primary care – and has therefore proposed they be requirements for participation regardless of size or experience. Practices then have the flexibility to determine how they will meet these functions for their patients – without prescriptive requirements on staffing and other organizational decisions. 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). We believe that annual requirements should guide the development of—and build the capability to—deliver these five functions in a primary care medical home.

To minimize administrative burdens for participating practices and CMS, we recommend that CMS support attestation that practices are achieving these key functions (as in CPC+), accompanied by an evaluation process that is driven by practice performance to recognize whether a practice meets the threshold requirements and to ensure beneficiaries are receiving high-quality and necessary care. Reporting could occur on a quarterly to annual basis, depending on the requirements 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.

We also urge CMS to harmonize quality, patient experience, and utilization data practices report 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. Harmonization across practices can also reduce variation across sites.

Last, in the case of primary care models, AAFP strongly believes a physician practice should not be required to pay a third-party accrediting body to receive recognition as a medical home. This would also reduce unnecessary financial and administrative burden that does not improve or support the physician-patient relationship.

Organizational and Other Requirements

The AAFP recommends that CMS maintain flexibility on organizational requirements for participation in a primary care model to ensure a wide range of practices can participate. For instance, based on discussions with our members, we believe the APC-APM has broad applicability because it does not require practices to have experience assuming risk or particular organizational requirements. We believe that practices will evaluate their ability to participate based on how the model can support the care delivery goals outlined above, while being financially viable. Last, we outlined later in our response, we believe that a primary-care focused model should include a payment approach similar to the APC-APM that strengthens payment to primary care through stable, prospective revenue streams that allow practices to assess their ability to assume risk and attest to the functions outlined above.

3. What support would physicians and/or practices need from CMS to participate in a DPC model (e.g., technical assistance around health IT implementation, administrative workflow support)? What types of data (e.g., claims data for items and services furnished by non-DPC practice providers and suppliers, financial feedback reports for DPC practices) would physicians and/or practices need and with what frequency, and to support which specific activities? What types of support would practices need to effectively understand and utilize this data? How should CMS consider and/or address the initial upfront investment that physicians and practices bear when joining a new initiative?

Practice Supports

CMS has invested significant resources in helping practices participate in programs, such as CPC+, through initiatives such as Small, Underserved, and Rural Assistance Providers and Practice Transformation Networks. We believe these programs and service providers could be leveraged to

help support practices, especially small, independent practices, to participate in future payment models. The AAFP has also considered similar questions in determining practice needs to implement the APC-APM – especially small and independent practices that do not have as much experience with practice transformation and APMs. Technical assistance should provide resources and opportunities to help practices implement health IT, understand and fulfill care delivery requirements, and take advantage of opportunities for peer-to-peer learning through multiple formats (online platform, national/regional in person/virtual meetings).

Access to Timely Data

For practices to successfully participate in alternative payment models, they must have access to timely, accurate, and actionable patient data and feedback reports. Data from all patient interactions with the various healthcare system components is integral to allowing the primary care physician the ability to truly track and manage a patient's care. The data should include any service outside the assigned primary care practice, including services from specialty providers and in inpatient and outpatient settings. This data could come from claims data CMS already has. Financial and outcomes feedback reports should be available for physicians in a timelier fashion to allow for corrective action by the practice. For instance, members within CPC+ report that feedback reports to date have been inaccurate, making them unusable. Reports would ideally be available quarterly, but no less often than bi-annually. Additionally, it would be prudent for CMS to consider conducting training on how to read and use the feedback reports – like training provided for CPC+ participants.

Timeline for Practice Transformation

Advanced primary care practice transformation is a complex and deeply involved process that includes technical upgrades, cultural changes, workflow renovations, and community outreach. In our experiences, this transformation can take between 18 and 36 months. Practices will achieve modest improvements in the early stages of transformation, but the truly fundamental and long-term quality and performance improvements come after an extended time period of transformation activities. We believe that the final evaluation for the original CPC program will also help inform how long practice transformation can take, what types of support practices with varying levels of experience and organizational resources and structure require, and what improvements practices can demonstrate over time.

Upfront Investments

For a variety of reasons, primary care services remain undervalued. The AAFP asks CMS to consider increasing payments to primary care in any primary care Direct Provider Contracting model in order to address payment inequities. The APC-APM payment methodology is designed to increase the overall spend in primary care by providing practices a prospective, risk-adjusted, monthly payment that accurately reflects the patient population they serve. As mentioned above, the prospective payments provide a predictable revenue stream for practices to reliably make the necessary investments in practice transformation, regardless of size.

4. Which Medicaid State Plan and other Medicaid authorities do States require to implement DPC arrangements in their Medicaid programs? What supports or technical assistance would States need from CMS to establish DPC arrangements in Medicaid?

We support CMS' interest in creating a multi-payer Direct Provider Contracting model that also allows Medicaid providers to participate. According to AAFP data, nearly 70 percent of our members accept new Medicaid patients which demonstrates how family physicians share the Direct Provider

Contracting models goal of ensuring access. As a result, the AAFP's APC-APM model is multi-payer by design, including state Medicaid agencies and managed care organizations (MCOs) making it accessible to primary care physicians, regardless of where they are or their type of practice.

In considering the use of Medicaid Section 1115 waivers in particular, we ask CMS to examine joint principles developed by a group of six front-line physician organizations (AAFP, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Osteopathic Association, and American Psychiatric Association), representing more than 560,000 physicians and medical students. We believe these principles will guard against restricted access for beneficiaries and strongly urge CMS and Medicaid agencies to follow the standards set by these principles to prevent beneficiary harm and continuity of care in the launch of any new model. The AAFP stands ready to work with CMS to identify innovative strategies to strengthen Medicaid and improve the outcomes of the high-quality care it finances.

5. CMS is also interested in understanding the experience of physicians and practices that are currently entirely dedicated to direct primary care and/or DPC-type arrangements. For purposes of this question, direct primary care arrangements may include those arrangements where physicians or practices contract directly with patients for primary care services, arrangements where practices contract with a payer for a fixed primary care payment, or other arrangements. Please share information about: how your practice defines direct primary care; whether your practice ever participated in Medicare; whether your practice ever participated in any fee-for-service payment arrangements with third-party payers; how you made the transition to solely direct contracting arrangements (if applicable); and key lessons learned in moving away from fee-for-service entirely (if applicable).

The AAFP views Direct Primary Care as a model that gives family physicians a meaningful alternative to fee-for-service insurance billing. We have extensive experience in the development, implementation and evaluation of Direct Primary Care practices. We determined the best mechanism for addressing this question was through an addendum to this document. To this end, we have provided an extensive response to this question as an Addendum to this document.

Questions Related to Beneficiary Participation

6. Medicare FFS beneficiaries have freedom of choice of any Medicare provider or supplier, including under all current Innovation Center models. Given this, should there be limits under a DPC model on when a beneficiary can enroll or disenroll with a practice for the purposes of the model (while still retaining freedom of choice of provider or supplier even while enrolled in the DPC practice), or how frequently beneficiaries can change practices for the purposes of adjusting PBPM payments under the DPC model? If the practice is accountable for all or a portion of the total cost of care for a beneficiary, should there be a minimum enrollment period for a beneficiary? Under what circumstances, if any, should a provider or supplier be able to refuse to enroll or choose to disenroll a beneficiary?

Beneficiary Enrollment

We believe connecting patients to a primary care physician through patient choice is critical to driving patient engagement, establishing the physician-patient relationship, and ensuring patients are aware of the alternative payment model. Indeed, it is so critical that, in 2017, the California marketplace connected every enrollee to a primary care clinic within 60 days as a first point of contact and advocate. The intent is to reclaim the supportive role of primary care physicians as the preferred initial

point of entry into a complex care system, and we believe there is no better way to express that preference than through patient choice. The AAFP recommends that CMS ensure patient choice is a central feature of any primary care Direct Provider Contracting model.

The AAFP has examined issues related to beneficiary enrollment and attribution in the development of its APC-APM, where we recommend that patient choice drives participation in the model. The Health Care Payment Learning and Action Network released a white paper on patient attribution and its importance to value-based payment programs. They deemed patient self-attestation as the gold standard for attribution for population-based payments, which rely on primary care as the starting point to coordinate care across the continuum.

We also note that some private payers already use self-attestation or patient choice for attribution – and that this choice should be extended to Medicare and Medicaid beneficiaries as well. For example, Blue Cross Blue Shield of Massachusetts' Alternative Quality Contract uses self-attestation to attribute patients to a participating provider by requiring patients in their health maintenance and point-of-service plans to designate a primary care provider.

Role of Attribution

While patient choice is the gold standard for the APC-APM – and should be for a Direct Provider Contracting model – a secondary, claims-based attribution methodology may also be necessary to ensure a model is financially viable for participating practices. This would ensure that populations covered by participating payers would all benefit from such a model and that practices would have predictable payments to support population-based care and practice transformation. In the APC-APM, if patient self-attestation is not exercised or not possible, then other steps toward accurate attribution can be taken via an algorithm that includes a 24-month claims look-back period.

As with the CPC+ Initiative, attribution in a Direct Provider Contracting model, whether by patient choice or historic claims algorithm, should occur on a quarterly basis. Based on our members' experience, attribution, including review and reconciliation, should occur at a minimum of once a year. In any case, at the beginning of a performance period, practices should know which patients they are responsible for managing and the expected performance period.

Limits on Enrollment in a DPC Model

The AAFP supports beneficiary choice and freedom, but we understand that this must be balanced in an APC-APM type model that also places providers at risk for the quality and cost of the care FFS beneficiaries receive. We believe that patients that enroll in or are attributed to a Direct Provider Contracting or APC-APM practice should have incentives to receive their primary care services through that practice. We offer suggestions later in our responses (see question 7), including waiving primary care co-pays for enrolled or attributed beneficiaries if they visit their designated practice. We also offer suggestions on the performance measurement framework to guard against stinting of care. The AAFP would be pleased to be a resource to CMS as we continue to develop policy solutions to the issue of beneficiary enrollment and attribution in Medicare FFS.

7. What support do practices need to conduct outreach to their patients and enroll them under a DPC model? How much time would practices need to "ramp up" and how can CMS best facilitate the process? How should beneficiaries be incentivized to enroll? Is active enrollment sufficient to ensure beneficiary engagement? Should beneficiaries who have chosen to enroll in a practice under a DPC model be required to enter into an agreement with their DPC-participating health care provider, and, if so, would this provide a useful or sufficient mechanism for active beneficiary engagement, or should DPC providers be permitted to use additional beneficiary engagement incentives (e.g., nominal cash incentives, gift cards)? What other tools would be helpful for beneficiaries to become more engaged and active consumers of health care services together with their family members and caregivers (e.g., tools to access to their health information, mechanisms to provide feedback on patient experience)?

Beneficiary Engagement and Enrollment

The AAFP believes that practices must assume the primary responsibility for engaging their patients. Indeed, in a primary care model, patient and caregiver engagement is one of the five key functions of a medical home -and all practices would be expected to attest to these functions in the APC-APM. Recognizing this, the AAFP provides resources and journal articles to our members to facilitate this process – and we are ready to serve as a resource to CMS on these issues.

However, CMS can design a primary care model that has the potential to engage beneficiaries more actively in their care – and to support the physician-patient relationship through an active, patient-driven election process. Based on our experience designing the APC-APM, we believe there are multiple ways in which CMS can facilitate beneficiary engagement. One is to make patient choice the primary means of patient attribution, as we have noted. The intent is to reclaim the supportive role of primary care physicians as the preferred initial point of entry into a complex care system, and we believe there is no better way to express that preference than through patient choice.

CMS already provides beneficiaries with a mechanism to designate their primary clinician online, which could be adapted or used to help Medicare FFS beneficiaries enroll into – or designate - a primary care practice in an APC-APM type model. Fee-for-service beneficiaries can now log in to MyMedicare.gov and select the physician or other health care professional they believe is responsible for coordinating their overall care. We agree with CMS that this process, also known as voluntary alignment, will strengthen beneficiaries' engagement in their health care and empower clinicians to better coordinate care – and could also be a tool for practices to use in helping patients designate a primary care practice for their care. We urge CMS to minimize any burden on participating practices from any selection or enrollment processes.

Beneficiary Incentives

CMS can structure beneficiary cost-sharing in such a way that beneficiaries are encouraged to receive services through the primary care practice to which they have self-attributed. **Ideally, there should be no cost-sharing for primary care services provided by the beneficiary's designated primary care practice.**

In regard to other incentives that CMS notes in the question, we believe a primary care model should be designed to allow any practice to participate – and should not advantage those with more financial or other resources.

Additionally, as CMS contemplates how to protect Medicare beneficiaries from undue incentives to enroll in specific practices under any model, including the APC-APM, we encourage CMS to carefully consider the distinction between “incentives” and “services,” especially services intended to address social determinants of health. For instance, free transportation to the practice may, at first glance, appear to be an “incentive” to choose a practice, but for a patient with limited transportation options, that “incentive” is a valuable service that addresses a social determinant of his or her health and contributes to the care of that patient. CMS has recently expanded how it defines the "primarily health-related" benefits that insurers may include in their Medicare Advantage policies to make it easier for Medicare Advantage beneficiaries to lead healthier, more independent lives. We urge CMS to keep this concept in mind as it considers how it addresses its concerns about enrollment incentives.

Patient Experience

Measuring patient experience in a meaningful way for both patients and physicians can help drive engagement as well. CMS can facilitate the measurement of patient experience of care by moving away from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and toward more innovative, less administratively and financially burdensome concepts, such as the net promoter score.

Finally, we believe that the policy options noted above – if implemented together – would promote beneficiary engagement, and support the physician-patient relationship without undermining beneficiary freedom and choice.

8. The Medicare program, specifically Medicare Part B, has certain beneficiary cost-sharing requirements, including Part B premiums, a Part B deductible, and 20 percent coinsurance for most Part B services once the deductible is met. CMS understands that existing DPC arrangements outside the Medicare FFS program may include parameters such as no coinsurance or deductible for getting services from the DPC-participating practice or a fixed fee paid to the practice for primary care services. Given the existing structure of Medicare FFS, are these types of incentives necessary to test a DPC initiative? If so, how would they interact with Medicare supplemental (Medigap) or other supplemental coverage? Are there any other payment considerations or arrangements CMS should take into account?

Beneficiary Cost-Sharing Impacts

The AAFP has been examining these issues during development and refinement of the APC-APM as the payments in the model would have implications for beneficiary cost-sharing under Medicare FFS. The goal of the APC-APM payment model (discussed in more detail below) is to incentivize the delivery of high-quality, coordinated care, with a focus on cost reduction across settings. In the APC-APM, physicians would receive prospective, risk-adjusted, primary care and population-based per-beneficiary per-month (PBPM) payments – in place of fees, making beneficiary cost-sharing or liability potentially difficult to calculate. This payment methodology would alleviate the constraints imposed by the current FFS approach by providing practices with more freedom to manage their patient panels independent of the face-to-face visit model. Practices could diversify available resources to manage care needs better and provide other services that yield improved, cost-effective care, making care delivery changes sustainable over time.

The AAFP recommends that CMS consider waiving primary co-pays for beneficiaries that have self-attributed to or have been attributed to an APC-APM type model or practice as this also serves as a

beneficiary engagement tool. As noted, CMS can structure beneficiary cost-sharing in such a way that beneficiaries are encouraged to receive services through the primary care practice to which they have self-attributed. Ideally, there should be no cost-sharing for primary care services provided by the beneficiary's designated primary care practice. Supporting information about the value of primary care to patients and payers in terms of its positive effects on costs, access, and quality, as well as policy details on how the APC-APM would advance these goals are described in an AAFP position paper.

In our ongoing work to refine the APC-APM following the PTAC deliberations and discussions with leading payment experts, we are trying to identify ways to structure cost-sharing for non-primary care services delivered by a practice, to assess the interactions with Medigap, and the potential for overutilization of services. The AAFP is ready to be a resource to share our learning with CMS.

Questions Related to Payment

9. To ensure a consistent and predictable cash flow mechanism to practices, CMS is considering paying a PBPM payment to practices participating in a potential DPC model test. Which currently covered Medicare services, supplies, tests or procedures should be included in the monthly PBPM payment? (CMS would appreciate specific Current Procedural Terminology (CPT®1)/ Healthcare Common Procedure Coding System (HCPCS) codes as examples, as well as ICD-10-CM diagnosis codes and/or ICD-10-PCS procedure codes, if applicable.) Should items and services furnished by providers and suppliers other than the DPC-participating practice be included? Should monthly payments to DPC-participating practices be risk adjusted and/or geographically adjusted, and, if so, how? What adjustments, such as risk adjustment approaches for patient characteristics, should be considered for calculating the PBPM payment?

Payment Design and Structure to Primary Care Practices

The AAFP supports the concept of a PBPM payment to practices to ensure a consistent and predictable revenue stream that supports the physician-patient relationship and practice transformation. Again, the AAFP has examined how such payments could best be structured to improve quality and outcomes, patient experience, and reduce costs as part of the developing of the APC-APM. Under the APC-APM, participating practices would be paid the following:

- A prospective, risk-adjusted, PBPM global primary care payment to cover all face-to-face E/M services provided to attributed patients
- A prospective, risk-adjusted, PBPM population-based payment to cover non-face-to-face services the practice provides in support of its attributed patient population
- Fee-for-service for all services not covered by either the global primary care payment or the population-based payment
- A prospective, performance-based incentive payment for meeting quality and cost/utilization benchmarks

As noted, the global primary care payment would cover all face-to-face E/M services provided to attributed patients. This could include such services as office visits, hospital visits, nursing facility visits, home visits, and preventive medicine visits. The population-based payment, in turn, would cover non-face-to-face service like transitional care management, chronic care management, emails, phone calls, and virtual encounters. The services would not be restricted to specific ICD-10-CM codes.

As CMS alludes in this question, prospective, risk-adjusted, PBPM payments "ensure a consistent and predictable cash flow mechanism to practices." That cash flow, in turn, allows primary care practices to invest in the infrastructure and resources necessary to provide the level of advanced primary care expected under the APC-APM, to the benefit of their patients.

The global primary care payment and population-based payment are not intended to cover items and services furnished by providers and suppliers other than the APC-APM-participating practice. CMS would continue to pay for those services under current Medicare payment mechanisms applicable to the items and services or providers and suppliers in question.

Again, in our continued refinement of the APC-APM so that it can be implemented in Medicare FFS, we are addressing some of the questions CMS raises above such as what services, tests and codes may be covered under the payment components outlined, and how services provided by a non-APC-APM practice to an APC-APM beneficiary should be treated. The AAFP is ready to be a resource to share our learnings with CMS.

Risk Adjustment
As indicated, the AAFP believes that PBPMs should be risk-adjusted. The risk-adjustment methodology should consider patient demographics (e.g. age, gender), health status (e.g. as reflected in the number and types of conditions a patient has, which are generally captured by ICD-10-CM codes), and social determinants of health (SDoH; i.e., the conditions under which people are born, grow, live, work, and age). Please see the AAFP policy on "Advancing Health Equity: Principles to Address the Social Determinants of Health in Alternative Payment Models" for how alternative payment models should account for SDoH in their payment methodologies.

10. How could CMS structure the PBPM payment such that practices of varying sizes would be able to participate? What, if any, financial safeguards or protections should be offered to practices in cases where DPC-enrolled beneficiaries use a greater than anticipated intensity or volume of services either furnished by the practice itself or furnished by other health care providers?

The AAFP believes it is critical to structure payments in a Direct Provider Contracting model to support any practice willing to participate. As a result, the APC-APM is agnostic with respect to practice size and location, because its PBPM payments (i.e., the global primary care payment and population-based payment) do not vary based on practice size or location. Rather, they vary based on the risk posed by the patients with whom they are associated. Accurate risk-adjustment is an essential safeguard to ensure that PBPM payments, in general, allocate the resources practices need to care for the patients attributed to them. Accurate risk-adjustment mitigates the insurance risk associated with caring for a patient.

Overutilization
In designing the APC-APM, the AAFP has had discussions with members about the potential for overutilization of services – and the subsequent impact on a practice. Based on our experience, practices are less concerned with overutilization under an APC-APM approach where payment for primary care services is strengthened and is prospective and risk-adjusted. For those beneficiaries that may be "overutilizers" APC-APM practices could deploy care management supports and resources that could address their needs to drive appropriate utilization over time. In addition, CMS

could examine service use among beneficiaries in a Direct Provider Contracting model to examine impacts on intensity of service use.

In examining the data on primary care use, the risk may not be not from over-utilization of primary care services but from under-utilization. In its *2016 Health Care Cost and Utilization* report, issued earlier this year, the Health Care Cost Institute (HCCI) noted that total spending on primary care office visits fell by almost 6 percent over five years (2012-2016) due to a decline in the number of visits. This was offset by a 31 percent spending increase on office visits to specialists. Concurrently, total spending per person is now growing at faster rates than prior years, with 4.6% growth in 2016 compared to. 4.1% growth in 2015, which followed 2 years of sub-3% growth from 2012 to 2014. HCCI's annual report analyzes health care spending and utilization for people up to age 65 with employer-sponsored health insurance.

11. Should practices be at risk financially ("upside and downside risk") for all or a portion of the total cost of care for Medicare beneficiaries enrolled in their practice, including for services beyond those covered under the monthly PBPM payment? If so, what services should be included and how should the level of risk be determined? What are the potential mechanisms for and amount of savings in total cost of care that practices anticipate in a DPC model? In addition, should a DPC model offer graduated levels of risk for smaller or newer practices?

Total Cost of Care

As CMS considers risk elements in a new model, based on knowledge of members' practices and their role in healthcare spending, the AAFP opposes putting primary care practices and their eligible clinicians at financial risk for anything beyond their own performance under this model. That particularly extends to insurance risk and utilization of services outside the control of the practice (e.g., total cost of care). "Insurance risk" is related to the patient's health status that is beyond the control of the physician, such as age, gender, and acuity differences. Insurance risk is properly borne by health plans and payers, not entity practice and its eligible clinicians. Assumption of risk for total cost of care may also reduce participation in a model – especially among small or independent practices.

Risk Structure/Type

However, primary care practices can be responsible for the performance risk associated with their attributed patients. "Performance risk" refers to the risk of higher costs associated with delivering unnecessary services, delivering services inefficiently, or committing errors in diagnosis or treatment of a condition (i.e., those risks that are within the control of the physician). Under the APC-APM, a large portion of the services provided by a practice will be paid on a PBPM basis through the global primary care payment and population-based payment, and the practice and its eligible clinicians will bear risk for performance related to those services. The assumption of risk for performance is based on the practice's demonstrated capabilities.

We understand that a key goal of the movement to value-based care is to control the total cost of care of patients. Measurement of any model should consider if, and how, it impacts total cost of care—and whether the model can help control those costs across the care continuum. At this time, we believe that practices entities can only be held accountable for total cost of care of attributed patients when all participants in the health care system (e.g., hospitals, sub-specialists, etc.) are operating under aligned value-based incentives.

Levels of Risk
The AAFP designed the APC-APM with a uniform payment methodology and risk structure that is simple for practices to understand and assess regardless of their size or experience in assuming risk. The payment methodology strengthens payment for primary care services – and provides upfront, predictable revenue streams that allow practices to engage in transformation and assume risk for their performance. Such an approach would allow practices to assess the viability of participation simply.

Potential Impacts on Total Cost of Care
Greater investments in primary care are necessary to support the delivery of continuous, longitudinal, and comprehensive care across settings and providers. Any reductions in total cost of care from investments in an advanced primary care APM should be assessed over the long term across the care continuum. Experts agree, investments in primary care APMs cannot be recouped in the short term. Evidence suggests that the longer payment reform programs to support primary care have been in place, the more evident cost savings and improved outcomes are.

If CMS were to launch a primary care Direct Provider Contracting Model based on the APC-APM, the model would most likely impact total cost of care in the areas of reduced inpatient hospitalizations and reduced emergency department use. Thus, the AAFP has included inpatient hospitalization utilization per 1,000 attributed beneficiaries and emergency department utilization per 1,000 attributed beneficiaries as two of the measures for which practices may be held accountable under the APC-APM to determine whether they retain their performance-based incentive payments.

12.What additional payment structures could be used that would benefit both physicians and beneficiaries?

This question has been answered in the AAFP's responses to questions 9 - 11.

Questions Related to General Model Design

13. As part of the Agency's guiding principles in considering new models, CMS is committed to reducing burdensome requirements. However, there are certain aspects of any model for which CMS may need practice and/or beneficiary data, including for purposes of calculating coinsurance/deductible amounts, obtaining encounter data and other information for risk adjustment, assessing quality performance, monitoring practices for compliance and program integrity, and conducting an independent evaluation. How can CMS best gather this necessary data while limiting burden to model participants? Are there specific data collection mechanisms, or existing tools that could be leveraged that would make this less burdensome to physicians, practices, and beneficiaries? How can CMS foster alignment between requirements for a DPC model and commercial payer arrangements to reduce burden for practices?

Practice and Beneficiary Data Considerations
The AAFP applauds CMS' efforts to reduce administrative and regulatory burdens on providers – especially for our small and independent practices. The AAFP has considered many of the questions CMS notes on designing a new primary care model that reduces administrative burden – a goal for our members – while balancing the need to collect necessary data for risk adjustment and other purposes. For instance, the APC-APM model is multi-payer by design, including Medicare Advantage

and Medicaid agencies, and is an evolution of CPC+. Under the APC-APM, practices will receive a risk-adjusted, prospective, per patient per month payment for all face-to-face E/M services provided to attributed patients. Those payments make the level of service for a given encounter immaterial and eliminate the need for E/M documentation requirements, allowing the medical record to once again be used as a tool for patient care. As the AAFP further refines the model, we are considering that practices participating in the model would instead submit "dummy claims" for payers to track only essential information, like HCC scores for risk adjustment and cost-sharing purposes.

Due to the APC-APM payment structure that also provides risk-adjusted, prospective, per patient per month payments for non-face-to-face care, practices will no longer need to file codes like CCM and TCM, further reducing burden to the practice and the agency. Any other needed data would ideally be drawn directly from the electronic health record. We ask CMS to consider this approach in designing new primary care models, which leverage existing infrastructure for participating practices.

Measure Harmonization

In particular, we believe there is significant opportunity to drive measure harmonization across payers and to reduce administrative burden and variation across practices– especially given the impacts of quality reporting programs on physician practices. A 2016 study found that physician practices spend an estimated $15.4 billion annually on quality reporting, with primary care practices estimated to spend $50,468 per physician. The researchers also estimated that primary care physicians spent an average of 3.9 hours per week on quality reporting activities – the most of surveyed specialties. According to the AAFP 2017 Value Based Payment study nearly six in 10 (58%) family physicians' practices received payment from 7 or more payers. The same survey showed one of the main barriers to implementing value based payment was the lack of standardization of performance measures/metrics, at 78%. The time and resources spent on disparate quality reporting programs and requirements detracts from the family physician's core purpose of patient care. The AAFP believes that aligning and simplifying quality measurement are critical to incenting greater participation in value-based payment programs.

14. Should quality performance of DPC-participating practices be determined and benchmarked in a different way under a potential DPC model than it has been in ACO initiatives, the CPC+ Model, or other current CMS initiatives? How should performance on quality be factored into payment and/or determinations of performance-based incentives for total cost of care? What specific quality measures should be used or included?

Quality and Utilization Measures

Accurately – and parsimoniously – measuring performance of participating practices is a central component of any model. In designing the APC-APM, the AAFP has recommended that practices participating will report on ten quality measures (including one outcomes measure). The measures were selected from the Comprehensive Primary Care Plus (CPC+) Quality Measures Set and the ten specified measures also appear in the Core Quality Measures Collaborative's (CQMC) Accountable Care Organizations, Patient Centered Medical Homes, and Primary Care measure set. All practices in the program will be evaluated on the same ten quality measures at the practice level, which will reduce measure burden and allow for comparison with existing Innovation Center models.

APC-APM practices will also be evaluated using two utilization measures from the Healthcare Effectiveness Data and Information Set: inpatient hospitalization utilization and emergency department utilization per 1,000 attributed beneficiaries. CMS could consider a similar approach for

evaluating performance to allow for cross-model comparisons and use of existing approaches and infrastructure.

Benchmarks and Performance-Based Incentives
To support evaluation of models and to leverage existing infrastructure and methodologies, the AAFP recommends that CMS base benchmarks for performance measures on performance of measures two years prior as in MIPS and CPC+. The AAFP has taken this approach in the APC-APM – and failure to meet established benchmarks will result in practices not keeping the full performance-based incentive payment, in a graduated fashion, and may lead to practices being removed from the program.

15. What other DPC models should CMS consider? Are there other direct contracting arrangements in the commercial sector and/or with Medicare Advantage plans that CMS should consider testing in FFS Medicare and/or Medicaid? Are there particular considerations for Medicaid, or for dually eligible beneficiaries, that CMS should factor in to designing incentives for beneficiaries and health care providers, eligibility requirements, and/or payment structure? Are there ways in which CMS could restructure and/or modify any current initiatives to meet the objectives of a DPC model?

As our nation grapples with the escalating costs of health care, we feel it is time to prioritize primary care and wide-scale testing of the APC-APM as an important step towards achieving our mutual goals.

The AAFP is ready to partner with CMS to implement and test this important model for Medicare beneficiaries, primary care physicians, and the Medicare Program overall.

Questions Related to Program Integrity and Beneficiary Protections

In advancing the APC-APM through the PTAC and working with external experts, the AAFP has designed the model to prevent unintended consequences such as cherry picking/lemon dropping and stinting of care. To address questions 16 – 20, the AAFP offers the following feedback on program and integrity and beneficiary protection policies based on our members' experience and designing the APC-APM. We believe the approach taken with the APC-APM – which includes patient experience, quality, and utilization measures to protect beneficiaries - offers a valuable template for CMS to consider in launching a primary care model.

Patient Selection Bias
CMS could prevent "cherry picking" and "lemon dropping" in at least two ways in a primary care-focused Direct Provider Contracting model. First, patient choice driving participation in a model allows patients to pick the practice rather than vice versa. Patients who do not choose any practice may still be attributed to a practice based on other criteria (e.g., claims for Welcome to Medicare and annual wellness visit, claims for all other E/M visits to a primary care physician, and claims for primary care prescriptions and other order events). Thus, under the APC-APM, practices would have relatively little opportunity to cherry pick or lemon drop the patients attributed to them because patient attribution is primarily in the hands of the patient and CMS, not the practice.

Second, the model should risk-adjusts payments as in the APC-APM for the primary care global and population-based payments. If the payer's risk-adjustment methodology functions properly, these

payments will vary based on the needs of the patients, such that the patients with the greatest needs will generate the greatest primary care global and population-based payments. Thus, the payment methodology should discourage cherry picking and lemon dropping (or at least not incentivize them).

Guarding Against Stinting of Care

Section 1115A of the *Social Security Act* (as added by section 3021 of the *Affordable Care Act*) created the Innovation Center for testing "innovative payment and service delivery models to reduce program expenditures …while preserving or enhancing the quality of care" for those individuals who receive Medicare, Medicaid, or Children's Health Insurance Program (CHIP) benefits. Thus, we remind CMS and potential Direct Provider Contracting plans that they must offer a complete benefit package for any beneficiary receiving care under an Innovation Center model.

Based on our experience working with the PTAC and payment experts on the APC-APM, we believe that CMS can prevent stinting of care in at least three ways. First, patients who perceive that the practice is stinting on their care may select another practice to which they choose to be attributed or they may self-refer to specialty care. In the case of the APC-APM, since the primary care global payment and the population-based payment are capitated and follow the patient, patients who choose to leave the practice and attribute themselves to another practice take both revenue streams with them. Those who self-refer will fare poorly on utilization and cost measures. This feature of the model provides an incentive to the practice to ensure patients feel they are receiving appropriate care.

Second, practices will be evaluated based on their performance on quality measures, including at least one outcomes measure. Performance on quality measures, in turn, helps determine whether practices may keep the performance-based incentive payments they have received for the reporting period. Practices that stint on care are likely to fare poorly on quality measures and lose their performance-based incentive payments. Poor performing practices may also be excluded from the APC-APM going forward. Thus, practices have incentives not to stint on care.

Third, retaining a FFS element in the payment methodology may also guard against in stinting. In the case of the APC-APM, to the extent that some of the appropriate care may be paid on a FFS basis, practices that stint on care will be depriving themselves of revenue.

Impacts of Patient Choice

We understand CMS's concern that patient attestation or choice in participating in a model could lead to beneficiaries being unduly influenced to choose a practice through the provision of "valuable incentives." To the extent CMS is concerned that incentives may lead practices to offset the cost of the incentives by providing medically unnecessary services or by substituting cheaper or lower quality services, we recommend an approach similar to the APC-APM. For instance, a PBPM or population-based payment approach would provide capitated payments, so providing medically unnecessary services is more likely to cost the practice rather than generate additional revenue, contrary to the prevailing FFS model. Second, reporting requirements on the quality of care practices deliver, and putting a more than nominal amount of their revenue (i.e. the performance-based incentive payment in the case of the APC-APM) at risk based on their quality and cost/utilization performance also guard against stinting.

Finally, with respect to the potential risk of identity theft, we do not believe a Direct Provider Contracting model similar to the APC-APM poses any greater risk than beneficiaries face under traditional fee-for-service or other models already available to them. CMS is already taking a

significant step to protect Medicare beneficiaries' identities by issuing them new Medicare cards with new numbers known as Medicare Beneficiary Identifiers that replace the existing Social Security Number-based Health Insurance Claim Number. Practices are well-aware of the need to protect patient privacy, including patient identity, because of the *Health Insurance Portability and Accountability Act*. We believe these safeguards are sufficient.

Questions Related to Existing ACO Initiatives

In developing the APC-APM, the AAFP designed the model to operate alongside or outside of an ACO – consistent with our goals for the model to allow for broad-based participation. We believe that a primary care Direct Provider Contracting model can be designed to accomplish the same objectives.

We appreciate the opportunity to provide these comments. Please contact R. Shawn Martin, Senior Vice President of Advocacy, Practice Advancement, and Policy at smartin@aafp.org or (202) 232-9033 for additional information.

Sincerely,

John Meigs, Jr., MD, FAAFP
Board Chair

Addendum

5. CMS is also interested in understanding the experience of physicians and practices that are currently entirely dedicated to direct primary care and/or DPC-type arrangements. For purposes of this question, direct primary care arrangements may include those arrangements where physicians or practices contract directly with patients for primary care services, arrangements where practices contract with a payer for a fixed primary care payment, or other arrangements. Please share information about: how your practice defines direct primary care; whether your practice ever participated in Medicare; whether your practice ever participated in any fee-for-service payment arrangements with third-party payers; how you made the transition to solely direct contracting arrangements (if applicable); and key lessons learned in moving away from fee-for-service entirely (if applicable).

Defining Direct Primary Care

The AAFP supports the physician and patient choice to, respectively, provide and receive health care in any ethical health care delivery system model, including the DPC practice setting.

In the RFI, CMS refers to "DPC" as "direct provider contracting." However, the AAFP defines "DPC" as "Direct Primary Care." While we understand why CMS likely chose to expand the definition of DPC to include non-primary care practices, we nevertheless encourage CMS to adopt the AAFP's established definition of Direct Primary Care. Within this addendum, we will associate the acronym "DPC" to stand for Direct Primary Care.

The AAFP actively supports family physicians who choose to practice in a delivery and payment model in which they contract directly with patients. The AAFP, in conjunction with our state chapters and the DPC Coalition, has been an integral part in the passage of 25 state laws that support DPC and/or define it as a medical service outside the scope of insurance regulation. Within these laws, DPC is defined as a practice that 1) charges a periodic fee for a defined set of services, 2) does not bill any third parties on a fee for service basis, and 3) sets any per visit charge at an amount less than the monthly equivalent of the periodic fee.

Under the DPC model, the payment for a defined set of primary care services is paid monthly or annually directly to the practice by the patient or, in some instances, a third-party on behalf of the patient. These services typically include increased access to a personal physician, extended visits, electronic communications, home-based medical visits in some cases, and highly personalized, coordinated, and comprehensive care management. Although a majority of DPC practices offer a common set of primary care services, each DPC practice is unique as it looks to meet the needs of its community.

Overview of DPC Practices

In March 2018, the AAFP conducted our most significant survey of DPC practices to date. The primary purpose of the survey was twofold:

1. To obtain a deeper profile of DPC practices and
2. To determine interest level in a CMS DPC demonstration project for Medicare beneficiaries. The analysis was designed for both current DPC practices and family physicians not practicing in a DPC practice setting, giving us a holistic view of the model.

As of 2017, approximately 3 percent of the AAFP's 131,400 members were practicing in a DPC setting. An additional 2 percent to 3 percent are in the process of transitioning their practices to the model. It is our assessment that the overwhelming majority of DPC practices are family physicians. There are a few internal medicine and pediatric practices, and a growing interest among some medical specialists, but the model is dominated by family medicine.

Overall, we estimate there are between 800 and 1,200 DPC practices nationwide, with an additional 400 to 600 under development. Based on our 2018 survey and nearly a decade of experience with DPC, we believe there are primarily two distinct types of DPC practices currently operating in the marketplace: pure and hybrid. For analysis purposes, the AAFP defined a "pure" DPC practice as one that does not bill any insurance and all membership fees are paid by a patient or employer. Hybrid practices continue to bill fee-for-service for a select patient panel, but have separate panel of DPC patients. According to our survey, 80 percent of DPC practices are in a "pure" DPC model with < 15 percent in the hybrid DPC model.

The DPC practice model remains a relatively new concept. Of the DPC practices currently operating, 83 percent have been open less than four years. Only a small portion, 8 percent have been open 8 or more years. Our survey found that the desired panel size for a DPC practice was approximately 600 patients and the majority of practices – 65 percent – charged between $50 and $75, per patient, per month for their services. The transition time from a traditional practice to a DPC model seems to be consistent with the transformation time for other practice models, about 20 months. This 20-month transformation period is in addition to the approximate 11 months practices take to plan for the transition to a DPC model. Collectively, from concept to full implementation, is a process that we believe takes 24-months to 36-months. According to the survey, only 17 percent of DPC practices have achieved their full desired panel size of 600 patients. The average panel size reported was < 350 patients. The AAFP is working to remove barriers that would help DPC practices to grow more rapidly. We urge CMS to investigate how they can help remove the legal barriers that currently prevent patients from receiving care from family physicians practicing in a DPC practice.

Once a physician has successfully transitioned to the DPC model, they tend to be highly supportive of and energized by the practice model. The professional satisfaction of DPC physicians appears to be higher than other physicians, but the AAFP has not measured this specifically.

Medicare and Medicaid Participation

One of the defining features of DPC is the disconnection from the third-party insurance system. Most DPC practices point to their desire to no longer engage with third-party payers as a fundamental reason they transitioned to the DPC model. Therefore, DPC practices do not typically participate in Medicare, Medicaid or with any other third-party payers, although DPC practices may provide care to Medicare and Medicaid beneficiaries.

In our survey, nearly 35% of current DPC practices converted from a more traditional practice setting, so they likely have experience participating in Medicare. We do not have data on Medicaid participation, past or present. The hybrid DPC practices typically establish a separate panel that allows the practice to continue billing Medicare fee-for-service for their Medicare and/or Medicaid eligible patients.

At this time, the AAFP is unable to predict how many DPC practices would participate in a Medicare demonstration program, but we would project that the willingness to participate will be higher among the hybrid DPC practices than among the pure DPC practices.

Positive Impacts of DPC Models on Practices

Although the DPC model represents a small portion of our overall membership, the AAFP sees continued interest and growth among family physicians adopting this practice model in all settings types, including rural and underserved communities. There are three contributing factors we would draw your attention to.

- Professional satisfaction – a common refrain among DPC physicians is their commitment to practicing medicine in a manner that is patient-centered. DPC provides physicians an opportunity to focus on patient care and, as a result, DPC physicians tend to have high professional satisfaction. How this professional satisfaction influences cost and quality remains to be evaluated.
- Administrative burden – the elimination of administrative and regulatory obligations is fundamental to the DPC model. The practices are built on the concept that such functions do not contribute to quality patient care, are costly, and create a distraction between physicians and patients. It is well documented that the electronic health record and complexity of administrative functions placed on modern physician practices are a leading cause of physician burnout.
- Independent practices – many physicians who have pursued the DPC model have done so in an effort to maintain or regain their independence from large health systems and hospitals. Consolidation and aggregation has resulted in fewer and fewer independent physician practices and many physicians find this trend unacceptable. Instead of selling their practices or leaving medicine all together, they are choosing the DPC model as a means of maintaining an independent community practice.

Highly functioning DPC practices have an opportunity to provide high-quality care at a reduced cost. They also have an opportunity to preserve the independent physician practices that are so critical to our health care system.

Key Items for Consideration with Design & Implementation

While the AAFP is generally supportive of exploring how a DPC model could be incorporated into fee-for-service Medicare, we do wish to raise several items that will require a thoughtful approach. We raise these items as a means of drawing attention to those areas of a potential demonstration that would need to be designed in a manner that positions the demonstration to be successful and, most importantly, to ensure that beneficiaries have access to services as guaranteed by the Medicare program.

- Attribution – like other APM models, the attribution methodology will be important to the design and operations of the demonstration. The AAFP prefers attribution that is based on self-selection and self-attribution to a primary care practice. Additionally, we would question whether beneficiaries attributed to a DPC practice would be subject to lock-in or lock-out provisions whereby they would no longer have the freedom to receive their primary care services from the outside DPC practice if they desired. The presence of lock-in or lock-out provisions would simplify the evaluation of the model, but would greatly limit access to care for participating beneficiaries. We also would encourage CMS to be carefully consider how beneficiaries would be identified, recruited, and enrolled in a DPC demonstration and, what options they would have to exit the demonstration at a future date.

- Primary Care Services – a key design feature will be the identification of the services that should be included in the per beneficiary, per month payment. The basket of services in existing DPC practices varies and it will be critical that CMS clearly define the services included in, or covered by, the per beneficiary per month DPC payment. The process for creating this menu of services should reflect the views of all DPC practices, large and small and be reflective of full-scope, comprehensive primary care.
- Quality & Performance Improvement – since most DPC practices have limited engagement with third-party payers, they may lack the infrastructure to transmit performance and quality data. The AAFP strongly supports quality improvement and practice improvement analysis that is based on measures that evaluate quality and performance through methodologies that measure primary care's impact on upstream spending – emergency room visits, hospital admissions, hospital readmissions, etc. We recognize that CMS likely will require participating DPC practices to report quality and patient satisfaction data, we would urge CMS to evaluate any DPC model on these measures, which are critical to protect beneficiaries against stinting and cherry picking.
- Care Delivery and Management – To ensure beneficiaries receive appropriate care, it is important that practices attest to meeting certain care delivery and management principles that support advanced primary care functions (i.e. Joint Principles of the Patient-Centered Medical Home) and the meet the definition of a true DPC practice.
- Beneficiary Cost-sharing – like other APM models, the DPC model presents some opportunity to re-determine the requirement of the 20 percent Part B beneficiary cost-sharing requirements. The AAFP believes that beneficiaries should not be required to pay the 20 percent cost-sharing for services provided as part of the per beneficiary, per month payment. However, we do believe that the cost-sharing requirement should continue for all services provided outside attributed DPC practices – including for primary care services provided by a non-attributed primary care physician and/or practice.
- Direct Payments to Medicare Beneficiaries – there have been suggestions that Medicare could provide a direct payment to Medicare beneficiaries who would then be responsible for contracting with a DPC practice for their primary care health care services. While there may be mechanism such as MSA or MA plans that could be established to facilitate this type of transaction and, recognizing that this is the preferred approach of DPC practices in the commercial marketplace, the AAFP would urge caution about such a policy being implemented in Medicare, even as part of a demonstration. This would place tremendous burden on beneficiaries and their caregivers as compared to other financing options. Additionally, under a direct payment to beneficiaries, it would require the beneficiary themselves to attest and potentially confirm how and where the finances were used. This seems inconsistent with Title 18 and the Innovation Center authorizing language.
- Balance billing – there have been suggestions that participating DPC practices be allowed to charge beneficiaries a fee above the determined per beneficiary, per month DPC payment. The AAFP would advise against allowing such actions on the part of DPC practices. Not only would it create confusion among beneficiaries, it would hinder the ability of CMS to evaluate the model. Similar to previous comments, we would also question if such actions would be legal under current law or consistent with the CMMI authorizing language.
- Cohort size – given the relatively low number of DPC practices nationwide, we have concerns that any evaluation of the DPC model would be distorted due to the small beneficiary cohort being analyzed. While we do think it is possible to evaluate the DPC model on a limited-scale

basis, it likely will be difficult to reach any definitive conclusions on quality, costs, and efficacy of the model.

Again, the AAFP welcomes the opportunity to work with CMS as they look to design a model that helps advance these concepts. The AAFP encourages CMS and the Innovation Center to seek feedback from DPC organizations who have experience in designing and implementing this type of payment model under Medicare Advantage and with self-funded employers, as well as the hundreds of independent DPC practices now operating nationwide.