March 27, 2017

Seema Verma, MPH, CMS Administrator
Centers for Medicare & Medicaid Services
U.S. 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 124,900 family physicians and medical students across the country, I write in response to the request for information on pediatric alternative payment model (APM) concepts as posted by the Centers for Medicare & Medicaid Services (CMS) on February 27, 2017.

The AAFP fully recognizes the leading role CMS takes in partnering with states and physicians regarding the health care coverage for more than one in three American children. Our commitment to low-income individuals and families is reflected in family physicians' participation in the Medicaid program. Currently, more than two-thirds (68%) of family physicians participate in the Medicaid program and accept new patients into their practices. Participation in Medicaid by family physicians is at its highest level since the AAFP began monitoring the issue in 2004. We are therefore pleased to comment on the design of APMs focused on improving the health of children and youth covered by Medicaid and the Children's Health Insurance Program (CHIP).

About Family Medicine
Family medicine plays a critical role in delivering care to Medicare, Medicaid, and CHIP beneficiaries in every community across the country. Family physicians are dedicated to treating the whole person. Family medicine's cornerstone is an ongoing, personal patient-physician relationship focusing on integrated care. Unlike other specialties that are limited to a particular organ or disease, family medicine integrates care for patients of all genders and every age, and advocates for the patient in a complex health care system. Because of their extensive training, family physicians are the only specialists qualified to treat most ailments and provide comprehensive health care for people of all ages– from newborns to seniors. Family physicians deliver a range of acute, chronic, and preventive medical care services and play an essential role in a wide range of communities from rural to urban settings.

In addition to diagnosing and treating illness, they also provide preventive care, including routine checkups, health-risk assessments, immunizations, screening tests, and personalized counseling on maintaining a healthy lifestyle.

The foundational role of family medicine in care delivery is clearly illustrated by the following:

- Family physicians are the most visited specialty—especially in underserved areas. Family physicians conduct approximately one in five office visits. This represents more than 192 million visits annually, which is 48 percent greater than the next most visited medical specialty. Family physicians provide more care for America's underserved and rural populations than any other medical specialty. More than two-thirds (68%) of family physicians participate in the Medicaid program and accept new patients into their practices.
- Strengthening primary care is critical to driving greater value for patients, payers, and communities. Transformation cannot be overly complex and burdensome to operationalize. However, there is not a one-size-fits-all solution, as patient panels, populations, and primary care practices vary. There is an emerging consensus that strengthening primary care is imperative to improving individual and population health outcomes, as well as to restraining the growth of health care spending.
- The complexity of care provided by family physicians is unparalleled in medicine. Data show that family physicians address more diagnoses and offer more treatment plans per visit than any other medical specialty. Furthermore, the number and complexity of conditions, complaints, and diseases seen in primary care visits is far greater than those seen by any other physician specialty. CMS and private payers must make new investments in primary care to truly capture and realize the value proposition of family medicine and primary care.
- Primary care is particularly affected by longstanding inequities in payment that must be corrected if it is to be the foundation of a transformed, patient-centered health system. Historically, family physicians' services have been undervalued in terms of payment rates in both Medicaid and Medicare. In 2012, the Medicaid and CHIP Payment and Access Commission reported that Medicaid payment rates "for a representative sample of primary care services eligible for the ACA payment increase were 58 percent of Medicare rates." Research shows that Medicare fee-for-service "(FFS) is not only flawed for its strong incentives to increase volume, but also in its disproportionate reimbursements for procedural rather than cognitive care." Payment experts offer similar assessments of the problems with testing and building value-based payment models on a flawed physician fee schedule. Though the *Health Care Education and Reconciliation Act* (HCERA) specified that Medicaid payments for primary care services would be at Medicare levels for certain primary care physicians in 2013 and 2014, this effective provision has expired. The AAFP is dismayed that many state Medicaid programs and Medicaid Managed Care Organizations have reverted to payment rates for primary care services that are lower than Medicare's rates. These reductions threaten access for millions of patients by dramatically cutting Medicaid payments for eligible primary care physicians.
    - The AAFP strongly urges CMS, Congress, and state Medicaid agencies to address this threat through policies that maintain Medicaid payments for primary care services at Medicare levels for primary care physicians treating Medicaid and Medicaid Managed Care.
    - It is essential that CMS ensure any pediatric APM be based on sufficient payment rates and incentives necessary to drive value of care over volume.

AAFP Principles to Support Patient-Centered Alternative Payment Models

The AAFP supports moving a larger percentage of payments from traditional FFS towards patient-centered APMs, and we support the creation of innovative payment models across payers that

achieve better care, smarter spending, and healthier people. The AAFP believes that to be truly successful in improving care and reducing cost, APMs need a strong foundation of primary care.

With implementation of the *Medicare Access and Children's Health Insurance Program Reauthorization Act*, the development of new APMs is accelerating. While some of these models may deliver comprehensive, longitudinal care, many run the risk of perpetuating (or even exacerbating) the fragmented care many patients receive under the current FFS system. Evidence shows that health systems built with primary care as the foundation have positive impacts on quality, access, and costs.

The AAFP only supports patient-centered advanced primary care models that promote comprehensive, longitudinal care across settings and hold clinicians appropriately accountable for outcomes and costs. To support the development and implementation of APMs that accomplish these objectives, the AAFP has developed a set of principles to support patient-centered APMs. These principles to guide our evaluation of proposed models to ensure that they place patients—and not clinicians—at the center, and we strongly encourage CMS and developers of APMs to closely consult and adhere to these principles. In summary, APMs:

- Must Provide Longitudinal, Comprehensive Care
- Must Improve Quality, Access, and Health Outcomes
- Should Coordinate with the Primary Care Team
- Should Promote Evidence-based Care
- Should be Multi-payer in Design

Advanced Primary Care - Alternative Payment Model (APC-APM)
As referenced in our February 16, 2017 letter to the Physician-Focused Payment Model Technical Advisory Committee (PTAC), the AAFP will soon submit a physician payment proposal—Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care. We will request that the PTAC review the model, provide feedback to the AAFP on it, and promptly recommend it to CMS for approval and nationwide expansion.

Primary care is the primary access point to the health care system for millions of Americans across a diverse range of communities. The AAFP's APC-APM proposal is an opportunity for CMS to make advanced APMs broadly accessible to Medicare, Medicaid, CHIP, and private payer beneficiaries—and to impact quality and spending in other parts of the health care system. We feel this will help achieve the goals of improving overall health outcomes of Medicare, Medicaid, and CHIP beneficiaries and the health of communities, as well as bring stability to the Medicare, Medicaid, and CHIP programs.

The APC-APM is built on the principle that patient-centered primary care is comprehensive, continuous, coordinated, connected, and accessible from the patient's first contact with the health system. While the APC-APM aims to improve clinical quality through the delivery of coordinated, longitudinal care—assessed through the Core Quality Measure Collaborative measure sets—the broader goal of the APC-APM is to use this approach to deliver care in a manner that improves patient outcomes and reduces health care spending, such as through decreased inpatient and emergency department visits.

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 the AAFP's position paper, "Advanced Primary Care: A Foundational Alternative Payment Model (APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care." In it, we present a transformational, primary care focused, and patient-centered model, including:

- The definition and recognition of an APC-APM participating physician;
- An appropriate, four-step methodology to attribute patients to the APC-APM;
- How global and performance-based incentive payments should be structured and made;
- Reporting quality measures and the calculation of value based payments; and,
- Financing for the model.

The proposal that we plan to submit to PTAC elaborates on and further develops the model outlined in this position paper.

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

Sincerely,

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

CC:
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