AMERICAN ACADEMY OF FAMILY PHYSICIANS

July 21, 2020

Jeffrey Bailet, MD
Committee Chair
Physician-focused Payment Model Technical Advisory Committee (PTAC)
Assistant Secretary for Planning and Evaluation (ASPE), Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Dr. Bailet:

I am writing on behalf of the American Academy of Family Physicians (AAFP), which represents more than 136,700 family physicians and medical students across the country, in response to the request for public input on PTAC's review of physician-focused payment models (PFPMs). We understand PTAC is seeking additional information to further enhance its reviews and believes it is important to obtain additional input and guidance from stakeholders on what issues they believe are material to PTAC's review of proposals.

The AAFP was an early participant in the PTAC review process with our proposal for an Advanced Primary Care Alternative Payment Model (APC-APM) and remains fully supportive of the PTAC's role in evaluating PFPMs as well as ASPE in providing operational and technical support to PTAC. We are pleased to respond to this current request for public input and will address each of the questions in turn.

Reflecting on the issues and topics presented in the care delivery, payment model or other issues that are addressed in the proposals that PTAC has reviewed, what are the other current challenges in healthcare delivery and payment? What is needed to push forward on addressing care delivery issues and alternative payment models? Are there other actual and potential PFPMs that have not heretofore been addressed in proposals submitted to PTAC?

The COVID-19 pandemic is the dominant, current challenge in healthcare delivery, and the accompanying challenge in payment, at least for primary care, is how to sustain a practice model dependent on fee-for-service (FFS) when the volume of patient visits has decreased by more than 50% in most cases, with telehealth services only partially compensating for that decline. We believe there is a window of opportunity to push forward in pursuit of the kind of health care system America wants and needs. What is needed to push forward in that window is to shift our focus from incremental achievements toward a better future for family medicine in favor of implementing big, substantive, consequential, and disruptive changes. We need a plan

bold enough to fundamentally change our health care system and consequential enough that the lives of future generations will be impacted by its scope. Here is where we should start on what some are already calling the Primary Care Marshall Plan.

Our health care system is largely a top-down model in which most of the spending is allocated to the least-used services. According to Health Affairs, health care spending in 2018 was $3.6 trillion, of which physician and clinical services represented about 20%. Hospital spending represented 33% of overall spending. Best estimates are that primary care represents about 5% of overall spending.

Meanwhile, according to statistics from the Robert Graham Center for Policy Studies in Family Medicine and Primary Care for 2018, a little less than 22 million people -- about 7% of the population -- received care in a hospital compared to the more than 190 million people -- roughly 60% of the population -- who received care from a family physician. Thus, an overwhelming majority of people rely on their family physicians and other primary care clinicians, yet we invest only pennies on the dollar in our primary care system.

FFS is incapable of supporting the primary care system that our health care system needs and that patients deserve. The whole construct of FFS, and especially the resource-based relative value scale (RBRVS), has failed primary care. Primary care is comprehensive, continuous, holistic, portable and patient-centered. The RBRVS is, by design, the complete opposite. It is focused on units of care, units of time, and sites of service. Family medicine has politely whispered for years that FFS was an illogical payment construct for primary care, and the COVID-19 pandemic simply put a giant spotlight on this issue.

The pandemic has brought to light how inflexible and unresponsive our health care system has become. Prospective payment would change this. Individuals within the commercial health insurance sector have told us that capitated primary care practices are coping better and more effectively with the current crisis. Imagine if every family physician would have had an attributed panel of patients and an associated prospective payment for each when the crisis hit. Transformation from office-based to virtual workflows would have been easier and quicker. When units of care and units of time no longer get measured, providing needed care to patients becomes the focal point. And, when providing care to patients is the focal point in an APM, family medicine wins.

The concept of prospective payments is not new. The AAFP has advocated adopting this type of payment model for years, and it was a key element of the APC-APM considered by the PTAC. Our model is the foundation of the Primary Care First model that the Centers for Medicare & Medicaid Services (CMS) will implement in 2021. We also have advocated for other global/prospective value-based APMs, such as direct contracting, physician-led accountable care organizations, and direct primary care arrangements. Although it is easy to focus on what makes these models different, it is more important to focus on what makes them similar: They all depend on population-based, advance payment for primary care.

In response to the COVID-19 crisis, Medicare, like other public and private payers, has altered benefit design and begun making advance payments to family physicians. We should build on this momentum and once and for all make a major shift away from the legacy FFS system

toward a new system that prospectively pays family physicians for the continuous, comprehensive, and coordinated care they provide.

This shift in payment models should be coupled with an increased investment in primary care. Research continues to show primary care is critical to the health of individuals and improves health outcomes. Primary care helps prevent illness and death and is associated with a more equitable distribution of health in populations. Patients who identified a primary care physician as their usual source of care had lower five-year mortality rates than patients identifying a specialist physician as their usual source of care. The populations of countries with higher ratings of "primary care orientation" experience better health outcomes and incur lower health care costs than populations in countries with lower degrees of primary care orientation.

Despite these benefits, primary care spending lags in the United States compared to similar investment in most other high-income countries. Across payers, including both public and private insurance, primary care spending in the United States amounts to approximately five to eight percent of all health spending, with an even lower percentage in Medicare, compared to approximately fourteen percent of all health spending in most high-income nations. As noted, nations with greater investment in primary care reported better patient outcomes and lower health care costs, and according to a Robert Graham Center analysis, states with higher levels of primary care investment also report better patient outcomes.

Accordingly, the AAFP recommends a doubling of primary care financing to 10– 12% of total health care spending. Such an investment, combined with a major shift toward prospective payment for primary care, would pay for itself through resulting reductions in overall health spending.

Primary care APMs, such as Comprehensive Primary Care Plus (CPC+) and the planned Primary Care First (PCF), have been inadequate, because they have not represented an increased investment in primary care. For instance, CPC+ helped primary care practices into advanced primary care, but the model did not represent a substantial increase in primary care investment, and it was incredibly burdensome for participating practices. Similarly, PCF expects practices to already be advanced primary care practices before it will invest in them. Primary care APMs need to increase investment in primary care to financially support small practices as they transition to and then sustain the advanced primary care functions required to be successful in value-based payment.

Consequently, the AAFP is embarking on a three-year project to develop and implement a new APM in collaboration with a commercial health insurance plan and primary care network yet to be determined. We will be happy to share the learnings from that project with PTAC at the appropriate time.

Reflecting on the issues and topics presented in the proposals submitted, in addition to the evaluative criteria, what other factors are those that stakeholders believe would be important to take into consideration to inform PTAC's evaluation of proposals, including factors related to engagement and adoption of models? For example, what attributes may serve to facilitate or act as barriers in the adoption and engagement in models for rural and small practices as well as large integrated delivery systems?

Based on our experience and observations, we believe PTAC's evaluation of proposals would be better informed by the availability of technical assistance, particularly actuarial expertise, to those submitting proposals. From our perspective those who submit proposals to PTAC do their best. However, they may not always have the data or technical capacity to address questions raised in the PTAC's evaluation process. It would be helpful if technical assistance was available through the PTAC from such sources as the Center for Medicare & Medicaid Innovation (CMMI) and CMS Actuary.

As noted, actuarial expertise would be particularly useful in this regard. The PTAC is appropriately interested in the potential impact of proposals. However, those making proposals to PTAC typically lack actuarial expertise and the necessary data to effectively model impacts. PTAC members and staff also lack that expertise and data. It would be helpful to PTAC and those proposing models to have access to actuarial data and expertise (e.g., through CMS) to support modeling needed to answer questions the PTAC has.

Another factor, especially related to engagement and adoption, is CMMI involvement and consultation up front and throughout the PTAC process. Given that CMMI will ultimately be tasked with testing any models recommended by PTAC and deemed worth testing by the Secretary of Health and Human Services, we believe it would make sense to involve and consult with CMMI upfront and throughout the PTAC process. Making such consultation and involvement at least available, if not a formal part of the process, would be an improvement from our perspective.

Lastly, the attributes that serve to facilitate the adoption of and engagement in APMs by rural and small practices as well as their large integrated delivery system counterparts are those attributes that adequately support and sustain the transition to advanced primary care functions necessary for success under value-based payment. Rural and small practices need more than mere technical assistance and a burdensome set of "do's and don'ts" to adopt and engage in an APM. They need a substantial increase in the level of investment payers are making in primary care, and they need that increased investment in the form of stable, prospective payments.

How might a proposed PFPM build on the learnings from earlier models?

The AAFP was appreciative of the ability to work with the PTAC preliminary review team (PRT) assigned to our proposal and receive feedback on the APC-APM. The PRT's questions and subsequent full PTAC deliberations led to the model's evolution and improvements from original submission. We have continued to build on what we learned as we have talked with CMMI staff about other APMs, such as Primary Care First. As we prepare to build a new, primary care oriented APM, we will take what we have learned to hopefully develop a model that:

- Continues to stress prospective patient attribution
- Is simpler in design
- Relies more on prospective payment
- Limits itself to measures that matter and over which physicians have control
- Appeals to both patients, physician practices, and payers

How might care models that are included in the proposals reviewed by PTAC be incorporated in broader models, like Accountable Care Organizations (ACOs)? Direct

Contracting? What factors would be important to take into consideration, such as barriers or facilitating factors for adoption?

Incorporating models reviewed by PTAC into ACOs and Direct Contracting may prove challenging and must be done with careful consideration. To date, most overlap between shared savings models has impacted benchmarking calculations when including any bonus or shared savings or losses from multiple programs in total expenditures. The AAFP believes transparent benchmarking methodologies that outline the impacts between all allowable overlapping models are critical for organizations making decisions about participating in multiple models. Additionally, to facilitate meaningful participation, reduce burden, and improve evaluability, we recommended aligning quality measures where appropriate. Finally, special considerations should be made when designing the evaluation methodologies for models that allow overlap to appropriately account for the impact of potential quality improvements and cost savings realized by dual participation.

Thank you for your time and consideration of this input. If you or the ASPE staff have any questions or the AAFP may be of further assistance, please contact Mr. Kent Moore, Senior Strategist for Physician Payment at the AAFP at kmoore@aafp.org or (913) 906-6398.

Sincerely,

John Cullen, MD
Board Chair