AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

November 18, 2015

Sam R. Nussbaum, MD, Work Group Chair
Alternative Payment Model Framework and Progress Tracking Work Group
Submitted via email

Dear Dr. Nussbaum,

On behalf of the nation's120,900 family physicians and medical students, I write to share the AAFP's support for and comments about the Alternative Payment Model (APM) Framework and the associated white paper created by the Alternative Payment Model Framework and Progress Tracking Work Group.

Overall, the AAFP is supportive of the white paper since it includes important information needed to provide a common and shared understanding of APMs and the key terms needed to define APMs. This Framework sets a foundation for the health care system to move forward with common goals, expectations, and concepts for the evaluation of APMs. The AAFP agrees with the Work Group that this common understanding is important to lay the groundwork for widespread adoption by both public and private payers. We also agree that rapid adoption by all payers is needed to provide essential support to primary care practices which will help ensure the successful adoption of APMs.

In looking at the white paper as a whole, the AAFP urges the Work Group to be cautious of rigidity in the Framework. Flexibility within the Framework is needed to allow for new and innovative models as well as make improvements to existing models. We caution the Work Group to not over-complicate the Framework. We are concerned that the creation of too many subcategories could make the Framework and decisions about payment models too complicated which would create barriers to their success. Finally, the AAFP encourages the Work Group to keep in mind a goal of promoting and incentivizing continuous quality improvement through the payment models outlined in the Framework. The payment models should not be used to punish poor performers or restrict provider participation in the Medicare program.

The AAFP provides the following comments on particular topics within the white paper:

Definition of Patient-Centered Care: The Work Group defines patient-centered care as "quality care that is delivered in an efficient manner, where the patient's or consumer's informed choices, values, priorities, and individual circumstances are paramount. It relies on Quality, Cost Effectiveness, and Patient Engagement." The AAFP defines patient-centeredness as "an ongoing, active partnership with a personal primary care physician who leads a team of professionals dedicated to providing proactive, preventive and chronic care management through all stages of life." We encourage the Work Group to expand their definition to include the partnership between the patient and their care team.

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Definition of Quality: The AAFP's finds the Work Group's definition of quality to be reasonable, clear, and consistent with relevant AAFP policies on Quality Healthcare in Family Medicine and Performance Measures Criteria. The AAFP strongly recommends that the Work Group advocate for the use of the core measure sets developed by the multi-stakeholder Core Quality Measures Collaborative to ensure alignment, harmonization, and the avoidance of competing quality measures among payers. These sets contain a variety of measure types.

Definition of Cost Effectiveness: The AAFP urges the Work Group to reconsider its proposed definition for cost effectiveness. The cost effectiveness definition should include:

- Optimization of team-based care and practice work flow;
- Low administrative burden to comply with regulations and payer requirements; and
- An emphasis on the important role that primary care plays in achieving cost effectiveness for the health care system as a whole. Family physicians and other primary care providers can be responsible for the management of the total cost of care as long as they have access to real-time quality and cost information and resources needed to monitor cost.

Definition of Patient Engagement: The AAFP urges the Work Group to expand their definition of patient engagement to acknowledge that an engaged patient goes beyond being "informed of health improvement and sharing in their own care." Engaged patients also take an active role in creating and implementing their care plans and share accountability in improving their own health outcomes. The PCMH model empowers patients to participate fully in their care—and places the patient at the center of the care team. In this role, patients play an active part in setting goals, participating in treatment decisions, engaging in self-care, and monitoring and assessing outcomes. Health care is a true partnership in which the physician and the patient both have responsibilities. However, this shared responsibility is currently not demonstrated in performance measurement; rather it rests with the physician. The goal of performance measurement is to improve patient outcomes, including improving the patient's health status, as well as reducing their morbidity and mortality. Therefore, it is important to engage all stakeholders that have an impact on these goals, including patients, family members or caregivers, clinicians, and the health care system.

The AAFP agrees with the Work Group's assertion that changes in payments are needed to help drive adoption of patient-centered care at the practice level. These changes need to provide multiple avenues for practices to earn payments for practice improvements and population health efforts without administrative burdens and needless reporting, both of which have proven to be barriers to practice improvement efforts in the past. In addition, through changes in payment and a shift toward value-based payment, the Work Group should look for ways to emphasize and incentivize the patient's role in healthcare and practice improvement. The AAFP reminds the Work Group of the "Joint Principles of the Patient Centered Medical Home," which outlines payment as one of the seven principles of the patient-centered medical home (PCMH) and insists that adequate payment is essential for the success of a PCMH. This APM Framework presents an opportunity to reinforce the payment models that are essential to the success of providing patient-centered and, effective primary care. According to the Joint Principles, payment should appropriately recognize the added value provided to patients by a medical home. The payment structure should:

- Reflect the value of physician and non-physician staff care management work that falls outside of the face-to-face visit.
- Pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- Support adoption and use of health information technology for quality improvement.
- Support provision of enhanced communication access such as secure e-mail and telephone consultation.

- Recognize the value of physician work associated with remote monitoring of clinical data using technology.
- Allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
- Recognize case mix differences in the patient population being treated within the practice.
- Allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- Allow for additional payments for achieving measurable and continuous quality improvements.

Category 4 in the APM Framework appears to meet the intent of the Joint Principles and the AAFP encourages the Work Group to carefully consider the guidance set out by the Joint Principles as they finalize and refine all Categories.

The AAFP strongly agrees with the Work Group's assertion that a shift from fee-for-service (FFS) to population-based payments (PBPs) is needed to sustain delivery systems that value quality, cost-effectiveness, and patient engagement. In general, we agree with the Work Group's statement that PBPs provide flexibility needed to coordinate and manage patient care. This flexibility will improve care, especially for chronic, complex illnesses. Through the original per patient per month (PMPM) care management fee provided in the Comprehensive Primary Care (CPC) initiative, we understand that the PMPM care management fee has allowed CPC practices to increase staff and time committed to assessing and meeting the needs of their patient population which in turn improves health outcomes, especially for high risk patients. While we agree with the intent of this assumption, the AAFP strongly urges the Work Group to clarify the statement and make it clear that PBP's are meant to allow primary care physicians the flexibility needed to address the needs of their patient populations, particularly those with chronic conditions**. PBPs should be provided only for those providing primary care services and not for sub-specialty medical practices.**

The AAFP agrees with the draft white paper that payment models need to be adopted consistently across public and private payers in order to achieve successful adoption and for practice financial sustainability. From a recent survey, we know that more than 60 percent of AAFP members have contracts with seven or more payers. The complexity created from complying with the separate programs and reporting requirements of multiple payers distracts from patient care and quality improvement efforts within the practice.

The AAFP agrees with the Work Group that changes in payment could result in unintended consequences. We encourage the Work Group to expand the list of items to be monitored to include adverse impacts on patient selection to ensure that higher risk patients are not losing access to care. We also encourage the Work Group to ensure that risk-adjustments for social determinants are providing adequate compensation for physicians dealing with patients with risk factors and barriers to care. In addition, we encourage the monitoring of reporting requirements of practices and regular checks over whether reporting requirements are creating barriers preventing the successful participation in APMs for practices, especially small, rural, and independent practices.

Looking at both the CMS payment Framework and the proposed APM Framework, the AAFP believes the progression through payment model categories will be positive and beneficial for primary care. However, these models will only be beneficial if traditional FFS is first fixed to appropriately value primary care services. The AAFP is concerned that FFS currently undervalues primary care services and without addressing this, future actuarial calculations for APMs will not adequately compensate primary care. **The HCP LAN and this Work Group must advocate for CMS to improve the value and payment for primary care services in**

the current FFS model. RVUs need to be immediately adjusted upward for common primary care services.

The AAFP offers the following comments on Principles:

- **Principle 1:** The AAFP agrees. Patient engagement is essential in improving health outcomes and lowering utilization. Providers need timely access to actionable data to share with patients to help inform them about high value providers as patients make decisions about specialty care.
- **Principle 2:** The AAFP agrees. The AAFP encourages the Work Group to strongly endorse and recommend that CMS and all payers use the core measure sets developed by the multi-stakeholder Core Measure Collaborative to ensure alignment and harmonization and the avoidance of competing quality measures among payers. These sets contain a variety of measure types targeting different clinical areas. This measure alignment needs to be a part of the payer alignment included in this principle.
- **Principle 3:** The AAFP strongly supports this principle to ensure that providers delivering care share in payment incentives. A recent AAFP member survey indicates that 26 percent of members' value-based payments are funneled to administration of a hospital or health system and not directly to physicians, while only 24 percent are distributed directly to physicians. The other 50 percent indicated a different model that includes both infrastructure investments and physician distribution (18 percent), or indicate they do not know how payment incentives are being shared (33 percent).
- **Principle 4:** The AAFP agrees with this principle, but recommends editing it for clarity to read: *Payment models that do not take quality and value into account will not be considered APMs for the purposes of tracking progress towards payment reform and therefore will not be classified under this Framework.*
- **Principle 5:** The AAFP agrees with this principle, but encourages revisions that would acknowledge and reward practices for improvements made over time. We appreciate the need for high expectations, but the models need to give providers the opportunity to ramp up to the high performance expectations.

The AAFP provides the following comments on the APM Framework Categories:

- **Category 1:** The AAFP is concerned that FFS currently undervalues primary care services and without addressing this, future actuarial calculations for APMs will not adequately compensate primary care. **The HCP LAN and this Work Group must advocate for CMS to immediately improve the value and payment for primary care in the current FFS model. The RVUs need to be adjusted upward for common primary care services.**
- **Category 2:** We appreciate that the Work Group acknowledges that beginning to report quality will be challenging for some physicians and that the Framework includes a time limited payment for reporting. We encourage the Work Group to also include a step of pay for demonstrating improvements in 2B or 2C after paying for reporting. We disagree with the statement that Category 2 does not include providers taking on risk. Category 2D includes penalties for providers who do not perform well. In addition, for a practice to improve quality to receive incentives in Category 2, they must invest time and money in quality improvement. Investments in improvement should be viewed as practices and providers taking on risk.
- **Category 3:** This category has its foundation in FFS, and the AAFP remains concerned that APMs will be built upon the current biased and inaccurate relative value utilization data currently used in the fee-for-service system. This system undervalues and underpays for primary care services. We feel more must be done to ensure that Medicare is paying appropriately for primary care physician services in these new payment models rather than paying based on this biased actuarial data that further exacerbates the undervaluation of primary care services. **The HCP LAN and this Work Group need to advocate for CMS to immediately improve the value and payment for primary care in the current FFS model. The RVUs need to be adjusted upward for common primary care services.**

- **Category 4:** The AAFP is very supportive of the person-centered focus of payments in Category 4. Investing in this type of payment will allow primary care physicians the opportunity to demonstrate improved outcomes and decreased utilization that primary care can produce when paid to meet the needs and manage the health of their patient populations. As written currently in the white paper, the distinction between PBPs in Category 4A and bundled payments as envisioned in Category 3 is unclear. We encourage the Work Group to more clearly define what differs between those two models.

The AAFP appreciates the inclusion of case studies to help illustrate the categories of the APM Framework. The Work Group should consider while looking at these case studies that many physicians have multiple payers and their ability to fully engage in APM models that are not aligned or designed as multi-payer projects, like CPC, will be limited. We encourage the Work Group to strongly advocate for APM models to be aligned and adopted across payers to increase support for primary care and improve physicians' ability to successfully engage in the shift to value-based payment and APMs.

We thank you for the opportunity to provide these comments and suggestions on the APM Framework draft white paper and we look forward to working further with the Work Group to develop APMs that transform our health care system, improve patient outcomes and experiences, and appropriately utilize our nation's limited financial resources. Please do not hesitate to call upon the AAFP for assistance. For additional information, please contact Tracey Allen-Ehrhart, Manager, Center for Quality, at tallen@aafp.org or (913) 906-6000, ext. 4114.

Sincerely,

Robert L. Wergin, MD, FAAFP
Board Chair