
November 15, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201
Submitted by email: CMMI_NewDirection@cms.hhs.gov

Dear Administrator Verma:

On behalf of the American Academy of Family Physicians (AAFP), which represents 129,000 family physicians and medical students across the country, I write in response to the request for information issued on September 20, 2017, by the Center for Medicare & Medicaid Innovation (the Innovation Center) within the Centers for Medicare & Medicaid Services (CMS). In this request, the Innovation Center seeks new direction to promote patient-centered care, test market-driven reforms that empower beneficiaries as consumers and provide price transparency, increase choices and competition to drive quality, reduce costs, and improve outcomes.

**Guiding Principles**

*Background*

The Innovation Center will carefully evaluate how models developed consistent with the new principles can complement what the agency is learning from the existing initiatives. The Innovation Center will approach new model design through the following guiding principles:

- Choice and competition in the market based on quality, costs, and outcomes;
- Provider choice and incentives, including a focus on developing voluntary models and reducing regulatory and administrative burden on physician model participants;
- Patient-centered care that empowers beneficiary choice;
- Benefit design and price transparency to ensure cost-effective, data-driven care;
- Transparent model design and evaluation that draws on a broad range of stakeholder perspectives; and
- Small scale testing of models—which may be expanded if initial testing is successful—with a focus on key payment interventions rather than on specific devices or equipment.

*AAFP Response*

The AAFP has reviewed the guiding principles the Innovation Center will use to inform its approach to new model design. In general, we are supportive of these principles and believe they represent a reasonable set of values on which the Innovation Center can rely.

For its part, the AAFP also has a set of guiding principles that inform our approach to the design and evaluation of new, alternative payment models. The AAFP's guiding principles seek to ensure that models:

- Provide longitudinal, comprehensive care
- Improve quality, access, and health outcomes
- Coordinate with the primary care team
- Promote evidence-based care
- Are multi-payer in design

Like the Innovation Center's guiding principles, those of the AAFP emphasize quality and outcomes and support patient-centered care that is longitudinal and comprehensive, and we ask the Innovation Center to consider ensuring that new models meet these principles as well. We elaborate on the AAFP's principles later in this response.

As future directions are considered, the AAFP encourages the Innovation Center to more rapidly expand promising value-based payment models to maximize positive outcomes for patients and physicians. We support the findings that the shift to value-based payment models through practice transformation efforts is a timely and costly process. Acknowledging this, we urge the Innovation Center to examine evaluation designs of current models and reassess what necessitates success to allow more aggressive expansion of models that have the potential for great impact. For instance, CPC Classic, a four-year demonstration project, showed limited success using the evaluation measures designed, potentially due to length of the project and evaluation measures chosen. Evaluations should be designed at the onset of a model's launch with careful consideration of outcome measures, and would also benefit from stakeholder input and consultation. Evaluations should be performed by entities intimately familiar with model components and design to ensure accurate assessment and conclusions. Finally, we urge the Innovation Center to ensure transparency in model design and in all facets of physician measurement analysis.

**Expanded Opportunities for Participation in Advanced Alternative Payment Models (APMs)**

*Background*

As part of the *Medicare Access and CHIP Reauthorization Act of 2015 (MACRA),* CMS administers the Quality Payment Program (QPP), and the Innovation Center bears primary responsibility for development of policies and operations relating to Advanced APMs. The Innovation Center seeks feedback from stakeholders on ways the Administration can be more responsive to eligible clinicians and their patients, and potentially expedite the process for providers that want to participate in an Advanced APM. The Innovation Center also seeks guidance from stakeholders on ways to capture appropriate data to drive the design of innovative payment models and strategies to incentivize eligible clinicians to participate in Advanced APMs.

*AAFP Response*

Like CMS, we expect the number of eligible clinicians choosing to participate in Advanced APMs will grow over time. To facilitate this growth, the AAFP would like to see CMS and the Innovation Center do at least two things, both of which we believe are consistent with the guiding principles through which the Innovation Center intends to approach new model design.

First, pending a recommendation from the Physician-focused Payment Model Technical Advisory Committee (PTAC), we would like to work with the Innovation Center to begin testing the Advanced

Primary Care Alternative Payment Model (APC-APM) proposed by the AAFP. The APC-APM builds upon CPC Plus (CPC+) and represents another evolutionary step away from fee-for-service (FFS) toward payment for value. APC-APM is consistent with the Innovation Center's guiding principles, as well as the AAFPs:

- **Market-based:** Participating practices are evaluated on and held accountable for quality, cost, and outcomes, which promotes competition in the market on that basis.
- **Physician-focused:** Physician participation in the model is voluntary, and the model reduces the administrative burden on physician participants:
    - To the extent evaluation and management (E/M) services are capitated and paid prospectively for attributed patients, practices will not need to file claims for them.
    - Practices will not need to comply with E/M documentation guidelines for capitated E/M services, which potentially simplifies the use of electronic health records.
    - Care management and transitional care management services are included in the prospective, capitated population-based payment, so practices do not need to file claims for them either.
    - Measure harmonization through multi-payer use of a core measure set simplifies quality reporting and reduces the associated reporting burden.
    - Participating practices have more freedom to manage patient panels independent of traditional face-to-face visits (e.g. group visits, e-visits).
- **Patient-centered:** Beneficiaries may choose the advanced primary care practice to which they are attributed.
- **Transparent:** The model is intended to be multi-payer, so it has the potential to draw on a broad range of stakeholder perspectives.
- **Payment-focused:** A focus of the model is its payment methodology, and the model of care does not depend on specific devices or equipment.

If implemented nationally, as the AAFP proposes, the APC-APM would expand opportunities for participation in Advanced APMs, and because the APC-APM is feasible for small practices, those expanded opportunities could help preserve solo and small independent practices, which is consistent with the principle of choice and competition in the market.

Second, we would like to see the Innovation Center continue to expand the CPC+ initiative. Building on the CPC Classic model, CPC+ is a voluntary model that provides choice and competition in the Innovation Center test markets. Participation in CPC+ provides an opportunity for primary care to receive more comprehensive, more flexible payment and engage in a robust learning community to better meet patient needs. The CPC+ payment model is beneficial for primary care, providing access to increased and up-front payment. CPC+ has three components that de-emphasize FFS and increase payment to support practice improvement and capacity building. CPC+ promotes patient-centered, cost-effective, and data-driven care through comprehensive, coordinated, and continuous primary care. The model focuses on key payment interventions and draws on a broad range of stakeholders as part of its model design. To date, the Innovation Center has pursued CPC+ through small scale testing in a total of 18 markets between Round 1 and Round 2 with support from 61 payers. We would like to see CMS further expand CPC+, so other beneficiaries and primary care physicians may benefit from what it offers.

**Consumer-Directed Care & Market-Based Innovation Models**

Per the request for information, the Innovation Center encourages Medicare beneficiaries to be empowered as consumers and drive change in the health system through their choices. The

Innovation Center is considering how to test models that enable Medicare beneficiaries to contract directly with physicians and have physicians offer prices to inform beneficiary choices and to promote transparency. The Innovation Center seeks feedback on how to operationalize these principles in models that best serve patients in terms of cost, quality, and access to care.

*AAFP Response*
The AAFP is pleased the Innovation Center is focusing on driving greater transparency and consumer choice within the healthcare system. The AAFP supports the innovation and testing of models that allow Medicare beneficiaries to contract directly with physicians and other healthcare providers.

The AAFP believes patient choice within the participation of alternative payment models is crucial to the success of the model and engagement of the patient. The AAFP's APC-APM focuses on making patient choice the primary attribution methodology. Patients who do not believe they are receiving the care they need may elect to leave an APM entity. The AAFP recommends a patient-based, prospective, four-step process that acknowledges patient selection is the best choice in attribution and should be prioritized as such.

The AAFP actively supports family physicians who choose to practice in a delivery and payment model in which they contract directly with patients, typically referred to as Direct Primary Care (DPC). Under the DPC model, the patient pays a monthly or annual fee directly to the practice for a defined set of primary care services. These services typically include increased access to a personal physician, extended visits, electronic communications, in some cases home-based medical visits, and highly personalized, coordinated, and comprehensive care administration. 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. DPC physician practices prosper on being fully transparent and consistent with their costs that the patient can access at any time. The AAFP has seen DPC practices nationwide negotiate substantially lower prices with local imaging and diagnostic centers, because their patients are paying out of pocket for the services.

Although this model represents a small portion of our membership, the AAFP sees continued growth and interest in family physicians adopting this practice model in all settings types, including rural and underserved communities. The AAFP encourages the Innovation Center to work with DPC organizations who have experience in designing and implementing this type of payment model under Medicare Advantage and with self-funded employers. We also encourage the Innovation Center to seek guidance from independent DPC practices that have typically chosen this practice model to free themselves from the administrative burdens of public and private insurers. Participation in any demonstration model should be voluntary and open to all physicians interested in participating. Many DPC physicians have opted out of Medicare to privately contract directly with Medicare patients for non-covered services. The Innovation Center should find a way to allow these physicians the opportunity to participate without having to wait for the two-year Medicare opt-out reinstatement window. Direct primary care thrives on removing the administrative requirements that are found in the current FFS system. A model that is looking to test how DPC can help reduce cost and increase quality should look to model those attributes. The AAFP welcomes the opportunity to connect CMS and the Innovation Center with our members practicing in this setting to gain further feedback.

**Physician Specialty Models**
*Background*

Per the request for information, the Innovation Center is interested in increasing the availability of specialty physician models and engaging specialty physicians in alternative payment models. The Innovation Center solicits feedback from stakeholders regarding their best ideas for new physician specialty models and appropriate quality measures. The Innovation Center also seeks comments on the role of the PTAC.

*AAFP Response*
The AAFP strongly supports moving a larger percentage of payments from traditional FFS towards APMs. TWe also recognize that MACRA creates incentives for physicians to participate in APMs and encourages the development of physician-focused payment models (PFPMs). Out of concern that haphazard payment models would be proposed that are not patient-centered, the AAFP created principles to support patient-centered APMs. The AAFP has and will continue to use these principles to react to APMs and PFPMs. We strongly maintain that APMs should support the delivery of comprehensive, longitudinal care for patients and promote quality of care over volume.

Family medicine's commitment to models of care that are built for patients is clear—among AAFP's clinically active members, 45% already work in an officially recognized patient-centered medical home (PCMH). Moving to a value-based health care system in a sustainable way requires transitioning away from a model of symptom and illness-based episodic care to a system of comprehensive, coordinated, primary care for children, youth, and adults.

While some of the APMs and PFPMs 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, such as CPC+.

The five principles that guide the AAFP's evaluation of proposed models to ensure they place patients—and not clinicians—at the center include:

1. **APMs Must Provide Longitudinal, Comprehensive Care**
    - APMs should support the delivery of team-based, comprehensive care, which includes all acute, chronic, and preventive services, not just episodic care.
    - APMs should provide continuous, coordinated, and connected longitudinal care in the most cost-effective setting.
    - APMs should not fragment care across clinicians and settings for patients since fragmentation weakens clinician accountability for outcomes and/or costs, and negatively impacts patient experience and outcomes.
    - Primary care APMs should be based on the core functions of the PCMH as articulated through the Joint Principles of the Patient-Centered Medical Home and CPC+ Initiative, which includes:
        - Access and continuity
        - Planned care and population health
        - Care management

- Patient and caregiver engagement
- Comprehensive and coordinated care

2. **APMs Must Improve Quality, Access, and Health Outcomes**
    - APMs must demonstrate how they will contribute to improvements in quality of care, access to care, and positive health outcomes for patients.
    - APMs should use the core measure sets developed by the multi-stakeholder Core Quality Measure Collaborative to ensure alignment, harmonization, and the avoidance of competing quality measures among payers in an effort to reduce administrative burden.
    - APM payments should be appropriately risk adjusted to ensure accurate assessment of provider performance and accountability.
3. **APMs Should Coordinate with Primary Care Team**
    - If condition-focused APMs are approved, they should be required to contact a patient's primary care physician and team (or primary care clinicians serving Medicare patients in a given geographic area). This will allow patients receiving care through a specialty- or disease-focused APM to also benefit from coordination with a primary care physician and team that will provide longitudinal care, in addition to treatment of a particular episode or condition.
    - APMs should include agreements with primary care physicians to enhance the working relationship between the specialty- or disease-focused physicians and the primary care physician and team.
4. **APMs Should Promote Evidence-based Care**
    - APMs should incent or require use of evidence-based recommendations to treat acute and chronic conditions and to provide preventive services.
    - APMs should be physician-led, team-based, and primary care oriented to ensure they are patient centered. Patient centeredness requires 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. This ensures that complex care management and care coordination issues are continually addressed.
5. **APMs Should be Multi-payer in Design**
    - APMs should be multi-payer in design to ensure that all patients—regardless of payer—have access to promising care models that can improve their health outcomes and care, and reduce costs.
    - APMs should be multi-payer in their design to allow the Centers for Medicare & Medicaid Services and other health care payer programs to leverage investments and learning in payment and delivery system reform.
    - Payments for primary care in any APM should be made mainly on a per patient basis through the combination of a global payment for direct patient care services and a global care management fee. APMs should avoid reliance on FFS payments.

The AAFP strongly encourages the Innovation Center and PTAC to use these five principles when evaluating any APM or PFPM, regardless of whether the model is oriented towards primary care, prevention, sub-specialty, geographic, or site-of-service models.

Regarding appropriate quality measures, the AAFP urges CMS and the Innovation Center to align and harmonize quality measures as part of an overall approach to reducing administrative burden. To

accomplish this, the AAFP recommends that HHS, in all federal programs and demonstrations, use the core measure sets developed by the multi-stakeholder Core Quality Measures Collaborative to ensure parsimony, alignment, harmonization, and the avoidance of competing quality measures among all payers.

Concerning PTAC, the AAFP continues to be fully supportive of their role in evaluating PFPMs. Considering that the PFPM submitted by the AAFP to the PTAC (Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care), is overtly multi-payer in design, and per our comments to CMS in response to the 2018 proposed Medicare physician fee schedule, we maintain full support in expanding PTAC's purview to examine PFPMs that include Medicaid and the Children's Health Insurance Program (CHIP) and a combination of public and private payers.

The existence of PTAC is relatively new, and to date, only a few payment models have received formal recommendations by the PTAC. Thus, stakeholders have not yet witnessed how the Innovation Center will receive or react to the PTAC's and the HHS Secretary's recommendations on PFPMs. The AAFP therefore strongly urges the PTAC, the Assistant Secretary for Planning and Evaluation, CMS, and the Innovation Center to clarify this process fully, so stakeholders can appropriately structure PFPMs and understand the timeline and expectations of the government agencies.

**Prescription Drug Models**

*Background*

The request for information discusses the desire to test new models for prescription drug payment, in both Medicare Part B and Part D and State Medicaid programs, that incentivize better health outcomes for beneficiaries at lower costs and align payments with value.

*AAFP Response*

The AAFP fully recognizes that prescription drug prices are escalating and thus causing significant challenges for too many patients to access life-saving medicines.

As the Innovation Center tests new models related to prescription drug costs, it should include primary care physician input. Per the AAFP policy on generic drugs, the family physician is the patient's advocate, and that responsibility demands that the family physician prescribe safe, efficacious pharmaceutical products to deliver high quality medical care, with sensitivity to the patient's individual medical and financial circumstances. Family physicians and other primary care physicians will be in a better position to do so if they are included in the design of prescription drug payment models.

We appreciate your willingness to examine value-based design with prescription drugs. We urge the Innovation Center to work with the physician and provider community, patient and consumer advocacy groups, plans, manufacturers, and other stakeholders across the supply chain to develop and test innovative value-based purchasing arrangements, and models that would increase drug pricing competition while protecting beneficiaries' access to effective drugs. We recognize finding this appropriate balance will be challenging and are committed to working with the Innovation Center and other stakeholders to achieve it.

**Medicare Advantage (MA) innovation Models**

*Background*

CMS wants to work with Medicare Advantage (MA) plans to drive innovation, better quality and outcomes, and lower costs. CMS is interested in what additional flexibilities are needed regarding supplemental benefits that could be included to increase choice, improve care quality, and reduce cost.

Additionally, CMS seeks comments on what options might exist beyond FFS and MA for paying for care delivery that incorporate price sensitivity and a consumer driven or directed focus and might be tested as alternatives to FFS and MA.

*AAFP Response*

In terms of the QPP and as CMS works with MA plans, the AAFP continues to support CMS's consideration of allowing physicians in MA plans that meet Advanced APM criteria to receive credit for Qualifying APM Participant status under the Medicare Option.

In regard to what MA Innovation Model designs the Innovation Center should consider, the AAFP developed and submitted an APC-APM to the PTAC. The AAFP expects this model to be multi-payer in design and would hope that it includes Medicare Advantage plans and would partner with the Innovation Center to design this model. We are currently communicating and meeting with commercial payers to solicit their involvement. The AAFP believes our PTAC proposal is consistent with the guiding principles within this request for information. In addition, the AAFP believes the structure, approach, and design of potential MA Innovation Models should reflect the AAFP's Principles to Support Patient-Centered Alternative Payment Models.

The AAFP also believes the CPC+ model, which builds on the existing CPC Classic program, should be considered. This model moves further away from FFS and better supports small and independent practices.

In addition, the AAFP believes CMS should consider testing models similar to a new, co-branded MA plan being offered by Cleveland Clinic and Humana, which has a $0 monthly premium, $0 primary-care physician office visit copay, and $0 copay for a 30-day supply of tier 1 prescription drugs and requires no referrals for in-network specialists for seniors in Cuyahoga County. The AAFP considers this plan to be consistent with our advocacy efforts and with our "Health Care for All" policy, which supports certain primary care services with no financial barriers. The AAFP believes this type of plan design would encourage beneficiaries to engage and participate in new models.

The AAFP calls for the onus of submitting payer arrangements to become an Advanced APM to be the burden of the payer. Private payers have a better understanding of what information CMS needs to consider and determine whether a payer arrangement satisfies the Medicare and the Other Payer Advanced APM criteria.

**State-Based and Local Innovation, including Medicaid-focused Models**

*Background*

CMS recognizes the critical role that States play in innovation and delivery of high quality care. With an interest in partnering with states to drive better outcomes for people based on local needs, CMS and the Innovation Center have worked with states on a variety of initiatives Healthcare providers and states could work with CMS and the Innovation Center to develop state-based plans and local

innovation initiatives to test new models. Models would vary based on the needs and goals of each state for improving care and lowering costs, but could include providing states with more flexibility for multi-payer reforms as well as increasing opportunities for physicians serving Medicaid and CHIP populations to participate in value-based payment models.

*AAFP Response*
Medicaid is a major source of funding for essential health services in communities across the country, and it is vital to the financial stability of safety-net providers. Overall, 76 million Americans get coverage from Medicaid, expansion and non-expansion states combined. For decades, state Medicaid programs have tailored services and developed innovative models of care through state plan authority to streamline health care delivery and improve health. We believe current Medicaid rules allow states sufficient flexibility to address local needs through innovative models, such as Medicaid health homes, shared savings, bundled payments, and other mechanisms.

When the Innovation Center works with states to design and launch models, the AAFP believes areas of focus should include catalyzing primary care infrastructure, streamlining the manner of primary care delivery, and emphasizing the centrality of primary care in building a high-value health system. If primary care practices are given the tools through Medicaid to redesign how they operate, such that they are more accessible to deliver consumer-directed care, promote prevention, proactively support patients with chronic illness, and engage patients in self-management and decision-making, health care quality and competition (especially for small, independent practices) improves along with the cost efficiency of care. Primary care is the only entity charged with the longitudinal continuity of care of the whole patient, and it is the primary care relationship and comprehensiveness that has the most effect on health care outcomes.

State-based and Medicaid models can also help strengthen the PCMH, infrastructure at the local level with appropriate payment for care management and chronic care coordination, 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. The Innovation Center can play a critical role in testing and implementing these models more broadly across Medicaid programs and should include collaboration between the physician's practice and Medicaid case management structures.

Traditional quality improvement activities are often the focus of system redesign, but the AAFP believes that Medicaid cost-containment as well as pay for performance should be rooted in evidence-based research. As the Innovation Center considers testing new Medicaid models, the AAFP believes that demonstration waivers should improve access in the program, maintain coverage, and, at a minimum, maintain current eligibility standards. As part of any demonstration, it is critical that rates paid by states, to either providers or plans, must be adequate and sufficient to encourage provider and plan participation and cover the cost of care for Medicaid patients. Affected individuals should also maintain timely access to any willing, qualified provider. These design elements are critical for creating a consumer-directed health system – and a Medicaid program that functions for all its beneficiaries. The AAFP also believes that waivers must be structured so categorically-eligible and medically-eligible enrollees continue to receive, at a minimum, all currently covered services.

**Mental and Behavioral Health Models**

*Background*

The request for information discusses the desire to explore payment models and behavioral health integration interventions focused on opioid use, substance use disorders, and dementia to enhance care integration and episodic based payment, including encouragement of mental health provider participation in Medicare, Medicaid, and CHIP.

*AAFP Response*

The AAFP strongly supports the development and testing of behavioral health integration delivery and payment models, especially as primary care clinicians play a key role in the identification, coordination, and treatment of mental and behavioral health conditions. The recent CMS Innovation Center Behavioral Health Summit facilitated valuable discussions on varying aspects of payment and care delivery models for treatment of behavioral health disorders. In response to these discussions, the AAFP urges the Innovation Center to consider delivery and payment models for mental health, behavioral health, and substance abuse disorders that meet the following criteria:

- Increase access, quality, and outcomes for patients with behavior health, mental health, or substance abuse disorders.
- Reduce costs associated with identification and treatment of behavioral health conditions through integration into primary care and across the care continuum.
- Support specific treatment options for behavioral health, mental health, and substance abuse disorders to meet the diverse needs of complex patient populations
- Ensure models address behavioral health issues across the full care continuum that incorporate and/or address Social Determinants of Health.
- Model participation should be voluntary and include incentives for physician participation, such as care management fees, appropriate and increased payment, reduced burden, etc.
- Include telehealth options for behavioral health, mental health, and substance abuse disorder delivery of services, which address:
    - Increased patient and provider access to allow early intervention and avoidance of hospital and emergency department admission.
    - Increased communication at all levels: patient and provider, clinician to clinician, and between patients (e.g. virtual support groups, group visits).
    - Increased continuity and consistency when utilizing evidence-based practices and specialist consults/referrals.
    - Increased cost savings for patients, clinicians, and payers.
    - Increased patient satisfaction and empowerment.

Since the Innovation Center request for information specifically requests suggestion on how to address opioid and substance abuse disorders, per the AAFP's position paper titled, "Chronic Pain Management and Opioid Misuse: A Public Health Concern," we suggest that CMS, the Innovation Center, other payers, and policymakers consider policies that:

- Work for adjustments in payment models, including appropriate payment and coding for care related to behavioral health conditions, to enable physicians to provide patient centered, compassionate care in the treatment of chronic pain and opioid dependence and to appropriately compensate them for providing such care.
- Allow for primary care and behavioral health billing on the same day.

- Expand governmental and private insurance coverage of medication-assisted treatment (MAT) in the primary care setting, with adequate payment for the increased time, staff, and regulatory commitments associated with MAT.
- Increase clinician training and engagement related to MAT.
- Expand the role of advanced practice nurses and physician assistants in providing MAT as part of a team supervised by a DATA 2000-waivered primary care physician to address workforce shortages for the treatment of behavioral health and substance abuse disorder.
- In states that lack appropriate laws, advocate for better access to naloxone and appropriate Good Samaritan protections for prescribers and lay rescuers.
- Work with state and federal licensing boards, the Drug Enforcement Administration, and the Substance Abuse and Mental Health Services Administration to destigmatize MAT, particularly in the setting of the community provider.
- Work with state and national partners to improve the functionality, utility, and interoperability of prescription drug monitoring programs, and develop best practices for their use and implementation.
- Expand governmental and private support of research into the management of chronic pain, as well as methods to better identify and manage opioid misuse.

The AAFP would support models for behavioral health that align with our APC-APM. Keeping the five key functions of medical homes in mind, the APC-APM expects APM entities to address behavioral and mental health issues. “Comprehensive and Coordination” implies caring for the whole patient and recognizing that the mind and body are interrelated and connected. Promotion of mental health and the diagnosis and treatment of mental illness are integral components of primary care.

We also encourage the expansion of the behavioral health integration components of CPC+ in addition to the expansion of the model nationwide. The AAFP advises the hybrid Comprehensive Primary Care Payment be offered to practices in both Tracks, not just Track 2, as this added payment component allows for further flexibility of care delivery models not traditionally supported by FFS. We also suggest extending the $100 per-beneficiary-per-month Care Management Fee for a Dementia diagnosis currently only available to Track 2 to all participating practices. Additional financial support for this work would be as outlined above (expansion of MAT payment, etc.).

**Program Integrity**

*Background*

The Innovation Center is seeking comment on ways that it may reduce fraud, waste, and abuse and improve program integrity. The costs and effectiveness of different approaches to program integrity could be tested to help the Innovation Center find the ideal balance between burdens on patients and additional workload created for the physician and effectiveness of the review. Such an approach could be tested as part of a new model and/or be layered on top of other models.

*AAFP Response*

As the Innovation Center contemplates ways in which it may reduce fraud, waste, and abuse and improve program integrity, we would urge it to focus more on outcomes related to quality and cost and less on procedural safeguards. Such an approach would be more consistent with the guiding principle of choice and competition in the market based on quality, costs, and outcomes than the current approach of subjecting beneficiaries and physicians to increasingly stringent forms, coverage criteria, and documentation requirements. For instance, why should a physician who is successfully

helping his or her patients with diabetes manage their condition, as evidenced through quality reporting, be subject to all the current hassles associated with prescribing and ordering diabetic testing supplies, which are otherwise driven by CMS concerns with fraud, waste, and abuse?

We note that the second guiding principle references "reducing regulatory and administrative burden on physician model participants." One way the Innovation Center could do this would be to streamline and bring consistency to the multitude of claims review processes and auditors under Medicare, many, if not all, of which support program integrity to one degree or another. Medicare alone has Medicare administrative contractors, zone program integrity contractors, recovery audit contractors, comprehensive error rate testing contractors, Meaningful Use auditors, etc. Within these audit programs, there are a multitude of requirements, appeals processes (if any), and differing deadlines. Communications from these entities are not easily understood by busy physicians nor are their deadlines easy to meet. We recognize some monitoring activity is necessary, but the AAFP strongly recommends that the Innovation Center look for opportunities to streamline CMS program integrity efforts, so the guideline of reduced regulatory and administrative burden as part of provider choice and incentives can be met.

To the extent that reducing regulatory and administrative burden on physician model participants is a key element of the guiding principle of provider choice and incentives, it should be a feature of any model design considered by the Innovation Center. We believe CMS, through the Innovation Center, should use Advanced APMs to help reduce physicians' regulatory and administrative burdens. Where an Advanced APM includes administrative requirements, the Innovation Center should ensure that payments provide appropriate compensation to physician model participants for collecting the needed data.

We appreciate the opportunity to provide these comments and make ourselves available for your questions. Please contact Bethany Burk, Quality and Practice Specialist, at (913) 906-6000, ext.4172 or bburk@aafp.org with any questions or concerns.

Sincerely,

John Meigs, Jr., MD, FAAFP
Board Chair