November 9, 2015

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Ave., SW
Washington, DC 20201

Dear Administrator Slavitt,

On behalf of the American Academy of Family Physicians (AAFP), which represents 120,900 family physicians and medical students across the country, I am responding to CMS's request for information regarding implementation of the Merit-Based Incentive Payment System (MIPS), promotion of Alternative Payment Models (APM), and incentive payments for participation in eligible APMs as published in the October 1, 2015 *Federal Register*.

Before the AAFP responds to the questions posed by CMS, we must reiterate our full support for the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). This law not only repealed the faulty sustainable growth rate formula, but it also set our health care system on a path away from episodic, fee-for-service payments toward more comprehensive and value-based payment. Furthermore, *MACRA* enables us to rebalance US care delivery systems to place greater emphasis on the value of comprehensive, continuous, coordinated, and connected primary care to both patients and payers.

Despite our strong support for MACRA, the AAFP remains very concerned that the MIPS and APM programs will be built upon the biased and inaccurate relative value data currently used in the fee-for-service system. We strongly recommend that more be done to ensure Medicare pays 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. To achieve this goal, we urge CMS to use its authority and take administrative actions to increase the values of primary care services in the Medicare program.

The AAFP looks forward to working with your agency. We remain an available resource as CMS further develops MIPS and APM options that will influence Medicare payments to physicians beginning in 2019. Our comments respond to your full set of questions, focusing on a subset of specific themes. The following is a summary of those themes:

- **Measure Harmonization**
  The AAFP supports reasonable and achievable quality improvement programs that promote continuous quality improvement and measure patient experiences. However, the AAFP opposes an approach that requires physicians to report on a complex set of measures that do not impact or

influence the quality of care provided to patients. Unfortunately, the current PQRS program does not support true quality improvement. Instead, it focuses on making physicians comply with burdensome reporting criteria, using resources that could otherwise be spent on continuous and meaningful quality improvement activities. By placing an emphasis on satisfying reporting requirements to avoid penalties, current programs distract attention from the real goal—providing high quality health care to patients. The AAFP strongly urges CMS to streamline, harmonize, and reduce the complexity of quality reporting in the MIPS and APM programs. All measures used must be clinically relevant, harmonized among all public and private payers, and minimally burdensome to report. To accomplish this, the AAFP recommends in numerous places that **CMS use 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 the Patient Centered Medical Home**
  The AAFP strongly supported the inclusion of the Patient-Centered Medical Home (PCMH) in *MACRA*. We continue to believe this advanced primary care delivery model, when aligned with an appropriate payment model, represents the best path for empowering primary care to deliver on the Triple Aim. We will state explicitly that we do not consider the PCMH tantamount to third-party recognition as a PCMH. The PCMH is a set of functions within a practice, not something granted by a third party. The AAFP encourages CMS to consider the *Joint Principles of the Patient-Centered Medical Home* and the key functions of the Comprehensive Primary Care (CPC) initiative as criteria for determining what constitutes a PCMH. The Joint Principles, when aligned with the five key functions of the CPC initiative, capture the true definition of a PCMH and its performance thresholds.

  Furthermore, we do not believe a physician should be required to pay a third party to secure the recognition necessary to participate in a Medicare program.

- **Comprehensive Primary Care Payment Reform**
  The AAFP strongly supports moving a larger percentage of payments from the traditional fee-for-service model toward APMs, a position also supported by Family Medicine for America's Health, a collaboration of leading family medicine organizations in the United States. We believe payment models should be designed to promote quality over volume. With respect to primary care, CMS should establish an APM that is a PCMH model based on the *Joint Principles of the Patient-Centered Medical Home* and the key functions of the CPC initiative.

  Furthermore, the AAFP proposes that payments for primary care services under this advanced primary care delivery model be made on a per-patient basis through the combination of a global payment for direct patient care services and a global care management fee. The global payment for primary care services would capture the "core primary care" services, a majority of which are provided by family physicians. AAFP records indicate these services number approximately 80. Any services provided by the family physician that fall outside the core primary care suite would be paid on a fee-for-service basis, through an appropriate bundle, or via a global payment structure. The second element of this blended payment model — a global care management fee—would capture those services performed by the physician or practice that contribute to the continuity and coordination of care, promote compliance and adherence, and facilitate appropriate use of health care resources.

  The AAFP further proposes both the global payment for core primary care services and the global payment for care management be risk-adjusted based upon patient health status, as well as demographic, socioeconomic, and geographic factors. We believe both the global payments for both

core primary care services and care management payments should be eligible for the five percent bonus payment under the APM program.

- **Virtual Groups**
  The AAFP sees great value and promise in the use of virtual groups as a means of allowing solo and small practices to aggregate patient populations, align resources, and form a structure to help them them to improve their performance while maintaining their independence.

  We believe virtual groups should be limited to physicians in the same discipline—or closely aligned disciplines—and connected by a reasonable geographic boundary. Considering that virtual group programs have already been established and have demonstrated favorable quality and cost performance before the implementation of MACRA, the AAFP believes there should be no limit on the number of virtual groups in the first year. To encourage the creation and growth of virtual groups, the AAFP calls on CMS to allow virtual groups to consist of multiple Taxpayer Identification Numbers (TINs) or to classify multiple TINs to be classified under a new TIN specific to the new virtual group. At least in the early years of the program, the AAFP encourages CMS not to allow TINs to split for the sake of administrative simplicity.

  In addition, the AAFP believes CMS should establish thresholds based on the eligible number of patient lives attributed to a virtual group, and not arbitrarily dictate and restrict the number of providers participating in a virtual group. To secure a statistically valid patient sample size, which we believe will also facilitate the production of desired outcomes, we recommend that the patient sample be more than 5,000 to assure statistical validity. However, we fully recognize that CMS needs to solve how this number will impact this creates an issue that CMS needs to solve in order to effectively engage those practices in rural, sparsely populated areas.

- **Patient Attribution**
  The AAFP encourages CMS to use the attribution methodology used in the Comprehensive Primary Care (CPC) initiative since that program uses a prospective attribution model. Prospective attribution dramatically increases patient engagement with a usual source of primary care and does not have to limit patient choice in any way. In addition, providing physicians with a prospective list of patients for which they are responsible facilitates proactive population management, which leads to improved outcomes. In contrast, retrospective attribution methodologies are particularly burdensome to physicians, because it is challenging for physicians to engage in effective population health management if they do not know which patients need to be targeted for delivery, management, and/or coordination of care. The AAFP also urges CMS to include a reconciliation process in whatever methodology it adopts. Under such a reconciliation process, a family physician should be able to review, add, or remove patients from the list received from CMS. This element is currently lacking in the CPC's attribution methodology.

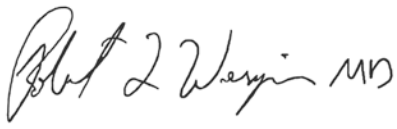
- **Meaningful Use**
  The AAFP believes several barriers exist to successfully meeting the MIPS quality performance category. The first and most significant barrier is the poorly designed meaningful use program and its lack of interoperability standards, which prohibit the sharing of patient information in a useful form. Physicians face significant challenges with their EHRs and meeting current meaningful use standards. Until the meaningful use program is improved and the EHR issues are resolved, it is difficult to foresee a large percentage of physicians—particularly physicians in small and independent practices—being successful in MACRA programs. EHRs should be a tool for success in a physician's practice, not an obstacle to overcome.

- **Clinical Practice Improvement Activities**
  The AAFP encourages CMS to offer physicians multiple options for completing clinical practice improvement activities. If a practice is a recognized PCMH, then CMS should immediately provide this practice with the maximum score and not require further verification from the practice. If an Eligible Provider (EP) completes an accredited Performance Improvement Continuing Medical Education (PI-CME) activity, as defined by the AAFP, AMA, AOA, AAPA or other nationally recognized credit systems with a formally defined PI-CME activity category, then CMS should immediately provide this practice with substantial points toward the score for the Clinical Practice Improvement Activities Performance Category, and need not require further verification from the practice. However, if the practice is not a recognized PCMH, and the EP has not completed an accredited PI-CME activity during the time frame under evaluation, then other options could be considered for completion of clinical practice improvement activities. Such options could include participation in clinical practice improvement activities required by hospitals and health systems, specialty certifying boards or societies, state Medicaid or payers.

- **Health Disparities**
  The AAFP supports reducing health disparities as a part of care delivery and urges CMS to move forward with expanding its risk-adjustment methodology in quality measures to incorporate social and economic factors such as race, income, education, and region. Risk-adjusting for socioeconomic status ensures the measures are fair and sets the standard for comparison of physician performance by adjusting for factors outside of the physician's control. Not adjusting could lead to misleading conclusions about physician performance. As a result, further disparities in care could be magnified. Through HealthLandscape, the AAFP has developed the Community Vital Signs tool that could assist practices of all sizes understand the social and economic status of their patient population.

We thank you for the opportunity to provide these comments and suggestions regarding *MACRA*. We look forward to working with you and your colleagues during the upcoming year to establish a regulatory framework that will 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 Shawn Martin, Senior Vice President for Advocacy, Practice Advancement and Policy at smartin@aafp.org or 888-794-7481 ext. 2500.

Sincerely,



Robert L. Wergin, MD, FAAFP
Board Chair

Enclosed:
-AAFP response to the Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models