

May 3, 2021

Elizabeth Fowler, JD, PhD
Director, Center for Medicare & Medicaid Innovation
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244

Dear Dr. Fowler:

Our organizations, which collectively represent the majority of the nation's primary care physicians, appreciate the Centers for Medicare & Medicaid Services' continued commitment to developing better primary care payment models that will significantly improve patient care and reduce Medicare spending. The Primary Care First (PCF) program is a significant step in the right direction. However, we are concerned that the current methodology of PCF will not meaningfully contribute to moving a greater percentage of primary care physicians away from the legacy fee-for-service system and into these alternative payment models. We are offering a set of recommendations to the program, in order of priority, that we believe would strengthen the model and contribute to its successful implementation. We stand ready to work with you and the Centers for Medicare & Medicaid Innovation (CMMI) team to accomplish this goal.

Adjust the flat visit fee and the Population Based Payment (PBP) based on changes finalized in the 2020 Physician Fee Schedule (PFS). The 2020 PFS final rule finalized a long overdue increase in the relative values of office/outpatient evaluation and management (E/M) services. The increased values went into effect January 1, 2021. While CMMI indicated they planned to reevaluate the flat visit fee (FVF) and population-based payment (PBP) to reflect this increase, the updated rates have not been integrated into the model. It is vital that PCF payment rates appropriately value high-quality, advanced primary care services. The request for applications for cohort 1 indicated the FVF was roughly equivalent to the 2018 Medicare PFS payment for a level 2 office/outpatient E/M service. Based on this logic, we recommend CMMI update the FVF to reflect the 2021 PFS payment level for a 99212, which is \$56.88. CMMI should also update the PBP to incorporate the recent payment changes for the various services included in it. Without these updates, the PBP will not be equivalent to 60% of what a practice would be paid in FFS, as CMS has said it would be. As such, we recommend the PBP be increased by 14 percent for all groups, making the Group 1 payment \$32 PMPM. To derive the recommended 14 percent increase, we conducted an internal analysis of 2021 payment changes for each code valued in the PBP and then weighted those payment changes by average annual utilization. We believe this methodology most accurately reflects the impact of the 2021 payment changes on the PBP. To ensure the PCF model is adequately investing in advanced primary care practices, we strongly urge CMMI to adjust both payment rates for the 2021 performance year and reevaluate these amounts as additional changes are made to the PFS.

Provide a bridge for practices transitioning to PCF from the Comprehensive Primary Care Plus (CPC+) model. As the CPC+ model sunsets, practices are facing a stark financial cliff that –without intervention– will result in the loss of staff and jeopardize their ability to provide ongoing care coordination and care management services for their patients and communities. While transitioning to PCF for these practices may ultimately result in high performance-based adjustments (PBA), those payments do not begin until the third quarter of the second program year (PY2) which will result in practices having to make drastic decisions impacting their care

delivery in the meantime. We recommend CMMI offer a bridge to CPC+ practices entering PCF that would allow them to continue to provide enhanced primary care services to their patients and communities without disruption. One such bridge that would not result in a net increase in spending to the program would be to prospectively estimate the PBA for program year 1 (paid in PY2) for CPC+ practices based on the quality and utilization data available to CMMI and pay 50% in advance in PY1, truing up in PY2. Without the presence of a bridge, many CPC+ practices will opt to return to FFS where they will have more control over their revenue. We are concerned that, since FFS does not adequately value advanced primary care services, reverting to FFS may ultimately show savings to Medicare and undermine CMMI's mission of moving to value-based payment. We strongly believe a short-term alteration in the PBA methodology, in addition to adjusting the PBP and FVF based on the 2021 PFS, will help CPC+ practices successfully transition to PCF while advancing the triple aim at the heart of CMMI's mission. Announcing a bridge is extremely urgent as the application period for the PCF cohort 2 closes in May, and all CPC+ practices need to decide now whether they will apply to PCF or revert to FFS.

Ensure accurate benchmarks for quality and utilization measures considering the impact of the COVID-19 pandemic. As PCF practices are held accountable for quality and utilization of their attributed beneficiaries, it is essential that the benchmarking methodologies be adjusted to guard against significant impact of the pandemic. For example, for the Acute Hospital Utilization measure, inpatient hospital utilization for patients with a COVID-19 diagnosis should be excluded from the numerator and denominator, both when setting the benchmark and measuring practice performance. We also ask that CMS develop an extreme and uncontrollable circumstances policy for PCF that limits reductions in quality scores and payment.

Modify the attribution methodology to ensure patients are accurately attributed to their primary care practice. The rapid expansion in telehealth has increased access and allowed practices to safely provide valuable services to patients during the PHE. However, we are concerned about the potential impact on patient attribution. We recommend the PCF attribution methodology exclude new patient telehealth visits, especially if those visits are for providing the Annual Wellness Visit (AWV), to ensure patients are accurately attributed to their primary source of care. The attribution methodology should prioritize plurality of care over the most recent AWV, as the AWV may not be provided by the patient's primary care physician. The presence of entities that provide direct-to-consumer telehealth outside a patient's usual source of care and the possibility that some private payers may create virtual healthcare carve-outs threaten continuity of care for patients. It is imperative that attribution methodologies accurately assign patients to ensure practices are appropriately paid to support the continuous longitudinal relationship between patients and their primary care physician.

Thank you again for taking the time to consider our recommendations. We welcome the opportunity to discuss our comments in greater detail. Please contact Kate Freeman, Care Delivery and Payment Strategist, at 913-906-6168 or katef@aafp.org for questions and potential times for a virtual meeting. We believe the PCF model is directionally appropriate and we stand ready to work with you and the CMMI team over the duration of the demonstration to make all of these critical and necessary improvements needed to ensure the success of this model.

Sincerely,

American Academy of Family Physicians
American College of Physicians