AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

May 9, 2016

Sanne Magnan, PhD, MD
Work Group Lead, Performance Measurement
Population-Based Payment (PBP) Work Group
Health Care Payment Learning & Action Network (LAN)
Submitted electronically through HCP LAN website

Dear Dr. Magnan,

On behalf of the American Academy of Family Physicians (AAFP), which represents 120,900 family physicians and medical students across the country, I write in response to the draft white paper titled. "Accelerating and Aligning Population-Based Payment Models: Performance Measurement" as released on April 21, 2016.

The AAFP applauds the work group for developing a draft white paper on performance measurement and supports the mission of the LAN as it will play an integral part in measure harmonization across all payers. The AAFP supports reasonable and achievable quality, cost, and other outcome measures that promote continuous quality improvement and measure patient experiences. The AAFP opposes any 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.

The AAFP agrees with the four priority issues identified in the paper as foundational to the success of PBP models: patient attribution, financial benchmarking, data sharing, and performance measurement. The AAFP also agrees with the four principles of performance measurement for PBP models:

Principle 1: Performance measurement must be foundational to PBP
Principle 2: Measures for PBP must span the entire continuum of care
Principle 3: Measures for PBP must be more outcomes based, but until these measures are developed, **core measure sets should be used in PBP models**
Principle 4: Measure for PBP must create meaningful incentives for physicians

The AAFP has the following comments on the recommendations laid out in the paper:

Recommendation 1: *Future measures must be based on results that matter to patients or the best available intermediate outcomes known to produce these results.*

The AAFP agrees with this recommendation and recognizes the challenges associated with its execution. The challenges described in the white paper of a cumbersome measure development process, lack of patient reported data capture in electronic health records, and the need for process measures to help with internal quality improvement activities must be overcome as part of future measure development and implementation.

The AAFP also believes outcome measures are an end point and not a starting point. Establishing strong and meaningful process measures tied to evidence-based outcomes can help lead a practice toward improvement. **The Core Quality Measure Collaborative's (CQMC) current core measures will help physicians make incremental changes that will roll up to more outcome orientated measures. These measures also allow for individual physicians to improve care and the health of their own panels.** Improvements at a physician practice or site is the only way to show meaningful impact on population based performance.

Recommendation 2: *Core measure sets are valuable and need to be comprehensive, parsimonious, and outcome oriented.*

The AAFP fully supports the work of the CQMC and appreciates the work group's recommendation to use the agreed upon core sets in the near term as new measures are developed. When new measures become available, we recommend they be taken to the CQMC for adoption into the core sets to ensure collaboration and measure harmonization across all payers. **Level 2 and 3 measures should be agreed upon by all stakeholders, like those represented at the CQMC, making it operationally efficient to develop, implement, monitor, and to show improvement.**

Measures must be being clinically relevant, harmonized among all public and private payers, minimally burdensome to report and cost-effective to gather. In addition, it is imperative that data back to physicians be timely, accurate, and actionable. Such data needs to be available to physicians and staff so they are empowered to help patients successfully transition between care environments and across the medical neighborhood.

A primary care provider's ability to improve performance relies heavily on the availability of timely, accurate, and actionable quality and cost data on all physicians and providers that provide care to their attributed population. Besides managing cost and quality for any referrals, understanding current performance is critical to monitoring improvement and understanding where continuous improvement needs to be made. It is only when a provider has access to timely and actionable data that they can be responsible for overall performance.

Recommendation 3: *A governance process is needed to oversee the measure development process.*

The current measure development process is long, cumbersome, and expensive and needs to be streamlined Adding to this complexity, measures to be included in the final list of measures in the Medicare Access and CHIP Reauthorization Act (MACRA), must first be submitted to a peer-reviewed journal. Because of this, the AAFP agrees the Secretary of Health and Human Services should lead the effort to establish measure priorities soliciting input from public-private partnerships like the CQMC.

When establishing a national network of measure developers, the AAFP would encourage the LAN to consider partnering with organizations like the Physician Consortium for Performance Improvement (PCPI) to help coordinate and accelerate the process. All major public and private payers need to be involved during measure development to ensure commitment and alignment throughout the process. Otherwise, one could foresee duplication of effort that would needlessly consume resources and potentially lead to opposing end points.

Recommendation 4: *A data infrastructure is needed nationally to collect, use, and report clinically rich and patient-reported data.*

The AAFP agrees with this recommendation and views this as a major obstacle, but one that can and must be overcome. The inconsistent data infrastructure between EHRs for the collection, integration, and aggregation, of data needs to be addressed. The LAN should collaborate with and learn from participants and vendors participating in the new Comprehensive Primary Care Plus initiative where data reporting directly from the electronic health record (EHR) will be required.

Recommendation 5: *Providers need meaningful incentives to deliver high-quality care, achieve favorable outcomes, and manage the total cost of care.*

Meaningful incentives need to include **an increased investment in primary care.** High-quality care needs to begin and be managed and coordinated through primary care providers and their staff or there will not be meaningful movement to provide better health, better care, at a lower cost. **An increased investment in primary care needs to come through higher reimbursement for primary care specific E/M visits, an adequate monthly care management fee from all payers to cover practice transformation and to sustain needed infrastructure, and meaningful financial incentives that channel down to the primary care provider and their staff.**

Since future reimbursement will be based on current expenditures, E/M payments specifically for primary care providers need to be increased. Current E/M codes, documentation guidelines, and payment models fail to account for the complexity of care that primary care physicians deliver. Therefore, the AAFP strongly recommends that LAN support higher reimbursement for primary care E/M reimbursement to recognize the breadth and complexity of services primary care physicians provide in an office visit and immediately increase the RVUs for common primary care services.

Adequate care management fees from all payers are needed so primary care providers and their staff can invest in practice transformation. Ongoing fees support the infrastructure needed to increase access, manage care and costs across the medical neighborhood, improve patient engagement, ensure safety, and for effective population management.

Meaningful financial incentives that channel down to the primary care provider are needed so those who can deliver care most efficiently and cost-effectively are rewarded for being instrumental in better care, better health, at a lower cost.

Recommendation 6: *Measurement systems should reward improvement, promote best practice sharing, and avoid a forced curve that mandates winners and losers.*

a. *Measurement targets should be set in absolute (not relative) terms and fixed for the minimum of one year:* The AAFP agrees absolute targets, that specify a predetermined score for a physician to achieve versus a relative score that compares performance peer to peer, is an advantageous incentive model. The work group identified the pitfalls with a relative score that discourages collaboration and sharing of best practices. The AAFP also agrees performance targets should be fixed, but given the lag time on data acquisition, **AAFP urges the LAN to support fixed targets for a minimum two year time frame.**

b. *Measure targets should include a range of scores on each measure to reward both performance and improvement* The AAFP agrees performance incentives paid on a sliding scale encourage incremental improvement. When connecting cost and quality, the AAFP would encourage the LAN to look for cost transparency from payers, availability of timely and accurate cost data to physicians, and a prospective and transparent attribution and reconciliation of patients for which physicians will be held accountable.

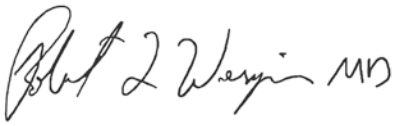
Recommendation 7: *All measures in PBP models must adhere to good measurement science.*

The AAFP is in agreement that, as the measure development process accelerates, incorporating new measures on a "report-only" basis would be a valuable way to consolidate the development process and gain experience with new measures. Before assigning weight to measures, payers need to assure that the data is valid and reliable. Therefore, the AAFP recommends the LAN supports phasing in measure weighting and not include it from the beginning of introducing new measures. Besides validating new measures, this incremental implementation also gives physicians and systems of care an opportunity to understand where they need to concentrate their improvement efforts.

AAFP also fully supports proper risk adjustment and appreciates the work group recognizing this as an essential part of performance measurement. The AAFP also supports reducing health disparities as a part of care delivery and urges the LAN to lead expanding its risk-adjustment methodology in performance 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. A barrier to implementing this immediately is that, at this time, most EHRs are not set up to collect information on social and economic factors that impact performance and improvement. It is however crucial to adjust for these factors because current risk adjustment methods may lead to misleading conclusions about physician performance. Physicians should not be penalized for taking care of more complex patients and higher risk populations. If this is not addressed in risk-adjustment further disparities in care could be magnified.

We thank you for the opportunity to provide input to the performance measurement draft white paper. Please do not hesitate to call upon the AAFP for assistance. For additional information, please contact Amy Mullins, MD Medical Director, Quality Improvement (913) 906-6000 extension 4120 or amullins@aafp.org.

Sincerely,



Robert L. Wergin, MD, FAAFP
Board Chair

CC: Amy Nguyen Howell