

AAFP Principles to Support Patient-Centered Alternative Payment Models

The American Academy of Family Physicians (AAFP) strongly supports moving a larger percentage of payments from traditional fee-for-service (FFS) towards alternative payment models (APMs). The AAFP believes 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.

With implementation of the *Medicare Access and Children's Health Insurance Program Reauthorization Act*, the development of new APMs, including physician-focused payment models, are accelerating. While some of these models 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 the Comprehensive Primary Care Plus (CPC+) Initiative.

To support the development and implementation of APMs that accomplish these objectives, the AAFP has developed a set of principles to guide our evaluation of proposed models to ensure that they place patients—and not clinicians—at the center.

Principle #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

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- Comprehensive and coordinated care

Principle #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.

Principle #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.

Principle #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.

Principle #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.