



May 20, 2019

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Administrator Verma,

On behalf of the American Academy of Family Physicians (AAFP), which represents 134,600 family physicians and medical students across the country, I write in response to the [request for information](#) on how to refine the Direct Contracting (DC) Geographic Population-Based Payment (PBP) model option as released by the Centers for Medicare & Medicaid Services (CMS) on April 22, 2019.

The AAFP applauds CMS' recent announcement of the Primary Care First (PCF) and Professional and Global Population-Based Payment Direct Contracting models—which demonstrate CMS' support for health care delivery and payment models that are foundational in primary care. We believe the PCF program will improve quality and outcomes and reduce costs for Medicare beneficiaries and we share CMS' recognition that strengthening primary care can result in improved outcomes, quality and lower costs. We have appreciated the opportunity to partner with CMS and look forward to continuing to support the agency's efforts to advance payment models that are patient-centered and have a foundation in longitudinal, comprehensive primary care.

The AAFP appreciates the opportunity to comment, since we applaud CMS' continued focus to improve quality of care and health outcomes for Medicare Fee-for-Service (FFS) beneficiaries, reduce Medicare expenditures through the alignment of financial incentives, and focus on patient choice and care delivery while maintaining access to care for beneficiaries. Over the past few years, the AAFP worked to develop a multi-payer, advanced primary care alternative payment model that would allow all our members – regardless of practice size, geography, or capacity – to provide high-quality care to their patients.

We appreciate the three DC models announced recently are part of CMS' strategy to redesign primary care as a pathway to drive broader delivery system reform and offer the following responses to the questions laid out in the RFI. Our comments—outlined in more detail below—focus on the following recommendations:

- Increase spending on primary care
- Ensure and support increased access to primary care providers
- Expand access to participation in Advanced APMs

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- Support small and independent practices in participating

Background

For the first performance year, CMS expects to limit DC Geographic PBP participation to four target regions. An applicant for the Geographic PBP model option may be a:

- healthcare organization consisting of a direct or affiliated network of healthcare providers,
- a health plan, or other type of organization that has formal partnerships or other contractual relationships with Medicare enrolled providers or suppliers in the target region.

CMS intends to allow an applicant to propose a target region for CMS approval, including that:

- The target region must have a minimum of 75,000 Medicare beneficiaries within it;
- Yield or exceed minimum savings targets in the form of a discount which CMS currently contemplates would be on the order of 3-5%;
- Align with administrative (e.g., city, county) and/or statistical (e.g., metropolitan statistical area) geographic units; and
- Factor in the natural boundaries of the target region and health care seeking patterns of the Medicare FFS population within that region.

Under the current model design, a Direct Contracting Entity's (DCE's) total cost of care (TCOC) accountability would be calculated based on the historical Medicare Parts A and B per capita spending in the target region. CMS would determine the Geographic PBP benchmark by calculating these historical expenditures for geographically aligned beneficiaries during a baseline period; trending these historical expenditures forward to the performance year; applying a geographic adjustment factor; and discounting the benchmark.

As currently envisioned, Geographic PBP DCEs would be paid on a capitated basis with the option for the DCE to contract with healthcare providers and pay these providers directly for any services used by aligned beneficiaries in the target region. For other healthcare providers in the target area that do not contract with the DCE, CMS would continue to make FFS payments with those payments reconciled against the DCE's benchmark. Alternatively, while the DCE would remain at full financial risk, the DCE could opt to continue having CMS make FFS claims payments to all healthcare providers in the target region (including healthcare providers with contractual arrangements with the DCE). Under this approach, performance year expenditures would be reconciled against the benchmark as part of final settlement with the DCE. DCEs would be given access to a "notional" account to track these expenditures.

The AAFP offers a number of recommendations in response to CMS' questions on how the agency can refine and implement a DC Geographic PBP model. Only questions for which we offer comment are included below:

Questions Related to General Model Design

- 1. How might DCEs in the Geographic PBP model option address beneficiary needs related to social determinants of health (such as food, housing, and transportation) with particular attention to whether the geographic scale contemplated under the payment model option creates new opportunities for success in terms of community-based initiatives? What barriers might prevent DCEs from addressing these social determinants of health? Are there additional incentives that CMS could offer to DCEs to motivate these entities to address social determinants of health?**

Social determinants of health have a significant impact on a patient's health and well-being. The AAFP believes that primary care practices are uniquely positioned to help address these issues but need the support of community resources.

We recommend CMS refer to successful State Innovation Models. These models are regionally focused by design similar to the proposed Geographic PBP model. States participating in the model were able to leverage community resources and partnerships to advance practice transformation and better address population health. The latest findings showed that over half the states advanced their population health interventions and many developed and operationalized systems to screen for Social Determinants of Health.

The AAFP [policy](#) on “Advancing Health Equity: Principles to Address the Social Determinants of Health in Alternative Payment Models” provides suggestions for how alternative payment models should account for SDoH in their payment methodologies and enable physician practices to overcome these barriers. We encourage CMS to review this policy to create similar structures and incentives to motivate and enable DCEs to address social determinants of health.

The AAFP believes that payments made to practices or DCEs to care for patients should be risk-adjusted to effectively address beneficiaries' health and SDoH needs. The risk-adjustment methodology should consider patient demographics (e.g. age, gender), health status (e.g. as reflected in the number and types of conditions a patient has, which are generally captured by ICD10-CM codes), and social determinants of health (SDoH; i.e., the conditions under which people are born, grow, live, work, and age).

There are multiple barriers that inhibit physician practices from addressing social determinants of health and that may also prevent DCEs from doing so. These include:

- The fee-for-service payment structure that does not support physician work related to SDoH;
- Health information technology that does not facilitate exchange of information between physicians;
- An already daunting administrative burden on physicians and other providers of healthcare; and
- Lack of appropriate resources and support to address SDoH.

- 2. Given the geographic basis for the design of the Geographic PBP model option, the evaluation will need to construct a comparison group from areas outside of the payment model option's target regions. While we anticipate there would be ample geographic areas not included as target regions in the Geographic PBP model option, we are seeking input on considerations that CMS should weigh to best identify a comparison group for this payment model option. Additionally, the selection of a target region itself (size, location) could impact the extent to which evaluation results would be representative of the broader Medicare population. Given the unique design of the payment model option relative to prior CMS Innovation Center models, what special evaluation considerations might CMS consider for this payment model option?**

Accurately – and uniformly – measuring performance of participating practices is a central component of any model. All practices across the three DC payment model options should

be evaluated on the same quality measures at the practice level, which will reduce measure burden and allow for comparison with existing Innovation Center models.

CMS should align its approach for evaluating performance with that used in other models to support cross-model comparisons and use of existing approaches and infrastructure.

Comparison groups should be matched to practices outside the selected target regions that have limited penetration of other Medicare advanced alternative payment models. Matching characteristics should include practice considerations such as size and location (urban, rural) and patient attributes such as average patient risk, age, and social need. Other attributes, such as similar utilization patterns and average Medicare expenditures per beneficiary should also be considered.

Questions Related to Selection of Target Regions

- 1. What criteria should be considered for selecting the target regions where the Geographic PBP model option would be implemented? For example, are there attributes of target regions, such as low penetration of advanced alternative payment models or higher healthcare costs than the national average, which CMS should consider in selecting target regions for the Geographic PBP model option? What impact would this have on competition in target regions where the Geographic PBP model option is ultimately implemented?**

To avoid interference with the evaluation of existing models and to increase physician participation in Advanced APMs, DC target regions should prioritize those areas with limited Medicare advanced alternative payment model penetration. The beneficiary demographics of the target region population should also be similar to the broader Medicare population, with priority given to areas with high costs.

CMS will need to monitor the effects of the DC model to ensure it does not limit competition or encourage consolidation. As DCEs will be responsible for the TCOC for aligned beneficiaries, they may wish to contract with as many providers as possible within the target region as a means of controlling cost. Area practices may feel pressured to join a DCE or see their patient panels re-assigned to practices within the DCE. Both would result in reduced competition and threaten the survival of small and independent practices. DCEs should be required to provide details on how they will work with small and independent practices in a way that continues to support these practices and promote competition.

- 2. What are the benefits and/or risks to access, quality, or cost associated with the implementation of the Geographic PBP model option in a target region that includes a rural area? What safeguards might CMS consider to preserve access and quality for beneficiaries in rural areas in a Geographic PBP target region? How would rural market forces (for example, out-migration, hospital closures, and mergers/acquisitions) affect the DCE's ability to lower cost and improve quality under the payment model option?**

The AAFP believes target regions should include rural areas, so beneficiaries in those areas can equally enjoy any benefits resulting from Geographic PBP implementation.

Likewise, the AAFP believes DCEs should not systematically pay less to rural physicians and providers. Geographic practice cost indices used in the Medicare physician fee schedule already underpay rural physicians for the same services provided by their urban

and suburban counterparts. The AAFP supports the elimination of all geographic adjustment factors from the Medicare Physician Fee Schedule except for those designed to achieve a specific public policy goal (e.g., to encourage physicians to practice in underserved areas). We would advocate for a similar principle in terms of DCE payment for physician services. The model should allow primary care practices of all sizes and in any location to participate.

Questions Related to DCE Eligibility

- 1. What are the benefits and/or disadvantages of the DCE selection criteria under consideration for the Geographic PBP model option, described above? What other selection criteria and core competencies should CMS consider requiring applicants to address? Please describe the benefits of including such additional selection criteria. What criteria are of the greatest importance and therefore should receive the greatest weight in our selection decisions?**

First, the AAFP asks CMS to require DCE's to submit a methodology outlining how the DCE will distribute capitated and shared savings payments to its participating PCPs in a manner that reflects an increase in primary care. Spending on primary care should be increased from current levels, because access to primary care is [associated](#) with improved individual and population-health outcomes and reduced costs. Today, primary care only [represents](#) approximately 2-5% of total Medicare spending on health care. We, and others, believe this should be increased to at least 12% of total spending. [Evidence](#) indicates increased spending on primary care will lead to a decrease in overall spending on a per-patient basis.

The need to increase United States spending on primary care reflects the experience of other Organization for Economic Cooperation and Development (OECD) countries. Most of those countries have health care systems where primary care is foundational, and [research](#) shows their spending per capita is well below that of the United States. Within the U.S., Rhode Island mandated an increase in primary care spending from 5.4% to 8% between 2007 and 2011. The Rhode Island Insurance Commissioner [reported](#) a 23% increase in primary care spending was associated with an 18% reduction in total spending—a 15-fold return on investment. Lastly, Portland State University completed a 2016 [study](#) of Oregon's Patient-Centered Primary Care Home (PCPCH) program and found that every \$1 increase in advanced primary care practice expenditures as part of the PCPCH model resulted in \$13 in savings in other health care services, including specialty, emergency room, and inpatient care.

Second, we encourage CMS to ensure network adequacy in its selection criteria. Strong network adequacy standards promote the primary care medical home model as a way to deliver higher quality, lower costs, and a stronger patient-physician relationship. A recent [study](#) in *JAMA Internal Medicine* reported that the supply of primary care physicians is associated with lower mortality rates. This suggests that the supply of primary care physicians impacts population health. Primary care capacity should be the focal point of network adequacy and should include the percentages of family physicians and other primary care physicians participating in the DCE. Additionally, when determining network adequacy, the ratios for primary care physicians to covered persons and for physicians to covered persons by specialty, should reflect physician FTEs, because physicians may practice part-time or in multiple locations. In addition, non-physician providers (i.e., nurse practitioners and physician assistants) should not be counted because listing these providers creates the illusion that there is more access to physicians

- 3. Should we consider allowing States to participate as a Geographic PBP DCE or in partnership with a Geographic PBP DCE? What would be the pros and cons associated with allowing State participation? Which authorities would States need in order to implement similar risk arrangements in their Medicaid programs? What supports or technical assistance would States need from CMS to establish risk arrangements in Medicaid?**

The AAFP supports multi-payer alternative payment models and urges CMS to allow states to participate in this model. Our members often work with 7-10 payers, including Medicaid. Allowing state participation provides another opportunity for our members to engage with a multi-payer model.

Questions Related to Beneficiary Alignment

- 1. CMS currently plans to select target regions with at least two DCEs to encourage competition. In the event that there are two or more DCEs in a given target region, we are considering either randomly aligning beneficiaries in the target region to one of the DCEs or allowing beneficiaries in the target region to voluntarily align themselves to a specific DCE. One potential benefit of a random alignment approach is that it could help to reduce reliance on risk adjustment, which is intended to account for differences in health risk in a given population. Where risk is taken on a large population basis, such as in the Geographic PBP model option, we would expect risk to be evenly distributed, making risk adjustment less necessary to account for differences, particularly if beneficiaries are aligned on a randomized basis as between DCEs operating in the same target region. Notwithstanding this interest, we seek information on what alternative alignment methodologies CMS might consider and the relative pros and cons of alternative approaches for beneficiaries and for DCEs operating in the same target region. Are there hybrid approaches to consider? For example, would stratified randomization of the beneficiary's residence be a preferable approach to complete randomization? What implications would either stratified randomization or allowing for voluntary alignment have on risk adjustment considerations?**

The patient attribution methodology is critical to payment, quality, and cost performance measurement and to defining accountability. A reliable, prospective, and transparent attribution method is important for the payer, the physician, and the patient. Payers can be confident they are providing payment for enhanced services to the correct physician for the correct patient population when attribution models are optimal. In addition, optimal attribution models confirm for physicians that they are receiving payment for quality and cost of appropriate patient care. Accurate attribution may also help patients understand the importance of their relationship with their primary care physician, as well as the need to include the physician in the patient's decisions about choices that impact their health.

In 2016, the Health Care Payment Learning and Action Network released a [white paper](#) on patient attribution, in which they deemed patient attestation as the gold standard for attribution for population-based payments that rely on primary care as the starting point to coordinate care across the continuum. Some private payers already use self-attestation in patient attribution. For example, Blue Cross Blue Shield of Massachusetts' Alternative Quality Contract uses self-attestation to attribute patients by requiring them to designate a primary care provider in their Health Maintenance Organization and point-of-service plans. Additionally, CMS launched patient selection as the first step of the CPC+ attribution methodology in 2019. The Primary Care First, Next Generation ACO, Medicare Shared

Savings Program (MSSP), and CPC+ models allow for beneficiaries to voluntarily align with a model participant—beneficiary voluntary alignment supersedes claims-based attribution. The AAFP recommends voluntary alignment through a patient-based, prospective process that includes a 24-month look-back period for attribution in the absence of patient choice.

A prospective methodology allows physicians to know for whom they are responsible in advance and facilitates proactive care planning and management while protecting patient choice. The AAFP does not recommend random beneficiary alignment in a region with two DCEs as this does not encourage or support beneficiary choice.

2. Are there transparency/notification requirements, in addition to or in lieu of the requirements described above, that CMS should consider to protect beneficiary freedom of choice of any Medicare provider or supplier for beneficiaries aligned to a DCE participating in the Geographic PBP model option?

Any and all beneficiary communications and marketing materials should include bold, plain language informing beneficiaries so that they retain freedom of choice, especially the choice to keep their current family physician or other primary care physician. Communications to aligned beneficiaries should include information explaining why and how the beneficiary was aligned with the DCE. CMS should look to previous and ongoing programs and align beneficiary notification requirements across models. Additionally, DCEs should be prohibited from cherry-picking or aggressively pursuing patients, or otherwise discriminating against patient populations for the purposes of voluntary alignment.

3. How might DCEs inform beneficiaries of the payment model option and engage them in their care? What barriers would DCEs face in engaging with beneficiaries in their target region?

The AAFP has examined issues related to beneficiary enrollment and attribution and we believe patient choice drives participation in the model and can support beneficiary engagement. DCE's should be required to verify a beneficiary's preferred method and primary language for communication. All materials should be in clear, plain language that is easily understood by the beneficiary. CMS can look to beneficiary notification requirements from other models, such as the MSSP, to inform the requirements of this model. However, CMS should ensure any such requirements do not increase administrative burden for participating physicians.

Additionally, beneficiary communications should include unbiased information as to what a beneficiary can expect as a patient of a DCE provider. Beneficiaries should also be informed about how the DCE is benefitting from the DC model. Beneficiaries may be confused by the barrage of information provided to them by Medicare and DCE's. Further, beneficiaries, particularly those with sporadic and uncoordinated care, may not understand the potential benefits of being aligned with a DCE.

Questions Related to Program Integrity and Beneficiary Protections

1. What monitoring methods can CMS employ to ensure beneficiary access to care is not compromised and that beneficiaries are receiving the appropriate level of care? What data or methods would be needed to support these efforts?

As with the Next Generation ACO, CMS should continue to monitor contract penetration (proportion of E/M revenue generated by aligned beneficiaries), continuity of care, and

leakage for aligned beneficiaries. CMS should assess a DCE's level of beneficiary continuity of care prior to and during the program. Significant changes should be reviewed to identify the cause. CMS could also consider monitoring high- and at- risk patients to ensure they are receiving regular care.

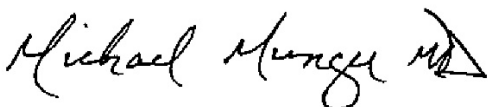
CMS should also monitor network adequacy to ensure adequate patient access. When determining network adequacy, the ratios for primary care physicians to covered persons and for physician to covered persons by specialty, should reflect physician FTEs, because there may be physicians who practice part-time or in multiple locations. In addition, non-physician providers (i.e., nurse practitioners and physician assistants) should not be counted because listing these providers creates the illusion that there is more access to physicians, especially in states where these providers do not have independent practice authority.

3. Providing incentives to beneficiaries to positively influence their behavior and healthcare decision-making could implicate the fraud and abuse laws and potentially raise quality of care, program cost, or competition concerns, particularly if the incentives would cause beneficiaries to be aligned to one DCE over another entity participating in DC or another CMS initiative. What safeguards should CMS put in place to ensure that any beneficiary incentives provided do not negatively impact quality of care, program costs, or competition?

The AAFP encourages CMS to continue waivers from its previous and exiting programs, such as the SNF 3-day, telehealth, and home visit waivers. Additionally, CMS should work with Congress to create copay waivers. By waiving copays, DCE practices would have more freedom to invest in primary care. Additionally, copays can often create barriers for beneficiaries to receive appropriate care and add administrative burden to practices as they try to collect copays. A copay waiver would reduce this administrative burden and encourage beneficiaries to seek the comprehensive and coordinated care provided by primary care physicians. Receiving timely, preventive care from primary care physicians is vital to improving the health of beneficiaries.

We appreciate the opportunity to comment. Please contact Kate Freeman, M.P.H., Quality Improvement Strategist at katef@aaafp.org or 913-906-6168, with any questions or concerns.

Sincerely,



Michael L. Munger, MD, FAAFP
Board Chair

About Family Medicine

Family physicians conduct approximately one in five of the total medical office visits in the United States per year—more than any other specialty. Family physicians provide comprehensive, evidence-based, and cost-effective care dedicated to improving the health of patients, families, and communities. Family medicine's cornerstone is an ongoing and personal patient-physician relationship where the family physician serves as the hub of each patient's integrated care team. More Americans depend on family physicians than on any other medical specialty.