



October 25, 2018

Daniel R. Levinson, Inspector General
Office of Inspector General
Department of Health and Human Services
Attention: OIG-0803-N
Room 5513, Cohen Building
330 Independence Avenue SW
Washington, DC 20201

Dear Inspector General Levinson:

On behalf of the American Academy of Family Physicians (AAFP), which represents 131,400 family physicians and medical students across the country, I write in response to the [request for information](#) (RFI) titled, “Medicare and State Health Care Programs: Fraud and Abuse” as published by the Office of Inspector General (OIG) in the August 27, 2018, *Federal Register*.

The AAFP welcomes and appreciates the continued opportunity to work with OIG to identify and implement policies that improve the Medicare program and promote the movement to value-based care and Advanced Alternative Payment Models (AAPMs). The AAFP believes the government must both commit to and invest in physician-led AAPMs that support advanced primary care practices to effectively strengthen the long-term solvency of the Medicare program and to deliver patient-centered care to beneficiaries.

The AAFP appreciates that OIG is seeking input on potential regulatory barriers impacting the development of new AAPMs. We urge OIG to confirm that any action from the Centers for Medicare & Medicaid Services (CMS) will allow for physician collaboration/new partnerships that improve care delivery and appropriate beneficiary incentives. **We urge OIG to offer timely, broad, and clear flexibility for AAPMs and for prompt and clear guidance on safe harbors.**

As fully articulated in our August 22, 2018, [letter](#) to CMS in response to the RFI regarding the physician self-referral law, the AAFP urges OIG and CMS to ensure policies do not hinder family physicians’ ability to transform their practices. Family physicians must have the flexibility to collaborate with other physicians and health care professionals to provide team-based, patient-centered care that incorporates new technologies and focuses on reducing the total cost of care. We urge the creation of a simple decision tree with clear safe harbors for medical practices to help determine if collaboration will trigger OIG or other scrutiny and if further costly compliance analyses may be needed.

Regarding beneficiary incentives, OIG asks questions examining the types of incentives physicians could offer beneficiaries to improve care, including reducing cost-sharing. The AAFP

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recommends that OIG allow for in-kind remuneration as a beneficiary incentive for wellness and managing chronic diseases. We believe rewarding adherence can help the patient understand the importance of the interaction between lifestyle, disease, and prescribed treatment. Wellness programs are worthwhile because they could substantially reduce the cost of health care over time. The AAFP urges Health and Human Services (HHS) to work with Congress to eliminate the applicability of deductible and co-insurance requirements for primary care services in general and the non-fee-for-service portions of AAPMs. Eliminating cost-sharing requirements for primary care services would facilitate greater utilization of these services and increase coordination of care for those beneficiaries with the greatest health care needs.

The AAFP also calls on the OIG to ensure care models have improved flexibility to address behavioral health issues across the full care continuum that may be currently prohibited under anti-kickback statute. In particular, social determinants of health are by definition multifactorial and can often be best addressed through interaction with the community outside of the doctor's office.

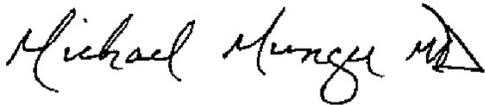
Finally, we offer OIG these recommendations for defining the following terms:

- Care coordination - The AAFP urges OIG to define "care coordination" so that primary care is explicitly recognized as the first point of contact for many patients, and therefore is the center of the patient's experience with health care. OIG should note in the definition that primary care is best positioned to coordinate care across settings and among physicians in most cases. Primary care medical homes work closely with patients' other health care providers to coordinate and manage care transitions, referrals, and information exchange. An advanced primary care practice is one that is based on the [Joint Principals of the Patient Centered Medical Home](#) and has adopted the five key functions of CPC+.
- Risk - The term "risk" by itself is ambiguous. OIG should be explicit in setting forth whether the term describes financial, health, performance, or insurance risk. We urge OIG to define the type of risk in the discussion for clarity. As OIG considers risk elements in new models, based on knowledge of members' practices and their role in healthcare spending, the AAFP opposes putting primary care practices and their eligible clinicians at risk for anything beyond their own performance under a model. That particularly extends to insurance risk and utilization of services outside the control of the practice (e.g., total cost of care). Assumption of risk for total cost of care may also reduce participation in a model – especially among small or independent practices. "Insurance risk" is related to the patient's health status that is beyond the control of the physician, such as age, gender, and acuity differences. Insurance risk is properly borne by health plans and payers, not entity practice and its eligible clinicians. To the extent primary care practices are at risk for their performance, the level of risk should be commensurate with the practice's capabilities. Primary care practices vary in their current stage of practice transformation and corresponding level of infrastructure. They are not all equipped to accept the same level of risk at the same time.
- Value-based care – The AAFP defines [value-based payment](#) as a concept by which purchasers of health care (government, employers, and consumers) and payers (public and private) hold the health care delivery system at large (physicians and other providers, hospitals, etc.) accountable for both quality and cost of care. Value-based payment's aim is to promote enhanced population health management that should result in the improvement of health and/or systemic cost containment or reduction. [Value-based insurance design](#) (VBID) is a strategy that minimizes or eliminates out-of-pocket costs for high-value services in defined patient populations. The primary objective of

VBID is to reduce and eventually eliminate financial barriers to high-value health care services. High value health care services are identified through evidence-based analysis. The more clinically beneficial and cost-effective the therapy is for a patient group, the lower the out-of-pocket costs.

We appreciate the opportunity to comment. Please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org with any questions or concerns.

Sincerely,

A handwritten signature in black ink that reads "Michael Munger MD". The signature is written in a cursive style with a distinct loop at the end.

Michael L. Munger, MD, FAAFP
Board Chair