



October 14, 2021

Jeffrey Bailet, MD
Committee Chair
Physician-focused Payment Model Technical Advisory Committee (PTAC)
Assistant Secretary for Planning and Evaluation (ASPE), Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Dr. Bailet,

On behalf of the American Academy of Family Physicians (AAFP), which represents 133,500 family physicians and medical students across the country, I write in response to the [request for information](#) that the Physician-Focused Payment Model Technical Advisory Committee (PTAC) solicited in September 2021 on how alternative payment models (APMs) including Physician Focused Payment Models (PFPMs) can incentivize health care providers to collect data related to SDOH and equity; use this data to ensure that patients' physical, behavioral health, and social needs are being met; measure the impact of these activities; and address related payment issues. The AAFP was an early participant in the PTAC review process with our proposal for an Advanced Primary Care Alternative Payment Model (APC-APM) and remains fully supportive of the PTAC's role in evaluating PFPMs. We are pleased to respond to this current request for public input.

What types of SDOH-related social needs data (e.g., food insecurity, housing or transportation needs) could be collected within the context of optimizing value-based care in APMs and PFPMs, by whom, and how?

Community-level data regarding unmet social needs, including food insecurity, housing, transportation needs, access to broadband, and other factors is essential to ensuring important SDOH factors are addressed at the community level. Primary care physicians play an important role in health-related social needs (HRSNs) and can connect patients with community resources when available. Primary care physicians often screen for these types of unmet needs but face barriers to addressing them in a meaningful way.

Due to a lack of standardization in screening tools and electronic health record (EHR) capabilities, recording this type of data adds to physicians' administrative burdens and can take time away from patient care. Health plans and agencies managing state and federal programs should also assist with collecting and sharing these data with primary care physicians. For example, health plans could screen for HRSNs upon enrollment which could be shared with their primary care physician (with permission). State and federal health agencies frequently have access to community-level SDOH information that informs a patients potential social and environmental needs, which could be used for population health planning or risk-stratification purposes.

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In addition to using these types of data to optimize care, they also should be used for risk-adjustment and to ensure primary care practices are being adequately compensated and evaluated to provide the required level of care for high-risk or vulnerable patients.

What types of equity-related data are currently being captured by providers within the context of optimizing value-based care in APMs and PFPMs to help implement efforts to intentionally advance health equity?

Advancing health equity requires effective mechanisms to both identify where inequities exist and address the factors that allow it to happen. Many of these occur outside clinic walls. The role of the primary care physician depends on the specific needs of the patient population, the financial support available to support practice assessment of HRSNs, and the availability of community resources available to address them once identified. Many primary care physicians screen for unmet social needs with the desire to connect patients to community resources. However, the lack of evidence-based research and standardized approaches to screening, as well as the lack of a comprehensive community resource strategy, makes operationalization a challenge. In 2017, AAFP surveyed 484 family physicians and found lack of time during the clinic visit, staffing challenges, inability to provide a solution, and insufficient financial support are the primary barriers for not identifying and collecting data on patients' social needs.

Other challenges include the limitations of EHR platforms and maintaining patient privacy of data across organizations. Some EHRs have incorporated social needs screening, but clinicians indicate the screening questions may be inadequate. Other EHRs do not have built-in social needs screening questions, resulting in physicians and care teams using additional digital platforms or paper collection methods to collect and exchange data which is administratively burdensome and results in fragmentation of the patient record.

Some opportunities to better collect, understand, leverage, and report SDOH data include the development, expansion, and updating of web-based platforms to help link individuals to services. Many examples of these web-based platforms exist such as [The Neighborhood Navigator](#), developed in collaboration between the AAFP and Aunt Bertha, specifically for physicians and care teams to locate local community resources for their patients.

How can health care providers effectively share SDOH- and equity-related data with payers, community-based organizations, and other partners across the continuum of care?

Improving interoperability and EHR usability are vital to reducing physicians' administrative burdens and improving the sharing of all patient information (clinical and non-clinical), including SDOH factors and documented HRSNs. Family physicians do not need incentives or utilization measures to increase their use of EHRs and other health technology. As primary care physicians manage and direct care teams, they are well aware of the value of sharing patients' health information and improving care coordination. Instead, EHR systems must be designed to be more user-friendly and readily adaptable to the physicians' clinical workflow without unreasonable expense. The practice time required to acquire these important data and the technology to support its management are important tasks that must be recognized in APMs and PFPMs

Federal agencies should continue to ensure the cost of implementing, maintaining, and updating EHR systems for physician practices is manageable by working with EHR vendors, as well as ensuring APMs adequately recognize these important functions. These costs are particularly prohibitive for small and rural practices, as well as those serving high proportions of patients in underserved communities. These practices may need additional financial and technical support to obtain, implement, and maintain EHRs and other information technology required for successful participation in APMs.

What are some of the identified barriers, challenges, and other concerns for providers, their partners, and patients, related to collecting, using, and/or sharing SDOH- and equity-related data?

Primary care physicians are trusted partners in patients' healthcare experience. They are well suited to act as an important partner in the data collection process, however they should not be considered the sole source for collection of patients SDOH and equity-related data. To better foster collaboration in data collection, required data should be standardized to ensure the uniform collection of many types of health care data, including HRSNs and demographic characteristics, such as race, ethnicity, and preferred language (REL). Many [states](#) have taken steps to standardize collection of REL data, using legislative and regulatory processes to ensure appropriate collection and use of data to protect patient privacy. Standardizing the data elements used for race, ethnicity, primary language, gender identity, sexual orientation, income status, and other characteristics will help ensure primary care teams can identify and facilitate addressing HRSNs.

What types of investments are needed to support services aimed at addressing the social needs of patients and advancing health equity, and by whom? What types of investments have been made by payers, health care providers, social service providers, and communities to assess and address patients' social needs? What role have APMs played in incentivizing activities related to addressing SDOH and advancing equity?

The AAFP's policy on [social determinants of health](#) outlines how family physicians are uniquely qualified to identify HRSNs with the goal of connecting patients with third-party services and public programs in their community to address those needs. To best address health equity and social determinants of health, we first need a public health infrastructure that is robust and healthy. While physicians and other clinicians, inclusive of all specialties, can assist in identifying and facilitate addressing HRSNs, they cannot and should not be held responsible for resolving community-level SDOH factors.

Existing FFS structures typically do not pay for or support robust activities that address HRSNs within a patient's community, such as community health workers or care coordination, which can disadvantage patients who require more support and the physicians who care for them. As such, APMs need to be designed to adequately resource primary care physicians to support the needs of patients, inclusive of HRSNs, without inappropriately holding primary care physicians responsible for outcomes outside their control.

When designing APMs, the AAFP believes payment for primary care should represent an increased investment in primary care, be prospective, include a comprehensive or global primary care payment, be risk-adjusted, and include evaluation of performance. This type of

payment adequately supports and sustains comprehensive, longitudinal patient-physician relationships. Additionally, these payments should be made within the context of a patient's regular source of primary care to avoid potential fragmentation, such as from third-party direct to consumer telehealth providers.

Not only is this payment infrastructure beneficial to practices intent on delivering wholistic, person-centered care, it's essential to ensuring access to high quality, continuous primary care for patients. When primary care practices are supported by a predictable, prospective revenue stream for the full range of care needs presented by their patients, primary care practices thrive, and patients have better outcomes.

This can be achieved through models that include adjustment of payment rates to provide additional resources to account for the HRSNs of their patient population. One approach, outlined in a recent Health Affairs [blog](#) post and used by the AAFP in the APC-APM, is to use geographic indices of social risk such as the Robert Graham Center's (RGC) [social deprivation index](#) (SDI). The RGC SDI is a composite measure of area level deprivation based on seven demographic characteristics collected in the American Community Survey and used to quantify the socio-economic variation in health outcomes. While there are mechanisms to adjust payments, the larger outstanding question of what it costs to manage populations with increased social risks remains.

To date, many APMs have been focused on the Medicare population, with limited attention provided to Medicaid and safety net providers. The AAFP acknowledges underserved populations should be more intentionally engaged in value-based care and calls for increased collaboration between the Centers for Medicare & Medicaid Innovation (CMMI), Medicare with Medicaid, as well as private payers. Embedding equity as a shared aim regardless of the patient population and across all models will resource providers more efficiently to ensure all patients receive high quality, affordable, patient-centered care.

Additional opportunities to increase equitable access exist, including expansion of geographic testing of models and incentivizing patient participation. Current primary care models have been geographically limited in scope and repeatedly tested in the same regions. Since primary care is uniquely qualified to care for patients of all ages in diverse settings nationwide, efforts should be made to expand where models are tested to increase equitable access and avoid further exacerbation of disparities. Additionally, models should be designed with incentives that remove patient barriers to access, such as waiving co-pays or co-insurance for primary care. Waived co-pays should be covered by the payer rather than being waived by the practice to avoid financially penalizing practices.

We appreciate the opportunity to provide these comments. Please contact Kate Freeman, Manager of Payment and Care Transformation, at 913-906-6168 or katef@aafp.org with any questions or concerns.

Sincerely,

A handwritten signature in black ink that reads "Ada D. Stewart, MD". The signature is written in a cursive style with a vertical line at the end.

Ada D. Stewart, MD, FAAFP
Board Chair
American Academy of Family Physicians