



January 18, 2017

Physician-Focused Payment Model Technical Advisory Committee (PTAC)  
c/o Angela Tejada  
Assistant Secretary for Planning and Evaluation  
200 Independence Ave. SW  
Washington, DC 20201

Dear PTAC committee members and Ms. Tejada:

On behalf of the American Academy of Family Physicians (AAFP), which represents 124,900 family physicians and medical students across the country, I write regarding [Project Sonar](#), a proposed payment model submitted by the Illinois Gastroenterology Group and SonarMD, LLC in a December 21, 2016 letter to the PTAC.

The AAFP supports moving a larger percentage of payments from traditional fee-for-service (FFS) towards patient-centered alternative payment models (APMs) and we support the creation of innovative payment models that achieve better care, smarter spending, and healthier people. The proposed model changes both care delivery and payment, based on clinical care guidelines for chronic gastroenterology related conditions. First, the model proposes to give participating practices a prospective chronic care management payment for related services. The model also includes retrospective reconciliation for payments to determine if participants are eligible for shared savings or at risk for capped losses above a target amount.

However, the proposed model's delivery change is characterized as the "first specialty-based Intensive Medical Home". The AAFP is concerned with the use of this term – and more importantly – with the development of specialty "medical home" APMs that would simply replace fragmented care under fee-for-service with fragmented care under APMs. The [Patient-Centered Medical Home](#) concept focuses on comprehensive coordinated primary care for children, youth and adults. Patient centeredness refers to 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. These personal physicians are responsible for the patient's coordination of care across all health care systems. Since Project Sonar focuses only on chronic gastroenterology related conditions, it should not claim to be or associate themselves with the term medical home. In examining this proposal, we ask that the PTAC consider how this physician focused payment model would promote the delivery of continuous, longitudinal care for Medicare beneficiaries – and not provider-centric care.

With implementation of the *Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015 (MACRA)*, the development of new APMs, including physician-

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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 fee-for-service system. Evidence shows that health systems built with primary care as the foundation have positive impacts on quality, access, and costs. Of the clinically active AAFP members, nearly half (45 percent) work in an officially recognized patient centered medical home. This demonstrates family physicians' commitment to 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 and illustrates the lack of need for specialty- and disease- focused APMs that can fragment care.

The AAFP is also concerned that the Project Sonar proposal neglects to detail how participants would coordinate with primary care physicians, which is essential to ensure that Medicare beneficiaries (many with multiple, co-morbid conditions) have a central provider that can coordinate and manage their care across settings. As detailed in the [AAFP's Principles to Support Patient-Centered Alternative Payment Models](#), 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. We have developed the following principles to guide in the development and review of proposed payment models, and ask that the PTAC closely consider them in evaluating how the current proposed physician focused payment model advances patient-centered care.

#### **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
  - 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.

For further details on how to construct an advanced alternative payment model (APM) that is patient-centered and meets beneficiary needs in a longitudinal, continuous and comprehensive manner, please consult the AAFP's [whitepaper](#), "Advanced Primary Care: A Foundational Alternative Payment Model (APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care."

We appreciate the opportunity to comment and make ourselves available for your questions. Please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or [rbennett@aafp.org](mailto:rbennett@aafp.org).

Sincerely,



Wanda D. Filer, MD, MBA, FFAFP  
Board Chair