AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

March 4, 2016

Mike Chernew, PhD
Work Group Lead, Financial Benchmarking
Population-Based Payment (PBP) Work Group
Health Care Payment Learning & Action Network (LAN)
Submitted electronically through HCP LAN website

Dear Dr. Chernew,

On behalf of the American Academy of Family Physicians (AAFP), which represents 120,900 family physicians and medical students across the country, I write in response to the draft white paper titled, "Accelerating and Aligning Population-Based Payment Models: Financial Benchmarking" as released on February 9, 2016.

The AAFP applauds the Work Group for developing a draft white paper on financial benchmarking. The AAFP supports the mission of the LAN and believes it will play an integral part in consistent deployment of alternative payment models (APMs) across all payers.

AAFP is supportive of APMs and believes that they need to be expanded to allow for increased participation. We strongly recommend that more be done to ensure appropriate payment for primary care physician services in these new payment models. To achieve this goal, we urge HCP LAN to use its leverage to increase the values of primary care services and appropriately value care management. In developed countries where there is higher investment in primary care (10-12 percent of total spend rather than the four-seven percent in the United States), there is a lower total cost of care with better population health outcomes.[1]

The AAFP agrees with the following principles and assumptions outlined in the beginning of the HCP LAN Financial Benchmarking document:

- **Principle 1:** Trust among payers, providers, and purchasers is essential for managing PBP models over time as benchmarks are updated, rebased, and risk adjusted.

[1] Organisation for Economic Co-operation and Development Health Statistics 2015.

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- **Principle 2:** Financial benchmarks in PBP models should incentivize high-quality, efficient care; enable accountability; compare performance across sites and over time; and establish a target that fairly rewards provider organizations.
- **Principle 3:** Payers should transparently communicate to providers the risk-sharing parameters involved in participating in a PBP model, such that providers can access the information they need to fully comprehend the risks associated with participation, understanding that there is an inherent tradeoff between simplicity and precision in payment design, and that it may not be possible to precisely quantify risk ahead of time.
- **Principle 4:** Successful approaches to financial benchmarking must simultaneously encourage participation while meeting financial, quality, and access objectives.
- **Assumption:** Participation in PBP models will likely be voluntary in the vast majority of circumstances, but participation in PBP models should be driven in part by decreasing the lucrativeness of FFS-based alternatives.

The AAFP opposes the third clause in Principle 5:

- **Principle 5:** The goal of financial benchmarks is to enable 1) efficient provider organizations to succeed; 2) struggling organizations to improve; and **3) failing organizations to fail.**

It would be a critical mistake for our country to allow any failing primary care based organizations to fail. As we stated in our introduction, we feel strongly that investing in primary care is the only way to lower total cost of care and improve individual patient and population health outcomes. This increased investment must include monthly care management payments so organizations can develop and sustain care management services and a long-term plan how to adequately value primary care.

Primary care must be the foundation of any successful PBP model. The United States cannot afford to lose access to cost-effective primary care services. AAFP cautions the Work Group that using overly aggressive financial benchmarks related to primary care providers could inadvertently lead to limited participation in APMs or, in the case of Medicare, providers may opt out entirely. Since primary care is already in limited supply in certain markets, this issue is expected to worsen with the aging of the baby boomers and a growing shortage of primary care providers. **The AAFP asserts that all payers need to provide the tools, resources, and financial support to lift up all primary care based organizations so they can build and sustain improved access and care management needed to improve quality and reduce the total cost of care.**

The AAFP looks forward to working with HCP LAN. There are several important concepts that should be incorporated into alternative payment models and financial benchmarking for primary care physicians to be effective in meeting the Triple Aim:

- **Quality Must Come First**
  While this paper discusses only financial benchmarking, quality thresholds must first be met before financial benchmarks are factored into the payment equation. The AAFP believes less expensive care is not necessarily better care.

- **Quality Measure and Financial Benchmarking Must Be Harmonized**
  The AAFP supports reasonable and achievable quality improvement and financial benchmarking metrics that promote continuous quality improvement and cost reduction. AAFP supports the core measure sets that are being developed by the multi-stakeholder Core Quality Measure Collaborative to ensure alignment, harmonization, and the avoidance of competing measures among payers. All measures and methodology must be simple, transparent, and harmonized across all payers to reduce administrative burden on providers.

- **Expansion or modification of the Center for Medicare and Medicaid Innovation Comprehensive Primary Care (CPC) Initiative or Similar APMs Needed**
  CPC allows small practices to participate in alternative payment models around a core set of comprehensive primary care functions. This initiative aligns expectations of the majority of regional payers and provides risk-adjusted population-based care management fees, technical assistance, and shared savings opportunities that support costs associated with practice transformation and increased care coordination by the primary care provider.

- **Definitions need to be transparent and consistent**
  Within the Work Group's definition of "financial benchmark," "spending" and "costs" need to be clearly and specifically defined. In addition, The AAFP calls for a differentiation between primary care costs and all other costs, which would require a list of appropriate "basket of services" for primary care. The AAFP notes that the Medicare Access and CHIP Reauthorization Act and Work Group's definition of "total cost of care" (TCOC) needs to be consistent. While family and primary care physicians can influence costs, they do not have control over costs once care is turned over to specialty level care. In a 2015 AAFP Value-Based Payment Survey, 76 percent of family physicians indicated that they do not have information on costs of services for appropriate referrals. The survey also found **only 28 percent of family physician practices had the ancillary staff who can significantly help with functions that contribute to controlling quality, costs and utilization, such as care coordination and management, preventing readmissions, registry support, and other population health management functions**. Family physicians cannot be part of the solution without adequate information and support. In addition, patient choice, adherence, and accountability should be quantified and factored into benchmark calculations.

- **Health Disparities**
  The AAFP supports reducing health disparities as a part of care delivery and urges HCP LAN members to move forward with expanding its risk-adjustment methodology in quality measures to incorporate social and economic factors such as race, income, education, and region. Risk-adjusting for socioeconomic status ensures the measures are fair and sets the standard for comparison of physician performance by adjusting for factors outside of the physician's control. Not adjusting could lead to misleading conclusions about physician performance. As a result, further disparities in care could be magnified. Through HealthLandscape, the AAFP has developed the Community Vital Signs tool that could assist practices of all sizes understand the social and economic status of their patient population.

Recommendation 1: Approaches to financial benchmarking should encourage participation in the early years of the model's progression, while driving convergence across providers at different starting points towards efficiency in the latter years.

Medical practices, regardless of being high- or low-performers, will succeed or fail depending on the financial benchmarks. According to the AAFP VBP survey, practice sustainability is the factor family physicians feel is the most important in evaluating the success of a VBP system (92 percent) and financial benchmarking plays a critical role in sustainability.
AAFP believes that a tiered methodology to financial benchmarking should be used to compare performance since practices will enter into participation with a wide variation. Recognition of those achieving high marks, with not only the high level financial award but also a premium bonus for being in the highest level of accomplishment, will ensure that practices at all levels continue to make improvements. Tiered methodology will encourage practices at all entry levels to participate. Higher incentives at higher levels would give further incentives to lower achieving practices to not only improve but also to strive for "best practice" standards.

When setting and updating financial benchmarks, the AAFP urges the Work Group to advocate for alignment among public and private payers—at least within a defined geographic region and for market segments. The AAFP agrees with the Work Group in that "local circumstances will necessitate different weightings of priorities, resulting in legitimate variations in the technical details that underwrite financial benchmarking approaches." The most striking finding of the AAFP Value-Based Payment Survey was that **61 percent of family physicians' practices submitted claims to seven or more payers** in the past year. Therefore, alignment among the financial measures and methodologies used to set, update, and rebase financial benchmarks, within a defined geographic region and for market segments, would significantly reduce the administrative burden for participating physicians and practices.

Lastly, physicians and practices will prospectively need to know how they are being measured, who they are being compared to, what their benchmarks are, and what precisely they are working toward. We urge the Work Group to recommend an extensive education and outreach program, jointly funded by all stakeholders to educate and empower all providers to operate with clarity and purpose within APMs.

Recommendation 1a: The initial baseline should be based on provider-specific spending, taking into account the provider organization's history and local market forces.

While the AAFP concurs with Work Group's statement on favoring lower efficiency organizations, the AAFP also hopes the Work Groups recognizes the conundrum this approach creates by potentially penalizing already high-performing practices. Those practices, that have historically controlled costs, may have their projected gains reduced when new benchmarks are set. Furthermore, it could penalize organizations that have already done a good job making their populations healthier. Financial benchmarking should use an incremental or tiered, rather than a single threshold approach, in order to assess practices' meaningful improvements at any level. Payers should recognize high-performing practices that are exceeding benchmarks and provide these practices with, not only the corresponding financial reward, but also a bonus for being in the highest level of performance. This would ensure

incentives for high-performing practices are not diminished over the long-term, while giving incentives for lower achieving practices to not only improve but to also strive for a “best in class” standard.

To address this issue, the AAFP believes payers should agree on a set of community-based benchmarks rather than provider-specific historical baseline. When setting the initial baseline on provider-specific spending, the AAFP believes similar peer groups should be used within benchmarks in order for similar providers to be as fairly compared to each other as possible. To that end, the peer groups should be structured and adjusted, along with the benchmarks, on two levels. The first level is the patient population served by the physician/practice. Comparability at this level is attained through risk-adjustment, which encompasses a patient’s medical diagnosis, socio-economic characteristics (income, education level, health literacy, race, ethnicity, gender, etc.), prior health care utilization (inpatient, outpatient, pharmacy, home health, durable medical equipment, etc.), health insurance status prior to attribution, and other relevant risk-adjusters. The second level encompasses the practice itself. The AAFP suggests the following peer groups accounting for statistical significance and mean variation of TINs with:

- One provider FTE
- Two to five provider FTEs
- Six to 12 provider FTEs
- 13 to 25 provider FTEs
- 26 to 50 provider FTEs
- 51 to 75 provider FTEs
- 76 or more provider FTEs

Comparability is especially critical to physicians who practice in solo, small, and/or independent practice environments, rural settings, and in health professional shortage and medically underserved areas. Those practices most likely will not have access to supporting services available to physicians who practice in large groups and/or urban settings. Supporting services may include care coordination, access to needed specialists, behavioral health, and pharmacy support. Additionally, physicians in smaller or less sophisticated practices may not have a robust HIT infrastructure, creating a disadvantage for monitoring quality, cost, and utilization. If public and private payers can structure its peer comparison methodology for financial benchmarking in such a way that comparability is attained at both the patient level and with like practices, then true peer-to-peer comparisons can be made.

Recommendation 1b: Updating and rebasing of the initial benchmark should not be based on provider-specific changes in spending.

Payers need to be transparent with the measures and calculation methodologies used for updating and rebasing benchmarks. Transparency in these processes will alleviate frustration and distrust that physicians may have about the nature of how these calculations are made. This transparency is crucial for reaching the first principle on trust included in the financial benchmarking white paper. Also, for physicians to truly understand how their performance is being measured and the performance that is expected of them, the financial benchmarks need to be published in advance of the performance year.

Updating or rebasing to the prior year alone rewards inconsistent behavior and can set up a system where practices have good years every other year, rather than steady performance improvements. Frequent updating of these benchmarks undermines the business case for investments by physicians to improve the effectiveness of care delivery and decreases certainty for financial planning and investments. The AAFP urges the Work Group to advise holding the benchmarks steady for at least two years, as it is done in the MSSP, instead of reassessing after each performance year. Another option may be to consider a rolling average of three to five years although rebasing would need to be less frequent to consider this option. The rolling average would allow for fluctuations in unusual situations such as a difficult or expensive flu season one year or some other short term event that may spike costs.

Recommendation 1c: Updating and rebasing of the initial baseline should quickly drive convergence around local spending rates, with an eventual movement to regional and national rates in the medium to long term.

The AAFP agrees with the Work Group that financial benchmarks should be used to drive convergence in adjusted payments from public and private plans within a common payer segment (e.g., between Medicare, Medicaid, and private payers). This approach inherently takes into account similar populations, but it will need to take into account the full gambit of relevant regional differences, patient risk-adjusters, including medical diagnosis, and socio-economic characteristics.

Family physicians who have been active in private and federal delivery and payment pilots and demonstration projects indicate that it is imperative to leave rates at a regional level. They also suggest that the only way to speed this convergence is to have consistency in quality and financial benchmarking across all private and public payers similar to CPC. **AAFP believes that it would be necessary to test how regional comparisons work before assuming that national benchmarking is possible.**

Recommendation 1d: There are multiple pathways to convergence, but the end point is what matters.

The AAFP agrees that there may be a variety of pathways to convergence. The AAFP also believes that there will be high variability depending upon individual market and the history of contracting, market share, and leverage. Today, there are several CMS and CMMI pilot studies that are examining various health systems and medical groups willingness to accept various levels of financial risk. As those pilots end, there should be a good picture over a variety of geographic markets of the levels of risks versus rewards that provider organizations are willing to take on and the speed to convergence. Collective agreements between CMS and the commercial payers with a slight extra reward offering to push the pace of convergence may be needed such as that in CPC.

The critical additional piece will be to transfer at least some of the risk and accountability, perhaps in the form of payment for exercising of free choice of access points, to patients themselves. There has been very little written about patient accountability or even transparency with patients/beneficiaries on payment and cost. This is a critical piece missing in the entire transformative process. Patient incentives or higher

personal responsibility may be necessary to promote more rapid changes in reducing the total cost of care.

Recommendation 2: Risk adjustment must strike a fine balance such that providers who serve higher-risk or disadvantaged populations are not unduly penalized, and disadvantaged populations do not receive substandard care.

The AAFP applauds the Work Group for this recommendation.

Recommendation 2a: The state of the art of risk adjustment is likely to change over time, and it will be important to keep up with recent developments that improve the precision of risk-adjustment approaches.

Today, everything related to risk adjustment seems to be proprietary and payers cannot explain the methodology when asked. Risk adjustment methodologies and correlation coefficients need to be transparent and consistent across all payers and be as simple and straightforward as possible. It will be important for physicians and practice staff to understand how risk is determined so that they can provide the information needed to appropriately assign risk or improve documentation to accurately reflect patient risk. These changes would considerably improve trust between payers and physicians.

Currently, in Medicare Advantage plans if patients are attributed to a provider, but choose not to come into a clinic for appointments, they may be assigned a risk score of 0.0 by CMS. This risk assessment is not appropriate and may lead physicians to drop patients that have chronic disease and are non-compliant.

Some risk-adjustment models account for drug costs more than others and, at times, fail to "keep up" with rising spend on subpopulations such as those with cancer or rheumatologic diseases. Given the continuous pipeline and unpredictable pricing of drugs, specifically biopharmaceuticals, risk-adjustment models may need to account for them differently or have them carved out for certain patient populations. Retrospective models could account for this, but may not allay the concerns of at-risk providers at the time of contracting.

Recommendation 2b: Risk-adjustment models should minimize the connection between utilization and risk score.

The AAFP agrees with the Work Group that “utilization should not be used as *prima facie* evidence that a provider organization is treating a sicker population….” Physicians and practices should be free to be innovative and create new care delivery, coordination, and management strategies that can make patients healthier by focusing on primary and secondary prevention and health wellness or promotion. The risk-adjustment model should not drive physicians to increase their intensity of treatment; rather these models should compensate physicians for rendering the right care, in the right place, at the right time to their patients.

"Gaming" diagnosis codes is rampant today and will continue to be an issue in the future without definitions of such terms as mild, moderate, and severe. These definitions should be universal and published by a reputable source, such as within the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) guidelines themselves. Currently, these classifications change with the scenario and can vary from publishing entity to entity. ICD-10-CM is the right instrument to allow for these definitions, as its use is mandated by the Health Insurance Portability and Accountability Act for covered entities.

Recommendation 2c: Successful risk-adjustment models should accurately predict spending at the population and subpopulation levels, but it is not important for models to accurately predict spending at the individual level.

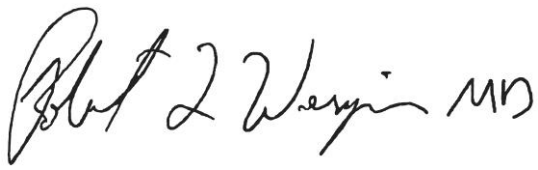
The AAFP agrees with this recommendation. If risk-adjustment models predicted spending at an individual level, it may embolden providers to drop high-cost or vulnerable patients from their practices. In addition, there are certain conditions, surgeries, prescriptions, etc., that are performed once (i.e., an amputation) and those costs should be mitigated in the models.

Recommendation 2d: PBP models should not disrupt care for needy populations, and risk adjusting for socioeconomic status (SES) may be one way to accomplish this. Nevertheless, SES adjustments should not be a mechanism for forgiving lower care for needy populations.

The AAFP agrees with this recommendation and would reiterate risk-adjusting for SES should use variables of the patient population listed in Recommendation 1a.

We thank you for the opportunity to provide input to the Financial Benchmarking Draft White Paper. Please do not hesitate to call upon the AAFP for assistance. For additional information, please contact Janelle Johnson, Health Care Finance and Delivery Manager at (913) 906-6000 extension 4178 or jjohnson@aafp.org.

Sincerely,



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