and all non-E/M services, including Healthcare Common Procedure Coding System codes beyond the selected “G codes,” would continue to be billed based on the current fee-for-service payment model. At level two, the primary care global payment should include all E/M codes as well as select “G codes.” All other services would be billed under codes via fee-for-service. Primary care global payments under both level one and level two practices should be risk stratified based on patient complexity and other factors.

(6) Medical Home Expanded Under Section 1115A(c) of the Act
(7) Application of criteria to current and recently announced APMs
In this section, CMS discusses how the Medical Home Model criterion cannot be met unless a Medical Home Model has been expanded under section 1115A(c). To date, there are no Medical Home Models expanded under section 1115A(c). CMS notes that satisfying expansion criteria is not sufficient to meet the requirements of the Advanced APM.

This rule also includes a list of potential Advanced APMs based on a preliminary application of the criteria. There are currently five Advanced APMs expected to be available for the first QP Performance Period, with the Oncology Care Model meeting the criteria beginning in 2018. CMS will post their official determination of Advanced APMs prior to the start of the first QP Performance Period.

AAFP Response
The AAFP believes the definition of a Medical Home Model expanded under 1115A is a very narrow definition that excludes many from participation in the APM program. CMS needs to broaden this definition to encourage participation in alternative payment models and to allow more of these models to meet the qualification criteria. The AAFP believes CMS should particularly modify its criteria regarding reducing spending. The predominant criterion under this requirement should be that a program “does not result in any increase in net program spending under the applicable titles.” As demonstrated by the CPC initiative, a program may take several years before it is able to show a reduction in net spending. Holding a program to such a high standard will significantly delay the expansion of valuable programs. Conversely, a program may be able to demonstrate that it does not result in an increase in net spending much more quickly – allowing for more rapid expansion of programs while also accelerating new demonstrations.

The AAFP appreciates the CPC+ model being made available as an Advanced APM option. CPC+ offers a great opportunity for primary care to enter into an Advanced APM. However, the AAFP is concerned about the limited availability for family physicians to participate in the program due a single enrollment period and limited regions selected. The AAFP strongly urges CMS to institute a rapid review of the original CPC initiative expand the program as quickly as possible.

We believe the Payment Technical Advisory Committee (PTAC) will play a vital role in the development of physician-focused payment models (PFPM) The PTAC will have strong influence on the identification of Advanced APMs, including models that are primary care focused and those that incorporate direct primary care (DPC). We encourage CMS to engage and closely consider the recommendations from the PTAC to ensure there are more primary care Advanced APMs available in the future.