AAFP Response
The AAFP supports a payment model that includes a primary care global payment for direct patient care, a care management fee, and a fee-for-service limited to services not otherwise included in the primary care global fee. Advanced primary care practices with patients that qualify for participation in this payment model would elect one of two levels of primary care global payment. At level one, the primary care global payment for patient care encounters should be a standardized payment that would only include care provided under the E/M and select “G codes” pertaining to ambulatory, office-based, face-to-face care. All other E/M codes 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 fee-for-service codes. Primary care global payments under both level-one and level-two practices should be risk-stratified based on patient complexity and other factors.

(7) Medicare Advantage (MA)
CMS proposes that under the All-Payer Combination Option for QP determinations, eligible clinicians and Advanced APM Entities can meet the QP threshold based in part on payment amounts or patient counts associated with Medicare Advantage plans and other payers, provided that such arrangements meet the criteria to be considered Other Payer Advanced APMs.

AAFP Response
The AAFP urges CMS to use its leadership role in the Health Care Payment Learning and Action Network (LAN) to drive alignment of MA APM frameworks with MACRA in order to align incentives, performance measures, and other components of value-based arrangements between public and private payers. Furthermore, we urge CMS to model future advanced APMs after the most successful MA models. It is imperative that qualifying physicians are able to execute value-based arrangements—within APM frameworks that are similar in nature and easy-to-understand—and deliver on the promise of population health management. Physicians already face huge administrative burdens with claims adjudication, pre-authorizations, and other tasks that do not directly contribute to improving clinical outcomes in the current fee-for-service system. It will only get more complicated within APM frameworks. Lastly, family physicians and other primary care providers do not see the people they treat as “Medicare patients” or “Medicare Advantage patients,” they are treating and caring for patients. Public and private payers need to reduce the administrative burden and needless variability among their APM frameworks so qualifying physicians can concentrate on their real mission: practicing medicine.

(1) Submission of Information for Other Payer Advanced APM Determination and Threshold Score Calculation
CMS proposes that APM Entities and/or eligible clinicians must submit certain information for CMS to assess whether other payer arrangements meet the Other Payer Advanced APM criteria and to calculate Threshold Scores a QP determination under the All-Payer Combination Option.

AAFP Response
The AAFP adamantly opposes CMS requiring APM Entities and/or eligible clinicians to submit information for CMS to assess whether other payer arrangements meet the Other Payer Advanced APM criteria. The onus of submitting relevant information on payer arrangements should be borne by the payer. Private payers have a better understanding of what information a