AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care

A Proposal to the Physician-Focused Payment Model Technical Advisory Committee

From the American Academy of Family Physicians

April 14, 2017

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Physician-Focused Payment Model Technical Advisory Committee
c/o Assistant Secretary of Planning and Evaluation Office of Health Policy
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Washington, DC 20201

Proposal – Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care

Dear PTAC Committee Members:

The American Academy of Family Physicians (AAFP) is fully supportive of the Physician-Focused Payment Model Technical Advisory Committee's (PTAC) role in evaluating physician-focused payment models (PFPMs) and making subsequent recommendations about those models to the U.S. Department of Health and Human Services (HHS). The AAFP believes that to be truly successful in improving care and reducing cost, PFPMs and alternative payment models (APMs) need a strong foundation of primary care. Therefore, on behalf of the AAFP, which represents 124,900 family physicians and medical students, I am particularly pleased to submit the following proposal—Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care. We request that the PTAC review the model, provide feedback to the AAFP on it, and promptly recommend it to HHS for approval and nationwide expansion.

Family medicine plays a critical role in delivering care to Medicare beneficiaries in every community across the country. The AAFP's Advanced Primary Care-Alternative Payment Model (APC-APM) proposal is an opportunity for the Centers for Medicare & Medicaid Services (CMS) to make advanced APMs broadly accessible to Medicare beneficiaries—and to impact quality and spending in other parts of the health care system. The foundational role of family medicine in care delivery is clearly illustrated by the following:

- Family physicians are the most visited specialty—especially in underserved areas. Family physicians conduct approximately one in five office visits. This represents more than 192 million visits annually, which is 48 percent greater than the next most visited medical specialty.[1] Family physicians provide more care for America's underserved and rural populations than any other medical specialty.
- Strengthening primary care is critical to driving greater value for beneficiaries, payers, and communities. Transformation cannot be overly complex and burdensome to operationalize. However, there is not a one-size-fits-all solution, as

patient panels, populations, and primary care practices vary. There is an emerging consensus that strengthening primary care is imperative to improving individual and population health outcomes, as well as to restraining the growth of health care spending.

- The complexity of care provided by family physicians is unparalleled in medicine. Data show that family physicians address more diagnoses and offer more treatment plans per visit than any other medical specialty. Furthermore, the number and complexity of conditions, complaints, and diseases seen in primary care visits is far greater than those seen by any other physician specialty.[2] CMS and private payers must make new investments in primary care to truly capture and realize the value proposition of family medicine and primary care.
- Primary care is particularly affected by longstanding inequities in payment that must be corrected if it is to be the foundation of a transformed, patient-centered health system. Research shows that fee-for-service "(FFS) is not only flawed for its strong incentives to increase volume, but also in its disproportionate reimbursements for procedural rather than cognitive care."[3] Payment experts offer similar assessments of the problems with testing and building value-based payment models on a flawed physician fee schedule. Drs. Robert Berenson and John Goodson wrote in the *New England Journal of Medicine*, "If the foundation of Medicare's fee schedule isn't sound, these systems will be unstable."[4] According to the 2016 Medicare Payment Advisory Commission (MedPAC) report, compensation continues to be much lower for primary care physicians than for physicians in subspecialty disciplines.[5]
- Distinct Advanced Alternative Payment Models (AAPMs) must be made available nationally to all primary care physicians. Though primary care oriented AAPMs will continue to clinically coordinate with other payment models, primary care AAPMs must be distinct from bundled payment models to maximize support for the delivery of continuous, longitudinal, and comprehensive care across settings and providers. Including primary care in bundled payments will not provide the support our health system needs to increase value and strengthen primary care.

Primary care is the primary access point to the health care system for millions of Americans across a diverse range of communities. The AAFP is pleased to present the APC-APM proposal to the PTAC to ensure that more Medicare beneficiaries have access to care delivered under advanced APMs. We feel this will help achieve the goals of improving overall health outcomes of Medicare beneficiaries and the health of communities, as well as bring stability to the Medicare program.

Thank you for your time and consideration of this proposal. For any questions you might have, please contact Mr. Kent Moore, AAFP Senior Strategist for Physician Payment, at (800) 274-2237, extension 4170, or kmoore@aafp.org.

Sincerely,

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

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ABSTRACT

The Advanced Primary Care-Alternative Payment Model (APC-APM) embodies the principle that patient-centered primary care is comprehensive, continuous, coordinated, connected, and accessible from the patient's first contact with the health system. The APC-APM aims to improve clinical quality through the delivery of coordinated, longitudinal care, and uses the approach to deliver care that improves patient outcomes and reduces health care spending.

The APC-APM is envisioned as a multi-payer model that builds on concepts already tested through the Comprehensive Primary Care (CPC) and CPC Plus (CPC+) initiatives. The APC-APM would be open to almost 200,000 primary care physicians and potentially impact more than 30 million Medicare patients. Based on available evidence, additional spending on primary care is projected to be more than offset by savings elsewhere in the health care system, resulting in a net savings to the payers involved.

Each APC-APM entity will be evaluated based on reporting six measures, with one being an outcomes measure in order to align with the Medicare Access and CHIP Reauthorization Act's (MACRA's) Merit-based Incentive Payment System (MIPS) reporting requirements. These measures will come from the core measure sets developed by the multi-stakeholder Core Quality Measures Collaborative to ensure focus, alignment, harmonization, and the avoidance of competing quality measures among all payers. These measure sets include patient experience measures, and all but one of the core measures are also measures under the MIPS.

The APC-APM would create a new payment structure for participating primary care practices consisting of a combination of four mechanisms:

- A prospective, risk-adjusted, primary care global payment for direct patient care;
- Fee-for-service limited to services not included in the primary care global fee;
- A prospective, risk-adjusted, population-based payment; and
- Performance-based incentive payments that hold physicians appropriately accountable for quality and costs.

Other features of the model require that physician practices be:

- Fully flexible to accommodate differences in clinical settings and patient subgroups covered by primary care;
- Able to be fully evaluated for quality and cost at the model and APM entity levels;
- Reflective of the Joint Principles of the Patient-Centered Medical Home (PCMH) and the five key functions of the CPC+;
- Attribute patients based primarily on patient choice; and
- Adopt, and ultimately use, interoperable, certified health information technology, with the expectation that at least 50% of qualifying participants will use certified electronic health record technology (CEHRT).

I. Background and Model Overview

The APC-APM is built on the principle that patient-centered primary care is comprehensive, continuous, coordinated, connected, and accessible from the patient's first contact with the health system. While the APC-APM aims to improve clinical quality through the delivery of coordinated, longitudinal care—assessed through the Core Quality Measure Collaborative measure sets—the broader goal of the APC-APM is to use this approach to deliver care in a manner that improves patient outcomes and reduces health care spending, such as through decreased inpatient and emergency department visits. As illustrated in our proposal, the APC-APM would accomplish this through a prospective, risk-adjusted primary care global payment for direct patient care, a population-based payment covering non-face-to-face patient services, along with fee-for-service (FFS) payments, which are limited to services not otherwise included in the primary care global payment. These payments are coupled with prospective performance-based incentive payments that hold physicians appropriately accountable for quality and costs by rewarding practices based on their performance on patient experience, clinical quality, and utilization measures.

Supporting information about the value of primary care to patients and payers in terms of its positive effects on costs, access, and quality, as well as policy details on how the APC-APM would advance these goals are described in the AAFP's position paper, "Advanced Primary Care: A Foundational Alternative Payment Model (APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care."[6] A copy of this position paper is found in Appendix A. In it, we present a transformational, primary care focused, and patient-centered model, including:

- The definition and recognition of an APC-APM participating physician;
- An appropriate, four-step methodology to attribute patients to the APC-APM;
- How global and performance-based incentive payments should be structured and made;
- Reporting quality measures and the calculation of value-based payments; and
- Financing for the model.

II. Scope of Proposed PFPM (High Priority Criterion)

In this section, PTAC seeks input on ways the APC-APM would broaden or expand CMS' APM portfolio by either addressing an issue in payment policy in a new way or including APM entities whose opportunities to participate in APMs have been limited.

Goals of PFPM. The AAFP appreciates that the PTAC and Center for Medicare and Medicaid Innovation (CMMI) are working to increase the number and variety of models available to ensure that a wide range of clinicians, including those in small practices and rural areas, have the option to participate in an Advanced Alternative Payment Model (AAPM) under the Medicare Access and CHIP Reauthorization Act (MACRA). While the AAFP fully supports that CMMI tested the CPC initiative and is currently testing the CPC+ model, as well as other primary care transformative models, those models are limited to specific markets in certain geographical regions. Patients not in those regions are unable to benefit from the same improved access to primary care and more coordinated care in regions where the CPC and CPC+ models are being tested. By recommending to HHS that the APC-APM be

implemented nationally, the AAFP is hopeful that all patients would benefit from primary care's positive effects on access, quality, cost, and health promotion.

The APC-APM concept is being actively tested through the multi-payer CPC and CPC+ models that promote longitudinal, comprehensive, and coordinated care with primary care teams. Early CPC evidence shows that participating practices:

- Continue to make progress in how they deliver primary care functions and are advanced in risk-stratified care management.
- Generate improved patient experiences among attributed Medicare beneficiaries.
- Reduce emergency department visits and Medicare Parts A & B expenditures.
- Reduce total monthly Medicare expenditures not including care management fees.
- Are more advanced in other aspects of care delivery than comparable practices.

The feasibility of the CPC and CPC+ models indicates that the APC-APM could be implemented across a diverse set of family medicine settings that are committed to practice transformation.

Physician Practices. The AAFP envisions the APC-APM to be available to all physicians with a primary specialty designation of family medicine, general practice, geriatric medicine, pediatric medicine, or internal medicine. The AAFP also envisions the APC-APM to be designated as an AAPM under MACRA.

Based on Physician Compare data, there are approximately 195,000 such primary care physicians that could practice within a designated AAPM entity. Given the evident merits of the model, the push from CMS to tie more Medicare payments to quality and value, and the current small number of AAPMs under MACRA, we anticipate that many of these physicians would express interest and willingness to participate in the model if it is approved and expanded to scale.

The APC-APM is equally applicable to physicians who are employed or independent, which is especially critical for increasing participation in AAPMs among rural and/or small practice physicians. The AAFP has supported member recruitment and education related to the CPC and CPC+ models and found widespread interest in participation, which we believe will lead to broad interest in participating in the APC-APM.

To the extent that a large portion of the services provided will be capitated through the global primary care payment and population-based payment, the APM entity and its eligible clinicians will bear risk for performance related to those services. Additionally, the APM entity and its eligible clinicians will bear performance risk through the performance-based incentive payments, since, as noted elsewhere, failure to meet agreed upon benchmarks would involve an APM entity repaying all or part of their incentive payments (depending on the level of performance). Since the APC-APM requires participants to only assume performance risk, we believe the model is feasible for small practices.

Patient Population. Based on the number of Medicare patients seen by primary care physicians in 2014, we estimate that more than 30 million Medicare patients would be impacted if the APC-APM were implemented nationally. To the extent the APC-APM is a multi-payer model, the actual number should be substantially more than that. The AAFP has experience working with commercial payers on multi-payer models (such as CPC and CPC+), and meets regularly with the largest national commercial health insurers on a variety of issues, including payment reform.

APM entities would be responsible for reporting and performance on selected performance measures in the Core Quality Measures Collaborative's Patient-Centered Medical Home (PCMH)/Accountable Care Organizations (ACO)/Primary Care Core Set. The collaborative's measures are found in Appendix B. We believe that these performance measures will help ensure that patients receive necessary care and are not harmed by efforts to achieve savings. This is of particular concern given that APM entities with performance that does not meet agreed upon benchmarks face recoupment of their incentive payments and potential expulsion from the APM.

We also think the APC-APM model supports patient safety by making patient choice the primary attribution methodology. Patients who do not believe that they are receiving the care they need may elect to leave an APM entity. Since the risk-adjusted, capitated primary care global fee and population-based payment (which will comprise a significant part of an APM entity's revenue stream) follow the patient from practice to practice, APM entities will have an incentive to treat patients appropriately and deliver high-quality, coordinated care.

Spending. As noted elsewhere in this proposal and based on research, the AAFP recommends that the percentage of total health care dollars spent on primary care be doubled.[3] At the same time, based on experience in Rhode Island[7,8] and other demonstrations,[9] there is evidence that such an increase can be accomplished without an increase in overall spending on health care. In fact, evidence indicates increased spending on primary care will lead to a decrease in overall spending on a per-patient basis. For instance, using a simulation model, Reschovsky, et al. projected that a permanent 10% increase in Medicare fees for primary care ambulatory visits would result in a six-fold annual return on lower Medicare costs for other services, primarily inpatient and post-acute care.[10] Accordingly, the AAFP estimates the overall anticipated impact on spending to be a net savings to the payers involved.

The AAFP believes spending on primary care under the APC-APM should be increased from current levels, given the evidence that access to primary care is associated with improved individual and population-health outcomes and reduced costs. Today, primary care only represents approximately 6-8% of total spending on health care.[11] We, and others, believe this should be increased to at least 12% of total spending.[9] The AAFP believes that such an increase can be accomplished without an increase in the overall spending on health care. In fact, evidence indicates increased spending on primary care will lead to a decrease in overall spending on a per-patient basis.[9]

This belief is rooted in the experience of other Organization for Economic Cooperation and Development (OECD) countries. Most of those countries have health care systems where primary care is foundational, and their spending per capita is well below that of the United States. Within the U.S., Rhode Island mandated an increase in primary care spending from 5.4% to 8% between 2007 and 2011.[12] The Rhode Island Insurance Commissioner reported a 23% increase in primary care spending was associated with an 18% reduction in total spending—a 15-fold return on investment.[12] Lastly, Portland State University completed a 2016 study of Oregon's Patient-Centered Primary Care Home (PCPCH) program and found that every $1 increase in primary care expenditures as part of the PCPCH model resulted in $13 in savings in other health care services, including specialty, emergency room, and inpatient care.[13]

Cross-Payer Impacts. The APC-APM model, similar to CPC and CPC+, can be a multi-payer APM. We believe this is a strength of the proposal, as it can improve care quality and reduce costs for other patient populations. It may also help advance the movement to "Other Payer Advanced APMs" in 2021.

III. Quality and Cost (High Priority Criterion)

In this section, PTAC seeks input on ways the APC-APM would improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost. The value proposition of the APC-APM is simple—we believe it will improve quality of care and outcomes and reduce overall costs (especially use of acute services), based on our analyses and early CPC results.

Care Delivery Impacts. The APC-APM would improve care delivery and achieve savings or improve quality in manners similar to the CPC and CPC+ models, including but not limited to:

- Reduced emergency department (ED) visits. Over the first three years of CPC, ED visits for Medicare FFS beneficiaries in CPC practices increased at a slower rate (2% less), relative to beneficiaries in comparison practices. The estimated effect on ED visits was a statistically significant difference.[14]
- Improved the quality of care among high-risk beneficiaries with diabetes at a statistically significant level.[14]

Barriers and Risks. Existing regulatory and administrative burdens that public and private payers impose on practicing family physicians are detailed in the AAFP's Agenda for Regulatory and Administrative Reforms.[15] Other barriers in federal laws and regulations that may prevent or discourage needed changes in delivery include, but are not limited to, provisions of the Stark Law and the requirement that patients must have a three-day inpatient hospital stay as a prerequisite for coverage of skilled nursing facility care. We believe that the proposed model can still have an impact, even if present regulatory barriers are not addressed. However, the potential impact will be diminished.

Metrics. Each APC-APM entity will be evaluated based on reporting six measures, with one being an outcomes measure in order to align with MACRA's MIPS reporting requirements. These measures come from the core measure sets developed by the multi-stakeholder Core

Quality Measures Collaborative to ensure parsimony, alignment, harmonization, and the avoidance of competing quality measures among all payers. These measure sets include patient experience measures.

We note that all but one of the core measures are also measures under the MIPS. Thus, the APC-APM meets the quality measurement standard for an AAPM.

Since primary care physicians treat a wide range of medical conditions for all patients, regardless of sex, age, or type of condition, the APC-APM will not need to develop any specialty-specific measures or other measures outside of those identified by the Core Quality Measures Collaborative. This approach would lead to streamlined quality measure reporting and assessment, and reduced administrative burden to physicians (especially small practices).

Data Issues. The APC-APM embraces the use of data from multiple sources to provide a complete view about quality and cost performance. This ensures that both APC-APM participants and CMS may readily identify numerators, denominators, inclusions, and exclusions contributing to assessments of quality and cost performance, as well as factors likely contributing to outlier quality and cost data. APC-APM participant use of data from multiple sources will be encouraged. It will help identify new insights into potential care interventions for patient populations that offer the greatest potential to maximize efficacy and efficiency of care that result in positive health outcomes.

APC-APM participants would work with their health IT vendors to generate timely and clinically actionable reports, including both practice- and provider-level data. Since a key objective of the APC-APM is continuous quality management toward value-based care and because quality improvements may lead to unintended and difficult to identify increases in disparities of care, the APC-APM will encourage participants to use social determinants of health data, to the extent possible. Social determinants of health data that include customized reports, analyses, and visualizations of performance and improvement activities can serve as a means of checks and balances.

Data may show the potential for specific-care interventions, improvement activities, or use of technology, such as patient-specific education and secure messaging that could result in unintended consequences. For example, while quality measure scores increase, disparities of care can be seen to increase if social determinants of health data are also present within the same reports or data visualizations. Use of data from multiple sources is encouraged to more readily identify increases in disparities among vulnerable patient populations. Drilling down into all factors may be useful to identify an undesirable increase in the disparity of care. This could enable corrections, which minimize potentially negative patient outcomes and correct what would result in eventual increases in cost of care.

Family physicians and other eligible clinicians benefit from timely performance feedback in order to adjust their performance or modify workflows. In this sense, the APC-APM will encourage participants to engage in electronic reporting more frequent than annual reporting.

However, family physicians provide varying levels of care and work among various care settings, which can include multiple locations using different health IT. This could impact their ability to report electronically more frequently than annually, quarterly, or semi-annually. Electronic reporting will not be required, though it will be encouraged, and at least 50% of qualifying participants are expected to use certified electronic health record technology (CEHRT).

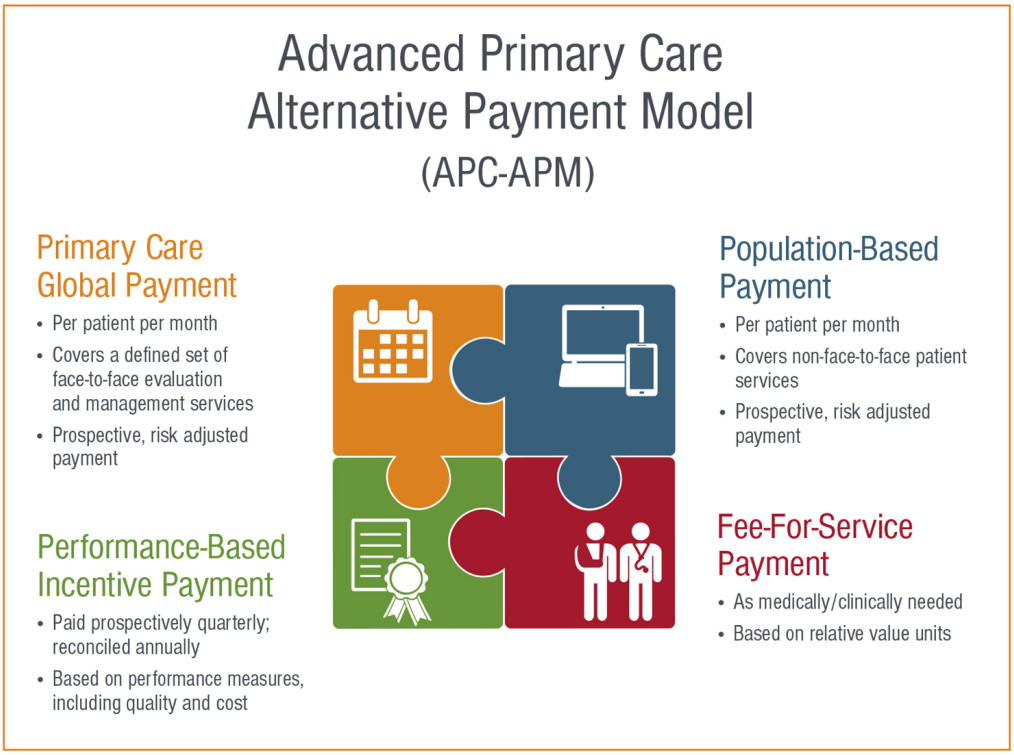
Capturing and sharing of data from electronic health records (EHRs) of all clinicians providing relevant care for an attributed patient population, as well as data aggregation and calculation of measures, will be encouraged. This will help align with the data aggregation policy previously outlined by CMS for providers practicing in multiple locations under the EHR Incentive Program.

APC-APM participants will be encouraged to monitor their performance on quality and cost on a more frequent basis in order to improve quality and cost measures. Higher performance scores correlate to positive health outcomes and improved patient experiences. Patients and physicians benefit from appropriate and effective resource management.

IV. Payment Methodology (High Priority Criterion)

As illustrated below, the APC-APM would create a new payment structure for participating primary care practices consisting of a combination of four mechanisms:

- A prospective, risk-adjusted primary care global payment for direct patient care;
- Fee-for-service limited to services not otherwise included in the primary care global fee;
- A prospective, population-based payment; and
- Performance-based incentive payments that hold physicians appropriately accountable for quality and costs.



This payment structure would incentivize the delivery of high-quality, coordinated care, with a focus on cost reduction across settings. It represents a blended payment strategy to minimize shortcomings of individual approaches.

Payment Methodology. APM entities should be able to elect one of two levels of prospective, primary care global payment. This will allow primary care physicians to move toward a more fully capitated payment arrangement at a reasonable pace for their particular practice, and to eventually replace FFS for face-to-face visits. The two levels of primary care global payment would be defined as follows:

- Level 1: Ambulatory, office-based, face-to-face evaluation and management (E/M) services
- Level 2: All E/M services regardless of site of service

Under Track 2 of CPC+, practices are prospectively paid CPC Payments (CPCPs) with a reduced FFS payment when services are actually provided. CPCP is a lump sum quarterly payment based on flawed historical FFS payment amounts. We believe this methodology must be improved upon.

It is well documented that historical FFS payment amounts undervalue E/M and other primary care services.[16] As MedPAC noted in its March 2016 report to Congress on Medicare payment policy, "The Commission remains concerned that the [Medicare physician] fee schedule and the nature of FFS payment leads to an undervaluing of primary care and overvaluing of specialty care."[5]

Drastic payment discrepancies continue to raise serious concerns about fee schedule mispricing and its resulting negative impact on primary care. Without remedying this flaw, future actuarial calculations for APMs will not adequately compensate primary care for the complexity of care provided, and could undermine goals to improve care and reduce costs.

The AAFP strongly recommends that CMS and other payers immediately adjust upward the relative value units (RVUs) for common primary care services in order to pay appropriately for those services now and in new payment programs and models (e.g., CPC+) that otherwise rely on such relative values.

Ideally, the primary care global payment under the APC-APM would not be based on historical FFS payment amounts for E/M services included in the payment. Instead, the primary care global payment amount would be calculated to support the proposition (discussed in section II) that a percent of total spending directed to primary care should double to at least 12% of total spending. In other words, participating payers would calculate current spending on primary care, double that amount, and then subtract payments for population-based, FFS, and incentive payments to arrive at an amount that would be paid for the primary care global payments.

Please refer to our response (in section II under Spending) for further recommendations on proper spending for primary care in the APC-APM.

At either Level 1 or Level 2 of the primary care global payment, all other services, including all non-E/M services, would continue to be billed and paid based on the current FFS payment model.

APM entities should receive a separate population-based payment for each of their patients. This capitated fee should be calculated and paid prospectively on a monthly basis (or at least quarterly, as is the case with CPC+), and it should be without risk to the physician and free of patient-cost sharing. Under CPC+, care management fees average $15 per beneficiary per month (PBPM) under Track 1. Under Track 2, they average $28 PBPM, ranging up to $100 PBPM to support patients with complex needs. The amount of the care management fee under CPC+ is determined by: (1) the number of beneficiaries attributed to a given practice per month; (2) the case mix of the attributed beneficiary population; and (3) the CPC+ track to which the practice belongs.

Evidence supports the proposition that implementing population-based payments delivers on the primary care function and results in positive outcomes. For instance, supplementing FFS with a $3 per member per month (PMPM) payment per network for extra staffing and a $2.50 PMPM per provider payment for medical home and population health activities, Community Care of North Carolina (CCNC) was estimated to save the state about $284 million to $314 million over one year.[17] Multiple health outcomes and health care utilization metrics improved under CCNC, including inpatient admissions; emergency department use; and A1c, blood pressure, and LDL control for patients with diabetes.[17] Likewise, CPC includes a care management fee with positive results noted elsewhere in this proposal.

Finally, APM entities should receive prospective, performance-based incentive payments to reward practices based on their performance of patient experience, clinical quality, and utilization measures. The CPC+ performance-based incentive payment is an example of such a payment mechanism. We believe performance-based incentive payments in the APC-APM should be structured the same as those under CPC+, except that the APC-APM would rely on the core measure sets of the Core Quality Measure Collaborative rather than the electronic clinical quality and utilization measures used in CPC+. For CPC+ Track 1, these incentive payments are $1.25 PBPM on quality/patient experience of care and $1.25 PBPM on utilization performance. For CPC+ Track 2, these incentive payments are $2 PBPM on quality/patient experience of care and $2 PBPM on utilization performance. As in CPC+, APM entities in the APC-APM would be “at risk” for up to the entire amount of their performance-based incentive payment. Thus, the APC-APM would meet the general financial risk standard required of advanced APMs.

Like CPC+, this APM ideally would include other payers, and all participating payers will use the same payment methodology. However, each payer will determine the amount of each payment mechanism in negotiation with the APM entity or entities. The AAFP intends to reach out to other payers to promote this model as a more enlightened way of paying for primary care.

We believe the operational dollars provided through this payment methodology would alleviate the constraints imposed by the current FFS approach by providing such practices with more freedom to manage their patient panels independent of the face-to-face visit model. This approach would allow such practices to diversify available resources to better manage ancillary care needs and provide other services that yield improved, cost-effective care, making care delivery changes sustainable over time. Ultimately, this APM should allow participating APM entities to move to a global payment that combines the primary care global payment and population-based payment into a single, risk-adjusted global payment for APC-APM participants. This would include additional FFS payment for services outside the defined services to be included in this combined fee, along with additional payment for quality improvement.

This is similar to the concept of comprehensive primary care payments introduced by Goroll, et al.[11] and exemplified by Iora Health. Instead of charging copays or payments based on RVUs, Iora Health receives a fixed, risk-adjusted fee per patient.[18,19] Ten percent of this is invested in primary care services,[19] which approximates the 12% increase directed to primary care recommended by the AAFP. In addition, Iora implements pay-for-performance payments for attaining quality benchmarks.[17] In order to prevent inappropriate underutilization of services,[17] the primary care incentive payment serves a similar function under the APC-APM. Comprehensive payment represents the best opportunity to eliminate the impediments created by FFS by investing in upfront, primary care infrastructure; discouraging the volume of services; and supporting data-enabled teams that connect to community services.[17] "Payment models [like the APC-APM] with a basis in PMPM fees allow necessary flexibility to use funds to meet varied patient needs while creating the opportunity for a proactive rather than reactive approach to patient care."[3]

Success is measured by assessments of quality and cost-effective care relative to benchmarks. APM entities that meet or exceed agreed upon benchmarks would retain their incentive payments and maintain their standing in the APM. Failure to meet agreed upon benchmarks would involve an APM entity repaying all or part of their incentive payments (depending on the level of performance) and potentially exiting the APM and returning to traditional FFS.

"Adequate risk adjustment is essential to protect against cherry picking patients, inappropriate underutilization of services, and undue risk on practices."[3] Both the primary care global fee and the population-based payment should be risk stratified based on patient complexity (e.g., comorbidities, cognitive impairment, self-care ability as measured by activities of daily living); patient demographics (e.g., age, gender); and other factors, such as sociodemographic factors that are social determinants of health. In practice, the Minnesota Complexity Assessment Method (which modifies earlier work) specifies certain domains for assessment of patient complexity that includes illness, readiness (to engage treatment), social, health system, and resources for care. This allows clinicians to assess patient complexity and identify areas of intervention.

The AAFP believes this tool represents the best approach to assess complexity that is not captured through a review of disease burden, and it can better direct care teams in patient management. Therefore, the AAFP recommends the use of the Minnesota Complexity Assessment Method to risk stratify primary care global payment and the population-based payment on an annual basis.

We acknowledge that there are other risk adjustment methodologies and are open to considering alternatives. For instance, Ash and Ellis[20] conceptualized a comprehensive payment model to appropriately risk adjust expected primary care activity levels (PCALs) and performance measures. This model explains 72% of practice-level variation, outperforming many prior scoring systems.[3]

As suggested, this APM differs from current physician payment under Medicare in that it replaces much of FFS with a combination of primary care global payment and population-based payment, both of which are prospective, capitated, risk adjusted, and paid on a monthly basis. Additionally, APM entities would be eligible for incentive payments that are not available under the current Medicare physician payment system.

This APM is most similar to Track 2 under CPC+. It differs from Track 2 under CPC+ in that Track 2 practices are prospectively paid CPCPs with a reduced FFS payment after services are rendered. CPCP is a lump sum, quarterly payment based on historical FFS payment amounts. Track 2 practices continue to bill as usual, but the FFS payment amount is reduced to account for the CPCP. Under the APC-APM, APM entities would receive a truer "comprehensive" primary care payment with no subsequent FFS for services otherwise covered by the primary care global payment. Those services paid outside the global primary care payment would be paid at full FFS amounts, rather than a discount.

Finally, the primary care global payment would be made monthly, rather than quarterly. As noted, the value of the primary care global payment would not be based on historical FFS payment amounts, since we view those amounts as undervalued. Because of these differences, we do not believe this APM could be tested under current payment methodologies. It could only be tested under existing CMMI models if CMMI otherwise modified Track 2 of CPC+.

Financial Risk. The APC-APM is based on the Medical Home Model, which is a preferred delivery model under both the MIPS and AAPM pathways. Our proposed model includes performance risk—not financial risk—for participating primary care physicians based on the original MACRA statute, which reflects Congressional intent regarding the qualification of Medical Home Models as AAPMs. The law clearly designates "a medical home expanded under section 1115A(c)" as an AAPM model. However, CMS introduced financial risk standards for Medical Home Models in its proposed rule—and maintained that stance in the final rule—despite the statutory language, which did not include a financial risk component.

The delivery of high-performing, team-based, patient-centered primary care is at the heart of the medical home. Significant evidence points to the clear trend that the medical home drives

reductions in health care costs and unnecessary utilization, such as ED visits, and hospital admissions and readmissions.[21] The Patient-Centered Primary Care Collaborative's most recent Annual Review of Evidence found that 21 of 23 programs reporting on cost measures found reductions in one or more measures, and 23 of 25 reporting on utilization measures found reductions in one or more measures.[21] Given these trends, imposing financial risk on the medical home model may be counterproductive and have a dampening effect on adoption. It is because of the medical home's importance to the success of the value-based payment model that they were provided protection from financial risk under the law.

As in CPC+, the APC-APM includes performance risk for participating physicians through the performance based incentive payments that hold them appropriately accountable for the quality of care they provide. "Performance risk" refers to the risk of higher costs associated with delivering unnecessary services, delivering services inefficiently, or committing errors in diagnosis or treatment of a particular condition (i.e., those risks that are within the control of the physician). Given the strong connection between payment and clinical outcomes with performance risk,[22] the APC-APM entities would be at risk for up to the entire amount of their performance-based incentive payment (depending on their level of performance). In addition, a large portion of the services provided will be capitated through the global primary care payment and population-based payment, and the APM entity and its eligible clinicians will bear risk for performance related to those services. The assumption of risk for performance is based on the APM entity's demonstrated capabilities. Consistent with the MACRA statute and the designation of CPC+ as an AAPM, the APC-APM should qualify as an AAPM.

The AAFP adamantly opposes putting APM entities and their eligible clinicians at financial risk for anything beyond their own performance under this model. That particularly extends to insurance risk and utilization of services outside the control of the APM entity (e.g., total cost of care). "Insurance risk" is related to the patient's health status that is beyond the control of the physician, such as age, gender, and acuity differences. Insurance risk is properly borne by health plans and payers, not the APM entity and its eligible clinicians.

Coding/Claims. We recognize that a patient's diagnoses and/or conditions will likely play a role in risk adjustment of the primary care global payment and population-based payment. We also recognize that, to the extent both are capitated, claims for some patients may be minimal or non-existent. Consequently, Medicare and other payers that participate in the model will need to rely on medical record data rather than claims data to identify patients' diagnoses and conditions. This approach has at least two advantages. First, it encourages good medical record documentation, which is otherwise already supported by clinical considerations and medico-legal requirements. The other advantage is that it relies on primary (i.e., the medical record) rather than secondary (i.e., claims) data sources, so diagnosis/condition-coding errors otherwise associated with moving from the medical record to the claim should be minimized.

We acknowledge that this approach may place a greater burden on Medicare and other participating payers to identify diagnoses/conditions, given that they will be less able to rely on readily-available claims data for this purpose. However, to the extent that the bulk of an

APM entity's payments will be risk-adjusted (at least partially on this basis), the APM entity has an incentive to work with its payers to facilitate the identification of diagnoses/conditions in the medical record for the payers.

For the primary care global payment and the population-based payment, the unit of payment is the patient, because both fees are capitated. As such, "clinical appropriateness" (i.e., medical necessity) is irrelevant or is otherwise addressed by the APM entity's performance relative to agreed-upon benchmarks. For those services still paid on a fee-for-service basis, payers may determine their clinical appropriateness in much the same way that they do now (e.g., medical review).

This APM does not employ episodes of care for payment purposes.

Barriers. The current FFS payment system creates impediments to an advanced primary care model that helps achieve goals of improving both the patient experience and the health of the population. Under FFS, physicians often provide time-intensive services, such as counseling, patient education, screening, and preventive medicine at a decreased level of efficiency, because total payment (i.e., revenue) is based on the overall volume of services. Likewise, temporal and financial constraints of a FFS system encourage primary care physicians to order diagnostic testing or refer to sub-specialists, which often increases the cost of care without necessarily improving either patient satisfaction or the health of the population. Finally, FFS payments often do not compensate key functions of advanced primary care, such as planned care for chronic conditions and coordination of care across the medical neighborhood.

As MedPAC has noted, "The [FFS] fee schedule is oriented toward discrete services and procedures that have a definite beginning and end. In contrast, ideally, primary care services are oriented toward ongoing, non-face-to-face care coordination for a panel of patients. Some patients in the panel will require the coordination of only preventive and maintenance services. Others will have multiple complex chronic conditions and will require extensive care coordination."[23] MedPAC observed that FFS is not well designed to support these types of activities.[23]

Thus, the AAFP recommends a payment method that will compensate APM entities for care not captured through traditional FFS billing, and empower them to commit temporal and supportive resources to their patients, particularly those of high complexity. As a result, the APC-APM payment methodology would address many of these financial barriers to deliver advanced primary care and enhance value across the health care system.

V. Value over Volume

Financial Incentives. The PTAC seeks input on how the proposal is anticipated to provide incentives to practitioners to deliver high-quality health care. Since performance-based incentive payments that hold physicians appropriately accountable for quality and cost is one of the four components of the APC-APM, this model has built-in financial incentives to encourage physicians to deliver high-value health care. As reviewed under section I, the

APC-APM concept is being tested with the multi-payer CPC and CPC+ models that promote longitudinal, comprehensive, and coordinated care with the primary care teams, with early positive evidence emerging from CPC.

VI. Flexibility

The APC-APM is designed to promote practice transformation and delivery of advanced primary care in a diverse set of settings.

Adapting the APM. Primary care practices serve as the patient's first point of entry into the health care system and as the continuing focal point for all needed health care services in urban, suburban, and rural settings. Further, they provide health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, day care, etc.).

Additionally, primary care practices provide comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern (the "undifferentiated" patient) not limited by problem origin (biological, behavioral, or social), organ system, or diagnosis. They do so by providing patients with ready access to their own personal physician, or to an established back-up physician when the primary physician is not available.

Primary care practices function in almost every setting imaginable, while caring for patients from cradle to grave with diagnoses and conditions covering the full-spectrum of health care. Since the proposed model is primary care centered, we believe it is fully adaptable to accommodate the breadth and depth of differences in clinical settings and patient subgroups.

Infrastructure Changes. In terms of adapting to operational burdens and reporting requirements, we believe the APC-APM will require an operational shift on the part of participating APM entities, their physicians, and other eligible clinicians, while offering a measure of burden and reporting relief. The APC-APM will require APM entities and their eligible clinicians to shift from a primarily FFS operation to a primarily capitated operation. For instance, there will be less focus on claims and evaluation and management documentation, and more on panel management, which will benefit patients. Since the model envisions all participating payers relying on the core measure set for performance measurement, there should be less reporting burden as compared to the payer-centric model with inconsistent measures that currently encumber practices.

Since almost all primary care practices are operationally proficient in managing the FFS claims process, participating APM entities will be ready to the extent the APC-APM will still involve FFS for some services. Likewise, almost all primary care practices are currently reporting quality and other measures to one or more payers, so the expectation that they do so under this APC-APM will not be new. Therefore, in some respects, the APC-APM will not significantly change the operational burdens or reporting requirements of the APM entities and their eligible clinicians.

How model participants prepare and build the infrastructure to implement the proposed model will depend on where potential participants currently are in the process of practice transformation. Primary care practices start the process of practice transformation from a variety of different points along the transformation continuum. The AAFP has extensive experience and proficiency in connecting primary care practices with the technical assistance and other resources that they need to transform from a more traditional care delivery and practice management model to the model that is inherent in this APC-APM. The AAFP continues to connect members with relevant resources, including those found on the AAFP website. The AAFP and the American Board of Family Medicine are collaborating as the PRIME Support and Alignment Network under the Transforming Clinical Practice initiative. We anticipate bringing that experience and knowledge to bear in helping model participants prepare and build the infrastructure to implement the APC-APM, as needed.

VII. Ability to be Evaluated

We believe the impact of the APC-APM is able to be fully evaluated in terms of both quality and cost. Evaluation of both quality and cost at the APM entity level should be relative to agreed-upon benchmarks, as is the case with CPC+.

Metrics. With respect to quality, the impact of the APM at the APM entity level should be evaluated based on changes in the quality, patient experience, and utilization using selected performance measures from the Core Quality Measures Collaborative's PCMH/ACO/Primary Care Core Set. The PCMH/ACO/Primary Care Core Set includes clinical quality, patient safety, patient experience, and resource use measures using the National Quality Strategy as a guide. The core set includes various types of measures, including process, intermediate outcomes, outcomes, and patient-reported outcome measures. As with CPC+, MIPS, and other programs, APM entities should have the opportunity to choose a set number of core measures that are meaningful to them. We do not expect each APM entity in this model to track all of the measures in the core measure set. Quality at the APC-APM level can be evaluated by rolling up the performance of APM entities on the selected measures.

Regarding cost, the APC-APM relies on attribution of identified patients to the APM entities involved. The attribution method is described in the AAFP's position paper, "Advancing Primary Care: A Foundational Alternative Payment Model (APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care."[6] A copy of this position paper is found in Appendix A.

In addition to the cost measures in the core measure set, we expect that APM entities may also be held accountable for the two cost measures used under CPC+. They are inpatient hospitalization utilization per 1,000 attributed beneficiaries and emergency department utilization per 1,000 attributed beneficiaries. At the level of the APC-APM, we anticipate that the payers involved should be able, based on claims and other information at their disposal, to determine the cost of care for these patients before and after implementation of the APC-APM. This includes the cost of payments to the APM entities in the model.

We note that a key goal of the movement to value-based care is to control the total cost of care of patients. Measurement of any APM should consider if, and how, it impacts total cost of care—and whether the model can help control those costs across the care continuum. However, APM entities within the APM should not be held accountable for the total cost of care in the current payment environment. APM entities can only be held accountable for total cost of care of attributed patients when all participants in the health care system (e.g., hospitals, sub-specialists, etc.) are operating under aligned value-based incentives.

Greater investments in primary care are necessary to support the delivery of continuous, longitudinal, and comprehensive care across settings and providers. Any reductions in total cost of care from investments in an advanced primary care APM should be assessed over the long term across the care continuum. Experts agree, investments in primary care APMs cannot be recouped in the short term.[24] Evidence suggests that the longer payment reform programs to support primary care have been in place, the more evident cost savings and improved outcomes are. Adequate time before measurement needs to be allowed.[21,25]

Other measures of utilization of services can help assess the impact of an APC-APM on patient care and costs, such as reduced admissions and readmissions, reductions in duplicative or clinically unnecessary testing, and reduced medication-related complications. In the long term, advanced primary care practices with a sufficient number of patients and well-developed care coordination and management capabilities should be able to demonstrate impact on total cost of care. As noted in the Health Care Payment Learning and Action Network's paper, "Accelerating and Aligning Primary Care Payment Models," primary care payment models can only be expected to deliver a return on investment over the long term.[26] This is the goal for an APC-APM, along with working in concert with the development of other specialty or condition-specific models, where appropriate.

Evaluations. The evaluable goals of the APC-APM are twofold:

- To maintain or improve quality, as defined by performance on selected measures in the Core Quality Measures Collaborative's PCMH/ACO/Primary Care Core Set; and
- To reduce, or not increase, the total cost of care of the population of patients attributed under the APM.

There are no evaluations of the APC-APM under development, underway, or previously done. However, similar versions of the model continue to be tested and refined with CMS and commercial payers.

VIII. Integration and Care Coordination

Provider and Care Coordination Impacts. To achieve desired outcomes, implementation of this APM will depend on primary care physicians leading teams of non-physicians. The AAFP defines an advanced primary care practice as one that is based on the Joint Principles of the Patient-Centered Medical Home and has adopted the five key functions of the CPC+.[27] The key functions are:

1. Access and Continuity – Medical homes optimize continuity and timely, 24/7 first-contact access to care supported by the medical record. Practices track continuity of care by physician or panel.
2. Planned Care and Population Health – Medical homes proactively assess their patients to determine their needs and provide appropriate and timely chronic and preventive care, including medication management and review. Physicians develop a personalized plan of care for high-risk patients and use team-based approaches to meet patient needs efficiently.
3. Care Management – Medical homes empanel and risk stratify their whole practice population and implement care management for patients with high needs. Care management has benefits for all patients, but patients with serious or multiple medical conditions benefit more significantly due to their needs for extra support to ensure they are getting the medical care and/or medications they need.
4. Patient and Caregiver Engagement – Medical homes engage patients and their families in decision making in all aspects of care. Such practices also integrate into their usual care both culturally competent self-management support and the use of decision aids for preference sensitive conditions.
5. Comprehensiveness and Coordination – Primary care is the first point of contact for many patients, and therefore is the center of patients' experiences with health care. As a result, primary care is best positioned to coordinate care across settings and among physicians in most cases. Primary care medical homes work closely with patients' other health care providers to coordinate and manage care transitions, referrals, and information exchange.[27]

The AAFP considers these five key functions equally important to delivering primary care. These functions depend on the support of enhanced and prospective accountable payments, continuous quality improvement driven by data, and optimal use of health information technology, including a certified electronic health record (EHR) with a data registry or repository capability. The APC-APM is built on these principles and would advance greater integration and care coordination across settings and practitioners.

In the context of the five key functions, we believe it is important to note that the APC-APM expects APM entities to address behavioral and mental health issues. "Comprehensive and coordination" implies caring for the whole patient and recognizing that the mind and body are interrelated and connected. Promotion of mental health and the diagnosis and treatment of mental illness are integral components of primary care.

Entities applying to participate in the APC-APM would be expected to attest to the fact that they perform these five key functions, or otherwise have a plan to do so within a reasonable time after entering the program, in the same manner as the CPC milestones. The validity of their attestation would be determined by their subsequent performance on the core measures.

IX. Patient Choice

Patient Choice. The APC-APM supports high-value primary care that fosters health for all patients (including underserved, at-risk, vulnerable, and complex patients); expands access to innovative methods of delivering effective care; and minimizes disparities in care. Therefore, it encourages greater attention to the health of the population served, while also supporting the unique needs and preferences of individual patients.

Disparities. Payment components of the APC-APM would be appropriately risk adjusted to reduce and account for disparities and minimize unintended consequences due to factors beyond the control of physicians that serve disadvantaged patients.

If available nationally, the APC-APM would greatly expand demographically and geographically the diversity of participating patients well beyond the geographical limitations of the CPC and CPC+.

X. Patient Safety

Patient Protections. As noted, APM entities would be responsible for reporting and performance on selected measures from the Core Quality Measures Collaborative's PCMH/ACO/Primary Care Core Set. We believe that these performance measures will help ensure that patients receive necessary care and are not harmed by efforts to achieve savings (e.g., by stinting on care). This is especially important given that APM entities whose performance does not meet agreed upon benchmarks face recoupment of their incentive payments and potential expulsion from the APM.

The model supports patient safety by making patient choice the primary attribution methodology. Patients who do not believe that they are receiving the care that they need may elect to leave an APM entity. Since the risk-adjusted, capitated primary care global fee and population-based payment, which will comprise a significant part of an APM entity's revenue stream, will follow the patient, APM entities have an incentive to treat patients appropriately, so that the patients remain attributed.

The APC-APM will ensure the integrity of its intended benefits through the required use of the measures noted above. As noted, performance measurement is an embedded part of the model that we expect both APM entities and payers will be monitoring, and which can be used to trigger necessary adjustments if unintended or other incongruent behaviors are observed.

XI. Health Information Technology

Privacy. Patient privacy and ensuring confidentiality is a prominent and pervasive concern in primary care and would continue to be so in the APC-APM. The principles of the APC-APM are highly dependent on the adoption and use of interoperable, certified health information technology (HIT), and at least 50% of qualifying participants are expected to use CEHRT. This dependence allows for innovation and ensures adoption leads to the desired health outcomes. A key role of HIT in the APC-APM is to support the capture, analysis, and exchange of health care cost and quality data. Patient and caregiver engagement is a central

principle of the APC-APM. The use of HIT, such as patient portals and the use of open application programming interfaces will play a key role in the APC-APM.

Transparency and Innovation. All five of the key functions of the advanced primary care practice (referenced above) depend on the support of enhanced and prospective accountable payments; continuous quality improvement driven by data; and optimal use of health information technology, including a certified EHR with a data registry or repository capability. The APC-APM describes and rewards continuity of care and requires 24/7 access to care supported by the medical record. APC-APM entities also work with the patient's other health care professionals to coordinate patient care, which is supported by interoperability among HIT systems. Additionally, risk stratification and quality measurement are important capabilities in the APC-APM, and these capabilities are highly dependent on access to data and support by HIT.

Interoperability and Choice. Current HIT is designed first, to support documentation and billing and only secondarily, to support delivery of care. The APC-APM model diminishes the focus on documentation and billing, and rewards a focus on improved quality, reduced cost, and improved patient experience. Although practices can be successful in this model with existing HIT, this new focus will allow newer HIT designed to improve care to be more readily available and adopted. Also, it exerts a force on existing HIT to transform to meet the needs of high-value care delivery or loss of market share.

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LIST OF APPENDICES

Advanced Primary Care:
A Foundational Alternative Payment Model (APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care

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AMERICAN ACADEMY OF FAMILY PHYSICIANS

The U.S. health care system is undergoing an intense period of transformation as physicians, along with public and private payers, test and implement value-based payment and care delivery models that aim to improve care and outcomes, and reduce costs. Most recently, passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) has accelerated this movement to value by providing payment incentives to move physicians into alternative payment models (APMs) that aim to improve quality for patients while also reducing costs.

Primary care is (and must be) a critical and foundational component of this system-wide transformation. Its value to patients and payers alike is well documented in terms of its positive effects on costs, access, and quality in the U.S. and numerous other health systems. Specifically, primary care helps prevent illness and death, and it is associated with a more equitable distribution of health in populations.[1] Primary care is also associated with enhanced access to health care services and better health outcomes, as well as lower costs through changes in utilization, such as lower rates of hospitalization and emergency department visits.[2] Lastly, primary care is associated with positive impacts on individuals—as well as population-level health and cost outcomes—because it preserves a holistic view of the patient, who is much more than a set of organ systems and disease conditions. The goal of primary care is to ensure that medicine does not lose sight of the whole patient and the patient's context, which affects a wide range of health outcomes.

There is an emerging consensus that strengthening primary care is imperative to improving individual and population health outcomes and restraining health care spending growth. The evidence supports increasing the ability of physicians to deliver primary care functions, and reorienting health systems to emphasize delivery of primary care can help accomplish these goals.[3] Accordingly, public and private payers are investing in enhanced primary care models through multiple efforts. While there are numerous efforts underway, some of the most well documented and studied include:

- Center for Medicare and Medicaid Innovation's (CMMI) Comprehensive Primary Care Plus (CPC+) and original Comprehensive Primary Care (CPC) initiatives;
- CareFirst BlueCross BlueShield's Patient-Centered Medical Home (PCMH) Program;
- Blue Cross Blue Shield of Michigan's Physician Group Incentive Program (PGIP); and
- Anthem's Enhanced Personal Health Care Program (EPHC).

These initiatives are showing a broad range of outcomes, including improved quality and/or cost savings.[4,5,6,7]

In sum, there is wide agreement on the need to reorient our health care system to one that is built on primary care. Aspirational words such as 'patient-centered' and 'whole person' care have returned to the health policy vernacular. Meanwhile, primary care physicians have begun to shift their infrastructure and workforce to achieve better coordination of care and integration of health information from a growing variety of data sources.

Primary care is comprehensive, continuous, coordinated, connected, and accessible through a patient's first contact with the health system, as well as being patient centered. In fact, among the American Academy of Family Physicians' (AAFP) clinically active members, 45 percent already work in an officially recognized PCMH. The AAFP calls this advanced primary care through the medical home model, and it is foundational to an efficient and effective health care delivery system.

In this position paper, the AAFP presents an advanced alternative payment model (APM) for primary care we believe is transformational to improving the health care system by placing patients at the center and connecting all of their care.

Definition and Recognition of Primary Care Medical Homes

Definition

The AAFP defines a primary care medical home as one that is based on the Joint Principles of the Patient-Centered Medical Home (PCMH)[8] and has adopted the five key functions of the Comprehensive Primary Care Plus (CPC+) Initiative.[9] The key functions are:

1. Access and Continuity

Primary care medical homes optimize continuity and timely, 24/7 first contact access to care supported by the medical record. Practices track continuity of care by physician or panel.

2. Planned Care and Population Health

Primary care medical homes proactively assess their patients to determine their needs and provide appropriate and timely chronic and preventive care, including medication management and review. Physicians develop a personalized plan of care for high-risk patients and use team-based approaches to meet patient needs efficiently.

3. Care Management

Primary care medical homes empanel and risk stratify their whole practice population and implement care management for patients with high needs. Care management has benefits for all patients, but patients with serious or multiple medical conditions benefit more significantly due to their needs for extra support to ensure they are getting the medical care and/or medications they need.

4. Patient and Caregiver Engagement

Primary care medical homes engage patients and their families in decision-making in all aspects of care. Such practices also integrate into their usual care both culturally competent self-management support and the use of decision aids for preference sensitive conditions.

5. Comprehensiveness and Coordination

Primary care is the first point of contact for many patients, and therefore is the center of patients' experiences with health care. As a result, primary care is best positioned to coordinate care across settings and among physicians in most cases. Primary care medical homes work closely with patients' other health care providers to coordinate and manage care transitions, referrals, and information exchange.

The AAFP considers these five key functions equally important to delivering primary care. These functions depend on the support of enhanced and prospective accountable payments, continuous quality improvement driven by data, and optimal use of health information technology, including a certified electronic health record (EHR) with a data registry or repository capability. Annual requirements should guide the development of—and build the capability to—deliver these five functions in a primary care medical home.

Recognition

The AAFP supports attestation, accompanied by an evaluation process that is driven by practice performance, as the method for recognizing whether a practice meets the threshold requirements for a medical home. A practice would attest to achievement of those requirements, similar to those used in the CPC+ Initiative. The reporting would be on a quarterly to annual basis, depending on the particular requirements being reported and the evolution of the practice. Practices that are more advanced may have fewer reporting requirements than those at earlier stages on the transformation continuum. The quality, patient experience, and utilization data practices report should be harmonized across all payers, consistent with the work of the Core Quality Measure Collaborative, and serve to validate whether a practice is delivering the performance to which it attests.

The AAFP strongly believes a physician should not be required to pay a third-party accrediting body to receive recognition as a medical home. The measure of medical home status by an accrediting body may not precisely capture actual improved functionality of primary care.

Attribution Methodology

Patient attribution methodology is critical to payment, quality and cost performance measurement, and defining accountability in a primary care medical home. A reliable, prospective, and transparent attribution method is important for the payer, the physician, and the patient. With a fine-tuned attribution process, a payer knows they are providing payment for enhanced services to the correct physician for the correct patient population. Physicians know they are receiving payment for the appropriate patients, and are assured they know who they are accountable to in terms of quality and cost. Accurate attribution may also help patients understand the importance of their relationship with their primary care physician, and the need to include the physician in the patient's decisions about anything that impacts their health care, such as when and how to seek medical care or even lifestyle choices that will affect their health.

The AAFP recommends a patient-based, prospective, four-step process that includes a 24-month look-back period for attribution. Patients attributed through this process should be the focus of payment and performance measurement under the recommended payment model. A prospective methodology allows physicians to know for whom they are responsible in advance and facilitates proactive care planning and management. Similar to the CPC+ Initiative, payers should attribute patients on a quarterly basis. For attribution purposes, a primary care physician should be defined as a physician who is in a family medicine, general internal medicine, geriatric medicine, general pediatrics, or general practice setting.

The Four-Step Attribution Process

1. Patient Selection of Primary Care Physician and Team

- This is the acknowledgement that patient selection is the best choice in attribution and should be prioritized as such.

2. Primary Care Visit Events: Wellness Visits

- If a patient is not attributed by self-selection of a primary care physician, payers should use well visits, including Welcome to Medicare, physicals, and Annual Wellness Visits provided by the patient's primary care physician or the practice team, as the next step in the attribution process.

3. Primary Care Visit Events: All Other E/M Visits

- If a patient is not attributed by a wellness visit, the next incremental step is to include all other evaluation and management (E/M) visits to a primary care physician. The payer should attribute the patient to the primary care physician who provides the plurality of E/M visits.

4. Primary Care Prescription and Order Events

- If the patient is not attributed by a wellness visit or any other E/M services, payers should consider claims related to medication prescriptions, durable medical equipment prescriptions, and lab and other referral orders made by primary care physicians. Payers should require a minimum of three such events before attributing a patient on this basis.

Please see table on the next page.

Step in Process	Event Type	Eligible Procedure or Event	Look-back Period	Assignment Criteria	Minimum Threshold for Assignment	In Event of a Tie
Step 1	Patient Selection of Primary Care Physician	N/A	N/A	N/A	N/A	N/A
Step 2	Primary Care Visits: Wellness Visits	Well Visit E/M and Select G Codes Only	24 months	Plurality	1 visit	Most recent visit
Step 3	Primary Care Visits: All Other E/M Visits	Any E/M Codes	24 months	Plurality	1 visit	Most recent visit
Step 4	Primary Care Prescriptions and Order Events	Any Rx code; claims related to medication prescriptions, durable medical equipment, and lab and referral orders	24 months	Plurality	3 events	Most recent event

Review and Reconciliation of Attributed Patients

No patient attribution methodology is perfect. The four-step methodology recommended above may still produce errors in assignment. Physicians should have the option to engage in a reconciliation process in which they can review, add, and remove patients from the formal list the payer supplies to them. Like the attribution process, review and reconciliation should occur quarterly and include enough time to adequately review the list.

Payment

Fee-for-service (FFS) payment systems create impediments to medical homes achieving the Triple Aim of cost effective care that improves both the patient experience and the health of the population. One study suggests that only 55% of adult patients receive recommended care.[11] Under a FFS payment system, physicians often provide time-intensive services such as counseling, patient education, screening, and preventive medicine at a decreased level of efficiency, because total payment (i.e. revenue) is based on the overall volume of services.[10] Likewise, temporal and financial constraints of a FFS system encourage primary care physicians to order diagnostic testing or refer to sub-specialists, which often increases the cost of care without necessarily improving either patient satisfaction or the health of the population.[12] Finally, FFS payments often do not compensate key functions of a primary care medical home, such as planned care for chronic conditions and coordination of care across the medical neighborhood.

The Medicare Payment Advisory Commission (MedPAC) and others share this view of the impediments to advanced primary care posed by FFS payment. For instance, in its March 2016 report to Congress on Medicare payment policy, MedPAC stated, "The Commission remains concerned that the [Medicare physician] fee schedule and the nature of FFS payment leads to an undervaluing of primary care and overvaluing of specialty care."

MedPAC also stated, "The Commission has also become concerned that the fee schedule is an ill-suited payment mechanism for primary care."[13] Accordingly, MedPAC has recommended Congress establish a per beneficiary payment for primary care.

MedPAC further noted, "The [FFS] fee schedule is oriented toward discrete services and procedures that have a definite beginning and end. In contrast, ideally, primary care services are oriented toward ongoing, non-face-to-face care coordination for a panel of patients. Some patients in the panel will require the coordination of only preventive and maintenance services. Others will have multiple complex chronic conditions and will require extensive care coordination."[13]

MedPAC observed that FFS is not well designed to support these types of activities.[13]

As noted, the key functions of a medical home depend on enhanced, prospective, and accountable payment. Accordingly, the AAFP recommends a payment method for primary care medical homes that will compensate them for care not captured through traditional FFS billing, and empower them to commit temporal and supportive resources to their patients, particularly those of high complexity.

Specifically, the AAFP recommends an APM that includes a primary care global payment for direct patient care, a care management fee, and FFS payments limited to services not otherwise included in the primary care global fee—coupled with performance-based incentive payments that hold physicians appropriately accountable for quality and costs. These prospective, performance-based incentive payments would reward practices based on their performance on patient experience, clinical quality, and utilization measures. The CPC+ performance-based incentive payment is an example of such a payment mechanism. Commercial payers are also showing the value of investing in enhanced, prospective payments that include mechanisms for accountability.

The AAFP's proposal and those put forth by others place an increased emphasis on the important role primary care plays in ensuring our health care system delivers low-cost, efficient health care. The expectations placed on modern primary care practices to transform workflows; invest in new technology; provide extended services beyond traditional face-to-face encounters; and manage populations of patients are all achievable, and primary care is positioned to deliver these objectives. However, it is unreasonable to ask primary care to do so when the overall payment structure continues to be based on a model that woefully underinvests in primary care.

The current FFS system and its payment levels for primary care are inadequate on every level. Our health care system should pay for what it truly values. As articulated by the current fee schedule, we do not value primary care. This proposal places a marker in the ground for how primary care should be paid differently and better to deliver an advanced level of care and services to every American. In return, it is essential that payment levels be dramatically increased to ensure this transformation is possible and sustainable over time. Extending current payment levels into this new delivery model would be a tragedy and disservice to our health care system and every patient.

Primary Care Global

Primary care practices should be able to elect one of two levels of prospective primary care global payment to allow primary care physicians to move toward a more fully capitated payment arrangement at a reasonable pace for their particular practice to eventually replace FFS for face-to-face care/visits. The two levels of primary care global payment would be defined as follows:

- Level 1: Ambulatory, office-based, face-to-face evaluation, and management (E/M) services
- Level 2: All E/M services regardless of site of service

At either level, all other services, including all non-E/M services, would continue to be billed and paid based on the current FFS payment model. Primary care global payments under both level one and level two should be risk stratified based on patient complexity (including social determinants of health) and other factors.

Care Management Fee

Primary care practices should receive a separate, risk-stratified care management fee for each of their patients. This capitated fee should be calculated and paid prospectively on a monthly basis (or at least quarterly), and it should be without risk to the physician and free of patient cost sharing. The care management fee should also be risk stratified based on the patient's complexity level and other factors (including social determinants of health). Assessments of quality and cost-effective care should later determine eligibility of the physician to continue receiving care compensation under this payment model, which is consistent with how the AAFP envisions the validation of attestation as a primary care medical home.

Risk Stratification

As noted, both the primary care global fee and the care management fee should be risk stratified based on patient complexity (e.g. comorbidities, cognitive impairment, self-care ability as measured by activities of daily living), patient demographics (e.g. age, gender), and other factors, such as sociodemographic factors that are social determinants of health. Patient complexity certainly is multifactorial, but it is essential to define it as precisely as possible in order to allow for an ordered and thorough evaluation of each patient. One suggested approach that could be applied in practice would define complexity as "interference with standard care and decision making by diagnostic uncertainty, system severity, impairments, lack of social safety, lack of participation, difficulty engaging care, disorganized care, and difficult patient-clinician relationships."[14]

In practice, the Minnesota Complexity Assessment Method, (which modifies earlier work)[14] specifies certain domains for assessment of patient complexity that includes illness, readiness (to engage treatment), social, health system, and resources for care. This allows clinicians to assess patient complexity and identify areas of intervention.[14]

The AAFP believes this tool represents the best approach to assess complexity that is not captured through a review of disease burden, and it can better direct care teams in patient management. Therefore, the AAFP recommends the use of the Minnesota Complexity Assessment Method to risk stratify the primary care global payment and the care management fee on an annual basis. Under this tool, patients can be classified as being of low, medium, or high complexity, and payment under the primary care global fee and care management fee should be stratified accordingly.

The AAFP believes a risk-stratified, two-level option for the primary care global fee would allow medical homes of various capacities to participate and encourage the move to a more robust care provision. Coupled with a risk-stratified, population-based payment, this payment model empowers medical homes to manage patients efficiently, manage health care costs, and dedicate the time for adequate screening, preventive care, patient education, robust care coordination, and social services that contribute to cost-effective care that improves both the patient experience and the health of the population (i.e. the Triple Aim).

Operational dollars would alleviate the constraints imposed by the current FFS approach by providing such practices with more freedom to manage their patient panels independent of the face-to-face visit model. This approach would allow such practices

to diversify available resources to better manage ancillary care needs and provide other services that yield improved, cost-effective care. The ultimate goal of such payment reform should be a global payment, which combines the primary care global and care management payments into a single, risk-adjusted global payment for medical homes (with additional FFS payment for services outside the defined services to be included in this combined fee, along with the additional payment for quality improvement).

Quality Measurement

Physician Performance and Patient Experience

Under the AAFP's recommended payment model for advanced primary care, payers should assess a physician's quality and resource utilization using selected quality measures. The physician's performance on those same quality measures will also allow a payer to validate a practice's implementation of advanced primary care functions.

Performance measures selected for evaluation should consist of the Core Quality Measures Collaborative's PCMH/Accountable Care Organization (ACO)/Primary Care Core Set. Key stakeholders of this collaborative include the Centers for Medicare & Medicaid Services (CMS), the National Quality Forum (NQF), America's Health Insurance Plans (AHIP), other health plans, and physician, consumer, and employer groups. This important effort uses a multi-stakeholder process to define core measure sets and thus promotes alignment and harmonization of measure use and data collection across public and private payers. This process recognizes high-value, high-impact, evidence-based measures that promote better patient health outcomes. It also provides useful information for clinical improvements, decision-making, and payment. Additionally, it aims to reduce the burden of measurement and volume of measures by eliminating low-value metrics, redundancies, and inconsistencies in measure specifications and reporting requirements across payers. The collaborative uses an iterative process that always seeks to include better and more desirable measures to meet the goals of the Triple Aim. Ideally, payments for primary care will be based on such an aligned set of comprehensive measures of primary care, rather than relying exclusively on a rigid set of disease-specific metrics. The latest and most-updated version of the PCMH/ACO/Primary Care Core Set should always be used in this model.

The PCMH/ACO/Primary Care Core Set includes clinical quality, patient safety, patient experience, and resource use measures using the National Quality Strategy as a guide. The core set includes various types of measures including: process, intermediate outcome, outcomes, and patient-reported outcome measures.

Regarding patient experience, the core set includes use of the Clinician and Groups Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) to evaluate patient experience. However, this assessment comes with great expense and is resource intensive, especially for smaller practices. Therefore, the Core Quality Measures Collaborative effort suggests payers provide the CAHPS survey at no cost to physician offices and their patients through an online process. This approach would remove the financial burden associated with CAHPS implementation to assess patient experience. The AAFP supports this approach.

Primary Care Impact on Total Cost of Care

A key goal of the movement to value-base care is to control the total cost of care of patients. Evaluation of any APM should consider if, and how, it impacts total cost of care—and whether the model can help control those costs across the care continuum. It is clear that greater investments in primary care are necessary to support the delivery of continuous, longitudinal, and comprehensive care across settings and providers. Given the central role that primary care would play in this construct, it is possible to assess an advanced APM on its ability to impact total cost of care—taking into consideration the relatively low spending on primary care compared to other specialties.

However, any reductions in total cost of care from investments in an advanced primary care APM would need to be assessed over the long term across the care continuum. Experts agree investments in primary care APMs cannot be "recouped" in the short term. However, other measures of utilization of services can help assess the impact of an advanced primary care APM on patient care and costs, such as reduced admissions and readmissions, reductions in duplicative or clinically unnecessary testing, and reduced medication-related complications. In the long term, advanced primary care practices with a sufficient number of patients and well-developed care coordination and management capabilities should be able to demonstrate impact on total cost of care. This is the goal for an advanced primary care APM, along with working in concert with the development of other specialty or condition-specific models, where appropriate.

Risk Adjustment

Like payment, physician performance outcomes, including total cost of care, should be adjusted for risk based on patient complexity (e.g. comorbidities, cognitive impairment, self-care ability as measured by activities of daily living); patient demographics (e.g. age, gender); and other factors, such as sociodemographic factors that are determinants of health. These factors can influence performance outcomes regardless of the care provided. Risk stratification and risk adjustment should occur annually. This process enables a physician's performance to be adjusted appropriately for factors outside of their control.

Baseline and Benchmarking

The baseline for performance should be a set time period prior to the performance year. A fixed baseline is needed to assess improvement, so the incentive to improve is not undermined. Frequently updating the baseline weakens movement towards improvement, and undermines investments by physicians to improve the effectiveness of care delivery. Payers should hold the benchmarks steady for at least two years (if not longer) instead of reassessing after each performance year.

Financing

The AAFP believes spending on primary care should be increased from current levels given the evidence that access to primary care is associated with improved individual and population health outcomes, and reduced costs. Today, primary care only represents approximately 6% of total spending on health care.[15] We believe this should be increased to at least 12% of total spending.[16] The AAFP believes that such an increase can be accomplished without an increase in the overall spending on health care. In fact, the AAFP believes increased spending on primary care will lead to a decrease in overall spending on a per patient basis.[16]

This belief is rooted in the experience of other Organization for Economic Cooperation and Development (OECD) countries. Most of those countries have health care systems where primary care is foundational, and their spending per capita is well below that of the United States. Within the U.S., Rhode Island mandated an increase in primary care spending from 5.4% to 8% between 2007 and 2011.[17] The Rhode Island Insurance Commissioner reported a 23% increase in primary care spending was associated with an 18% reduction in total spending—a 15-fold return on investment.[17] Last, Portland State University completed a 2016 study of Oregon's Patient Centered Primary Care Home (PCPCH) program and found every $1 increase in primary care expenditures as part of the PCPCH model resulted in $13 in savings in other health care services, including specialty, emergency room, and inpatient care.[18]

Public and private payers are investing in the advanced primary care model through multiple efforts. Such investments demonstrate the AAFP is not alone in its belief that appropriate financing of advanced primary care can pay dividends for payers, as well as patients.

With respect to business and practice transformation, primary care physicians will require financial and technical assistance to ensure their practices remain financially viable in advanced alternative payment models. Primary care physicians will also need enhanced training in methods to partner effectively with patients. Since primary care in advanced alternative payment models is a data-driven endeavor, primary care physicians will require considerable support with the data analytics that enable them to identify high-need patients, monitor and design comprehensive care plans, and make informed decisions at the point of care. Payers and other outside organizations (e.g., professional associations) will play a prominent role in providing support and technical assistance that focuses on these areas.

Finally, primary care physicians will need time to transform their practices. Primary care, by definition, is concerned with delivering patient-centered, longitudinal, and coordinated care, and changing such care delivery does not happen quickly.

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Appendix B

Core Quality Measures Collaborative's PCMH/ACO/Primary Care Core Measure Set

Measure Title	NQF	Quality ID
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	59	001
Medication Reconciliation Post-Discharge (Replaces PQRS #130)	97	046
Breast Cancer Screening	2372	112
Colorectal Cancer Screening	34	113
Antibiotic Treatment for Adults with Acute Bronchitis: Avoidance of Inappropriate Use	58	116
Diabetes: Eye Exam	55	117
Diabetes: Medical Attention for Nephropathy	62	119
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	421	128
Diabetes: Foot Exam	56	163
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	68	204
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	28	226
Controlling High Blood Pressure (See also the HEDIS measure with slightly different criteria)	18	236
Cervical Cancer Screening	32	309
Use of Imaging Studies for Low Back Pain	52	312
CAHPS for PQRS Clinician/Group Survey (NQF 0005 & 0006)	5	321
Depression Remission at Twelve Months	710	370
Persistent Beta Blocker Treatment After a Heart Attack	71	442
Non-recommended Cervical Cancer Screening in Adolescent Females (HEDIS Measure)	N/A	443
Medication Management for People with Asthma (MMA) (Replaced #311)	1799	444
Measures not in MIPS		
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	57	N/A
Depression Response at Twelve Months-Progress Towards Remission	1885	N/A
Controlling High Blood Pressure (HEDIS 2016)	N/A	N/A

Appendix C

APC-APM frequently used policy terms

Advanced Primary Care Alternative Payment Model – The APC-APM will provide a primary care global payment for direct patient care, a population-based payment, and fee-for-service (FFS) payments, limited to services not otherwise included in the primary care global payment. These are coupled with performance-based incentive payments that hold physicians appropriately accountable for quality and cost. The prospective, performance-based incentive payments would reward practices based on their performance on patient experience, clinical quality, and utilization measures. The four components of the APC-APM are:

- **Primary care global payment** includes a defined set of face-to-face evaluation and management services, with monthly, prospective, risk-adjusted, per capita payment.
- **Population-based payment** includes non-face-to-face patient services and coordination services, with monthly, prospective, risk-adjusted, per capita payment.
- **Fee-for-service payment** is limited to services not otherwise included in the primary care global payment, including face-to-face, non-evaluation and management services, as medically/clinically needed, and based on relative value units.
- **Performance-based incentive payment** holds physicians appropriately accountable for quality and costs. These are based on performance measures, including quality and cost, and paid quarterly and reconciled annually.

Comprehensive Primary Care Plus (CPC+) – CPC+ is considered a Medical Home Model Advanced APM (AAPM). CPC+ qualifies as an AAPM by meeting the Medical Home Model financial risk standards. For a Medical Home Model to be an AAPM, it must include provisions that potentially:

- Withhold payment for services to the APM entity and/or the APM entity's eligible clinicians;
- Reduce payment rates to the APM entity and/or the APM entity's eligible clinicians;
- Require the APM entity to owe payment(s) to CMS; or
- Lose the right to all or part of an otherwise guaranteed payment or payments.

The four provisions stated above should go into effect if either of the following occurs:

- Actual expenditures for which the APM entity is responsible under the APM exceed expected expenditures during a specified performance period; or
- APM entity performance on specified performance measures does not meet or exceed expected performance on such measures for a specified performance period.

Under CMS' proposal, CPC+ is currently the only Medical Home Model that qualifies as an AAPM.

Family medicine – It is the medical specialty, which provides continuing, comprehensive health care for the individual and family. It is a specialty in breadth that integrates the biological, clinical, and behavioral sciences. The scope of family medicine encompasses all ages, both sexes, each organ system, and every disease entity.

Medical home – The AAFP defines a medical home as one that is based on the Joint Principles of the Patient-Centered Medical Home (PCMH), and the five key functions of the CPC+ initiative. These key functions are:

1. **Access and Continuity –** Medical homes optimize continuity and timely, 24/7, first-contact access to care supported by the medical record. Practices track continuity of care by physician or panel.
2. **Planned Care and Population Health –** Medical homes proactively assess their patients to determine their needs and provide appropriate and timely chronic and preventive care, including medication management and review. Physicians develop a personalized plan of care for high-risk patients, and use team-based approaches to meet patient needs efficiently.
3. **Care Management –** Medical homes empanel and risk stratify their whole practice population, and implement care management for patients with high needs. Care management has benefits for all patients, but patients with serious or multiple medical conditions benefit more significantly due to their needs for extra support to ensure they are getting the medical care and/or medications they need.
4. **Patient and Caregiver Engagement –** Medical homes engage patients and their families in decision making in all aspects of care. Such practices also integrate into their usual care both culturally competent self-management support, and the use of decision aids for preference sensitive conditions.
5. **Comprehensiveness and Coordination –** Primary care is the first point of contact for many patients, and therefore is the center of patients' experiences with health care. As a result, primary care is best positioned to coordinate care across settings and among physicians in most cases. Primary care medical homes work closely with patients' other health care providers to coordinate and manage care transitions, referrals, and information exchange.

The functions of a medical home depend on the support of enhanced and prospective accountable payments, continuous quality improvement driven by data, and optimal use of health information technology.

Medical Home Model – This model focuses on primary care and accountability for empaneled patients across the continuum of care. An example of a medical home model is CPC+. CPC+ is explicitly designed to support a diversity of practice sizes by encouraging

practices within a region to collaborate with other practices and other payers to build improvement infrastructure and share staffing resources to support practice transformation.

Primary care – In defining primary care, it is necessary to describe the nature of services provided to patients, as well as to identify who are the primary care providers. The domain of primary care includes the primary care physician, other physicians who include some primary care services in their practices, and some non-physician providers. However, central to the concept of primary care is the patient. Therefore, such definitions are incomplete without including a description of the primary care practice.

Total cost of care (measurement and accountability for) – This includes dollars spent by health care purchasers for health care services, which includes payment for the complete basket of health care services utilized by a patient or population. The AAFP believes that while it is appropriate to measure total cost of care under the APM-APM, APM entities within the APC-APM should not be held accountable for total cost of care in the current payment environment.