

## Advanced Primary Care: A Foundational Alternative Payment Model

I would like to submit my endorsement for accepting and building upon the Advanced Primary Care: Alternative Payment Model (APC-APM) recently proposed to the PTAC by American Academy of Family Practice (AAFP) and follow up on comments I made at NC Medicaid Reform Public Comment forum in Asheville, NC with information and experiences from my life and practice of family medicine. The APC-APM brings so much together from studies of care being provided in beneficial ways across the country that it could also be a strong foundation for our whole medical system. A better foundation than the medical care we are providing with managed care. Certainly, such a foundation could enable us to expand Medicaid and Medicare services to *all* those in need and to those in high-risk/high-cost populations. The APC-APM is the missing piece for a practice design I have been working toward during a 20-year journey as a family physician and palliative care provider in economically challenged communities in North Carolina. I feel compelled to share stories from experiences with patients, and my thoughts that developed from them, but I also fear that the effort in telling is probably wasted. Nevertheless, I take the time and effort to write as interestingly as I can out of respect for the lives of real people from the past and in the present that inspire a renewed vision for the future.

Some of those real people from the past were the men and women who wrote and fought to promote and defend their self-evident but revolutionary thoughts that we are all created equal, with certain rights. These rights, named in our Declaration of Independence, and the ideals we expect our government to provide as described in the Constitution of the U.S.A. are all to do with Health: Life, the blessings of Liberty, the pursuit of Happiness, Justice, domestic tranquility, promotion of the general Welfare and our Posterity. Even providing for the common defense includes health issues, as more and more threats to human Life come from biological sources, and as we advance in technology both to cause and repair injuries from weapons of defense. Another source of inspiration is from a patient and his family who shared a book written by Dr. Benjamin Washburn, a pioneer in U.S. Public Health, "A Country Doctor in the South Mountains" about his early practice of medicine. The remainder of the people who bring inspiration are patients and folks I have worked with, devoted to serving people and doing the right thing.

If governmental payers (i.e. taxpayer supported programs: CMS, state Medicaid programs, and whatever you want to call legislature to assure coverage for other people) adopted a model such as the APC-APM with prospective payments directly to physician-led primary care teams for coordinating, managing and providing defined components of primary care to *everyone*, with additions to the APC-APM to cover specialty care for specific populations integrated through those primary practices (behavioral health, women of child-bearing age, intellectually or developmentally disabled, substance use disorders, dementia, homebound patients of any age or combination of problems, palliative care/hospice, or other gaps in care in particular communities), using integrative/collaborative care models already in use across the country, and private insurance companies competed for the additional coverage of advanced or truly catastrophic care that could be purchased at fair market prices by individuals or by employers, we could achieve the ideal of the Triple Aim for everyone, without collapse of any part of our current economic system. Private insurers could go back to insuring against the risks that can be estimated from actuarial data, and get out of the business of insuring against health events that are common but unpredictable, at which they are failing miserably with great cost to everyone. Surgeries, oncologic

treatments, advanced specialty care, emergency care, and any other care outside the defined primary or integrated services could continue as fee for service and require authorization/approval from payers, as services outside the defined set in the APC-APM are described.

Taxpayers are paying three times for health care in our current system: first with work or money for premiums to insurance companies and contributions to Medicare to cover future *risks*, secondly with taxes to cover government payments to insurance companies, or other CMS programs (Medicaid, PACE, Hospice) to absorb *risks* of the disadvantaged or terminally ill, and thirdly with copayments, deductibles or self-payments for a large part of the actual *care* the taxpayer receives. These costs are inflated by payments for risks, rather than actual care given, and by the need for private businesses to be assured a profit for their stockholders after salaries to their executives and administrators, who do not directly contribute to care. Tax revenue should cover *care*, not *risks* of someone else covering payments to those providing care. Health is not a business. It is not a game with a score. Healthcare workers should not be posed as competitors for a set pot of money. Profit should not accrue beyond an appropriate income to those directly providing the care, services, or supplies that do maintain or improve health.

People are not satisfied with their experiences with managed care organizations. MCOs fail at the Triple Aim: care is obstructed; health is often damaged: people suffer or die because of delays or lack of access to care or not obtaining tests and medications identified by their doctors as necessary; costs are manipulated, not contained. Unnecessary and ineffective services are duplicated while necessary and beneficial services are not allowed to overlap at all. Prior authorization processes have escalated to prohibitive wastelands. Wasting precious medical expertise (physicians, pharmacists, and their clinical staff are bogged down daily with these absurd requirements), wasting health of patients, wasting money in the future to save pennies today.

Here's an example of what our days are filled with that explains one of the ways that managed care reduces access to medical expertise. My clinical assistant spent over an hour yesterday, and ultimately required my time as well, to complete a new version of electronic PA by BCBSNC for Celebrex. The patient is an octogenarian who has been using this medication for years to retain ability to walk and enjoy life without pain from multiple joint arthritis. Celebrex is not without risks, but it has lower risk profile for her age group than other anti-inflammatories for the benefit it gives, and it helps reduce the amount of narcotic or other sedating, more risky medications that might be needed to control pain and maintain function. These are facts, not only for her but for most people who do not have other disease processes that make Celebrex too risky. This is medical risk/benefit analysis that doctors complete on every decision we make, and part of what occurs in split seconds in our brains when we renew any medication. Why should we have to devote time to explain this to a payer? We were told the eP.A. would take 3-5 minutes. It required information such as an *exact* date a medication had been started, which was 2 years ago, before the patient had moved to an assisted living facility where I became her primary doctor. We had to call her pharmacy to obtain this information. Details of other medications tried must be proven year after year to renew the same medications: names, doses, and intolerances, most of which is hidden in entrails of electronic records; a physician's word that we have tried the alternatives is not trusted. As we crossed these hurdles, more questions were added, attempting to daunt us. After completing and submitting this full dossier, we were told to call in the morning to submit a request for early approval if we needed sooner than 48 hours. The patient is on her last pill. An extra task for today. As I edit this document, I'm on the phone waiting for a supervisor to explain how they do not have the information that I have printed proof we sent last night. BCBSNC has no

documentation of our calls during the process of filling out the form or explaining the urgent review process when they gave use the number to call this morning. Medical staff have been told by payers that if it's not documented, it didn't happen. We documented it. How in this electronic world, does BCBSNC not have documentation of our calls and the form we submitted? Living with such absurdities will lead to insanity. BCBSNC just hung up on me while I was waiting to talk to a supervisor.

Do we require orders from a military officer to be authorized before being followed in their promotion of defense? The crucible of medical training is no less intense or difficult, physically or mentally, than that of military officers. We fight battles every day protecting the general welfare of far greater numbers of people from imminent and insidious threats of disease and death. Doctors are trained in ways that develop judgement about the best, quickest way to support life in any situation. The successful application of that judgement lies in the power of the relationships with patients. No other training provides this type of understanding; no other relationship approaches that power for healing. No administrator can enhance it. Some CMS rules to prevent and monitor for fraud over-reach that intent and result in unnecessary costs. Physician judgement should be respected and placed at the center of our system of care. Physicians accountable to patients and their outcomes aren't likely to pursue fraudulent means and don't need to be monitored like bad-behaving adolescents. The APC-APM would go a long way toward reclaiming the power in physician-patient relationships, and repairing the disintegration of primary care systems. As one mother who spoke in Asheville said, "If you are not ready to pay for basic care that prevents people from dying, don't call yourself Pro-Life".

People feel badgered or bewildered by calls from strangers hired by MCOs and mailings promoting one trend or another in a uniform way, but can't get individualized assistance for supplies for urinary incontinence or nutritional supplements that affect them and their risk of readmission every single day. Most people won't even answer phone calls from case managers who live in other states paid by MCOs to monitor risks and make a stab at improving care. This may be well-intended in theory, but it is not satisfying or effective in practice. I know of only a few cases where contact from a managed care case manager has helped people. Even those benefits lie in the fact that these case managers had access to the primary physician and continuity in their own position. All very rare in the typical delivery of these supportive services by MCOs.

Our home-based Palliative Care team nurse, visiting in the home of a patient and his family in a neighboring county who were in a downward spiral of despair and close to collapse with physical, mental, and financial problems, finally convinced the wife/grandmother/caregiver to accept a call from the number we knew was their BCBSNC case manager in Virginia, near Washington D.C. This nurse had information that would help them obtain prescription medications. Eventually all our efforts combined did reduce his hospitalizations, but better yet, we improved their general welfare. One of the prime goals of our more perfect Union!

Inspect this success story to find what made the crucial difference for this family. Other home-based services had not felt this family to be appropriate or were unable to obtain necessary face to face visits from providers to certify need for services. Again, the attending doctors' "orders" for such services are not enough in the managed care world. This man whose family had lived and contributed to the culture of our area for generations, whose grandfather owned the mule team that hauled the crush and run for Highway 321 through Lincolnton, could not qualify for skilled rehabilitation after amputation of part of his foot for long enough to recover his general health in a less stressful environment. They were not

answering the phone because most calls were from creditors. They were about to lose their house to foreclosure because the wife had become overwhelmed with mental illness from demands of caring for her ailing husband and young grandchild, and was disabled from her job in the school system. She was also refusing calls from government mandated banking programs that could help save their home. Over the course of months, we developed their trust through visits and calls, mostly through kindness and listening, that allowed them to accept the basic medical care he needed. We communicated by phone with their PCP office to coordinate mental health services for the wife and granddaughter through their county hub for Behavioral Health partners. His BCBSNC case manager in Virginia and I had many phone conversations about ways she could help when she wasn't able to make contact them. We also shared another complex patient with ALS that she had helped with the same dogged determination to meet clerical requirements to be able to solve clinical problems. Within 8-9 months they were safely out of crisis and mending well. Only a few of my interactions were billable. We were effective because of our healing presence in relationships with each member of the family, and through caring actions that helped this family feel our concern for them and real desire to help them. Even the help from a case manager almost two states away was finally accepted, but only through the conduit of the primary/palliative team.

Managed Care, and now high deductible insurance plans limit and sometimes prevent access to care. When the first Medicare Advantage Plan was hawked at Walmart here in Shelby, NC, unsuspecting elderly patients incurred full responsibility of expenses for tests ordered by their doctors and performed at our local hospital which was not a participating facility. Anyone familiar with human behavior, particularly in that generation, could have predicted how these patients responded. They didn't return for any medical care or buy any prescriptions until that debt was paid. After I saw how this was affecting patients, I wrote to the NC Insurance Commissioner objecting to these policies being sold in communities where none of the hospitals participated in the plans. That was just the beginning. Now, almost everyone, whether insured or not, avoids seeking early medical attention before problems worsen because of the high cost of basic services.

Fast forward through the interval years since that first managed care model. Picture primary care doctors learning 2, 3 or 4 different electronic record systems (implemented reluctantly to defend their livelihood and avoid penalty or achieve monetary incentives), to be able to function in all the settings where they take care of patients or communicate with colleagues they now rarely see, weeding through notes bloated with unnecessary documentation, (also aimed at achieving coding levels for higher reimbursement), to find scraps of information vital to decisions affecting life and death or simply to answer patient questions, converting to expanded coding systems and implementing complex scoring systems to "measure" quality of care that is, again, focused on reimbursement or costs. But more importantly, imagine what managed care feels like for patients. "Managed" has led to more costs, while the true "care"-actions that help people adapt-are largely non-reimbursable in our current system.

Imagine how Paul (not his real name) and his family might feel. His managed care coverage has interfered with his primary goal of living as long as possible with his wife, Martha. He retired from work as a mechanic, but then ran a convenience store for a time until he suffered a series of strokes that left him with a tracheostomy and eventually dependent on ventilator support with artificial feedings through a tube in his stomach. He communicates with lip movements and gestures and indicated satisfaction with his life, even during difficult times and health crises. His goals were always to share his life for as long as he could with Martha, who has cared for him at home between hospitalizations and

skilled nursing stays, now with the help of private duty nurses for 12 hours/day after he became bedfast and totally dependent for care. He has enjoyed life with her, even with these severe limitations. They live on the edge of two counties served by different, competing hospital systems. His insurance coverage is through a Medicare Advantage Plan. Paul's continued existence has brought good things to his family: wisdom and humility, an acceptance of help and support from others, an understanding of unpredictable and unavoidable risks, the joys of simple things. I heard his grandson describe how much he loved hearing Paul laugh.

I became involved with this family through community based Palliative Care after one of Paul's hospitalizations when other providers felt they needed help with establishing more realistic goals and expectations. Through many discussions as he continued to decline despite most aggressive care, both Paul and Martha maintained his goal of being able to live together as long as possible, and they related stories of several times that he had survived when everyone expected him to die. Because of these experiences, he could not tolerate the mention of hospice.

I became Paul's primary care doctor after he had another hospitalization in a different hospital system than where his longtime primary care doctors work. His doctor was not able to provide the face to face certification for home health services when he returned home because the group's doctor devoted to their hospitalized patients had not seen him during this hospital stay in another system, and it was too difficult for Paul to travel to their office in the next county. He lost the accumulated knowledge of years with that doctor. Soon after I assumed his care, Martha told me that the liquid Zantac preferred by his insurance was not working as well as the other type of medication he had used before. His Medicare Advantage plan would not approve the proton pump inhibitor that worked best before to reduce acid production and protect against inflammation of the stomach and esophagus, and against reflux and aspiration to his lungs of stomach contents. His wife told me the problems he had in the past with their preferred medication, but I didn't have access to the actual data to include on the Prior Authorization request, so we were forced to repeat trials of medications at the risk of causing him harm and increasing costs from obstruction of his feeding tube or aspiration to lungs. I conferred with the PharmD of Community Care of NC, partners with Medicaid in NC and available to help with patient care, to discover the least risky of the alternatives, and educated the family and nurses on how to administer, but nonetheless, the preferred medication clogged his feeding tube. I resumed the effort to get approval for the medication proven to be effective and tolerable for him. This took hours of my time but most concerning is that the delay in getting what he needed harmed him and his family. That delay caused acceleration of problems that have now placed him at the end of his life. This was looming anyway, but it is happening sooner than it would have. He can't communicate now, but opens his eyes at times. This gives Martha hope. He is still fighting for more time with Martha. If he miraculously survives again, as they still hope he will, it will be at a much lower quality of life.

This is the trend. If you think the telling of this story is tedious, imagine yourself in the daily grind of completing these processes on an average of one prescription per patient per day, while recognizing how crucial the medications or the services are for supporting patient lives. This illustrates the way that managed care companies obstruct care and cause harm to delay expenditure for a few days in the quest for earnings.

Back to the grind. I completed a detailed form with questions about other products Paul had used and their effect after I researched home health records and information with the nurse. This required a

doctor's perusal to accumulate the information to answer the questions. Omnicare responded with a very rapid phone message left on voice mail on Friday morning with a deadline, specifying physician response before a date that expired over the weekend. (I have noticed over years of prescribing that this is a common tactic of many managed care companies: call on Friday requiring a return call before the end of the day). I returned the call to the number on the voice message in the early afternoon, but that number went to a department where no one knew anything about prior authorizations, or about this patient. I was transferred several times, going through the whole explanation each time, but never found the person who had called or anyone to complete whatever else was necessary. Finally, someone did re-calculate the deadline based on my earlier submission of the form, and assured me that it would not expire over the weekend. On Monday, the original prior authorization specialist called again. She asked two yes/no questions, both of which had been answered in the written information submitted on the form I sent two weeks before, then said the medication was approved. This patient was at risk for three weeks while we jumped through arbitrary hoops. I complained to the state of NC Insurance Commissioner and was forwarded to someone who responded that they could investigate if I called back to give more details about what had occurred. More details than what I just related here? Is this not enough?

Later that same week Paul developed symptoms of pneumonia that did not respond to antibiotics at home and led to further deterioration of health. He is close to death. He has had two more hospitalizations, 3 emergency visits, Infectious disease consultations, IV antibiotics in hospital and through a PICC line at home. I met them at the ER several times and coordinated with ER staff and community agencies to provide as much of this care as possible at home at the lowest expense. Each visit to the hospital or to obtain PICC line results in ambulance fees. I visited their home on a Sunday to convince Martha that she needed to agree to a Do Not Resuscitate status if she wanted him to be able to remain at home after the private duty nurse notified me they were on the verge of calling EMS again as per their policy for Full Code patients after she was not able to get his oxygen saturation above 88%. At a family meeting their son told his mom that he had been waiting for her to accept what was coming, and they all agreed for DNR.

Martha has health problems too, and is getting exhausted with struggling all night to keep Paul alive and comfortable. I requested an increase in Private Duty Nursing hours to reduce the time that she is caring for him by herself. Hospice services are still considered duplicate services with private duty nurses in this situation. We expect that Martha will panic and call EMS when his heart stops, if she is there alone. The extra hours have still not been added, so I arranged for the nurse assisting me who has experience with crisis care through hospice services to be available to them to coach them through the end of his life. We overcame their fear of using liquid morphine to keep him comfortable. We have handled phone calls about his care almost every day over the past two weeks. Martha frets about adding back tube feedings, and whether we are doing enough to give him a chance for another miracle.

Only a small part of the care we have provided Paul and his family is reimbursable in the current system without a high burden of administrative chores to prove the time spent and value produced. Even with recent attempts to reduce these obstacles to new billing codes, most software companies still do not have adequate methods for achieving time keeping or secure electronic communication with other health partners in various agencies for all the myriad steps and conversations scattered among days to accomplish simple things, and the reimbursement does not meet the cost of tabulating those things. The APC-APM is the only model I have come across that addresses these short-comings of our current

system with a practical and cost-effective way payment system. It needs to be adopted and promoted. It would be ideal if we integrated other essential specialties to form a medical care foundation that could gradually replace the ACA without all the political posing and bickering we are paying for now.

Cost savings with the primary care foundation model I am pursuing are certain. Quality and satisfaction are equally assured and supported by research on similar models, as the primary physician-led teams work to manage disease processes and meet patient goals. Avoid added costs throughout the system for patients with transportation obstacles through management by phone or telemedicine follow-up with the team coordinator or home health nurse, and home visits or rare office visits determined by the provider based on necessity and risks, rather than volume. Avoid emergency visits and hospitalizations with around-the-clock on-call support from the team who knows the patient and their plan of care from other integrated providers, and can assemble local resources to support safely at home, or assist with transition to appropriate level of care. Services can be added or discontinued as the physician-led team determines appropriate for the time during which they are necessary, *when events can be expected or actually occur*, avoiding extra expense due to our inability to accurately predict death or other events. Think of it as a modification of the PACE program. Each partner contributes to the care plan maintained at the primary physician hub through care communicators. Even the expanding costs of palliative and hospice services could be tailored to a closer fit with patient and family needs and changes in prognosis for overall cost savings if hospice and palliative providers were also integrated through primary physician practices. Retain the years of knowledge primary physicians have about their patients and families. Share prospective payments reflective of needs and complexity among such partners for the services determined necessary at each stage of life or decline to death, and discontinue integrated services at each stage of improvement or stabilization.

The APC-APM is an excellent physician-focused alternative payment model. It is also an excellent beginning to the foundation for a system of comprehensive primary care throughout all outpatient care settings for *everyone*, with no disruption in the relationships that help all of us make wiser choices. Add components of integrative/collaborative models of care to provide prospective payments for essential specialty services and we will have a comprehensive, high quality system of primary care delivered locally, uniform for all participants and without excessive burdens to prove quality or avoid liability.

It's never the wrong time to do the right thing.

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May 18, 2017

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Dear Dr. Bailet:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to comment on the proposal, Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care. The AMA is supportive of the effort to develop a nationwide medical home model, particularly one that builds on the Comprehensive Primary Care Plus (CPC+) program, which we strongly support.

The only national advanced primary care medical home model is CPC+, a five-year model which includes two primary care practice tracks with advanced care delivery and payment options. CPC+ is implemented through a public-private partnership that is currently aligned with 54 payers in 14 regions across the country, including Arkansas, Colorado, Hawaii, Greater Kansas City Region of Kansas and Missouri, Michigan, Montana, North Hudson-Capital Region of New York, New Jersey, Ohio and Northern Kentucky Region, Oklahoma, Oregon, Greater Philadelphia Region of Pennsylvania, Rhode Island, and Tennessee. Practices located in up to 10 new regions will be eligible to apply in the summer 2017.

Practices located outside of the CPC+ regions currently do not have the opportunity to participate in CPC+, or any other primary care medical home model. The AMA agrees with the APC-APM proposal that a medical home alternative payment model needs to be available that would be open to all practices that provide patient care through a patient-centered primary care medical home delivery model, regardless of their geographic location.

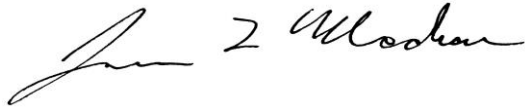
Medical home models provide more coordinated care for patients, which can improve health care quality and decrease health expenditures. A major advantage of the CPC+ approach over other Centers for Medicare & Medicaid Services (CMS) models is that it measures participating physicians' performance on factors that they can influence, such as avoidable emergency department visits and hospital admissions, instead of factors that are beyond their control, such as total spending in the state. The AMA agrees with the APC-APM proposal that it is inappropriate to evaluate physician performance under the model based on a total cost of care metric.

Jeffrey Bailet, MD  
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In addition, medical home models can provide benefits for high-risk beneficiaries through improved care-coordination, access to non-face-to-face services, and patient and caregiver engagement. The AMA strongly supports the further development of both primary care medical homes and similar specialty models as Advanced APMs.

Bonus payments for qualifying participants in Advanced APMs can be used to help practices with the cost of transitioning to a medical home approach; however, these bonuses are time limited. Therefore, the Physician-Focused Payment Model Technical Advisory Committee (PTAC), CMS, and the U.S. Department of Health & Human Services must act quickly to allow physicians to take advantage of these bonus payments. The AMA looks forward to continuing to work with the PTAC, the American Academy of Family Physicians, and other medical specialty societies to further refine and implement a medical home APM that is widely available to physicians throughout the country. Thank you for your consideration.

Sincerely,

A handwritten signature in black ink, appearing to read "James L. Madara". The signature is fluid and cursive, with a large initial "J" and "M".

James L. Madara, MD



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May 18, 2017

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Submitted via email to: PTAC@hhs.gov

**RE: Public Comment - [Advanced Primary Care: A Foundational Alternative Payment Model \(APC-APM\) for Delivering Patient-Centered, Longitudinal, and Coordinated Care](#) (American Academy of Family Physicians Proposal)**

Dear Chairperson Bailet:

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to submit comments on the American Academy of Family Physicians proposal: *Advancing Primary Care – A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care*, posted on the Office of the Assistant Secretary for Planning and Evaluation (ASPE) website, on April 28, 2017.

BCBSA is a national federation of 36 independent, community-based, and locally operated Blue Cross and Blue Shield companies (“Plans”) that collectively provide healthcare coverage for one in three Americans. Plans offer coverage in every market and every zip code in the United States. Plans also partner with the government in Medicare, Medicaid, the Children’s Health Insurance Program, and the Federal Employees Health Benefits Program.

We strongly support the objectives of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to transition the health care delivery system from one based on fee-for-service design that largely rewards volume to one that pays based on quality and effectiveness of care. Blue Cross and Blue Shield Plans are spearheading innovative and successful payment reform initiatives across the country, partnering with clinicians so they have the support, data, and tools they need to be successful. Moreover, as the only private payer selected in the original Comprehensive Primary Care Initiative (“CPC

Classic”) in all seven regions, and in fourteen of the eighteen regions for the Comprehensive Primary Care Initiative Plus (CPC+) model (Phases 1 and 2), Blue Plans are uniquely qualified to offer insights because this proposed model builds off of the CPC+ model.

Broadly, we support the overall goals and concepts of both CPC+ and the AAFP model, and see these as being a priority of payers nationally, especially as the AAFP has built an inclusive model that does not limit payer/provider participation.

However, we have major concerns about this model’s potential financial impact:

- The proposal heavily outlines what a payer must contribute – programmatically and financially – for the model to be successful, but does not demonstrate that AAFP took into consideration the impact on payers and the commitment of resources that would be needed.
- In addition, designers of models that advance upfront costs to providers to stand up the model should consider the effects of the upfront costs on premiums. AAFP anticipates that this structure will pay off in the long run, but heavy financial investment may impede implementation in the short term.

We offer additional comments below, structured by topic area in the model: Attribution; Cost of Care – Accountability for Outcomes; FFS Rates; Quality Measures; Integration of Behavioral Health; Risk Stratification; Health Information Technology; Reimbursement Target; and Support for Rural Providers.

\* \* \*

### **Attribution**

AAFP recommends a patient-based, prospective, four step process that includes a 24-month look-back period for attribution.

1. Patient selects primary care physician and team.
2. If a patient is not attributable by self-selection, payers should use well visits.
3. If not attributable by well visits, use all other E/M visits.
4. If not attributable by well or E/M visits, use medication prescriptions and other order events.

The proposed attribution methodology gives providers the option to review, and possibly reject, attributed members.

We are concerned that this methodology is overly complex: both payers and providers need flexibility to ease adjustment to a new APM. To encourage participation of payer and providers, we recommend an attribution model that is either based on PCP member choice or assignment, or a variation of an attribution model that does not include PCP alteration of attributed members.

### **Cost of Care – Accountability for Outcomes**

BCBS companies support the drive to prioritize primary care financially. However, the financial implications of this proposal in regards to the four payment mechanisms will need to be simulated and tested by payers to see if they are a viable option for payers without negative impacts on medical expense.

A key issue is that the proposal seems to limit the responsibility of the PCP to be held accountable for the total cost of care (more of a focus on performance risk rather than financial risk). The proposal asserts that if PCPs were paid more, they would no doubt be able to reduce the total cost of care over time. As many BCBS Plans have demonstrated in their local programs, holding PCPs accountable for total cost of care via shared savings and risk arrangements across the continuum is preferable for both the PCP organizations and our Plans' customers, and can generate more quality of care improvements and sustainable cost savings.

### **FFS Rates**

The AAFP proposal proposes to pay non-E&M codes at 100 percent FFS, which could have the unintended outcome of incenting providers to ratchet up non-E&M codes. We know that the calculation of future PCP capitation rates requires a significant increase to historical FFS payment rates, and believe there is a potential for a net increase if implemented as proposed. We support instead the CPC+ concept to gradually transition providers away FFS.

In addition, we seek clarification regarding Chronic Care codes for non-face-to-face services. We see this being addressed already through CPT codes 99490 and G0506 that are currently being covered and paid – would this be considered “double dipping” if payers pay the population based-payment (non-face-to-face)?

### **Quality Measures**

Almost all of the proposed measures are adult measures and do not relate to children or include pediatric measures such as well children visits. Given that PCPs are often family practitioners seeing a range of ages, including pediatrics, we suggest that the measures take into account all patient types the PCP is likely to see.

### **Integration of Behavioral Health**

We did not see behavioral health called out with enough specificity in how this could be included in the payment model to primary care. Nationally, the health system is struggling with ways to improve behavioral health care delivery, and it would be beneficial to see an Advanced APM for Primary Care that clearly includes behavioral health care at the PCP site.

### **Risk Stratification**

The model recommends the Minnesota Complexity Assessment Method to risk-stratify the population. While this model does have merit, our experience is that it is very site-subjective. We recommend that PTAC fully explore any risks associated with asking providers to self-stratify the patients attributed (and then assigned a capitated rate based on this self-stratification).

An alternative that some health plans are using is Verisk data to risk-stratify. The state of Rhode Island is looking at the creation of an assessment that incorporates social determinants of health (SDOH) into the risk, and could be accepted by all providers as a means to site-identify high risk members. Those gaps could also then be tracked back to the particular need of a community (more of a comprehensive public health identification process to address SDOH that also drive increased healthcare costs, e.g., housing, food, substance use disorder, parental incarceration, behavioral health institutionalization, etc.).

### **Health Information Technology**

The model references the importance of patient portals and open application programming as playing a key role in its implementation. The use of open application programming is an issue that rests heavily on the information technology (IT) vendor rather than the provider. Health IT is a relationship in healthcare that can be advocated and paid for, but the vendor ultimately decides its ability and level of interoperability. Market competition prevents some vendors' participation in advancing this concept.

**Reimbursement Target**

The model proposes an increase of 12 percent of total PCP costs to provide adequate resources to PCPs. While we value primary care and agree that more dollars should flow through primary care, we do not support the proposal that “payers should take 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” – this is too ad hoc and untried an approach for an advanced APM. In contrast, we have considerable experience showing that giving PCPs incremental resources in the form of care management fees and shared savings opportunities creates strong incentive to better manage the total cost of care.

**Support for Rural Providers**

We support and encourage rural providers being included in AAFP model. Our concern is that rural practices may lack educational and consultative resources to appropriately implement advanced primary care concepts despite the desire and will to do so – many BCBS Plans have seen this first-hand with practices working to implement patient centered medical homes. We recommend consultative partnerships (beyond the payer and payer partnerships) or funds set aside by the AAFP to support its constituents specifically for this purpose, as we have seen this be helpful within programs aimed to support independent primary care physicians.

\* \* \*

Thank you for your consideration of our comments. If you have questions, please contact Anshu Choudhri at [anshuman.choudhri@bcbsa.com](mailto:anshuman.choudhri@bcbsa.com) or 202.626.8606.

Sincerely,



Joel Slackman  
Executive Director, Legislative and Regulatory Policy  
Office of Policy and Representation

# Consumer-Purchaser ALLIANCE

Better information. Better decisions. Better health care.

May 18, 2017

Members of the Physician-Focused Payment Model Technical Advisory Committee  
c/o Angela Tejada  
Office of the Assistant Secretary for Planning and Evaluation  
Department of Health and Human Services  
200 Independence Ave. SW  
Washington, DC 20201

## **RE: AAFP Advanced Alternative Payment Model proposal**

Dear members of the Physician-Focused Payment Model Technical Advisory Committee (PTAC):

The Consumer-Purchaser Alliance is a collaboration of leading consumer, labor, and employer organizations committed to improving the quality and affordability of health care through the use of performance information to guide consumer choice, payment, and quality improvement.<sup>1</sup> We appreciate the opportunity to provide input on the proposed physician-focused payment models, including the American Academy of Family Physicians proposal for a primary care alternative payment model (APM).

Primary care is foundational to a high-performing, patient-centered health care system. Individuals need consistent access to a health professional trained to provide quality medical care as the primary access point to the health care system and as a central relationship supporting an individual's overall health. We are very pleased to see an APM proposal that focuses on primary care providers, particularly because this model holds primary care practices financially accountable for both patient outcomes and costs of care - a key combination that drives improved care, innovation, and group-level quality improvement initiatives.

We are very pleased that the APM replaces fee-for-service payments for E&M services with a primary care global payment, allowing primary care physicians more flexibility in care delivery. We encourage AAFP to clarify how this payment model promotes comprehensive team-based care in which all members of the team are able to practice at the top of their license.

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<sup>1</sup> For brevity, we refer in various places in our comments to "patient" and "care," given that many Medicare Part B programs are rooted in the medical model. People with disabilities frequently refer to themselves as "consumers" or merely "persons." Choice of terminology is particularly important for purposes of care planning and care coordination, when the worlds of independent living and health care provider often intersect.

[www.consumerpurchaser.org](http://www.consumerpurchaser.org)

Pacific Business Group on Health  
575 Market Street, Suite 600, San Francisco, CA 94105  
415.281.8660 | tel

National Partnership for Women & Families  
1875 Connecticut Avenue, NW Suite 650, Washington, DC 20009  
202.986.2600 | tel



We support the all-payer aspect of this model, which streamlines and strengthens the financial incentives experienced by a provider group. We strongly support the use of all-payer data for performance measures, including patient experience measures, to create a more comprehensive picture of a provider group's performance. We are very pleased to see the proposed model's use of the Core Quality Measures Collaborative (CQMC) PCMH/ACO/Primary Care Core Measure Set, reflecting the consensus priorities of a variety of stakeholders. A multi-stakeholder consensus-based decision-making approach is critical in achieving a patient-centered health care system that truly meets the needs of consumers, purchasers, and other stakeholders.

Our comments and recommendations below focus on strengthening the measurement component of the APM, to ensure that the payment model rewards truly high quality care. Consumers, patient caregivers, and purchasers need reliable cost and quality information to compare and select providers. Measuring providers using a standard core measure set provides comparable information on provider performance that benefits all stakeholders, including consumers and purchasers, and sends a consistent message to participating practices about the program's priorities regarding quality and care delivery. We strongly encourage AAFP to evolve this model over time to require reporting of a uniform core measure set, used to evaluate all participating practices. We support a menu approach to measure selection only in the short-term, given that the APM's proposed measures pull from the CQMC measure set and contingent on our recommendations below to provide incentives for practices to choose the highest value measures (e.g., patient-reported outcome measures, or PROMs).

In the near term, the APM model should call out care coordination measures, population health measures, and PROMs as high-value measures and require APM participants to report at least one such high-value measure. This aligns with the MIPS approach, which designates two of the six self-selected measures as specific measure types required for reporting.

Patients' perspectives must play a substantial role in defining 'value' in health care to achieve a truly patient-centered health care system that assesses and mobilizes to respond to patient needs. Patient-reported outcomes (PROs) can be used to determine if patients benefit from treatment in ways that matter to them, to providers, and to society: improved functioning, reduced pain, and improved quality of life. As indicated by expert consensus, a number of domains and PROs are appropriate for assessment of primary care in accountability programs.<sup>2</sup> We strongly recommend that PROs and PROMs are prioritized when assessing the quality and value of providers. We are glad to see PROMs included in the proposed measures, including Depression Remission at Twelve Months, and recommend that AAFP include additional options: the NQF-endorsed measure Gains in Patient Activation at 12 Months (NQF #2483) and a reporting option for PROMIS-Global. Providers who choose to report PROMs as part of their quality measures should be eligible for a larger quality incentive. We strongly encourage AAFP to build in an incentive for practices to voluntarily collect and report PRO information.

Finally, we support including the two cost measures used under CMS's Comprehensive Primary Care Plus (CPC+) program in this model for accountability purposes: Inpatient Hospitalization

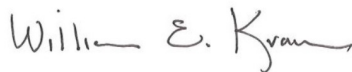
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<sup>2</sup> Murphy, Mairead, Sandra Hollinghurst, and Chris Salisbury. "Agreeing the Content of a Patient-reported Outcome Measure for Primary Care: A Delphi Consensus Study." *Health Expectations* 20.2 (2016): 335-48. Web.

Utilization per 1,000 Attributed Beneficiaries and Emergency Department Utilization per 1,000 Attributed Beneficiaries. Patients' acute care utilization falls directly within a primary care physician's responsibilities, and we recommend aligning the cost measures between these two programs. This allows for a more comprehensive assessment of a practice's performance, the program's impact on acute care utilization, and allows for comparisons between the two programs.

Thank you again for the opportunity to comment on the proposed alternative payment model. Improving delivery of and access to primary care represents a significant opportunity to improve our nation's health care system through more appropriate care, improved care coordination, better quality, and lower costs. If you have any questions about our comments, please contact Stephanie Glier, Senior Manager for the Consumer-Purchaser Alliance, at [sglier@pbgh.org](mailto:sglier@pbgh.org).

Sincerely,



Bill Kramer  
Executive Director, National Health Policy  
Pacific Business Group on Health  
and  
Co-Chair, Consumer-Purchaser Alliance



Debra Ness  
President  
National Partnership for Women & Families  
and  
Co-Chair, Consumer-Purchaser Alliance



May 18, 2017

Physician-Focused Payment Model Technical Advisory Committee (PTAC)  
U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Washington, D.C., 20201

Dear PTAC Members:

On behalf of the American College of Physicians (ACP), I would like to express our sincere appreciation for the efforts of the American Academy of Family Physicians (AAFP) to propose a framework for an Advanced Alternative Payment Model (APM). The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 148,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

The Advanced Primary Care-Alternative Payment Model (APC-APM) supports the principle that patient-centered primary care is comprehensive, continuous, coordinated, connected, and accessible from the patient's first contact with the health system. This model is also based on the concepts of the Comprehensive Primary Care Plus (CPC+) model, as well as the Joint Principles of the Patient-Centered Medical Home (PCMH), both of which the College strongly supports. The PCMH is an innovative, team-based approach to providing health care services that establishes and builds trusting relationships between patients and their primary care physicians. A growing body of evidence documents the many benefits of PCMHs, including improved quality, patient experience, continuity of care, prevention, and disease management.

Consistent with the Joint Principles, the College has long been supportive of a per-member per-month (PMPM) payment that covers the non-face-to-face services that are essential to coordinating care within a PCMH. The population-based payment included in the APC-APM is a key element that fills this role by providing participants in the model with a prospective, risk-adjusted payment for each attributed patient. These payments should be reflective the work value of physician and non-physician staff and administrative care coordination activities that are provided outside of face-to-face visits as well as the practice overhead costs of providing these enhanced services that are not currently paid under fee-for-service.

ACP is very interested in the ongoing testing of PCMH models and shares the goal of ensuring the primary care clinicians nationwide have access to models like the APC-APM to help facilitate practice

transformation and enhanced patient care. The College looks forward to the PTAC's discussion of the APC-APM, as proposed by AAFP, and we welcome the opportunity to work with the Academy, the PTAC, and others to potentially refine and improve upon this model.

ACP also looks forward to having the opportunity to work with other medical specialty societies and other key stakeholders to facilitate the testing and implementation of additional innovative delivery-system and payment models that promote quality and value, as well as to expand the CMS advanced APM portfolio to clinicians who currently have limited opportunities to participate.

Thank you for the opportunity to comment—and we hope to be able to continue participating in the discussions regarding the APC-APM and other proposed models throughout the PTAC's consideration process. If you have any questions, please contact Brian Outland, Director, Regulatory Affairs at [boutland@acponline.org](mailto:boutland@acponline.org).

Sincerely,

A handwritten signature in black ink that reads "Jacqueline W. Fincher MD". The signature is written in a cursive, flowing style.

Jacqueline W. Fincher, MD, MACP  
Chair, Medical Practice and Quality Committee  
American College of Physicians

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**From:** PTAC (OS/ASPE)  
**Subject:** FW: Public Comment - Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care

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**From:** Alanna Goldstein [<mailto:agoldstein@americangeriatrics.org>]  
**Sent:** Monday, May 22, 2017 4:42 PM  
**To:** PTAC (OS/ASPE)  
**Subject:** Public Comment - Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care

*Thank you again for the opportunity to comment and for the extra few days to get this in. Please let us know if you have any questions.*

*Sincere Regards,  
Alanna Goldstein  
Director, Public Affairs and Advocacy  
American Geriatrics Society*

\*\*\*

FOR PUBLIC COMMENT -

The American Geriatrics Society (AGS) agrees conceptually with the approach outlined by the American Academy of Family Physicians (AAFP) for an Advanced Primary Care Alternative Payment Model (APM). However, given that the AAFP does not want to set the payment metrics for the monthly capitation and monthly fee for non-face-to-face care based on existing benchmarks, it is not clear to us how those payment amounts would be determined. Additionally, we believe that cost and quality measures should be only used to affect payment if they are reliable and valid for the population size of the practice/organization being affected. It is also not clear from the application how the performance metrics would be benchmarked and what sort of risk is being taken by APM entities who would participate. That said, we agree that primary providers are underpaid and we would be happy to work with the committee to provide additional information to address these issues.



July 5, 2017

Jeffrey Bailet, MD, Committee Chairperson  
Physician-Focused Payment Model Technical Advisory Committee  
Office of the Assistant Secretary for Planning and Evaluation  
U.S. Department of Health & Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Dr. Bailet:

On behalf of the Colorado Academy of Family Physicians (CAFP), I write in support of the American Academy of Family Physicians' proposal, Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care. CAFP represents over 2,300 family physicians, residents, and medical students. We encourage the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to recommend that the Secretary of Health and Human Services (HHS) implement the APC-APM on a national level.

We support the APC-APM proposal, because it builds upon the Comprehensive Primary Care Plus (CPC+) program, which we also strongly support. Since CPC+, a program using a public-private partnership, is currently implemented in limited locations, most primary care practices do not have the opportunity to participate in CPC+ or any other primary care-oriented advanced alternative payment model. In Colorado, we have found early successes through family physicians' participation in the CPC Initiative, where net savings of 2.2% were achieved in 2015, along with the lowest all-cause hospital readmission rates of any CPC region. The practice transformation occurring within Colorado must be continued to realize the full benefits to cost and quality of care, and these efforts should be expanded to other regions. Therefore, we encourage PTAC to recommend that the Secretary of HHS APC-APM implement APC-APM on a national level.

Implementation of a multi-payer APC-APM nationally will support advanced primary care practices, which provide more coordinated care for patients, improve health care quality, and decrease health expenditures. Such practices, which serve as medical homes for their patients, also provide other benefits for patients, including greater access to care and enhanced patient and caregiver engagement.

Thank you for your time and consideration. If you or PTAC staff have any questions about this letter, please contact CAFP Deputy CEO for Policy and External Affairs at [ryan@coloradoafp.org](mailto:ryan@coloradoafp.org), or 303-696-6655, ext. 17.

Sincerely,

A handwritten signature in black ink, appearing to read "Monica Morris".

Monica Morris, DO  
President

August 31, 2017

Jeffrey Bailet, MD  
Committee Chairperson  
Physician-Focused Payment Model Technical Advisory Committee  
Office of the Assistant Secretary for Planning and Evaluation  
U.S. Department of Health & Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

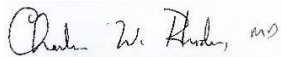
Dear Dr. Bailet:

On behalf of the North Carolina Academy of Family Physicians and our 4,000 members across the state, I write in support of the American Academy of Family Physicians' proposal, Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care. We encourage the Physician Focused Payment Model Technical Advisory Committee (PTAC) to recommend that the Secretary of Health and Human Services (HHS) implement the APC-APM on a national level.

We support the APC-APM proposal, because it builds upon the Comprehensive Primary Care Plus (CPC+) program, which we also strongly support. Since CPC+, a program using a public-private partnership, is currently implemented in limited locations, most primary care practices do not have the opportunity to participate in CPC+ or any other primary care-oriented advanced alternative payment model. Therefore, we encourage PTAC to recommend that the Secretary of HHS APC-APM implement APC-APM on a national level. Implementation of a multi-payer APC-APM nationally will support advanced primary care practices, which provide more coordinated care for patients, improve health care quality, and decrease health expenditures. Such practices, which serve as medical homes for their patients, also provide other benefits for patients, including greater access to care and enhanced patient and caregiver engagement.

Thank you for your time and consideration. If you or PTAC staff has any questions about this letter, please contact our Executive Vice President, Gregory K. Griggs, MPA, CAE at 919-833-2110 or [ggriggs@ncafp.com](mailto:ggriggs@ncafp.com).

With best regards,



Charles W. Rhodes, MD, President  
NC Academy of Family Physicians

cc: Gregory K. Griggs, MPA, CAE, Executive Vice President & CEO



December 1, 2017

Jeffrey Baillet, MD  
Chair  
Physician-Focused Payment Model Technical Advisory Committee  
Office of the Assistant Secretary for Planning and Evaluation  
U.S. Department of Health & Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

Dear Dr. Baillet:

On behalf of Ascension, the largest nonprofit health system in the United States and the world's largest Catholic health system, I write in support of the American Academy of Family Physicians' proposal, *Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care*. We encourage the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to recommend the Secretary of Health and Human Services implement the APC-APM on a national level.

We support the APC-APM proposal because it is similar to a model Ascension has implemented with our clinically integrated network for our self-insured business and it has been successful at delivering value to our members by improving quality and service while holding down costs. Like the APC-APM proposal, Ascension has created a primary care professional capitation model with self-assignment for member attribution. Under this model, primary care physicians see the value in member lives under management because they see their incentives are aligned and are able to leverage services provided to improve the care of their patients, thus creating tighter relationships with the members. Specialists, in turn, change behaviors to work with the primary care physicians that have these lives. This promotes coordination of care as specialists see that when they provide value to the attributed lives they increase their referrals and share in financial value creation. Like the APC-APM, quality is an entry ticket and payments are adjusted based on quality performance indicators that are important to the members and enhance engagement.

We find much in the APC-APM model appealing. For instance, implementation of a multi-payer APC-APM on a nation level would support more primary care practices in practice transformation, which provides more coordinated care for patients, improves healthcare quality, and decreases health expenditures for all their patients—not just patients covered by certain payers. Likewise, the attribution method that puts patient choice first is novel and consistent with our use of self-assignment in attribution. We have found this voluntary attribution enhances engagement and continuity of care within a clinically integrated network. Lastly, the APC-APM begins to reduce the administrative burden that physicians face under current fee-for-service arrangements. This burden reduction, combined with more freedom to manage patient panels independent of traditional face-to-face visits, makes this model uniquely positioned to empower and support small, independent, primary care practices as they transition from volume to value and leverage community resources.



Thank you for your time and consideration. If you have any questions, please contact Mark Hayes, Senior Vice President for Federal Policy and Advocacy at 202.898.4683 or [mark.hayes@ascension.org](mailto:mark.hayes@ascension.org).

Sincerely,

A handwritten signature in blue ink that reads "Rev. Dennis H. Holtschneider" followed by a horizontal line.

Reverend Dennis H. Holtschneider, C.M.  
Executive Vice President and Chief Operations Officer  
Ascension

cc: Kent Moore (American Academy of Family Physicians)



AMERICAN OSTEOPATHIC ASSOCIATION

142 E. Ontario St., Chicago, IL 60611-2864 ph (312) 202-8000 | (800) 621-1773 | [www.osteopathic.org](http://www.osteopathic.org)

December 13, 2017

Jeffrey Bailet, MD  
Committee Chairperson  
Physician-Focused Payment Model Technical Advisory Committee  
Office of the Assistant Secretary for Planning and Evaluation  
U.S. Department of Health & Human Services  
Washington, DC 20201

Dear Dr. Bailet:

The American Osteopathic Association (AOA), on behalf of the nearly 130,000 osteopathic physicians and osteopathic medical students we represent, is pleased to support the American Academy of Family Physicians' (AAFP) proposal, *Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care*. We encourage the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to advance this model.

We are pleased that the Centers for Medicare and Medicaid Services (CMS) has provided incentives for Advanced Alternative Payment Models (AAPMs) as part of the implementation of the Medicare Access and CHIP Reauthorization Act (MACRA). However, due to the limited number of payment models CMS recognized as meeting the criteria set forth on AAPMs, few opportunities exist for physicians to participate in these models. In particular, the Comprehensive Primary Care Plus (CPC+) program is the only primary care AAPM. In order to accommodate demand, we strongly urge the PTAC and CMS to advance other models that meet the principles of the triple aim. We believe the AAFP proposal is a positive step in that direction. If such a model were recognized as an AAPM, we anticipate significant numbers of MACRA eligible clinicians would participate.

In addition, we have long supported increasing payments to primary care providers to better reflect the value they provide. In particular, primary care physicians provide care to patients of every age and gender, for multiple medical conditions, and at a variety of progressions of disease. This breadth requires a great scope of knowledge and experience, and the ability to consider the whole person rather than a single disease. As such, primary care providers spend significant non-patient-facing time to consider clinical information and plan interventions. Furthermore, primary care providers share relevant patient medical information with other clinicians to coordinate patient care. These resource-intensive activities are underaccounted and underpaid, despite their value in advancing high-quality care and favorable patient outcomes. We appreciate that the AAFP model includes risk-adjusted payments to account for this care.

As per the PTAC's title, physicians' roles in payment models should be a focus. Payment models should provide flexibility to participating physicians to provide care in ways that make the best sense

for their patients, staff, and workflows. The upfront per member per month (PMPM) payment of the AAFP model provides such an opportunity for physicians to manage a portion of their payments to advance patient care in innovative ways.

In conclusion, we are enthusiastic about the potential of models like that proposed by AAFP to provide additional pathways for primary care physicians to participate in AAPMs, receive payments that reflect the value they provide to patients and the healthcare system, and innovate care delivery that advances patient health.

Sincerely,

A handwritten signature in black ink, appearing to read "Mark A. Baker DO". The signature is fluid and cursive, with the initials "DO" clearly visible at the end.

Mark A. Baker, DO  
President

*The American Osteopathic Association (AOA) represents more than 130,000 osteopathic physicians (DOs) and osteopathic medical students; promotes public health; encourages scientific research; serves as the primary certifying body for DOs; is the accrediting agency for osteopathic medical schools; and has federal authority to accredit hospitals and other health care facilities.*



**NATIONAL  
NURSE PRACTITIONER  
ENTREPRENEUR  
NETWORK**

a New Paradigm

Sandra Berkowitz, RN, JD

Tel.: 215.498.6594  
Email: sandy@nnpn.org

December 19, 2017

Ladies and Gentlemen of the Physician-Focused Payment Model Technical Advisory Committee:

1. My name is Sandra Berkowitz and I am the CEO of NNPEN, a network of Nurse Practitioners (NPs) who aspire to be owners of, and employees within, nurse-led clinical practices. These NPs are included within MACRA's QPP definition of "eligible clinician" and CPC+'s definition of "practitioner".
2. My comments relate to AAFP's payment proposal specifically, but more generally to PTAC itself, in fact, to the Committee's very name, which currently reads.: The Physician-Focused [~~not Practitioner-Focused~~] Payment-Model-Technical-Advisory-Committee.
3. Almost as an afterthought, the PTAC F-A-Q addresses the discrepancy this way:

"PTAC welcomes the input of non-physician providers on all processes and invites the submission of payment models from all eligible professionals as defined by MACRA"

4. This answer, buried as it is half-way through the FAQ, does not execute MACRA's intent. As currently titled, PTAC in practice narrows the solicitation to PHYSICIAN respondents.
5. PTAC's narrowed solicitation of payment proposals eliminates responses from nearly 200,000 Nurse Practitioners, the 80% of the profession who can independently deliver primary care services in ways that boost access and convenience for their patients.
6. If 10% of the 200,000 NPs in primary care—roughly 20,000 NPs-- choose to own their own practices, they too need innovative payment models that sustain their operations year after year.
7. Closing off these NPs means closing off access to primary care services to the patient panels of those 20,000 NPs: roughly 30M or more underserved or even unserved consumers of care.
8. In Scripture, Jacob wrestles with an angel and at dawn receives a new name and sets out on a new path. Renaming—or even clarifying in big font —PTAC's title corrects an HHS error committed at Committee inception. Unaddressed, PTAC cleaves to the past rather than welcoming the new "eligible clinicians" and "practitioners" envisioned by MACRA .
9. Renaming PTAC is a procedural first step. With respect to substance change: NNPEN urges PTAC to require that proposals like AAFP's--which explicitly "builds on CPC+"--be read to insert the more broadly inclusive term "practitioner" where "physician" now appears—for example, in AAFP's attribution modeling.
10. On behalf of 30M consumers and 20,000 NP entrepreneurs, NNPEN thanks you for our opportunity to comment today.

Sandy Berkowitz, RN, JD  
CEO, NNPEN