

**The PTAC Preliminary Review Team’s Questions on
Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for
Delivering Patient-Centered, Longitudinal, and Coordinated Care
Submitted by the American Academy of Family Physicians (AAFP)**

Questions for the Submitter

- 1) Given the many similarities between the proposed model and CPC+, please provide a table showing which elements of the model are the same as CPC+ and which elements are different from CPC+. In particular, please include methods of risk adjustment and risk stratification.**

The APC-APM builds on the Comprehensive Primary Care (CPC) and CPC+ models, incorporates lessons learned where possible, and includes several design features that further move primary care physicians away from fee-for-service (FFS) payments. We believe many of our members are ready for this model, which is a logical extension of recent and existing Center for Medicare and Medicaid Innovation (CMMI) primary care efforts—and is similar to the evolution of Accountable Care Organization (ACO) programs at CMS.

Major differences between the two models include:

- ***The APC-APM moves the majority of payments for primary care services away from FFS.*** *The APC-APM’s population-based payment and primary care global payments are per member per month (PMPM), prospective, risk-adjusted payments for face-to-face evaluation and management (E/M) services, and non-face-to-face patient services. These two components of the APC-APM move participating physicians further from FFS than CPC+, in which even the CPC payments under track 2 are advances on FFS payments that the physician or practice will bill later.*
- ***The APC-APM would be more widely available than CPC+.*** *Broad testing and implementation of the APC-APM would ensure that primary care physicians committed to practice transformation and the delivery of comprehensive, coordinated, and longitudinal care could participate in an advanced Alternative Payment Model (APM). Currently, CPC+ is only operating in 13 states and five regions. We believe the limited availability of advanced APMs for primary care physicians slows the movement away from FFS to value-based care, and restricts beneficiary access to value-based care.*

APC-APM is designed with goals of MACRA in mind and is an evolution of the CPC models. *The Medicare Access and CHIP Reauthorization’s (MACRA’s) overarching goal is to move physician payments away from FFS to value. The APC-APM is designed to fulfill this goal more directly than CPC or CPC+ models because it moves payment for primary care services away from FFS. Moving primary care payment away from FFS, where they have been historically undervalued, is essential for creating a strong primary care foundation for health system transformation.*

A comparison of key design features of the two models is forthcoming.

- 2) The PRT wants to better understand how the model could be operationalized. Please provide two specific examples in two practice settings of varying sizes to demonstrate how this model could operate. Please include specific information on selecting Level 1 or Level 2 participation, patient attribution, payment flow, selection of quality measures, accountability of providers and the APM Entity, and application of health information technology within the model.**

We plan to address this question in a later iteration.

- 3) **What is the business case for a practice to participate in this model? What costs would a practice incur? Is the model more feasible or appropriate for certain kinds of physician practices (e.g. small and rural providers), particularly in comparison to CPC or CPC+?**

We plan to address this question in a later iteration.

- 4) **Who does AAFP anticipate would serve as the APM Entity?**

The AAFP anticipates that the physician's practice, as identified by its Tax Identification Number (TIN), would serve as the APM Entity.

- 5) **Page 7 of the proposal states, "APM entities should be able to elect one of two levels of prospective, primary care global payment...to move toward a more fully capitated payment arrangement at a reasonable pace for their particular practice." The PRT is interested in better understanding why the two levels are important and how these two levels were decided upon. Also, please indicate whether the two levels of payment would be risk adjusted in the same manner.**

The two levels are important for the following reasons:

- *First, not all primary care practices are in the same position with respect to accepting and managing a risk-adjusted, prospective, primary care global payment for direct patient care and the associated performance risk.*
- *Multiple levels allow participating practices to choose the one with which they are most comfortable as a starting place for moving away from FFS.*
- *The two levels also recognize that not all primary care practices provide the same scope of (E/M) services. For instance, some primary care practices provide only ambulatory, office-based E/M services, while others, especially those in rural parts of the country, do E/M services in multiple sites of service (e.g., office, hospital, nursing facility, etc.).*

The AAFP recommends two levels in an effort to keep the model relatively simple for both participating practices and participating payers. Level 1 (ambulatory, office-based face-to-face E/M services) represents the services most commonly provided in the typical primary care practice. It is the core of the direct patient care provided in most primary care practices. The AAFP decided that it would be a good starting place or common denominator for practices as they transition away from FFS. Given the desire to keep the model simple, the AAFP structured Level 2 to encompass all E/M services, regardless of site of service. We believe that E/M services, as a whole, represented a reasonable, understandable group of services for those practices that are in a position to manage the performance risk associated with a broader basket of primary care services.

Both levels would be risk adjusted in the same manner. Details on the risk adjustment are forthcoming.

- 6) **The proposal notes a need for longer time horizons to achieve savings in primary care payment reform. How much time might be needed to achieve savings? Please provide additional information on the process through which overall health care savings will be achieved, in the short term and the long term (i.e. 1-2 years, 2-5 years, 5+ years), particularly among the Medicare population.**

Based on literature, we know practice transformation can take 18-36 months. A limitation of many studies examining the impacts of practice transformation is that the duration of the

studies does not lend itself to a thorough evaluation. However, practice transformation models do show progress and early impacts that are promising, such as:

- CPC. The third-year evaluation report for the CPC program found that it reduced emergency department (ED) visits, as well as expenditures for skilled nursing facilities, outpatient services, and primary care clinician services. The program was also associated with a 1-percent decrease in total Medicare expenditures. While not all of these results were statistically significant, they demonstrate the potential impact on costs, even while medical home model implementation efforts are ongoing.
- CareFirst. A three-year evaluation of CareFirst's patient-centered medical home (PCMH) program found that by the third year, annual adjusted total claims payments were \$109 per participant or 2.8 percent lower than pre-intervention or relative to non-participants. A closer look at the spending reduction revealed that 42 percent was attributable to lower inpatient care, emergency care, and prescription drug spending. Lastly, the reduced spending was also greatest for enrollees with chronic conditions.

Experts agree that these payment reforms may need to be evaluated over longer time periods to realize greater savings than stakeholders have expected. This is underscored by Rhode Island's multi-year and multi-payer initiative to increase investment in primary care transformation. They have found that primary care transformation and the resulting return on investment (ROI) took several years. As with CPC, they found a trend toward lower rates of inpatient use in the first two years. Since then, they have shown more dramatic reductions for inpatient use of 7.2 percent. In addition, Blue Cross Blue Shield of Rhode Island conducted a 5-year study of practices that have undergone a PCMH transformation and found a 5-percent reduction in costs relative to other primary care practices. The Rhode Island experience underscores that primary care transformation and investments have positive impacts on health system costs—but that the ROI and other impacts may take several years to realize.

The Health Care Payment Learning and Action Network's (HCPLAN) paper, "Accelerating and Aligning Primary Care Payment Models," supports this position. The paper states:

Although it will take some time for primary care practices to adapt to [primary care payment models] PCPMs and begin to realize savings from improved clinical outcomes (see Recommendation 19 below), the Work Group does not anticipate that additional investments in primary care infrastructure will require purchasers to spend more on health care. Rather, the Work Group expects that payment mechanisms in PCPMs will unleash value in other parts of the health care system, and ultimately result in a return on investment.

Indeed, Recommendation 19 in the same paper states, "Although incremental progress should be made much more quickly, PCPMs can only be expected to deliver a return on investment over the long term. Therefore, payers should develop business models that do not require investments in PCPMs to be recouped from reductions in total cost of care in the short term." The HCPLAN paper proceeds to justify this recommendation in terms of the nature of primary care and the traditionally minor part of the total cost of care attributed to primary care.

- 7) **Page 12 of the proposal states, "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 provide additional detail on how the amount of the global payment (level 1 and level 2), population-based payment, and performance-based payments would be determined. Do you have estimates for the base payments or payment ranges for each? Would the amounts vary by geographic region or primary care specialty?

For anti-trust and other reasons, we do not believe it is appropriate for us to provide such estimates. The amount of these payments will need to be determined by the participating public and private payers in negotiation with the participating practices.

However, we can say a few things about the relative proportions of the four pieces of the payment methodology. First, the performance-based incentive payment is the piece at risk, and which otherwise allows the model to meet the risk criterion for being an advanced APM. Under current rules, models that qualify as advanced APMs must bear a certain amount of greater than nominal financial risk or qualify as a Medical Home Model expanded under CMMI. To meet the revenue-based standard for more than nominal financial risk, an average of at least 8 percent of revenues must be at-risk for participating APMs. Therefore, we would expect the performance-based incentive payment to be at least 8 percent of total revenues, which is otherwise represented by all four pieces of the payment methodology.

Second, we believe that the majority of what an advanced primary care practice does is represented by the primary care global payment and the population-based payment. Accordingly, these two pieces, taken together, should represent more than 50 percent of practice revenues, increasing to 75 percent after two years. This is similar to the Combination All-Payer and Medicare Payment threshold options in the APM track under MACRA. The percentage of revenue attributed to FFS will depend on the scope of services provided by the practice. Those that are anticipated to provide a broad range of services, including a significant volume still paid on a FFS basis, should expect the percent of revenue attributed to the primary care global payment and the population-based payment to be less than a practice whose services fall predominantly outside of FFS. How payments are divided between the primary care global payment and the population-based payment would be a matter of negotiation between the payers and the practices.

In essence, we advocate that participating payers take a top-down approach to setting payments. This approach starts with the desired level of investment in primary care as a percentage of total health care spending, and apportions that investment among the four pieces of the methodology in such a way that the resulting portion attributed to each piece supports both the model of health care delivery represented by advanced primary care and the desire to move away from volume to value.

We also advocate for not determining payments in a bottom-up fashion that simply converts current FFS payments and observed service volumes to some sort of equivalent capitation. As noted in our proposal, the current level of investment in primary care is inadequate to achieve the desired system results. Further, the current values assigned to primary care services, particularly E/M services, undervalue those services relative to other services. Using the current FFS payment methods to value payments under this or any other alternative payment model will only perpetuate existing problems with physician payment.

We acknowledge that some payers are already investing more than the average 6 percent of total spending in primary care, such that doubling their investment would not be appropriate. The point is to invest in participating practices under the APC-APM at a level where they can

provide what is expected of them, rather than simply rearranging current payments to fit a different cash-flow mechanism.

In general, the AAFP supports the elimination of all geographic adjustments to physician payments, except for those designed to achieve a specific public policy goal (e.g., to encourage physicians to practice in underserved areas). Additionally, the AAFP has historically opposed varying physician payments on the basis of physician specialty. Accordingly, as we envision, the amounts would not vary by geographic region or by primary care specialty.

8) The proposal indicates that the ultimate goal is to combine the primary care PMPM and the population-based PMPM into a single global payment. What is the rationale for the two separate PMPMs in this model?

The AAFP believes that separate PMPM payments for the primary care global payment and population-based payment will be a less radical departure from current payment models than combining both into one from the outset. Two separate PMPM payments in this model is such a methodology that mimics current payment models, and thereby facilitates transition to a model in which both are ultimately combined. Current payment models pay for face-to-face and non-face-to-face services separately. For instance, under the Medicare physician fee schedule (PFS), face-to-face services, such as office visits are paid separately from chronic care management codes. Likewise, under both original CPC and CPC+ models, payers pay a care management fee separate from the payments made for face-to-face services provided by the practice. A less radical departure, in turn, will provide practices and payers with an opportunity to become comfortable with both PMPM payments in preparation for their eventual combination. The AAFP is open to combining the PMPM payments in a future iteration of the model.

9) The proposal recommends using the Minnesota Complexity Assessment Method as a potential risk-adjustment method. The PRT is trying to better understand the details of this method and how it would be used in the model.

- a) Please describe the proposed risk-adjustment method including its components and how it would be calculated.
- b) How would the risk-adjustment be applied in the model? (e.g., continuous vs. categorical, how many categories, etc.)
- c) Would the risk-adjustment for the global primary care PMPM and the population-based PMPM be the same or different?
- d) If the data for the risk-adjustment are coming from the EHR, who collects this information to calculate the risk adjustment and the risk-adjusted payment? How would objectivity of ratings for the subjective components of the risk-adjustment be assured?
- e) Please also provide a description of how risk-adjustment could positively or negatively influence payments for the different specialties under the proposed payment.

We plan to address this question in a later iteration.

10) The proposal indicates that prospective patient self-attribution would be the primary method of attribution within the model. How does attribution work in practice including documentation, reporting, and tracking of attributed patients? Can anything override the patient self-attribution? What happens if a patient uses a different provider after self-identifying? It would be helpful to see hypothetical examples to understand how the attribution methodology would work under different scenarios.

Appendix A of our proposal (pages 27-34) includes a description of the proposed attribution methodology. All payers would use the same methodology. Under this methodology, sometime before the start of the performance period, a payer would analyze its patient membership in the following stepwise fashion:

1) Has the patient self-identified a responsible primary care physician? If so, the patient is attributed to the APM entity to which that physician belongs.

2) If not, from which primary care physician has the patient received a plurality (the most recent, in case of a tie) of his or her wellness visits within the past 24 months? The patient is attributed to the APM entity to which that physician belongs.

3) If the patient has not received a wellness visit within the past 24 months, from which primary care physician has the patient received a plurality (most recent, in case of a tie) of his or her other evaluation and management (E/M) visits within the past 24 months? The patient is attributed to the APM entity to which that physician belongs.

4) If the patient has not received an E/M visit within the past 24 months, from which primary care physician has the patient received a plurality (minimum of three and most recent, in case of a tie) of his or her prescriptions or other order events (e.g., durable medical equipment, labs, imaging, etc.) within the past 24 months? The patient is attributed to the APM entity to which that physician belongs.

If the patient cannot be attributed to an APM entity after the fourth step, the patient remains unattributed for the performance period.

The Health Care Payment Learning and Action Network (HCPLAN) released a white paper on patient attribution and its importance to value-based payment programs. They deemed patient self-attestation as the gold standard for attribution for population-based payments, which rely on primary care as the starting point to coordinate care across the continuum. The authors define patient self-attestation as patient self-reporting, declaration, or confirmation of primary care provider. In the event that patient self-attestation is not possible, the authors describe other methodologies for accurate attribution. Similarly, the APC-APM includes a four-step attribution process and accounts for patients that do not accurately self-attest.

Thus, the APC-APM approach to patient attribution is consistent with the recommendations of the HCPLAN white paper. Similar to the APC-APM method, the HCPLAN white paper states that patient attribution, relies on a patient's declared or revealed preferences regarding his or her primary care provider. Patient self-report represents a patient's declared choice; and use of claims or encounter data enables identification of a patient's revealed preferences regarding their primary care physician."

We also note that some private payers already use self-attestation in patient attribution. For example, Blue Cross Blue Shield of Massachusetts' Alternative Quality Contract (AQC) uses self-attestation to attribute patients to a participating provider by requiring patients in their health maintenance and point-of-service plans to designate a primary care provider.

Once a payer has attributed its patient membership, it shares the list of patients attributed to an APM entity with that entity for review and reconciliation. The list would identify each patient and the basis by which the patient was attributed to the entity. During this period of review and

reconciliation, the entity may request to add or remove patients from the formal list the payer supplies to them, with documentation to support their requests, as needed. At the end of the reconciliation process, the patient list would be set for the performance period, and the payer and practice would provide patients with transparent information about their attribution. During the performance period, an APM entity would track its attributed patients in a manner that is most efficient for the entity. Reporting would be done consistent with the requirements of the performance measurement process.

Since the AAFP recommends that performance-based incentive payments be paid on a quarterly basis, the attribution process, including review and reconciliation, should also occur quarterly. The AAFP recognizes that this may not be feasible for some payers. In this case, a longer performance period and less frequent attribution process may be necessary. Attribution, including review and reconciliation, should occur at a minimum of once a year. At the beginning of a performance period, APM entities should know which patients they are responsible for managing and the expected time period for management (i.e., the performance period).

In general, nothing can or should override patient self-attribution, which otherwise supports both patient choice and patient safety under the model. An exception would be patient behavior that is clearly contrary to the patient's self-attribution. For instance, if a patient moves out of the APM entity's service area or if the two-year look-back period demonstrates that the patient is receiving a majority of his or her services from providers outside the APM entity, the APM entity could successfully challenge the patient's nominal self-attribution to the APM entity. Instead, the patient would attribute to another APM entity where the patient actually resides or from which the patient actually receives his or her services. In such circumstances, the model would still honor patient self-attribution, albeit based on the patient's actions rather than his or her nominal choice of APM entity.

If a patient uses a different provider after self-identifying and changes his or her self-attribution in the process, then the risk-adjusted, capitated primary care global fee and population-based payment will cease flowing to the previous APM entity. Instead, it begins flowing to patient's new choice of APM entity. Likewise, responsibility for the cost and quality of services provided to that patient from that point forward shifts to the patient's new choice of APM entity.

If a patient uses a different provider after self-identifying and does not change his or her self-attribution in the process, then the APM entity which the patient self-identifies would retain the risk-adjusted, capitated primary care global fee and population-based payment associated with that patient. Likewise, the APM entity continues to be responsible for the cost and quality of services provided to that patient, including those of the other provider. However, the other provider will be paid by the patient's health plan, not the APM entity. Self-referral to providers outside the APM entity by patients attributed to that APM entity should reflect negatively on the APM entity's performance, with the consequence that it may lose its performance-based incentive payments and its ability to continue participating in the program. As noted above, there is an opportunity for an APM entity to challenge a patient's ongoing self-attribution to the APM entity if the patient consistently chooses to receive services from providers outside the APM entity.

We have will include examples of the attribution methodology at work in both of the hypothetical case studies provided in response to Question 2 in a later iteration..

- 11) The proposal indicates that APM Entities will be evaluated on 6 measures, one being an outcomes measure. The proposal also mentions an inpatient hospitalization measure and an emergency**

department utilization measure. A list of measures is provided in Appendix B, but it does not seem consistent with the description in the proposal and it has many more than 6 measures.

The measures for use in the APC-APM are the PCMH/ACO Core Measures developed by the multi-stakeholder Core Quality Measure Collaborative. There are more than six measures available in this measure set. However, the APC-APM requires physicians to choose only six measures that are most applicable to their practice. This is consistent with the quality category of the Merit-based Incentive Payment System (MIPS) where clinicians have the ability to choose six measures from a menu of measures.

- a) Please clarify which measures the APM Entities are held accountable for, which measures individual physicians are held accountable for, and which are intended for evaluation of the model.**

The six measures chosen by physicians for evaluation will be used to measure physicians at the individual level. The APM entity will be evaluated using two measures from the Healthcare Effectiveness Data and Information Set (HEDIS): inpatient hospitalization utilization and emergency department utilization per 1,000 attributed beneficiaries. The APC-APM model will be evaluated by measuring annual hospitalizations, emergency department visits, and specialist visits (consistent with CPC).

- b) In addition, which measures are tied directly to payment (e.g. result in payment adjustments)?**

The only measure tied to payment in the APC-APM individual physician measure set is National Quality Forum (NQF) #0052: Use of Imaging Studies for Low Back Pain. There are two other utilization measures (also in CPC+) that are included in our model—inpatient hospitalization utilization per 1,000 attributed beneficiaries and emergency department utilization per 1,000 attributed beneficiaries. Also, the APC-APM's incentive payment is tied to quality. Therefore, if physicians are not meeting quality standards, their payment will be affected.

- c) Is payment based on performance for all of the measures or is payment based upon reporting?**

In regards to quality reporting, payment will be based on performance of chosen measures, not just reporting of the measures.

- d) What are the performance benchmarks?**

Similar to MIPS, benchmarks for performance measures will be based on performance of measures two years prior.

- e) Would there be minimum numbers of patients required for a measure, and what would be done if a small practice did not have enough patients to meet the minimums?**

Similar to MIPS, a 20-patient case minimum will be needed in order for a measure to receive a score for performance. In the unlikely event that a practice is unable to meet the case minimum, they would be given partial credit for reporting.

- f) Would each APM Entity or practice be able to select different measures?**

An APM entity and practices can choose any six measures from the set of measures listed in the appendix.

g) Since the payments are no longer based on visits, how would the model assure patient access?

Although not measured directly, access will be evaluated indirectly through the APM entity level utilization measures. A physician's quality of care will be negatively affected if access is poor.

12) On pages 5-6, the proposal states the proposed model will encourage 1) use of data from multiple sources, 2) use of social determinants of health data, 3) identification of potential increases in disparities among vulnerable populations, 4) electronic reporting and more frequent reporting, 5) capturing and sharing of data from EHRs of all clinicians providing care for an attributed patient population, and 6) monitoring provider performance on quality and cost. Please provide more detailed information on specifically how the proposed model encourages these things, how the information would be collected, and what the expected benefit is to patients and providers?

The model encourages the (1) use of data from multiple sources and (5) capturing and sharing of data from EHRs of all clinicians providing care for an attributed patient population by requiring the adoption and use of certified EHR technology (CEHRT). The 2015 Edition CEHRT expands the interoperability capabilities of the EHRs, which will enable sharing and using of data from multiple sources. Additionally, the model embraces the use of performance-based incentive payments to hold physicians accountable for quality and cost performance. This provides an avenue to use clinical quality measures and cost measures that are interoperability sensitive. Finally, prospective payments provide physician practices with the needed revenue to invest in infrastructure to support interoperability.

The model encourages the (2) use of social determinants of health data and (3) identification of potential increases in disparities among vulnerable populations through the use of clinical quality measures that are sensitive to social determinants of health, just as the model is able to use interoperability sensitive measures. Additionally, the model includes risk-adjusted, population-based payments, which can be leveraged to encourage the capture and reporting of social determinants as part of the risk-stratification model. Finally, the requirement to use CEHRT ensures a practice is able to collect, record, and store data on social determinants of health in the EHR (granted, it is not the full set of social determinants, but it is a start).

The model encourages (4) electronic reporting and more frequent reporting and (6) monitoring provider performance on quality and cost by requiring the adoption and use of CEHRT. We expect that CEHRT will have the capability to provide not only external electronic measure reporting, but also internal reporting to the physician and staff. By aligning the incentives (i.e., performance-based incentive payments and risk-adjusted primary care global and population-based payments) to value quality and cost, the model incentivizes physicians and practices to better understand their level of quality and resource utilization. In turn, this creates a market for products and services geared toward the capture, reporting, and analysis of practice-based quality and cost data. For these reasons, we believe the APC-APM will drive more frequent reporting and drive more monitoring of provider performance on quality and cost.

The following are ways that the APC-APM could be supported to ensure these outcomes:

- *Published information about the APC-APM could include recommendations and best practices that participants would be encouraged to follow (within the bounds of what is feasible) given each APC-APM participant's unique circumstances, available resources, and available supporting health IT infrastructure.*
- *Resources and toolkits could be developed to achieve awareness building among APC-APM participants about each of the aforementioned topics and associated recommendations. Language within the resources and toolkits could expressly indicate that recommendations are intended to provide insights into the supporting infrastructure (reports, workflows, and processes) commonly required to achieve and demonstrate actual performance that meets or exceeds the associated benchmarks or expected thresholds across applicable measures. Resources and toolkits would clearly articulate the value proposition for APC-APM participants for choosing to adhere to items "recommended" or "encouraged." Such recommendations reduce administrative burden for clinicians, improve workflows, maximize efficiencies, contribute to better health outcomes for patients, and/or help contain the cost of care for patients. These beneficial outcomes could be clearly identified within published resources and toolkits.*

We believe that the incentives in the APC-APM will help physicians and practices value such resources and toolkits and establish a market for the development them.

- 13) The proposal indicates that providing customized reports on social determinants of health data to providers can serve as a means of checks and balances. Please provide more detailed information on the proposed system of checks and balances, and how specifically it could work in practice. In addition, which social determinants of health would be included?**

We plan to address this question in a later iteration.

- 14) The proposal mentions extracting data from the clinical record rather than from claims. How would this work? Would APM Entities be responsible for the extraction? What is the anticipated burden on practices and providers?**

We plan to address this question in a later iteration.

- 15) Why is self-attestation to the five key functions necessary and what can be achieved by self-attestation? Would auditing of practices to verify the attestations be required? Also, please provide examples of how patient and caregiver engagement would be better supported under the model than under FFS or CPC+.**

Self-attestation to the five key functions, which are the same as those currently present in CPC+, is necessary as part of the application process to ensure that participating practices understand what is expected of them and what is perceived to be necessary on their part in order to succeed under the payment model. Self-attestation achieves these ends without the necessity of requiring that practices certify their status as an advanced primary care practice with a third party.

We note that self-attestation is already a significant part of MIPS. For instance, physicians attest to improvement activities, and some of the elements of advancing care information rely on physician attestation. We see self-attestation as equally valid in the proposed payment model.

Auditing of practices to verify the attestations would not be required, per se. The AAFP contends that the veracity of the attestations can be verified through the performance measurement process. That is, the outcomes the practice achieves in terms of quality and cost will substantiate

whether or not the practice's attestations were accurate. The AAFP does not object to auditing a practice's performance.

- 16) How does the model prevent unintended consequences such as cherry picking, stinting of care, or referring patients to specialists for services that a primary care physician could perform? (The PRT's understanding of the core measure set is that there are few measures directed at areas where stinting might occur.)**

We plan to address this question in a later iteration.

- 17) AAFP, along with the American Board of Family Medicine, collaborate as the PRIME Support and Alignment Network under TCPI. What specifically is AAFP's role within TCPI? How many physicians is AAFP supporting, and what provider types are part of the Alignment Network? Would participation in the Network be required for participation in the proposed PFPM.**

The AAFP has three areas of focus in our Transforming Clinical Practice initiative (TCPI) work. It focuses on: (1) recruiting AAFP members to enroll with Practice Transformation Networks (PTNs) and participate in TCPI; (2) supporting a TCPI Member Interest Group (MIG), providing AAFP members a peer network related to this practice transformation and Quality Payment Program (QPP) preparation work; and (3) supporting TCPI through providing TCPI-related education through continuing medical education (CME) sessions at our annual conference, Family Medicine Experience (FMX).

As of the beginning of year two of TCPI, we have confirmed that there are 1,144 AAFP members enrolled in a PTN. During the TCPI project, to date there are 130 AAFP members who have participated in the TCPI Member Interest Group. The AAFP and American Board of Family Medicine (ABFM) support family physicians. However, the PRIME Registry, which is offered by the ABFM as a part of the Support and Alignment Network (SAN) is open to other providers.

Participation in the network would not be required for participation in the proposed physician-focused payment model.

- 18) The proposal indicates that the model would allow new HIT to be adopted more readily. Specifically, how does the model encourage adoption of newer HIT?**

We plan to address this question in a later iteration.

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(Last Revised and Updated: August 3, 2017)

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Major differences between the two models include:

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- **The APC-APM would be more widely available than CPC+.** *Broad testing and implementation of the APC-APM would ensure that primary care physicians committed to practice transformation and the delivery of comprehensive, coordinated, and longitudinal care could participate in an Advanced Alternative Payment Model (AAPM). Currently, CPC+ is only operating in 13 states and five regions. We believe the limited availability of AAPMs for primary care physicians slows the movement away from FFS to value-based care, and restricts beneficiary access to value-based care.*

A major similarity between APC-APM and CPC+ is that both models better facilitate team-based care than the traditional FFS model. Since each model, but especially APC-APM, offers a payment methodology that does not depend on discrete services provided by individual health professionals, each model encourages health professionals to work together as multidisciplinary, integrated teams with the goal of providing the most effective, efficient, and accessible evidence-based care in the best interest of patients.

Advanced primary care represents an example of an integrated practice arrangement in which a licensed primary care physician works with other health care personnel to manage the care of an individual patient and a population of patients using a multidisciplinary, collaborative approach to health care. The APC-APM payment methodology, which includes global primary care payments and

population-based payments, supports this interdependent, team-based approach to comprehensive care delivery. The payment methodology, with its de-emphasis on FFS, also supports enhanced communication and processes that empower non-physician staff to effectively use the skills, training, and abilities of each team member to the full extent of their professional capacity.

APC-APM is designed with goals of MACRA in mind, and is an evolution of the CPC models. The Medicare Access and CHIP Reauthorization's (MACRA's) overarching goal is to move physician payments away from FFS to value-based models. The APC-APM is designed to fulfill this goal more directly than CPC or CPC+ models because it moves payment for primary care services away from FFS. Moving primary care payment away from FFS, where they have been historically undervalued, is essential for creating a strong primary care foundation for health system transformation.

A comparison of key design features of the two models is attached.

- 2) **(Answer New)** The PRT wants to better understand how the model could be operationalized. Please provide two specific examples in two practice settings of varying sizes to demonstrate how this model could operate. Please include specific information on selecting Level 1 or Level 2 participation, patient attribution, payment flow, selection of quality measures, accountability of providers and the APM Entity, and application of health information technology within the model.

(NOTE: The APC-APM is intended to be multi-payer. However, to simplify this example, we will focus just on the Medicare aspects.)

Level 1 Participation Example (Suburban Group Practice)

Practice Profile

Tomahawk Creek Family Medicine (TCFM), is a family medicine group practice in Wichita, Kansas. A health system in Wichita owns the practice. The practice employs the following on a full-time equivalent basis:

- Six family physicians
- Two nurse practitioners
- One physician assistant
- Two registered nurse (RN) care managers
- Nine medical assistants
- Six non-clinical staff, including:
 - o One office manager
 - o Two front desk/receptionists
 - o Three coding and billing staff

Tomahawk Creek Family Medicine is part of a commercial accountable care organization (ACO) run by its health system. Wichita is not in an area where either CPC or CPC+ is available. TCFM participates in traditional Medicare and at least one Medicare Advantage plan. TCFM also participates in Medicaid and plans offered by Blue Cross Blue Shield of Kansas. Most of the practice revenue comes from fee-for-service billing, but TCFM also receives some shared savings through the ACO. TCFM has successfully reported for Physician Quality Reporting System (PQRS) through its certified electronic health record technology (CEHRT), and it has met Meaningful Use requirements. TCFM has avoided any penalty under Medicare's Value-based Modifier.

- **Qualifying Physician:** TCFM's services are all office-based and include acute, chronic, and preventive care, office procedures (e.g., laceration repair, joint injections), vaccinations, and some waived laboratory testing. TCFM physicians do not see patients at the hospital since the health system employs hospitalists for this purpose. TCFM physicians also do not visit patients at nursing facilities or at home. TCFM does provide pre-natal maternity care and post-natal care of mother and child in the office, but delivery services and related inpatient care are handled by another group owned by the health system.
- **Core Primary Care Functions:** TCFM physicians and clinical staff provide care management and care coordination for their patients. For instance, they use their CEHRT to send patient reminders of appropriate preventive services and track and monitor the care given to chronically ill patients, and the practice coordinates care for patients with other specialists in and out of the health system. Medicare patients, particularly those with multiple chronic conditions, have individualized care management plans that are maintained and updated in the CEHRT, and TCFM physicians and clinical staff handle phone calls and other non-face-to-face interactions with patients between visits. The RN care managers are employed full-time to provide care management services for those patients in the highest risk categories based on the risk stratification system used in the practice.
- **Patient Population:** TCFM has a panel size of 12,000. Of those, 30 percent (3,600) are enrolled in Medicare (either traditional or Medicare Advantage), 40 percent have private health insurance, 20 percent have Medicaid, and the remaining 10 percent either have no insurance or some other coverage. One-third (4,000) of TCFM's patients are overweight or obese. Two-thirds (2,400) of TCFM's Medicare patients have two or more chronic conditions. The most common chronic conditions in the practice are diabetes, hypertension, heart disease, arthritis, and chronic obstructive pulmonary disease (COPD). Of the 2,400 Medicare patients eligible for chronic care management (CCM), only 30 percent (720) have agreed to receive it, and among that 30 percent, TCFM bills Medicare for about half of those (360) each month.
- **Stratification:** TCFM risk stratifies their patients as part of their care management. They use the Minnesota Complexity Assessment Method (MCAM) tool for this purpose. Typically, the MCAM tool is used at the first encounter with every new patient while obtaining the patient's past medical, social, and family history. TCFM physicians and staff may also use the MCAM tool when a physician begins to note that a patient is taking up a lot of resources or needs additional resources to achieve health goals (e.g., needs social work services, ride assistance, meals, etc.). TCFM risk stratifies all their patients at least annually. TCFM would like to reach out to all patients that are identified to be in the highest risk tiers, but only has enough clinical staff to address the needs of the very highest tiered patients.
- **CEHRT:** TCFM has CEHRT. Patients may access a member of the care team 24/7 via phone, and care team members have 24/7 access to the patient's medical record via CEHRT.

Assessing APC-APM Participation

Tomahawk Creek Family Medicine is given the opportunity to participate in the APC-APM. The practice notes that the APC-APM offers four revenue streams for the attributed patients of participating payers. To assess the impact of participation on revenue and care delivery, the practice compares current Medicare FFS revenue with projected payments under the APC-APM.

Level of Participation:

The first revenue stream, a “primary care global payment,” is a prospective, risk-adjusted per patient per month payment to cover E/M services. The APC-APM offers two options in this regard. One option (Level 1) only covers ambulatory E/M services (e.g., office visits, preventive medicine visits, Welcome to Medicare visits). The other option (Level 2) covers all E/M services regardless of site of service. Medicare indicates that it will risk adjust the primary care global payment based on Hierarchical Condition Category (HCC) scores and social determinants of health. Based on its risk adjustment methodology, Medicare will place attributed patients into five tiers, with payment amounts varying by tier. Since this revenue stream is prospective and capitated, it does not require the practice to continue submitting claims for such services. That will reduce administrative burden and save the practice time and money, especially if it can reduce the number of coding and billing staff as a result.

- **Financial Modeling:**

Since TCFM only provides E/M services in the office setting, the practice anticipates choosing Level 1 for the primary care global payment. The office manager runs a report from the practice management/billing system. It shows the revenue (Medicare payments plus any associated patient cost sharing in the form of deductibles and coinsurance) generated from office-based E/M visits to Medicare patients in 2016. The office manager then calculates the corresponding revenue expected to be generated under Level 1. For ease of calculations, the office manager assumes all of the Medicare patients in TCFM’s panel are all attributed to the practice and spread across the five tiers used in Medicare’s methodology in a normal, bell-shaped distribution. He multiplies the assumed number of patients in each tier by the corresponding payment level and 12 (number of months in the year) to estimate annual revenue, which he compares to current revenue.

The second revenue stream, “population-based payment,” is a prospective, risk-adjusted, per patient per month payment for non-face-to-face patient services, such as phone calls with patients, calls to the local pharmacy, and virtual interactions with other specialists. Unlike for CCM, the practice will not need to file claims to receive this payment, which represents a cost savings to the practice. Further, the practice will receive some level of population-based payment for all of its attributed Medicare patients, rather than CCM payments for only a subset of their Medicare patients. Medicare indicates that it will risk adjust the population-based payment based on HCC scores and social determinants of health. Based on its risk adjustment methodology, Medicare will place attributed patients into five tiers, with payment amounts varying by tier. Medicare indicates that it plans to use the same tiers and payment amounts used under CPC+ Track 2.

The office manager runs another report from the practice management/billing system. This report shows the revenue (Medicare payments plus any associated patient cost sharing in the form of deductibles and coinsurance) generated from CCM codes billed to Medicare in 2016. He then calculates the corresponding revenue expected to be generated under the population-based payment. For ease of calculations, the office manager assumes all of the Medicare patients in TCFM’s panel are attributed to the practice and spread across the five tiers used in Medicare’s methodology in a normal, bell-shaped distribution. He multiplies the assumed number of patients in each tier by the corresponding payment level and 12 (number of months in the year) to estimate annual revenue. The calculated revenue projection exceeds actual revenue generated in 2016 for chronic care management to Medicare patients.

Under the third revenue stream, Medicare will continue to pay for direct patient care not included in the primary care global payment using FFS under the Medicare physician fee schedule (PFS). TCFM understands that this means Medicare will pay them basically the same amount in the same way it always has when they suture a laceration, inject a joint, or provides other non-office-based E/M services to their attributed Medicare patients. They will also receive FFS for any non-attributed Medicare patients they treat. This aspect of APC-APM does not represent a change to the practice or its revenue stream.

The last revenue stream, “performance-based incentive payment,” offers a prospective payment on a quarterly basis for quality care delivered cost-effectively. TCFM understands that Medicare may recover all or part of these payments if their actual performance does not meet benchmarks set by Medicare. TCFM currently receives no additional payment from Medicare under the Value-based Modifier or quality reporting under PQRS, so the performance-based incentive payment offered under APC-APM potentially represents new revenue to this practice. TCFM successfully reported under PQRS and thus avoided any negative payment adjustment associated with PQRS. TCFM also avoided any negative payment adjustment under the Value-based Modifier. This early experience, coupled with the APC-APM payment structure will allow TCFM to expand its practice capabilities and identify and manage high-risk or at-risk patients more effectively. Thus, TCFM believes they can retain Performance-based Incentive Payments (PBIPs) under the APC-APM.

Looking at all the revenue projections together in comparison to 2016 revenue generated by Medicare patients, TCFM determines that the APC-APM offers an increase in Medicare revenue, which will allow them to expand their practice and care management capabilities to impact patient outcomes and downstream service utilization (e.g., emergency department visits, avoidable hospitalizations, etc.). Further, as noted, TCFM will no longer have to file claims for E/M services provided in the office to attributed Medicare patients, which represents a time and cost savings to the practice. TCFM decides to enroll in APC-APM for 2018.

Participation and Reporting in APC-APM

Patient Attribution: *As part of the enrollment process, TCFM attests that the practice meets the five key primary care functions expected of participating practices, and Medicare informs TCFM how Medicare beneficiaries may select the practice for purposes of attribution under APC-APM and the deadline for patients to do so to be attributed to the practice effective January 1, 2018. TCFM communicates this information to its current Medicare patients.*

At the same time, Medicare analyzes beneficiary claims over the past 24 months to identify beneficiaries who received a plurality of their Welcome to Medicare and Medicare Annual Wellness Visits (AWV) from any of the physicians in the practice. These beneficiaries are attributed to TCFM. For those beneficiaries that did not have a Welcome to Medicare or Medicare AWV during that period, Medicare further analyzes the claims to identify beneficiaries who received a plurality of all other E/M visits from TCFM. Those beneficiaries are also attributed to TCFM. Finally, for those beneficiaries that did not have any E/M services (including a Welcome to Medicare visit or AWV) during the 24-month look-back period, Medicare analyzes its claims for Part D, durable medical equipment, clinical lab, and other services requiring a physician’s prescription/referral/order. In doing so, Medicare identifies any beneficiary with at least three such events who had a plurality of events for which a TCFM physician was the prescribing/referring/ordering physician. Those beneficiaries are attributed to TCFM.

After the initial deadline for patient choice of practice, Medicare sends to TCFM for its review a list of all Medicare beneficiaries attributed to the practice based on patient choice or its claims analysis. The list includes the name (and any other information necessary to identify) each patient, the basis on which the patient was attributed to the TCFM, and the risk score for each attributed beneficiary. During this period of review, TCFM may request to add or remove patients from the list, with documentation to support their requests as needed. TCFM notes two patients on the list who have recently moved to Florida. TCFM asks that these patients be removed from the list and provides documentation of their moves. At the end of the review process, Medicare agrees to remove the two beneficiaries in question, and the patient list is set for the performance period, which is the first quarter of 2018. Medicare and TCFM both notify the patients on the list about their attribution, and TCFM staff notes in the CEHRT which patients are attributed under APC-APM.

TCFM understands that, because the performance-based incentive payments are paid on a quarterly basis, the attribution process, including review, will also occur quarterly. This ensures that TCFM will know at the beginning of a performance period for which patients the practice is responsible.

Quality Measures: *Before the first performance period begins, TCFM decides on which quality measures it will report. TCFM understands that it must report on six measures, one of which is an outcome measure. TCFM reviews the list of measures on the Core Quality Measures Collaborative's Patient-centered Medical Home (PCMH)/ACO/Primary Care Core Measure Set, which is the designated list of measures from which it can choose for APC-APM. Recognizing that they need at least 20 observations for each measure, TCFM compares this list with the most common conditions seen in the practice. As noted above, those include diabetes, hypertension, heart disease, arthritis, and chronic obstructive pulmonary disease. With these conditions and the percentage of patients who are overweight or obese in mind, TCFM decides to report on the following quality measures for the first performance period:*

- *Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)*
- *Diabetes: Eye Exam*
- *Diabetes: Medical Attention for Nephropathy*
- *Diabetes: Foot Exam*
- *Controlling High Blood Pressure*
- *Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan*

Both "Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)" and "Controlling High Blood Pressure" are intermediate outcomes measures. TCFM physicians and clinical staff will track these measures and the practice's performance using the CEHRT.

Payment: *On the first business day of each month, beginning in January 2018, TCFM receives by electronic funds transfer from their Medicare administrative contractor the primary care global payment and population-based payment for patients attributed under APC-APM. The corresponding electronic remittance advice details which patients are included in the payment and how much the global primary care payment and population-based payment is for each patient. TCFM staff reconciles this remittance advice against the final attribution list received from Medicare.*

On the first business day of the performance period (i.e., first day of the first month of the quarter in this example), TCFM also receives by electronic funds transfer the performance-based incentive

payment for the performance period. The corresponding electronic remittance advice details how the incentive payment was calculated. TCFM staff reconciles this remittance advice against the related information received from Medicare in advance of the performance period.

As TCFM's physicians, nurse practitioners, and physician assistant provide services outside the primary care global payment to attributed patients or any service to a non-attributed patient (e.g., Mrs. Jones, who just became eligible for Medicare in January), TCFM files claims for those services with Medicare, just as they always have. Medicare pays those claims per its normal coverage and payment rules. The normal business process applies to these services.

Performance: When the performance period (i.e., quarter, in this example) is over, TCFM reports its data on the six quality measures they selected to Medicare using the CEHRT, just as they have with PQRS in the past. Medicare compares TCFM's performance on each of the quality measures selected plus two utilization measures (inpatient hospitalization utilization per 1,000 attributed beneficiaries and emergency department utilization per 1,000 attributed beneficiaries) with corresponding benchmarks for those measures. Medicare sends TCFM a quality and resource use report that describes its performance relative to the benchmark for each measure. TCFM's first report shows that they successfully met or exceeded the benchmark in each case, so they may keep the performance-based incentive payment that they received in January. Had TCFM failed to meet one or more of the benchmarks, the report would have indicated how much of the performance-based incentive payment they must refund to Medicare (or that Medicare would otherwise recover). In this way, TCFM is held accountable for the quality and cost of care provided to attributed beneficiaries.

If Medicare determines that the APC-APM is an AAPM, TCFM may also be eligible for the 5 percent bonus payable to qualified APM participants.

Level 2 Participation Example (Small/Rural Practice)

Practice Profile

Jane Smith, MD, is a solo family physician in rural, western Kansas who owns her own practice, a professional corporation to which she assigns her payments as an individual physician. She employs an LPN, a medical assistant, and a front office staff person who welcomes patients, schedules appointments, and does other clerical/administrative tasks. Dr. Smith employs her husband (Mr. Smith) as her office manager and biller.

Dr. Smith has not been invited to be part of an ACO, and she is not in an area where either CPC or CPC+ is available. She participates in traditional Medicare, but no Medicare Advantage plans. She also participates in Medicaid and plans offered by the area Blue Cross Blue Shield affiliate. All her revenue comes from fee-for-service billing. She has successfully reported to PQRS through her CEHRT, and she has met Meaningful Use requirements. She has avoided any penalty under Medicare's Value-based Modifier .

- **Qualifying Physician:** Dr. Smith practices full-scope family medicine. In her office, she provides acute, chronic, and preventive care, including office procedures (e.g., laceration repair, joint injections), vaccinations, and some waived laboratory testing. In addition, she rounds on patients at the local hospital, visits patients at the nursing facility in town, makes an occasional home visit, and helps manage transitions of care across settings. She still provides maternity care.

- **Core Primary Care Functions:** *Dr. Smith and her clinical staff provide care management and care coordination for their patients as their schedules allows. For instance, they use their CEHRT to send patients reminders of appropriate preventive services. Medicare patients, particularly those with multiple chronic conditions, have individualized care management plans that are maintained and updated in the CEHRT, and Dr. Smith and her clinical staff handle some phone calls and other non-face-to-face interactions with patients between visits. The practice would like to have more room in the schedule for care management, but the fee-for-service payment methodology encourages them to bring everyone in for an office visit, even when the patient's situation might be handled virtually or telephonically. Dr. Smith's office coordinates care for patients with other specialists in Wichita.*
- **Patient Population:** *Dr. Smith has a panel size of 2,000. Of those, 30 percent (600) are enrolled in Medicare, 40 percent have private health insurance, 20 percent have Medicaid, and the remaining 10 percent either have no insurance or some other coverage. One-third (667) of Dr. Smith's patients are overweight or obese. Two-thirds (400) of Dr. Smith's Medicare patients have two or more chronic conditions. The most common chronic conditions in her practice are diabetes, hypertension, heart disease, arthritis, and chronic obstructive pulmonary disease. Of the 400 Medicare patients eligible for CCM, only 30 percent (120) have agreed to receive it, and among that 30 percent, Dr. Smith is only able to bill Medicare for about half (60) each month, because she and her clinical staff do not have the capacity to do more, given everything else that they must do for their patients.*
- **Stratification:** *Dr. Smith and her clinical staff also risk stratify their patients as part of their care management. They use the MCAM tool for this purpose. Typically, the MCAM tool is used at the first encounter with every new patient while obtaining the patient's past medical, social, and family history. Dr. Smith and her staff may also use the MCAM tool when Dr. Smith begins to note that a patient is taking up a lot of resources or needs additional resources to achieve health goals (e.g., needs social work services, ride assistance, meals). Dr. Smith and her staff try to risk stratify all their patients at least annually, which allows them to assess the needs of their patient population, make decisions about allocation of resources based on patient needs, and support longitudinal care management. They would like to use the tool with more frequency and track patient outcomes if time and resources permitted.*
- **CEHRT:** *Dr. Smith has CEHRT. She provides her patients with her mobile/home phone number for 24/7 access outside of office hours. She and her clinical staff have 24/7 access to the patient's medical record via CEHRT.*

Assessing APC-APM Participation

Dr. Smith is given the opportunity to participate in the APC-APM. She notes that the APC-APM offers four revenue streams to her practice for the attributed patients of participating payers. To assess the impact of participation on her practice revenue and care delivery, the practice compares current Medicare FFS revenue with projected payments under the APC-APM.

Level of Participation:

The first revenue stream, a "primary care global payment," is a prospective, risk-adjusted per patient per month payment to cover E/M services. The APC-APM offers two options in this regard. One option (Level 1) only covers ambulatory E/M services (e.g., office visits, preventive medicine visits, "Welcome to Medicare" visits). The other option (Level 2) covers all E/M services that Dr. Smith provides, including hospital, nursing facility, and home visits. Medicare indicates that it will risk adjust the primary care global payment based on HCC scores and social determinants of health.

Based on its risk adjustment methodology, Medicare will place attributed patients into five tiers, with payment amounts varying by tier. Since this revenue stream is prospective and capitated, it does not require her to continue submitting claims for such services. That will reduce administrative burden and save her practice time and money.

- **Financial Modeling:**

Since Dr. Smith provides E/M services in multiple settings (office, hospital, nursing facility, and patients' homes), the practice anticipates choosing Level 2 for the primary care global payment. In his role as office manager, Mr. Smith runs a report from the practice management/billing system. It shows the revenue (Medicare payments plus any associated patient cost sharing in the form of deductibles and coinsurance) generated from all E/M visits (including those in the hospital, nursing facility, and patients' homes) to Medicare patients in 2016. Mr. Smith then calculates the corresponding revenue expected to be generated under Level 2. For ease of calculations, he assumes the 600 Medicare patients in Dr. Smith's panel are all attributed to the practice and spread across the five tiers used in Medicare's methodology in a normal, bell-shaped distribution. He multiplies the assumed number of patients in each tier by the corresponding payment level and 12 (number of months in the year) to estimate annual revenue, which he compares to current revenue.

The second revenue stream, "population-based payment," is a prospective, risk-adjusted, per patient per month payment for non-face-to-face patient services, such as phone calls with patients, calls to the local pharmacy, and virtual interactions with other specialists in Wichita. Medicare indicates that it will risk adjust the population-based payment based on HCC scores and social determinants of health. Based on its risk-adjustment methodology, Medicare will place attributed patients into five tiers, with payment amounts varying by tier. Medicare indicates that it plans to use the same tiers and payment amounts used under CPC+ Track 2.

Mr. Smith runs another report from the practice management/billing system. This report shows the revenue (Medicare payments plus any associated patient cost-sharing in the form of deductibles and coinsurance) generated from CCM codes billed to Medicare in 2016. Mr. Smith then calculates the corresponding revenue expected to be generated under the population-based payment. For ease of calculations, he assumes the 600 Medicare patients in Dr. Smith's panel are all attributed to the practice and spread across the five tiers used in Medicare's methodology in a normal, bell-shaped distribution. He multiplies the assumed number of patients in each tier by the corresponding payment level and 12 (number of months in the year) to estimate annual revenue. The calculated revenue projection exceeds actual revenue generated in 2016 for CCM to Medicare patients.

Under the third revenue stream, Medicare will continue to pay for direct patient care not included in the primary care global payment using FFS under the Medicare PFS. Dr. Smith understands that this means Medicare will pay her basically the same amount in the same way it always has when she sutures a laceration, sets a broken bone, or provides other non-E/M services to her attributed Medicare patients. She will also receive FFS payment for any non-attributed Medicare patients she treats. This aspect of APC-APM does not represent a change to her practice or its revenue stream.

The last revenue stream, "performance-based incentive payment," offers a prospective payment on a quarterly basis for quality care delivered cost effectively. Dr. Smith understands that Medicare may recover all or part of these payments if her actual performance does not meet benchmarks set by Medicare. Dr. Smith currently receives no additional payment from Medicare under the Value-based Modifier or her quality reporting under PQRS, so the performance-based incentive payment offered

under APC-APM potentially represents new revenue to her practice. Dr. Smith successfully reported under PQRS and thus avoided any negative payment adjustment associated with PQRS. She also avoided any negative payment adjustment under the Value-based Modifier. This early experience, coupled with the APC-APM payment structure, will allow Dr. Smith to expand her practice capabilities and identify, and manage high-risk or at-risk patients more effectively. As a result, Dr. Smith believes she can retain PBIPs under the APC-APM.

Looking at all the revenue projections together compared to 2016 revenue generated by Medicare patients, Dr. Smith determines that the APC-APM offers an increase in Medicare revenue, which will allow her to expand her practice and care management capabilities to impact patient outcomes and downstream service utilization (e.g., ED visits, avoidable hospitalizations, etc.). The practice will no longer have to file claims for any E/M services that Dr. Smith provides to her attributed Medicare patients, which represents a time and cost savings to the practice. Dr. Smith decides to enroll in APC-APM for 2018.

Participation and Reporting in APC-APM

Patient Attribution: *As part of the enrollment process, Dr. Smith attests that her practice meets the five key primary care functions expected of participating practices. Medicare informs Dr. Smith how Medicare beneficiaries may select her practice for purposes of attribution under APC-APM and the deadline for patients to do so to be attributed to the practice effective January 1, 2018. Dr. Smith communicates this information to her current Medicare patients.*

At the same time, Medicare analyzes beneficiary claims over the past 24 months to identify beneficiaries who received a plurality of their Welcome to Medicare and Medicare AWW from Dr. Smith. These beneficiaries are attributed to Dr. Smith's practice. For those beneficiaries that did not have a Welcome to Medicare or Medicare AWW during that period, Medicare further analyzes the claims to identify beneficiaries who received a plurality of all other E/M visits from Dr. Smith. Those beneficiaries are also attributed to Dr. Smith. Finally, for those beneficiaries that did not have any E/M services (including a Welcome to Medicare visit or Medicare AWW) during the 24-month look-back period, Medicare analyzes its claims for Part D, durable medical equipment, clinical lab, and other services requiring a physician's prescription/referral/order. In doing so, Medicare identifies any beneficiary with at least three such events who had a plurality of events for which Dr. Smith was the prescribing/referring/ordering physician. Those beneficiaries are attributed to Dr. Smith's practice.

After the initial deadline for patient choice of practice, Medicare sends to Dr. Smith for her review a list of all Medicare beneficiaries attributed to her practice based on patient choice or its claims analysis. The list includes the name of (and any other information necessary to identify) each patient, the basis on which the patient was attributed to the entity, and the HCC risk score for each attributed beneficiary. During this period of review, Dr. Smith may request to add or remove patients from the list, with documentation to support her requests, as needed. Dr. Smith notes two patients on the list who have recently moved to Florida. She asks that they be removed from the list and provides documentation of their moves. At the end of the review process, Medicare agrees to remove the two beneficiaries in question, and the patient list is set for the performance period, which is the first quarter of 2018. Medicare and Dr. Smith both notify the patients on the list about their attribution, and Dr. Smith's staff notes in the CEHRT which patients are attributed under APC-APM.

Dr. Smith understands that because the performance-based incentive payments are paid on a quarterly basis, the attribution process, including review, will also occur quarterly. This ensures that she will know at the beginning of a performance period for which patients her practice is responsible.

Quality Measures: *Before the first performance period begins, Dr. Smith decides which quality measures she will report. She understands that she must report on six measures, one of which is an outcome measure. Dr. Smith reviews the list of measures on the Core Quality Measures Collaborative's PCMH/ACO/Primary Care Core Measure Set, which is the designated list of measures from which she can choose for APC-APM. Recognizing that she needs at least 20 observations for each measure, Dr. Smith compares this list with the most common conditions seen in her practice. Those include diabetes, hypertension, heart disease, arthritis, and chronic obstructive pulmonary disease. With these conditions and the percentage of her patients who are overweight or obese in mind, Dr. Smith decides to report on the following quality measures for the first performance period:*

- *Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)*
- *Diabetes: Eye Exam*
- *Diabetes: Medical Attention for Nephropathy*
- *Diabetes: Foot Exam*
- *Controlling High Blood Pressure*
- *Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan*

Both "Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)" and "Controlling High Blood Pressure" are intermediate outcomes measures. Dr. Smith and her clinical staff will track these measures and the practice's performance using the CEHRT.

Payment: *On the first business day of each month, beginning in January 2018, Dr. Smith's practice receives by electronic funds transfer from their Medicare administrative contractor the primary care global payment and population-based payment for patients attributed under APC-APM. The corresponding electronic remittance advice details which patients are included in the payment and how much the global primary care payment and population-based payment is for each patient. Mr. Smith, in his role as office manager, reconciles this remittance advice against the final attribution list received from Medicare.*

On the first business day of the performance period (i.e., first day of the first month of the quarter in this example), Dr. Smith's practice also receives by electronic funds transfer the performance-based incentive payment for the performance period. The corresponding electronic remittance advice details how the incentive payment was calculated. Mr. Smith reconciles this remittance advice against the related information he received from Medicare in advance of the performance period.

As Dr. Smith provides non-E/M services to her attributed patients or any service to a non-attributed patient (e.g., Mrs. Jones, who just became eligible for Medicare in January), Mr. Smith files claims for those services with Medicare, just as he always has. Medicare pays those claims per its normal coverage and payment rules. The normal business process applies to these services.

Performance: *When the performance period (i.e., quarterly, in this example) is over, Dr. Smith's practice reports its data on the six quality measures she selected to Medicare using the CEHRT, just as they have with PQRS in the past. Medicare compares Dr. Smith's performance on each of the quality measures she selected, plus two utilization measures (inpatient hospitalization utilization per*

1,000 attributed beneficiaries and emergency department utilization per 1,000 attributed beneficiaries) with corresponding benchmarks for those measures. Medicare sends Dr. Smith a quality and resource use report that describes her performance relative to the benchmark for each measure. Dr. Smith's first report shows that she successfully met or exceeded the benchmark in each case, so she may keep the performance-based incentive payment that she received in January. Had Dr. Smith failed to meet one or more of the benchmarks, the report would have indicated how much of the performance-based incentive payment she must refund to Medicare (or that Medicare would otherwise recover). In this way, both Dr. Smith and her practice are held accountable for the quality and cost of care provided to attributed beneficiaries.

If Medicare determines that the APC-APM is an AAPM, Dr. Smith may also be eligible for the 5 percent bonus payable to qualified APM participants.

- 3) **(Answer New)** What is the business case for a practice to participate in this model? What costs would a practice incur? Is the model more feasible or appropriate for certain kinds of physician practices (e.g. small and rural providers), particularly in comparison to CPC or CPC+?

Level 1 Participation Example (Suburban Group Practice)

Current Revenue

In a typical year, TCFM provides 35,424 office visits. Those visits generate approximately \$3,251,000 in revenue to the practice, of which \$975,000 comes from Medicare.

Additionally, TCFM can bill Medicare for CCM for about 360 patients per month. That produces an additional \$176,000 in revenue for the practice.

Tomahawk Creek Family Medicine provides a variety of non-E/M services (e.g., skin procedures, joint injections, etc.) that generate about \$1,147,000 in revenue, of which about \$344,000 comes from Medicare.

Thus, TCFM has a current total revenue for all services across all payers of approximately \$4,574,000. Of that, about \$1,495,000 comes from Medicare.

Current Expenses

Against these revenues, TCFM has the following expenses:

Clinical staff salaries:	\$648,000
Non-clinical staff salaries:	\$229,000
Fringe benefits and payroll taxes attributed to staff salaries:	\$193,000
CEHRT:	\$ 72,000
IT (other than CEHRT):	\$ 94,000
Ancillary Services:	\$140,000
Medical Supplies:	\$276,000
Building & Occupancy:	\$253,000
Other General Operating	\$183,000
Malpractice premiums:	\$549,000

Total:

\$2,637,000

This leaves TCFM with approximately \$1,937,000 per year to cover physician salaries and associated fringe benefits and payroll taxes.

Revenue from APC-APM

As noted, TCFM's current total Medicare revenue is about \$1,495,000. Assuming this is consistent with 6 percent of total Medicare spending going to primary care, and assuming CMS agrees to invest an additional 1 percent of total Medicare spending under APC-APM instead, TCFM's total Medicare revenue under APC-APM would increase to about \$1,744,000.

Comparison of Current State and APC-APM

In its current state, TCFM receives about \$1,495,000 in revenue from Medicare. Under the APC-APM model, with an investment level of 7 percent of total spend in primary care, TCFM could expect to receive an additional \$249,000 in revenue from Medicare. Assuming that 8 percent of revenue (almost \$140,000) is at risk as a performance-based incentive payment, TCFM practice has \$109,000 left to safely invest in practice enhancement for the benefit of its patients. Among the enhancements that TCFM could afford with this investment are:

- *Upgrades to its CEHRT to enhance patient engagement*
- *Addition of telehealth capabilities*
- *Addition of another full-time registered nurse care manager*

The average Medicare payment for a hospital discharge in fiscal year (FY) 2014 was \$10,897. At this rate, TCFM would only need to prevent 23 discharges among its 3,600 Medicare patients to more than offset the increase in Medicare spending to the practice under APC-APM. This does not account for any other savings Medicare might accrue from decreased ED usage or other services not needed because TCFM can do more for its patients.

Level 2 Participation Example (Small/Rural Practice)

Current Revenue

In a typical year, Dr. Smith provides 3,552 office visits, 240 hospital visits, 96 nursing facility visits, and 48 home visits. Those visits generate approximately \$363,000 in revenue to the practice, of which \$109,000 comes from Medicare.

Additionally, Dr. Smith can bill Medicare for CCM for about 60 patients per month. That produces an additional \$29,000 in revenue for the practice.

Finally, Dr. Smith provides a variety of non-E/M services (e.g., maternity care, skin procedures, joint injections, etc.) that generate about \$128,000 in revenue, of which about \$38,000 comes from Medicare.

Thus, Dr. Smith's practice has a current total revenue for all services across all payers of approximately \$492,000. Of that, about \$177,000 comes from Medicare.

Current Expenses

Against these revenues, Dr. Smith has the following expenses in her practice:

Clinical staff salaries (LPN and MA):	\$68,000
Non-clinical staff salaries (receptionist and office manager):	\$78,000
Fringe benefits and payroll taxes attributed to staff salaries:	\$32,000
CEHRT:	\$ 8,000
IT (other than CEHRT):	\$10,000
Ancillary Services:	\$15,000
Medical Supplies:	\$30,000
Building & Occupancy:	\$27,000
Malpractice premiums:	\$61,000
Total:	\$329,000

This leaves Dr. Smith with approximately \$163,000 per year to compensate herself.

Revenue from APC-APM

As noted, Dr. Smith's current total Medicare revenue is about \$177,000. Assuming this is consistent with 6 percent of total Medicare spending going to primary care and assuming CMS agrees to invest 7 percent under APC-APM instead, Dr. Smith's total Medicare revenue under APC-APM would increase to over \$206,000.

Comparison of Current State and APC-APM

In its current state, Dr. Smith's practice receives about \$177,000 in revenue from Medicare. Under the APC-APM model, with an investment level of 7 percent of total spending in primary care, Dr. Smith's practice could expect to receive an additional \$29,000 in revenue from Medicare. Assuming that 8 percent of revenue (about \$14,000) is at risk as a performance-based incentive payment, Dr. Smith's practice has \$15,000 left to safely invest in practice enhancement for the benefit of her patients. Among the enhancements that Dr. Smith's practice could afford with this investment are:

- Addition of a chronic care module to her CEHRT
- Addition of telehealth capabilities
- Addition of another part-time medical assistant to further support care management

The average Medicare payment for a hospital discharge in FY 2014 was \$10,897. At this rate, Dr. Smith's practice would only need to prevent three discharges among her 600 Medicare patients to more than offset the increase in Medicare spending to her practice under APC-APM. This does not count any other savings Medicare might accrue from decreased ED usage or other services not needed because Dr. Smith's practice can do more for her patients.

This example demonstrates that the APC-APM model is feasible even for small and rural physician practices.

4) (Answer Unchanged) Who does AAFP anticipate would serve as the APM Entity?

The AAFP anticipates that the physician's practice, as identified by its Tax Identification Number (TIN), would serve as the APM entity.

- 5) **(Answer Revised)** Page 7 of the proposal states, “APM entities should be able to elect one of two levels of prospective, primary care global payment...to move toward a more fully capitated payment arrangement at a reasonable pace for their particular practice.” The PRT is interested in better understanding why the two levels are important and how these two levels were decided upon. Also, please indicate whether the two levels of payment would be risk adjusted in the same manner.

The two levels are important for the following reasons:

- *Multiple levels allow participating practices to choose the one with which they are most comfortable as a starting place for moving away from FFS.*
- *The two levels also recognize that not all primary care practices provide the same scope of E/M services. For instance, some primary care practices provide only ambulatory, office-based E/M services, while others, especially those in rural areas, provide E/M services in multiple sites of service (e.g., office, hospital, nursing facility, etc.).*

The AAFP recommends two levels in order to keep the model relatively simple for both participating practices and participating payers. Level 1 (ambulatory, office-based face-to-face E/M services) represents the services most commonly provided in the typical primary care practice. It is the core of the direct patient care provided in most primary care practices. The AAFP decided that it would be a good starting place for practices as they transition away from FFS. Given the desire to keep the model simple, the AAFP structured level 2 to encompass all E/M services, regardless of site of service. We believe that E/M services, as a whole, represent a reasonable, understandable group of services for those practices that are in a position to manage the performance risk associated with a broader basket of primary care services.

Both levels would be risk adjusted in the same manner. Details on the risk adjustment are found in the response to question 9.

- 6) **(Answer Unchanged)** The proposal notes a need for longer time horizons to achieve savings in primary care payment reform. How much time might be needed to achieve savings? Please provide additional information on the process through which overall health care savings will be achieved, in the short term and the long term (i.e. 1-2 years, 2-5 years, 5+ years), particularly among the Medicare population.

Based on literature, practice transformation can take 18 to 36 months. A limitation of many studies examining the impacts of practice transformation is that the duration of the studies does not lend itself to a thorough evaluation. However, practice transformation models do show progress and early impacts that are promising, such as:

- *CPC. The third-year evaluation report for the CPC program found that it reduced ED visits, as well as expenditures for skilled nursing facilities, outpatient services, and primary care clinician services. The program was also associated with a one percent decrease in total Medicare expenditures. While not all of these results were statistically significant, they demonstrate the potential impact on costs, even while medical home model implementation efforts are ongoing.*
- *CareFirst. A three-year evaluation of CareFirst’s patient-centered medical home (PCMH) program found that by the third year, annual adjusted total claims payments were \$109 per participant or 2.8 percent lower than pre-intervention and for non-participants. A closer look at the spending reduction revealed that 42 percent was attributable to lower inpatient care, emergency care,*

and prescription drug spending. Lastly, the reduced spending was also greatest for enrollees with chronic conditions.

Experts agree that these payment reforms may need to be evaluated over longer time periods to realize greater savings than stakeholders have expected. This is underscored by Rhode Island's multi-year and multi-payer initiative to increase investment in primary care transformation. They have found that primary care transformation and the resulting return on investment (ROI) took several years. As with CPC, they found a trend toward lower rates of inpatient use in the first two years. Since then, they have shown more dramatic reductions for inpatient use of 7.2 percent. In addition, Blue Cross Blue Shield of Rhode Island conducted a 5-year study of practices that have undergone a PCMH transformation and found a 5-percent reduction in costs relative to other primary care practices. The Rhode Island experience underscores that primary care transformation and investments have positive impacts on health system costs—but that the ROI and other impacts may take several years to realize.

The Health Care Payment Learning and Action Network's (HCPLAN) paper, "Accelerating and Aligning Primary Care Payment Models," supports this position. The paper states:

Although it will take some time for primary care practices to adapt to PCPMs [primary care payment models] and begin to realize savings from improved clinical outcomes (see Recommendation 19 below), the Work Group does not anticipate that additional investments in primary care infrastructure will require purchasers to spend more on health care. Rather, the Work Group expects that payment mechanisms in PCPMs will unleash value in other parts of the health care system, and ultimately result in a return on investment.

Indeed, Recommendation 19 in the same paper states, "Although incremental progress should be made much more quickly, PCPMs can only be expected to deliver a return on investment over the long term. Therefore, payers should develop business models that do not require investments in PCPMs to be recouped from reductions in total cost of care in the short term." The HCPLAN paper proceeds to justify this recommendation in terms of the nature of primary care and the traditionally minor part of the total cost of care attributed to primary care.

- 7) **(Answer Revised)** Page 12 of the proposal states, "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 provide additional detail on how the amount of the global payment (level 1 and level 2), population-based payment, and performance-based payments would be determined. Do you have estimates for the base payments or payment ranges for each? Would the amounts vary by geographic region or primary care specialty?

For anti-trust and other reasons, we do not believe it is appropriate for us to provide such estimates. The amount of these payments will need to be determined by the participating public and private payers in negotiation with the participating practices.

However, we can say a few things about the relative proportions of the four pieces of the payment methodology. First, the performance-based incentive payment is the piece at risk, and which otherwise allows the model to meet the risk criterion for being an AAPM. Under current rules, models that qualify as AAPMs must bear a certain amount of greater than nominal financial risk or qualify as a Medical Home Model expanded under CMMI. To meet the revenue-based standard for more than nominal financial risk, an average of at least 8 percent of revenues must be at-risk for

participating APMs. Therefore, we would expect the performance-based incentive payment to be at least 8 percent of total revenues, which is otherwise represented by all four pieces of the payment methodology.

Second, we believe that the majority of what an advanced primary care practice does is represented by the primary care global payment and the population-based payment. Accordingly, these two pieces, taken together, should represent more than 50 percent of practice revenues, increasing to 75 percent after two years. This is similar to the Combination All-Payer and Medicare Payment threshold options in the APM track under MACRA. The percentage of revenue attributed to FFS will depend on the scope of services provided by the practice. Those that are anticipated to provide a broad range of services, including a significant volume still paid on a FFS basis, should expect the percent of revenue attributed to the primary care global payment and the population-based payment to be less than a practice whose services fall predominantly outside of FFS. How payments are divided between the primary care global payment and the population-based payment would be a matter of negotiation between the payers and the practices.

If we apply these principles to the two examples used to answer questions 2 and 3, the Medicare payments and percent of practice revenues under APC-APM might be as follows:

Tomahawk Creek Family Medicine

<i>Global Primary Care Payment + Population-based Payment</i>	<i>\$1,260,480</i>	<i>72%</i>
<i>Fee-for-Service</i>	<i>\$344,000</i>	<i>20%</i>
<i>Performance-based Incentive Payments</i>	<i>\$139,520</i>	<i>8%</i>
<i>Total Revenue under APC-APM</i>	<i>\$1,744,000</i>	<i>100%</i>

Dr. Smith's Practice

<i>Global Primary Care Payment + Population-based Payment</i>	<i>\$151,520</i>	<i>74%</i>
<i>Fee-for-Service</i>	<i>\$38,000</i>	<i>18%</i>
<i>Performance-based Incentive Payments</i>	<i>\$16,480</i>	<i>8%</i>
<i>Total Revenue under APC-APM</i>	<i>\$206,000</i>	<i>100%</i>

In essence, we advocate that participating payers take a top-down approach to setting payments. This approach starts with the desired level of investment in primary care as a percentage of total health care spending, and apportions that investment among the four pieces of the methodology in such a way that the resulting portion attributed to each piece supports both the model of health care delivery represented by advanced primary care and the desire to move from volume to value. To this

last point, we note that, in both examples, volume payment (i.e., fee-for-service) is only a small portion of the total practice revenue.

We also advocate for not determining payments in a bottom-up fashion that simply converts current FFS payments and observed service volumes to some sort of equivalent capitation. As noted in our proposal, the current level of investment in primary care is inadequate to achieve the desired system results. Further, the current values assigned to primary care services, particularly E/M services, undervalue those services relative to other services. Using the current FFS payment methods to value payments under this or any other alternative payment model will only perpetuate existing problems with physician payment.

We acknowledge that some payers are already investing more than the average 6 percent of total spending in primary care, such that doubling their investment would not be appropriate. The point is to invest in participating practices under the APC-APM at a level where they can provide what is expected of them, rather than simply rearranging current payments to fit a different cash-flow mechanism.

In general, the AAFP supports the elimination of all geographic adjustments to physician payments, except for those designed to achieve a specific public policy goal (e.g., to encourage physicians to practice in underserved areas). Additionally, the AAFP has historically opposed varying physician payments on the basis of physician specialty. Accordingly, as we envision, the amounts would not vary by geographic region or by primary care specialty.

- 8) **(Answer Unchanged)** The proposal indicates that the ultimate goal is to combine the primary care PMPM and the population-based PMPM into a single global payment. What is the rationale for the two separate PMPMs in this model?

The AAFP believes that separate PMPM payments for the primary care global payment and population-based payment will be a less radical departure from current payment models than combining both into one from the outset. Two separate PMPM payments in this model is such a methodology that mimics current payment models, and thereby facilitates transition to a model in which both are ultimately combined. Current payment models pay for face-to-face and non-face-to-face services separately. For instance, under the Medicare PFS, face-to-face services, such as office visits are paid separately from CCM codes. Likewise, under both original CPC and CPC+ models, payers pay a care management fee separate from the payments made for face-to-face services provided by the practice. A less radical departure, in turn, will provide practices and payers with an opportunity to become comfortable with both PMPM payments in preparation for their eventual combination. The AAFP is open to combining the PMPM payments in a future iteration of the model.

- 9) **(Answer New)** The proposal recommends using the Minnesota Complexity Assessment Method as a potential risk-adjustment method. The PRT is trying to better understand the details of this method and how it would be used in the model.

In our proposal, we use the terms “risk stratification” and “risk adjustment” to describe how practices would assess the needs of their patients and how payments to those practices would reflect the intensity of patient needs, respectively. More specifically, the APC-APM model proposes to use a risk stratification tool—the Minnesota Complexity Assessment Method (MCAM) in this case—to initiate assessment of patient needs.

Risk stratification is a process designed to guide the physician and the care team in grouping patients into levels (i.e., strata) of risk, based on factors such as health severity, social determinates, etc. Risk stratification is done at the practice level to support longitudinal care management, and it provides a

framework to allocate practice resources proportional to the needs of patients as reflected by the level of risk associated with those patients. Risk stratification ensures that the patients most in need of care management and other key functions receive the most of those services.

Risk adjustment is a process designed to guide the payer in modifying per patient per month payments based on factors such as demographics, health severity, etc. Risk adjustment occurs at the payer level and provides a means to allocate payer resources proportional to the needs of patients as reflected by the level of risk associated with those patients. Risk adjustment ensures that practices have the necessary resources they need to care for patients consistent with the needs of those patients.

a) Please describe the proposed risk-adjustment method including its components and how it would be calculated.

As noted in our proposal, we recommend that practices risk stratify their patients using the Minnesota Complexity Assessment Method (MCAM). The assessment can be completed by a health care provider, including the physician or the nurse doing intake, and this should be left up to individual practices. A copy of the MCAM is attached for your information. The tool is accompanied by robust description, and if the interviewer or the person doing the documentation is aware of the various aspects of complexity as described in the tool, the results have been shown to be fairly objective.

In a practice, the MCAM could be used first in meeting with every new patient and obtaining their comprehensive past medical/social/family history. It could also be done retrospectively, after the patient has been seen. However, the team would need to be familiar with the MCAM to document clearly what would be "counted" on the assessment tool as higher or lower complexity. Finally, it could also be used when a physician begins to note that a patient is taking up a lot of resources or needs additional resources to achieve health goals (e.g., needs social work services, ride assistance, meals). Practices should risk stratify their patients at least annually.

Indeed, the role the MCAM can play in a practice is to help describe a patient that is highly complex from a practice perspective, but whose complexity is not adequately captured by traditional billing data. For example, the physician may not be ordering a lot of studies for this patient, but the patient may have non-medical issues (e.g., social situation) that hinder his or her ability to comply with treatments.

While our proposal recommends use of the MCAM for risk stratification within the practice, we do not believe all participating practices should be required to use this particular instrument for risk stratification. We acknowledge that there are other risk-stratification rubrics that also encompass a broad range of aspects of health in patient assessments, including physical health, mental health, and social determinants of health. Another example is the Patient Centered Assessment Method, which has its origin in the MCAM, and the AAFP has a [risk-stratified care management rubric](#) that practices could use.

The tool or method the practice uses to risk stratify its patient panel is less important than the fact that the practice does engage in risk stratification. Indeed, an essential element of the key function of care management is that the medical home empanels and risk stratifies the whole practice population.

The AAFP does not have a recommended method for risk adjustment by payers. As noted in our proposal, we acknowledge that there are multiple, effective risk-adjustment methodologies and

are open to alternatives. For instance, we anticipate that CMS will use the Hierarchical Condition Category (HCC) scoring method to do its risk adjustment, just as it does now under CPC+. Private payers may use other methodologies. For instance, in its comment letter on our proposal, the Blue Cross Blue Shield Association (BCBSA) referenced that some health plans are using Verisk data.

Regarding HCC, we note that it has at least three methodological problems that may not make it useful under APC-APM in the long run. First, under HCC as used by CMS, there is an 18-month delay in the update to risk scores and risk-adjusted payments. For instance, in CPC+, diagnoses in 2017 will not be reflected in risk-adjusted payments until the third quarter of 2019. We believe that CMS needs to shorten that delay if risk-adjusted payments under APC-APM are to effectively support APM entities participating in the model.

Second, HCC depends on diagnoses derived from claims data. However, under APC-APM, most of what APM entities do will be paid through capitated global primary care and population-based payments that do not require or depend on the generation of a claim. For years beyond the first, CMS will need to find alternate sources (e.g., CEHRT) of diagnosis data if it wants to continue to use an HCC scoring method that relies on current diagnoses.

Lastly, HCC does not reflect social determinants of health. We advocate that payers use risk-adjustment methodologies that also factor in social determinants of health. Risk-adjustment methodologies that do not are inadequate, in our opinion. We note the BCBSA comment letter referenced that the state of Rhode Island is looking at the creation of an assessment that incorporates social determinants of health into risk. CMS and other users of HCC may want to look at this methodology as an alternative.

In any case, we offer to work with CMS, BCBSA, and other payers to identify or develop a risk-adjustment methodology that works for them as payers, and is useful for APC-APM over time in a way that HCC may not be.

b) How would the risk-adjustment be applied in the model? (e.g., continuous vs. categorical, how many categories, etc.)

The number of categories or levels in a practice's risk-stratification rubric will depend on which rubric the practice uses. We encourage practices to risk stratify their patient population at least annually. Depending on practice resources, electronic health record (EHR) functionality, etc., a practice may have the ability risk stratify some or all of its patients more frequently. Ideally, risk stratification of a particular patient would be reconsidered (but not necessarily changed) at each encounter.

Similarly, whether a payer's risk-adjustment methodology is continuous or categorical and how many categories it has (if it is categorical) will depend on the methodology. We believe that a payer should risk adjust the global primary care PMPM and the population-based PMPM at least annually. If a payer and a practice have the capability to accommodate more frequent risk adjustments to these payments, then the model should support those more frequent adjustments.

c) Would the risk-adjustment for the global primary care PMPM and the population-based PMPM be the same or different?

We strongly recommend that the risk adjustment for the global primary care PMPM and the population-based PMPM be the same.

- d) **If the data for the risk-adjustment are coming from the EHR, who collects this information to calculate the risk adjustment and the risk-adjusted payment? How would objectivity of ratings for the subjective components of the risk-adjustment be assured?**

To the extent a practice's risk-stratification method relies on data in its EHR, we expect that clinical staff in the practice would collect and input the necessary information. We do not believe that objectivity of subjective components of a risk-stratification methodology need to be assured to effectively risk stratify a patient population within a practice.

To the extent a payer's risk-adjustment method relies on data in practice EHRs, we expect that the contract between a payer and its practices would specify who collects this data. We also expect that a payer's risk-adjustment methodology would have some mechanism to assure the objectivity of otherwise subjective components. As noted above, we believe that a payer should risk adjust the global primary care PMPM and the population-based PMPM at least annually. If a payer and a practice have the capability to accommodate more frequent risk adjustments to these payments, then the model should support those more frequent adjustments.

- e) **Please also provide a description of how risk-adjustment could positively or negatively influence payments for the different specialties under the proposed payment.**

The payment model does not anticipate any differences in payment among the primary care specialties that would be eligible to participate in the model. As such, the risk adjustment should influence payments for all participating specialties in the same way.

- 10) **(Answer Unchanged)** **The proposal indicates that prospective patient self-attribution would be the primary method of attribution within the model. How does attribution work in practice including documentation, reporting, and tracking of attributed patients? Can anything override the patient self-attribution? What happens if a patient uses a different provider after self-identifying? It would be helpful to see hypothetical examples to understand how the attribution methodology would work under different scenarios.**

Appendix A of our proposal (pages 27-34) includes a description of the proposed attribution methodology. All payers would use the same methodology. Under this methodology, sometime before the start of the performance period, a payer would analyze its patient membership in the following stepwise fashion:

1) Has the patient self-identified a responsible primary care physician? If so, the patient is attributed to the APM entity to which that physician belongs.

2) If not, from which primary care physician has the patient received a plurality (the most recent, in case of a tie) of his or her wellness visits within the past 24 months? The patient is attributed to the APM entity to which that physician belongs.

3) If the patient has not received a wellness visit within the past 24 months, from which primary care physician has the patient received a plurality (most recent, in case of a tie) of his or her other E/M visits within the past 24 months? The patient is attributed to the APM entity to which that physician belongs.

4) If the patient has not received an E/M visit within the past 24 months, from which primary care physician has the patient received a plurality (minimum of three and most recent, in case of a tie) of his or her prescriptions or other order events (e.g.,

durable medical equipment, labs, imaging, etc.) within the past 24 months? The patient is attributed to the APM entity to which that physician belongs.

If the patient cannot be attributed to an APM entity after the fourth step, the patient remains unattributed for the performance period.

The Health Care Payment Learning and Action Network (HCPLAN) released a [white paper on patient attribution](#) and its importance to value-based payment programs. They deemed patient self-attestation as the gold standard for attribution for population-based payments, which rely on primary care as the starting point to coordinate care across the continuum. The authors define patient self-attestation as patient self-reporting, declaration, or confirmation of primary care provider. If patient self-attestation is not possible, the authors describe other methodologies for accurate attribution. Similarly, the APC-APM includes a four-step attribution process and accounts for patients that do not accurately self-attest.

Thus, the APC-APM approach to patient attribution is consistent with the recommendations of the [HCPLAN white paper](#). Similar to the APC-APM method, the HCPLAN white paper states that patient attribution, “relies on a patient’s declared or revealed preferences regarding his or her primary care provider. Patient self-report represents a patient’s declared choice; and use of claims or encounter data enables identification of a patient’s revealed preferences regarding their primary care physician.”

We also note that some private payers already use self-attestation in patient attribution. For example, Blue Cross Blue Shield of Massachusetts’ Alternative Quality Contract (AQC) uses self-attestation to attribute patients to a participating provider by [requiring patients in their health maintenance and point-of-service plans to designate a primary care provider](#).

Once a payer has attributed its patient membership, it shares the list of patients attributed to an APM entity with that entity for review and reconciliation. The list would identify each patient and the basis by which the patient was attributed to the entity. During this period of review and reconciliation, the entity may request to add or remove patients from the formal list the payer supplies to them with documentation to support their requests, as needed. At the end of the reconciliation process, the patient list would be set for the performance period, and the payer and practice would provide patients with transparent information about their attribution. During the performance period, an APM entity would track its attributed patients in a manner that is most efficient for the entity. Reporting would be consistent with the requirements of the performance measurement process.

Since the AAFP recommends that performance-based incentive payments be paid on a quarterly basis, the attribution process, including review and reconciliation, should also occur quarterly. The AAFP recognizes that this may not be feasible for some payers. In this case, a longer performance period and less frequent attribution process may be necessary. Attribution, including review and reconciliation, should occur at a minimum of once a year. At the beginning of a performance period, APM entities should know which patients they are responsible for managing and the expected time period for management (i.e., the performance period).

In general, nothing can or should override patient self-attribution, which otherwise supports both patient choice and patient safety under the model. An exception would be patient behavior that is clearly contrary to the patient’s self-attribution. For instance, if a patient moves out of the APM entity’s service area or if the two-year look-back period demonstrates that the patient is receiving a majority of his or her services from providers outside the APM entity, the APM entity could

successfully challenge the patient's nominal self-attribution to the APM entity. Instead, the patient would attribute to another APM entity where the patient resides, or from which the patient receives his or her services. In such circumstances, the model would still honor patient self-attribution, albeit based on the patient's actions rather than his or her nominal choice of APM entity.

If a patient uses a different provider after self-identifying and changes his or her self-attribution in the process, then the risk-adjusted, capitated primary care global fee and population-based payment will cease flowing to the previous APM entity. Instead, it begins flowing to patient's new choice of APM entity. Likewise, responsibility for the cost and quality of services provided to that patient from that point forward shifts to the patient's new choice of APM entity.

If a patient uses a different provider after self identifying and does not change his or her self attribution in the process, then the APM entity which the patient self identifies would retain the risk-adjusted, capitated primary care global fee and population-based payment associated with that patient. Likewise, the APM entity continues to be responsible for the cost and quality of services provided to that patient, including those of the other provider. However, the other provider will be paid by the patient's health plan, not the APM entity. Self referral to providers outside the APM entity by patients attributed to that APM entity should reflect negatively on the APM entity's performance, with the consequence that it may lose its performance-based incentive payments and its ability to continue participating in the program. As noted above, there is an opportunity for an APM entity to challenge a patient's ongoing self-attribution to the APM entity if the patient consistently chooses to receive services from providers outside the APM entity.

- 11) (Answer Revised)** The proposal indicates that APM Entities will be evaluated on 6 measures, one being an outcomes measure. The proposal also mentions an inpatient hospitalization measure and an emergency department utilization measure. A list of measures is provided in Appendix B, but it does not seem consistent with the description in the proposal and it has many more than 6 measures.

The measures for use in the APC-APM are the PCMH/ACO Core Measures developed by the multi-stakeholder Core Quality Measure Collaborative. There are more than six measures available in this measure set. However, the APC-APM requires APM entities to choose only six measures that are most applicable to their practice. This is consistent with the quality category of the Merit-based Incentive Payment System (MIPS) where clinicians have the ability to choose six measures from a menu of measures.

To illustrate both example practices in the answer to question 2 above, we chose the following six measures from among those listed in Appendix B as the quality measures on which they would be evaluated during the first performance period under APC-APM:

- *Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)*
- *Diabetes: Eye Exam*
- *Diabetes: Medical Attention for Nephropathy*
- *Diabetes: Foot Exam*
- *Controlling High Blood Pressure*
- *Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan*

Both “Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)” and “Controlling High Blood Pressure” are intermediate outcomes measures.

- a) Please clarify which measures the APM Entities are held accountable for, which measures individual physicians are held accountable for, and which are intended for evaluation of the model.**

The six measures chosen by physicians for evaluation will be used to measure physicians at the individual level. The APM entity will also be evaluated using two measures from the Healthcare Effectiveness Data and Information Set (HEDIS): inpatient hospitalization utilization and emergency department utilization per 1,000 attributed beneficiaries. The APC-APM model will be evaluated by measuring annual hospitalizations, emergency department visits, and specialist visits (consistent with CPC).

- b) In addition, which measures are tied directly to payment (e.g. result in payment adjustments)?**

The only measure tied to payment in the APC-APM individual physician measure set is National Quality Forum (NQF) #0052: Use of Imaging Studies for Low Back Pain. There are two other utilization measures (also in CPC+) that are included in our model—inpatient hospitalization utilization per 1,000 attributed beneficiaries and emergency department utilization per 1,000 attributed beneficiaries. Also, the APC-APM’s incentive payment is tied to quality. Therefore, if physicians are not meeting quality standards, their payment will be affected.

- c) Is payment based on performance for all of the measures or is payment based upon reporting?**

In regards to quality reporting, payment will be based on performance of chosen measures, not just reporting of the measures.

- d) What are the performance benchmarks?**

Similar to MIPS, benchmarks for performance measures will be based on performance of measures two years prior.

- e) Would there be minimum numbers of patients required for a measure, and what would be done if a small practice did not have enough patients to meet the minimums?**

Similar to MIPS, a 20-patient case minimum will be needed for a measure to receive a score for performance. In the unlikely event that a practice is unable to meet the case minimum, they would be given partial credit for reporting.

- f) Would each APM Entity or practice be able to select different measures?**

An APM entity and practices can choose any six measures from the set of measures listed in the appendix.

- g) Since the payments are no longer based on visits, how would the model assure patient access?**

Although not measured directly, access will be evaluated indirectly through the APM entity level utilization measures. A physician's quality of care will be negatively affected if access is poor.

- 12) (Answer Unchanged)** On pages 5-6, the proposal states the proposed model will encourage 1) use of data from multiple sources, 2) use of social determinants of health data, 3) identification of potential increases in disparities among vulnerable populations, 4) electronic reporting and more frequent reporting, 5) capturing and sharing of data from EHRs of all clinicians providing care for an attributed patient population, and 6) monitoring provider performance on quality and cost. Please provide more detailed information on specifically how the proposed model encourages these things, how the information would be collected, and what the expected benefit is to patients and providers?

The model encourages the (1) use of data from multiple sources and (5) capturing and sharing of data from EHRs of all clinicians providing care for an attributed patient population by requiring the adoption and use of certified EHR technology (CEHRT). The 2015 Edition CEHRT expands the interoperability capabilities of the EHRs, which will enable sharing and using of data from multiple sources. Additionally, the model embraces the use of performance-based incentive payments to hold physicians accountable for quality and cost performance. This provides an avenue to use clinical quality measures and cost measures that are interoperability sensitive. Finally, prospective payments provide physician practices with the needed revenue to invest in infrastructure to support interoperability.

The model encourages the (2) use of social determinants of health data, and (3) identification of potential increases in disparities among vulnerable populations through the use of clinical quality measures that are sensitive to social determinants of health, just as the model is able to use interoperability sensitive measures. Additionally, the model includes risk-adjusted, population-based payments, which can be leveraged to encourage the capture and reporting of social determinants as part of the risk-stratification model. Finally, the requirement to use CEHRT ensures a practice is able to collect, record, and store data on social determinants of health in the EHR (granted, it is not the full set of social determinants, but it is a start).

The model encourages (4) electronic reporting and more frequent reporting and (6) monitoring provider performance on quality and cost by requiring the adoption and use of CEHRT. We expect that CEHRT will have the capability to provide not only external electronic measure reporting, but also internal reporting to the physician and staff. By aligning the incentives (i.e., performance-based incentive payments and risk-adjusted primary care global and population-based payments) to value quality and cost, the model incentivizes physicians and practices to better understand their level of quality and resource utilization. In turn, this creates a market for products and services geared toward the capture, reporting, and analysis of practice-based quality and cost data. For these reasons, we believe the APC-APM will drive more frequent reporting and drive more monitoring of provider performance on quality and cost.

The following are ways that the APC-APM could be supported to ensure these outcomes:

- Published information about the APC-APM could include recommendations and best practices that participants would be encouraged to follow (within the bounds of what is feasible), given each APC-APM participant's unique circumstances, available resources, and available supporting health IT infrastructure.*
- Resources and toolkits could be developed to achieve awareness building among APC-APM participants about each of the aforementioned topics and associated recommendations.*

Language within the resources and toolkits could expressly indicate that recommendations are intended to provide insights into the supporting infrastructure (reports, workflows, and processes) commonly required to achieve and demonstrate actual performance that meets or exceeds the associated benchmarks or expected thresholds across applicable measures. Resources and toolkits would clearly articulate the value proposition for APC-APM participants for choosing to adhere to items “recommended” or “encouraged.” Such recommendations reduce administrative burden for clinicians, improve workflows, maximize efficiencies, contribute to better health outcomes for patients, and/or help contain the cost of care for patients. These beneficial outcomes could be clearly identified within published resources and toolkits.

We believe that the incentives in the APC-APM will help physicians and practices value such resources and toolkits and establish a market for the development them.

- 13) (Answer New)** The proposal indicates that providing customized reports on social determinants of health data to providers can serve as a means of checks and balances. Please provide more detailed information on the proposed system of checks and balances, and how specifically it could work in practice. In addition, which social determinants of health would be included?

Just as the APC-APM supports interoperability sensitive measures, it supports the use of clinical quality measures and improvement activities that are sensitive to social determinants of health. Since the APC-APM promotes risk-adjusted primary care global payment, risk-adjusted population based payment, and performance-based incentive payments, these incentives, plus social determinants of health sensitive measures serve as levers to drive practice change focused on improvements in quality and performance tied to social determinants of health. Such practice change could include data-driven routine assessments of performance on these measures to enable timely identification of undesirable deviations or variations in performance or modifiable social determinants. Should addressable deviations in performance on measures or improvement activities sensitive to social determinants of health be observed, it could then be possible to further identify missed opportunities for improvement in the delivery of quality care for the impacted patient population. The incentives of the APC-APM encourage model participants to work with their health IT vendors to develop customized reports to support the practice’s data-driven efforts.

Regarding which social determinants of health data could be included, we believe selection should have a foundation rooted in evidence. When capturing and reporting on social determinants of health data element(s), if the triple aim is not improved, it may be too early to include that social determinants of health data element in the current set of social determinants of health data. We realize that it is early in the evidence building around social determinants of health and that initial social determinants of health data element selection may need to be based around expert opinion.

Fortunately, there are national efforts to identify social determinants. One is the Institute of Medicine’s Committee on Recommended Social and Behavioral Domains and Measures for Electronic Health Records. The group uses consensus-based approaches that identify social determinants of health data. A parsimonious set of social determinants could be culled from this work. Additionally, prioritization could be informed by those social determinants already included in CEHRT. For these reasons, a first set could be demographic information that is part of CEHRT with additional poverty and education level information.

- 14) (Answer New)** The proposal mentions extracting data from the clinical record rather than from claims. How would this work? Would APM Entities be responsible for the extraction? What is the anticipated burden on practices and providers?

Yes, APC-APM practices would be responsible for extracting data from the clinical records contained in their CERHT. How this would work and the burden on practices and providers will depend on two factors: the data needed by the payer(s) and the capability of the practice's CEHRT to provide the necessary data in an automated fashion.

There will be an increasing reliance on data extracted from clinical records rather than claims as the health care system moves from volume to value. Thus, we believe what we are suggesting represents the future of where the market is going.

Many practices must already provide payers with data from their clinical records. For instance, Medicare Advantage plans often request medical records data from practices to support the risk score reported to CMS. Thus, in some respects, the anticipated burden on practices and physicians may not be any more than it is now. In fact, the anticipated burden on such practices may be less, because they will not have to file claims for much of the work that they do for patients.

Finally, as noted in our proposal, the APC-APM entity has an incentive to work with its payers to facilitate the identification of diagnoses, conditions, and other data in the medical record. It will be indirectly compensated for doing so to the extent that the bulk of the APC-APM entity's payments will be risk-adjusted, at least partially on the basis of this data. This contrasts with the fact that practices are typically uncompensated for the time and effort currently required to provide payers with data from their clinical records.

- 15) (Answer Unchanged) Why is self-attestation to the five key functions necessary and what can be achieved by self-attestation? Would auditing of practices to verify the attestations be required? Also, please provide examples of how patient and caregiver engagement would be better supported under the model than under FFS or CPC+.**

Self-attestation to the five key functions, which are the same as those currently present in CPC+, is necessary as part of the application process to ensure that participating practices understand what is expected of them and what is perceived to be necessary on their part to succeed under the payment model. Self-attestation achieves these ends without the necessity of requiring that practices certify their status as an advanced primary care practice with a third party.

We note that self-attestation is already a significant part of MIPS. For instance, physicians attest to improvement activities, and some of the elements of advancing care information rely on physician attestation. We see self-attestation as equally valid in the proposed payment model.

Auditing of practices to verify the attestations would not be required, per se. The AAFP contends that the veracity of the attestations can be verified through the performance measurement process. That is, the outcomes the practice achieves in terms of quality and cost will substantiate whether or not the practice's attestations were accurate. The AAFP does not object to auditing a practice's performance.

- 16) (Answer New) How does the model prevent unintended consequences such as cherry picking, stinting of care, or referring patients to specialists for services that a primary care physician could perform? The PRT's understanding of the core measure set is that there are few measures directed at areas where stinting might occur.**

The model prevents "cherry picking" in at least two ways. First, under the four-step attribution methodology, patients are attributed to practices by patient choice first, so patients pick the practice rather than vice versa. Patients who do not choose any practice may still be attributed to a practice based on one of the other three steps (i.e., claims for Welcome to Medicare and AWV, claims for all other E/M visits to a primary care physician, and claims for primary care prescriptions and other

order events). Thus, under the APC-APM, practices would have relatively little opportunity to cherry pick the patients attributed to them because patient attribution is primarily in the hands of the patient and CMS, not the practice.

The model also prevents cherry picking by risk-adjusting payments for the primary care global and population-based payments. If the payer's risk-adjustment methodology functions properly, these payments will vary based on the needs of the patients, such that the patients with the greatest needs will generate the greatest primary care global and population-based payments. Thus, the payment methodology should discourage cherry picking (or at least not incentivize it), especially given that the primary care global and population-based payments represent the clear majority of the revenue received by the practice.

The model prevents **stinting** of care in at least three ways. First, patient choice is the primary means of patient attribution. Patients who perceive that the practice is stinting on their care may select another practice to which they choose to be attributed. Since the primary care global payment and the population-based payment are capitated and follow the patient, patients who choose to leave the practice and attribute themselves to another practice take both revenue streams with them. This feature of the model provides an incentive to the practice to ensure patients feel they are receiving appropriate care.

Alternatively, patients who perceive that the practice is stinting on their care may choose to go elsewhere for their care, even if they do not self-attribute to another practice. Patients who self refer to other specialists for services the primary care practice could have provided will have noticeably different utilization patterns and higher costs. As noted below, under APC-APM, practices will be evaluated on this aspect of performance. Performance on utilization and cost, in turn, helps determine whether practices may keep the performance-based incentive payments they have received for the reporting period. Practices that stint on care, leading to self referral of patients to other specialists for services that a primary care physician could perform are likely to fare poorly on utilization and cost measures, and lose their performance-based incentive payments. Poor performing practices may also be excluded from the APC-APM going forward. Thus, practices have incentives not to stint on care, so patients receive needed services in the practice rather than self referring to other specialists for those services.

Second, practices will be evaluated based on their performance on quality measures, including at least one outcomes measure. Performance on quality measures, in turn, helps determine whether practices may keep the performance-based incentive payments they have received for the reporting period. Practices that stint on care are likely to fare poorly on quality measures and lose their performance-based incentive payments. Poor performing practices may also be excluded from the APC-APM going forward. Thus, practices have incentives not to stint on care.

Third, the APC-APM model retains a FFS element in the payment methodology. Stinting inherently conflicts with FFS. To the extent that some of the appropriate care under APC-APM may be paid on a FFS basis, practices that stint on care will be depriving themselves of revenue. Thus, the FFS element of the payment methodology, even though it is a much smaller revenue stream than in other models, still provides an incentive not to stint on care.

Finally, the model uses utilization and cost measurement to prevent **referring patients to other specialists for services that a primary care physician could perform**. Medicare and other

participating payers will know the services their beneficiaries and members use inside and outside of the APM entity (i.e., the practice), as well as the cost of those services. Medicare and other participating payers will be able to evaluate the performance of practices based on this aspect of performance. Performance on utilization and cost measures, in turn, helps determine whether practices may keep the performance-based incentive payments they have received for the reporting period. Practices that refer patients to other specialists for services that a primary care physician could perform are likely to fare poorly on utilization and cost measures, and lose their performance-based incentive payments. Poor performing practices may also be excluded from the APC-APM going forward. Thus, practices have incentives not to refer patients to other specialists for services that a primary care physician could perform.

- 17) (Answer Unchanged)** AAFP, along with the American Board of Family Medicine, collaborate as the PRIME Support and Alignment Network under TCPI. What specifically is AAFP's role within TCPI? How many physicians is AAFP supporting, and what provider types are part of the Alignment Network? Would participation in the Network be required for participation in the proposed PPFM.

The AAFP has three areas of focus in our Transforming Clinical Practice initiative (TCPI) work. It focuses on: (1) recruiting AAFP members to enroll with Practice Transformation Networks (PTNs) and participate in TCPI; (2) supporting a TCPI Member Interest Group (MIG), providing AAFP members a peer network related to this practice transformation and Quality Payment Program (QPP) preparation work; and (3) supporting TCPI through providing TCPI-related education through continuing medical education (CME) sessions at our annual conference, Family Medicine Experience (FMX).

As of the beginning of year two of TCPI, we have confirmed that there are 1,144 AAFP members enrolled in a PTN. During the TCPI project, to date, there are 130 AAFP members who have participated in the TCPI Member Interest Group. The AAFP and American Board of Family Medicine (ABFM) support family physicians. However, the PRIME Registry, which is offered by the ABFM as a part of the Support and Alignment Network (SAN) is open to other providers.

Participation in the network would not be required for participation in the proposed physician-focused payment model.

- 18) (Answer New)** The proposal indicates that the model would allow new HIT to be adopted more readily. Specifically, how does the model encourage adoption of newer HIT?

Achieving high levels of success in the APC-APM is dependent on the adoption of health IT (HIT) and access to health information. Fortunately, family medicine has a high adoption rate of EHRs, with more than 80 percent of family physicians using an EHR. Primary care, in general, also has a high rate of EHR adoption (69 percent). This dependence on health IT, rather than mandate, allows for innovation and helps ensure adoption leads to the desired outcomes. Although practices can be successful in this model with existing HIT, which has a focus on documentation and billing, the APC-APM model diminishes that focus, and instead rewards a focus on improved quality, reduced cost, and improved patient experience. This new focus, plus flexibility in which HIT systems are implemented, will incentivize physicians within the APC-APM to increase market demand for HIT that supports improving care and the physician needs associated with value-based care (e.g., population health support, risk stratification, and patient-specific decision support). To provide this implementation flexibility, the APC-APM does not mandate how the EHR or other HIT would be used, unlike the prescriptive requirements in Meaningful Use, some of which are continued in the ACI

component of MIPS. The APC-APM's payment structure does not prescribe how participating entities must use HIT. Instead, it ensures model participants are focused and rewarded on outcomes.

APC-APM creates market forces that reward new HIT applications that support natural clinician workflows, and implement sound, user-centered design principles (otherwise physicians and practices will not purchase). Vendors can no longer just pass certification. Rather, that becomes only the price of entry into the market. Additionally, we expect that the addition of the criterion of 2015 edition CEHRT to provide an open Application Programming Interface (API) will help spur new products and services as add-ons to legacy EHR products, as well as provide a path to replacement, next-generation HIT.



Comparison of CPC+ and APC-APM Components

Requirement/ Component	CPC+ Components ¹	Advanced Primary Care: Alternative Payment Model (APC-APM)	Comparison/Contrast Between CPC+ and APC-APM
Qualifying Criteria	<p>Participating practices must execute five key primary care functions:</p> <ol style="list-style-type: none"> 1. Access and Continuity 2. Care Management 3. Comprehensiveness and Coordination 4. Patient and Caregiver Engagement 5. Planned Care and Population Health 	<p>Participating practices must execute five key primary care functions:</p> <ol style="list-style-type: none"> 1. Access and Continuity 2. Care Management 3. Comprehensiveness and Coordination 4. Patient and Caregiver Engagement 5. Planned Care and Population Health 	Similar approaches
CEHRT	Practices must use CEHRT	Practices must use CEHRT	Similar approaches—both meet Advanced APM criteria
Quality Measures	<p>Quality measures include patient experience of care measures from the CAHPS Clinician and Group Patient-Centered Medical Home Survey and clinical quality using eQMs.</p> <p>Practices must report at least nine of the 14 CPC+ eQMs (all of which are MIPS measures). Practices must report on at</p>	<p>APM Entities responsible for reporting/performance on six measures, including one outcomes measure.</p> <p>Measures selected from the Core Quality Collaborative CMH/ACO/ Primary Care Core Set, which ensures</p>	APC-APM uses core measure set developed with multi-stakeholder input and consensus, including CMS. Promotes alignment of measure use and data collection across payers.

¹[Alternative Payment Models in the Quality Payment Program](#) and [CPC+ Fact Sheet](#) dated December 16, 2016. Both tracks of CPC+ are included on the list of an Advanced APMs and this determination was based on medical home model-specific requirements. For payment years 2019 through 2024, clinicians who meet the threshold for sufficient participation in Advanced APMs and who meet requirements, as applicable for 2018 onward, regarding parent organization size are excluded from the Merit-based Incentive Payment System (MIPS) reporting requirements and payment adjustments and qualify for a five percent APM incentive payment.

	least two of three outcomes measures, at least two of four complex care measures, and any five of the remaining measures ²	focus, alignment, harmonization, and the avoidance of competing quality measures among all payers. This measure set includes patient experience measures. All but one of the core measures are also measures under the MIPS.	APC-APM requires six measures, one of which is an outcomes measure, while CPC+ requires nine measures, at least two of which must be outcomes measures.
Payment	<p>3-Part Payment includes:</p> <ul style="list-style-type: none"> • Performance-based incentive payments (PBIP) based on patient experience, clinical quality, and utilization • Care management Fee based on beneficiary Risk (4 tiers in Track 1; 5 tiers in Track 2) • Straight FFS (Track 1); Comprehensive Primary Care Payment plus reduced FFS (Track 2); the Comprehensive Primary Care Payment is prospective and equal to a percentage of expected Medicare payment for E&M claims) <p>CMMI estimates that CPC+'s PBIPs are approximately 10 percent of expected provider revenue for CPC+ Track 1 (higher for CPC+ Track 2).³</p>	<p>4-Part Payment includes:</p> <ul style="list-style-type: none"> • Prospective, performance-based incentive payments to reward practices based on their performance on patient experience, clinical quality, and utilization measures, • Prospective, risk-adjusted, population based payment for non-face-to-face care, • Prospective, risk-adjusted primary care global payment for direct patient care. Includes two levels: <ul style="list-style-type: none"> ○ Level 1: Ambulatory, office-based, face-to-face evaluation, and E/M services ○ Level 2: All E/M services regardless of site of service, • Fee-for-service (FFS) payments (limited to services not otherwise included in the primary care global payment fee). 	<p>Both CPC+ and APC-APM offer prospective performance-based incentive payments.</p> <p>Both CPC+ and APC-APM offer prospective, risk-adjusted payments for non-face-to-face care (called “care management fee” under CPC+ and “population-based payment” under APC-APM).</p> <p>Face-to-face services under CPC+ are paid either through straight FFS (Track 1) or FFS plus a Comprehensive Primary Care Payment (equal to a percentage of expected Medicare payment for E&M claims). In comparison, face-to-face services under APC-APM are paid primarily through a prospective, risk-adjusted primary care global payment for a defined set of E/M services; face-to-face services outside the</p>

² CPC+ Quality Reporting Overview for Performance Year (PY) 2017, March 2017.

³ CMMI, *CPC+ Payment Methodologies: Beneficiary Attribution, Care Management Fee, Performance-Based Incentive Payment, and Payment Under the Medicare Physician Fee Schedule*, “Chapter 4: Performance-Based Incentive Payment,” January 1, 2017.

<p>Payment (Cont.)</p>		<p>Instead of being based on historical FFS payment amounts for E/M services included in the payment, the primary care global payment and population-based payment were designed to support the proposition that the percent of total spend dedicated to primary care should be higher than current 6%.</p> <p>AAFP estimates the performance-based incentive payment—which practices are at full risk for—would be at least 8 percent of total revenues.</p>	<p>primary care global payment continue to be paid straight FFS. Primary care global payment allows physicians to move toward a more fully capitated payment arrangement at appropriate pace for their practice.</p> <p>CPC+ “tracks” are based on practice capabilities. APC-APM “levels” reflect the continuity of care a primary care physician provides across settings.</p>
<p>Risk</p>	<p>CPC+ participating practices are considered to have met “nominal risk” requirements established for Medical Homes Models.</p> <ul style="list-style-type: none"> The special financial risk and nominal amount standards for medical home models only apply to APM Entities in CPC+ that have 50 or fewer eligible clinicians in the organization through which the APM Entity is owned and operated.⁴ 	<p>APC-APM participants would assume performance risk. APM entity must repay all or part of performance-based incentive payments if they fail to meet benchmarks.</p> <p>APC-APM’s inclusion of performance risk—not financial risk—is based on the original MACRA statute, which reflects Congressional intent regarding the qualification of Medical Home Models as AAPMs.⁵</p>	<p>APC-APM includes performance risk. Entities would be at risk for up to the entire amount of their performance-based incentive payment (expected to be 8% of revenue). This meets the AAPM criteria.</p>
<p>Risk Stratification</p>	<ul style="list-style-type: none"> CMS-HCC risk adjustment model used to stratify beneficiary into a risk 	<ul style="list-style-type: none"> Proposes use of Minnesota Complexity Assessment Model (MCAM) for risk stratification within 	<p>APC-APM designed to use comprehensive assessment tool to inform care planning. Risk</p>

⁴ CMS, [Comprehensive Primary Care Plus \(CPC+\) Request for Applications Version: 3.3](#), Updated for CPC+ Round 2, Last Modified: January 6, 2017. CMS’ proposed rule for CY2018 updates to the Medicare Access and CHIP Reauthorization Act’s (MACRA) Quality Payment Program (QPP) proposes to expand definition of certified PCMH to include the CPC+ model.

⁵ 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.

<p>Risk Stratification (Cont.)</p>	<p>tier for purposes of CMF. (see below)</p> <ul style="list-style-type: none"> Practices may use risk stratification to identify high-need patients. 	<p>practice—beneficiaries classified as low, medium, or high complexity.</p> <ul style="list-style-type: none"> Method allows for assessing complexity not captured through a review of disease burden and can direct care teams in patient management. Specifies certain domains for assessment of patient complexity that includes illness, readiness (to engage treatment), social, health system, and resources for care. Risk stratification occurs <u>at least</u> annually and can be used for longitudinal assessment and evaluation of patients. 	<p>stratification tools, such as MCAM, assess not only medical needs but incorporate social determinants of health and other factors into stratification of patients.</p> <p>MCAM allows for longitudinal assessment of patient needs and can be used in evaluation of the model. Proposal allows for practices to use other, relevant risk stratification tools.</p>
<p>Risk Adjustment</p>	<ul style="list-style-type: none"> CMS-HCC risk adjustment model used to determine beneficiary risk score. Risk score used to stratify beneficiaries into a risk tier for purposes of CMF (based on how beneficiary’s risk score compares to other CPC+ eligible, Medicare FFS beneficiaries in their region).⁶ CMF tiers: <ul style="list-style-type: none"> Beneficiaries in CPC+ Track 1 assigned to 1 of 4 risk tiers. Beneficiaries in CPC+ Track 2 assigned to 1 of 5 risk tiers. 	<ul style="list-style-type: none"> Current risk-adjustment methodologies are inadequate in incorporating social determinants of health (SDoH). Under this model, the AAFP would work with CMS to identify and test more comprehensive risk adjustment approaches that go beyond HCC to include SDoH. 	<p>APC-APM offers opportunity to test more comprehensive approaches to risk adjustment. The current CMS-HCC risk adjusted approach (used under CPC+) does not assess or include the impacts of SDoH factors into risk stratification or payment, which undervalues the work of primary care.</p>

⁶ CMMI, *CPC+ Payment Methodologies: Beneficiary Attribution, Care Management Fee, Performance-Based Incentive Payment, and Payment Under the Medicare Physician Fee Schedule*, January 1, 2017.

	Tier assignment occurs quarterly and determines monthly CMF payment.		
Payer Participation	Multi-payer	Multi-payer	Similar approaches
Settings of Care	Office-based E&M and non face-to-face interactions (e.g., email, phone, patient portal, etc.).	Multi-Setting (e.g., office, post-acute care, in-home, telehealth, and transitions across settings.) Includes, but not limited to, services provided in ambulatory and office-based settings as well as face-to-face evaluation and E/M services regardless of site of care.	APC-APM incorporates care provided by primary care physicians across settings of care. Levels reflect practice types and continuity of care delivered.
Patient Attribution	Medicare claims are used to attribute beneficiaries to CPC+ Practice Site based on recent use of Chronic Care Management (CCM) services or plurality of eligible primary care visits for that beneficiary. Beneficiaries assigned to CPC+ Practice site, not individual practitioner. ⁷	4 step attribution process with 24-month look-back; patient choice as first option <ol style="list-style-type: none"> 1. Patient Selection of Primary Care Physician and Team 2. Primary Care Visit Events: Wellness Visits 3. Primary Care Visit Events: All Other E/M Visits 4. Primary Care Prescription and Order Events 	Unlike CPC+, APC-APM uses patient choice as primary method of attribution. Claims based attribution, which is the primary methodology under CPC+, is used secondarily to patient choice in APC-APM.
Geographic Distribution	18 regions (Round 1 and 2) <ul style="list-style-type: none"> • Arkansas: Statewide • Colorado: Statewide • Hawaii: Statewide • Kansas/Missouri: Greater Kansas City Region • Louisiana: Statewide • Michigan: Statewide 	AAFP recommends the APC-APM be implemented nationally	Whereas CPC+ implementation is limited to certain regions, APC-APM is intended to be implemented nationally

⁷ CMMI, *CPC+ Payment Methodologies: Beneficiary Attribution, Care Management Fee, Performance-Based Incentive Payment, and Payment Under the Medicare Physician Fee Schedule*, January 1, 2017.

	<ul style="list-style-type: none">• Montana: Statewide• Nebraska: Statewide• New Jersey: Statewide• New York: North Hudson-Capital Region;• New York: Greater Buffalo Region (Erie and Niagara Counties)• Ohio: Statewide/Northern Kentucky Region• North Dakota: Statewide• Oklahoma: Statewide• Oregon: Statewide• Pennsylvania: Greater Philadelphia Region• Rhode Island: Statewide• Tennessee: Statewide		
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From: Kent Moore
To: [PTAC \(OS/ASPE\)](#)
Subject: Re: PTAC: Questions from PTAC Preliminary Review Team on AAFP Proposal
Date: Thursday, October 05, 2017 11:05:50 AM

Dear ASPE PTAC staff,

This email is in follow-up to the September 19, 2017, conference call that we had with members of the preliminary review team (PRT) assigned to the American Academy of Family Physicians' (AAFP) proposal for an Advanced Primary Care Alternative Payment Model (APC-APM). We appreciated the opportunity to further discuss the AAFP's proposal with the PRT members, and we hope they found it as helpful as we did.

As we reflected on and reviewed our notes from the call, we identified three of the original 18 PRT questions on which we want to elaborate. Specifically, below we hope to provide clarity related to three issues discussed during the call,

- 1) Need for Levels 1 and 2 options for primary care global payment,
- 2) Estimating payments under the APC-APM, and
- 3) Measures used to assess cost/utilization.

We also have a few logistical questions for your consideration.

Need for Levels 1 and 2 options for primary care global payment (PRT Question 5)

First, during the call, we perceived that some PRT members remain either confused or concerned about our proposal to include two levels of prospective, primary care global payment as part of the model. A member of the PRT asked if having two levels was essential.

As stated during the call, we do not believe that two levels are essential. Our intent in offering them in our original proposal was a recognition that not all primary care practices provide the same scope of evaluation and management (E/M) services. For instance, some primary care practices provide only ambulatory, office-based E/M services, while others provide E/M services in multiple sites of service (e.g., office, hospital, nursing facility, etc.). However, our conversations with the PRT have persuaded us that offering participating practices the choice of multiple levels may not be necessary so long as the scope of the primary care global payment is consistent with the scope of the E/M services provided by the practice.

Estimating payments under the APC-APM (PRT Question 7)

Next, PRT members inquired if it was possible to present estimates for the base payment or payment ranges for the primary care global payment, population-based payment, and performance-based payments. We continue to believe the amount of these payments will need to be determined by the participating public and private payers in negotiation with the participating practices, and Medicare payment rates vary geographically, so it is not possible to accurately estimate those payments now.

Further, the APC-APM is not meant to be prescriptive at this stage. Rather, the approach is for payers to identify a level of investment in primary care as a percentage of total health care spending and apportion that investment among the four components of the APC-APM payment methodology. However, as described in our written response to the PRT questions and as reflected in the Center for Medicare and Medicaid Innovation (CMMI) work already done for the Comprehensive Primary Care (CPC) initiative, the PRT can think about each of these pieces of the APC-APM payment methodology in ways that allow them to get some estimate of what Medicare might pay.

Performance-Based Incentive Payment (PBIP). For example, the performance-based incentive payment is the piece at risk, allowing the model to meet the risk criterion for being an advanced APM. Therefore, we would expect the performance-based incentive payment to be equal to at least eight percent of total revenues, which is otherwise represented by all four pieces of the proposed APC-APM payment methodology. The performance-based incentive payment (PBIP) piece of the CPC+ payment methodology qualifies that model as an advanced APM, and CMMI has set the total PBIP under CPC+ as \$2.50 per beneficiary per month (PBPM) for Track 1 CPC+ practices and \$4.00 PBPM for Track 2 CPC+ practices. We expect the Medicare performance-based payments under APC-APM to be comparable.

Population-Based Payment. Like the care management fees offered under CPC+, the population-based payment under APC-APM is intended to enable participating practices to provide non-face-to-face services to their attributed patients. Track 2 practices under CPC+ (which would be most comparable to the types of practices participating under APC-APM) can expect to receive care management fees ranging from \$9 to \$100 PBPM, depending on the risk tier in which a beneficiary is categorized.

Global Primary Care Payment. The global primary care payment will be the most difficult to estimate. As noted in our previous written responses to the PRT, we believe that most of what an advanced primary care practice does is represented by the primary care global payment and the population-based payment. Together, these two pieces should represent more than 50 percent of practice revenues, increasing up to 75 percent after two years. We note this expectation is consistent with the findings in the *Health Affairs* article cited during our call with the PRT, which supports that high levels of capitated payments are needed to shift primary care toward practice transformation. We have also stated primary care payments should initially increase from 6% to 7% of total health care spending. Given that, we suspect the Office of the Actuary (OACT) or someone else with similar capabilities should be able to estimate what CMS might pay practices for a risk-adjusted, PBPM global primary care payment, assuming it plus the population-based payment equal 50%-75% of total practice revenue and assuming other estimates referenced above apply.

Measures used to assess cost/utilization (PRT Question 11(b))

Finally, we would like to provide additional information related to which measures are tied directly to payment (e.g. result in payment adjustments).

Under the APC-APM, payment is tied directly to eight measures: six quality measures (including at least one outcomes measure) chosen by the practice plus two other utilization measures (also in CPC+) that are included in our model—inpatient hospitalization utilization per 1,000 attributed beneficiaries and emergency department utilization per 1,000 attributed beneficiaries. How a practice performs on all eight measures relative to benchmarks set by the payer will determine whether the practice keeps the performance-based incentive payments made under the model.

As noted in our proposal and in our written response to the PRT questions, the pool of quality measures from which the practice may choose the six quality measures is the PCMH/ACO Core Measures developed by the multi-stakeholder Core Quality Measure Collaborative. There are more than six measures available in this measure set, but like MIPS, the APC-APM requires APM entities to choose only six measures.

Under the APC-APM, payment is tied directly to performance on the six quality measures (including at least one outcomes measure) a practice chooses from the Core Measure set plus two other utilization measures: inpatient hospitalization utilization per 1,000 attributed beneficiaries and emergency department utilization per 1,000 attributed beneficiaries. We noted in our response to the PRT question that of the 22 measures in the Core Measure set, the only measure whose technical specifications are tied to payment is “NQF #0052: Use of Imaging Studies for Low Back Pain,” however, as noted above, performance and payment under APC-APM is based on the six quality measures chosen by the practice plus two additional utilization measures.

Our logistical questions for you are as follows:

- We understand that the APC-APM proposal is expected to be on the December agenda of the Physician-focused Payment Models Technical Advisory Committee (PTAC), which is scheduled for December 18-20, 2017, in Washington, DC. Is it possible for us to present on the morning of Tuesday, December 19th, to accommodate the schedule of our President, who is one of our presenters?
- When will the PRT report to the PTAC be available for our review in preparation for the PTAC meeting?
- What is the status (if any) of ASPE or PRT discussions about the AAFP’s proposal with staff at the Centers for Medicare & Medicaid Services (e.g. OACT, CMMI)?

Thank you for your time and consider of this email. If you or members of the PRT have other questions or if we may be of further assistance in facilitating the PRT’s consideration of our proposal, please let us know. We look forward to your reply to our logistical questions at your earliest convenience.

Kent Moore

Senior Strategist for Physician Payment
American Academy of Family Physicians



December 6, 2017

Jeffrey Bailet, 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. Bailet:

On behalf of the American Academy of Family Physicians (AAFP), I write in response to the November 15, 2017, preliminary review team (PRT) [report](#) to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) regarding our [proposal](#), “Advanced Primary Care: A Foundational Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care.” As discussed further below, we appreciate the PRT’s work and, in general, agree with its conclusions. We also take this opportunity to further address two of the criteria where the PRT felt our proposal was lacking and some of the key weaknesses perceived in our model.

First, we thank the PRT members, Kavita Patel, MD, MSHS, Tim Ferris, MD, MPH, and Harold D. Miller, for all the time and effort they have put into reviewing our proposal. They asked excellent questions as part of the review process, and the two conference calls we had with them were productive and instructive from our perspective. Our thinking about the proposal has evolved as a result.

Second, in general, we appreciate the conclusions that the PRT reached in its report. We are gratified to know the PRT concluded our proposal met eight of the ten criteria set by the Secretary, including all three high priority criteria. We also took note of the following sentence in the final paragraph of the report: “The PRT believes that the proposal is sufficiently different from CPC+ [Comprehensive Primary Care Plus initiative] and other current CMS APMs and that those differences hold sufficient promise for improving patient care and reducing spending to justify testing this model in addition to CPC+.” We could not agree more.

We acknowledge and agree with the PRT that our proposal is not perfect. The PRT concluded that our proposal did not meet the criteria of “Ability to be Evaluated” and “Integration and Care Coordination.” The PRT members also observed what they perceived as three key weaknesses in the model: (1) making patient choice the primary method of attribution, (2) the use of two per-beneficiary per-month (PBPM) payments, and (3) the use of two levels of payments for evaluation and management (E/M) services. Finally, the PRT also noted in a few areas that quality measurement could be strengthened. We take this opportunity to further address each of these points in advance of the full PTAC’s consideration of our proposal– and believe that our proposal does meet these last two criteria.

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Ability to be Evaluated Criterion

The PRT stated that it “does not see how valid benchmarks could be established under the proposed model, given that patient choice is the primary method of determining which patients the primary care practice will receive payment and be accountable for.” In response, we observe that patient attribution, including attribution by patient choice, is prospective under our proposed model. Both payers and practices will know in advance of the relevant performance period which patients are attributed to which practices. As such, we are unclear what information payers will lack that will otherwise prohibit them from establishing valid benchmarks. We look forward to clarifying this point with the PRT and the rest of the PTAC when we meet with the full PTAC on December 19.

The PRT also observed, “The model creates two different tracks with small differences in terms of the services that are bundled into the monthly payments, so in order to evaluate these options, separate comparison groups would be needed, which could be challenging to create depending on how many practices and which types of practices choose these tracks.” We note there are other ways to evaluate alternative payment models besides strict comparison groups. For instance, the model could be evaluated based on key metrics measured before and after its implementation. Further, if the model was nationally available, as proposed, there may be less need to worry about small numbers in each of the evaluation arms. Indeed, the APC-APM creates the opportunity for a large-scale evaluation of a national model, which can help to fill existing gaps in the evaluations of medical homes and other advanced primary care practices in terms of their impact on quality, utilization, and cost. The AAFP remains committed to working with the Centers for Medicare & Medicaid Services to leverage current evaluation approaches underway in other models, such as CPC and CPC+.

Integration and Care Coordination Criterion

The PRT notes that there are no requirements or measures of care coordination for individual patients, nor has the AAFP provided any indication as to how physicians outside of the primary care practice, such as consulting specialists, would be compensated for time spent in communication and coordination with the primary care practice. As the PRT notes, practices participating in this model are expected to attest that they meet the Joint Principles of the Patient-Centered Medical Home, one of which is “Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community- based services).” Likewise, participating practices must attest to the functions that guide delivery transformation under the CPC+ initiative, and one of those functions is “comprehensiveness and coordination.” Practice’s performance on quality and utilization measures, including at least one outcomes measure, will serve to validate whether they are, in fact, fulfilling these expectations. Thus, we would argue that practice performance on care coordination is being measured.

As to how physicians outside the practice will be compensated for their time and efforts, the PRT is correct that the model does not address this point. We view that as a matter for those physicians to determine with the payers who are otherwise compensating them for their services. The scope of the APC-APM is primary care, an already large scope given the numbers of visits Medicare beneficiaries make to primary care. From our perspective, compensation of specialists is outside the scope of the delivery and payment model we have proposed.

According to the comment letter it submitted to the PTAC, Ascension health system has a model like that proposed by the AAFP. Under Ascension’s similar model, specialists change behaviors to work with the primary care physicians, which promotes coordination of care, because specialists see that

when they provide value to the attributed lives they increase their referrals and share in financial value creation.

Patient Attribution and Choice

The PRT unanimously found the model met the criterion of “Patient Choice” at least in part based on patient choice being the primary method of attribution. However, we hope to gain further clarification from the committee on why this is also a key weakness of the model – especially given that current attribution methodologies also face challenges. We also note that the Health Care Payment Learning and Action Network [white paper](#) on “Accelerating and Aligning Population-Based Payment Models: Patient Attribution” encourages patient choice of a primary care physician as the primary method of patient attribution, stating, “The ideal method for patient attribution is active, intentional identification or self-reporting by patients.” Finally, other stakeholders that have reviewed our model describe the use of patient choice as the primary attribution method as novel and preferable.

We believe connecting patients to a primary care physician, preferably through patient choice, is critical to driving patient engagement, establishing the physician-patient relationship, and ensuring patients are aware of the alternative payment model. Indeed, it is so critical that, in 2017, Covered California connected every enrollee to a primary care clinic within 60 days as a first point of contact and advocate. The intent is to reclaim the supportive role of primary care physicians as the preferred initial point of entry into a complex care system, and we believe there is no better way to express that preference than through patient choice.

PBPM Payments

The AAFP is open to discussing combining the PBPM payments in a future iteration of the model, as we stated in response to questions from the PRT. The AAFP continues to believe that separate PBPM payments for the primary care global payment and population-based payment will be a less radical departure from current payment models than combining both into one from the outset. Two separate PBPM payments in this model mimics current payment models, which pay for face-to-face and non-face-to-face services separately, to the extent non-face-to-face services primary care physicians deliver in support of their patient population are compensated at all. For instance, under the Medicare physician fee schedule, face-to-face services, such as office visits, are paid separately from chronic care management codes. Likewise, under both original CPC and CPC+ models, payers pay a care management fee separate from the payments made for face-to-face services provided by the practice. Thus, from our perspective, two PBPM payments facilitate transition to a model in which both are ultimately combined, and a less radical departure from current payment methods will provide practices and payers with an opportunity to become comfortable with both PBPM payments in preparation for their eventual combination.

Levels of E/M Payment

Our intent in offering two levels of primary care global payment for face-to-face E/M services in our original proposal was a recognition that not all primary care practices provide the same scope of E/M services. For instance, some primary care practices provide only ambulatory, office-based E/M services, while others provide E/M services in multiple sites of service (e.g., office, hospital, nursing facility, etc.). However, our conversations with the PRT have prompted us to rethink necessity of multiple levels if the scope of the primary care global payment is consistent with the scope of the E/M services provided by the practice. We understand the PRT’s assessment and are open to discussing further to ensure that the payment model is simple and minimizes unintended consequences.

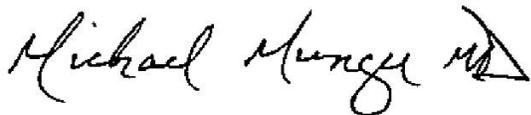
Quality Measurement

Last, the PRT expressed concerns about the robustness of quality measurement under the model. The APC-APM proposed to use consensus-based quality measures – through the Core Quality Measure Collaborative – a public-private partnership that aims to drive measure harmonization and reduce administrative burden. We believe these goals – aligning and simplifying quality measurement - are critical to incenting greater participation in value-based payment programs. In addition, the AAFP has designed the APC-APM to meet Advanced APM criteria, which require that the model provide payment for professional services based on quality measures comparable to measures in the Merit-Based Incentive Payment System. The AAFP would welcome the opportunity to work with CMS to ensure quality measurement is meaningful, actionable, and safeguards against cherry picking or other potential unintended consequences; however, we believe that adding measures or reporting requirements should also prioritize measure harmonization and reduction in physician burden

Again, we commend the PRT for its report and the time and effort the PRT members put into developing it. We find much in the report with which we agree, including the PRT's conclusion that there is justification to test our model. The feedback to the report offered in this letter is intended to further facilitate a constructive conversation with the PRT and the rest of the PTAC when the full PTAC considers our proposal on December 19. We look forward to that conversation and to addressing other questions or concerns PTAC members may have with our 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,

A handwritten signature in black ink that reads "Michael Munger MD". The signature is written in a cursive, flowing style.

Michael Munger, MD
President

Cc: Kent Moore

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3 PHYSICIAN-FOCUSED PAYMENT MODEL
4 TECHNICAL ADVISORY COMMITTEE (PTAC)
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10 PRELIMINARY REVIEW TEAM (PRT)

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12 CONFERENCE CALL
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16 Monday, June 12, 2017
17 5:00 p.m.
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23

24 PRESENT:

25
26 TIM FERRIS, MD, MPH, PTAC Committee Member
27 HAROLD MILLER, PTAC Committee Member
28 KAVITA PATEL, MD, MSHS, PTAC Committee Member
29 Mary Ellen Stahlman, PTAC Staff Director, Office of the
30 Assistant Secretary for Planning and Evaluation (ASPE)
31 SARAH SELENICH, MPP, ASPE
32
33

34 American Academy of Family Physicians (AAFP)
35 ANDREW ADAIR, Government Relations Representative
36 PURVA RAWAL, Principal at CapView Strategies; Adjunct
37 Assistant Professor at Georgetown University
38 ROBERT BENNETT, Federal Regulatory Manager
39 BETHANY BURK, Quality and Practice Specialist
40 ROBERT HALL, Director of Government Relations
41 JANE KRIEGER, RN, JD, Division Director of Practice
42 Advancement
43 SHAWN MARTIN, Senior Vice President of Advocacy, Practice
44 Advancement and Policy
45 KENT J. MOORE, Senior Strategist for Physician Payment
46

47 P R O C E E D I N G S

1 [5:04 p.m.]

2 DR. PATEL: Let's go ahead and get things
3 kicked off. I'm not sure if people realize this is
4 Kavita Patel from the PTAC, and we have Harold
5 Miller also from the PTAC along with Sarah and --
6 Sarah, I am not sure who else is on from ASPE, from
7 PTAC.

8 MS. SELENICH: Right now, it's just me.

9 DR. PATEL: Okay. And we're expecting
10 probably to beep in any minute now, Tim Ferris.
11 Tim, Harold, and myself comprise kind of the
12 preliminary review team that I think you all have
13 seen some of our questions, and we arranged this
14 conference call, so thank you. I know that we're
15 all on different time zones, and I appreciate that
16 you're taking your time out of your day at the end
17 of a day on a Monday. But it sounded like it would
18 be helpful for you all to have some context and
19 dialogue, and it would also be helpful perhaps for
20 us to give you some context.

21 And I'll just start. I'm going to be very
22 brief, and then, Harold, I'd love to just hand it
23 over to you as well to add in some comments.

24 I'll just say that we're very excited to

1 be able to talk live. To set some context, you'll
2 see -- and there's a beep. Who just joined?

3 DR. FERRIS: Tim.

4 DR. PATEL: Hey, Tim. It's Kavita, and I
5 went ahead and did a little bit of queueing of
6 introductions. We have a large team from the AAFP,
7 some in speaking and participatory mode and some
8 largely in listening mode, and then you have me,
9 Harold, and Sarah from the PTAC/ASPE side.

10 DR. FERRIS: Thanks so much. Sorry I'm
11 late.

12 DR. PATEL: No, no worries. We were just
13 doing intros, recordings, et cetera.

14 And, Tim, just for a formality, because
15 this is being transcribed and recorded, when you do
16 speak, just announce who you are.

17 So, again, I'll just say for our sake, we
18 wanted -- and we can go through some of the
19 questions. We all have, hopefully, the document in
20 front of us with some of our questions, with some
21 of your responses as a submitter.

22 I'll just say, broadly speaking, we really
23 would love to understand, and some of your
24 responses were very helpful in giving us a little

1 more depth. And we know that 20 pages is sometimes
2 just, obviously, not enough room.

3 One, we wanted to understand a little bit
4 about how this would work if perhaps, as you
5 identified, an APM Entity such as a practice were
6 actually to step up and say, "Yes, we would like to
7 do this model," and so you'll kind of see that some
8 of our questions really kind of get a little bit
9 more into the weeds of how would this work. That
10 is just one broad-brush stroke.

11 I'd say the second one -- and you can see
12 it also reflected in some of our questions and your
13 responses -- we as a PTAC have an obligation to
14 think about the Medicare program. We care very
15 much about how other payers are informed or aligned
16 or might adopt this, but certainly, because of our
17 authorization in MACRA, that's actually what's
18 front of mind for us.

19 So, if it's helpful, Kent and Shawn and
20 others who are on the call, I would say that it's
21 helpful to probably start with that Medicare
22 context in mind, and so you'll see some of our
23 questions try to get at things like cost estimates
24 or potential burdens. We're looking at that. We

1 know that that can vary from payer to payer, but to
2 be kind of the great equalizer of sorts, we are
3 thinking about the Medicare program.

4 And I would say just as a point 2B, the
5 second brush stroke is that we also then want to
6 understand, obviously, given how much of the
7 country is interested in primary care
8 transformation, whether it be CPC+, some of the
9 ACOs that are out there, we would love -- one of
10 the areas we've been interested in learning more is
11 how this model, when you think about the existing
12 Medicare opportunities, how you would think about
13 this model in comparison or contrast to that. And
14 that's where you can see some of the spirit of our
15 questions.

16 So I'll just stop there and ask if Harold,
17 Tim, or Sarah have any other contextual kind of
18 elements that they want to just offer before we go
19 into a discussion.

20 MR. MILLER: This is Harold.

21 I will just add two things. One is just
22 for everybody's benefit, I guess. This merry
23 little band of preliminary review team that Kavita
24 and Tim and I are on is not a decision-making body.

1 We are really an information-gathering entity,
2 because it's the full PTAC that makes the decision.
3 And, in fact, we changed our process, that the PRT
4 isn't even going to be making any kind of a draft
5 recommendation as to what the PTAC should do.

6 So all of these questions are really
7 trying to make sure that we get the best and most
8 complete information for all of our colleagues on
9 the PTAC, all of whom are volunteers, and while we
10 would probably all love to be involved in every
11 call, just inherently don't have the time to be
12 able to do that.

13 The second thing is that we are
14 statutorily constrained to evaluate proposals
15 against the criteria that the Secretary
16 established. So it's not just a matter of whether
17 we think it's a good idea or not. It's really to
18 specifically have to assess it against all of those
19 criteria, and one of those criteria is this issue
20 of how is this different than things Medicare is
21 already doing, and is it giving an opportunity for
22 people who don't have an opportunity to participate
23 in things like that.

24 So some of our questions are really

1 designed to try to get very specifically at those
2 criteria, which is why there are so many questions
3 in some cases, and some of them may seem redundant
4 in some cases, but it's because we are trying to be
5 able to get at those criteria.

6 So, hopefully, that helps maybe you
7 understand a little bit kind of the process that
8 we're going through.

9 DR. FERRIS: And this is Tim.

10 I'll just add one more point to what
11 Harold said on the same theme. Something that
12 we've noticed that people didn't understand about
13 our prior evaluations and maybe may seem a bit odd
14 is that we are prohibited from deliberating, as
15 that term is understood by lawyers at CMS, as a
16 group, except in public. So one of the things you
17 may notice is that while the rest of the PTAC will
18 get our sort of informational summary of our
19 discussions with you and our review of the
20 proposal, there is likely to be quite a bit of
21 redundancy at the PTAC level in terms of the
22 questions and so forth. We will try to avoid that,
23 but it is literally true that we do not talk about
24 this proposal as a PTAC prior to the public

1 meeting, and a lot of people didn't get that the
2 first time around. They thought it was sort of odd
3 that we were having such a frank and open and --
4 let's just say we were displaying our ignorance to
5 one another, and that's because we literally do not
6 deliberate, except in public. I just wanted to add
7 that to Harold's comment.

8 DR. PATEL: This is Kavita.

9 I'll round out by saying that the
10 transcript of this call is one of the documents
11 that will be available to all PTAC members, but
12 there would not be any discussion between our
13 Preliminary Review Team and any of the other
14 members of PTAC. So it's just for helpful context,
15 so just to underscore Tim's, kind of, comment, that
16 you might wonder why people are referencing things.
17 It's because they would only have discovered it, so
18 to speak, when they're doing their own individual
19 reading and not through any prior discussions.

20 So, with that, I believe, Kent, I just
21 want to -- I'm not trying to identify you only, but
22 I know that we wanted to have a discussion to be
23 able to address some of the questions we had. Did
24 some of the context give you a little bit of a --

1 just a broad sense of why we had some of the
2 questions? And then perhaps we can go into the
3 questions directly.

4 MR. MOORE: So this is Kent at the AAFP,
5 and the context that you provided was very helpful.
6 And I think we're prepared to go into the questions
7 that we had relative to the questions you had that
8 we have yet to answer as well as address any
9 additional questions you may have based on the
10 answers we've already given to some of the
11 questions you asked.

12 DR. PATEL: Okay, great.

13 So, without further ado, we can go ahead
14 and just go in order, Kent. This is Kavita. We
15 can just either go in order or happy to -- myself,
16 Tim, Harold, and Sarah know this very, very well,
17 so we can go back and forth, whatever makes sense.
18 But I know No. 2, there were a couple of questions
19 -- 2, 3 -- and several, but we wanted to be able to
20 have a chance for you to ask us anything and then,
21 hopefully, just have a dialogue.

22 MR. MOORE: So this is Kent again.

23 You're correct. Questions 2 and 3 are the
24 two on which we are seeking clarification on this

1 call. If you want to address those first, that's
2 fine. If you want to start with Question 1 and
3 deal with those when we get to them, that's okay
4 too. Either way is fine.

5 DR. PATEL: Okay. Why don't I move us
6 through, for the sake of time. They're all
7 somewhat related. So what we were trying to
8 understand -- and perhaps we'll get into it when
9 you say a comparison of key design features of the
10 two models in answer to Question 1, that might
11 help. But I know that if we get to 2 and 3, we
12 might be able to provide you the information to
13 give us some of those key design features.

14 So let's just go to 2, and then we can
15 circle back if we have some time, because we are
16 interested. The reason we are interested in the
17 comparison, as you alluded to in the answer to No.
18 1, is just so that we can understand for the
19 context of the Medicare population what are some of
20 the differences. And if you are sitting in a
21 primary care practice that's thinking about
22 becoming an APM Entity, how you might see the
23 differences between these models. And so we're
24 trying to take the perspective of the physicians,

1 since that's our physician-focused payment model.

2 So, in No. 2, we ask that we could
3 understand just some examples in potentially
4 different practice settings about how this would
5 operate, and this is really to, I would say, kind
6 of several issues.

7 One is potentially how an APM Entity
8 practice, for example, might go about thinking
9 through whether they are a Level 1 or a Level 2
10 participant, and really just walking us through
11 almost, if you were to put on, the hat of a
12 practice manager to the physician leadership at a
13 practice, how you would think about kind of taking
14 up this opportunity, if it were deemed an
15 alternative payment model.

16 And so the goal of asking that question --
17 I feel like I don't want to sound, Kent, like I'm
18 just repeating the question. Really, the goal was
19 to actually, virtually kind of understand, you
20 know, would a practice that's potentially a smaller
21 size or has been a participant in another Medicare
22 model be interested in one level versus another.
23 How would they select some of the quality measures?
24 You've offered a lot of examples. And just walking

1 through kind of potentially if you are in the shoes
2 of a lead of a practice, that's really, actually,
3 kind of what we're trying to get at, not just with
4 2 and 3, but some of the other questions as well.

5 MR. MOORE: So this is Kent. That's
6 helpful and addresses sort of one of the two
7 questions we had related to Question 2, that
8 question being sort of what level of detail you're
9 seeking in response to the question, so I have a
10 better feel for that based on what you've said.

11 The other question we had related to
12 Question 2 is sort of the format that you would
13 prefer to see that in. Are you looking for sort of
14 a -- I'll describe it as a side-by-side table where
15 you'd have one column for one example and the
16 second column for the second example, and each row
17 would be a different facet of the thought process,
18 or are you looking for what might be described as
19 sort of a narrative case study for each of the two
20 examples? I'm just trying to get a better feel for
21 what you expect to see in response to the answer.

22 DR. PATEL: Just to show you that our team
23 does not practice any of this, I'll go ahead and
24 state what I think, but I want Harold and Tim to

1 weigh in as well.

2 I'll briefly just say that it's whatever
3 format would allow for you to give us the more
4 detail. So if a narrative case study lends itself
5 to that, fine. If a table lends itself to that,
6 that's fine.

7 I would say that we're looking -- in my
8 opinion, what we're really trying -- you're
9 probably wondering, "Where are they trying to go?"
10 What we're really trying to understand is how this
11 would look kind of on the ground with a practice or
12 at least how an APM Entity, as you proposed it,
13 would think about making a decision between Level 1
14 and 2. And this also strikes into the feasibility
15 issues, which we allude to in No. 3, just to try to
16 get a sense of would you anticipate that more of
17 the smaller practices might be interested in Level
18 1, for example, or larger practices.

19 So I would say whatever format lets you
20 describe what we're looking for, and we're not
21 trying to tell you what that is, but just give you
22 that flexibility.

23 Tim, Harold, any thoughts there?

24 MR. MILLER: Well, I would agree with what

1 you said. Maybe I would just also say it's
2 whatever format you think best describes why and
3 how you think this model is going to be helpful.

4 One of the things that we -- if you look
5 at the applications that we have received,
6 proposals we have received so far, and that we
7 discussed at the April meeting, they kind of fell
8 into two categories.

9 One was proposals that really started with
10 a care model concept: We want to deliver care in
11 the following way, and we can't do it under the
12 current payment system, and here is a very specific
13 payment solution for that.

14 The other approach was: Here's a
15 different way to pay, and there's much more
16 flexibility, et cetera, under it than exists today,
17 and we're not quite sure what's going to happen.

18 And the ideal in some cases, in many ways,
19 is to be able to understand both. So how does a
20 payment model work, and how is it going to enable
21 care to be delivered differently? So, to some
22 extent, that Question No. 2 was a little bit, at
23 least from my perspective -- again, we all have
24 different points of view about this -- is really

1 how do you see a practice doing something different
2 with this model to be able to improve patient care,
3 save money, et cetera, et cetera, et cetera, rather
4 than just struggling with the administrative burden
5 of having a new and different payment system than
6 they had before? And some of the choices, Kavita
7 said about Level 1 or Level 2, for example, it just
8 honestly was not at all clear, and I have to say
9 wasn't clear from the responses that you gave in
10 other questions, as to why you had that distinction
11 and why a practice might or might not want to pick
12 one or the other. And so we're trying to
13 understand a little bit better, how a physician
14 practice might do that.

15 So, when we say two specific examples, it
16 was only to try to -- you can give 10, if you want.
17 It was only to say that we understand that there
18 may not be just one way people go at this. We
19 would like to understand how it might differ, but
20 you don't need to feel like as if how you are only
21 giving the only two ways. It is just really
22 illustrations to make sure we understand what's in
23 your mind about what this proposal is designed to
24 help primary care practices achieve.

1 DR. PATEL: Tim?

2 DR. FERRIS: I don't have anything to add.
3 I agree with what you said.

4 DR. PATEL: All right. Kent, any
5 clarifications or responses to that, that you need?

6 And you'll see we offer -- I should just
7 say, you'll see that we put a lot on the -- in
8 comparison also to CPC or CPC+. So I think we're
9 trying to do all of this and understand what does
10 it mean when -- and we know that there's -- you
11 pointed out in some of your responses why CPC+ is
12 not an option for many practices, but we're really
13 trying to understand, again, evaluating against the
14 Secretary's criteria kind of where there are
15 overlaps as well as differences. So that's what
16 we're trying to answer.

17 So, if you attended the first PTAC
18 meeting, you'll see that we really did try to
19 adhere to the criteria, but as Harold mentioned,
20 we're somewhat constrained by that as well.

21 MR. MARTIN: Kent, let me jump in.

22 Kavita, this is Shawn Martin.

23 Would it be beneficial for us to outline a
24 core set of assumptions, so of kind of our view of

1 primary care, the state of primary care in general?
2 It seems that some of the questions around
3 capability, willingness, interest could benefit
4 from a kind of baseline analysis on our part of
5 where we think the majority of physician practices
6 are on June 12th.

7 DR. PATEL: This is Kavita.

8 Shawn, any of that context will help,
9 because I think, obviously, as a submitter, you're
10 coming in with that knowledge, and so I definitely
11 think it's better to err on the side of inclusion.

12 I would just say that what we have done --
13 I mean, this is definitely kind of our
14 responsibility. When you've made references to the
15 LAN, to some of these other papers, we've looked at
16 those. So what I would say is that anything you
17 do, don't feel like you need to repeat what you
18 might have already cited, but I think any context
19 you can add about readiness of practices, variation
20 in size, and kind of your understanding of that,
21 and then potentially how that might impact
22 decisions to be in a Level 1 or 2, and then just
23 practically speaking kind of what those differences
24 are, if a certain type of practice or entity might

1 choose one versus the other and then how that would
2 work, that would definitely help.

3 I mean, we asked about feasibility. You
4 know, this is, again, referencing some of the
5 Secretary's criteria. So we wanted to ask about
6 barriers. We wanted to ask about feasibility. We
7 wanted to ask about quality impact on cost, and
8 then you'll recall that in some of those
9 information requirements, we're also being asked to
10 kind of think through could an existing CMS model
11 address some of the gaps in this physician-focused
12 payment area.

13 So you can see kind of where we want to be
14 able to concretely answer each of those questions
15 as a Preliminary Review Team.

16 MR. MILLER: And this is Harold.

17 I would just add, Shawn, I mean, anything
18 you want to provide is certainly welcome. I'd be
19 happy to read anything.

20 But I think we as a sort of advocacy for
21 more support for primary care, it is going to be
22 less helpful than specifics about how this
23 particular -- we're evaluating a specific payment
24 proposal. We're not taking a position on whether

1 primary care physicians need to be paid better or
2 differently. I'm with you on that.

3 The issue is we have to decide whether
4 this particular payment model works, and back to
5 the points that we've all made, we have to evaluate
6 against the criteria. And one of the criteria is
7 that it has to be different than things that -- or
8 at least one of the options for the criterion is it
9 has to be different than things CMS is doing.

10 So we're trying to understand as clearly
11 as we can, which is why there are these questions
12 about CPC. Don't take any of that, that somehow we
13 love CPC+ and somehow you have to prove that your
14 model is better.

15 The issue is, to what extent is it
16 different, and what is it doing differently, and in
17 what sense is that going to be more helpful to
18 specific practices and why? And as specific as you
19 can get about that will help us and help you.

20 MR. MARTIN: This is Shawn.

21 That was very helpful. Thank you.

22 Kent?

23 MR. MOORE: This is Kent.

24 I think that addresses all of our

1 questions regarding No. 2. I would like to shift
2 to Question No. 3 briefly and ask if you could
3 elaborate on what you mean by a, quote, "business
4 case," end quote. Again, give us a little feel for
5 what level of detail you're seeking, especially
6 when you talk about what costs the practice would
7 incur and whether you anticipate or expect any
8 quantitative modeling to accompany that answer, or
9 whether you're just looking for a narrative answer.

10 DR. PATEL: This is Kavita.

11 I will start briefly. So this overlaps a
12 little bit with Question 7 in some way in that we
13 are looking even for -- it could be if you have
14 done modeling, that would be great to even just
15 see. Maybe, again, we're talking about the
16 Medicare program as a foundation, so potentially,
17 in the Medicare program, are there cost estimates
18 for what a practice might need to do to undergo
19 that long process of transformation? If you are
20 thinking that a small practice might need to make
21 investments on a certain FTE size or cost, et
22 cetera, that is only if that exists or if you've
23 thought about that.

24 We also are looking for estimates, and

1 this is where it does overlap a bit, by the way,
2 with No. 7, where we are trying to understand kind
3 of how this spending on primary care alignment with
4 the payment might be calculated.

5 And, again, we're really not looking to
6 hold you and say, "Well, the submitter said it
7 would be \$20 per bene per month." It's really just
8 so that we can get literally a more granular
9 understanding of the flow of funds, and so one of
10 our challenges has been -- in reading the current
11 proposal is how to actually diagram kind of where
12 would the money flow potentially from the Medicare
13 program to the APM Entity, and what would the
14 burden be on that APM Entity to actually do the
15 transformation that you're alluding to.

16 Harold, Tim, anything to add there?

17 MR. MILLER: No. I think that's a good
18 summary.

19 DR. FERRIS: I guess I would -- it is a
20 good summary. I think maybe if I could encourage
21 being a little bit more explicit, encourage the
22 model -- again, I know it might be challenging to -
23 - there's so many different ways to do the
24 modeling, but when you think about the business

1 case here, there's the business case for the
2 practice, and there's the business case for CMS.
3 Right? And so what is a plausible cost for the
4 infrastructure that is going to deliver some ROI to
5 CMS? Right?

6 And there's lots of publications that
7 could be used on the ROI from care management
8 programs or from blah-blah-blah, whatever a
9 plausible scenario for the investment from the
10 infrastructure dollars goes towards, because just
11 putting your -- if I were sitting in the PTAC's
12 shoes, hat on for a minute -- that didn't really
13 work, shoes and hat.

14 MR. MILLER: You're still in the clothing
15 range.

16 [Laughter.]

17 DR. FERRIS: Yeah.

18 That the PTAC evaluators have to be able
19 to plausibly say that there is an ROI to the CMS on
20 this, and so providing that -- I don't know if you
21 want to call it a narrative or a model, but walk us
22 through where's the investment, what's the expected
23 ROI of that investment. And the ROI can be both in
24 terms of financial ROI, decreased ED visits, and as

1 you put in your proposal, potentially decreased
2 hospitalizations, just to give a bit more
3 specificity around a plausible scenario for how
4 that might work.

5 I don't know if that is obfuscating or
6 helpful.

7 MR. MARTIN: Tim, this is Shawn Martin.

8 Let me reframe and ask my previous
9 question a different way. So our assumption would
10 be based upon some generalizable facts of practice
11 capabilities, if that practice currently
12 participated in the Medicare program.

13 So I think my question back would be, Is
14 the practice opening its doors for the first time,
15 in your opinion, or is this a practice that is
16 currently on June 11th participating in the
17 Medicare program in some capacity and on June 12th
18 would like to do that, and you're asking us to
19 articulate the differences in performance
20 capabilities between those two dates, or are you
21 saying if they started from scratch? Because I
22 think the cost factor that we're trying to address
23 will be distinctly different based upon how you
24 respond to that question.

1 DR. FERRIS: Yeah. So you added a level
2 of complexity that I had not intended.

3 I would say sort of steady-state pre and
4 state-state post, assuming there's some period of
5 implementation in between those two, that where
6 things are changing, and you're hiring and
7 rearranging and doing all this stuff of changing
8 workflows. But a plausible scenario of steady-
9 state pre and steady-state post -- and I'm trying
10 to answer your question with the simplest possible
11 scenario. I believe that would be the simplest
12 possible scenario, but tell me if you think there's
13 a simpler way to do it.

14 DR. PATEL: And, Tim, let me just -- I'll
15 just say, Shawn, I could see us quickly going down
16 like a large rabbit hole. I think our intention in
17 asking the question is not for you to necessarily -
18 - when we asked that question in No. 2 with kind of
19 how it practices, the different sizes, I think that
20 comes from the fact that you're talking to three
21 members of a Preliminary Review Team who really do
22 understand the heterogeneity of primary care. So
23 we're trying to understand not are they a CPC
24 classic and they have got this in this kind of a

1 market.

2 We actually really just want to understand
3 in the Medicare program, because we know that other
4 things might be proprietary in the commercial
5 setting, would you anticipate that maybe it's a
6 small and a large or someone with less or more
7 experience, whatever it might be, in taking risk.
8 What would a Level 1 entrant look like kind of on a
9 steady-state kind of average, and then what would
10 being in Level 1 then look like? Would it be
11 roughly X dollars per month per bene, and then here
12 they would select the quality measures and be held
13 accountable?

14 Really, if I had my druthers, Shawn, I
15 would love to fast forward and say, Could we
16 interview a practice that's actually doing this and
17 ask them these questions? Again, this is all to
18 get back to our ability to evaluate the proposal
19 against the Secretary's criteria, so this gets at
20 scope. It gets at quality. It gets at
21 feasibility, evaluability, et cetera.

22 So that's why we're asking that. We do
23 not need for you to feel burdened, "Oh, my gosh, we
24 need to go through 20 scenarios," that it's a

1 Northwest practice of a certain size that's in year
2 one of CPC+. And I'm making this up. We really
3 are trying to just get your sense, because you
4 know. You know better than anybody as the
5 submitters who might be the people that step up on
6 January 1st and say, "I want to do this." And then
7 what would "this" look like? That's actually what
8 we need.

9 MR. MILLER: This is Harold.

10 Let me just add one other thing, Shawn.
11 Don't view this -- this is not like -- this is not
12 the Supreme Court argument.

13 DR. PATEL: Right, right.

14 MR. MILLER: It's not like as if, you
15 know, whatever you send us it the last chance you
16 have. Right?

17 DR. PATEL: That's right.

18 MR. MILLER: And if it wasn't perfect,
19 then we're going to say, "Aha. They didn't do that
20 one right."

21 DR. PATEL: That's right.

22 MR. MILLER: Our general desire --
23 everybody on the Committee has agreed -- we want to
24 see things approved. So these questions are

1 intended to be helpful to try to be able to get the
2 information in whatever fashion we can to make sure
3 everybody is educated and feels comfortable. Maybe
4 in some cases, they will elicit for you some things
5 that you hadn't thought of and that you may want to
6 tweak in some fashion. That's up to you, but the
7 point of them is to be able to elicit information.

8 And if you send us in something, believe
9 me, this would not be the first time it's happened
10 so far. If you send us in something and it doesn't
11 quite get at what we wanted, we'll ask you again.

12 DR. PATEL: We'll get back to you. Yes,
13 yes.

14 Don't think of this one hour as like, "Oh,
15 this is it. This is your only chance to
16 communicate." I guess probably because we're new
17 at this, if anything, we want to have quite the
18 opposite. Please feel free to communicate as often
19 as you need to, to be able to answer these
20 questions.

21 MR. MARTIN: Right. So this is Shawn.

22 I appreciate all that kind of context and
23 background because I think our team has struggled a
24 little bit in the fact that primary care broadly

1 has more than a decade of progress under its belt,
2 and some of the other proposals that have come are
3 really starting from a different position.

4 So our assumptions of capabilities may be
5 a little bit different than other disciplines of
6 medicine with respect to what we think is capable.

7 So this has all been very helpful. I
8 think it's just helping us better understand how to
9 answer the questions, so thank you.

10 DR. PATEL: This is Kavita.

11 I am not trying to jump ahead, but other
12 things like Questions 9 and 10, we keep kind of
13 reinforcing like very -- it might seem like very
14 weedy questions, like what would a sample risk
15 adjustment methodology be. I can imagine in your
16 minds, you're thinking, "My goodness, there could
17 be so many things."

18 So if it would be helpful to caveat things
19 and just say this would be an illustrative example
20 so that you're not feeling boxed in, that would be
21 fine.

22 So just keep -- maybe a great kind of
23 caveat I could say is that anything you write in
24 response, as Harold and Tim have said in different

1 ways, you will not be kind of required to hear --
2 you won't have Secretary Price a year from now
3 going, "But you said you were going to use this for
4 risk adjustment, and you didn't do it." So it
5 really would be to give us the granularity to be
6 illustrative, and so it can really be a
7 hypothetical example.

8 It could maybe even be an APM Entity, a
9 practice that you've actually been kind of shadow-
10 modeling and working with. It could be any of the
11 above or none of the above.

12 MR. MARTIN: Okay. Kent?

13 MR. MOORE: This is Kent. I don't have
14 any other clarifying questions in terms of the
15 remaining questions we have to answer. I have a
16 few, what I would call, logistical questions at the
17 end of the call, but that's it for now.

18 DR. PATEL: And one thing I'll say, what
19 we struggled with a little bit is -- Harold
20 mentioned it. I think we really could use -- and
21 apologies if this is just our dense -- you know,
22 we're just being dense and not getting it. It
23 would help us in these examples or narratives,
24 however you want to format it -- it really would

1 help us to understand kind of Level 1 versus Level
2 2 and, again, kind of how to think about I'll take
3 your answer in -- sorry -- I'll use your answer in
4 response to our Question 8 in kind of understanding
5 payment for face-to-face services and then how
6 things are non-face-to-face and paid for.

7 And what we're having a hard time doing is
8 just kind of walking through what would -- and use
9 Medicare as the grounding foundation just to make
10 it easier. What would Medicare payment in this
11 model look like if you were Level 1 versus Level 2
12 or if you were in that kind of global primary care
13 PMPM and the population-based PMPM? That would
14 definitely help me as part of the PRT process.

15 MR. MARTIN: This is Shawn.

16 Do you want a preliminary explanation of
17 that here, or are you requesting that in writing?

18 DR. PATEL: I think it would benefit the
19 whole PTAC to have that in writing so we don't have
20 to have that here. If you feel like you've given
21 that to us already in the proposal and we just
22 haven't seen it, please point us to it, because,
23 again, we're trying to do as much as we can to not
24 have you do a lot of extra work.

1 So if you're like, "You know what, Kavita,
2 it's there. Could you please just go to X page,"
3 we have -- I would say some of us have read the
4 proposal more than three or four times just to make
5 sure we're not missing it, but I felt personally --
6 I'm going to speak for myself -- that if I had to
7 stand up at a podium and explain it, I could not do
8 a good job.

9 MR. MARTIN: Kavita, this is Shawn.

10 I think that's a fair request, and we're
11 working to provide some more depth that's not
12 included in the paper in response to your
13 questions.

14 I think one of the ways to think about it
15 is that primary care provides evaluation and
16 management services potentially in a multitude of
17 sites, and in our mind, there are those sites that
18 are self-contained, and then there are those
19 practices that are multi-site-oriented,
20 particularly incorporating care in a hospital or
21 LTC environment that could be incorporated.

22 But we will provide that more in-depth
23 explanation in writing to kind of help everybody
24 better understand what we mean.

1 DR. PATEL: And that's where I think the
2 three of us -- because we are -- I think Harold --
3 Harold is -- let me offer my like -- you know, what
4 we want to be able to do is just accurately
5 represent your intention. We know that you have
6 put so much time, effort, and resources into this.
7 We want to be able to have a discussion that's the
8 most informed.

9 And I'll just say for myself, Tim, as I
10 think all of you know, you've got a group of -- I
11 mean, Harold is practically a primary care
12 physician. You know, the three of us --

13 [Laughter.]

14 DR. PATEL: I mean, like the three of us
15 live and breathe it.

16 MR. MILLER: Not quite. Not quite. Not
17 quite. Don't represent that on the record. I want
18 it on the record, no, Harold is not almost a
19 primary.

20 DR. PATEL: It is. That's true. I'm
21 sorry.

22 MR. MILLER: But I do have great respect
23 for them.

24 DR. PATEL: We have great respect, and Tim

1 and I continue to practice in a primary care
2 setting.

3 So I think you can be as -- just like you
4 said, Shawn, you can actually use an example of a
5 typical primary care practice's day is comprised of
6 X E&M visits and Y, you know, non-face-to-face
7 visits, et cetera, and what our population-based
8 PMPM would do is take the proportion that's not
9 currently -- you know, you could even be as
10 explicit as saying the proportion of non-face-to-
11 face visits, which are currently not reimbursed,
12 but add value, et cetera, would be rolled into
13 that. Those are the kinds of practical explanations
14 that I think will help us, and that's what we're
15 looking for.

16 DR. FERRIS: Yeah. This is Tim.

17 And just to underscore that, you really,
18 really don't need to worry about the permutations
19 of different types of primary care practices. Just
20 pick one.

21 DR. PATEL: Right. Walk us through it.

22 DR. FERRIS: And just pick any permutation
23 you want, like as part of a group practice or not,
24 but whatever it is, just pick one. Then we're just

1 looking for a credible scenario in the one you
2 picked.

3 And the rest of it, I think, between our
4 knowledge of primary care and the diversity of
5 primary care and our imaginations, we can put in
6 the pieces.

7 DR. PATEL: Kavita again.

8 If you have done any data modeling or have
9 even thought about just any estimates that could be
10 useful, include that, knowing that we are not going
11 to hold you to that, nor would the CMS Office of
12 the Actuary hold you to that. I think it's just
13 more information pieces for us to be able to
14 evaluate against the Secretary's criteria.

15 Keep in mind whenever you're kind of -- it
16 helps us to also kind of use those criteria, albeit
17 as wide and as encompassing they are, those are
18 what we use to really think through how -- as
19 you've seen from our first meeting, that's how we
20 think through evaluating the proposal.

21 MR. MARTIN: Okay. This is Shawn.

22 Kent, I don't have anything additional at
23 this point.

24 MR. MOORE: This is Kent. I don't either.

1 Like I said, I have a couple logistical questions
2 at the end of the call, but I'll hold those for
3 now.

4 DR. PATEL: Sarah, is there something
5 we're missing? I know we didn't go question by
6 question, but I think we offered at least a little
7 bit of context for the ones we have.

8 MS. SELENICH: Yeah, I think that's right,
9 unless Kent or anyone else had other questions that
10 they need clarification on.

11 DR. PATEL: Kent, this is Kavita. You
12 mentioned you had some logistical questions?

13 MR. MOORE: Yes. This is Kent again.

14 So, first of all, I just wanted to confirm
15 our presumption that this will likely be on the
16 PTAC September agenda. Is that a fair assumption
17 on our part?

18 DR. PATEL: This is Kavita. We were
19 aiming for that, but what we don't want to do is
20 have you feel rushed in the process, and we will
21 make sure that we don't shortchange any of the
22 discussion that needs to happen. Let's say, for
23 example, you do come back with more questions or
24 need more time.

1 MR. MOORE: Okay. Thank you.

2 Other than the questions for which we
3 still owe you answers, is there anything else that
4 you would like to see from us or get from us in the
5 meantime?

6 DR. PATEL: In Question 1, I just want to
7 make sure -- it's Kavita -- I just want to make
8 sure I very clearly verbally articulate that you do
9 have this comparison coming forth around kind of
10 CPC+ and some of the models.

11 Keep in mind that we do want to be able to
12 kind of answer -- it would help us to really
13 understand what elements are similar and what
14 elements are different, and if you haven't thought
15 through all of that, it would be nice if you had
16 the time to be able to respond to that Question 1
17 with that comparison.

18 So, Kent, I just want to make sure that we
19 articulated that in the question, that I want to
20 make sure you have that as part of your response.

21 MR. MOORE: This is Kent.

22 Yes, very clearly understand that that
23 sort of comparison and contrasting table is
24 understood to be part of the answer to the

1 question, and it is forthcoming.

2 DR. PATEL: Okay.

3 DR. FERRIS: Great.

4 MR. MILLER: This is Harold.

5 Let me just add, Kavita, I think it's
6 certainly okay for you to -- you don't just have to
7 answer the things you haven't answered, but if you
8 want to revise the answers that you gave already,
9 given that we expressed that some of them we didn't
10 quite understand, they didn't quite help us
11 understand some of the details, that is also
12 welcome.

13 So, for example, I mean, I don't think we
14 felt that we got a clear understanding of the Level
15 1 and Level 2 concept and why it was there, and we
16 didn't fully understand the answer to Question 8
17 about the distinction between the two different
18 PMPMs. So things like that, if you can provide
19 supplemental or additional detail, that's certainly
20 okay. This wasn't your only -- you didn't only get
21 one shot at the question.

22 MR. MOORE: This is Kent.

23 Thank you. Are there other questions that
24 we thought we answered that we maybe need to go

1 back and reassess besides Question 8?

2 DR. PATEL: I do -- the question -- I
3 generally have all of these memorized. It's
4 Question 7, yes. When we asked about page 12 of
5 the proposal with the calculation of current
6 spending on primary care with the quote from the
7 proposal, we asked for additional detail on kind of
8 the amount of the global payment.

9 So you mentioned -- or not you, Kent, but
10 in the response, you mentioned that kind of
11 inability to articulate the estimates. We hoped
12 that maybe if we just say at least in like a
13 Medicare setting, where at least some of those
14 estimates are knowable and not necessarily
15 proprietary, it would be nice to have that answer
16 in the Medicare context, for example.

17 MR. MILLER: We were also somewhat
18 unclear. I should just speak for myself, but I
19 think I was unclear about the answer to Question 11
20 and how you're envisioning what the APM Entity is
21 accountable for versus --

22 DR. PATEL: The individual --

23 MR. MILLER: -- individual physicians, and
24 given that, conceivably, an APM meant that you

1 could be in a solo physician practice or not,
2 because some of the questions seemed to reference
3 individual measures and others -- anyway, it was
4 just -- it was a little confusing there in terms of
5 how you envisioned that working.

6 And one of the reasons why we asked
7 Question 2 was simply to try to get it into a
8 practical sphere. I mean, sometimes these
9 questions are just hard to answer, generically, and
10 we found in a couple of other cases that getting an
11 answer sort of put in a real context of a real
12 example helps to understand exactly what you meant,
13 rather than simply providing more words, you know,
14 in terms of general.

15 But I think that in both cases, that would
16 be helpful. Those were ones that I flagged as
17 being ones where I really didn't fully understand
18 what you meant by the answers.

19 MR. MOORE: Thank you.

20 DR. PATEL: This is Kavita.

21 Any other -- from anybody, anybody at PRT,
22 PTAC, AAFP, anybody with any questions?

23 MR. MOORE: This is Kent.

24 We have no more questions on this end.

1 DR. PATEL: Great. Again, this is a call,
2 but certainly feel -- absolutely feel free to reach
3 out to Sarah from ASPE if you go back and huddle
4 and still have a couple more questions, and we'll
5 do the same if we have anything else that we forgot
6 to mention.

7 Thank you so much for making time.

8 Sarah, is there anything else we need to
9 cover?

10 MS. SELENICH: Nope. We're all set.

11 DR. PATEL: Great.

12 MR. MARTIN: Thank you all very much.
13 It's very nice to visit with you.

14 DR. PATEL: Yeah. Thank you.

15 MR. MARTIN: Thank you for your time.

16 DR. FERRIS: And thank you for all your
17 work on this.

18 DR. PATEL: Yeah. Thank you so much.

19 DR. FERRIS: It's very important work.

20 DR. PATEL: I look forward to reading your
21 responses.

22 MR. MARTIN: Thank you all. Have nice
23 day.

24 DR. PATEL: Take care.

1 MR. MARTIN: Bye.

2 [Whereupon, at 5:52 p.m., the conference
3 call concluded.]

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PHYSICIAN-FOCUSED PAYMENT MODEL
TECHNICAL ADVISORY COMMITTEE (PTAC)

PRELIMINARY REVIEW TEAM (PRT)

CONFERENCE CALL

WITH THE PROPOSAL SUBMITTER

AMERICAN ACADEMY OF FAMILY PHYSICIANS (AAFP)

Tuesday, September 19, 2017
3:00 p.m.

PRESENT:

TIM FERRIS, MD, MPH, PTAC Committee Member
HAROLD MILLER, PTAC Committee Member
KAVITA PATEL, MD, MSHS, PTAC Committee Member

SARAH SELENICH, MPP, Office of Assistant Secretary for
Planning and Evaluation (ASPE)
ADELE SHARTZER, PhD, Urban Institute
JANET PAGAN-SUTTON, PhD, Social & Scientific Systems, Inc.
(SSS)

ROBERT BENNETT, Federal Regulatory Manager, AAFP
BETHANY BURK, Quality and Practice Specialist, AAFP
ANNIE CLOKE, MPA, Director, CapView Strategies
KENT J. MOORE, Senior Strategist for Physician Payment,
AAFP
AMY MULLINS, MD, CPE, FAAFP, Medical Director of Quality
Improvement, AAFP
PURVA RAWAL, PhD, Principal, CapView Strategies; Adjunct
Assistant Professor, Georgetown University
ERIN SOLIS, Regulatory Compliance Specialist, AAFP

1 P R O C E E D I N G S

2 [3:03 p.m.]

3 DR. FERRIS: Well, then let me -- Harold,
4 I'm just going to take the bull by the horns here
5 if that's okay and [unintelligible].

6 MR. MILLER: Go right ahead.

7 DR. FERRIS: Okay. So -- so just going --
8 down our list, first of all, let me thank you for
9 being so responsive.

10 Is that Kavita?

11 DR. PATEL: Yes.

12 DR. FERRIS: Okay. Hi, Kavita.

13 DR. PATEL: Hi there.

14 DR. FERRIS: So, Kavita, I was just -- I
15 was just about to launch in.

16 DR. PATEL: That's okay.

17 DR. FERRIS: Yeah.

18 DR. PATEL: Go ahead if you want to start
19 with the questions or to -- I did want to thank the
20 group for a very thoughtful set of responses, so I
21 --

22 DR. FERRIS: Good. Yes. And -- and this
23 is -- I would characterize this as our -- as we
24 continue to try to think through the implications
25 of this in what is a very carefully constructed and

1 well-thought-through proposal, we had sort of a set
2 of four categories of areas that we wanted to
3 explore a little further and then possibly some
4 more after that.

5 And -- and I -- the first category is --
6 is payer involvement, and we -- we wanted to sort
7 of see what you were thinking about from the payer
8 perspective on sort of the multipayer nature or not
9 of this proposal. I don't know --

10 DR. PATEL: And, Tim, can I add? I know
11 one of the things we especially -- we wanted to
12 understand, because you did a good job at
13 explaining in your proposal, as well as in your
14 responses to our questions, just some of the
15 complexities around other payers being involved,
16 and that being a limiting opportunity, for example,
17 with the CPC+ (Comprehensive Primary Care Plus)
18 program. So you -- I think you did a nice job
19 contrasting that.

20 But we did -- one of the things that I
21 think you'll see in at least just our own due
22 diligence has been to try to understand, you know,
23 how essential is it to have other payers involved
24 for several reasons, including kind of the volume
25 issues for the practice transformation, so I just

1 wanted to add that note to kind of what --

2 DR. FERRIS: Yeah.

3 DR. PATEL: -- this kind of broader
4 category that Tim opened up.

5 DR. FERRIS: And I think actually just
6 putting an exclamation point on that, I haven't had
7 a chance to read it yet, but I did read the
8 abstract in this week's *Health Affairs* produced by
9 Bruce Landon, Asaf Bitton, and a few others that
10 actually suggest that there is a percent of
11 practice threshold that needs to be achieved in
12 order to make the kind of pattern of care delivery
13 changes that would lead to success, and so with
14 that -- and I don't know if anyone's had a chance
15 to read it yet. I think I got it yesterday.

16 But I just wanted to highlight that there
17 -- that argument, which I guess now has been made
18 formally, has been circulating, and we just wanted
19 to understand how you thought about that argument
20 of, you know, needing -- needing a certain
21 proportion of the practice to be under an
22 alternative payment in order to really convert to
23 the behaviors that are necessary.

24 MR. MOORE: So this is Kent.

25 And I think that we agree that that's

1 essentially a valid argument. That to be
2 successful, this model will depend on it being
3 multipayer, that practices will find it difficult,
4 if not impossible, to transform if only a
5 relatively small percentage of their patients are
6 being paid in this way. So from that perspective,
7 I think that we would agree with the authors of the
8 article -- I know which one you're talking about --
9 that, you know, there has to be a certain
10 percentage of the income coming in, in a capitated
11 way, as we've suggested, in order for practices to
12 be successful under this model, and therefore, you
13 know, unless the practices, you know, 50 or more
14 percent Medicare, that they're going to have to be
15 -- it's going to have to be a multi-payer model.

16 DR. PATEL: And when you think about that,
17 Kent, do you have just -- in consideration for what
18 you've laid down in the PFPM (physician-focused
19 payment model) proposal, do you think about how
20 this could be maybe -- you know, you offered us in
21 your responses kind of two scenarios, two different
22 kinds of practices. Would part of this maybe
23 include kind of simultaneous discussions with other
24 payers to adopt the same methodology? Have you had
25 any conversations with other payers about the types

1 of payment attribution or the two levels at risk
2 taking, et cetera?

3 MR. MOORE: The short answer to that
4 question is yes. We have -- we as an Academy meet
5 regularly with the six or seven largest national
6 commercial insurance companies in the country, and
7 in those meetings that we've had with them, since
8 we released the proposal or submitted the proposal,
9 we have shared it with them.

10 We have gotten some feedback from some of
11 them. You know, for example, Aetna told us that
12 they would look at it on a market-by-market basis
13 to see whether it made sense to try it in a
14 particular market. So, to the extent that we
15 understand and believe that it has to be multipayer
16 --

17 DR. PATEL: Mm-hmm.

18 MR. MOORE: -- we are doing what we can to
19 lay the ground work for that now so that if it is
20 recommended for testing and if CMS (Centers for
21 Medicare and Medicaid Services) agrees to test it,
22 we will both sort of have our ducks in a row in
23 that regard.

24 We also met with the staff in the Blue
25 Cross and Blue Shield Association in follow-up to

1 the comment letter that they submitted to ASPE in
2 response to our proposal, and, you know, so we're
3 talking with not only individual payers, but with
4 payer trade associations as well.

5 DR. PATEL: Okay, great. That's just
6 helpful background to know.

7 DR. FERRIS: Yeah.

8 MR. MILLER: Well, if I could just -- this
9 is Harold.

10 Kent, I guess maybe the more specific
11 question relative to the model is how would you
12 envision that being incorporated into the model in
13 the sense that -- would there be a requirement that
14 a practice had to have all of those payers at that
15 level lined up themselves in order to participate?
16 Would you see it being done the way Medicare has
17 done CPC (Comprehensive Primary Care) and CPC+,
18 which is that they would select markets where the
19 payers had agreed and exclude markets where the
20 payers hadn't agreed? Do you -- because I -- it --
21 I mean, it seems clear from reading the proposal
22 and what you just said that you think that that
23 should be the case, but it's not clear how that
24 would actually be executed in implementing the
25 model.

1 MR. MOORE: So I would answer that
2 question by saying I think it -- we envision it
3 more the latter way. That we would envision that
4 it would be more like CPC+, where payers would be
5 invited to participate in the model, wherever it
6 was being implemented. And I think the burden
7 falls on us as an organization, as I said earlier,
8 to get those ducks in a row to make that a reality,
9 if possible.

10 I don't think it necessarily falls to the
11 practice to make that happen. I don't think
12 they're in a position to make that happen.

13 I would -- I sort of -- I guess the only
14 caveat I would put in there, the asterisk I would
15 put in there is I would -- I would suggest that if
16 a practice wanted to do it with Medicare only
17 paying under this model, I don't think that they
18 should be prohibited, just because other payers
19 aren't involved.

20 As we've talked about earlier, they are
21 less likely to be successful, but if they want to
22 give it a try with Medicare only, I don't think
23 that they should be prohibited from doing so.

24 MR. MILLER: So it sounds like you're
25 saying that you would see Medicare doing some sort

1 of a solicitation, CMS solicitation, the way they
2 have, that if payers didn't step up, then in a
3 particular state or region, then that -- that
4 region would essentially be precluded -- practices
5 there would be precluded from participating unless
6 they stepped forward and said, "We think we can do
7 this just with Medicare payment."

8 MR. MOORE: I think that's essentially
9 correct. I mean, I think we -- you know, it would
10 be offered -- in some sense, offered everywhere,
11 but with the understanding that, you know, if
12 you're in these select regions, you can count on X,
13 Y, and Z payers, as well as Medicare participating,
14 but if you're outside of those regions, it's going
15 to be a Medicare-only type of pilot.

16 MR. MILLER: Mm-hmm. Okay. Because I'm
17 just -- I'm sort of curious as to why -- I mean,
18 since that is the approach that was followed in CPC
19 and it appears that a number of -- probably the
20 majority of the country -- didn't step up to that,
21 whether it might be more effective from getting
22 practices involved to do it in the other direction,
23 which is to say, "We'll put you into the model and
24 then try to" -- once it was clear what practices
25 could do, try to encourage maybe private purchasers

1 to become involved in this and push their plans to
2 participate.

3 MR. MOORE: So, again, I think that's an
4 argument for allowing practices to participate in
5 the model, even if you don't have all the payers
6 lined up in a particular market, you know, a
7 practice, or a health system with a group of
8 practices in a particular market that doesn't --
9 didn't have them lined up initially may come
10 forward and say, "We'd like to give it a try, and
11 we think we can get" --

12 MR. MILLER: Mm-hmm.

13 MR. MOORE: -- "some of the payers in our
14 local market to sign on board if we go ahead and do
15 this." So I think that's just an argument for
16 allowing --

17 MR. MILLER: Okay.

18 MR. MOORE: -- opening it to everybody,
19 even if we in CMS aren't able to line up, you know,
20 payers in every market.

21 MR. MILLER: So it's kind of like Plan A
22 and Plan B. Plan A would be to try to get CMS to
23 try to get the payers involved, and if that didn't
24 happen and the practices wanted to do it, then that
25 would be Plan B. They could still participate, and

1 it would be up to them to try to find -- find
2 additional payers.

3 MR. MOORE: I think we'd be okay with
4 that.

5 MR. MILLER: Okay.

6 DR. PATEL: Can we shift gears to
7 something that's related somewhat to this
8 conversation about aspects? You did an awfully
9 nice job with this comparison with CPC+. We were
10 trying to -- and we thought it would be just worth
11 asking the question -- did you get a sense, since
12 you've been doing a lot of work with stakeholders,
13 that if there were -- I'll just say expanded or
14 modified CPC+, is that a potential option? And --
15 and the reason I ask is because they're -- you're
16 clearly building on real strengths and successes
17 from at least parts of the CPC+, but as we just
18 have been discussing, there's sincere limitations,
19 obviously, even with just geographic involvement.

20 So would there be just in thinking about
21 an existing program that offers some basics to this
22 -- Can you just give us your sense of how you would
23 feel if the current structure were modified or if
24 things were kind of augmented in a way that allowed
25 for broader participation?

1 And I guess that -- for myself, I'll speak
2 for myself and let Tim and Harold add. For me, it
3 -- it made me wonder, Is this really about how we
4 can take an existing model and make it better and
5 potentially more broadly available, as you alluded
6 to in your introduction on the PFPM proposal?

7 MR. MOORE: So I think the way I would
8 answer that is -- this is Kent. The way I would
9 answer that is I think simply expanding the
10 existing model of CPC or CPC+ is not what we have
11 in mind here. Just making that available to more
12 people is not what we're after.

13 If folks at CMMI (Center for Medicare &
14 Medicaid Innovation) wanted to take this model and
15 make it, you know, CPC+ Version 2.0 and pay the way
16 we're suggesting practices be paid and attribute
17 patients the way we're suggesting patients be
18 attributed and so forth, I think we would be very
19 open to having it tested in that way. So that's
20 the way I would answer that question.

21 DR. PATEL: That's helpful.

22 Tim, Harold, are there any other kind of
23 either related around that question or domain?

24 MR. MILLER: No, I don't think so right
25 now.

1 DR. PATEL: Okay. Okay.

2 Then, Kent, just -- or for anybody on the
3 call, the third area is just in trying to think
4 through the steps required to participate in the
5 model that you proposed, we were -- we're trying to
6 kind of understand the -- I'll call it the
7 administrative burdens or some of the more complex
8 aspects of the model; for example, you know, taking
9 into account kind of social determinants of care,
10 things that may or may not be traditionally
11 populated in the EMR (electronic medical record)
12 and might require either manual entry or augmented
13 data sources, and you referenced in the proposal
14 kind of that there would be process or at least
15 message to try to do some of this work. But we
16 wanted to understand a little bit more about your
17 thinking and how to balance what is already pretty
18 much a very busy set of primary care practices with
19 their own kind of internal demands and weighing the
20 needs of what you would need -- what you would need
21 to do to be a part of this model with the benefits
22 of it. And so we just wanted to hear a little more
23 feedback about how you may have thought through
24 either minimizing burden or thinking through just -
25 - certainly you know -- literature with starting in

1 accountable care organizations, starting any of
2 these efforts, and you acknowledge some of that in
3 trying to have some of these up-front prospective
4 payments, but we wanted to have a little bit of an
5 understanding of kind of what would be some of the
6 complexities or burdens to just do some of the work
7 that's involved.

8 MR. MOORE: So I think -- this is Kent --
9 the way I would respond to that question is this.
10 We state in the proposal that practices who want to
11 participate in this model will have to attest that
12 they essentially provide the five key functions of
13 an advanced primary care practice as described
14 under CPC+ and under the joint principles of the
15 patient-centered medical home.

16 To the extent a practice is already doing
17 that, I don't see this model as particularly adding
18 to the burden that they will face because they
19 should already, for example, be risk-stratifying
20 their patient panel. They should already be
21 providing care management services, to the extent
22 that they can, within the capabilities of their
23 practice, et cetera.

24 So the things that we are asking and
25 expecting would be things that the practice would,

1 in some sense, already be attesting to by virtue of
2 being in the model.

3 For those that are in the process of
4 transforming, yes, there will be -- there is a
5 burden and a cost associated with practice
6 transformation, which I think that this model would
7 actually support, to the extent that we're
8 proposing that the, you know, percent of spend go
9 from, you know, say six to seven and to the extent
10 that they will have more flexibility in the revenue
11 stream, as opposed to it being tied to fee-for-
12 service.

13 So, I guess in my way of thinking, the
14 model itself should not add a lot of extra burden
15 to the practice if they're -- if they're doing the
16 things that they're attesting to.

17 In some respects, I would add -- suggest,
18 that the model may actually relieve them of some
19 burden because they won't be filing claims as much
20 as they are now. They won't have to worry about
21 all the ins and outs of documenting chronic care
22 management, E&M (evaluation and management) levels,
23 et cetera.

24 I think another way in which the model
25 does not add to the burden is that, in most of

1 these practices, whether they are advanced or not,
2 are probably reporting for PQRS (Physician Quality
3 Reporting System) and value-based payment. That
4 would continue, so there's no added burden there.

5 So I guess from my perspective, I'm not
6 seeing -- or not perceiving a lot of add -- added
7 burden based on the model, and I think there may
8 actually be some burden reduction based on the way
9 we've structured the payment methodology, in
10 particular.

11 DR. PATEL: Tim, any comments about that?

12 That's helpful. Thanks, Kent.

13 DR. FERRIS: No, that was helpful.

14 DR. PATEL: And then maybe -- this is a
15 little bit related as well. Just the methodology
16 for the risk stratification, the Minnesota Complex
17 Care, or just the MCC.

18 We looked up the articles and some of the
19 references related to that particular risk
20 stratification methodology. I think we all
21 acknowledge the limitations of current risk
22 adjustment and then risk stratification, so two
23 separate concepts.

24 Kent, do you mind speaking a little bit
25 more than what you've written about the -- any of -

1 - any of either modeling or potentially work that
2 you've done with the Minnesota model and then also
3 thinking about this concept of the risk
4 stratification as you talk about, for example, in
5 those two exemplar practices and how they would be
6 able to -- a practice would be able to kind of
7 understand a little bit more about their own
8 population to also, as you kind of just mentioned
9 earlier in this call, risk-stratify patients and
10 understand kind of what the levels of appropriate
11 care are? So both kind of domains with risk. One
12 is related to the Minnesota model and then the
13 second, around the stratification process that
14 might go on.

15 MR. MOORE: So let me take the first
16 question first. I am not an expert on the
17 Minnesota Complexity Model. That is outside my
18 area of expertise, so I really can't answer that
19 question. And I'll just confess my ignorance up
20 front on that part.

21 So, restate the second question for me,
22 please.

23 DR. PATEL: Talking about how -- what's --
24 talk about those practices that you used in
25 examples and how they might decide what levels of

1 risk that they would take, you know, kind of the
2 two levels for payments and risk. How would a
3 practice -- some of that decision on kind of which
4 one to -- which level to go into, comes from some
5 knowledge of their existing patient panel, the
6 complexity of those patients, et cetera, so, in
7 essence, kind of a risk stratification of the types
8 of patients that they have. How would you imagine
9 -- I just want a little bit more of like a boots on
10 the ground. How would a practice kind of start to
11 do that, and is this -- I'm not going to try to put
12 words or answer the question, but is this a matter
13 of looking at retrospective claims? Is this a
14 matter of looking at internal patient charts? Does
15 that help, Kent? Just trying to understand how
16 someone would identify the issues and problems that
17 they're dealing with in their own populations in
18 order to develop a sense of which levels to pick in
19 the APM (Alternative Payment Model), but then also
20 to think about how to actually manage that care.

21 MR. MOORE: So this is Kent.

22 I think we're sort of mixing a little --
23 to use a cliché, we are mixing apples into oranges
24 in that question.

25 So, the two levels that you refer to,

1 which relate to the global primary care payment
2 that is part of the model, those levels do not
3 directly relate to the risk of the patients.

4 DR. PATEL: Not the clinical risks, but
5 you referenced in your response that people would
6 look at their population to understand the
7 financial risks they might take.

8 MR. MOORE: I think they would look at the
9 scope of primary care that they provide.

10 So going back to the two examples that we
11 used, the rural family physician is going to be
12 providing services in multiple settings, not just
13 the office. So from her perspective, getting
14 capitated for all E&M services, not just
15 ambulatory-based, makes sense from the perspective
16 of the continuity of care that she provides. And
17 so, therefore, she would be, in our example, more
18 likely to choose the level of global primary care
19 payment that caps her for all E&M services, not
20 just those in the ambulatory setting. And that's
21 not so much related to the mix of patients she has,
22 but the mix of settings in which she delivers care.

23 In comparison, the suburban, you know, the
24 mythical suburban practice that we, you know, wrote
25 up is one that would typically not be providing

1 care outside of the office setting because their
2 health system has hospitalists to take care of
3 patients in the hospital, and they don't go to the
4 nursing home, and they don't go to the patient's
5 home the way the doc out in western Kansas does.

6 So for them, getting capped for all E&M
7 services really doesn't make sense. It only makes
8 sense to get capped for the ambulatory E&M codes
9 that they provide on a day-in, day-out basis.

10 So, again, they're going to be choosing
11 the level or the option in terms of the global
12 primary care payment based on the scope of services
13 that they typically provide, irrespective of the
14 mix of patients they're seeing.

15 MR. MILLER: Kent, this is Harold.

16 Let me -- because that part confuses me
17 frankly.

18 DR. PATEL: Right.

19 MR. MILLER: And what you just said makes
20 me think that you're actually saying something
21 different than I thought was said in the paper.

22 So when I read your responses, basically
23 you said, "Here's one practice that basically does
24 all of its E&M in the -- in the practice, doesn't
25 do any real hospital-based E&M." So you'd said

1 they should pick Level 1. Here's one that does
2 stuff in the hospital, so they should pick Level 2.

3 But it's -- I mean, you're basically
4 saying they would simply get capitated for what
5 they do. So there's no need to have two levels.
6 You would just say you get capitated for your E&Ms.

7 What I thought I heard you potentially
8 saying there -- and I wasn't sure -- was whether
9 you were saying that under Level 2, the practice
10 takes responsibility for any E&Ms that the patient
11 gets in the hospital from anybody?

12 MR. MOORE: No. So --

13 MR. MILLER: Okay. Then if that's not
14 true, then I don't understand why you need two
15 levels, because why wouldn't you just say the
16 practice --

17 DR. PATEL: Can only do -- yeah.

18 MR. MILLER: -- gets capitated for whatever
19 E&Ms it does?

20 DR. PATEL: For E&Ms that that office
21 would perform. Right. That's --

22 MR. MILLER: Right. Because if you're
23 saying that they -- because, I mean, your examples
24 basically said they would pick the option that
25 matches what they do, which would be equivalent to

1 saying there's only one option. It's just to
2 capitate everything you do.

3 So the only -- the thing you need to
4 explain to us is tell me about a practice that does
5 both hospital-based visits and practice -- clinic-
6 based visits that would pick Option 1 and why it
7 would pick Option 1 to leave its hospital-based E&M
8 separately and why we shouldn't worry about that,
9 because that sort of implies that somehow any
10 patient that the doc -- the patient the doc sends
11 to the hospital means extra revenue for them,
12 rather than saying all of a sudden you're -- you
13 know, you're indifferent to where the patient is
14 treated because all of your E&Ms are capitated.

15 MR. MOORE: So I can imagine -- let's go
16 back to the rural doc, where we said was Level 2.
17 I can imagine a similar rural doc who was
18 uncomfortable with the notion of getting capped for
19 everything she did from an E&M perspective. I mean
20 --

21 MR. MILLER: Why? Why would she be
22 uncomfortable?

23 MR. MOORE: Maybe she's never been capped
24 before, lack of [unintelligible] of how that works.
25 I mean, there could be a lot of reasons why a

1 physician would be uncomfortable with suddenly
2 going from 100 percent fee-for-service to, you
3 know, 75 or 80 percent capitation.

4 MR. MILLER: But that's -- that's true of
5 the model in general. I guess the question, the
6 specific question is, Why would they be
7 uncomfortable -- why would they be comfortable
8 being capitated for their ambulatory office-based
9 visits but not for their hospital-based visits?

10 MR. MOORE: Well, I guess I would say that
11 to the extent that there is performance risk
12 associated with capitation, you know, there's a
13 certain -- people have different levels of risk
14 tolerance. So from that perspective, somebody
15 might be less comfortable being capped for all of
16 their E&Ms than they would be for just their office
17 E&M, even if they're doing both.

18 MR. MILLER: So do you view that as a
19 critical element of this model having that --
20 having that -- those two levels?

21 MR. MOORE: I would say my initial
22 reaction is, no, that's not critical.

23 MR. MILLER: Okay. Can I shift back to
24 the risk adjustment? Because the -- I think what
25 you said in your responses to us is different than

1 what you said in your proposal, and I want to be
2 clear about what you mean.

3 In your proposal on pages 9 and 10, you
4 said that you thought both -- you said both the
5 primary care global fee and the population-based
6 payment should be risk-stratified based on patient
7 complexity, patient demographics, and other
8 factors, such as sociodemographic factors. And
9 then you talked about the Minnesota Complexity
10 Method, and you said the AAFP believes this tool
11 represents the best approach to assess complexity;
12 therefore, the AAFP recommends the use of the
13 Minnesota Complexity Assessment Method to risk-
14 stratify primary care global payment and the
15 population-based payment on an annual basis.

16 In your responses that you sent to us, you
17 said something different, which is that you said
18 you viewed the Minnesota Complexity Assessment
19 Method as a method that the practice would use to
20 risk-stratify its patients for its management
21 purposes, and then you said the AAFP does not have
22 a recommended method for risk adjustment by the
23 payers.

24 So, it sounds like in your responses to
25 us, you sort of shifted more to the way CPC+ is

1 being done, where they have HCCs (hierarchical
2 condition categories) is done [unintelligible] is
3 risk-adjust their payment, but they are required to
4 also risk-stratify their patients using a more
5 sophisticated method than HCCs.

6 So, did you change, or did you really mean
7 one or the other?

8 MR. MOORE: I think the short answer is we
9 changed.

10 MR. MILLER: Okay.

11 MR. MOORE: Alluding to our conversation
12 at the beginning of this call, there's always room
13 for improvement, as you said, and I think that's
14 one area where we attempted to improve between our
15 proposal and our Q&As (questions and answers).

16 I mean, quite honestly, we used the words
17 "risk adjustment" and "risk stratification"
18 interchangeably --

19 MR. MILLER: Mm-hmm.

20 MR. MOORE: -- in our proposal, and as --
21 I'll say as the principal author for that, I take
22 responsibility that that was a mistake.

23 MR. MILLER: Okay. Well, let me follow
24 up, though, on that because if that's the case, I
25 actually like -- personally, I liked your

1 [unintelligible] said in your proposal better than
2 what you said in your response.

3 I mean, when I have talked to practices
4 that are in CPC+, they find this issue of having a
5 risk stratification method that is not the
6 difference in the way their payments are risk-
7 adjusted to be incredibly confusing and
8 problematic, because they're getting a payment
9 that's risk -- essentially risk-stratified based on
10 HCCs, which may or may not reflect the genuine
11 differences in what they see as the different needs
12 of the patients.

13 They're doing the risk stratification for
14 their own management purposes, and they may find
15 that, you know, patient with a higher risk
16 stratification score, whatever method they use,
17 Minnesota or AAFP or whatever, needs more time, et
18 cetera, but they're not getting paid more for those
19 patients. So there's kind of a big disconnect
20 between having a risk stratification method that
21 says these patients need more time and a payment
22 model that risk-adjusts differently.

23 So why do you think it's a good idea to
24 have two different systems?

25 MR. MOORE: So this is Kent.

1 I mean, I think, ideally, it would be nice
2 if the risk stratification system used by the
3 practice aligned with the risk adjustment tool used
4 by the payer for all the reasons that you just
5 talked about, but I think what we are trying to
6 advocate here is for some flexibility. That if a
7 practice has a risk stratification tool that works
8 for them, that allows them within the practice to
9 allocate resources that they have in a way that
10 makes sense for their patient panel, they shouldn't
11 necessarily have to up and change that just because
12 the payer or payers use a risk adjustment
13 methodology that's different.

14 I think the other thing that we have to
15 factor in here is if we are successful in making
16 this a multi-payer model, the odds that all of the
17 payers in a particular market are all going to use
18 the exact same risk adjustment methodology is
19 probably on the slim side.

20 So, regardless of what risk adjustment
21 method -- risk -- excuse me -- risk stratification
22 method you're using in a practice, you're probably
23 going to be at variance with one, at least one of
24 the payers in the mix.

25 So, again, I think it's an attempt to

1 advocate for flexibility in support of the
2 practices and what they are doing, but as you said
3 -- and I would agree -- ideally, the two would
4 align.

5 DR. PATEL: So, Kent, is there -- this is
6 Kavita. Is there any -- I guess let me put aside.
7 So forget the Minnesota-specific tool for a second.

8 What is the state of practices? I would
9 imagine unless someone is already in a model of
10 some kind that there is not really some sort of
11 proactive risk stratification that's going on, or
12 is there? I guess that's the question. Do you
13 have, in working with practices across the country,
14 a sense that something is happening, unless it's
15 already being kind of implemented upon them by an
16 existing model?

17 MR. MOORE: So the consensus around the
18 table here is that you're probably correct that
19 practices who are not already advanced primary care
20 practices are probably not risk-stratifying their
21 patient panel, but that is something that we would
22 expect them to do if they're going to attest that
23 they want to participate in the model.

24 DR. PATEL: Okay. That is helpful. I
25 just wanted to clarify that you've got some sense

1 of that.

2 DR. FERRIS: Yeah. I mean, this is just -
3 - chiming in here, it -- I don't -- I know of very
4 few situations around the country where the risk
5 adjustment model and the practice-based
6 stratification model are the same, although they
7 may often use similar underlying tools. They
8 typically diverge in the process because the
9 practice-[unintelligible] usually involves a lot of
10 clinical judgment in addition to whatever
11 statistical approach or software package is used.

12 And I'm not sure, just as an intellectual
13 contribution to this discussion, that I see the
14 benefit of aligning those. One is to capture
15 payment in a fair way, and the other typically is
16 used for actually clinical management and care
17 coordination. And the assignment of risk to
18 capture complexity for payment and payment
19 outcomes, it's well known in the development of
20 weights for these models that the weights are
21 different if you look at their -- at the main
22 outcome as cost or if you look at the main outcome,
23 say, as admissions.

24 So, anyway, I don't mean to get into an
25 intellectual debate, but it was an interesting

1 discussion that is -- I would say, nationally, is
2 still under considerable evolution, as I think Kent
3 pointed out.

4 DR. PATEL: I can't think -- this is
5 Kavita. I can't think of any other questions we
6 had. Tim? Harold? Sarah? Anybody?

7 MR. MILLER: I had one more.

8 Kent, I'm -- I guess I find the statement
9 that it's not appropriate for you to give an
10 estimate of how much the practice would be paid
11 because of antitrust reasons to be inappropriate,
12 frankly, in this context because we're looking at
13 this from a Medicare perspective. We're looking at
14 what Medicare would pay.

15 So I think it leaves us with a pretty
16 significant gap to have nothing from you that says
17 what you think the practice needs to be paid and
18 how that would -- how that would relate, and there
19 is no antitrust issue, obviously, in terms of
20 Medicare because there is no -- there's not going
21 to be any negotiation there. It's going to be
22 whatever Medicare ends up deciding.

23 So the only -- the only hint that you've
24 given on that is in these examples that you gave.
25 You used the notion that it would be seven percent

1 of the Medicare total spending in primary care, and
2 that the goal would be to give the practice seven
3 percent of Medicare total spending in terms of its
4 PMPM (per member per month).

5 So, is that what you see as the target
6 being?

7 MR. MOORE: So I think we said in the
8 proposal that the target is actually 12 percent of
9 total cost of care, total spend. We acknowledge in
10 our Q&A that it's probably unrealistic to expect
11 payers to jump from six to 12, some of whom are
12 already, you know, at or above six percent.

13 One of the -- some of the feedback that
14 we've gotten from private payers that we've talked
15 to is they would be willing to make a -- if you
16 will, a down payment on that 12 percent by going
17 from six to seven percent, seeing what the return
18 on investment is, and then assuming that, you know,
19 justifies, you know -- justifies it, moving from
20 seven to eight percent or whatever on up, you know.
21 But the target remains 12 percent from an Academy
22 perspective.

23 MR. MILLER: So you would argue that you
24 would take a practice. You would look at its
25 Medicare population. You would calculate the total

1 cost of care for those patients in the practice,
2 and then you would set -- in your ideal world, you
3 would set the PMPM at 12 percent of that number?

4 MR. MOORE: I think the way I would say it
5 is -- and I misused -- I should not have said
6 "total cost of care." That's the wrong term.

7 So I think what we've said is that total
8 health, the percent of total health care spend
9 going to primary care should be 12 percent. So for
10 purposes of our example, we are -- we said -- let's
11 assume that Medicare's current spend on primary
12 care is six percent. So I -- you know, we would
13 advocate that a payer -- let's say Medicare --
14 would figure out how much they're paying Practice
15 A. Assume -- let's assume that's six percent of
16 total spend.

17 MR. MILLER: Total spend. But I'm trying
18 to be clear. Total spend on that practice's
19 patients?

20 MR. MOORE: No. Total spend -- I mean, so
21 the goal is 12 percent of --

22 MR. MILLER: You would look across the
23 whole Medicare population --

24 MR. MOORE: Right.

25 MR. MILLER: -- and you would say if

1 Medicare is spending, on average, \$10,000 per year
2 per patient, then you would say that the practice
3 should basically get -- a primary care practice
4 should get 12 percent of that or \$1,200 or \$100
5 PMPM?

6 MR. MOORE: So, yes, if Medicare is
7 spending \$10,000 on that patient for a year --

8 MR. MILLER: No, no, no. That's what I
9 was asking. It's not that patient. I thought you
10 were saying you were going to look across the whole
11 Medicare population. If Medicare is spending
12 \$10,000 per beneficiary per year on average across
13 its whole population, then you would say it ought
14 to pay primary care practices 12 percent of that,
15 which would be \$1,200 or \$100 PMPM, and every
16 practice would get \$100 PMPM. I mean, with the
17 risk adjustment then applied to it.

18 MR. MOORE: Right, right.

19 MR. MILLER: That would be the -- that
20 would be the -- the kind of the base level that
21 then would be risk-adjusted, would be 12 percent of
22 Medicare, Medicare average per-beneficiary
23 spending.

24 MR. MOORE: I believe that's correct.

25 MR. MILLER: Okay.

1 DR. PATEL: And if you find something
2 different, will you just send us an e-mail? That's
3 how we interpreted it, but I just want to make sure
4 since this is an important point, and we want to
5 make sure we capture it accurately. If it's not
6 consistent with what you meant, just let us know by
7 e-mail. It's fine. Or call us.

8 MR. MOORE: Yeah, absolutely. If I get
9 any feedback from my colleagues on the phone or in
10 the room that I have misspoke, I'll follow up with
11 an e-mail to correct that.

12 DR. PATEL: Okay, great.

13 MR. MILLER: So, just as a quick follow-
14 up to that, then it sounds like that would be your
15 ideal. You would presumably say -- I don't want to
16 put words in your mouth, but you just -- I'll say
17 this, and then you tell me if you disagree. The
18 practice would need to get at least the PMPM
19 equivalent of what it is getting today in E&M, and
20 you would want to see ideally it get more than
21 that, up to where it was that 12 percent target of
22 an average national Medicare spending.

23 MR. MOORE: Yes, I believe that's correct.
24 I think we argue in the -- in either the original
25 proposal or the Q&A or both that the current level

1 of investment in primary care in this country is
2 insufficient to achieve the practice transformation
3 and the change in the delivery of care that
4 everybody agrees is needed.

5 MR. MILLER: Okay. Thanks.

6 DR. PATEL: Anything else from anyone on
7 the PRT?

8 [No response.]

9 DR. PATEL: Sarah, are you --

10 MS. SELENICH: What's that?

11 DR. PATEL: Are you on? Is there anything
12 else?

13 MS. SELENICH: Yep, yep. I'm on.

14 DR. PATEL: Okay.

15 MR. MILLER: Well, if we -- if we have one
16 more minute, let me just ask one more question
17 because one other thing that sort of perplexed me
18 is whenever I was looking -- whenever I was looking
19 at the model, where it talked about quality
20 measures, if I recall, there was a reference to
21 basically there was one measure, back pain. That
22 was the only thing that the practice was actually
23 going to be at risk for, and I'd have to look for
24 that now. But I was somewhat perplexed by whether
25 that was -- whether I was misreading something or

1 you were literally saying that the only thing that
2 the practice would be at risk for was a back pain
3 imaging measure or whatever. Am I -- maybe you can
4 clarify that for me.

5 It was on -- it was on --

6 DR. PATEL: It was in one of the examples.

7 MR. MILLER: No, it was on page 24 of your
8 response.

9 DR. PATEL: Response, yes.

10 MR. MILLER: The only measure tied to
11 payment in the APC-APM (Advanced Primary Care-APM)
12 individual physician measure set, is National
13 Quality Form 052, Use of Imaging Studies for Low
14 Back Pain.

15 MR. MOORE: I think the answer to that
16 question is that's the only measure in the core
17 measure set that is tied to payment, per se.

18 I think we tried to make clear in our
19 proposal and in our Q&A that the practice in terms
20 of its utilization and cost would also be evaluated
21 on other measures, including, you know, inpatient
22 admissions, ED (emergency department) use, et
23 cetera. So I would not -- so while that is the
24 only measure within the core measure set tied to
25 payment, I don't -- I wouldn't go so far as to say

1 that that's the only way a practice in this model
2 would be -- would have their cost and utilization
3 measured.

4 DR. PATEL: So, Kent, was that just the
5 way it -- it's what exists in that core measure set
6 now, just -- I'm just rephrasing exactly what you
7 said to make sure we captured it. It is -- it is
8 in the core measure set as being tied to payment
9 now, but you did not intend to write that as the
10 only measure that could be tied to payment.

11 MR. MOORE: I think that's correct, yes.

12 MR. MILLER: So, may I ask why did you
13 pick that one as opposed to any others?

14 MR. MOORE: The only reason I referenced
15 it is because it's in the core measures that's why
16 --

17 MR. MILLER: I'm asking why. I mean,
18 there's other measures in the core measure set.
19 Why did you pick this one and not any other ones?

20 MR. MOORE: That's the only one tied to
21 payment in the core set, and that's all I was doing
22 was pointing it out, that that's the sole measure
23 in the core set tied to payment.

24 I mean, I'm not quite sure I'm following
25 your question, Harold.

1 MR. MILLER: I'm a little lost in terms of
2 --

3 MR. MOORE: But that's [unintelligible]
4 complicating for anything here. I was simply
5 reporting the facts.

6 DR. PATEL: Do you mean are you -- let me
7 try to interpret. Why bring that one -- I guess
8 we're just trying to make sure.

9 MR. MILLER: You're defining your own
10 model here. I'm not quite sure why --

11 DR. PATEL: Right.

12 MR. MILLER: If you're defining your own
13 model, why are you only picking that one measure?

14 MR. MOORE: I'm not sure that we're
15 picking a measure per se. I mean, we're just
16 advocating that the core measure set -- for
17 purposes of measuring quality, the core measure set
18 should be the measure set used in this model to
19 align measure and harmonization across the multiple
20 payers that we hope will participate in the model.

21 There are other measures for cost in the
22 model, but they're -- those are outside the core
23 measure set.

24 MR. MILLER: Okay. I'm still confused.
25 So you have here a list. There's a list of quality

1 measures. You had them listed, for example, on
2 page 23, diabetes, high blood pressure, et cetera.
3 And then it says please clarify which measures the
4 APM Entities are held accountable for. So, the APM
5 Entity will be -- it says -- will be evaluated
6 using two measures, inpatient hospital utilization
7 and emergency department utilization. Then it says
8 the only measure tied to payment in the individual
9 measure set is the use of imaging studies for low
10 back pain. So, that's -- I guess, unless I'm
11 missing something, what I was reading this as
12 saying is that the only measure of -- this is -- I
13 mean, it's obviously utilization measure or quality
14 would be the imaging studies for low back pain,
15 that there is no -- in your -- your definition of
16 the model, there is no accountability for diabetes,
17 for blood pressure, for preventive care and
18 screening or anything like that, or am I
19 misunderstanding that?

20 MR. MOORE: I think you're
21 misunderstanding that.

22 So, we advocate that the practice would
23 have to choose at least six quality measures from
24 the core set. In the two examples that we gave,
25 each practice chose, I think, three or four

1 measures related to diabetes, one related to
2 hypertension. They will be evaluated on those
3 measures of their choosing, which gets to the
4 quality of care they're providing for, you know,
5 some of the more chronic -- common chronic
6 conditions that Medicare and their patient
7 population is dealing with.

8 MR. MILLER: And when they are evaluated
9 on them, then what happens?

10 MR. MOORE: So, if they fail to meet the
11 benchmarks that CMS has set for those measures,
12 they risk losing some or all of the primary care
13 incentive payments that they will be paid up front
14 on a quarterly basis, just like under CPC+, and if
15 they're sufficiently poor performers, they risk not
16 being allowed to continue in the program. That's -
17 - and it's that risk, that risk tied to the primary
18 care incentive payment that allows, in our opinion,
19 the model to be considered an Advanced Alternative
20 Payment Model.

21 So, those quality measures are directly
22 tied to the incentive payments, and those incentive
23 payments are at risk based on their performance on
24 those quality measures as well as the costs and
25 utilization measures that we referenced.

1 MR. MILLER: Okay. Let me just ask, if
2 you could just go back and re-read what you wrote
3 and sent us and if there is something to clarify
4 that, because it's just when I read this, I'm not
5 seeing that comprehensive picture described here in
6 a way that I can confidently say I understand what
7 measures are affecting who, when.

8 MR. MOORE: So you're referring to the
9 original proposal or the Q&As that we sent
10 subsequently?

11 MR. MILLER: I'm talking about the Q&As
12 that were sent.

13 DR. PATEL: Q&A.

14 MR. MILLER: Because, I mean, back to the
15 earlier point about risk adjustment, you said
16 something different in the Q&A than what was in the
17 proposal, so I'm interpreting that what's in the
18 Q&A is your current version of what you think
19 should be in the proposal, so --

20 MR. MOORE: Right. And remind me again
21 what part of the Q&A you're referring to, so I'm --

22 MR. MILLER: I'm looking at pages 23 and
23 24.

24 MR. MOORE: Twenty-three and 24. Okay.
25 So this will be Question 11 -- Question 11, then.

1 MR. MILLER: Yes, Question 11. Mm-hmm.
2 Sorry. I scribbled page numbers at the bottom of
3 mine because it was easier to find where I was
4 talking about, but yes, Question 11.

5 MR. MOORE: Understood. Okay. We'll go
6 back and take a look at that.

7 MR. MILLER: All right. Thanks.
8 That's all I got, Kavita.

9 DR. PATEL: Harold, Sarah, is there
10 anything else?

11 [No response.]

12 MS. SELENICH: No.

13 DR. PATEL: No? All right.

14 Well, thanks so much, Kent. I know I
15 think -- I think having the written response is
16 helpful, but I think always having the phone
17 conversation to clarify things even more so. So,
18 go ahead and look through just several of those
19 issues, if there's anything you want to send us --
20 you don't need to feel obliged to do so, but let us
21 know if there's anything else you want to clarify.

22 MR. MOORE: Okay. Will do.

23 MR. MILLER: Yep. Thanks very much.

24 DR. PATEL: Thanks so much.

25 DR. FERRIS: Thank you.

1 [Whereupon, at 3:55 p.m., the conference
2 call concluded.]

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