

**AAFP Statement for the Record to the  
Energy and Commerce Committee,  
Health Subcommittee**

**“MACRA and Alternative Payment Models: Developing Options for Value-based Care”  
November 9, 2017**

On behalf of the American Academy of Family Physicians (AAFP), representing 129,000 family physicians and medical students, thank you for the opportunity to submit this Statement for the Record for the U.S. House Energy and Commerce Committee Health Subcommittee regarding the implementation of the Medicare Access and Children’s Health Insurance Program Reauthorization Act (MACRA) and the development of new alternative payment models (APMs) called for in MACRA.

The AAFP supported MACRA’s passage and the movement away from fee-for-service to value-based physician payment delivery and payment models. With implementation of MACRA, the development of new APMs, including physician-focused payment models, is accelerating. While some of these models may deliver comprehensive, longitudinal care, many run the risk of perpetuating (or even exacerbating) the fragmented care many patients receive under the current fee for service (FFS) system. It is our overall assessment that there needs to be a greater focus on the development of comprehensive, longitudinal APMs and the pace of development needs to increase significantly.

**Strengthening Primary Care**

Evaluating MACRA’s effectiveness and the strength of APMs should first recognize the central role of primary care physician, and family medicine’s role in the health care ecosystem.

Family physicians are the largest primary care specialty and the most visited, especially for individuals in underserved areas. One of five US office visits are conducted with a family physician. This represents 123 million visits annually, 48 percent more than the next-highest medical specialty.<sup>1</sup> Family physicians also provide more care in rural and underserved areas than any other medical specialty.<sup>2</sup> The complexity of care provided by family physicians is unparalleled in medicine. Family physicians address more diagnoses and offer more treatment plans per visit than any other medical specialty. Furthermore, the number and complexity of conditions, complaints, and diseases seen in visits with family physicians is far greater than those seen by any other physician specialty.<sup>3</sup>

There is an emerging consensus that strengthening primary care is imperative to improving individual and population health outcomes, as well as to restraining the growth of health care spending.<sup>4</sup> Strengthening primary care is critical to driving better value for patients, payers, and communities. Health systems built with primary care as the foundation have positive impacts on quality, access, and costs. Transformation cannot be overly complex or burdensome to operationalize. In addition, it must be recognized that there is no one-size-fits-all solution, as patient panels, populations, and primary care practices vary. Finding the proper balance between flexibility and simplicity remains elusive.

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CMS and private payers must make new investments in primary care to truly capture and realize the value proposition of family medicine and primary care. Though primary care oriented Advanced Alternative Payment Models (AAPMs) will continue to clinically coordinate with other payment models, primary care AAPMs must be kept distinct from bundled payment models to maximize support for the delivery of continuous, longitudinal, and comprehensive care across settings and providers. Including primary care in bundled payments will not provide the support our health system needs to increase value and strengthen primary care.

The American Academy of Family Physicians (AAFP) is fully supportive of the Physician-Focused Payment Model Technical Advisory Committee's (PTAC) role in evaluating physician-focused payment models (PFPMs) and making subsequent recommendations about those models to the U.S. Department of Health and Human Services (HHS). The AAFP has developed an Advanced Primary Care Alternative Payment Model ([APC-APM](#)), which has been submitted to the PTAC to quicken the migration of family physicians away from the current inefficient FFS payment system. The APC-APM is a foundational model for delivering patient-centered, longitudinal, and coordinated care to Medicare beneficiaries – and establishes a payment structure that will begin to appropriately compensate family physicians for delivering this type of care.

### **Principles for Evaluating APMs**

The AAFP also developed the following set of principles to guide the ongoing evaluation of proposed models to ensure that they are patient-centered. In our view, any APM implemented should meet these criteria:

Longitudinal, Comprehensive Care. Primarily, APMs should support the delivery of team-based, comprehensive care, which includes all acute, chronic, and preventive services, not just episodic care. They should provide continuous, coordinated, and connected longitudinal care in the most cost-effective setting. APMs should not fragment care across clinicians and settings for patients since fragmentation weakens clinician accountability for outcomes and/or costs, and negatively impacts patient experience and outcomes. Primary care APMs should be based on the core functions of the Patient-Centered Medical Home (PCMH) as articulated through the Joint Principles of the Patient-Centered Medical Home and CPC+ Initiative, which focuses on care coordination, population health, care management, patient and caregiver engagement, and comprehensive and coordinated care.

Improving Quality, Access, and Health Outcomes. Approved APMs must demonstrate how they will contribute to improvements in access to high quality of care and increase positive health outcomes for all patients. New models should use the core measure sets developed by the multi-stakeholder Core Quality Measure Collaborative to ensure alignment, harmonization, and the avoidance of competing quality measures among payers in an effort to reduce administrative burden. APM payments should be appropriately risk adjusted to ensure accurate assessment of provider performance and accountability.

APMs Should Coordinate with Primary Care Team. It is our strong belief that APMs should not fragment care across clinicians and settings for patients since fragmentation weakens clinician accountability for outcomes and/or costs, and negatively impacts patient experience and outcomes. Furthermore, we believe that a health care system built on and around longitudinal and comprehensive primary care can reduce the frequency and overall utilization of specialty care, for some patients. In the event that condition-focused APMs are approved, they should be required to contact and coordinate care with a patient's primary care physician and team (or primary care clinicians serving Medicare patients in a given geographic area). This will allow patients receiving care through a specialty- or disease-focused APM to also benefit from coordination with a primary care physician and team that will provide longitudinal care, in addition to treatment of a particular episode or condition. APMs should

include agreements with primary care physicians (reimbursed through separate, primary care APM) to enhance the working relationship between the specialty- or disease-focused physicians and the primary care physician and team.

APMs Should Promote Evidence-based Care. APMs should incent or require use of evidence-based recommendations to treat acute and chronic conditions and to provide preventive services. New models of care should be physician-led, team-based, and primary care oriented to ensure they are patient centered. Patient centeredness requires an ongoing, active partnership with a personal primary care physician who leads a team of professionals dedicated to providing proactive, preventive, and chronic care management through all stages of life. This ensures that complex care management and care coordination issues are continually addressed.

APMs Should be Multi-payer in Design. Approved APMs should be multi-payer in design to ensure that all patients—regardless of payer—have access to promising care models that can improve their health outcomes and care, and reduce costs. Payment models should be multi-payer in their design to allow the CMS and other health care payer programs to leverage investments and learning in payment and delivery system reform. Payments for primary care should be made mainly on a per patient basis through the combination of a global payment for direct patient care services and a global care management fee. APMs should attempt to avoid reliance on FFS payments.

### **The 2018 Final Quality Payment Program (QPP) Regulation**

While physicians transition away from fee-to-for-service to APMs, it is important to examine how those systems are working. The following are the AAFP's observations for the Merit-based Incentive Payment System (MIPS).

Low Volume Threshold - CMS is raising the low volume threshold in 2018 to exclude those who care for less than or equal to 200 Medicare Part B beneficiaries, or receive less than or equal to \$90,000 in Medicare Part B payments. Raising the low volume threshold should exclude more small practices from MIPS. The AAFP advocates for an opt-in option so that anyone who wishes to participate might be able to do so.

Virtual Groups – The AAFP is discouraged with the manner in which the virtual group policy has been developed and implemented. While we are somewhat pleased that Virtual Groups will begin in 2018, we are concerned that they will not benefit solo and small group practices in a manner consistent with legislative intent. We believe that the virtual group policy will be a key contributor to assisting solo and small group practices transition away from fee-for-service, yet remain independent. Overall, we believe there is much work to be done to ensure that this policy achieves its original goals.

Performance Period - Quality and cost will both be measured for an entire year in 2018. Increasing the quality reporting from “Pick Your Pace” to full year reporting is a bigger step than many are ready to take. Along with this, the data completeness criteria increased to 60%. We appreciate the 5 bonus points added to the final score for small practices. However, this was only finalized for one year. We would like to see this extended into future years of the program.

MIPS APMs – AAFP remains steadfastly opposed to the entire MIPS APM category. This entire category was created outside of the statutory requirements and introduces an unnecessary level of complexity to an already complex program. The AAFP strongly encourages consistency and equal reporting standards among all MIPS-eligible clinicians. Concurrently, we are concerned that eligible clinicians may intentionally remain in MIPS APMs, given the scoring advantage they have been given,

instead of progressing towards AAPMs, which is the intent of the QPP. We urge CMS to closely monitor participants who may be intentionally avoiding the progression to AAPMs.

**Level Playing Field** – AAFP believes all specialists and subspecialists should be required to meet the same program expectations as other MIPS participants. In the same vein, AAFP is concerned that using dual-eligible status as an indicator of patient complexity may severely underestimate the number of truly complex patients, not to mention the fact that not all states have expanded Medicaid. Dual eligibility cannot be consistently applied and would not be an accurate indicator of patient complexity and thus creates an uneven playing field from state to state.

**Risk** – The AAFP adamantly opposes putting APM entities and their eligible clinicians at financial risk for anything beyond their own performance. AAFP believes it is appropriate for primary care physicians in Medical Home Models to accept performance risk—not financial risk—based on the original MACRA statute, which reflects Congressional intent regarding the qualification of Medical Home Models as AAPMs. The AAFP strongly recommends that Congress require CMS to remove the Medical Home Model financial standard in its entirety and reiterates our strong belief that medical homes should not be subject to any financial risk. We object to the application of a nominal amount standard to Medical Home Models. Further, the AAFP does not understand CMS' logic in creating separate risk standards for AAPMs and Other Payer AAPMs. The risk standard should be the same for all AAPMs, except for Medical Home Models.

### **Conclusion**

Thank you for the opportunity to comment on the implementation of MACRA. As policy makers evaluate MACRA's impacts, we urge you to remain focused on changes that will strengthen primary care and its role in bolstering system-wide reforms.

For more information, please contact the AAFP's Government Relations Department at 202-232-9033.

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<sup>1</sup> AAFP, Family Medicine Specialty, <http://www.aafp.org/about/the-aafp/family-medicine-specialty.html>

<sup>2</sup> AAFP, Rural Practice, <http://www.aafp.org/about/policies/all/rural-practice-paper.html>

<sup>3</sup> Complexity of ambulatory care visits of patients with diabetes as reflected by diagnoses per visit

Moore, Miranda et al. Primary Care Diabetes, Volume 10, Issue 4 , 281 - 286

<sup>4</sup> Macinko J, Starfield B, Shi L. Quantifying the health benefits of primary care physician supply in the United States. *Int J Health Serv.* 2007;37(1):111-26.