Physician-Focused Payment Model Technical Advisory Committee
LOI: Environmental Scan and Relevant Literature

American Academy of Family Physicians (AAFP)
Letter Dated: 2/16/2017
Letter Received: 2/16/2017

The American Academy of Family Physicians (AAFP) is proposing a payment model that facilitates the delivery of advanced primary care through the medical home model called the Advanced Primary Care Alternative Payment Model (APC-APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care.

The APC-APM will provide a primary care global payment for direct patient care, a care management fee, a fee-for-service (FFS) payment limited to services not otherwise included in the primary care global fee -- coupled with performance-based incentive payments that hold physicians appropriately accountable for quality and costs. These prospective, performance-based incentive payments would reward practices based on their performance on patient experience, clinical quality, and utilization measures. The Comprehensive Primary Care Plus (CPC+) performance-based incentive payment is an example of such a payment mechanism. While the APC-APM aims to improve clinical quality through the delivery of coordinated, longitudinal care -- assessed through the Core Quality Measure Collaborative measure sets -- the broader goal of the APC-APM is to use this approach to deliver care in a manner that improves patient outcomes and reduces healthcare spending, such as through decreased inpatient and emergency department use.

AAFP expects that any primary care physicians currently not in the CPC+ regions would be most interested in participating in the APC-APM. Any FFS Medicare beneficiary not attributed to another APM could participate in the APC-APM, and the AAFP would propose a four-step attribution process in its submission. Additionally, the APC-APM could also be adapted for us with other payers and populations.

Key Search Terms

American Academy of Family Physicians (AAFP); AAFP Alternative Payment Model; Care-Management Fees; Comprehensive Primary Care Plus; Coordinated Care; Global Payment; Patient-Centered Care; Patient-Centered Medical Home; Payment Reform; Primary Care; Primary Care Global Payment; Primary Care Payment Models; Primary Care Redesign

Research Task	Section	Contents
Environmental Scan	Section 1	Key documents, timely reports, grey literature, and other materials gathered from internet searches (10).
Relevant Literature	Section 2	Relevant literature materials (4).
Related Literature	Section 3	Related literature materials (1).
References	Section 4	References to both relevant and related literature.

Section 1. Environmental Scan

Environmental Scan		
Key words: American Academy of Family Physicians (AAFP); AAFP Alternative Payment Model; Care-Management Fees; Comprehensive Primary Care Plus; Primary Care Global Payment; Primary Care Payment Models		
Organization	**Title**	**Date**
American Academy of Family Physicians (AAFP)	Care Management Fees	Accessed: 3/1/2017
Purpose/Abstract		
Background: One innovation that is growing in popularity is the blended payment model. In this model, a practice functioning as a patient-centered medical home (PCMH) is paid a combination (i.e., a "blend") of enhanced FFS payments, incentives for quality performance, and a per member per month (PMPM) care management fee to cover care that falls outside of the traditional office visit. ***Summary:*** As defined by the American Academy of Family Physicians (AAFP), "care management" refers to activities performed by health care professionals with a goal of facilitating appropriate patient care across the health care system. In this article, AAFP identifies eight core activities covered by a PMPM care management fee within the context of a PCMH. These include: 1) non-physician staff time dedicated to care management, 2) patient education, 3) use of advanced technology to support care management, 4) physician time dedicated to care management, 5) medication management, 6) population risk stratification and management, 7) integrated, coordinated care across the health care system, and 8) care planning.		
Additional Notes/Comments		

Environmental Scan

Key words: American Academy of Family Physicians (AAFP); AAFP Alternative Payment Model; Care-Management Fees; Comprehensive Primary Care Plus; Primary Care Global Payment; Primary Care Payment Models

Organization	Title	Date
Center for Medicare & Medicaid Services (CMS)	Comprehensive Primary Care Plus	Updated: 2/27/2017 Accessed: 3/1/2017

Purpose/Abstract

Background: Through a unique public-private partnership with 54 aligned payers in 14 regions, the Comprehensive Primary Care Plus (CPC+) payment redesign gives practices the additional financial resources and flexibility they need to make investments that will improve quality of care and reduce the number of unnecessary services their patients receive. CPC+ is a five-year model: Round 1 began in January 2017 and Round 2 will begin in January 2018.

Summary: In this webpage, CMS provides an overview of the CPC+ model details and practice and payer selection. Additionally, CMS provides links to supplementary materials for more information on the CPC+ model. Please see the below link in "Additional Notes/Comments" to view the CPC+ fact sheet.

Additional Notes/Comments

Please use the following link to access the CPC+ Fact Sheet: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-04-11.html

Environmental Scan

Key words: American Academy of Family Physicians (AAFP); AAFP Alternative Payment Model; Care-Management Fees; Comprehensive Primary Care Plus; Primary Care Global Payment; Primary Care Payment Models

Organization	Title	Date
Health Care Payment Learning & Action Network (LAN)	Accelerating and Aligning Primary Care Payment Models	2/1/2017

Purpose/Abstract

Background: The Health Care Payment Learning & Action Network (LAN) was created to drive alignment in payment approaches across and within the public and private sectors of the U.S. health care system. To advance this goal, the Primary Care Payment Model Work Group (the Work Group) was convened by the LAN Guiding Committee. It was charged with establishing consensus on the best way to pay for primary care using Category 3 or 4 population-based alternative payment models (APMs), and with making practical recommendations for accelerating adoption of these models. Composed of diverse health care stakeholders, the Work Group deliberated, incorporated input from LAN participants, and reached consensus on many critical issues related to primary care payment models (PCPMs), the subject of this White Paper.

Summary: A critical goal of the White Paper is to inform health care stakeholders about how value-based arrangements in PCPMs can drive delivery system transformations that strengthen primary care's capacity to achieve better care, smarter spending, and healthier people, and to offer recommendations for structuring these types of arrangements. Throughout this White Paper, the HCPLAN Work Group puts forth a payment model that would meet categories 3 or 4 as found in the APM framework. In doing so, the Work Group lays out 7 principles and 19 recommendations for PCPMs based on the challenges primary care physicians face. The recommendations in this White Paper lay out an approach to PCPMs that can be used nationally by commercial and public payers.

Additional Notes/Comments

Environmental Scan

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Organization	Title	Date
American Academy of Family Physicians (AAFP)	AAFP Letter to PTAC on Project Sonar	1/18/2017

Purpose/Abstract

Background: On January 18, 2017, the American Academy of Family Physicians (AAFP) submitted a letter to the PTAC committee regarding Project Sonar, a recently proposed payment model submitted by the Illinois Gastroenterology Group and SonarMD, LLC in a letter on December 21, 2016.
Summary: The AAFP supports Project Sonar's proposed payment model in regards to changing payments from traditional fee-for-service (FFS) towards patient-centered alternative payment models (APMs) and supporting the creation of innovative payment models that achieve better care, smarter spending, and healthier people. However, the AAFP is concerned with Project Sonar characterizing their delivery change as the "first specialty-based Intensive Medical Home." The AAFP states that in the patient-centered medical home concept, the physicians are responsible for providing comprehensive care coordination for patients across all health care systems. Since Project Sonar focuses only on chronic gastroenterology related conditions, it should not claim to be or associate themselves with the term medical home. The AAFP is also concerned that the Project Sonar proposal neglects to detail how participants would coordinate with primary care physicians. In response to these concerns, the AAFP developed five principles to guide the development and review of proposed payment models to advance physician-focused payment models for patient-centered care.

Additional Notes/Comments

Environmental Scan

Key words: American Academy of Family Physicians (AAFP); AAFP Alternative Payment Model; Care-Management Fees; Comprehensive Primary Care Plus; Primary Care Global Payment; Primary Care Payment Models

Organization	Title	Date
Center for Medicare & Medicaid Innovation (CMMI)	CPC+ Payment Methodologies: Beneficiary Attribution, Care Management Fee, Performance-Based Incentive Payment, and Payment Under the Medicare Physician Fee Schedule	1/1/2017

Purpose/Abstract

Background: Comprehensive Primary Care Plus (CPC+) is a national advanced primary care medical home model, tested under the authority of the Center for Medicare & Medicaid Innovation (CMMI), that aims to strengthen primary care through multipayer payment reform and care delivery transformation. CPC+ is a five-year model that includes two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the United States. CPC+ aims to improve patients' health and quality of care and decrease total cost of care. To this end, CPC+ offers three payment elements to support and incentivize practices to better manage patients' health and to provide higher quality of care. The payment designs vary slightly for Track 1 and Track 2 CPC+ practices.

Summary: This paper describes the payment methodologies that comprise the CPC+ model. Chapter 2: Beneficiary Attribution (page 15), describes the purpose and methodology for beneficiary attribution to CPC+ practices. Chapter 3: Care Management Fee (Page 21), documents the methodology used to calculate the care management fee (CMF) under CPC+. Chapter 4: Performance-Based Incentive Payment (page 29), describes the CMS approach and technical methodology for the performance-based incentive payment (PBIP). Chapter 5: Payment under the Medicare Physician Fee Schedule (page 45), describes and explains the hybrid payment for CPC+ Track 2 practices.

Additional Notes/Comments

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Organization	Title	Date
American Academy of Family Physicians (AAFP)	AAFP Letter to CMS on MACRA Final Rule: Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models	12/15/2016

Purpose/Abstract

Background: On December 15, 2016, the American Academy of Family Physicians (AAFP) submitted a letter to the Centers for Medicare & Medicaid Services (CMS) responding to the Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models final rule published on November 4, 2016.

Summary: In this letter, the AAFP highlights key areas for which to improve the MIPS and APM pathways. Starting on page 31 of the letter, the AAFP discusses multiple facets of Advanced Alternative Payment Models (APMs) under CMS' final rule. Throughout this section, the AAFP clearly states and provides explanations for why they only support patient-centered advanced primary care models that promote comprehensive, longitudinal care across settings and hold clinicians appropriately accountable for outcomes and costs.

Additional Notes/Comments

Link to final rule: https://www.federalregister.gov/documents/2016/11/04/2016-25240/medicare-program-merit-based-incentive-payment-system-mips-and-alternative-payment-model-apm

Environmental Scan

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Organization	Title	Date
American Academy of Family Physicians (AAFP)	AAFP Principles to Support Patient-Centered Alternative Payment Models	12/14/2016

Purpose/Abstract

Background: With implementation of the Medicare Access and Children's Health Insurance Program Reauthorization Act, the development of new APMs, including physician-focused payment models, are 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 FFS system. Evidence shows that health systems built with primary care as the foundation have positive impacts on quality, access, and costs.

Summary: To support the development and implementation of Alternative Payment Models (APMs), the AAFP developed a set of five principles to guide evaluation of proposed models to ensure that patients—and not clinicians—are placed at the center. The five principles include: 1) APMs must provide longitudinal, comprehensive care; 2) APMs must improve quality, access, and health outcomes; 3) APMs should coordinate with Primary Care Teams; 4) APMs should promote evidence-based care; and 5) APMs should be multi-payer in design.

Additional Notes/Comments

Environmental Scan

Key words: American Academy of Family Physicians (AAFP); AAFP Alternative Payment Model; Comprehensive Primary Care Plus; Primary Care Global Payment; Care-Management Fees; Primary Care Payment Models

Organization	Title	Date
American Academy of Family Physicians (AAFP)	Advanced Primary Care: A Foundational Alternative Payment Model (APM) for Delivering Patient-Centered, Longitudinal, and Coordinated Care	12/14/2016 Updated: 1/2017

Purpose/Abstract

Background: Passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) has accelerated this movement to value-based care by providing payment incentives to move physicians into alternative payment models (APMs) that aim to improve quality for patients, while also reducing costs. Primary care is a critical and foundational component of this system-wide transformation.
Summary: In this position paper, the AAFP presents an advanced alternative payment model (APM) for transforming primary care to improve the health care system by placing patients at the center, and connecting all of their care. In presenting their APM, the AAFP discusses the definition and recognition of Primary Care Medical Homes (PCMH), attribution methodology, payment, quality measurement, and financing.

Additional Notes/Comments

Environmental Scan

Key words: American Academy of Family Physicians (AAFP); AAFP Alternative Payment Model; Comprehensive Primary Care Plus; Primary Care Global Payment; Care-Management Fees; Primary Care Payment Models

Organization	Title	Date
The New England Journal of Medicine (NEJM)	Keeping Score Under a Global Payment System	6/24/2016

Purpose/Abstract

Background: The current fee-for-service payment system provides incentives to physicians to increase the delivery of services, which results in excessive utilization. Moreover, neither individual physicians, nor the patients receiving the services, bear the brunt of these utilization decisions. Many observers are calling for fundamental redesign of the ways in which physicians and hospitals are compensated for the care they provide. Most options call for bundling payments to physicians; specific approaches range from prospective payments for discrete episodes of care (e.g., coronary-artery bypass surgery) to global payment or risk-based models of care.

Summary: This article addresses the use of global payment amongst Accountable Care Organizations (ACOs) and their ability to effectively determine who has earned what portion of payments. As global payment systems are currently designed, primary care physicians stand to be among the big winners, but will also have to shoulder the largest burden of work. Primary care physicians are the point of access and are responsible for care coordination and management. As such, they have perspective on the whole patient, and have the ability to manage the care of a patient population. To accomplish the care-management and quality goals, primary care physicians will need substantial resources. Hybrid approaches, such as ACOs that incorporate global incentives but continue to keep score using fee-for-service payments, will face serious challenges as they attempt to place increasing burdens on the already-stressed primary care system.

Additional Notes/Comments

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Organization	Title	Date
Health Affairs	A Global Budget Pilot Among Provider Partner and Blue Shield of California Led to Savings in First Two Years	9/2012

Purpose/Abstract

Background: The main impetus for the pilot Sacramento accountable care organization (ACO) was the need to address the risk to the three partners' collective price for services and, by extension, market share. The partners collectively face strong competition from a more tightly integrated health system operating in the same market, such as Kaiser Permanente, which has 3.2 million members in Northern California alone. The partners began talking about the collaboration in 2007 and signed an agreement in April 2009. Because all 41,000 members of the system that participated in the pilot accountable care organization are assigned to Hill Physicians Medical Group, and about 70–75 percent of their spending for services in health care facilities goes to Dignity Health, the parties had the critical mass that they needed to work together on the pilot organization.

Summary: This article provides insight into and discusses the results of the pilot Sacramento ACO using a global payment structure. The model shows early promise for its ease of implementation and effectiveness in controlling costs. During the two-year period, the total compound annual growth rate for per member per month cost was approximately 3 percent, or less than half the rate at which premiums rose over the past decade. Some of the savings stemmed from declines in inpatient lengths-of-stay and thirty-day readmission rates. Results suggest that the approach can achieve considerable financial savings in as little as one year and can gain wide acceptance from reform-minded providers.

Additional Notes/Comments

Section 2. Relevant Literature

Relevant Literature		
Key words: Coordinated Care; Global Payment; Patient-Centered Care; Patient-Centered Medical Home; Payment Reform; Primary Care; Primary Care Redesign		
Journal	**Title**	**Date**
Journal of the American Board of Family Medicine	The Transition of Primary Care Group Practices to Next Generation Models: Satisfaction of Staff, Clinicians, and Patients	9/6/2016
Purpose/Abstract		
Introduction: Restructuring primary care is essential to achieve the triple aim. This case study examines the human factors of extensive redesign on 2 midsized primary care clinics (clinics A and B), in the Midwest United States, that are owned by a large health care system. The transition occurred at the same time as principles for patient-centered medical home were being rolled out nationally, and before the Affordable Care Act. ***Methods:*** After the transition, interviews and discussions were conducted with 5 stakeholder groups: health system leaders, clinic managers, clinicians, nurses, and reception staff. Using a culture assessment instrument, the responses of personnel at clinics A and B were compared with comparison clinics from another health system that had not undergone transition. Patient satisfaction scores are presented. ***Results:*** Clinics A and B were similar in size and staffing. After gathering responses regarding the transition of primary care group practices to next generation models, three human factor themes emerged: responses to change, professional and personal challenges due to role redefinition, and the importance of communication. The comparison clinics had an equal or higher mean culture score compared with the transition clinics (A and B). Patient satisfaction improved in Clinic A. ***Conclusions:*** The transition took more time than expected. Health system leaders underestimated the stress and the role adjustments for clinicians and nurses. Change leaders need to anticipate the challenge of role redefinition until health profession schools graduate trainees with more experience in new models of team-based care. Incorporating experience with team-based, interprofessional care into training is essential to properly prepare future health professionals.		
Additional Notes/Comments		

Relevant Literature

Key words: Coordinated Care; Global Payment; Patient-Centered Care; Patient-Centered Medical Home; Payment Reform; Primary Care; Primary Care Redesign

Journal	Title	Date
Journal of General Internal Medicine	The CareFirst Patient-Centered Medical Home Program: Cost and Utilization Effects in its First Three Years	7/29/2016

Purpose/Abstract

Background: Enhanced primary care models have diffused slowly and shown uneven results. Because their structural features are costly and challenging for small practices to implement, they offer modest rewards for improved performance, and improvement takes time.
Objective: To test whether a patient-centered medical home (PCMH) model that significantly rewarded cost savings and accommodated small primary care practices was associated with lower spending, fewer hospital admissions, and fewer emergency room visits.
Design: This paper compared medical care expenditures and utilization among adults who participated in the PCMH program to adults who did not participate. The authors computed difference-in-difference estimates using two-part multivariate generalized linear models for expenditures and negative binomial models for utilization. Control variables included patient demographics, county, chronic condition indicators, and illness severity.
Participants: A total of 1,433,297 adults, aged 18–64 years, residing in Maryland, Virginia, and the District of Columbia, and insured by CareFirst for at least 3 consecutive months between 2010 and 2013.
Intervention: CareFirst provided enhanced fee-for-service payments to practices, offered a retrospective bonus if annual cost and quality targets were exceeded, and provided information and care coordination support.
Measures: Outcome measures included quarterly claims expenditures per member for all covered services, inpatient care, emergency care, and prescription drugs, and quarterly inpatient admissions and emergency room visits.
Results: By the third intervention year, annual adjusted total claims payments were $109 per participating member (95% CI: −$192, −$27), or 2. % lower than before the program and compared to those who did not participate. Forty-two percent of the overall decline in spending was explained by lower inpatient care, emergency care, and prescription drug spending. Much of the reduction in inpatient and emergency spending was explained by lower utilization of services.
Conclusions: A PCMH model that does not require practices to make infrastructure investments and that rewards cost savings can reduce spending and utilization.

Additional Notes/Comments

Relevant Literature

Key words: Coordinated Care; Global Payment; Patient-Centered Care; Patient-Centered Medical Home; Payment Reform; Primary Care; Primary Care Redesign

Journal	Title	Date
Annals of Family Medicine	The Cost of Sustaining a Patient-Centered Medical Home: Experience from 2 States	9/1/2015

Purpose/Abstract

Purpose: As medical practices transform to patient-centered medical homes (PCMHs), it is important to identify the ongoing costs of maintaining these "advanced primary care" functions. A key required input is personnel effort. This study's objective was to assess direct personnel costs to practices associated with the staffing necessary to deliver PCMH functions as outlined in the National Committee for Quality Assurance Standards.

Methods: This study developed a PCMH cost dimensions tool to assess costs associated with activities uniquely required to maintain PCMH functions. The authors interviewed practice managers, nurse supervisors, and medical directors in 20 varied primary care practices in 2 states, guided by the tool. Outcome measures included categories of staff used to perform various PCMH functions, time and personnel costs, and whether practices were delivering PCMH functions.

Results: Costs per full-time equivalent primary care clinician associated with PCMH functions varied across practices with an average of $7,691 per month in Utah practices, and $9,658 in Colorado practices. PCMH incremental costs per encounter were $32.71 in Utah, and $36.68 in Colorado. The average estimated cost per member per month for an assumed panel of 2,000 patients was $3.85 in Utah, and $4.83 in Colorado.

Conclusions: Identifying costs of maintaining PCMH functions will contribute to effective payment reform and to sustainability of transformation. Maintenance and ongoing support of PCMH functions require additional time and new skills, which may be provided by existing staff, additional staff, or both. Adequate compensation for ongoing and substantial incremental costs is critical for practices to sustain PCMH functions.

Additional Notes/Comments

Relevant Literature

Key words: Coordinated Care; Global Payment; Patient-Centered Care; Patient-Centered Medical Home; Payment Reform; Primary Care; Primary Care Redesign

Journal	Title	Date
American Journal of Managed Care	Global Payment Contract Attitudes and Comprehension Among Internal Medicine Physicians	8/1/2015

Purpose/Abstract

Objectives: Global payment contracts (GPCs) are increasingly common agreements between insurance payers and healthcare providers that incorporate aspects of risk-adjustment, capitation and pay-for-performance. Physicians are often viewed as potential barriers to implementation of organizational change, but little is known about internist opinion on GPC involvement, or specific internist attributes that might predict GPC support. This paper aimed to investigate internist and internal medicine subspecialist support of GPC involvement and identify associations between physician attributes, GPC knowledge, and GPC support.

Study Design: Cross-sectional

Methods: General medicine and internal medicine subspecialist physicians, within the Beth Israel Deaconess Department of Medicine, were surveyed four years after care organization entry into a GPC. Measurements collected included reported support for GPC involvement, reason for support, and demonstrated comprehension of key GPC details.

Results: Of the 281 respondents (49% response rate), 85% reported supporting involvement in a GPC. In a multivariate ordinal logistic regression model, exposure to prior information about GPCs, demonstrated comprehension of key GPC details, longer time since completion of residency, and lower clinical time commitment were all independently associated with higher levels of GPC involvement support.

Conclusions: Four years since first engaging in a global payment contract, a majority of internal medicine physician respondents support this decision. Understanding predictors of physician support for GPC involvement within care organization may help other health systems approach organizational change. Health system leaders debating GPC involvement should consider engaging physicians via educational interventions geared towards improving GPC support.

Additional Notes/Comments

Section 3. Related Literature

Related Literature		
Key words: Coordinated Care; Global Payment; Patient-Centered Care; Patient-Centered Medical Home; Payment Reform; Primary Care; Primary Care Redesign		
Journal	**Title**	**Date**
Health Affairs	The Early Impact Of The 'Alternative Quality Contract' On Mental Health Service Use And Spending In Massachusetts	12/1/2015
Purpose/Abstract		
Background: Accountable care using global payment with performance bonuses has shown promise in controlling spending growth and improving care. This study examined how an early model, the Alternative Quality Contract (AQC), established in 2009, by Blue Cross Blue Shield of Massachusetts (BCBSMA), has affected care for mental illness. **Study Data:** The authors used 2006–2011 inpatient, outpatient, and pharmacy claims data from Blue Cross Blue Shield of Massachusetts. The authors also performed semi-structured interviews with senior administrators and clinical leaders at AQC organizations and specialty mental health provider organizations in Massachusetts. **Study Methods:** This study used a two-part, difference-in-differences models to estimate changes in the probability of mental health spending and use attributable to the AQC. In the second stage, the authors estimated the AQC's effect on spending using linear regression. ***Results:*** The study found a significant 1.41 percent decrease in the probability of using mental health services among BCBSMA enrollees in AQC organizations relative to the comparison group. There was no difference in the probability of using mental health services in the no-risk group relative to the comparison group. There was no effect of the AQC on mental health spending for mental health service users overall, or in the AQC behavioral health risk or no-risk groups. Non-mental health service users experienced statistically significant improvements attributable to the AQC in three of five performance measures studied (nephropathy monitoring, LDL screening, and retinal exam, among individuals with diabetes). ***Conclusions:*** This study provides the first empirical examination of how this new model of paying for and delivering care affects individuals seeking mental health treatment. As accountable care evolves, it will be critical for payers considering these models, as well as providers operating under these contracts, to understand how they affect care for often high-cost individuals with mental health treatment needs.		
Additional Notes/Comments		

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