

May 25, 2018

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Submitted via E-Mail: [DPC@cms.hhs.gov](mailto:DPC@cms.hhs.gov)

**RE: Direct Provider Contracting Models - Request for Information**

The Patient-Centered Primary Care Collaborative (PCPCC) appreciates this opportunity to provide input on new models with the potential to enhance the patient-clinician relationship and allow providers to innovate to enhance the quality of care for Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries. PCPCC is pleased to offer this feedback to the Request for Information, but given the expansive nature of this request, strongly encourages CMS to plan another opportunity for input prior to implementing such a model.

**PCPCC Key Points**

PCPCC is pleased to see CMS focused on the challenge of empowering primary care in a value-based environment. We believe there is potential for innovation that strengthens the patient-clinician relationship, provided it is done in a deliberate manner with significant additional guidance. Our key points include:

- CMS must further develop its thinking in this area, focusing this effort on unique opportunities to affect change, then create another opportunity for more detailed feedback and guidance.
- Strong beneficiary protections, dependent on how the model is structured, will be needed – including strong risk adjustment and quality measurement, which needs further investment. While direct contracting offers new opportunities to engage and empower patients and clinicians, it also comes with significant risks.
- While PCPCC supports new efforts to engage more providers in value-based care, CMS should avoid changes that might undermine existing programs that are already creating change due to limitations in CMMI's staff and funding capacity.

- Direct contracting in primary care should be an opportunity to increase funding for, and capability of, primary care to address health needs both within and outside of the practice.
- Cost containment should not be the primary emphasis of a new model, as it will lead to the wrong priorities when designing and launching a model. Improving quality through a stronger patient-clinician relationship must be the goal. A primary care-focused model may create cost savings for the health system, but it can take years for this type of transformation to take hold and the savings will not materialize within the scope of a primary care contract.

## **PCPCC Background and Vision for Primary Care**

Founded in 2006, PCPCC is a not-for-profit multi-stakeholder membership organization dedicated to advancing an effective and efficient health system built on a strong foundation of primary care and the patient-centered medical home. Representing a broad group of public and private organizations – including payers, healthcare clinicians and other providers, leading corporations and patient and consumer advocacy groups – the PCPCC’s mission is to unify and engage diverse stakeholders in promoting policies and sharing best practices that support growth of high-performing primary care to achieve the “Quadruple Aim”: better care, better health, lower costs, and greater joy for clinicians and staff in delivery of care.

In 2017, PCPCC published the [Shared Principles of Primary Care](#) (attached) – identifying an ideal vision of primary care that builds upon advanced primary care concepts such as the Patient Centered Medical Home (PCMH). These Shared Principles were developed by stakeholders representing all aspects of healthcare and more than 280 organizations have signed on in support of them. They are designed to move the United States toward a vibrant future of person-centered, team-based, community aligned primary care that will drive better health, better care, and lower costs. They also put an emphasis on all stakeholders stewarding precious healthcare resources. It is important that any effort to empower primary care take note of the consensus principles and make progress in work to achieve the vision they represent.

## **The Role of Direct Provider Contracting in Transforming Healthcare**

### Creating New Opportunities to Strengthen the Patient-Clinician Relationship

PCPCC agrees that direct provider contracting models, with the proper safeguards, potentially offer an appealing opportunity to allow patients and clinicians to transcend the transactional nature of much of the current primary care environment. We believe that primary care should be a continuous, comprehensive relationship between the patient and their care team – a relationship in which interaction is driven by patient desire to stay

healthy, health concerns, health questions, and health planning. We are confident that both patients and clinicians could thrive in such a model.

The opportunity for greater emphasis on the central role of the patient in selecting a primary care practice could be strengthened in a relationship in which the revenue stream is less central to the interaction. We believe that tools and supports which empower the beneficiary, their families, and their caregivers could be further incented and become a way to further attract and retain beneficiaries. These tools and services (such as telemedicine and after-hours service, care coordination tools, and easy access to electronic health information) should be the mechanism by which patients are incented to maintain a close relationship with the contracted provider – even while retaining flexibility to obtain care from other providers. If implemented carefully, patient incentives for beneficiaries to select a primary care provider and selectively use that provider could further strengthen this relationship.

We must also note that direct provider contracting by CMS will never be able to replicate the straightforward patient-clinician relationship that exists in private sector direct primary care practices. This is understandable and appropriate, as CMS (due to its expanse of services) must institute strong beneficiary protections, protect against fraud and abuse, and monitor quality, cost and utilization. There are significant possible benefits from direct provider contracting, and we encourage CMS to focus on these opportunities, rather than attempting to replicate a private sector model that would be unrealistic for CMS to implement.

#### Finding Value in Direct Provider Contracting

PCPCC believes that a primary emphasis on cost containment in the planning stages of a new model is problematic, as it will lead to the wrong priorities in designing and launching a model. Instead, CMS should seek to enhance the quality of care for Medicare, Medicaid, and CHIP beneficiaries without increasing costs. The research shows that cost savings will emerge from a model that strengths primary care access, capability, and aligns incentives, but believe that these savings should result from improved health and emerge over time. It can take several years for this type of transformation to take hold and catalyze system transformation.

When designing a model that incorporates value, CMS should first seek to ensure the model is attractive to both beneficiaries and providers. Our first imperative is to continue the transition to value, and to motivate those who have not yet participated to begin providing and receiving care in an outcome-focused, value-based environment. One part of that should be a continued “glide path” approach that allows new provider participants to transition their organization and payments together over time. Second, CMS should ensure that the model is stable and sustainable so that it can drive changes over time through improved health and through that improved health, a shift to lower-cost preventative healthcare approaches.

A cautionary note. There also exists a significant potential for CMS to lower value and increase disparities if efforts to reduce costs promote a race-to-the bottom on costs or create a selection bias against high-cost, high-need patients.

### Implementation Challenges

On its face, direct provider contracting seems very attractive for larger medical groups that are already equipped to take on risk. It is less clear that it will be attractive to smaller practices without the ability to manage risk on their own to participate in a direct provider contracting model. Even if they were able to accept that risk, such a program would likely have a level of administrative complexity that deters small practices. We believe that CMS would benefit by providing smaller practices an opportunity to provide input on how the model may be modified to meet their challenges.

In short, the proposed model seems to be most attractive to organizations already on the path to value-based payment, and less attractive to those organizations most in need of encouragement to get on the value path. Given that CMS expressed strong interest in driving engagement at the practice-level, we look forward to working with CMMI on designing the right approaches to engage and support smaller primary care practices.

### **Specific Safeguards to Protect Patients**

#### Develop Stronger Quality Measurement, Including Patient Reported Primary Care Measures

Recognizing our previous statements about administrative burden, PCPCC believes quality and outcome measurement will remain an absolutely critical component to realizing this opportunity. CMS must strike a delicate balance between effectively evaluating contracted arrangements and giving patients and providers the freedom and flexibility they are seeking to improve care delivery and the patient-clinician relationship. We strongly encourage CMS to think about opportunities to develop effective patient reported outcome measures (PROMs) that effectively measure primary care and are applicable to direct provider contracting. These measures should be convenient, technology-enabled, and create minimal burden on patients and clinicians.

#### Patient Outreach

In support of this effort, CMS must have an active role in the outreach and education of beneficiaries considering obtaining care from a practice with a direct provider contracting model. It should leverage existing consumer engagement partners, and work with participating organizations to ensure that the right transparency, decision tools, and resources exist and are utilized by consumers.

#### Financial Protections

The opportunity to provide more flexibility for patients and clinicians is not without risk. If CMS moves forward with models that encourage risk in smaller, independent practices, additional protections are needed for patients in the event a practice encounters a financial

risk it cannot absorb. The development of reinsurance, or risk standards and guidance from CMS would be important to help prevent these occurrences

## **Contracting for Comprehensive, Coordinated Primary Care**

### Comprehensive Primary Care Models

PCPCC has long advocated for advanced primary care models such as the PCMH. We believe that such team-based models, which encompass all primary care services, must be a requirement of any contracting model. They should be patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. These models empower patients and providers by meeting patients where they are and are designed to enable and support strong and trusting relationships between patients and clinicians. We believe that comprehensive models such as these are the only feasible way to contract for primary care. Recognized criteria for certification as a recognized PCMH or similar advanced primary care model can help to ensure consistent quality, safeguards, and tools needed to support patients.

### Tied to Total Healthcare Costs

PCPCC believes that the opportunities for patient engagement and health intervention in primary care are the leading driver of higher value in a variety of alternative payment models. As noted by CMS, primary care forms the foundation of accountable care organizations (ACOs) – in addition to its important role in beneficiary attribution, one reason for this is because more patient needs are captured in the primary care setting, preventing the need for higher cost, or lower value interventions. Primary care also acts as the patient's system integrator to better coordinate and integrate care – therefore reducing duplication and making sure proposed interventions make sense and are in alignment with patient needs and preferences.

PCPCC would therefore like to caution CMS against attempting to evaluate primary care value within the narrow scope of a direct provider primary care contract. Due to the preventative nature of most primary care interventions, that value is created and captured in other settings, or in overall health and cost outcomes due to reductions in expensive chronic disease and improvements in overall health. An attempt to measure cost savings in addition to quality from primary care transformation should focus on select areas of health spending that primary care can actually affect.

PCPCC believes that contract-based approaches to paying for primary care have a significant potential to reduce complexity and increase flexibility within globally capitated payment arrangements, where incentives are aligned across the healthcare continuum for investment in strong, preventative primary care services. We are therefore strongly supportive of approaches that create additional flexibility to experiment with contracting for comprehensive primary care services within other existing payment programs, provided these arrangements hew to the principles laid out with regard to comprehensive primary care and beneficiary protections.

### Support the Development of Strong Risk Adjustment Tools

As acknowledged by CMS, direct provider contracting models that empower patients to select their provider have the potential to create problems of “cherry picking” or “lemon dropping.” CMS can prevent these challenges with the development of strong risk-adjustment tools that protect against discrimination and ensure those with chronic disease, socioeconomic challenges, or other impediments to health have equal access to care. It may even be worth designing the model to incentivize the participation of these individuals, who could most benefit from strong, comprehensive primary care. Additionally, CMS must build into any model a plan to actively monitor for any disparities or biases that emerge as such models are implemented.

### **Opportunities to Empower Primary Care**

#### Primary Care Capability

PCPCC believes that direct contracting has the potential to be an important tool to strengthen primary care infrastructure and capability. In addition to the potential for contracting to simplify and focus the patient-clinician relationship on health rather than transactions, it could allow primary care providers to make patient-serving investments (like technology or care coordinators) that improve their ability to provide continuous, comprehensive care. A per-patient fee incentivizes practices to develop and implement tools that keep patients healthy and out-of-the primary care office. We believe this would lead to an expansion in the use of telemedicine, care coordinators, predictive data analysis, and other tools that are currently underutilized in efforts to keep patients healthy.

As primary care clinicians and organizations continue expanding their capability to deliver comprehensive, value-based care we anticipate that they will be further empowered to address broader health needs, such as challenges related to behavioral health that are closely tied to health yet currently often go unaddressed in the primary care setting. We also anticipate closer and more affective alignment between relevant community benefit organizations and primary care providers.

However, a critical step on this journey will be adequately supporting primary care clinicians and organizations. First, CMS must support the path to more empowered primary care as outlined in the Shared Principles of Primary Care (attached). CMMI, through programs such as Comprehensive Primary Care Plus (CPC+) has already recognized the need to financially support practices in their transformation. This type of support would also be needed to enable primary care clinicians and organizations to expand their current scope of services and meet the full spectrum of patient primary care needs (some of which are currently addressed in other, lower-value settings). In addition to financial support, it is also important to support the learning and process improvement capacity of primary care practices, and their ability to collect and leverage data. Second, to maintain this progress, long-term payment must reflect the high-value and desirability of treating patients in the primary care setting (including telemedicine/other care that is tied to primary care). A new per beneficiary per month (PBPM) payment should provide adequate resource to delivery this care. Our health system currently undervalues primary care, allocating between five to

eight percent to primary care services while many of the highest performing health plans and healthcare systems allocate much more. A translation of current primary care spending to a capitated model will not yield the transformational results that both PCPCC and CMS desire. If the intent of CMS is to bend the cost curve by empowering primary care clinicians to keep people healthy, there must be more CMS investment in primary care to reflect that priority.

#### Administrative Burden

PCPCC believes that a PBPM payment has the potential to reduce administrative burden on primary care clinicians. This is one of the most attractive features of a direct contracting model. At the same time, we understand that CMS must retain oversight and ensure accountability for the provision of quality, high-value healthcare. There is no easy solution here, but we encourage CMS to focus on aligning incentives and lowering reporting requirements. We believe that empowered patients, and empowered clinicians can transform the system, but must be given the freedom to do so.

However, we are also concerned that the process for entering and evaluating direct provider contracts could have the opposite effect. These payments should not go to an infrastructure of non-clinical services that have to “manage” the contract. CMS should seek to automate efforts to measure outcomes through the use of data from electronic health records and other tools.

### **An Innovative CMMI Driving the Transition to Value**

#### Maintain Progress on Existing Models

PCPCC supports continued experimentation to identify new models that will support the shift to value but urges that it not come at the expense of continued momentum and support for existing models. We recognize that CMMI has limited staff time and resources to support nationwide value-based transformation and want to ensure that ongoing efforts – with significant and enthusiastic stakeholder buy-in – are not undermined by new models.

Specifically, the CPC+ program represents a transformational opportunity for primary care, with committed practices and a clear research agenda. Our understanding is that these practices are beginning to see transformative changes but will need the full five years of the demonstration to achieve significant patient outcomes and cost reduction. These empowered practices, which benefit from the support of CMS, will likely be some of the most attractive targets for a new model, however we strongly urge CMS not to disrupt the ongoing effort by recruiting from within this population. A new provider contracting model from CMMI should seek to target organizations that are not on the path to value-based transformation and think about what tools and incentives they may need.

#### Build on and Align Progress with Previous Models

PCPCC urges that any new models created by CMS be distinct from past models, while building upon knowledge and lessons learned in other demonstrations. Strong primary care service definitions and measurement of high quality and comprehensive primary care have

been developed for the CPC+ program. High cost populations have been identified and targeted in such models, and efforts to drive multi-payer alignment should prove educational when developing a new model. Existing models have also shown the importance of strong technical assistance to implement their transformation.

Similarly, CMS should seek opportunities to align tools, measures, and processes that are not being specifically evaluated in this potential demonstration with other models. Greater continuity across programs will help the system as a whole identify and begin to move in the same value-based direction. It will also create additional predictability for private sector organizations looking to engage in parallel transformation.

### **Learn from Commercial Payer Efforts at Capitating Primary Care**

Commercial payers have significant experience with efforts to capitate primary care, incentivize its use, and measure outcomes and costs. They are also already deploying direct provider contracting arrangements. We encourage CMS to specifically look to payers for best practices in supporting patient designation of a primary care provider, the development of patient panels, concerns about care being delivered in settings outside the contract and setting and adjusting payment rates. We also believe that integration/alignment with commercial payers and other alternative payment programs is critical to ensuring a limited clinician burden for those interacting with a variety of payers (both public and private).

### **A Collaborative Provider – CMS Partnership**

To engage providers in direct contracting arrangements with CMS, the agency must make special effort to be a collaborative and supportive partner. When pursuing conversations with healthcare providers who engage in contracting arrangements outside of CMS, we repeatedly heard that the providers were seeking additional flexibility, control, and to escape burdensome regulations. While we recognize the importance of CMS setting clear guidelines, enforcing patient protections, and measuring outcomes, we believe the agency can do more to attract and engage participants. We believe that by injecting new energy into the shift to value-based care, sharing data with participants in a timely way, and creating opportunities for innovative thinking, CMS can begin to change this narrative. We also believe that CMS should work to build upon incentive payment structures to eventually reach true shared savings between the agency and contracted participants.

### **Conclusion**

Thank you for requesting input this opportunity to strengthen primary care. PCPCC supports the Administration's stated goals of promoting patient-centered care, empowering beneficiaries, and aligning payment to support improved quality, reductions in total costs, and improved outcomes. We are encouraged by some of the ideas outlined by CMS but urge the agency to plan another opportunity for stakeholder – particularly patient/family and consumer organizations —feedback as these ideas develop into potential models.



PCPCC and its multisector members look forward to working with you to support new and continued models that will drive higher-value care and improved patient outcomes. Please feel free to contact Christopher Adamec, Director of Policy at [cadamec@pcpcc.org](mailto:cadamec@pcpcc.org) or 202-640-1212 with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Ann C. Greiner". The signature is written in a cursive, flowing style.

Ann Greiner  
President & CEO

Attachment

# Shared Principles of Primary Care

*Primary care is widely acknowledged to be essential for better health and wellbeing in the US health care system and should be foundational to all health care systems worldwide (WHO, 2008) (IOM, 1994) (Starfield, 1992). Access to high-quality primary care can help people live longer, feel better, and avoid disability (Commonwealth Fund, 2013).*

*Primary care has experienced significant changes in the way it is organized, financed and delivered in response to greater demand for high-quality services, rising health care costs, and increasing burden of disease across populations (Bitton et al 2016). Concepts such as the Patient Centered Medical Home emerged to describe a more advanced model of primary care. Based on lessons learned over the past decade and the continued rapid pace of change, the time is right to revisit the future of primary care.*

*Realizing the ideal vision of primary care occurs faster when all stakeholders can speak with one voice. These Shared Principles--developed by stakeholders representing all aspects of health care-- are designed to move the United States toward a vibrant future of person-centered, team-based, community aligned primary care that will help achieve the goals of better health, better care, and lower costs. Achieving this future requires a common vision as well as appropriate payment, investment, training, workforce and other resources to support it.*

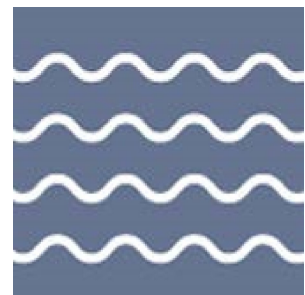
## 1. Person & Family Centered

- Primary care is focused on the whole person - their physical, emotional, psychological and spiritual wellbeing, as well as cultural, linguistic and social needs.
- Primary care is grounded in mutually beneficial partnerships among clinicians, staff, individuals and their families, as equal members of the care team. Care delivery is customized based on individual and family strengths, preferences, values, goals and experiences using strategies such as care planning and shared decision making.
- Individuals are supported in determining how their family or other care partners may be involved in decision making and care.
- There are opportunities for individuals and their families to shape the design, operation and evaluation of care delivery.



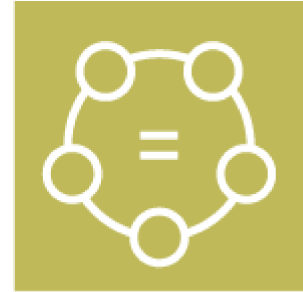
## 2. Continuous

- Dynamic, trusted, respectful and enduring relationships between individuals, families and their clinical team members are hallmarks of primary care. There is continuity in relationships and in knowledge of the individual and their family/care partners that provides perspective and context throughout all stages of life including end of life care.



### 3. Comprehensive and Equitable

- Primary care addresses the whole-person with appropriate clinical and supportive services that include acute, chronic and preventive care, behavioral and mental health, oral health, health promotion and more. Each primary care practice will decide how to provide these services in their clinics and/or in collaboration with other clinicians outside the clinic.
- Primary care providers seek out the impact of social determinants of health and societal inequities. Care delivery is tailored accordingly.
- Primary care practices partner with health and community-based organizations to promote population health and health equity, including making inequities visible and identifying avenues for solution.



### 4. Team-Based and Collaborative

- Interdisciplinary teams, including individuals and families, work collaboratively and dynamically toward a common goal. The services they provide and the coordinated manner in which they work together are synergistic to better health.
- Health care professional members of the team are trained to work together at the top of their skill set, according to clearly defined roles and responsibilities. They are also trained in leadership skills, as well as how to partner with individuals and families, based on their priorities and needs.



### 5. Coordinated and Integrated

- Primary care integrates the activities of those involved in an individual's care, across settings and services.
- Primary care proactively communicates across the spectrum of care and collaborators, including individuals and their families/care partners.
- Primary care helps individuals and families/care partners navigate the guidance and recommendations they receive from other clinicians and professionals, including supporting and respecting those who want to facilitate their own care coordination.
- Primary care is actively engaged in transitions of care to achieve better health and seamless care delivery across the life span.



## 6. Accessible

- Primary care is readily accessible, both in person and virtually for all individuals regardless of linguistic, literacy, socioeconomic, cognitive or physical barriers. As the first source of care, clinicians and staff are available and responsive when, where and how individuals and families need them.
- Primary care facilitates access to the broader health care system, acting as a gateway to high-value care and community resources.
- Primary care provides individuals with easy, routine access to their health information.



## 7. High-Value

- Primary care achieves excellent, equitable outcomes for individuals and families, including using health care resources wisely and considering costs to patients, payers and the system.
- Primary care practices employ a systematic approach to measuring, reporting and improving population health, quality, safety and health equity, including partnering with individuals, families and community groups.
- Primary care practices deliver exceptionally positive experiences for individuals, families, staff and clinicians.



The vision outlined in these Shared Principles of Primary Care will result in excellent outcomes for individuals and families, and more satisfying and sustainable careers for clinicians and staff. It is a vision that is aspirational yet achievable when stakeholders work together.