Patient-Centered Primary Care Collaborative (PCPCC) Comments as requested by the Center for Medicare and Medicaid Innovation on Advanced Primary Care Model Concepts

The PCPCC appreciates this opportunity to comment on the proposed population-based payment (PBP) model for Advanced Primary Care practices outlined in this Request for Information (RFI). The PCPCC strongly supports the transition from volume-driven fee-for-service payment to more value-oriented payment models in primary care linked to quality and efficiency.

RESPONSE TO QUESTIONS CONTAINED IN THE RFI

1. Please comment on the above description of Population Based Payments (PBPs) in terms of the (a) impact on the delivery of advanced primary care. (b) primary care practices' readiness to take on such arrangements.

The Patient-Centered Primary Care Collaborative (PCPCC) is dedicated to advancing an effective and efficient health system built on a strong foundation of primary care and the patient-centered medical home (PCMH). Representing more than 1,200 medical home stakeholders and supporters throughout the United States, from health care providers to industry to consumers, the PCPCC actively promotes the framework for PCMH as set forth by the Agency for Healthcare Research and Quality (AHRQ), which evolved from the Joint Principles of the Patient-Centered Medical Home[1]. **Those founding principles included a focus on payment reforms that appropriately recognized the added value provided to patients and their families receiving advanced primary care and are generally consistent with PBPs as described in Center for Medicare and Medicaid Innovation (CMMI's) Request for Information (RFI) on advanced primary care model concepts**. The Joint Principles endorsed a payment structure that:

- reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit;
- pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources;
- support adoption and use of health information technology (HIT) for quality improvement;
- support provision of enhanced communication access such as secure e-mail and telephone consultation;
- recognize the value of physician work associated with remote monitoring of clinical data using technology; allow for separate fee-for-service (FFS) payments for face-to-face visit (with payments for care management services that fall outside of the face-to-face visit, not resulting in a reduction in the payments for face-to-face visits);
- recognize case mix differences in the patient population being treated within the practice;
- allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting; and
- allow for additional payments for achieving measurable and continuous quality improvements.

Since the Joint Principles[1] were published, various payment reforms to promote advanced primary care are currently being implemented and evaluated. Barr[2] suggests that it is important to match payment reforms to the "construction needs" of each medical home in order to customize payment to where the practice is terms of transformation[2]. Specifically, payment reform efforts should be appropriately phased in in order to support practices in first adopting structural changes (facility, personnel, technology), followed by workflow/process modifications (team building, efficiency of operations, care coordination), and finally outcome improvements (quality, cost, patient

experience). Because various kinds of payment models – FFS; comprehensive global payment, evidence-informed case rates, episode groups, and various blended models – each have advantages and drawbacks in terms of incentivizing transformation, Barr suggests that an ideal reimbursement model would "match the appropriate methodology of payment to the needs of the practice at each stage of PCMH (advanced primary care) development in order to facilitate transformation in the most logical and expedient manner".[3] This stepwise approach to supporting transformation is consistent with research from the University of California at San Francisco's (UCSF) Center for Excellence in Primary Care (CEPC), the American Board of Internal Medicine (ABIM), and the Commonwealth Fund which suggests that there are incremental building blocks or phases for developing "high-performing primary care" practices[45]. **Accordingly, the PBPs being proposed in this RFI would be appropriate for practices that are further along the path to transformation.**

Key phases as outlined by Barr:

- **Phase I**. In Phase 1 of transformation to a PCMH (**"laying the foundation"**), primary care practices are seeking to identify the competencies and skills of staff, review practice workflows, examining their HIT and infrastructure needs, and determining whether external consultants or health coaches are needed. Payment reforms in this phase should provide concomitant infrastructure support to the practice rather than place the practice at financial risk for meeting specific performance measures. Barr suggests that the most appropriate payment in this "building phase" is FFS that is appropriately valued together with a prospective payment (structured as a per person per month (PMPM) or other periodic payment) that "covers the incremental costs associated with the transition and initial provision of services not associated with generating increased volume of services or procedures".[6] Thus, this initial phase requires payment reforms that invest in helping the practice build a foundation for further transformation without expectations for meeting outcome measures.
- **Phase II**. In Phase 2 (**"introduction of new services"),** Barr outlines that new processes and services -- such as enhanced access for patients via open access scheduling, web-portals and personal health records, email communication and telephone visits, care coordination, developing connections to community based organizations, integrating behavioral health, and facilitating information sharing with sub-specialists and hospitals, etc. – are best supported by payment reforms that shift more of the reimbursement away from FFS (which does not pay for the majority of these enhanced services) and toward prospective payments which can be used to support these advanced primary care services as deemed appropriate by the practice. During this transition phase of one to two years, practices could be "held harmless" by ensuring that they not earn less than a set baseline of funding from a previous year. Introducing opportunities for performance based compensation through shared savings from the reduction in costs achieved from the practice would encourage further utilization of cost-effective and health-promoting services.[7] **This is the phase in which many of the Comprehensive Primary Care (CPC) practices began and the funding provided through the increased PMPM has been extremely helpful in assisting practices to incorporate additional processes and services[8].**
- **Phase III**. Finally, in Phase 3 **("the optimization of performance"**), practices should have stable processes in place that support a culture of team-based, patient-centered care, consistent with meeting performance goals for clinical quality, cost, and patient and family experience"[9]. Accordingly, practices should be in a position to tolerate more financial risk in return for more financial rewards based on Triple Aim performance metrics. Consistent with this phase of PCMH construction, payment models such as global capitation, evidence-

informed case rates, and episode groupers should be used. A risk-adjusted performance based primary care capitation model, as described in more detail under question two and three, provides the support for a high-functioning advanced primary care that is foundational to an efficient and effective health system. **Thus, the PBP payment would support enhanced primary care services that promote the Triple Aim, especially those related to care coordination and asynchronous communication.**

(a) **Impact.** The impact of a embracing a Population Based Payment (PBP) to support advanced primary care – with a commensurate shift away from the current FFS model -- is expected to be positive, although there is limited data for this payment model from which to draw concrete conclusions. As Barr suggests above, matching the payment strategy to the construction need (or developmental phase) of the practice will most effectively promote advanced primary care in a way that fully supports practices' transformation efforts.

Since the inception of the PCPCC in 2006, the body of evidence associating advanced primary care and/or the PCMH with improvements in the Triple Aim continues to expand. However, most payment models that support PCMH delivery reforms still maintain FFS as a central feature and supplement FFS with additional per beneficiary per month (PBPM/PMPM) payments, regardless of the development stage of the practice. Rarely are the PMPM payments adequate to invest in and support advanced primary care, to include reimbursement that supports adequate electronic health records (EHRs), care coordinators/health coaches, population health management tools, and the administrative costs associated with implementation, such as practice coaching or facilitation, changing work flow, dedicated time for training, certification or recognition program fees, and other on-going quality improvement efforts.[10] We believe that a PBP can help to accelerate PCMH delivery reforms by providing funding for needed infrastructure, staff, and HIT if it adequately shifts away from the FFS payment system which has historically undervalued primary care. **For the PCMH model to be sustainable in the long term, programs that are proven to successfully move away from the current volume-based payment system and promote aligned incentives for population health outcomes and total cost of care reductions should be scaled and deployed as quickly as is feasible.**

Even with limited payment reform, the impact of the PCMH on Triple Aim outcomes is growing. In just the past year, the PCPCC published a report that analyzed a total of 28 publications that explored the relationship between medical homes (or advanced primary care) and cost and utilization of care, which was the largest number of PCMH evaluations in a single year[11]. These publications come from a combination of the peer-reviewed literature (n= 14), state PCMH program evaluations (n= 7), and industry reports (n= 7). The data support the assertion that the PCMH model can lead to a reduction in health care costs and emergency department (ED) and inpatient hospitalization utilization.

- Peer reviewed scholarly publications. Of the 10 peer-reviewed studies that examined whether the PCMH was associated with a reduction in costs, six reported reductions (60 percent). Of the 13 studies that investigated the association between PCMH and unnecessary utilization, 12 found a reduction in one or more measures (92 percent).
- State government reports (non-peer reviewed). All seven state government evaluations reported reductions in at least one cost metric (100 percent) and six reported improvement in one or more measurement of utilization (86 percent).

- Industry reports (non-peer reviewed) (n=7). Six of the seven industry publications reported reductions in at least one utilization metric (86 percent) and four reported reductions in one or more cost metrics (57 percent).
- Quality and/or Satisfaction measures. Although our inclusion criteria centered on cost and utilization measures associated with primary care PCMHs, several of these studies also reported statistically significant improvements in quality of care metrics, access to primary care services and patient or clinician satisfaction.

In addition, the recently released first-year results from both the CPC Initiative and the Multi-Payer Advanced Primary Care Practice Demonstration (MAPCP) – two large and important multi-payer advanced primary care initiatives built on a FFS payment structure with significantly enhanced risk adjusted PMPM for case management – suggest early reductions in unnecessary utilization and the potential for health care cost savings[12]. **With additional financial incentives in the form of a PBP, we believe some of the primary care practices are ready to progress to the next phase of transformation in a more timely fashion. However, it is important to continue supporting the less developed practices as they continue to evolve and transition in the next phase of the CPC.**

PCPCC KEY CONCEPTS:

- **Innovative payment and service delivery models in primary care that are currently being tested should not be disrupted.** Innovative practice redesign strategies, coupled with alternative payment reforms that are currently underway, such as the CPC initiative and MAPCP, should continue under current arrangements and agreements in order to successfully evaluate the model. Evaluation of these programs in their current form will be extremely helpful in determining the support required by practices to change their care delivery model, the associated costs with transforming the practice, and actual spend in primary care based on the population of patients attributed to the practice. Exceptions could be granted to more transformed (or Phase 3) practices who demonstrate capacity and willingness to transition to a risk-adjusted capitated model of payment with larger financial incentives for managing total cost of care and health outcomes.
- **Use the Transforming Clinical Practice Initiative (TCPI) to prepare a new cohort of practices for participation in new PBP models.** As described below, delivery system change in primary care takes time to accomplish and only the highest-performing primary care practices that have fully transformed to a technology-enabled, team-based, coordinated, patient-centered model of care delivery, will be able to optimize PBPs. The new TCPI (to commence this Spring) will provide an ideal opportunity for non-transformed practices to incorporate successful lessons gleaned from programs like the CPC and MAPCP. Building on lessons learned from current initiatives will lead to greater success in future programs.
- **Work toward the development of more innovative population-based payment strategies not structured on the flawed methodology of FFS.** Utilize evaluations and data from new models of primary care delivery (both in the public and private sector) to better understand the true costs of providing primary care to a population of patients. New opportunities exist to assess and test what investments in primary care are necessary to achieve improvement in health outcomes without relying solely on FFS calculations.

(b) **Readiness.** The extent to which practices are able to embrace a new PBP or a risk-adjusted primary care capitation model depends on the extent to which they are incentivized to do so, and the barriers to adoption are minimized. When payment aligns with practice readiness with appropriate technological support and access to real time data, it is clear that primary care practices across the country are eager to embrace advanced primary care delivery reforms. When the PCPCC began tracking PCMH initiatives in 2009, only a few local and regional initiatives had been operational long enough to evaluate improved health outcomes and lower costs of care.[13,14,15] Even fewer of the early PCMH pilots received on-going financial support to help drive transformation. As the evidence demonstrates, both adequate time for implementation and financial investment to support the PCMH model are critical to its long-term success.[16,17,18,19] A recent nationwide study of PCMH initiatives found that between 2009 and 2013, PCMHs supported by payment incentives had increased in number (from 26 to 114), patients served (from nearly five million to almost 21 million), and states embracing PCMH transformation expanded from 18 to 44.[20] In 2014, the PCPCC unveiled a new searchable, publicly available national database that tracks the increasing number of primary care innovations and PCMH initiatives (www.pcpcc.org/initiatives) together with data about the impact that these initiatives are having on the Triple Aim. **Today there are nearly 500 programs dedicated to improving the health system through enhanced primary care.**

For advanced primary care to reach its full potential, however, we must both increase the total financial support for and investment in primary care, but these higher payments must also be fundamentally restructured to support enhanced primary care services especially those related to care coordination and asynchronous communication. Because advanced primary care models call for more of the care to be delivered outside of traditional face-to-face office visits, FFS is not a sufficient mode of payment if health system transformation is the goal.[21,22,23] **Although recent changes to chronic care management (CCM) coordination Current Procedural Terminology (CPT) codes are a short term solution for helping reimburse for these important services,[24] broader payment reform for optimized advanced primary care is still imperative if Triple Aim outcomes are too be fully realized.[25]**

2. What portion of expected FFS payments for the basket of services would practices be interested in receiving via “rolled-up” FFS?

The preference for that portion of expected FFS payments that would be “rolled up” into a basket of services is likely to differ by readiness of the practice to implement the PCMH, which is influenced by the size of the practice, whether the practice is integrated into a large health system, as well as numerous other characteristics that are associated with the health care marketplace in which the practice is located. Moreover as suggested earlier, matching the payment strategy to the construction need (or developmental phase) of the practice will most effectively promote advanced primary care in a way that fully supports practices’ transformation efforts.

Currently, there are five types of infrastructure financing models have been observed in public, private, and shared initiatives: (1) global budgets, which effectively share both upside and downside risk with the physician and physician group; (2) non-FFS upfront payments, typically in the form of PMPM; (3) enhanced FFS billing rates, which allow the physician to earn more for services rendered over time; (4) shared savings, adjusted for risk and quality; (5) in-kind provision of infrastructure elements, both

personnel and information, provided by the payer[26]. Nichols suggests "There is no heaven on earth: all payment models entail trade-offs." In addition to rigorously answering the important questions of whether PCMHs work to lower costs and improve quality directly, he suggests that analysts begin planning meta-analyses to offer guidance about which combinations of financing models, paired with which local conditions, seem to perform best in relative terms. He suggests that the question is not just, "is model A better than model B," rather it is, "is model A better than model B and is it feasible where I live?"

Several noted academics and a growing number of stakeholders are recommending an expedited, phase out of Resource Value Unit (RVU) based FFS payment, replacing it with risk-adjusted comprehensive payment for comprehensive primary care (risk-adjusted primary care capitation)[27,28]. They recommend that the risk adjusted primary care capitation be offered to practices that choose to provide services consistent with the PCMH. Although early results from PCMHs demonstrate that PMPM care management fees have facilitated transformation for many practices, many argue that they are not enough to sustain advanced primary care practices. Because FFS continues to incentivize the volume of services delivered and underscores the low Relative Value Scale Update Committee (RUC) valuations for primary care's Evaluation & Management (E&M) services[29], stakeholders for primary care are increasingly pushing toward more comprehensive payment that aligns with the goals of patient-centered care. A payment model that replaces the RVU rushed, "hamster-wheel" practice environment of primary care[30] would both recruit and retain primary care providers and sustain delivery of high-performance primary care.

PCPCC KEY CONCEPTS:

- **Provide options to practices on the amount of services included in a risk-adjusted, capitated payment based on key practice qualities that indicate readiness to provide fully-optimized advanced primary care.** As described by Barr, primary care practices have not all reached the same level of optimization in delivering care based on advanced practice models. Although many practices are interested in moving toward more advanced payment models, there should be flexibility based on their capacity to incur financial risk, report on health outcome measures, and fully-manage populations.
- **Provide assurances that financial incentives to improve care quality reach the level of the provider.** Even in innovative payment arrangements that provide financial incentives to improve quality and lower costs, such as ACO's and shared-savings programs, front-line health professionals delivering the care are predominantly still paid based on productivity constructs (RVUs). Payment contracts with providers should incentivize quality care provided by an interdisciplinary team for a population of patients.

3. What services should be included in the basket (e.g., all primary care Evaluation and Management (E&M) services; primary care E&M services based on certain diagnoses; primary care E&M services plus certain procedures; all services in primary care)? Please provide a rationale for the recommendation.

The services provided through a comprehensive primary care payment model should be sufficient to cover all of the practice's operating expenses and necessary investments associated with delivery of advanced primary care services. As suggested by Goroll and colleagues, [31] this would include E&M

services but also include support for expanded care teams, to include behavioral health and care management.[32] In addition, Goroll would include HIT, clinician compensation, support-staff salaries, rent, and insurance as part of the comprehensive primary care payment. Carved out of the payment would be payment for tests, medications, specialty care, hospitalizations, etc. Additionally, the authors suggest a risk-adjusted bonus program of up to 25 percent to the primary care practice for achieving contractually agreed upon exceptional performances in measures of cost-containment, quality, and patient experience. The bonus payment would be determined by analyzing utilization measures that that are within the control of primary care practices, such as testing, imaging, pharmacy, specialty referrals, ambulatory sensitive ER visits and admissions. A final and critically important component of the model is accountability for quality. Risk adjusted and validated quality performance metrics would be included.

Rationale. The rationales for supporting a model similar to one outlined by Goroll and colleagues are myriad.

- It values and rewards high-performing primary care, allowing these practices to thrive by appropriately investing in the infrastructure and operational support necessary for team-based patient-centered care. Providing a comprehensive primary care payment supports the useful monitoring of clinically important outcomes supplemented by periodic audit of practice structure and function.
- Administrative benefits accrue because this model removes the daily, unproductive, and increasingly burdensome medical-record documentation and billing requirements of RVU-based FFS. In removing the volume-maximizing and administrative burden of FFS, the primary care physician can perform the essential diagnostic work, treatment planning, patient and family education, and counseling requisite for maximizing population health.
- New innovations in care delivery such as group and virtual visits are compensated under this model, promoting new opportunities for peer-support among patients and innovations in the health care marketplace.
- Total-practice base primary care payment is likely to exceed total practice revenue under RVU-based FFS[33]. Thus, this model provides opportunity for chronically underpaid primary care physicians to earn an income more congruent with the work required, responsibility undertaken, and value created[34].
- The model is designed to work in synergy with emerging network and ACO risk-adjusted global payment contracts and with medical home and medical neighborhood arrangements outside of integrated networks.
- From a payer's perspective, the advantage of a comprehensive aggregate primary care payment is that spending is much more predictable and controllable. It also eliminates most of the cost to the payer of claims processing, billing, and utilization review systems and personnel, since the only "bill" that has to be processed is a monthly check to the physician, with fewer health insurance claims being submitted, fewer claims to review. Since the physician would have to live within the budget set by the monthly capitation payment, there would be decreased need to review the physicians' utilization of tests, procedures and visits[35].

PCPCC KEY CONCEPTS:

- **Allow for some variability in the amount and type of services that are included in the basket based on the practice's capacity and patient population.** Beyond the services included in the fee schedule, a capitated primary care fee or PBP should also include the practice's operating expenses, expansion of professionals included in the

care team, care coordination services, and integration of new technologies. The fee should be risk-adjusted to adequately reflect the care needs of the patient population, to include behavioral health. Additionally, the fee should consider adjustments based on location and adequacy of primary care services available in the local community (i.e. rural practices may need additional enhancements related to co-management with providers outside their community).

- **Allow for flexibility in how services are delivered**. PBP should recognize that enhanced primary care services will be provided in a variety of encounters that do not always include face-to-face visits. Practices should be allowed the flexibility to develop innovative arrangements with other providers of services, such as community-based organizations, to provide non-traditional services such as health coaching, peer support, etc. Practices must be required to establish clear accountability for provision of these services as part of the package of primary care services.

4. To what extent are primary care practices willing to be accountable for total cost of care?

Primary care practices are not a homogenous group and those willing to be accountable for the total cost of care are likely to differ by the size of the practice, whether the practice is integrated into a large health system, as well as numerous other characteristics that are associated with the health care marketplace in which the practice is located. The current payment model for advanced primary care practices also varies within a given marketplace. Primary care practices will thus need adequate incentives and technical assistance as they shift to models of payment that support advanced care. Capitation or PBP models must be appropriately risk-adjusted so that practices with complex patients are adequately compensated. Moreover, movement to a comprehensive primary care payment must be embraced by multiple payers. Multi-payer collaboratives are particularly valuable to practices because different types of payers agree to use the same set of payment methods and quality metrics. These multi-payer arrangements, as demonstrated by the MAPCP states and the CPC, encourage health care providers that the daunting task of redesigning their clinical practice is worth the time, effort, and investment because a majority of their payer-mix supports the re-design.[36,37] The practices in the MAPCP and CPC are providing useful lessons for health system transformation and early evaluations of the MAPCP have been highlighted in a recent Milbank Memorial Fund report[29.]

PCPCC KEY CONCEPTS:

- **Because primary care practices are at various states of readiness, allow for practices/providers to move to payment models that have higher accountability for total costs of care as soon as they are able.** Provide pathways that allow for easy transition from payment models that carry less financial risk to models with higher capitation and larger bonuses attributed to improved health outcomes and lower total costs of care. For example, only high-performing CPC practices who are willing to share accountability for total costs of care should be allowed to move to a new payment model while still participating in the CPC. It should not be required of all practices.
- **Promote opportunities for multi-payer collaboration.** Medicare should continue to reach out to both Medicaid, commercial payers, and self-insured employers to advocate for payment models that support optimized advanced primary care.

5. Through what mechanism should practices be accountable for total cost of care (e.g., savings paid or losses collected annually; withhold a portion of PBPs and pay/collect the difference between the withhold and saving/losses; modify (increase/decrease) future PBP amounts based on savings/losses; bonus/penalty)?

Under the comprehensive primary care payment proposed by Goroll[38], a practice would qualify for payment under this model if it demonstrated the present or expected capacity to provide advanced primary care services. This could be accomplished by certification or recognition programs or by payer and consumer audit. Important to patients, consumers, and primary care providers, is that this model not repeat the mistakes of the 1990s managed care conflicts of interest around limitation of care. To counter the potentially perverse gaming incentives of capitated payment models (e.g., cherry-picking of patients, transferring out complex patients, excessive increase in panel size, inappropriate decrease in spending on services), Goroll's model specifies robust risk-adjustment and a substantial (up to 25 percent without withhold) risk-adjusted performance bonus for achieving desired and contractually-specified outcomes in cost (utilization), quality, and patient experience. Loss of the large performance bonus would be the penalty for inappropriate growth in panel size or skimping on care. Per-patient risk adjustment of both the base payment and bonus negates benefit from shunning patients with complex conditions and greatest need.

The Comprehensive Primary Care initiative also holds several lessons for advancing advanced primary care payment models, although the evaluations are still early and the shared savings component of CPC has yet to begin. CMS intends to use a single shared savings method for Medicare beneficiaries consistent with the methodology for Medicare ACOs, however, private payers in the CPC intends to use their own approach, with some payers adopting a shared savings program at a health system level, while others take a regional or national approach. The lack of alignment across payers creates hardships for practices, which will be evaluated as part of the CPC initiative. Payers in some regions are actively discussing ways to align shared savings methodologies so they are easier for practices to understand and provide clear incentives.

PCPCC KEY CONCEPTS:

- **Because primary care practices are at various states of readiness, allow for variation in the mechanism by which practices are held accountable.** Practices in a transitional phase should not be penalized for "downside risk" but certification or recognition programs (by payer and consumer audit) are appropriate for all practices. As practices advance through a transition phase and into optimal performance they should be provided with opportunities to receive shared savings and/or a risk-adjusted performance bonus for achieving specific performance measures consistent with patient-centered advanced primary care.

6. What key challenges do primary care practices face in assuming financial accountability? a. What supports or mechanisms could assist practices in overcoming those challenges (e.g., limitations on total practice financial benefit or risk during reconciliation]; exclusion of specified high cost beneficiaries during reconciliation; allowing pooling of risk among practices)?

There are several key challenges for primary care practices in assuming financial accountability, and these are likely to differ significantly by practice. **Adequate payment, risk-adjustment, HIT capacity and**

interoperability, real-time access to data, and financial sustainability are all concerns. Doherty notes that practices are concerned that providing care within a capitated primary care monthly global budget will not be adequate to cover their costs, payments may not adequately adjust for the complexity and risk of the patients that they have in their practice and that the budget will put them at financial risk for spending they are unable to control (such as services provided by non-primary care physicians that the patient is also seeing.) Additionally, practices have concerns that even if the initial monthly payment is sufficient, payers may have an incentive to ratchet down the payment over time[39].

In terms of adequacy of the payment, the model proposed by Goroll and colleagues recognizes and attempts try to allay these challenges by proposing that the monthly payments be directed to cover all practice expenses and salaries related to operating a robust, modern advanced primary care practice[40]. They project that total practice revenue would markedly increase compared to that currently offered under RBRVS, and would be far less administratively burdensome. They also carve out payment for those things that primary care practices are less able to influence, such as hospital and specialist services and ancillaries such as medications, laboratory tests, and some imaging studies. Goroll's model maintains that these would remain the responsibility of payers and not the practice. In terms of risk adjustment, they suggest using a validated risk-adjustment framework that incorporates the full spectrum of important risk determinants, including those accounting for patient behaviors will be needed. Finally, in terms of the sufficiency of payment over time, Goroll and colleagues note try to avoid these pitfalls by balancing the financial/actuarial risk to insurers with that of the primary care practices who must also be financially and clinically accountable.

PCPCC KEY CONCEPTS:

- **Primary care providers face several potential challenges when assuming financial accountability in new innovative payment structures including adequate payment and risk adjustment, HIT capacity and interoperability, access to data at the point of care, and financial sustainability.** To mitigate these challenges, practices will require time, expert coaching to acquire new quality improvement and data management skills, and resources to adequately prepare the practice to assume greater financial risk.
- **Practices will require accurate and timely utilization, cost and health outcome data.** Practices will need time and opportunity to acquire data analytic skills, capabilities and technologies to effectively use data in a manner that will help them partner with patients to make decisions regarding the most effective and efficient use of resources. The data should also be used to drive activities to make improvements to the delivery of services to segments of the patient population or for the entire practice.

7. The move from FFS to PBPs could allow a revision of current medical documentation requirements. What elements of documentation could be revised to be consistent with PBP and not affect patient care negatively?

Under a comprehensive primary care payment consistent with Goroll and colleagues, medical documentation should be mitigated since the medical-record documentation and billing requirements of RVU-based FFS will be removed. In removing the volume-maximizing and administrative burden of FFS, the primary care physician can perform the essential diagnostic work, treatment planning, patient and family education, and counseling requisite for maximizing population health. EHRs which are

currently designed to facilitate FFS/RVU based accounting and billing and not the monitoring of personal and population health will need to adapt. The shift to health information technologies that support advanced primary care delivery and population health, to include telehealth, mobile technologies and wearable devices, are innovations that are proving to be both patient and customer service oriented and effective.

PCPCC KEY CONCEPTS:

- **The move from FFS to PBPs could potentially eliminate current documentation guidelines for E&M services.** Under a capitated primary care payment or PBP, documentation should focus on clinical status and activities directed toward progressing patients to achieving their health goals. Primary care clinicians would benefit greatly by removing many of the burdensome, unproductive elements of documentation and redirecting that time toward higher-value activities such as care planning, team consultations, and patient/family education.

8. Practices caring for patients with complex needs–either the practice's full population or a subpopulation of its patients–could receive additional incentives and resources to deliver enhanced services to these patients, including better integration with social and community based services, behavioral health, and other health care providers and facilities. What are the best methodologies to identify patients with complex needs (e.g., a claims-based comorbidity measurement (Hierarchical Condition Category scores, age, specific conditions, and/or JEN frailty calculation); a claims-based utilization measurement; attribution of a population of local beneficiaries without primary care utilization; and/or practice identification through a risk assessment tool and/or clinical intuition)? Please be specific in your responses and provide examples if possible.

a. Is there a minimum number of patients with complex needs required for a practice to develop the necessary infrastructure and services to offer these patients?

Within an advanced primary care practice or PCMH, patients with high-cost complex needs are identified and managed more intensively by the care team which coordinates their care across the health care continuum[41]. Without appropriate access and continuity of care in primary care settings to include accurate and timely data at the point of care, high-need patients will often delay seeking necessary care or obtain care in the emergency room. Many vulnerable patients have social or behavioral health issues that exacerbate their physical condition, or vice versa. As an example, nearly 60 percent of those with mental illness will seek those services in a primary care setting.[42] Recognizing the importance and value of filling this gap in care, advanced primary care practices risk stratify their patient panel in order to better serve their complex patients with care management, behavioral health, and other services, such as palliative care.

Risk stratification identifies patients with complex needs through systematic assessment of each patient's health risk status, using criteria from multiple sources to develop a personalized care plan. A patient's health status may be reflected by a score or placement in a specific category, based on the most current information available. The identification of a patient's health risk category is the first step towards planning a personalized, mutually agreed upon care plan. Depending on the patient's priorities, the plan may address a need for more robust care coordination with other providers, intensive care management, or education and connection to community resources.

There are multiple risk stratification methodologies. While a patient's medical condition has historically been the primary factor for risk stratification, meshing severity data with social and environmental factors, as well as levels that indicate patient activation or confidence can help care managers determine the priority they assign to their patients and the type and level of support required. For example, high-risk patients may need more personalized attention, whereas those in the medium-risk category may only require self-management support, automated messaging and online education. Low-risk patients may simply be prompted to maintain their health and get appropriate preventive care. Stratifying patients by their risk, however, is not simple.

Early results from the CPC initiative reported that most primary care practices found risk stratification to be more complex and time and resource intensive than anticipated. In fact, risk stratification was one of the CPC "Milestones" that practices found most challenging. Practices that used complex risk stratification algorithms with data derived from multiple sources (EHRs, hospital, patient derived surveys) often struggled to integrate the data and use it to categorize patients. Practices that used the American Academy for Family Physician (AAFP) guidelines, which recommend a fairly "simple" method for creating six levels of risk within three existing public health prevention categories found the process to be more straightforward. Practices using this methodology used a combination of clinical diagnoses and utilization data, clinical judgment, a health risk assessment questionnaire, and/or other patient-reported health status information. Regardless of the type of stratification used, practices wrestled with how to record risk status within their EHR so that the information was available to the entire care team. Despite these challenges, CPC practices reported that they found that risk-stratified care management was important to improving patient care and improved communication among the care team, particularly in regard complex patients.

PCPCC KEY CONCEPTS:

- **The ability to stratify patients according to risk is key to effective population management and critical to consider when factoring PBP for providing comprehensive, team-based primary care services.** Accordingly, advanced primary care practices value risk stratification as a tool to improve the care of their complex patients by creating opportunities for care management. We recommend using risk-stratification methodologies that are as simple as possible for the practice and:
    a. are embedded with the EHR;
    b. integrate data from multiple sources to include patient self-reported health data and behavioral, social, and environmental data;
    c. allow for the easy creation of registries that are prioritized by the practice and used by the care team for management of complex patients;
    d. include adequate training and support in order to maximize the potential of the risk stratification; and
    e. provide flexibility for the practice to meet the needs of their particular patient panel.

b. Should the payment structure discussed in questions 1-7 above differ for these patients? If so, how?

Yes. Under the model proposed by Goroll and colleagues, monthly primary care payments must be directed to cover all practice expenses and salaries related to operating a robust, modern primary care practice, one that would qualify as an advanced medical home. **Payments for complex populations must therefore be appropriately risk adjusted to take into the complexity of the patient population**

including behavioral health and other psychosocial needs, as well as reflect the geographic disparity in health care costs.

c. What would the estimated costs be on a per-patient-per month basis to develop the necessary infrastructure and provide ongoing advanced primary care to these patients? Please provide justification to support these estimates.

As described previously, Goroll suggests a comprehensive, risk-adjusted payment to primary care could include E&M services, support for expanded care teams to include behavioral health, and care coordination, as well as HIT, clinician compensation, support-staff salaries, rent, and insurance.[43] The methodology used to develop an accurate cost estimate for these services will be complex and will be highly variable in regards to the location and size of the practice.

d. What performance metrics are most appropriate and meaningful to assess the quality of care for these patients?

Primary care practices need performance metrics by which to assess their progress in providing high quality of care to complex populations. Unfortunately, there is a lack of agreement and alignment across performance metrics that are currently required by various entities, ranging from payers, to licensing bodies, to accrediting organizations. The multiple measures pose a significant and growing burden to practices who struggle with the administrative burden of collecting and reporting different measures for different purposes, such as for public reporting and accountability versus quality improvement. The measures currently required of primary care practices are myriad including but not limited to Meaningful Use, PQRS, Value based modifiers; primary care providers must also participate in continuing education, Maintenance of Certification, and for many practices various certification and accreditation programs (to include PCMH). In addition, there is a lack of agreed upon measures that assess patient reported outcomes (PROs) which are critical in determining the patient's priorities, engagement and experience of care – each of which is central to a medical home model of care delivery. Accordingly, **assessing and developing parsimonious performance metrics for assessing complex patients must become a high priority in any PBP payment model.**

Although there are multiple efforts for improving performance metrics across the health system, there are concerns that for a care delivery model that includes "patient-centered" in its title, PCMH metrics are not yet sufficiently "patient-centered" and continue to be focused on medical measures. This is especially the case for complex patients who often have social and behavioral health issues that are equally important as their medical conditions. For example, many studies use proxies for health, such as cancer screening or diabetes and blood pressure control, but do not directly measure the patient's experience, satisfaction with their care, or level social support. Having blood pressure within a target range is not the same as being functionally in good health or feeling in a subjective state of well-being. In a study from 2012, the Regence Blue Shield Intensive Outpatient Care program sponsored by Boeing in Washington, researchers included a comprehensive set of measures of health status, detecting improvements in patient-reported physical and mental function, and a reduction in patient-reported missed workdays.[43] Similar metrics could be applied and considered for PCMH evaluations in other settings. Patient satisfaction measures are sometimes included, although not uniformly, and additional core measures of self-reported health status and well-being could enhance our understanding of patient-centeredness in future studies. In light of new payment models focused on value, caution for undue emphasis on cost-cutting and creation of new barriers for patients, providers, and other stakeholders is warranted. **New payment systems must incorporate and incentivize patient-centered**

attributes of value and maximize patient and consumer engagement, especially for those that are most vulnerable.

The CPC initiative uses a set of standard Milestones to measure practices' progress in implementing advancing primary care features. Each year of the initiative, additional Milestones are added that build from the prior year. By the end of the first year, nearly all practices were reporting on the Milestone measures. Practices varied in their assessment of the measures, however, there was significant variation in reporting the clinical quality measurements (CQM), with many practices pointing to their EHRs inability to report these measures. This is critical since practices are ineligible to garner any shared savings without meeting all of the CQM reporting requirements. For high risk patients, the CPC Milestone requires care management for at least 80 percent of highest risk patients (those that are clinically unstable, in transition, and/or otherwise need active, ongoing, intensive care management), with one or more of the following three specific care management strategies: (1) Integration of behavioral health; (2) Self-management support for at least three high risk conditions; or (3) Medication management and review. All three are important performance measures that should be incorporated into any payment model.

PCPCC KEY CONCEPTS:

- **Performance metrics that assess quality of care must become more uniform and patient-centered.** Currently, there is a lack of consensus across payers, licensing organizations, and accreditors as to what constitutes an appropriate measurement of quality care. Meaningful quality of care metrics must become more uniform across entities, but also more patient-centered through the measurement of patient experience, satisfaction with care, and/or level social support.

9. What data do practices need from payers to perform well and manage population health in a model that includes PBPs, financial accountability, and specified requirements for primary care delivery? Please be specific in describing helpful feedback or utilization reports in terms of timing, content (e.g., patient characteristics, services used, providers of services), and format.

The data needs for population health management are significant and continue to evolve, especially those that relate to patient experience of care, patient engagement, and patient expectations. AHRQs domains for population health management are particularly instructive and outline the wide variety of data that are needed to improve population health, all of which need to be captured inside of interoperable HIT platforms. Most of the data needs for primary care physicians are best used when they are both timely and accurate at the point of care. Given the current state of HIT interoperability, data at the point of care is often insufficient.

Table 2: AHRQ's Five Domains of Population Health Management

Domain	Description	Sample HIT Applications
Identify subpopulations of patients	Identify subgroups of patients that will benefit from additional services or demonstrate gaps in care	• Apply **evidence-based guidelines** to integrated population data sets that continuously identify preventive and chronic care opportunities • Use predictive models for **risk stratification**

Examine detailed characteristics of identified subpopulations	Information management systems identify patients in greatest need of services, using flexible criteria that filters critical patient information	• Provide care teams with tools to **filter populations** of patients by criteria such as disease status, recent hospitalizations, and multiple chronic conditions
Create reminders for patients and providers	Information management systems can be used to create automated communications that remind patients, clinicians and staff about patient care needs	• Provide customized **notifications** for patients via letters, telephone/text messages, emails, electronic reminders • Generate **automatic alerts** for providers and care teams about patients who meet criteria for preventive care or disease management at the point of care and between encounters
Track Performance Measures	Provides information that allows clinicians, staff, and systems to track quality and outcomes against national guidelines, peer groups, and to demonstrate longitudinal improvements	• Produce **real-time reports** on how practices, providers, and care teams, are meeting quality, financial and utilization goals • Profile **clinical patterns** within practice by provider (risk level, most frequent diagnoses, number of smokers, etc.) • Allow practices to identify individual patients needing intervention to improve overall performance
Data is available in multiple forms	Information is most helpful and effective to practices when it can be printed, saved, or exported and if it can be displayed graphically	• Facilitate **data-sharing** within organizations and **health information exchange (HIE)** with external providers • Allow providers, care teams and patients to view and understand health care data and trends in real-time

The CPC evaluation found that primary care practices reported that real time data about their care gaps in single, integrated reports were most valuable[44]. However, private payers, especially national ones, were less willing to adapt their data reports to providers. This is another example of where alignment across payers would be useful for practices and reduce administrative burden.

PCPCC KEY CONCEPTS:

- **Data elements and sources should be transparent and standardized among payers and programs.** There needs to be consensus and standardization of data among all payers and it needs to be provided to the practices in a way that allows them to monitor performance and make modifications. Information on individual patients must be timely and accurate to allow for the quick deployment of services when needed (e.g. transition from hospital to home).

10. What transformative changes to HIT – including EHRs and other tools – would allow primary care practices to use data for quality measurement and quality improvement, effectively manage the volume and priority of clinical data, coordinate care across the medical neighborhood, engage patients, and manage population health through team-based care (e.g., transitioning from an encounter-based to a patient-based framework for organizing data; using interoperable electronic care plans; having robust care management tools)? a. In what ways, if any, could CMS encourage advanced primary care practices to implement innovative HIT tools (e.g., facilitate collaboration between HIT vendors and practices)?

Health IT offers a structure to help primary care practices in and across the medical neighborhood provide better access to care, better communicate, and enhance teamwork. When implemented effectively, it also has tremendous potential to identify health trends in local communities, exchange information across organizations, coordinate care as patients transition between providers, and enable secure communications between providers and their patients and families. **Despite upward trends in health IT adoption, there is still a lag in implementing a sophisticated population health management approach.** For example, in an international comparison, 50 to 90 percent of doctors in developed

countries routinely use advanced health IT tools, such as computerized alerts, reminder systems to notify patients about preventive or follow-up care, and prompts to provide patients with test results. [45] In the United States, just one in four doctors has such a system, and 40 percent or more report they have neither a manual nor electronic system for such tasks.[46]

Implementing an EHR and other technologies that can help practices identify the needs of the population being cared for is critical, but technology alone is not sufficient.[47,48] Although EHR adoption rates are currently at 70 percent among primary care physicians, in a recent survey two-thirds of primary care physicians practicing internal medicine (65 percent) and family medicine (63 percent) reported that investing in EHRs had led to revenue losses for their practices.[49] Health systems and practices must utilize a combination of technology to provide data for population management along with practice changes that will enable the allocation of resources and personnel to patients when needed and members of the care team that are accountable for ensuring the deployment of those resources.[50] Moreover, there is a critical lack of interoperable population management technology. **Additional pressure should be placed on IT developers to develop compatible and functional products that are interoperable, provides data to the entire care team at the point of care that is both timely and accurate, and integrates population health and risk stratification tools directly into the EHR.**

In response to these challenges, the PCPCC provides an overview of the role that health IT can play in supporting improved health outcomes across the medical neighborhood, specifically as an approach to gather, interpret and use patient data to have a direct and tangible impact on patient experience and health outcomes. Given the critical role of the PCMH, we also provide a set of potential health IT tools that enhance the five key attributes of the PCMH and strengthen key connections with patients, providers, practices, and organizations throughout the medical neighborhood

Table 1: Five Attributes of the PCMH and Health IT Strategies

PCMH Attribute	Definition	Sample Health IT Strategies
Person-centered	A partnership among practitioners, patients, and their families ensures that decisions respect patients' wants, needs, and preferences, and that patients have the education and support they need to make decisions and participate in their own care.	• Care teams use **EHRs** to capture patient needs and medical history, document care plans, as well as information about language, culture, family support, and communication preferences. • **Shared decision-making** and other patient-support tools are made available through patient portals and patient communication
Comprehensive	A team of care providers is wholly accountable for a patient's physical and mental health care needs, including prevention and wellness, mental health, acute care, and chronic care.	• Care teams used **structured data fields**, **custom reporting**, and **analytics tools** to track patient outcomes and gaps in care. • **Automated outreach** is sent to patients for gaps in recommended care; and notifications are sent to providers when patients fail to fill prescriptions or miss scheduled immunizations.
Accessible	Patients are able to access services with shorter waiting times, "after hours" care, and/or same day.	• **Telephone or e-mail consultations** are available with clinicians during evenings and weekend hours. • **Patient portals** or **mobile apps** allow online appointment scheduling and email with providers.
Coordinated	Care is organized across all elements of the broader health care system, including specialty	• Primary care providers are **alerted** when a patient is admitted or discharged from the hospital.

	care, hospitals, home health care, community services and supports.	• Interoperable **EHRs** exchange and capture information shared between specialists and primary care providers.
Committed to quality and safety	Clinicians and staff enhance quality improvement through the use of health IT and other tools to ensure that patients and families make informed decisions about their health.	• **Clinical decision support** tools are used to specify order sets for diabetic patients. • **Population health management** tools stratify patients by risk level to determine level of attention from care coordinator.

The CPC practices again provide us with an early snapshot of the opportunities and challenges that practices face when implementing advanced primary care. The vast majority of practices were able to access their EHRs after hours and use them to guide care, although modes of access varied (62 percent VPN, 35 percent using web-based or cloud computing). However, practice level HIT often lacked functionality required to support shared decision making work processes, the documentation of risk stratification information, and sharing information across the care team for care management. In addition, many practices lacked direct access to electronic health information from providers in other care settings (such as hospitals and specialists) thus necessitating inefficient work arounds for care coordination and care management. Practices also lacked access to effective health information exchanges (HIEs) – so data was inconsistently shared between various providers.

PCPCC KEY CONCEPTS:

- **Transformative changes to HIT including EHR implementation, the development of patient portals, the use of analytics tools and automated outreach, as well as telephone and/or email consultations** allow primary care practices to use data for quality measurement and quality improvement, effectively manage the volume and priority of clinical data, coordinate care across the medical neighborhood, engage patients, and manage population health through team-based care. Practices should be allowed, even encouraged, to adopt a wide-range of technologies best suited for providing primary care to their particular population of patients.
- **Interoperability is essential but the burden should not fall to the practice.** Although additional pressure should be placed on IT developers to develop compatible and functional products that are interoperable and provide data to the entire care team at the point of care that is both timely and accurate is essential to population health management, practices/clinicians should not be penalized if technology used by the practice does not achieve this goal. Practices will need time and resources to locate and implement new technologies to effectively perform the new functions required to participate in a new PBP system.

11. The development of advanced primary care practices within ACOs could potentially yield synergistic improvements in cost and quality outcomes. What resources (financial and/or technical assistance) do ACOs currently provide to primary care practices/providers to enable care delivery redesign, and are they sufficient to deliver advanced primary care as described in this RFI? a. Should primary care practices within ACOs receive PBPs? b. What should be the relationship, if any, between ACOs and primary care practices receiving PBPs?

As a subset of the medical neighborhood, **Accountable Care Organizations** (ACOs) are expected to play a leadership role in improving population health. Formally arranged through contractual agreements, an

ACO is comprised of clinicians, hospitals, and other health care organizations that share mutual responsibility for a population of patients with the goal of improving quality and health outcomes, and reducing health costs and inefficiencies. **As defined by the Centers for Medicare and Medicaid Services (CMS), primary care is the foundational must-have element in an ACO. However, it is unclear whether most ACOs are overtly measuring their primary care spend and the extent to which ACOs are providing adequate support for non-FFS elements for advanced primary care, such as care coordination services, patient communication, telephone and email encounters, population health management, and quality improvement.**

Different ACO models are currently being implemented and evaluated, and are testing various risk-sharing agreements. ACOs that deliver more cost-effective care for a given population as compared with baseline estimates, will share with Medicare any savings generated on a percentage basis. When an ACO takes financial risk for care, it must have tools for evaluating both clinical and financial performance. To track care provided outside of the network, health plan claims data is also required. As ACOs and ACO-like structures continue to emerge, population health management will be an increasingly valuable tool in assessing health costs, understanding which populations are contributing to costs, and informing financial risk. So too will understanding how ACOs are overtly supporting primary care practices and providing incentives consistent with a medical home model of care. **Within ACOs, increased and sustainable streams of funding need to be earmarked toward primary care in order to achieve ACO goals.**

Kavita Patel in a guest commentary for the PCPCC[51], suggests that ACOs offer an important opportunity for PCMHs to be meaningfully integrated into an advanced delivery model with a greater degree of financial and clinical risk for providers. Many accountable care organizations to date have largely been primary care centered with aligned financial incentives aimed at enhanced quality performance, improved care coordination and population health level interventions. PCMHs share these very tenets but often differ in the attribution and financial arrangements; ACOs usually involve some form of patient attribution along with shared savings and PCMHs involve attribution but with a PBPM model for financial alignment which tends to still focus on one beneficiary rather than care for an overall population. The ACO model allows for primary care providers especially to transition to increased risk while still managing a plurality of patients that had been in FFS models. ACOs need to earmark funding for PCMH practices. Newer models of ACOs have also been targeted at specialties such as oncology and cardiology, again offering an opportunity for lessons learned in advanced PCMHs to inform all aspects of patient care.

PCPCC KEY CONCEPTS:

- **ACOs must make additional investments in primary care to realize the goals of population health.** It is not enough to simply include primary care as part of the service delivery system in an ACO. Rather to achieve the more advanced primary care model as described in question number one it will be critically important for ACO's to invest time, resources, and staff to the primary care team.
- **ACOs have the potential to provide an optimal environment for primary care to accept higher financial risk for total cost of care.** Under the goals of most ACOs, participating primary care practices will be held jointly accountable for total cost of care across a larger network of providers that might include not only specialists, but hospitals, rehabilitation facilities, etc. With adequate resources directed to the primary care team and financial incentives for improving quality and lowering costs that reach the providers (including co-

managing specialists), the ACO can realize its greatest potential for achieving its quality and financial goals.

12. What potential program integrity issues for CMS are associated with the payment and care delivery concepts discussed in this RFI? a. How can these issues be prevented or addressed? b. What data elements should CMS collect to detect any fraud, waste or abuse issues? Please be specific in your responses and provide examples if possible.

No comments or recommendations at this time

13. For stakeholders involved with primary care for Medicaid beneficiaries, please provide comments on any of the concepts discussed in this RFI and any unique considerations to be taken into account for the Medicaid population.

Certainly a more detailed financial analysis of the primary care package of services for special populations, such as children and dual-eligibles, will be important to consider in any capitated primary care payment and risk-adjustment formula. For example, the Patient Protection and Affordable Care Act (ACA) recognized the importance of preventive care for children by including a critical provision to ensure that children enrolled in all individual and group non-grandfathered health care plans receive the gold standard of preventive care—all preventive care screenings and services recommended by the AAP/Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents without cost-sharing. The cost of providing all of these age-specific recommended preventative visits for children and adolescents must be considered when determining a capitated primary care reimbursement for pediatric practices. For more additional information on developing an appropriate primary care payment formula in pediatrics, we encourage CMS to work with PCPCC members, the American Academy of Pediatrics (AAP), and reference their payment policies: http://pediatrics.aappublications.org/content/126/5/1018.full

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