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September 8, 2015

Andy Slavitt  
Acting Administrator, Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS – 1631-P  
P.O. Box 8013, Baltimore, MD 21244–8013

Dear Acting Administrator Slavitt:

The Patient-Centered Primary Care Collaborative (PCPCC) appreciates the opportunity to provide comments on the proposed rule titled “Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule (PFS) and Other Revisions to Part B for CY 2016” as published by the Centers for Medicare & Medicaid Services (CMS) in the July 15, 2015 *Federal Register*.

Founded in 2006, the Patient-Centered Primary Care Collaborative is a 501(c)(3) not-for-profit membership organization dedicated to meeting the Triple Aim by advancing an effective and efficient health system built on a strong foundation of primary care and the patient-centered medical home. The PCMH model embraces the relationship between primary care providers and their patients, families, and caregivers; promotes authentic communication and patient engagement; and coordinates whole-person, compassionate, comprehensive, and continuous team-based care; all of which are crucial to achieving meaningful health system transformation that improves outcomes and lowers costs. The PCPCC achieves its mission through the work of its five Stakeholder Centers, led by experts and thought leaders dedicated to transforming the U.S. health care system through delivery and payment reform, patient engagement, and benefit redesign. Today, the Collaborative’s membership has grown to over 1,200 diverse stakeholder organizations that represent health care providers across the care continuum, payers and purchasers, and patients and their families.

### **Context for our comments: support for moving away from Fee-For-Service Reimbursement Model.**

The PCPCC appreciates CMS’s commitment to supporting primary care and the agency’s focus within the proposed rule on several issues related to high-performing primary care, to include: care management, behavioral health, advance care planning, the Comprehensive Primary Care Initiative, and specific provisions within the Medicare Access and CHIP

Reauthorization Act (MACRA). The PCPCC's top priority for payment reform is to move the US towards a risk-adjusted comprehensive primary care payment necessary for optimized advanced primary care that is focused on patient outcomes and minimizes administrative burden. However, the Medicare Physician Schedule proposed rule highlights several issues that extend beyond the current Fee-For-System payment system and are of interest to the PCPCC and its stakeholder members. Accordingly, we appreciate the opportunity to offer our comments below.

Fundamental to the PCPCC is our belief that in order for advanced primary care to reach its full potential, we must increase the total financial support for primary care, as well as restructure enhanced primary care services in order to best serve patients' needs. This cannot be accomplished in the current FFS payment setting. Because advanced primary care models call for more of the care to be delivered outside of traditional face-to-face office visits (for example, e-mail, phone, telemedicine, group visits, etc.) and in partnership with non-traditional providers (for example, community based organizations like YMCAs and Meals on Wheels who help patients address the social determinants of health), FFS is not a sufficient mode of payment if health system transformation is the goal. We appreciate that this view was recently shared by CMS leadership: "Long-term success will require clinicians and organizations to make fundamental changes in their day-to-day operations—and, for any individual clinician or organization, making operational changes will be attractive only if the financial incentives are large enough."<sup>1</sup> FFS alone cannot provide those incentives.

We strongly support Secretary Burwell's January announcement to increase alternative payment models within Medicare, including ACOs and bundled payments, as well as innovative care delivery models, like patient-centered medical homes. We applaud HHS' goal of tying 30 percent of traditional Medicare payments (based on fee-for-service) to quality or value through alternative payment models by 2016 and 50 percent by 2018, working in partnership with the private sector. CMS' "Payment Reform Taxonomy" succinctly and appropriately outlines the need to shift health care delivery away from "category 1—fee-for-service with no link of payment to quality" to "category 2—fee-for-service with a link of payment to quality" to "category 3—alternative payment models built on fee-for-service architecture" to "category 4—population-based payment." Updates to the PFS are temporary solutions to the long-term goal of population-based payment, which should improve patient and population health outcomes and at the same time reduce administrative burden on practices.

Although continued development of FFS through the Physician Fee Schedule is necessary as Alternative Payment Models are developed and implemented, the PCPCC will continue to advocate for a risk-adjusted comprehensive primary care payment necessary to achieve the Triple Aim, consistent with our detailed response to the CMS Request for Proposal for Advanced Primary Care.<sup>2</sup> Thank you for the opportunity to offer our recommendations on improvements to

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<sup>1</sup> Rajkumar, R., Conway, P.H., Marilyn, T. (2014). CMS—Engaging Multiple Payers in Payment Reform. *JAMA*. 311(19):1967-1968. doi:10.1001/jama.2014.3703.

<sup>2</sup> PCPCC. (2015). Patient-Centered Primary Care Collaborative (PCPCC) Comments as requested by the Center for Medicare and Medicaid Innovation on Advanced Primary Care Model Concepts. Retrieved from: [https://www.pcpcc.org/sites/default/files/news\\_files/PCPCC%20CMMI%20RFI%20Advanced%20Primary%20Care%20FINAL.pdf](https://www.pcpcc.org/sites/default/files/news_files/PCPCC%20CMMI%20RFI%20Advanced%20Primary%20Care%20FINAL.pdf)

the PFS as we transition to a payment model that better encourages and incentivizes advanced primary care.

## **Improving Payment Accuracy for Primary Care and Care Management Services (Section E).**

### ***1. Improved Payment for the Professional Work of Care Management Services***

Currently, the majority of revenues received by primary care practices are from fee-for-service (FFS) payments derived in large part from the Medicare Physician Fee Schedule. In most cases, the payment models designed to support PCMH-level care maintain FFS as a central feature and supplement those payments with additional fixed per beneficiary per month (PBPM/PMPM) payments. Unfortunately, the revenues generated by the typical primary care practice are not sufficient or predictable enough to sustainably cover these costs. This is especially so for smaller practices who have little “reserve capacity” or flexibility to devote to new complex-need patients in need of care management. Moreover, current FFS payment models, even when coupled with modest PBPM payments, do not provide full compensation for the complete scope of services that are not paid for at all or are poorly compensated in primary care. These are critical clinical interventions that occur outside of a patient office visit and are an integral part of patient-centered primary care. For instance, following up with a patient after a visit to ensure they filled their prescription and understand the dosage instructions may be covered under the CCM code, while paying for a consult with the clinical pharmacist or behavioral health specialist may not.

The PCPCC concedes that the chronic care management (CCM) code can be a short-term solution for some practices seeking reimbursement for these important services. However, health care providers continue to raise concerns about the number of administrative hurdles associated with the current fee-for-service payment system. Accordingly, we encourage CMS to work with provider associations to better reduce the myriad barriers related to fee-for-service billing for primary care services. We have seen consistent barriers for primary care practices to participate in new payments, even when they are meant to provide compensation for care management being provided to most patients (i.e. CCM code barriers include documentation, patient co-payments, etc.) Accordingly, **the PCPCC asserts that broader payment reforms consistent with a risk-adjusted comprehensive primary care payment would better support care management as practices “right size” their CCM based on the needs of their patients and without the administrative burdens that the current CCM code creates.**

### ***2. Establishing Separate Payment for “Collaborative Care”***

Within the proposed rule, CMS recognizes that Medicare beneficiaries with multiple chronic conditions – which are often accompanied by behavioral health issues – often require robust care management services including extensive discussion, planning, and information-sharing between a primary care physician and behavioral health specialists. The PCPCC is encouraged by CMS’ query regarding reimbursement for these critically important services. However, we reiterate our concerns expressed above that in focusing on short-term solutions via establishment of more CPT codes, we perpetuate the volume-based fragmentation and administrative burden of FFS payment. Again we advocate for a longer term solution that would drive system transformation

by moving toward a risk-adjusted comprehensive primary care payment with the goal of integrating behavioral health and medical services to enhance patient outcomes, as supported by scientific evidence.

The PCPCC strongly supports behavioral health integration (BHI) in which care is delivered by a practice team of primary care and behavioral health clinicians working together with patients and their families. As noted in the proposed rule, Collaborative Care is an evidence-based model for integrating behavioral health services into primary care that is often provided through a care team consisting of a primary care provider and a care manager, working in collaboration with a psychiatric consultant. This comprehensive, coordinated approach to behavioral health integration has led to improved patient outcomes and has shown capability to reduce health care costs. Because Collaborative Care can be resource intensive, it may not be feasible for practices with limited resources, or be easily scalable depending on panel size, patient population health needs, and workforce capacity in the region. Accordingly, **the PCPCC urges CMS to recognize that the Collaborative Care model merits consideration for enhanced reimbursement and we encourage CMS to simultaneously review for enhanced reimbursement other evidence-based care delivery models that support behavioral health integration into primary care.**

The proposed rule also seeks stakeholder input on the potential to test the Collaborative Care model through a Center for Medicare and Medicaid Innovation (CMMI) demonstration. The PCPCC supports further testing and experimentation of behavioral health integration models, to include the Collaborative Care model, through CMMI. The continued testing of various evidence-based models of behavioral health integration through CMMI demonstrations will help to identify:

- the care delivery strategies that lead to improved patient outcomes and reduced costs;
- the optimal staff and infrastructure requirements to support behavioral health integration models;
- the workforce capacity and necessary training required to support effective care;
- the optimal communication and staff time required to support reimbursement that minimize administrative hurdles to patient care (in the short term: a CPT code/s and per-member-per-month behavioral health payments; in the longer term, risk-adjusted comprehensive primary care payments that include behavioral health and primary care);
- the appropriate and meaningful performance measures to gauge successful and effective integration and promote patient health.

## **Valuation of Specific Codes (Section I)**

### ***1. Advance Care Planning (ACP) Services***

The PCPCC supports CMS's proposal to enhance advanced care planning in order to promote shared decision making between patients and their care teams. Advance care planning services, including the explanation and discussion of advance directives and completion of related forms, help patients and their families receive the care they want and need as they face sometimes difficult medical care decisions. The proposal to provide reimbursement for these services will afford a strong incentive for providers to deliberately engage patients and families in evidence-based ACP services, which lead to higher quality of care, improved patient and family

experience, reductions in unnecessary health care utilization, and lower rates of caregiver distress and depression. Further, the delivery and reimbursement of ACP services is especially important for Medicare beneficiaries, who often have more complex health care needs. Discussions about advance care planning are complex, sensitive, and often include family members and other caregivers who become integral members of their primary care team. Accordingly, the PCPCC **encourages CMS to reimburse health care providers for advance care planning, even when they are not associated with another health care service, in order to encourage the full participation of families and caregivers, and to provide the appropriate time and focus on the patient's end of life questions and concerns.**

### **Physician Payment, Efficiency, and Quality Improvements—Physician Quality Reporting System**

#### ***Request for Input on the Provisions Included in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)***

As you are aware, the Medicare Access and CHIP Reauthorization Act (MACRA) repealed the sustainable growth rate (SGR) in favor of a new Medicare reimbursement model that values quality of care, over the quantity of services delivered. While states and commercial payers have long been involved in piloting PCMH and advanced primary care demonstrations, MACRA is the first piece of federal legislation that incorporates comprehensive value-based reimbursement in the Medicare program. MACRA offers two innovative pathways for physician reimbursement: the Merit-based Incentive Payment System (MIPS), which adds a value component to traditional fee-for-service reimbursement; and Alternative Payment Models (APMs), which consist of risk-bearing arrangements. The statute explicitly names the PCMH as a model that providers can use to achieve either the quality component for MIPS or an eligible payment model under the APM pathway.

**The PCPCC recommends that CMS begin considering and seeking stakeholder input on the definition of PCMH for the (Merit-Based Incentive Payment System) MIPS and Alternative Payment Model (APM) reimbursement pathways.** As CMS considers how it will recognize PCMH practices for the purpose of MACRA implementation, it is important to acknowledge that current standards for achieving PCMH recognition, accreditation, or certification vary across accrediting organizations, health plan payers, and clinician practices. Although a growing number of health plans and payers use PCMH recognition as a means to validate high performing practices and reward practices with increased reimbursement, the specific elements, processes, administrative burden, and costs for undergoing recognition differs significantly across recognition programs. Moreover, recognition, certification, or accreditation as a PCMH is not always synonymous with meaningful practice transformation.<sup>3</sup>

In light of the recent passage of MACRA, as well as increased concern that PCMH recognition/certification programs should result in high-quality patient-centered care that

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<sup>3</sup> McNellis, R.J., Genevro, J.L., & Meyers, D.S. (2013). Lessons learned from the study of primary care transformation. *Annals of Family Medicine*. 11(1). S1-S5.

promotes meaningful primary care practice transformation consistent with the professionalism inherent in learning organizations, the PCPCC Board of Directors has created the PCPCC Accreditation Workgroup. The workgroup is comprised of health care experts representing patients, physicians, nurses, behavioral health, health plans, and researchers, and is advised by a group of technical experts from national and state accreditation organizations. The PCPCC welcomes an opportunity to assist CMS as we seek to unify the definition and purpose of PCMH accreditation based on the recommendations of this diverse, expert, stakeholder panel; potentially useful as the public and private sectors move toward value-based reimbursement. The workgroup will be identifying and analyzing opportunities and challenges in the current PCMH certification/recognition marketplace, outlining the outcomes or attributes that a PCMH should ideally achieve in order to serve as a “good housekeeping seal of approval” for patient-centered care; for example, offering economic value for patients, providers, and payers. In addition, the workgroup will be outlining ways in which to improve the current certification process; for example, incentivizing innovation while minimizing administrative burden, and tracking meaningful measures that are increasingly centered on patient outcomes instead of practice processes.

### ***Alternative Payment Models***

In the current FFS system, primary care practices are increasingly being asked for performance metrics that assess their progress in providing high quality care. 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 that 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.

**As CMS considers the definition of eligible PCMHs and other clinical practice improvement activities as part of MACRA, the PCPCC strongly recommends alignment and harmonization of performance measures.** As new quality measures are developed through MIPS, and replace existing PQRS and VBPM programs, the PCPCC urges CMS to ensure the new measures do not impose extensive administrative burden and documentation on providers, which would take up time that could otherwise be spent caring and collaborating with patients and families. In addition, as measures are being selected for the MIPS and APM programs, we strongly encourage the Secretary to consider the use of measures currently in development by the Core Measure Harmonization workgroup that is being led by AHIP, CMS, and NQF, and that now includes consumer representation.

## Potential Expansion of the Comprehensive Primary Care (CPC) Initiative (Section K)

### *Considerations for potential model expansion*

The PCPCC applauds CMS's prioritization of the development and implementation of current initiatives designed to improve payment for, and encourage long-term investment in, primary care and care management services. **Accordingly, the PCPCC strongly encourages CMS to expand the CPC initiative in existing CPC regions, as well as in additional geographic regions.** In the first evaluation of the program, researchers found that the program's investment and emphasis on comprehensive primary care led to reductions in inappropriate and unnecessary utilization, and led to a 4% reduction (nearly statistically significant) in 30-day readmissions program-wide. After the first year of implementation, the reduction in expenditures from avoiding ED visits and hospital admissions nearly offset the care management fees allocated by CMS.

### *Practice readiness*

The PCPCC was encouraged by the program's preliminary results, and strongly believes that this program should expand to additional regions. That said, it is important to evaluate practice readiness when considering a potential expansion of the program. When payment aligns with practice readiness, 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.

Because primary care practices are at various states of readiness, CMS should allow for practices/providers to move to payment models that have higher accountability for total costs of care as soon as they are able. In addition, CMS should 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 that 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.

### *Practice standards and reporting*

CMS seeks input on the value and operational burden of the CPC Milestones approach (paragraph FR 41883). 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 most Milestone measures, despite ongoing concern about administrative burden that undermined focus on patient care. 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. The PCPCC encourages CMS to work with provider organizations to address unnecessary administrative burden of CPC practices. In addition, due to the large number of individuals presenting with behavioral health conditions in a primary care setting, the PCPCC recommends that CMS add behavioral health integration as an additional milestone for the next phase of current CPC initiative participants.

### ***Interaction with state primary care transformation initiatives***

CMS also seeks comment on whether a potential CPC expansion could and should exist in parallel in a state with a separate state-led primary care transformation effort. **The PCPCC suggests that the CPC program can and should be integrated into additional states and regions, regardless of if those localities have existing and ongoing primary care initiatives. However, it is important that as the CPC program integrates into existing programs and that alignment and collaboration across participants is achieved. Moreover, 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 that are currently underway, to CPC as well as the Multi-payer Advanced Primary Care Program (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. In the independent evaluation of the program's first year, Mathematica researchers found that, "payers in Oregon felt that aligning CPC with their state medical home program would have avoided confusion by practices."

If the CPC initiative is expanded to additional regions, it will be important for CMS to demonstrate comparable flexibility to those in first iteration of initiative participants. At the onset of the program, CMS required that all reporting be exactly the same, however commercial payers took issue and CMS responded by granting flexibility when feasible. Because all health delivery is local, it is important that communities are able to work together at the local and regional level and that Medicare where possible allows flexibility for them to do so.

### ***Learning activities***

CMS also seeks comment on willingness and ability of existing state and regional primary care or patient centered medical home learning collaboratives to support practices in a potential expansion of the CPC initiative. We believe that the willingness and ability of existing collaboratives to support practices in an expansion of the CPC will be highly dependent on the scope of work currently underway by current PCMH learning collaboratives, as well as number of practices enrolled. Should an expansion occur, additional resources would be needed to expand current PCMH initiatives and integrate CPC milestones and measures. **The PCPCC would strongly encourage collaboration between CPC and the upcoming Transforming Clinical Practices Initiative (TCPI), as many of CPC lessons learned can inform the development of the TCPI, one of the largest federal investments uniquely designed to support clinician practices through nationwide, collaborative, and peer-based learning networks that facilitate practice transformation.**



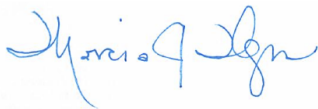
### ***Patient/family engagement within CPC***

While CMS does not explicitly request stakeholder input on issues pertaining to a potential expansion and patient/family engagement, the PCPCC recommends that CMS consider the following recommendations. First, the Mathematic independent evaluation of the CPC initiative reports, *“Despite these positive ratings of their CPC providers, CPC practices across all regions face substantial opportunities to improve patient experience, as we would expect as the initiative began. Patients rated their providers and practices most poorly on their provision of timely care, shared decision making on whether or not to take a prescription medication, and provision of adequate support for patients to take care of their own health.”*

Primary care transformation can be daunting for practices, and requires strong leadership, culture change, along with financial and technical support. As CMS considers CPC expansion, the agency should ensure practices have significant support that includes ongoing, tailored technical assistance, resources and support from organizations that can facilitate practice transformation in meaningful partnership with patients, families and the communities being served.

Thank you for this opportunity to provide our input on the proposed rule and for your efforts to support advanced primary care and improved patient outcomes. If the PCPCC can be of service to you in these efforts, or if you need additional information, please do not hesitate to contact me.

Sincerely,

A handwritten signature in blue ink, appearing to read "Marci Nielsen".

Marci Nielsen, PhD, MPH  
CEO, Patient-Centered Primary Care Collaborative