Patient-Centered Primary Care COLLABORATIVE

November 20, 2017

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW, Room 445-G
Washington, DC 20201

Submitted via E-Mail: CMMI_NewDirection@cms.hhs.gov

Re: Centers for Medicare & Medicaid Services – Innovation Center New Direction

Dear Administrator Verma:

The Patient-Centered Primary Care Collaborative (PCPCC) appreciates this opportunity to provide input on a new direction to promote high-value, patient-centered care through the Innovation Center. We strongly support the Administration's stated goals of promoting patient-centered care, empowering beneficiaries, and aligning payment to support improved quality, reductions in total costs, and improved outcomes. We are encouraged by the ideas outlined by CMS and urge the agency to use this opportunity to allay stakeholder concerns about the possibility of slowing government leadership in the transition to value/outcome-based payment.

PCPCC strongly encourages continued CMS leadership in efforts to drive the shift to value, while empowering beneficiaries through the support of reliable access to primary care. By setting forth and maintaining a vision for high-value care, CMS can continue to incent change and expand participation in both the public and private sector. We support CMS efforts to leverage payment models from other public and private programs and assign credit to clinicians and other providers participating in value-based models wherever due. Finally, we encourage CMS to actively work toward an environment in which the administrative burden on clinicians and other providers participating in value-based payment is both manageable and consistent across all public and commercial payment programs.

PCPCC Background and Vision for Primary Care

Founded in 2006, the Patient-Centered Primary Care Collaborative is a not-for-profit multi-stakeholder membership organization dedicated to advancing an effective and efficient

health system built on a strong foundation of primary care and the patient-centered medical home. Representing a broad group of public and private organizations – including payers, healthcare clinicians and other providers, leading corporations and patient and consumer advocacy groups – the PCPCC's mission is to unify and engage diverse stakeholders in promoting policies and sharing best practices that support growth of high-performing primary care to achieve the "Quadruple Aim": better care, better health, lower costs, and greater joy for clinicians and staff in delivery of care.

In 2017, PCPCC published the Shared Principles of Primary Care (attached) – identifying an ideal vision of primary care that builds upon advanced primary care concepts such as the Patient Centered Medical Home (PCMH). These Shared Principles were developed by stakeholders representing all aspects of healthcare and currently more than 260 organizations have signed on to support them. They are designed to move the United States toward a vibrant future of person-centered, team-based, community aligned primary care that will drive better health, better care, and lower costs. They also put an emphasis on all stakeholders stewarding precious healthcare resources.

New Opportunity for Patient-Centered Innovation

PCPCC is pleased to see this opportunity for the Innovation Center to grow and evolve to continue to meet the needs of patients and clinicians. We are particularly pleased to see an increased emphasis on giving beneficiaries and providers the tools and information they need to make decisions that work best for them as outlined in PCPCC's Shared Principles of Primary Care. We believe that empowered beneficiaries, their families, and caregivers are best able to take ownership of their health with the support of reliable primary care physicians and other clinicians. These clinicians should be accessible when needed, have a continuous personal relationship with the patient, and have a team-based approach that coordinates with other healthcare organizations. We believe that benefit and payment designs promoting high-value care can and will support this vision of patient-centered primary care.

PCPCC encourages CMS to continue its focus on the long-range vision of what our healthcare system should be and what individual steps are needed to achieve that vision. We should focus on long-term efforts to ensure every American has access to primary care physicians and other clinicians in their community, that healthcare providers engage in coordinated team-based care and preventative and population-based health, that patients are engaged and active participants in their health and well-being and that payment emphasize value – not volume in healthcare delivery. This ongoing vision is critical to ensure continuity and stability in the approaches taken by the Innovation Center, as we believe this continued leadership toward a defined goal is essential to health system transformation.

Drive Beneficiary Engagement
Actively engaging and empowering patients in their health and the prioritization of their health should be an important part of any patient-centered care model. This engagement is particularly important to transformation initiatives' sustainability and impact. As described in the shared principles, an emphasis on patient and family engagement must be an important focus – with improved communication and guidance from the care team, patients are better able to utilize high-value services and avoid low-value interventions.

As you proceed, we encourage mechanisms to ensure beneficiaries and their advocates are involved in the development, implementation, and evaluation of these models. This input could be collected through a consumer and patient advisory councils, beneficiary involvement in Technical Expert Panels (TEPs), public feedback on proposed model designs, public engagement, publicly shared data for each model, enhanced support via 1-800-MEDICARE and State Health Insurance Assistance Programs (SHIPs), readability testing of patient-facing content for each model; and through an APM Ombudsman.

We also encourage the expanded use of Patient Reported Outcome Measures (PROMs), as the ultimate success of alternative payment models should consider the patient experience alongside cost and quality. These measures must emphasize overall health and wellness as episode-specific measures could lead to overutilization. They must also have sufficient sample sizes and offer a longitudinal look at the patient care experience as new models are tested by the innovation center and later implemented by CMS.

One interesting potential opportunity for patient engagement could be providing patients with the opportunity to share in savings from these more efficient, high-quality care models. This could be an important lever to both drive patient engagement, and also drive patients to seek out high-value clinicians and services.

Expanded Participation in Advanced Alternative Payment Models (AAPMs)
PCPCC believes that there is an opportunity for the Innovation Center to play an even more important role in driving progress toward value-based payment throughout the healthcare system. As outlined by CMS, the Innovation Center should work to expand physician and other clinician and provider participation in alternative payment models and test new approaches for adoption in both the public and private sector. As part of this effort, CMS should work to ensure that all clinicians in the patient care team have equal opportunity to participate in future demonstrations and advanced payment models.

CMS can create these opportunities by ensuring that experimentation with value-based payment is a compelling option for those confident in their ability to provide high-value, patient-centered care. To encourage providers to take on real performance-based risk, financial incentives must be meaningful and closely tied to patient outcomes.

Additionally, CMS should continue efforts to encourage those not yet moving toward performance-based risk (through either alternative payment models or Merit-Based Incentive System (MIPS) incentives) by developing targeted efforts that emphasize relatively low-risk, low complexity opportunities as pathways to value-based care. These broad-based, low barrier-to-entry opportunities are critical to ensure that the entire healthcare system takes steps to shift toward value. It will benefit neither patients nor the broader healthcare system if we allow some to avoid a value-based environment and find ourselves with two discrete healthcare delivery models in future years.

It is also important that CMS be strategic in the implementation of its shift to greater emphasis on voluntary participation in alternative payment models. While some valid concerns were raised with past mandatory models, voluntary participation could distort outcomes and undermine efforts to evaluate the efficacy of models. Self-selection by participants may reduce variation in measure performance across participants and undermine the ability of CMS to extrapolate the effect of the model if expanded. Careful selection of measures and participants will be necessary to address variation and produce a meaningful effect that can ultimately continue to move us on the value path.

Finally, CMS must take care that efforts to drive value-based payment in specific physician specialties do not undermine broader, more comprehensive health system movement toward value-based payment. It is conceivable that a payment model based on specific episodes of care or a similarly narrow event could prove too compelling (either in payment or administrative simplicity) and lead to a balkanization of what should be a patient-centered, whole person approach to health with a strong primary care foundation. PCPCC and its members believe that care must be coordinated, integrated, and comprehensive – any episode-based model must emphasize in its performance criteria the need for this episode to be fully aligned with the patient's broader care team and across any settings of care.

New Opportunities to Expand Participation in Advanced Alternative Payment Models

As previously noted, PCPCC believes that it is essential for the Innovation Center to focus on broadening opportunities for AAPM participation through dynamic, attractive opportunities for physicians and other clinicians and providers to take on financial risk and demonstrate results. CMS has highlighted several very promising and innovative options that PCPCC believes have the potential to elevate coordinated, patient-centered, high-value care. These opportunities include: leveraging Medicare Advantage strengths, expanding value based insurance designs (VBID), developing population health models that address the social determinants of health, and developing models seeking to better integrate behavioral health. The incorporation of successful models from Medicare Advantage (MA), Medicaid, and commercial payers can expand participation opportunities for value-based payment - increasing access for consumers, increasing participation by clinicians and other providers, and allowing for more innovative value-based approaches by private payers. We

encourage you to explore and facilitate outside models, including those in which traditional Medicare is not a participant. PCPCC is encouraged by the recent announcement that CMS will develop a demonstration project to test how risk-based Medicare Advantage contracts might be included in the AAPM pathway.

PCPCC believes that the expansion of value-based insurance design (VBID) models, as well as other managed care programs, have the potential to help drive care toward high-value practices like patient-centered primary care. VBID is built on the principle of lowering or removing financial barriers to essential, high-value clinical services and offers a path forward to allow expanded access to affordable, comprehensive care. It is widely known that access to skilled primary care is one of the highest-value pathways to improve patient outcomes. PCPCC believes that any value-based insurance design model must recognize and incorporate the critical role of primary and chronic care services in implementing a value-based approach. Patient support from trusted primary care physicians and other clinicians is needed to ensure the success of these models by explaining incentives to patients and caregivers and by helping to steer patients toward the right high-value options for them. The expertise and perspective of primary care is also needed to help identify special situations in which the common high-value treatment is not the right treatment for a specific patient. With these considerations, VBID concepts should be expanded for further trial in MA as well as other managed care programs, both public and private.

PCPCC and many other healthcare organizations believe that the future of the healthcare system will be a population-health based approach that supports high-value interventions to address key social determinants of health. CMS should use the authority of the Innovation Center to test additional models that allow health organizations to experiment with new population health-based approaches. CMS should also expand efforts to test high-value interventions designed to address the social determinants of health that drive up health care costs and complexity. These interventions should include the patient's care team, counseling programs, community organizations and input from the patient's family, when appropriate. Without development and experimentation in this area, we will not be able to address challenges related to home/shelter, food choices or lack of food, education, work environment, and other factors that significantly affect health outcomes. Without effective approaches to risk adjustment that compensate for these challenges, clinicians and other providers cannot succeed in an outcome-based payment environment. These approaches may also need to recognize special challenges for rural and underserved areas that need additional support as well as special emphasis on tools such as telehealth needed to improve patient outcomes.

PCPCC strongly supports CMMI leadership in exploring potential models focused on behavioral health and the incorporation of behavioral health into existing models. We believe that behavioral health is underaddressed in the health system – even while mental health challenges, dementia, and substance use disorders drive a high percentage of health

challenges in our nation. As you are aware, access to substance use disorder data remains an obstacle to any successful behavioral health model. PCPCC encourages the Innovation Center to consider models oriented around behavioral health integration with primary care. Too frequently the physical ailments of patients are treated without an evaluation of potential behavioral health challenges that could be related or causal. One particularly strong model in this area is the PCMH PRIME in Massachusetts which seeks to provide benefits to practices and their patients by supporting the use of evidence-based guidelines, helping increase patient access to behavioral health care services, recognizing practices that deliver comprehensive care by addressing both physical and behavioral health in the practice setting, providing opportunities for practices to receive technical assistance, and helping practices identify behavioral health issues before they become acute.

Build Upon Promising Models with Potential for Success

When considering new and innovative approaches to promote patient-centered care and test market-driven reforms, PCPCC strongly encourages CMS to build upon and incorporate lessons learned from current models.

PCPCC emphasizes the continued importance of primary care-driven models as primary care continues to be a key opportunity for high-value, patient centered care. In November, the Medicare Payment Advisory Commission (MedPAC) staff again reported on the widely acknowledged shortage of primary care providers and the challenge of providing these services – which are often labor intensive and require additional time to meet the needs of the patient. PCPCC believes that value-based payment models emphasizing leadership by the primary care team continue to be a significant opportunity to drive patient-centered, high-value care. In keeping with CMS interest in exploring new opportunities, we would emphasize that this model is compatible with a variety of alternative payment situations – the critical element is keeping the primary care service provider as the coordinating and integrating hub of a value-focused model.

Two models that PCPCC believes must remain key initiatives of the Innovation Center's future are the Comprehensive Primary Care + initiative and the Transforming Clinical Practice Initiative (TCPI). CPC+ offers the potential of greatly strengthening the ability of internists, family physicians, pediatricians, nurse practitioners, and other primary care clinicians, in thousands of practices nationwide, to deliver high value, high performing, effective, and accessible primary care to millions of their patients. While it is too early to expect results, we believe that the success of this program will depend on Medicare and other payers providing physicians and their practices with the sustained financial support needed to transform their practices and achieve the quadruple aim. We also believe that the TCPI is a critical tool to help clinicians transition to a more efficient, value-based healthcare system. As you know, the decisions of millions of individual providers have the potential to drive huge changes throughout the system. PCPCC has partnered with CMS in the TCPI effort to support primary care and specialist care practice transformation efforts

working with 120,000 clinicians across the country. In this effort, PCPCC has partnered with the Choosing Wisely initiative to engage both patients and physicians at the point of care when they are making decisions and can avoid wasteful or unnecessary medical tests, treatments, and procedures. Choosing Wisely is an effort led by the American Board of Internal Medicine Foundation in partnership with Consumer Reports.

Improve Programs and Processes

PCPCC appreciates CMS efforts to increase program effectiveness, reduce burdens on patients, and reduce additional workload created for clinicians and other providers. As noted, the right balance between financial incentives and additional burden is critical when attempting to encourage greater participation in models that will ultimately benefit patients.

To support efforts that will drive increased engagement in value-based payment models, a comprehensive look needs to be taken at reported measures for programs under traditional Medicare, MA, Medicaid, and the commercial market. As you know, MA plans have Star Rating incentive structures and risk agreements in place that drive substantial portions of their revenues, many Medicaid programs have also invested heavily in bundled or global payment initiatives, and a variety of approaches exist in the commercial market. CMS and other appropriate agencies should work closely with clinicians and other providers to create greater alignment of outcome measures across programs and the healthcare system and reduce the complexity of engaging in alternative payment arrangements. The ultimate goal of this effort should be to make participation in an alternative payment model under various public and private payers a similar experience for any given clinician. Through closer alignment and prioritization of measures (validated by a consensus body such as the National Quality Form) it would be much easier for providers to participate in value-based arrangements with multiple payers and significantly reduce administrative complexity. An additional benefit of more closely aligned measures would be in the ability to consistently track and collect quality improvement data longitudinally and across programs. We sincerely appreciate work that CMS has undertaken to streamline measures thus far, but emphasize that there is much more to be done. PCPCC strongly supports ongoing work by the Core Quality Measures Collaborative to approve and implement core measure sets that are aligned and harmonized across all payers.

The Innovation Center can work to develop a standard set of compliance and benefit waivers to reduce administrative complexity for AAPMs. A standardized approach to common challenges such as the use of telemedicine, possible complications to collaboration under the physician self-referral (Stark) law, and other concerns could significantly reduce the cost burden of participating in an alternative payment arrangement – and would be particularly necessary if CMS were to allow commercial market APMs to be considered under MIPS/AAPM criteria.

Finally, PCPCC encourages CMS to continue work with key stakeholders to identify opportunities to measure outcomes without special tracking effort on the part of the clinician. Any opportunity to collect measurement data and evaluate outcomes without creating significant additional burden on the clinician or other provider will both improve workflow and make the innovation center research intervention more valid by reducing additional factors that may influence clinician behavior.

Thank you for requesting input on a new direction for the Innovation Center. PCPCC and its multisector members look forward to working with you to support new and continued models that will drive higher-value care and improved patient outcomes. Please feel free to contact Christopher Adamec, Director of Policy at cadamec@pcpcc.org or 202-640-1212 with any questions.

Sincerely,

Ann Greiner
President & CEO

Shared Principles of Primary Care

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

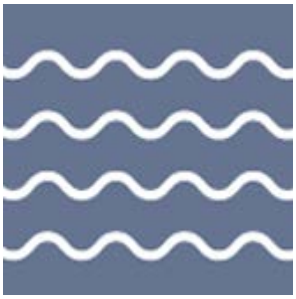
Primary care has experienced significant changes in the way it is organized, financed and delivered in response to greater demand for high-quality services, rising health care costs, and increasing burden of disease across populations (Bitton et al 2016). Concepts such as the Patient Centered Medical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

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

1. Person & Family Centered

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

2. Continuous



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

3. Comprehensive and Equitable

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

4. Team-Based and Collaborative

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

5. Coordinated and Integrated

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

6. Accessible

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

7. High-Value

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

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

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Executive Members

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