Patient-Centered Primary Care COLLABORATIVE

September 10, 2018

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program [CMS–1693–P]

The Patient-Centered Primary Care Collaborative (PCPCC) appreciates this opportunity to provide several comments on the proposed physician fee schedule and quality payment program. We applaud the administration for proposing bold changes designed to move the health system forward while also seeking to improve care delivery and reduce clinician administrative burden. PCPCC continues to support Centers for Medicare & Medicaid Services (CMS) efforts to expand the use of value-based and alternative payment models, while simultaneously reducing documentation requirements that are less necessary under payment models tied to outcome measures.

PCPCC Background and Vision for Primary Care

Founded in 2006, PCPCC is a not-for-profit multi-stakeholder membership organization dedicated to advancing an effective and efficient health system built on a strong foundation of primary care and the Patient-Centered Medical Home (PCMH). 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 – identifying an ideal vision of primary care that builds upon advanced primary care concepts such as the PCMH. These Shared Principles were developed by stakeholders representing all aspects of healthcare and nearly 300 organizations have signed on in support of them. They are designed to move the United States toward a vibrant future of person-centered, team-based, community aligned primary care that will drive better health, better care, and lower costs. They also put an emphasis on all stakeholders stewarding precious healthcare resources. It is important that any

effort to empower primary care take note of the consensus principles and seek to achieve the vision they represent.

PCPCC's multisector members have identified several areas in the proposed rule that are particularly relevant for feedback and comment. While we address them at a high level here, our members have addressed these and other issues in much more detail in their individual comments.

Continued Trajectory to Value-Based Payment

PCPCC appreciates the Administration-wide strategy to create a healthcare system focused on better accessibility, quality, affordability, empowerment, and innovation. We believe the path to these goals lies though alternative payment arrangements that tie payment to patient outcomes. Outcome-based models will support and catalyze the type of patient-centered primary care exemplified by the PCMH, while the fee-for-service system struggles to support it—even with significant improvements. CMS should continue its focus on efforts to transition the healthcare system into advanced alternative payment models through more incentives and opportunities, including physician-focused payment models. We encourage CMS to continue to view these changes as a small step on the path to a much larger transformation.

Physician Fee Schedule

<u>Reducing Clinician Burden and Evaluation and Management (E/M) Payments</u>

PCPCC appreciates CMS efforts to reduce unnecessary administrative burdens for clinicians. As noted, we believe that the overall trend toward outcome-based payment should allow for greater clinician discretion in what documentation is most appropriate for high-quality patient care. We do, however, believe that a broader effort with significant stakeholder input will be necessary for successful implementation of changes to reduce clinician documentation burden.

Specifically, PCPCC supports allowing clinicians to avoid re-documenting information that has already been entered in the patient's record by practice staff or by the patient. We also support removing the need for a clinician to justify providing a home visit instead of an office visit. Finally, we believe it is logical to change documentation requirements to focus on the interval history since the previous visit. These changes, along with continued transformation to outcome-based payment will allow clinicians to spend more time focusing on achieving the best results for the patient.

For these changes to be successful, CMS must seek to align proposed documentation changes across federal programs as well as with private-sector organizations. A detailed examination of where and how this documentation is used in the healthcare system is needed to ensure that changes are sustainable and made in a way that simplifies documentation for clinicians. Alignment between private payers (including Medicare Advantage plans) will be needed to ensure that documentation changes are made in a way that is feasible for all and does not create confusion or conflicting requirements. CMS should consider a test of these changes,

with active multistakeholder participation and guidance, and should delay implementation to achieve these goals.

It is currently unclear what impact the specific proposed changes to E/M payment codes and respective add-on codes will have on primary care practices and clinicians. PCPCC encourages CMS to engage in further study or testing of this payment structure prior to making a change this significant. It is also possible that further examination would support an alternative approach which could encourage greater patient centricity (such as a system more focused on clinician time) or other structure developed by a group of stakeholders with documentation and coding expertise. Most importantly, CMS must ensure that any meaningful change is a step on the path to greater value-based care.

Technology-Based Communication Services (eConsults)

PCPCC applauds CMS for continued efforts to allow for modern technologies to transform the way care is delivered. These technologies can empower consumers to engage with their primary care clinicians and allow primary care clinicians access to additional resources facilitating more care delivered in a convenient, familiar primary care setting from a trusted clinician.

In particular, PCPCC is enthusiastic about the inclusion of new codes supporting eConsults, which have the potential to improve care coordination, integration, and communication between primary care providers and specialists in the ambulatory setting. These codes have the potential to increase access to specialty care, while strengthening the continuous and ongoing relationship with the primary care provider. We believe these tools will also reduce unnecessary specialist visits, and therefore reduce costs for patients and taxpayers.

PCPCC encourages CMS to look closely to private payers and seek to align best practices across payers. This would allow CMS to learn from working programs and simplify implementation for clinicians. PCPCC also encourages CMS to make changes that will prevent a consumer from being charged multiple co-payments for the service. Billing the consumer multiple times could discourage this cost-effective and patient-centered service.

As previously mentioned, CMS should be deliberate in viewing these and other changes as a path to value-based payment arrangements where a care team's incentives are closely aligned with those of payers and patients. These interactions are a first step toward collaborative clinician care teams working under a value-based care arrangement that will provide superior quality and more efficient care with less documentation.

Shifting to Site-Neutral Payments

PCPCC strongly supports CMS actions and stated intentions of continuing to alter the payment system to eventually equalize payments with non-hospital physician offices. Site-neutral payment policies are an important step in improving the value the healthcare system offers to consumers and allowing transformative care and payment models to flourish. Common arguments against site-neutral payment often present valid health system needs – which may

need to be funded separately – but physician payment rates are not the appropriate mechanism for this support. PCPCC believes that similar services should have similar payment, regardless of the setting of care, and that separate resources should be identified to fund needs (such as critical access hospitals) that are supported by the current system.

Quality Payment Program

Promoting Interoperability

PCPCC applauds CMS for continued work to support greater electronic health record (EHR) interoperability and patient access to health information. We believe that CMS should provide the Promoting Interoperability Auto-Credit for recognized PCMHs that have met rigorous health IT standards to exchange data. CMS cites goals of reducing clinician burden, promoting interoperability, and focusing on outcomes. PCPCC believes that nimble, private-sector accreditation programs are one of the best ways to achieve these goals. These programs are able to reduce the reporting burden for clinicians who have met requirements to meet PCMH status, and incent high-quality, coordinated care. CMS should seek to reduce redundancy in requirements when there are highly-functioning private sector alternatives.

Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI)

PCPCC supports the proposed demonstration that would allow clinicians who participate sufficiently in Medicare Advantage arrangements to waive Merit-based Incentive Payment System (MIPS) reporting and payment adjustments. We believe that globally capitated payment arrangements, where incentives are aligned across the healthcare continuum inevitably lead to more investment in strong, preventative primary care services. We are therefore strongly supportive of approaches that create additional flexibility to experiment with outcome-based approaches within other existing payment programs, provided these arrangements provide comprehensive primary care services and include strong beneficiary protections.

Conclusion

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. We 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 steps taken by CMS but urge the agency to focus efforts on steps that lead clinicians out of the fee-for-service system permanently. 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