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November 17, 2015

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

Dear Acting Administrator Slavitt:

The Patient-Centered Primary Care Collaborative (PCPCC) appreciates the opportunity to provide comments on the Request for Information titled "Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models" as published by the Centers for Medicare & Medicaid Services (CMS) in the October 1, 2015 *Federal Register*.

Founded in 2006, the PCPCC 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 (PCMH). The PCMH embraces the relationship between the primary care team 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 brings together experts, innovators and thought leaders dedicated to transforming the U.S. health care system through primary care 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 that convene as a unified voice for primary care.

The PCPCC recognizes CMS's commitment to advancing primary care and appreciates the agency's focus on innovative payment reforms that provide greater financial support and investment in advanced primary care models, including the PCMH. In order for advanced primary care to reach its full potential, we must increase total financial support for primary care, as well

as restructure enhanced primary care services in order to best serve patients' needs. However, it is critically important that CMS remain flexible and allow continued experimentation with payment arrangements that support delivery system transformation. Health care providers and practices need time to learn from best practices and innovate without undue administrative burden and financial penalty.

The Patient-Centered Medical Home and MACRA Implementation

The PCPCC strongly supports Secretary Burwell's January 2015 announcement to increase alternative payment models within Medicare, including Accountable Care Organizations (ACO) and bundled payments, as well as innovative care delivery models, like PCMH. 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, while 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." Although continued development of FFS through the Physician Fee Schedule is necessary as Alterative Payment Models (APM) 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.[1]

As CMS drafts regulations for the purposes of MACRA implementation, the PCPCC recommends that the agency recognize the PCMH as a care delivery model, not a payment model. Numerous alternative payment models can support PCMH implementation and sustainability. The chart below provides a snapshot of various innovative payment arrangements currently being implemented in public and private health care marketplaces nationwide.

Payment model	Description[2]
Enhanced Fee-for-service (FFS)	FFS payments augmented to practices recognized as PCMHs
FFS with PCMH-specific billing codes	Practices able to bill for new PCMH-related activities.
Pay for Performance	Practices paid for meeting process measures (HEDIS), utilization targets (ED use, generic prescribing), or patient experience
Per-member-per-month	Practices paid capitated risk-adjusted, monthly fee in addition to typical FFS billing, often adjusted for PCMH recognition level.
Shared Savings	Practices rewarded with portion of savings, if the total cost of care for their patient panel increases more slowly than a preset target.

[1] 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

[2] Edwards et al. (2014). Structuring Payment to Medical Homes After the Affordable Care Act. JGIM. doi: 10.1007/s11606-014-2848-3

Comprehensive or Population Based Payment	Complete risk for cost of care with primary care practice.

The Alternative Payment Model Framework and Progress Tracking (APM FPT) Work Group also challenged the notion that PCMHs be considered payment models in its draft white paper released in late October. The Work Group suggests that because PCMH practices are paid under several different value-based arrangements "these delivery system models enable APMs and, in many instances, have achieved successes in advancing quality, but they should not be viewed as synonymous with a specific APM."[3]

Merit-Based Incentive Payment System (MIPS)

Measurement Harmonization

The ability to "measure what matters" is imperative to advancing primary care and improving health outcomes. When used efficiently and effectively, performance measures can drive improvement and provide access to accurate and meaningful information about health care quality. That said, the measurement burden (data collection and reporting) is palpable for health care practices and providers. If the quality measures used in the MIPS and APM programs are not streamlined and harmonized, this burden will increase. In 2012, the Institute of Medicine reported that excessive administrative and measurement burden cost the U.S. health care system $190 billion per year.[4] **The PCPCC recommends that a methodologically sound, parsimonious and aligned set of core quality measures be used across the MIPS and APM programs. We strongly encourage the use of measures currently in development by the multi-stakeholder Core Quality Measures Collaborative.**

However, is it not enough to harmonize and align measures across the MIPS and APM programs. As the PCMH model gains traction in both public and private markets, standardization and alignment of performance measures can be as important as payment. The public and private markets must join forces to align quality measures and coordinate efforts to support practice transformation. Under the current fractured payment system, primary care providers express concern regarding new payment streams that are different across payers,[5] creating financial risk and additional administrative burden. Finally, the PCPCC actively promotes patient, families, and caregivers as partners in improving primary care delivery and achieving transformation to medical homes. **The PCPCC recommends that CMS ensure that the core quality measures are patient focused and 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.**

Clinical Practice Improvement Activities Performance Category

Under MIPS, "certified medical home" practices are eligible to receive full credit (all 15 points) for the clinical practice improvement activities performance category. The patient-centered medical

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[3] https://publish.mitre.org/hcplan/work-groups/apm-framework-and-progress-tracking-work-group/
[4] Institute of Medicine. (2012). Better care at lower cost: the path to continuously learning health care in America. Washington, DC: The National Academies Press.
[5] Dulsky Watkins, L. (2014). Aligning payers and practices to transform primary care: a report from the Multi-State Collaborative. The Milbank Memorial Fund.

home (PCMH) is a model or philosophy of advanced primary care derived from the Joint Principles of the PCMH[6] that embraces the relationship between a primary care team and their patients, families, and care-givers. As set forth by the Agency for Healthcare Research and Quality[7], the five core attributes that define the ideal PCMH are**:**

- **Patient-centered:** The PCMH supports patients in learning to manage and organize their own care based on their preferences, and ensures that patients, families, and caregivers are fully included in the development of their care plans as well as participants in quality improvement, research, and health policy efforts.
- **Comprehensive:** The PCMH offers whole-person care from a team of providers that is accountable for the patient's physical and behavioral health needs, including prevention and wellness, acute care, and chronic care.
- **Coordinated:** The PCMH ensures that care is organized across all elements of the broader health care system, including specialty care, hospitals, home health care, and community services and long term supports.
- **Accessible:** The PCMH delivers accessible services with shorter waiting times, enhanced in-person hours, 24/7 electronic or telephone access, and alternative methods of communication through health IT innovations.
- **Committed to Quality and Safety:** The PCMH demonstrates commitment to quality improvement and the use of data and health information technology (HIT) and other tools to assist patients and families in making informed decisions about their health.

Due to a growing concern about PCMH certification potential lack of alignment with meaningful primary care practice transformation,[8] the definition and recognition/certification of PCMH is in need of a timely update**.** The PCPCC recently convened a multi-stakeholder workgroup to identify the aspirations of the medical home model of care and where there are needed improvements in the current approach and/or standards. **At its foundation, the PCPCC[9] believes PCMH certification should ultimately be a "good housekeeping seal of approval" demonstrating achievement of the attributes (outcomes) ensuring consumer confidence in the practice and its clinicians**. In the near term, certification should focus on a simplified set of evidence-based "change concepts" that reflect attributes of an ideal PCMH. **The PCPCC strongly recommends that CMS allow practices multiple pathways to achieve "certified medical home" status under MACRA. PCMH certification should not be tantamount to third-party recognition, rather it should recognize ideal PCMH attributes derived from a parsimonious, evidence-based change concepts that allow for flexibility to address the particular needs of the patient population and community.**

The PCPCC believes that the PCMH model of care is foundational to health system reform. As such, it is imperative that the certification process reflects the ideal attributes of the model, is outcomes

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[6] AAFP, AAP, ACP, AOA. (2011) Guidelines for Patient-Centered medical Home (PCMH) Recognition and Accreditation Programs. Retrieved from http://www.aafp.org/online/etc/medialib/aafp_org/documents/membership/pcmh/pcmhtools/pcmhguidelines.Par.0001.File.dat/GuidelinesPCMHRecognitionAccreditationPrograms.pdf

[7] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality (AHRQ). *Patient-centered medical home resource center, defining the PCMH.* Retrieved from http://pcmh.ahrq.gov/page/defining-pcmh

[8] PCPCC Annual Review of the Evidence (2015); Stout & Weeng (2014); Sugarman et al (2014), Friedberg et al (2015)

[9] PCPCC Accreditation Work Group 2015

focused and demonstrates what is most important to patients, families, caregivers and consumers. Ensuring that the ideal model of a transformed primary care practice is continually reflected in the PCMH certification process is integral if our goal is to support this model of care as foundational to health system reform. As the PCMH model is scaled and spread, the alignment of certification, payment, performance measurement, and individual patient and family care needs will provide increased value to all health care stakeholders – and help ensure that PCMHs are foundational to ACOs and/or other integrated health systems that demonstrate cost effective, higher quality health care system.

The PCPCC also supports the RFI's inclusion of the Clinical Practice Improvement Activity subcategory that will reward behavioral health integration in primary care practices. A large number of individuals continue to present with behavioral health conditions in primary care settings. CMS should consider the role of behavioral health integration (BHI) in which care is delivered by a care team of primary care and behavioral health clinicians working together with patients and their families as a clinical improvement activity under MIPS.

Alternative Payment Models

State Medicaid Medical Homes

States have long been incubators for innovative care delivery reforms, including the PCMH, through their Medicaid, Children's Health Insurance Program (CHIP), and state employee health programs. As of July 2015, 46 states had included PCMH as a model of care delivery in their Medicaid program and as of April 2014 seven states included the PCMH in their state insurance exchange standards for Qualified Health Plans (QHP).[10] Because states are uniquely positioned with economies of scale and the ability to convene stakeholders by addressing challenges of anti-trust barriers, they are able to lead "all-payer" or "multi-payer" PCMH initiatives.[11] These collaboratives typically include Medicaid, commercial health plans, employers and/or labor unions, and sometimes Medicare. CMS has already allocated funding to several state-based initiatives that test new models of primary care delivery and innovative payment strategies including the Comprehensive Primary Care Initiative (CPC), the Multi-payer Advanced Primary Care Practice (MAPCP) demonstration, and the State Innovation Models (SIM) Initiative.

To date, 16 (of the 34) states that have received SIM funding are using the PCMH model as the foundation of their delivery system transformation. [12,13] While the payment arrangements supporting these delivery reforms vary by state, each participating state has adopted payment arrangements with

[10] State Reforum. (2014). Health insurance exchanges and patient-centered medical home initiatives. Retrieved from https://www.statereforum.org/exchanges-medical-home-initiatives
[11] Wirth, B., & Takach, M. (2013). Issue brief: state strategies to avoid antitrust concerns in multipayer medical home initiatives. Retrieved from http://www.nashp.org/sites/default/files/1694_Wirth_state_strategies_avoid_antitrust_ib.pdf
[12] CMS. (2015). State Innovation Models Initiative: Model Test Awards Round One. Retrieved from: https://innovation.cms.gov/initiatives/State-Innovations-Model-Testing/index.html

[13] Van Vleet, A., Paradise, J. (2014). The State Innovation Models (SIM) Program: an overview. The Henry J. Kaiser Family Foundation. Retrieved from: http://kff.org/medicaid/fact-sheet/the-state-innovation-models-sim-program-an-overview/

the goal of supporting and sustaining transformation.[14] Many states have pioneered care delivery reforms founded on the attributes of the medical home model tailored to the unique patient population served by Medicaid. However, the definition of "medical home" varies by state, with some states codifying a definition in statute and others relying on medical home recognition set forth by national accrediting organizations. Similarly, the CPC initiative requires participating practices to deliver five functions: (1) access and continuity, (2) planned chronic and preventive care, (3) risk-stratified care management, (4) patient and caregiver engagement, and (5) coordination of care across the medical neighborhood. These five functions align with the core attributes of the PCMH model. If this initiative is expanded under the authority of CMMI and therefore is deemed as an eligible alternative payment model, state Medicaid programs that are founded upon comparable attributes should be recognized as APMs as well.

States that have incorporated the PCMH model within their Medicaid programs, and have supported these programs with an alternative payment model arrangement, deserve to be recognized for their commitment to patient-centered care delivery transformation. **The PCPCC supports the inclusion of Medicaid medical homes as recognized APMs when such models fulfill comparable requirements as those expanded under CMMI.**

Eligible Alternative Payment Models Requirements

An eligible alternative payment model (EAPM) entity is defined as an entity that:

(1) participates in an APM that requires participants to use certified EHR technology (as defined in Medicare) and provides for payment for covered professional services based on quality measures comparable to measures under the performance category quality performance category); and
(2) bears financial risk for monetary losses under the APM that are in excess of a nominal amount or is a medical home expanded under section 1115A(c) (CMMI).

These requirements afford a very narrow window for providers to satisfy eligibility requirements and earn the 5% bump in reimbursement. Care delivery transformation requires substantive upfront investment and non-billable costs, including those related to additional technology and personnel required to satisfy the data collection and reporting requirements associated with being part of an eligible APM entity. Practices that commit to delivering patient-centered care through the medical home model are expected to undergo substantive transformation, are therefore assume a form of risk that is not currently accounted for under CMS's current definition of "nominal financial risk."

Technical Assistance (TA) to Small Practices and Practices in Health Professional Shortage Areas

Access to the right kind of TA at the right time can be a powerful lever to help drive the pace of change as practices engage in delivery redesign and practice transformation. However, there needs to be acknowledgement that just as we have a shortage of primary care and high-impact primary care,

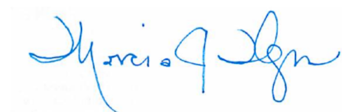
[14] The Henry J. Kaiser Family Foundation. (2015). The State Innovation Models (SIM) Program: a look at round 2 grantees. Retrieved from: http://kff.org/medicaid/fact-sheet/the-state-innovation-models-sim-program-a-look-at-round-2-grantees/

there is a shortage of TA resources available to help expand and strengthen primary care under MACRA and other initiatives designed to incentivize providers toward value. This is problematic and suggests the need for significant investment to build TA capacity. Borrowing from the success of bringing practices together to learn from one another, it makes sense to establish a learning community for TA providers to share challenges, approaches and impact data. This type of collaboration will strengthen the TA products and services delivered to practices across all TA providers. TA models must assess the root causes of the challenges facing practices in order to support care delivery redesign that results in better experiences of care and outcomes for patients without focusing too heavily on certification or recognition processes alone.

Practice transformation TA is an inherently high-touch activity, involving on-going engagement with practice leadership and staff over a sustained period of time. TA should not be seen as a silver bullet when the sought-after goal is complex and adaptive, such as high-impact primary care and care delivery transformation. Given the dearth of resources, TA models should leverage economies of scale without sacrificing more direct engagement. An example of this is the "train the trainer" model, in which experienced TA providers transfer knowledge and capacity directly to the practice enabling the practice to "own" their own QI/TA capacity over the long term. The PCPCC believes that now is the time to build and improve upon the experiences of TA models that have been implemented through state-based PCMH programs and federal quality improvement programs like the Comprehensive Primary Care Initiative and the Transforming Clinical Practices Initiative, as well as innovative, private-sector models for care delivery redesign.

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,



Marci Nielsen, PhD, MPH

CEO, Patient-Centered Primary Care Collaborative