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June 27, 2016

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 “Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models” as published by the Centers for Medicare & Medicaid Services (CMS) in the May 9, 2016 *Federal Register*.

Founded in 2006, the mission of the PCPCC – a 501(c)(3) not-for-profit membership organization – is to unify and engage diverse stakeholders in promoting policies and sharing best practices that support *high-performing primary care in order to achieve the “Quadruple Aim”* of better care and better health for patients, caregivers, and communities; lower costs for employers, consumers, health systems and health plans; and greater joy for clinicians and staff in delivery of care. The PCPCC convenes 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 more than 1,200 diverse stakeholders broadly representing organizations of health professionals, patients and consumers, employers and purchasers, and other committed stakeholders of high performing, team-based, patient-centered primary care.

The Medicare Access and CHIP Reauthorization Act (MACRA) aims to accomplish what primary care practices have long sought: (1) opportunities for clinicians to participate in sustainable payment models that better reward the unique functions of high-performing primary care; (2) streamlined quality and performance measurement that overtly acknowledges the value of the patient-centered medical home, specifically within the Medicare FFS payment system; and (3) a critical opportunity to strengthen care delivery for Medicare beneficiaries and their caregivers by valuing the trusted healing relationship between clinicians and their patients. Given Medicare’s influence on the U.S. health care marketplace, MACRA’s reach will extend far beyond the confines of CMS and Medicare. Its successful implementation will prove crucial in driving sustainable health system delivery reform across the country.

As a key supporter of payment reform embodied in MACRA, we appreciate CMS' substantial work in crafting proposed regulations that seek to implement this critically important and complex statute. Leading a careful, clear, and workable implementation of this historic law is an immense challenge, but its importance cannot be overstated. As a unique coalition representing health care providers, patients, and payers, the PCPCC stands ready to assist CMS in engaging the diversity of organizations keenly interested in supporting payment reform that supports high-performing, team-based, patient-centered primary care for all.

The PCPCC is particularly supportive of provisions in the MACRA proposed rule that:

- **Acknowledge the Role of Patient-Centered Medical Homes.** Among a number of provisions aimed at supporting high-performing primary care, MACRA singles out and rewards care delivered through patient-centered medical homes, recognizing the value and unique function that primary care offers Medicare beneficiaries. The emphasis on high-performing primary care is apparent throughout the MACRA statute, with the medical home recognized as a preferred delivery model under both the Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) pathways.
- **Improve Quality Measurement and Reporting.** In addition to better valuing the myriad functions that primary care practices provide to beneficiaries, MACRA also intended to simplify and align the numerous quality and performance requirements placed on practices in the MIPS program. We strongly support CMS recommendations to: narrow to six measures on which primary care clinicians are required to report; work toward better outcome measurement and measures derived from data collected as a natural part of clinical workflow (via health information technology); develop and use patient-reported outcome measures (PROMs) as a meaningful component of patient engagement and accurate assessment of health and wellness; and create new programs – such as the Clinical Practice Improvement Activity (CPIA) performance category – where new quality and outcome measures can be developed, tested, and implemented.
- **Advance the Comprehensive Primary Care Plus (CPC+) Program.** The PCPCC is a solid supporter of CPC+, the largest-ever CMS multi-payer initiative to transform and improve primary care delivery nationwide by promoting regional collaboration among Medicare, Medicaid, commercial plans, employers, labor unions, and primary care practices, together with their patients and families. CPC+ builds from the original Comprehensive Primary Care (CPC) Initiative launched in 2012, incorporating “lessons learned” that represent the next step in high-performing primary care delivery and payment design. The proposed rule includes CPC+ as an Advanced Alternative Payment Model, which the PCPCC fully supports.
- **Promote New Categories Within the Clinical Practice Improvement Activities (CPIA).** The PCPCC applauds the inclusion of CPIAs in MIPS that promote the long-term health needs of patients and communities and enhance population-level health management. In addition, CPIA includes new subcategories of activities for “Achieving Health Equity” and “Integration of Behavioral and Mental Health.” As significant priorities of the PCPCC and those who support high-performing primary care for patients, families and communities, we are encouraged that the proposed rule adopts these types of CPIA activities within MIPS and we look forward to assessing how these activities can drive improved health outcomes for patients and families, and especially for those in at-risk communities with challenging health and social needs.
- **Elevate the Physician-Focused Payment Model Technical Advisory Committee (PTAC).** As proposed by Congress, the PTAC provides CMS with a unique opportunity to engage nationally known payment experts in continued development of physician-focused delivery and payment models (PFPM), beyond those initially included in the MACRA statute and final rule. The PCPCC enthusiastically encourages CMS to collaborate with the PTAC to: expand the adoption of innovative

primary care focused Advanced APMs; evaluate additional successful models for recognition as Advanced APMs, such as Medicare Advantage; and engage the PTAC to assist in the development, tracking, and reporting of primary care spending as a share of total health care spending. Monitoring overall spending on primary care – including types of primary care service and payment models used to pay primary care clinicians and their care teams – can provide invaluable insight to key drivers of quality and total cost of care, in both MIPS and APMs. Primary care is increasingly recognized as a necessary building block of delivery reform, but funding for primary care clinicians must also be sufficient. Tracking the percent of total health care costs spent on primary care by payment model will allow the PTAC and commensurately CMS to monitor whether enhanced payments are explicitly shared with primary care clinicians and their teams, or merely reserved for larger organizations and health systems with better access to financial and political capital.

Although the PCPCC remains a strong advocate of MACRA’s overall goals, we have considerable concern about specific provisions of the proposed rule to implement it. Despite the complexity of the law itself, the proposed rule in its current form is cumbersome and ill-timed, misses the mark on opportunities to simplify and streamline aspects of performance measurement, and unnecessarily limits the scope and spread of the medical home model of care that could enhance health care delivery to beneficiaries across the United States. The PCPCC offers specific suggestions for improving the implementation of MACRA from the perspective of primary care clinicians and their care teams, patients and families, and payers and purchasers of health care services.

Specifically, the PCPCC strongly encourages CMS to reconsider:

- **Medical Homes as Advanced Alternative Payment Models.** Consistent with our interpretation of Congressional intent, the PCPCC firmly supports multiple pathways by which high-performing primary care practices can be recognized and rewarded as medical homes, specifically as (advanced) APMs. Utilizing strict criteria, CMS has identified only six models that it anticipates would qualify as Advanced APMs for the 2017 performance year, only one of which is primary care focused. Together with the Academy of Family Physicians (AAFP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA), the PCPCC strongly recommends that CMS undertake an expedited analysis of the Comprehensive Primary Care initiative (CPC) to determine whether CPC meets statutory requirements for expansion (and thus qualify as an advanced APM). We also recommend establishing and implementing a new medical home deeming program that enables high-performing practices enrolled in medical home programs run by states (including state Medicaid programs), other non-Medicare payers, and employers to be deemed as having met criteria “comparable to medical homes expanded under section 1115A(c).” This deeming process should be defined and implemented prior to January 1, 2018. Finally, while the PCPCC appreciates CMS’ acknowledgement that medical homes have limited ability to assume significant financial risk in comparison to larger health care organizations, we question whether Congress intended *any* financial risk requirement for the Medical Home Model based on the statute, and thus encourage CMS to revisit this in the proposed rule.
- **Expand Accreditation of Patient-Centered Medical Homes.** While the goals or attributes for PCMH practices are often similar, the PCMH model is not “one size fits all.” Likewise, PCMH certification (or recognition) programs vary, with different meaning to patients and consumers, health care providers, and payers/health plans. Research suggests that PCMH recognition or certification of a practice by an accrediting body may not accurately capture actual advanced primary care functionality. Accordingly, the PCPCC recommends that CMS closely review and adopt the recommendations of the PCPCC Accreditation Workgroup – a broad stakeholder group convened to assess the purpose of and improvements to current PCMH accreditation¹ – to inform CMS criteria for certification (or recognition) of the patient-centered medical home. Beyond the four nationally recognized accreditors outlined in the proposed rule as assigning credit for the CPIAs within MIPS,

the PCPCC recommends that CMS broaden the definition of patient-centered medical home accreditors to include other recognition programs that have a demonstrated track record of support by non-Medicare payers, state Medicaid programs, employers, or others in a region or state. The programs to be included should be clearly articulated by CMS in advance, along with transparent criteria and methodology for the addition of new PCMH programs. Examples include robust regional programs such as Blue Cross Blue Shield of Michigan's Patient-Centered Medical Home Program² and Oregon Coordinated Care Organizations.³

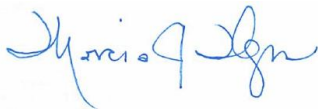
- **Acknowledge the Challenges of Solo and Small Group Practices.** CMS recognizes and appreciates the unique challenges facing many solo and small group practices that may be disproportionately affected by the new payment methodologies. Given the requisite investment in infrastructure, the cost of practice transformation, the lack of ability to spread risk throughout a larger patient panel, and a patient population that is disproportionately medically underserved, solo and small group practices warrant special consideration in the proposed rule. As they begin the steep climb to prepare for payment reform, the PCPCC strongly encourages CMS to better support solo and small group practices by revisiting the proposed creation of virtual groups, which are essential to begin building networks that would encourage small practices to progress toward more sophisticated delivery models such as medical homes and accountable care organizations. The PCPCC recommends a “safe harbor exemption” for any solo clinician or small group that participates in the MIPS program, making them eligible for positive payment updates if their performance yields such payments, but exempt from any negative payment update *until such time that the virtual group option is available*. To ensure that Medicare participating physicians continue to pursue quality and performance improvement, any physician or small group that fails to participate in the MIPS-required activities would be subjected to the full negative update. In addition, while the PCPCC strongly supports leveraging existing reporting technologies such as registries, Qualified Clinical Data Registries (QCDRs), and electronic health records (EHRs) to transmit measure information to CMS, these technologies remain out of reach for many small practices. We are therefore disappointed that under the proposed rule, this option is restricted to groups of 25 clinicians or larger and encourage CMS to revisit this in the proposed rule.
- **Change the Implementation Timeline.** The proposed rule states that payment adjustments will begin in 2019 for both MIPS and APMs. Participating MIPS clinicians will receive their first payment in 2019, covering the first period of performance from January 1, 2017 through December 31, 2017, for data reported in 2018. This has significant implications because the proposed rule allocates 50 percent of the first year MIPS score to the quality category, which requires clinicians to report on six measures. The PCPCC is concerned that the proposed rule outlines an implementation timeframe that is too aggressive for many clinicians, especially solo and small practices. A January 1 start date does not provide adequate time to develop a quality plan, ensure EHR functionality, identify and select relevant clinical practice improvement activities, and make necessary changes to reporting mechanisms, as well as align with similar activities in Medicare Advantage, Medicaid, and the commercial insurance markets. The PCPCC urges CMS to start the initial period of assessment no earlier than July 1, 2017. While setting the performance period in 2018 is preferable, delaying it until at least July 1, 2017, will provide additional, much needed time for practices to prepare.
- **Streamline Quality Measurement by including the Core Measure Set.** Given the increasing “measurement fatigue” that primary care practices face in light of different and constantly changing requirements from various health plans and payers, both public and private, the PCPCC recommends that the proposed rule identify and adopt measures that encourage all providers to report on a parsimonious unified set of quality measures. CMS should consider adoption of the recommendations from the Core Quality Measures Collaborative, developed through a multi-stakeholder process intent on reducing administrative burden and clinician burn-out. Creating core sets of measures for primary

care and subspecialists is essential for comparing clinicians across payment models. The proposed rule for the Advancing Care Information (ACI) performance category, based on the legacy meaningful use (MU) program, appears to have missed the mark on streamlining and simplifying performance reporting, and appears to be another complex and burdensome program, representing only marginal improvements, if any, on the original program.

- **Strengthen Beneficiary Engagement.** The PCPCC echoes the comments of the National Partnership of Women and Families, Community Catalyst, and other patient and consumer organizations to encourage CMS to move beyond the current definition of beneficiary engagement that too often limits patient engagement to the point of care. Optimally, engagement should occur at all levels of care: care redesign, governance, and in the community. We recommend that the regulation include measures that encourage partnership with beneficiaries across all six CPIA subcategories. Among the many promising activities and measures supported by the PCPCC, we cite opportunities that link to our Support and Alignment Network grant, such as community-based supports that integrate social determinants of health and promote social and community involvement by linking the EHR to community and social services, the creation of Patient and Family Advisory Councils (PFACs), and the inclusion of beneficiary/family caregiver representatives on key governance and decision-making bodies.

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. We appreciate the substantial work that CMS has already invested to ensure the successful implementation of MACRA, and we respectfully request consideration of our recommendations to simplify, spread, and scale high-performing primary care. 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

President and CEO, Patient-Centered Primary Care Collaborative

¹ PCPCC Board of Directors (November 2015) “Improving Patient-Centered Medical Home (PCMH) Recognition: Board Endorsed Recommendations of the Accreditation Work Group” Patient-Centered Primary Care Collaborative, published June 2016.

² <https://www.pcpcc.org/initiative/blue-cross-blue-shield-michigan-physician-group-incentive-program>

³ <https://www.pcpcc.org/initiative/oregon-coordinated-care-organizations-ccos>