

Patient-Centered
Primary Care
COLLABORATIVE

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Adam Boehler

Deputy Administrator and Director of the Center for Medicare and Medicaid Innovation
Centers for Medicare and Medicaid Services

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Via email: Adam.Boehler@cms.hhs.gov

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Dear Director Boehler:

On behalf of the Patient-Centered Primary Care Collaborative (PCPCC), a multi-stakeholder nonprofit coalition of organizations dedicated to strengthening primary care, I am writing to offer our feedback on the Primary Care First model released in April of this year.

For more than a dozen years, the PCPCC has been a stalwart advocate for re-orienting our health care system towards primary care, which evidence demonstrates is both more efficient and patient-centered. We are advocates of leveraging advanced primary care to further the “quadruple aim” — better care, better health, lower costs, and greater joy for clinicians and staff in delivery of care. Our vision of advanced primary care is embodied in the [Shared Principles](#) which over 330 organizations have signed onto.

We deeply appreciate the ongoing collaboration we have with CMMI, and your openness to feedback from our diverse stakeholder community as CMMI has rolled out, tested, and evaluated different primary care models. Our diverse executive membership – consumers, clinicians, health plans, employers, practice transformation organizations, quality groups and industry – have informed the comments contained within. Please see the attached list of PCPCC executive members.

We believe that the intent of the Primary Care First (PCF) model are positive, and we were enthusiastic early supporters. However, as we have learned more details about the model, we have become concerned about key features that we believe need to change in order to attract a large number of practices to participate.

Summary of PCF Concerns

These model attributes that we would propose changing include the per beneficiary per month (PBPM) payment amounts, the approach to risk adjustment, the quality measures tied to the incentive payments, the level of incentive payment, the lack of alignment across payers with launch of the model, and yet to be detailed incentives for beneficiaries. Recognizing the timeframe and the OMB approval structure under which you are working, we have attempted to provide recommendations that we hope can be considered within these constraints.

At the highest level, our concern is that the proposed PCF model does not provide sufficient financing to be truly viable. We would like to work with you to adjust the model to get more investment into it in order to make it attractive to a broader array of practices. From [recent research](#), we know that there is under-investment in primary care as a percentage of total healthcare spending. A recent RAND [report](#) showed that Medicare spends less than 5% of total healthcare spend on primary care, even when primary care is defined broadly. Primary Care First, as currently designed, may fail to support both the practices who are ready and eager to take on more accountability for outcomes, and those who have yet to build the clinical team and infrastructure necessary to manage patients on a population health basis.

More specifically, early adopter practices with experience managing risk are concerned about the large amount of financing dedicated to the performance payment, the associated financial uncertainty for practices, and the statistical validity of the groupings. They are also concerned about the “fairness” of high performing practices competing with each other for a fixed incentive pool. A number of PCPCC executive members believe that a fatal flaw is that “losing” practices would drop out each year, in spite of high absolute performance, since incentives are based only on relative performance. There is a large amount of statistical variation and “noise” in payment models that cover relatively small numbers of beneficiaries, as PCF will do for many practices. Practices may fall on the wrong side of cut points due to the influence of outlier cases or large confidence intervals, or other factors unrelated to performance.

Consequently, we recommend the following changes to the proposed model, which would involve shifting of funds from the performance recognition “bucket” to the PBPM “bucket.” That may not allow you to meet OMB guidelines within the given timeframe, but we at least wanted to explore this solution as a possible option.

The chart below summarizes our top concerns and offers some recommendations. We elaborate further on our recommendations in the text following this chart.

PCF Design Elements	Proposed Approach	PCPCC Concerns and Recommendations
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Professional Population-based Payment	PBPM risk-adjusted payment; with practice risk averaged, assigned to 1-5 risk level groups.	Concern: PBPM inadequate for small and many mid-size practices. Recommendation: Increase Group 1 monthly payment to at least \$30; increase risk adjustment scaling factors for Groups 3-5 and risk adjust for SDOH.
Quality Measures	Acute Hospitalization Utilization in Years 1-5; 5 high value eCQM, CAHPS measures added in Years 2-5; Quality gateway for practices serving high-needs model.	Concern: High weight placed on AHU hospitalizations could lead to risk avoidance behavior. Recommendation: Clarify if AHU will be risk-adjusted; supplement AHU with 2-3 measures collected by CMS in Year 1 to evaluate access, beneficiary experience, prevention and ambulatory-sensitive hospitalizations.
Performance Incentives	Multi-step process based on 1) exceeding national quality gateway threshold AHU; 2) relative performance within top 50% of PCF cohort; 3) separate continuous bonus based on practice level improvement	Concern: Amount of financing in performance incentives may not be reflective of CMS ability to differentiate meaningfully among practices. There is also a concern about using relative performance given that high performers are likely to be attracted to this model. Recommendation: Put less initial funding in the incentive compensation and more in PBPM. Create absolute performance thresholds to remove the arbitrary winners and losers methodology and reward all high performing practices that meet the set performance benchmark. Random variation will affect small practice AUC results; allow option of longer period/smoothing for performance incentive; allow practices to “pay back” any negative adjustment out of positive adjustment in later year(s). Use absolute as opposed to relative benchmarks.

Multi-payer Alignment	CMMI to leverage progress made in CPC+ with other payers, work of the Learning and Action Network	Concern: Practices located in states left out of model. Also, the ability to attract commercial payers to align in a timely manner so practices must juggle different payment models. Recommendation: If commercial payers are rolling out national models, consider allowing practices in all states to participate if commercial payer alignment commitment exists.
Waivers and beneficiary incentives	To be announced	Recommendation: Allow modest incentives, such as: waiving telehealth geographic and patient site requirements and co-pays to encourage beneficiaries to use clinical advice lines, CCM, urgent care options, telehealth, etc; Allow skilled nursing facility order without 3-day hospitalization; allow limited use of standing orders to support team care; authorize Advanced Practice Nurses (APRNs) and Physician Assistants) PAs to practice at the top of their license.

Comments on Specific Design Elements

Professional Population-Based Payment

The PBPM payment supports transformation and innovation by allowing practices to support non face-to-face care and do more outreach, follow up, and ongoing population health monitoring using technology and teams. We are in full support of this approach and believe CMMI should invest more total and relative payment resources in this model design element. At a minimum, we would recommend raising the Group 1 PBPM amount to \$30 to provide more guaranteed revenue to smaller practices and reflect the relative cost of caring for lower risk beneficiaries. We do not want to see this recalculated into quartiles. Ideally, all proposed PBPM payments would rise.

Risk-Adjustment

It is especially important to risk adjust the PBPM payment accurately because acute hospital utilization will be weighted so heavily in the model performance metrics. By taking into account the social determinants of health (SDOH) and scaling the risk adjustment payment to provide more resources to practices serving beneficiaries in groups 3-5, Primary Care First would better compensate practices for the more intense care management needs of these beneficiaries. Among other stakeholders, patient groups in the PCPCC membership also see risk adjustment as important so that patients can receive a more comprehensive set of needed services. Consumers are concerned that if risk adjustment does not adequately compensate primary care physicians for taking care of high-needs beneficiaries, they will avoid them.

Quality Measures

The PCPCC appreciates the parsimonious measure set and the focus on outcomes and indicators of care management. However, we are concerned about unintended consequences of placing such a high weight on acute hospital utilization, particularly in the first year of the model. Some practices may begin avoiding new high-risk patients, and random variation in hospital utilization related to insurance risk could affect hospitalization rates (particularly for small and medium size practices) despite effective and reliable care management programs implemented by practices. We recommend that CMS consider other measures that are evidence based, patient-centered and actionable in the first year that can be collected easily from claims and that could also serve as early indicators of access issues. We also are concerned about whether eQMs will be sufficiently tested by 2021 when the model goes into effect.

Performance Incentives

In light of the limitations of the quality measures and the variation in size and other characteristics of practices, the PCPCC believes the level of total compensation allocated to the performance incentive “bucket” is too high. We recommend instead that some of the funding estimated for this model component be shifted into the PBPM component.

In addition to the limitations of the quality measures, the high percentage—up to 50% --of practice revenue subject to dramatic swing on a yearly basis will undermine practices’ ability to continue to invest in care management infrastructure. Since Medicare accounts for a high share of total practice revenue for many primary care practices, many such practices will find such potential revenue volatility too difficult to manage.

In Medicare Advantage, by contrast, the quality stars’ performance bonuses represent a much smaller share of the total payment to health plans, and the plans have much more capacity to manage risk across large numbers of beneficiaries and hold capital reserves. The Medicare Advantage stars are also a true add-on to the PMPM (i.e. high performers are not financed by low performers).

Multi-payer Alignment

Much progress has been made through the CPC+ program to align various payers such as Medicare fee-for-service, State Medicaid Agencies, Medicare Advantage, Medicaid Managed Care Plans, and Commercial Health Insurers. The PCPCC has some concern that payer alignment does not proceed model launch and that this lack of alignment will be problematic for practices and complicated for them to manage. Additionally, there are many states that are left out of the model and this could interfere with alignment efforts. The current framework for overlap does not address how different models can be synergistic, such as ACOs, specialty medical homes, primary care, etc. More outreach and education on the model, as well as more detail guidance related to model synergies could help to increase uptake.

Waivers and Beneficiary Incentives

Many of Medicare's fee-for-service payment rules were designed to minimize inappropriate utilization. The more that primary care payment is made on a PBPM basis, the less incentive practices have to generate revenue through visit volume. If primary care practices are going to be held accountable for hospitalization utilization under Primary Care First, and beneficiaries remain free to self-refer and otherwise seek care not coordinated by their PCP, practices will need incentives to encourage beneficiaries to engage in their care.

Such incentives should be modest and related to improving and maintaining health, such as co-pay waivers or "extra" benefits such as transportation assistance. These types of incentives should be exempt from inducement and kickback rules.

Furthermore, we do not believe financial incentives alone are sufficient for meeting goals of improved patient engagement and strengthened patient and provider relationships. To this end, incentives should also be accompanied by extensive beneficiary outreach, education, and engagement so that beneficiaries understand the model and its implications for their care.

Participants in Primary Care First should also be eligible for payment waivers similar to waivers that ACO participants in two-sided risk are eligible for such as telehealth. This will enable care teams to seamlessly offer 24/7 home-based access to advanced primary care capabilities as emphasized by CMMI. In addition, CMS should consider waivers that enable selective delegation to other qualified care team members, flexibility on supervision and the removal of barriers that may prevent providers from practicing at the top of their license. For example, practices with interoperable EHRs and shared teams can perform some supervision of the team electronically and authorize nurse practitioners to certify for home health services. We would also like to encourage alignment of waivers among all AAPMs for primary care, ensuring that waivers considered for Direct Contracting are also implemented in Primary Care First.

Data Sharing and Reduction of Administrative Burden

The PCPCC is strongly in favor of efforts to reduce unnecessary administrative burden for clinicians and to streamline data sharing. Allowing participants to view their data through analytic tools in comparison with their peers will be beneficial to practices working on improvement. However, our concern comes from the fact that the model does not make it clear how administrative burden will be reduced. One recommendation is to clarify what steps the data sharing/analysis will take to show how the proposed process reduces administrative burden and documentation.

Key Takeaways

We have a growing number of primary care practices across the country who have some experience participating in Medicare, Medicaid, and commercial payer value-based models. Many are ready to take the next step on their practice transformation journey, and several components of the Primary Care First model can assist them as they build more robust infrastructure for care coordination and chronic disease management.

However, we believe that in order for these practices to get engaged with the PCF model, a number of changes are needed to make it more attractive and possible for them to participate. These include the amount of upfront investment captured by a higher PBPM payment, adjustments to the risk adjustment approach to make it more accurate, better quality measures that are evidence-based and actionable at the primary care level, absolute benchmarks as opposed to variable based on the participant pool, and finally more focus on payer alignment and beneficiary incentives. Additionally, we would like to explore with CMMI adding another Primary Care track with little or no fee-for-service for practices ready to take on more risk.

As you well know, there is a wide diversity of primary care practices across the United States, and related differences in their capacity and readiness to move ahead on the value journey, from those just embarking to those ready to accept comprehensive payment for a comprehensive set of primary care services. We stand at the ready to work in partnership with you as you evolve the Primary Care First and Direct Contracting models and as you develop and introduce additional primary care delivery and payment models that address this wide spectrum of practice readiness.

Kind regards,

Ann Greiner
President and CEO

Executive Members

Accreditation Association for Ambulatory Health Care (AAAHC)
Aetna
Alzheimer's Association
American Academy of Child and Adolescent Psychiatry (AACAP)
American Academy of Family Physicians (AAFP)
American Academy of Pediatrics (AAP)
American Academy of Physician Assistants (AAPA)
American Association of Nurse Practitioners (AANP)
American Board of Family Medicine Foundation (ABFM Foundation)
American Board of Internal Medicine Foundation (ABIM Foundation)
American College of Clinical Pharmacy (ACCP)
American College of Lifestyle Medicine (ACLM)
American College of Obstetricians and Gynecologists (ACOG)
American College of Osteopathic Family Physicians (ACOFFP)
American College of Physicians (ACP)
American Osteopathic Association (AOA)
American Psychiatric Association Foundation
American Psychological Association
America's Agenda
Anthem
Bess Truman Family Medical Center
Black Women's Health Imperative (BWHI)
Blue Cross Blue Shield Michigan
Blue Cross Blue Shield of North Carolina
CareFirst BlueCross BlueShield
Collaborative Psychiatric Care
Community Care of North Carolina
Community Catalyst
CVS Health
Doctor on Demand

Geisinger Health
Harvard Medical School Center for Primary Care
HealthTeamWorks
Humana, Inc.
IBM
Innovaccer
Institute for Patient and Family-Centered Care (IPFCC)
Johns Hopkins Community Physicians, Inc.
Johnson & Johnson
Mathematica
MedNetOne Health Solutions
Mental Health America
Merck & Co.
Morehouse School of Medicine - National Center for Primary Care
National Alliance of Healthcare Purchaser Coalitions
National Association of ACOs (NAACOS)
National Association of Chain Drug Stores (NACDS) Foundation
National Coalition on Health Care
National Interprofessional Initiative on Oral Health (NIIOH)
National PACE Association
National Partnership for Women & Families
NCQA
Pacific Business Group on Health (PBGH)
Permanente Federation, LLC
PCC EHR Solutions
Primary Care Development Corporation (PCDC)
Society of General Internal Medicine (SGIM)
Takeda Pharmaceuticals U.S.A.
The Verden Group's Patient Centered Solutions
University of Michigan Department of Family Medicine
UPMC Health Plan
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YMCA of the USA