

September 24, 2018

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

**Re: Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Requests for Information on Promoting Interoperability and Electronic Health Care Information, Price Transparency, and Leveraging Authority for the Competitive Acquisition Program for Part B Drugs and Biologicals for a Potential CMS Innovation Center Model [CMS-1695-P]**

The Patient-Centered Primary Care Collaborative (PCPCC) appreciates this opportunity to provide comment on payment changes for the Medicare hospital outpatient prospective payment system (OPPS) and the Medicare ambulatory surgical center (ASC) payment system for CY 2019.

PCPCC strongly agrees with Centers for Medicare & Medicaid Services (CMS) Administrator Verma's July 25 comments that, "setting prices based on provider costs ... means we reward inefficiency" and that "paying for things differently based on the site of care ... creates misaligned incentives." While PCPCC recognizes that current payment differences sometimes support valid health system needs, we do not believe that clinician payment rates are the appropriate tool to remedy these structural issues. In short, to support the shift to value-based payment arrangements, legacy payment structures must support the delivery of care in the highest value setting, through the most efficient models of care delivery. We look forward to working with you to facilitate the delivery of high-value, continuous, and comprehensive care to consumers.

**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.

### **Primary Care and the Continued Transition to Value**

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 through value-based and alternative payment arrangements that tie payment to patient outcomes. A critical step in this transition is the elimination of misaligned incentives that create barriers to broader system transformation that rewards higher value, improved clinical outcomes, and is better attuned to patient preferences.

As you know, the alignment of incentives is critical to transforming the health system and achieving important patient outcomes. To drive a system transition to value-based payment tied to outcomes, we must ensure that incentives which run counter to the value-based payment do not continue to exist for clinicians. When participants in value-based models must balance this effort with misaligned incentives created by Medicare Fee-For-Service (FFS) system it dramatically undermines progress in value-based payment transformation. We recognize that it is difficult to change payment structures and are pleased that CMS is taking bold steps to reduce the role of Medicare FFS in incentivizing the delivery of care in one setting over another. With payments in different settings more closely aligned, healthcare providers are freer to make decisions based on clinical outcomes and patient preferences.

Reducing the complexity created by varied payment rates also has the potential to simplify the healthcare system for both clinicians and consumers. Often, complex and unexpected healthcare costs arise from transitions in the site of care, leading to frustration for both consumers and the healthcare professionals caring for them. The proposed rule would empower patients to make more informed healthcare decisions by making costs more predictable and more transparent.

PCPCC believes that outcome-based models support and catalyze the type of patient-centered primary care exemplified by the PCMH, while the fee-for-service system struggles to enable advanced primary care—even with significant ongoing improvements. We support continued CMS efforts to transition the healthcare system by reducing regulatory and payment barriers as

well as though outcome-focused incentives and opportunities. We encourage CMS to continue work to transition the healthcare system to one focused on value and outcomes and we believe the proposed changes are an important step in that direction.

### **2019 Changes to the OPPS and ASC**

In the proposed rule, CMS proposes to reduce Medicare spending on clinic visits by applying a Physician Fee Schedule-equivalent payment rate for clinic visits performed at an off-campus provider-based department and allow more services to be provided in the ASC setting. CMS will also address other payment differences between sites of service, so that patients can choose the setting that best meets their needs. PCPCC believes that similar services should have similar payment, regardless of the setting of care, and supports these changes.

CMS cites about \$150 million in lower patient copayments for clinic visits – a welcomed change for consumers and a trend that must continue if we plan to effectively manage population health concerns, prevent and manage chronic disease, and maintain a continuous relationship between clinician and consumer. High co-pays are a significant barrier to patients availing themselves of needed services and we must do everything possible to mitigate said barrier.

PCPCC and its members will note that common arguments against site-neutral payment often do present valid health system needs – but our members believe that physician payment rates are not the appropriate mechanism to address these concerns. We encourage CMS to examine these concerns and identify other sources of support for these important priorities (such as critical access hospitals) that rely upon the current system to remain financially solvent.

### **Conclusion**

PCPCC believes that 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. Our 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 contact Christopher Adamec, Director of Policy at [cadamec@pcpcc.org](mailto:cadamec@pcpcc.org) or 202-640-1212 with any questions.

Sincerely,



Ann Greiner  
President & CEO