

## ACP Comments on CMMI Request for Information on Advanced Primary Care Model Concepts

March 16, 2015

**Background:** The American College of Physicians submitted the comments below in response to the questions contained in the Centers for Medicare and Medicaid Services' (CMS) [Request for Information](#) on Advanced Primary Care Model Concepts. CMS was seeking input through its Center for Medicare and Medicaid Innovation (CMMI) on "initiatives to test innovations in advanced primary care, particularly mechanisms to encourage more comprehensive primary care delivery; to improve the care of patients with complex needs; to facilitate robust connections to the medical neighborhood and community-based services; and to move payment from encounter-based towards value-driven, population-based care." CMS describes the basics of the Advanced Primary Care Model Concepts as follows:

The next generation of advanced primary care model(s) could test moving payment for primary care services from encounter-based, or encounter-based with care management fees (as is being tested in the Comprehensive Primary Care Initiative), towards population-based (payment based on a practice's population of beneficiaries). Population-based payments (PBPs) could cover two components:

- (1) Severity-adjusted, non-visit based care management services, and
- (2) A portion or all of the expected, severity-adjusted fee-for-service (FFS) payment for a basket of services provided in primary care ("rolled-up FFS")

With PBPs, services billed by primary care practices that are not included in the basket would continue to be paid via FFS. Practices that receive only a portion of expected FFS payment for the basket through "rolled-up FFS" would continue to receive traditional FFS payment for billed services in the basket, but at a rate reduced by the amount of the "rolled-up" portion (e.g., if a practice elects to receive 50% of expected FFS for the basket in "rolled-up FFS," then traditional FFS payment for billed services in the basket would be reduced by 50%). Practices could also be accountable for clinical quality metrics, patient satisfaction, and the total cost of care.

### ACP Comments:

***1. Please comment on the above description of PBPs in terms of (a) the impact on the delivery of advanced primary care and (b) primary care practices' readiness to take on such arrangements.***

The American College of Physicians (ACP) appreciates this opportunity to comment on the proposed population-based payment (PBP) model for Advanced Primary Care practices outlined in the recently released Innovation Center Request for Information (RFI). ACP policy strongly supports the transition from volume-driven fee-for-service payment to more value-oriented payment models linked to quality and efficiency. This effort to explore transition to PBP models for Advanced Primary Care practices is

consistent with our position. Before commenting specifically on the proposed PBP model, the College wants to commend the Innovation Center for the progress made and promising early results of the Comprehensive Primary Care (CPC) initiative. The stability of payer/practice participation, the ability of most practices to meet significant practice transformation milestones, and the first year cost and quality data are beyond reasonable expectations and offers evidence for the validity of this approach. As a result, **the College strongly recommends that CMS continue to support the program involving current participating practices and begin actively planning to implement significant expansion of the program to other regions throughout the country if results in subsequent years remain positive.**

Very few primary care practices outside of an integrated system or entity (e.g., Accountable Care Organization) have the infrastructure, capabilities/skills and financial capability to embrace the PBP model (or similar models) proposed in the RFI --- **the CPC initiative, with its inclusion of a monthly payment to support necessary transformation and infrastructure development, its structured learning component to assist in the practice transformation process, and its protection from down-side risk is more in line with most primary care practices' current capabilities and can serve as an important step to prepare practices for a more risk-bearing, population-based bundled payment approach.**

**Limited data are available regarding experiences and results with the type of PBP model outlined in the RFI, so it is important that this be tested as a potentially expandable demonstration project under the authority of the Innovation Center to answer critical questions regarding the requirements for successful implementation.** ACP encourages CMS to consider requiring participating practices in such a test to have, at a minimum, the functionalities being developed under the CPC initiative. Our responses to the rest of the questions are offered to help inform this recommended demonstration or test of the proposed PBP model. It is important that this testing takes place in an environment in which there is **substantial multi-payer participation (i.e., substantial payment penetration), a community infrastructure that facilitates necessary data aggregation and exchange, and a strong regional education structure (e.g., collaborative) to support the continued skill building required.** Regarding the educational structure, successful implementation of the Transforming Clinical Practice Initiative (TCPI) can potentially fulfill this requirement.

## ***2. What portion of expected FFS payments for the basket of services would practices be interested in receiving via "rolled-up" FFS?***

Ideally, the payment should cover the full, risk-adjusted basket of services required to provide comprehensive primary care to patients within the defined population --- FFS should be limited and used only for services (procedures) not included in the bundle for specific reasons (e.g., to incentivize specific services or because of significant variability in capability/availability among practices). This would allow practices the maximum freedom to provide the right care by the right member of the clinical team in the right setting through the most appropriate means without being linked to specific billing requirements (e.g., an office visit). Unfortunately, the shift from FFS-based to a bundled, partial capitation model is a significant step both operationally and psychologically. **Most practices, even those that have engaged in substantial transformation consistent with the Advanced Primary Care model, will require a "safety-net" that ensures that the change will not adversely affect their income and this freedom from downside risk should be maintained for a substantial time period.** An approach similar to the "one-sided" risk approach used within the Medicare Shared Savings program should be considered.

In addition, the College would not be opposed to testing the suitability of a gradual roll-up of services (through either percentage of the total basket or through diagnoses covered) over time; these options

may be attractive to certain practices considering participation within this type of payment model. We do have concerns that an approach that continues to provide a substantial portion of payment under FFS will significantly slow down practices' efforts to make the necessary changes to succeed under a PBP model.

**3. What services should be included in the basket (e.g., all primary care Evaluation and Management (E&M) services; primary care E&M services based on certain diagnoses; primary care E&M services plus certain procedures; all services in primary care)? Please provide a rationale for the recommendation.**

The basket should include all services provided by a practice that are visit based. At a minimum, this would include all primary care E&M services and all preventive services (including annual wellness visits and all services recommended for primary care with a grade of A or B by the United States Preventive Service Task Force). The services should be explicitly identified by Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes. Traditional primary care services appropriately carved out of the payment would be payment for immunizations, tests, medications, specialty care, hospital services, and other services that may be separately identified with other CPT or HCPCS codes and separately payable from the PBP. CMS may want to consider some flexibility in the basket --- for example some participating practices may want to include low-cost CLIA-waived testing within their in-office labs or the cost of immunization administration or some frequently performed procedures (e.g., specific minor surgeries, EKG, Spirometry). If there is variation in the contents of the basket, payment should be adjusted accordingly. As this potentially expandable demonstration project under the authority of the Innovation Center progresses, there should be a mechanism for new services to be added to the basket as identified and supported by the primary care physician community.

Payment consideration under the proposed PBP model cannot only address the above FFS bundle. It must also recognize the payment component for non-visit based care management services. It is important that this payment component is sufficient to fund necessary non-visit based care coordination and care management services, and also cover the development and maintenance of the required infrastructure (e.g., necessary staff, health information technology) to provide this set of services expected within an Advanced Primary Care practice. This payment would also need to cover those services currently included under the Transitional Care Management and Chronic Care Management codes (unless these codes are included within the FFS basket).

Both the FFS basket and care management components must be risk-adjusted, geographically adjusted, and preferably per-capita payment ("base payment") for both components are made periodically throughout the year.

**4. To what extent are primary care practices willing to be accountable for total cost of care?**

It is important to highlight that, at the level of the typical independent primary care practice/clinician, the concept of being accountable for total cost of care does not seem realistic. Immediate reaction is that it is "a non-starter" for most of our members --- a comment we clearly heard during a recent review of the proposed PBP model with one of our member advisory committees. Holding members **accountable for the quality and efficiency of the actual services they have control of and provide is more acceptable --- and there is increased acceptance of the linkage of quality and efficiency measures to payment for such services (e.g., value-based payment)**. A more in-depth discussion of accountability with ACP's membership reveals recognition of the significant role primary care can have in effecting total health care costs (and quality), particularly under such models as the Patient-Centered

Medical Home (PCMH). On a theoretical level, our members further understand that accepting accountability (and related risk) for total cost of care may be possible at some future time but only under a specific set of conditions that is currently unattainable --- even within the substantial support available within many integrated delivery settings. These conditions include:

- Access to accurate, timely data regarding the utilization and cost of services provided to their defined patient panel. This data needs to be available across payers (aggregated) and include spending across the medical neighborhood.
- Access to accurate and timely information on the quality and efficiency of service provided by their referral network.
- Opportunities to acquire the data analytic skills and capabilities to effectively understand and use the above information.
- Availability of effective and efficient means for bi-directional communication between the practice and the medical neighborhood.
- Availability of reliable capital inflow and reserves to support and maintain the required service delivery and infrastructure components.

***5. Through what mechanism should practices be accountable for total cost of care (e.g., savings paid or losses collected annually; withhold a portion of PBPs and pay/collect the difference between the withhold and saving/losses; modify (increase/decrease) future PBP amounts based on savings/losses; bonus/penalty)?***

As mentioned above, the transition to the type of PBP model outlined in the RFI represents a significant step both operationally and psychologically from the current FFS payment model. Practices, even Advanced Primary Care practices, will require time to adjust to the requirements to successfully function under this type of payment. **Thus, the College reiterates that the most effective mechanism CMS can employ to facilitate transition to PBP would be to provide adequate time for willing practices to operate under and learn about the model without any significant financial risk (e.g., comparable to the one-sided risk option within the Shared Savings Program).**

***6. What key challenges do primary care practices face in assuming financial accountability?***

Please refer to our answer to question 4.

***6. a. What supports or mechanisms could assist practices in overcoming those challenges (e.g., limitations on total practice financial benefit or risk during reconciliation; exclusion of specified high cost beneficiaries during reconciliation; allowing pooling of risk among practices)?***

Any or all of the three mechanisms used as examples within the question will assist practices in assuming accountability (and financial risk) under a PBP model similar to the one outlined within the RFI. Other mechanisms to consider include:

- A payment system that ensures a reliable flow of income throughout the year to fund the necessary infrastructure to successfully address the needs of their defined population in an effective and efficient manner. This could include “up-front” payments linked to projected savings.
- The establishment of low-cost and/or federally guaranteed loan programs to increase access to required capital resources.
- The availability of a resource to provide technical support to the practice to facilitate its ongoing ability to address the needs of their defined population in an effective and efficient manner.

- A patient attribution methodology that allows for patient self-attribution, as well as attribution based on where patient has received a majority of primary care services historically. This could include benefits to patients who self-attribute (e.g., reduced co-payment) and has the potential to enhance patient engagement with their primary care practice and facilitate improved care and health outcomes.

**7. The move from FFS to PBPs could allow a revision of current medical documentation requirements. What elements of documentation could be revised to be consistent with PBP and not affect patient care negatively?**

Internists in almost every system have the heaviest burden regarding documentation. Under the proposed model, the current documentation guidelines for E&M services should be eliminated since those services would no longer be paid on a FFS basis. Documentation should be focused on the clinical needs of the patient and the related services provided by the clinician to address those needs. There would be many administrative benefits from removing the daily, unproductive, and increasingly burdensome medical-record documentation requirements linked to RVU-based FFS, which were not created for use with E&M codes. In removing the volume-maximizing and administrative burden of FFS, the primary care physician can perform the essential diagnostic work, treatment planning, patient and family education, and counseling requisite for maximizing population health.

ACP also strongly recommends that CMS update chapter 3 of the Medicare Program Integrity Manual; particularly its documentation rules should be better aligned with a team-based care model. Documentation, like the care itself, should be done by the team with documentation provided by all members of the team. Physicians should be able to document what is necessary for appropriate patient care rather than what is required for billing.

The proposed PBP model should also decrease the administrative complexity currently linked to the following:

- The ordering of durable medical equipment (DME);
- Authorization of home health services; and
- Various prior authorizations (e.g., prescriptions, imaging).

**8. Practices caring for patients with complex needs—either the practice’s full population or a subpopulation of its patients—could receive additional incentives and resources to deliver enhanced services to these patients, including better integration with social and community-based services, behavioral health, and other health care providers and facilities. What are the best methodologies to identify patients with complex needs (e.g., a claims-based comorbidity measurement (Hierarchical Condition Category scores, age, specific conditions, and/or JEN frailty calculation); a claims-based utilization measurement; attribution of a population of local beneficiaries without primary care utilization; and/or practice identification through a risk assessment tool and/or clinical intuition)? Please be specific in your responses and provide examples if possible.**

The ability to stratify patients according to risk is key to population management. Studies have shown that cost of care is not evenly distributed across beneficiaries. Risk stratification at the beneficiary level allows for focusing of appropriate services in the most cost effective setting. It also provides a mechanism to begin to allocate payments to providers equitably. The calculations for per member per month (pmpm), bundled payments, and shared savings formulas should take beneficiary risk stratification into consideration.

The literature does not support any optimal risk stratification methodology. There are not currently standard models used for assigning risk, and there may not be a single model that will work in all settings. What needs to occur is for the model to have components from:

- Claims data for utilization;
- Clinical data for disease states, co-morbidities, and individual health status;
- Socioeconomic data for patient support; and
- Patient activation for patient engagement/self-management.

There needs to be transparency in the data that are used for risk calculations. The data needs to be validated quality data. Physicians need to understand the data source, formula for risk calculations and not be required to do additional documentation. Their input needs to be solicited and incorporated into creation, implementation and refinement of any risk stratification model.

***8. a. Is there a minimum number of patients with complex needs required for a practice to develop the necessary infrastructure and services to offer these patients?***

There should be a sufficient total number of attributed patients in the Advanced Primary Care practice for risk pooling to occur. This risk pooling will encourage practices to accept medically complex patients and care for patients who may become costly to treat (i.e., due to a diagnosis of a chronic disease/condition, injury, etc.) without subjecting them to undue risk. This number would be dependent upon what services are considered to be provided through pmpm and what services are in the non-FFS basket. The other variable is the amount allocated for pmpm and the “basket.” The goal should be to provide enough financial support to a practice for a core set of services as well as the staff and technology to supply those services.

***8. b. Should the payment structure discussed in questions 1-7 above differ for these patients? If so, how?***

Yes. It is assumed that the beneficiaries with a higher risk score will require more care coordination services and support. Support services could be behavioral health and community-based services that focus on healthy lifestyles. Furthermore, discussions with various health systems indicate that risk-adjustment based on severity/complexity is not linear --- the cost of care increases at a more rapid rate as complexity increases. The risk-adjusted payment must reflect this observation to support the required services adequately.

***8. c. What would the estimated costs be on a per-patient-per month basis to develop the necessary infrastructure and provide ongoing advanced primary care to these patients? Please provide justification to support these estimates.***

The pmpm should be based on the cost for a practice to maintain the infrastructure to provide the identified services. This becomes a complex formula based on:

- Attributed beneficiaries;
- Beneficiary risk status; and
- Practice’s current ability to provide population management services.

Practices need the resources to develop their infrastructure to be able to provide patients and their care givers with the following functions that have been implemented by Comprehensive Primary Care (CPC) initiative practices:

- Access & Continuity;
- Planned Care for Chronic Conditions and Preventative Care;
- Risk Stratified Care Management;
- Patient and Caregiver Engagement; and
- Coordination of Care across the Medical Neighborhood.

One potential methodology to use to develop valid cost estimates for these services is the method employed by the AMA Relative Value Update Committee (RUC) in 2008 in establishing recommendations for a proposed Medical Home demonstration project.

***8. d. What performance metrics are most appropriate and meaningful to assess the quality of care for these patients?***

Quality measures need to be calculated using data that is currently or easily attainable. Many of the current quality measures are process measures due to the data source being claims data. As we move to the data source being clinical data from an EHR, the measures should be more outcomes focused. Physicians should have input into the process for defining the quality measures and have a clear understanding of how they can affect those measures. The data required for these measures should be currently and easily collected without having to modify their clinical workflow to enable data collection in their EHR.

Performance metrics should be based upon a formula that not only includes the clinical quality measures but also takes into consideration cost, utilization, patient experience, and has a modifier for the severity of patients attributed to the practice. The metrics should be calculated at the practice level to mitigate the effect of small numbers.

There should be transparency in the sources of data for measure numerator, denominator and exclusion criteria for all data used in the performance metrics. The measures employed should be harmonized among all participating payers.

The College also directs CMS to review the thoughtful recommendations on quality measurement recently offered by the Brookings Institute available at:

<http://www.brookings.edu/research/papers/2015/01/27-medicare-physician-payment-reform-mcclellan>

***9. What data do practices need from payers to perform well and manage population health in a model that includes PBPs, financial accountability, and specified requirements for primary care delivery? Please be specific in describing helpful feedback or utilization reports in terms of timing, content (e.g., patient characteristics, services used, providers of services), and format.***

There needs to be consensus, standardization, and transparency among payers and programs on data sources and the data elements used in report generation. The ideal would be a single multipayer data source. The data elements should be data that are collected in the regular workflow of providing evidence-based care to the patient. Practices need the data provided in both aggregated and individually identifiable reports. The aggregated reports would need to be generated in a timely fashion with the most recent data provided to monitor performance and allow for modifications.

The individually identifiable reports would need to be as current as possible to allow for targeted services to be implemented for a specific beneficiary. An example would be making hospital admission

reports available to the practice daily. This would allow for the monitoring of post-discharge visits and care management services needed. Physicians and care teams need to have input into the structure of the reports that are created in order to ensure that they are in a format that clearly provides the information that is needed for the most appropriate care.

At a more global level practices will need:

- Access to accurate, timely data regarding the utilization and cost of services provided to their defined patient panel.
- Access to accurate and timely information on the quality and efficiency of service provided by their referral network.

Many small practices may not have experience with connecting clinical and financial data or sophisticated analytics. Technical support may be required at the practice level for interpretation and integration of the reports into practice processes to improve clinical care.

***10. What transformative changes to HIT – including electronic health records and other tools – would allow primary care practices to use data for quality measurement and quality improvement, effectively manage the volume and priority of clinical data, coordinate care across the medical neighborhood, engage patients, and manage population health through team-based care (e.g., transitioning from an encounter-based to a patient-based framework for organizing data; using interoperable electronic care plans; having robust care management tools)?***

The best way for CMS/CMMI to facilitate transformative use of health IT in practices is to avoid the temptation to over-specify the technology requirements. The history of IT is a history of innovation by entrepreneurs who develop specific solutions to address specific requirements. The recent tendency of CMS and the Office of the National Coordinator for Health IT (ONC) to add more and more requirements to EHR systems actually runs counter to what has worked successfully in the past and is working well now in fields not under the supervision of CMS and ONC. A recent polling of a panel of our members shows adoption of a broad range of IT tools of all sorts that the practices use regularly to perform specific tasks. Implementing the new Chronic Care Management (CCM) code has spawned development of many new products and services to support specific functions, such as supporting team-based care and managing the distribution of care plans. Most of these tools did not exist at the time the program proposal was written. It is impossible for CMS to make decisions about appropriate use of technologies in advance of the market deciding what to build. Stated in another way, CMS should only specify the functionalities required to support the required care delivery and let the practices and marketplace decide on the best way to achieve them. Fulfilling these functionalities should not be restricted to the EHR if there are other technologies available and more practical for them to use.

Furthering the implementation of IT must not be a goal of this project. Requiring or prohibiting use of a particular product or service for a particular function inappropriately ties the hands of the participants and jeopardizes the likelihood of positive outcomes. One of the goals of this project should be to identify new and innovative technology approaches that have not yet been thought of. This cannot happen if technology use is specified in advance.

It is clear that participating practices will need to locate and implement new technologies to effectively perform the new functions they will be taking on. Much of this activity will be trial and error. Practices will need to understand that the burden of the costs of these activities will not be theirs alone --- it will need to be reflected in the payment system.



The most effective action CMS can take to spread innovation and interoperability is to focus on identifying and disseminating best practices as they arise. Amazing innovations are occurring every day in practices large and small, but no one is making a dedicated effort to identify and spread them.

**10. a. In what ways, if any, could CMS encourage advanced primary care practices to implement innovative HIT tools (e.g., facilitate collaboration between HIT vendors and practices)?**

The health care community needs to stop thinking about incentivizing the use of a standard, or interoperability in general. Instead, we must move towards a sustainable business case for appropriate use of an effective interoperable infrastructure. Incentives, penalties, mandates, and structural and process measures are inappropriate and only point out that the business case for exchange in many situations is lacking. If there are real and visible benefits to exchange information in a particular situation, there will be no need for incentives, penalties, mandates, and measures. The focus should be on identifying supportive business cases for exchange and then reducing the current barriers and friction points that are impeding implementation. Current barriers and friction points include inadequate implementation of communication standards (e.g., excessive flexibility), the inclusion of unnecessary administrative burdens within the exchange process, and the current high cost associated with information exchange (e.g., high cost of interfaces between different informational systems).

**11. The development of advanced primary care practices within ACOs could potentially yield synergistic improvements in cost and quality outcomes. What resources (financial and/or technical assistance) do ACOs currently provide to primary care practices/providers to enable care delivery redesign, and are they sufficient to deliver advanced primary care as described in this RFI?**

There is significant variability in the resources that ACOs currently provide to their participating primary care practices. **Nonetheless, the College agrees that the ACO structure is well-suited to provide the necessary resources to these practices to transition successfully under a PBP model and encourages CMS to test this option.**

**11. a. Should primary care practices within ACOs receive PBPs?**

The ACO could provide the primary care practice with assistance in developing the necessary infrastructure and service capacities expected from an APC practice. Most importantly, the ACO structure would provide the practice with the financial capability of accepting downside risk associated with total cost accountability. The College notes that incorporating the proposed primary care PBP model within the current Medicare Shared Saving program will only be possible if there is substantial alignment with the requirements under each program (e.g., harmonized set of performance metrics).

**11. b. What should be the relationship, if any, between ACOs and primary care practices receiving PBPs?**

Please refer to our answer in question 11.a.

**12. What potential program integrity issues for CMS are associated with the payment and care delivery concepts discussed in this RFI?**

The primary integrity issue that should be of concern to CMS centers on the extent to which a practice collects payment for delivery of the defined basket of services, but either does not actually provide the

services, or provides them in a manner that primarily serves the financial interests of the practice, and not the care and welfare of their patients.

**12. a. How can these issues be prevented or addressed?**

CMS should collect data (see 12.b.) that can be compared to relevant benchmarks to provide potential evidence for significant and inappropriate reduction in required services or the quality of services provided in an attempt to inappropriately increase the financial gains of the practice. It is recommended that CMS integrity efforts focus on outliers, and the recommended initial response should be educational, as opposed to punitive, in nature.

**12. b. What data elements should CMS collect to detect any fraud, waste or abuse issues? Please be specific in your responses and provide examples if possible.**

Data that CMS should collect to address this central concern adequately includes:

- Continued collection of CPT and HCPCS for services included in the basket delivered to patients within the defined population. Other forms of documentation for the services delivered within the basket should be reduced and modified as outlined in our response to question 7.
- Practice performance on nationally-recognized quality, efficiency and patient experience of care measures. The measures used should be harmonized among payers to reduce practice administrative burden.

**13. For stakeholders involved with primary care for Medicaid beneficiaries, please provide comments on any of the concepts discussed in this RFI and any unique considerations to be taken into account for the Medicaid population.**

No comments.