



July 10, 2019

Adam Boehler
Director
Centers for Medicare and Medicaid Innovation
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS Primary Cares Initiative

Dear Director Boehler,

On behalf of the American College of Physicians (ACP), I would like to share our thoughts on the Centers for Medicare and Medicaid Innovation's (CMMI's) Primary Care First (PCF) Model. ACP is the largest medical specialty organization and second-largest physician group in the United States. ACP members include 159,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

We appreciate the Innovation Center's efforts to deliver more Advanced Alternative Payment Model (APM) options, particularly in the primary care space. Models like this give physicians opportunities to deliver transformative, innovative, and patient-centered care for Medicare beneficiaries while breaking down administrative barriers, restoring the physician-patient relationship and reducing costs. However, with implementation for this model now less than six months away, ACP is concerned that numerous important details about the application process and design of the model are still outstanding. ACP also wishes to express its thoughts on, and in some cases, concerns with different aspects of the model's design, as explained in greater detail in this letter. Specifically, we are unconvinced by the information available that reimbursement levels are adequate to support the types of enhanced primary care services inherent to the model design, and we are worried that this coupled with eligibility restrictions and other barriers could severely inhibit participation in the model. We look forward to continuing to partner with CMMI to improve the design and rollout of this and other APMs to ensure internal medicine specialists continue to lead the charge to transform healthcare in this country to deliver patient-centered, high-value care to patients.

Timeline

January 1, 2020 is now less than six months away, yet to date there have been no formal application deadlines announced or request for applications made publicly available. Important details regarding payment, patient assignment, and quality measurement are outstanding and may not be available until late 2019, potentially after applications are due and only weeks out from the scheduled implementation date. The accuracy of risk adjustment, patient assignment and financial benchmarking can make or break a participant's decision to participation in the model. Once a practice does make the decision to participate, they also cannot implement overnight. Making necessary preparations, including training their staff and updating practice management software and other system upgrades, can takes months. **While we continue to support the expedient development of new APMs, ACP worries that rushing the application timeline and not giving practices all of the information they need to responsibly make participation decisions nor adequate time to consider this information will threaten participation in and successful implementation of this model. We urge CMMI to make this information available as soon as practical and to consider a rolling application process for the first performance year.** This would help to strike the right balance between not delaying implementation for participants who are ready to start Jan. 1, 2020 while giving practices who need it more time to consider and prepare for participation without waiting an additional year.

If CMMI cannot make this information available in the coming weeks, we recommend it delay the January 1, 2020 implementation date and preserve a second opportunity to apply. This would allow for a less rushed implementation alleviating pressure on potential applicants and CMMI staff, and would likely lead to a smoother rollout and larger class of participants given there would be more time to collect applications and educate participants. It would also give CMMI time to test and finalize performance measures and would allow more opportunities for input from ACP and other stakeholders, who did not have an opportunity to comment on the model before it was announced. Finally, a delay in implementation could allow for practices currently participating in the Comprehensive Primary Care Plus (CPC+) Model to join for the first participation year, likely significantly expanding the pool of applicants.

Financial Risk and Payment Adequacy

ACP strongly supports CMMI's approach to offer a higher proportion of upside risk relative to downside risk to incentivize voluntary participation in this and other risk-bearing models. As ACP has noted in the past,¹ this approach encourages clinicians to move toward downside financial risk while protecting the Medicare trust funds. The most effective way to a long-lasting transition to value is a diverse offering of voluntary payment models that accommodate a wide range of practices and patient populations, including various specialties, sizes, settings, and geographic locations. The growing level of participation in APMs, including risk-bearing APMs,² demonstrates that internal medicine physicians have an interest in and desire to join new innovative APMs, provided they are evaluated accurately and sufficiently rewarded for their

¹ https://www.acponline.org/acp_policy/letters/acp_response_to_dc_geographic_option_rfi_2019.pdf

² <http://hcp-lan.org/workproducts/apm-discussion-2018.pdf>

efforts, investments, and financial risk. Appropriately calibrating the level of financial reward and downside risk is critical to the success of any model, but particularly voluntary models, both for soliciting sufficient initial interest and retaining participants year after year.

However, ACP has concerns about the overall structure of the performance-based adjustment that pits practices against one another to compete for a higher adjustment. If all PCF practices are successfully delivering high-quality, advanced primary care and other services while maintaining or reducing costs, they should all be rewarded accordingly. If all practices perform similarly well, barely distinguishable differences in performance would still yield major differences in payment adjustments. It is much more effective to prospectively set transparent, consistent performance benchmarks based on objective high-quality low-cost standards grounded in clinical evidence. Physicians prefer when financial incentives are tied to fixed performance targets and/or improvement over relative performance³ because it puts them in a better position to successfully manage and improve patient care and meet performance targets when they know what patients they are responsible for managing and what benchmarks or performance targets they are expected to achieve, so that they can intervene early, plan accordingly, and monitor their progress through data. The majority of private payers have already recognized this and begun moving in this direction.⁴ **ACP urges CMMI to base performance-based adjustments on absolute, evidence-based, and prospective performance targets, rather than retrospective, relative targets based on peer group comparisons that give practices no clear target for which to shoot and create arbitrary winners and losers.**

Based on a combination of independent analyses⁵ and anecdotal analyses from our members, **we are concerned that the payment levels themselves are insufficient to cover the advanced clinical interventions that CMMI envisions with this model.** Moreover, it is unclear how CMMI calculated performance-based payment amounts or flat visit fees, or how exactly these fees will be geographically adjusted, which makes it difficult for ACP and other stakeholders to make more sophisticated suggestions regarding the methodology. As noted by CMMI, the maximum potential upside performance-based adjustment of 50% is substantial. However, only 10% of PF participants have a chance to attain this. The maximum upside then rapidly drops off. Half of practices would receive no more than a 3.5% positive adjustment, and that would be contingent on surpassing national benchmarks.

While the overall structure of this model to offer prospective payments can be an effective way to incentivize value; the prospective population-based payments appear to be based on current payment rates, which are widely accepted as undervalued.^{6,7} The Primary Care Incentive Payment Program (PCIP) temporarily awarded primary care physicians a 10% bonus, as recommended by the Medicare Payment Advisory Commission,⁸ and CPC+ similarly assumed a

³ <https://www.gao.gov/assets/660/651103.pdf>

⁴ <https://www.gao.gov/assets/660/651103.pdf>

⁵ http://www.chqpr.org/downloads/Fixing_Problems_with_Primary_Care_First.pdf

⁶ <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.W5.376>

⁷ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4872854/>

⁸ http://www.medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0

10% inflation rate for delivering advanced primary care services. Based on the information provided to date, PCF does not appear to offer any similar increase to the baseline payment for participating primary care physicians, despite requiring them to deliver a range of “enhanced” primary care services that can be expensive to implement, including 24/7 access to a care team member. **We urge CMMI to follow past examples and increase baseline payments by at least 10% to appropriately compensate primary care physicians for the valuable services they provide.** Access to primary care has been associated with higher quality of care, lower mortality rates, higher patient satisfaction, and lower total system costs. If CMMI and the Centers for Medicare & Medicaid Services (CMS) at large do not address this chronic undervaluing of the critical services internal medicine specialists provide, we will see the existing shortage of primary care physicians in this country continue to widen. This further threatens access to vital preventive services at a time when physicians and other clinicians are already stretched thin due to more patients gaining insurance coverage, an increasingly medically complex and aging population, and an increasing and important focus on preventive care and care management.⁹ Furthermore, this model comes at a time of great uncertainty regarding the larger reforms to payment for Evaluation and Management services, which adds greater complexity to these cost-benefit decisions practices must make and should be reflected in the value equation when it comes to financial risk and model payments. **With regard to the Seriously-Ill Population (SIP) Option, we are concerned that payments for those patients would only occur for 12 months and urge CMS to extend this timeframe, as this will provide practices with greater assurance that they will be supported in providing longitudinal care to this at-risk patient population.** Further, should CMMI proceed with their approach of using relative targets for performance-based adjustments, we recommend that the continuous improvement bonus be increased for practices that are at the lower end of performance compared to other PCF practices, but still beat national benchmarks. By participating in the model, these practices demonstrate a real desire to improve patient outcomes and costs, but can only do so with sufficient support.

Eligibility

ACP is concerned that eligibility restrictions could hinder participation in the model. It is ACP’s understanding that CMMI intends for this model to qualify as an Advanced APM under the medical home model (MHM) threshold, and to apply the 50-clinician cap accordingly. ACP has repeatedly called for the Innovation Center to reconsider the 50-clinician cap¹⁰ because it creates an arbitrary distinction that only prevents advanced practices from qualifying as Advanced APM participants. In either case, the 10% downside risk should satisfy the nominal financial risk standard and allow PCF participants to qualify without subjecting them to the 50-clinician cap for the MHM standard.

ACP is equally concerned that requiring primary care services to account for a minimum of 70% of practice revenue is unnecessarily high and threatens to exclude practices that deliver a majority of primary care services. Instead, we recommend CMMI adopt the 60% threshold that was previously used under the PCIP. Additionally, it is critical CMMI include the wide array of

⁹ https://news.aamc.org/press-releases/article/workforce_report_shortage_04112018/

¹⁰ <https://www.acponline.org/acppolicy/letters/cmscommentletterrecy2018macraqppproposedrule.pdf>

billable services that primary care physicians and their care teams commonly administer, so that these are not counted against them in determining this threshold (including electronic check-ins, interprofessional consultations, and vaccinations). In addition, we understand it is important to set a minimum patient panel size to ensure accurate performance measurement, and consider the 125 patient minimum reasonable, but it is unclear whether the SIP Option would have a patient minimum of its own or take a different approach to mitigate potential downswings in performance that could be the result of random variation.

We seek more clarification on what would constitute sufficient experience with value-based arrangements and urge CMMI not to further alienate potential participants by setting this bar unreasonably high, particularly given the fact that participants are accepting downside risk. Building stop gaps, risk corridors, and other risk mitigating mechanisms into the payment structure could help to mitigate extreme fluctuations in financial performance and allow CMMI to lessen front-end eligibility restrictions. Moving forward, we urge CMMI to permit overlap with existing Medicare APMs as this is an effective way for practices to achieve different targets and reach different patient populations. It will be important for the Innovation Center to identify in advance how overlap impacts performance evaluation under each model.

ACP has repeatedly cautioned about the negative impact control groups have on participation rates, both by preventing a subgroup of applicants from participating and by disincentivizing potential future applicants from applying in the first place. While ACP appreciates and understands the importance of conducting robust program evaluations, there are multiple ways to evaluate the model effectively without restricting participation in the program. CMMI could compare PCF practices to similar practices in non-participating geographic regions, or conduct a time series comparison of participating practices in the years leading up to participation in PCF compared to during active participation in the program. In the event the Innovation Center does move forward with control groups, we urge them to limit the size of the control groups as much as possible and to directly compensate control group practices for their efforts.

We have major concerns that current CPC+ participants are prohibited from participating until 2021. We urge CMMI to allow CPC+ participants to participate in PCF starting with the first performance year, regardless of whether or not they are completing their fifth performance year in CPC+. While we understand the importance of program evaluation, reasonable measures could be taken to isolate the impacts of the two programs. CMMI would still have four CPC+ performance years to evaluate, plus not every CPC+ practice will transfer into PCF given the higher risk, so CMMI will still have a robust pool of CPC+ applicants to evaluate. More importantly, this reason alone does not justify alienating what would likely be thousands of additional clinicians participating in the PCF Model and delivering better care for their patients.

Administrative Burden

CMMI has noted repeatedly that they aim to significantly reduce administrative barriers through this model. However, **based on the information provided so far, it is unclear how the model would help to significantly reduce administrative burden.** CMMI cites a smaller set of

quality measures, but PCF practices must still report on five quality measures starting in performance year two, only one measure less than the six required for full participation in Merit-based Incentive Payment System (MIPS). Moreover, the five measures are all pre-set; practices have no flexibility to choose from a menu of measures based on which are most appropriate for their unique patient population. Through its *Patients Before Paperwork Initiative*, ACP has striven to partner with CMS and other payers to eliminate unnecessary red tape in our nation's health system that adds unnecessary costs, contributes to physician burnout, and most importantly, detracts from patient care. We support CMS' continued efforts to reduce physician burden and restore the physician-patient relationship through its own *Patients Over Paperwork* and *Meaningful Measures Initiatives*. We appreciate the intent behind the payment design to take emphasis off of individual services and facilitate caring for the whole patient, including a more seamless and comprehensive set of services administered both within and outside of the office. However, true administrative efficiency can only be realized to the extent to which we shift away from coding on a fee-for-service (FFS) basis. **We implore CMMI to make every effort to eliminate unnecessary administrative tasks related to medical billing and documentation for this and other models featuring capitated payments, including when it comes to documentation requirements for the flat visit fee.**

We also urge CMMI to exercise its waiver authority to remove hurdles to billing certain high-value services, allow practices flexibility in how best to use model payments to benefit patients, and remove compliance barriers that hinder value-centric compensation arrangements. Given physicians are already held accountable for quality and utilization performance, PCF practices should be freed from duplicative administrative hoops originally designed for a FFS environment. Prior authorization and appropriate use criteria for instance only add unnecessary bureaucracy and expense and delay patient care. PCF practices should be given autonomy to decide how to invest model payments in innovative ways that will most positively impact the patients they serve, including but not limited to offsetting transportation costs and/or patient copays. ACP reiterates its calls¹¹ for broad waivers from the Physician Self-Referral "Stark" Law and Anti-Kickback Statute for all APMs, including PCF. These restrictions serve as a barrier to the very value-focused relationships and compensation structures that APMs aim to foster and serve as an unnecessary and counterintuitive barrier to the growth and development of new APMs. They should be reevaluated and modernized on a broad scale to ensure they facilitate, and not impede, efforts to improve care coordination and patient outcomes.

ACP supports promoting use of Certified EHR Technology and other Health Information Technology (IT) to help improve patient care. However, CMMI should be careful not to impose explicit technology requirements that are prohibitively expensive or not widely available and could impose undue burden and expense on practices and threaten participation, particularly by smaller or independent practices. **We support a one-year delay of 2015 CEHRT criteria for practices participating in the SIP Option and encourage the Innovation Center to consider additional flexibilities as necessary and appropriate for other Health IT requirements.**

Advance payments help practices to overcome some of these costly obstacles to participation.¹²

¹¹ https://www.acponline.org/acp_policy/letters/acp_aks_rfi_comments_2018.pdf

¹² https://www.acponline.org/acp_policy/letters/acp_response_to_dc_geographic_option_rfi_2019.pdf

Performance Measurement

Accuracy of measures, risk-adjustment, and patient attribution methodologies can make or break the performance of an APM, and more importantly, ensure patient safety and access to care. Four out of five of the “quality gateway” measures were rated as invalid by ACP’s Performance Measurement Committee (PMC) for a variety of reasons ranging from promoting overuse of unnecessary treatments, to insufficiently defining what constitutes “poor control” and failing to stratify into well-defined risk groups. **We urge CMMI to make necessary adjustments to PCF quality measures to address known deficiencies identified by ACP’s PMC or select different measures that more accurately capture true quality of care.**

While ACP does not dispute that hospital utilization can be an important indicator of the quality of effective preventive and primary care services, we are concerned it would be the sole quality or utilization measure used in the first performance year. It is unclear how this measure would be weighted relative to the quality measures (if at all) for purposes of satisfying the “quality gateway” requirements starting in performance year two; or how it might impact performance-based payments beyond this, which is of critical importance when it comes to the cost benefit analysis of participating in the model. ACP feels strongly that in addition to being expected to meet minimum quality requirements, participants should be rewarded for demonstrating superior quality outcomes in the form of a higher performance-based adjustment. We also have concern that participants are to be evaluated on two different sets of quality measures based on their risk tier, particularly when they are directly competing against other PCF practices for higher performance-based adjustments. We seek more detail on how CMMI plans to retroactively adjust continuous improvement scores for practices with small patient panels, including assurances it will not unduly lower them citing random variation.

ACP appreciates CMMI being responsive to past ACP recommendations¹³ to not move forward with new quality measures unless they are independently endorsed by the National Quality Forum (NQF) and to assess quality and utilization performance at the practice level, which is often the most accurate, particularly in this increasingly value-focused, team-based care delivery environment. Having an independent, third party hold quality measures accountable to a rigorous, transparent review process will improve the credibility and accuracy of quality performance measurement and has the strong support of ACP. **We urge CMS to only measure practices based on measures that have been proven to be clinically accurate, statistically valid, proven to positively impact patients, and vetted by an independent third party,** including any proxy measures CMS may use in the interim as it works to develop new measures.

CMMI has yet to release detailed information on risk adjustment methodologies, which makes it difficult for ACP and other stakeholders to properly evaluate the model, much less for practices to perform the necessary calculations to determine if participating would be viable. ACP has repeatedly expressed¹⁴ concerns with the Hierarchical Condition Category (HCC) risk-adjustment methodology that is commonly used across Medicare programs and models. **We**

¹³ https://www.acponline.org/acp_policy/letters/acp_comments_2019_qpp_pfs_proposed_rule_2018.pdf

¹⁴ [ACP Response to CMS Innovation Center RFI on Direct Provider Contracting Models \(2018\)](#)

urge CMS to incorporate several important indicators of risk not currently accounted for in the HCC methodology, including comorbidities, severity of condition, and social determinants of health. If low income, complex, or aged populations are not appropriately risk adjusted, physicians who treat a disproportionate amount of these patients could be unjustly penalized, creating access issues for already vulnerable patients.

ACP appreciates and supports CMMI recognizing the importance of prospective, ideally voluntary patient assignment to accurate performance measurement. We urge CMS to expediently develop additional ways to proactively identify patient-physician relationships, including the use of patient relationship codes. Prioritizing voluntary assignment over claims-based assignment helps to put patients at the center of their own care. Assigning patients prospectively, rather than retrospectively, helps to ensure clinicians are aware of the patients for whom they are accountable and gives them greater ability to proactively manage their care in the hopes of improving outcomes and potentially reducing costs. In addition to attestation through the MyMedicare.gov portal, we urge CMS to develop and use patient-relationship codes, which will help to establish more accurate relationships between patients and the clinicians responsible for their care, particularly in an increasingly collaborate environment. We appreciate that patient assignment would occur on a quarterly basis and that costs for services received outside of the PCF practice would be accounted for through a “leakage rate.” These improvements will lead to more accurate assignment of patients and the costs associated with their care, giving potential participants more confidence to participate in the model.

In Conclusion

We appreciate CMMI’s ongoing commitment to transform our healthcare delivery and payment system to put patients at the center of their own care and reward physicians for delivering high-quality care in a cost-efficient way through new, innovative payment models. We consider Primary Care First an important step toward advancing comprehensive primary care and building the robust internal medicine foundation to sustain a patient- and value-centric delivery system model. It is our goal to work with CMMI to ensure these models are financially viable for the physicians who participate in them while protecting the Medicare trust funds to ensure a robust pool of participating clinicians and patients who benefit. We welcome an opportunity to further discuss the thoughts raised in this letter. Please contact Suzanne Joy by phone at 202-261-4553 or e-mail at sjoy@acponline.org. We look forward to continuing our collaborative relationship with CMMI to help ensure the successful development and implementation of PCF and other APMs, particularly those geared toward internal medicine specialists.

Sincerely,



Ryan D. Mire, MD, FACP
Chair, Medical Practice and Quality Committee
American College of Physicians