

UnityPoint Health Response – March 16, 2015

Center for Medicare and Medicaid Innovation Request for Information on Advanced Primary Care Model Concepts

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.

PBPs have the potential to positively impact the delivery of advanced primary care. To realize this potential, CMS must appropriately structure PBPs to incentivize appropriate clinical care and target appropriate primary care services. Whereas PBPs may fund population-based care coordination not otherwise reimbursed by traditional FFS, the PBP must be sufficient to enable appropriate clinical care. In addition, not all primary care services are equally suited to this payment mechanism. Primary care services may be characterized into three categories: (1) Preventive care, (2) chronic care management and coordination, and (3) minor acute care. PBP would have the greatest impact on categories 1 and 2.

Practice infrastructure and program constraints will influence arrangement readiness. One infrastructure constraint is health information technology. Many primary care practices lack the sophisticated data analytics capacity required to assure performance under the proposed model and may depress practice participation rates. In terms of patient participation / enrollment, we would suggest that CMS consider embedding strong patient accountability requirements related to network access. Without shared responsibility by the patient, the primary care practice bears risk for avoidable care over which the practice has little control.

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

To generally understand how this model works, we suggest a 100% full basket payment pilot that incorporates a bonus if quality and total cost of care outcomes exceed benchmarks. Despite this general position, we urge CMS to provide further detail on a couple issues to assist practices in evaluating this question. First, we would be interested in CMS' definition of primary care services – whether the three categories mentioned in the #1 response (e.g. (1) Preventive care, (2) chronic care management and coordination, and (3) minor acute care) are all proposed for inclusion within the roll-up FFS. We believe that a rolled-up FFS mechanism would be most appropriate for primary care services characterized as "minor acute care." Second, we request further information on whether the "rolled up" payments are paid prospectively versus retrospectively and how accurately the "expected" rolled up FFS accounts for actual service provided.

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.

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We recommend that the basket include “primary care E&M services plus certain procedures.” This would target primary care E&M for patients with chronic disease who exceed a certain risk score. This is the patient population that most warrants non-visit based management services. While we believe PBP is best targeted to this risk-stratified group, we also recognize that it would be important to eliminate the need for two work flows (one for PBP and one for FFS) within one practice.

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

We believe that primary care practices will be very interested in assuming accountability for the total costs of primary care. This belief is based on several assumptions. First, payment incentives should be commensurate with clinical risk. Second, practices have access to sophisticated health information technology capacity to satisfy managed patient populations. Third, the management of total cost of care must be connected to this initiative – its primary care roots. A significant problem arises when the payment model attributes all costs to primary care practices, essentially holding primary care practices accountable for specialty care services, hospital services, out-of-network services, etc. Fourth, patients should "pick" a primary care provider and be held accountable for accessing avoidable services or services outside designated primary care practice ACO or affiliated network.

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)?

Among the options listed in this question, we prefer a withhold structure to fund any potential losses as the operating margin for most practices is not large. As an alternative, we would support a structure to modify (increase/decrease) future PBP amounts based on savings/losses. If the latter alternative is chosen, we urge CMS to enact a relatively short accounting period to incent changes in provider behavior.

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

Key challenges are the lack of actionable intelligence (e.g. data granularity to the provider / patient / procedure level) at the point-of-care as well as the limited financial capacity to absorb risk.

- 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)?**

We encourage CMS to incorporate creative supports and mechanisms to enable primary care practices to participate in this initiative. CMS could enhance actionable intelligence by: (a) Establishing clear and transparent clinical and financial targets, (b) providing routine, timely,

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accurate and reliable data reporting that would ideally reside in point of care data systems, and (c) financially supporting robust EHR, health information technology, and analytic support systems.

In terms of mitigating risk, CMS could enact: (a) Risk/reward incentives that are commensurate with the practice's ability to impact outcomes, (b) PBP amounts that are commensurate with risk, (c) risk pooling for primary care practices within a network or IDS practices functioning within a single provider system, (d) penalties or incentives for patients to stay in the ACO network and comply with care plan, (e) remove co-pays / co-insurance for all preventive services and visits for patients with multiple co-morbidities, and (f) infrastructure seed money to provide care management capabilities.

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?

Documentation of clinical care should no longer be driven by patient visits, but rather documentation that summarizes courses of care. This reduces provider work flow burden and increases focus on patient care, while still requiring documentation to assess evidence-based patient care. In particular, we urge CMS to examine the current level of documentation for E&M level of service as well as the detailed documentation requirements to meet care coordination or chronic care management billing requirements.

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.

We recommend a claims-based comorbidity measurement in combination with claims-based utilization management and a risk assessment tool.

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?

Yes, there is a minimum patient number required to provide a return on investment for infrastructure, program development and ongoing training. We estimate a minimum of 150 patients per clinical site. For larger medical groups with multiple locations in a medical neighborhood model, we believe the minimum would be an estimated 500 patients with heightened access to additional advanced care services, such as medication therapy management, social work, and behavioral health.

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

Possibly – the care management and coordination time and effort is significantly higher for high complexity than low complexity patients. If there are rewards for quality and total cost of care metrics, then cost is higher as complexity and acuity level increases. Perhaps CMS should consider a tier-type model based on level of patient complexity in the panel. In any case, payment should be matched to the IDS that employs the additional resources to provide this level of advanced care.

- 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 calculation of a PMPM is dependent upon program requirements and the acuity / severity of enrolled patients. Among infrastructure needs and ongoing advanced primary care include Advanced Care Management; Call Center; Care Coordination Visits – Home; Data Analytics and Risk Stratification Functionality; Electronic Medical Record Interoperability Expansion; Health Risk Assessment; Emergency Department Consistent Care Program; Palliative Care; Patient Profile; Patient Portal; Patient-Centered Medical Home; and Telephonic Disease Management.

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

We suggest the use of outcomes-based metrics, e.g. ED utilization, hospitalization rate, rate of functional improvement, readmission rates, risk scores, and disease-specific outcome measures.

- 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.**

In general, timely, monthly, and actionable data at the provider level is minimally required. Real-time, accurate, reliable clinical data must be sufficient to guide providers in the day-to-day management of patient populations. This includes point-of-care data systems as well as claims-based data systems. Ultimately, we would like accessible data in a standardized format that enables analytic functions to produce timely care opportunity reports for providers.

- 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**

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organizing data; using interoperable electronic care plans; having robust care management tools)?

HIT underlies a practice's ability to timely and proactively deliver care. Among transformative changes that CMS should support (1) improved inter-operability across electronic health records, including the ability to transfer patient-specific data between electronic platforms and across care settings, (2) clinical analytic engines that are accessible by clinical providers/managers, (3) incorporation of decision support tools, and (4) tracking of compliance and deviation of electronic care plans and subsequently creating provider alerts.

- 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)?**

CMS could mandate interoperability at the point-of care from HIT vendors and also change payment to necessitate practice investments in population-based care management 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?

Existing financial resources provided to ACOs participating in a shared savings/risk program are vastly insufficient to deliver the proposed advanced primary care model, though ACOs are required to deliver on advanced care model programming.

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

We support this concept; however, PBPs should be received by the contracting entity. We recommend that providers should be compensated based on performance and not on productivity.

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

Since support of the Triple Aim and improving total cost of care are the goals of ACOs, an ACO structure would be a natural vehicle to support this work.

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

We anticipate that setting PMP rates will be a challenge. For areas that have high FFS utilization, practices could benefit if rates are set at the county level. We would propose that average national utilization rates be used to determine PBP rates with cost-of-living adjustments.

For program integrity generally, we urge (a) clarity, specifics and consistency of CMS criteria and (b) adequacy of payment incentives to providers to enable appropriate clinical care.

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a. How can these issues be prevented or addressed?

We suggest that CMS implement efforts to increase engagement of the provider community in feedback and responsiveness.

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.

We suggest better analytics of CMS claims to "forensically" identify potential abuse followed by closer audits to objectify/validate abuse.

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.

Population health requires holistic care. Medical information/records are often limited to diagnoses and health conditions, medical procedures, test results and other biometrics, and family medical history. Healthcare decisions and inferences about patient needs that are based solely on "medical" information provide an incomplete picture. This data/information does not reflect a patient's potential for success and motivation for treatment and achieving healthcare goals. This disconnect is *social determinants of health*, which are potential barriers to making healthy choices. This is especially true for vulnerable, safety net populations. If an individual lacks transportation, the probability that they will not keep medical appointments increases. If an individual lacks financial resources, the probability that they will not fill required prescriptions or split pills increases.

The impact of social determinants of health on the Medicaid population underscores the importance of a standard health risk assessment. Without patient engagement, the ability to improve health through UPH population health strategies will not succeed. The Medicaid population may prove as a testing ground for innovation regarding community partnerships and supports that translates to all payers and populations.