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

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Request for Information (RFI)

SUMMARY: The Centers for Medicare & Medicaid Services (CMS) is seeking input 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.

DATES: To be assured consideration, comments must be received by March 16, 2015.

ADDRESSES: Comments should be submitted electronically to: APC@cms.hhs.gov.

FOR FURTHER INFORMATION, CONTACT: APC@cms.hhs.gov with "RFI" in the subject line.

BACKGROUND: Section 1115A of the Social Security Act, as added by section 3021 of the Affordable Care Act, authorizes the Secretary of Health and Human Services to test innovative models of payment and service delivery that have the potential to reduce program expenditures while preserving or enhancing the quality of care for Medicare, Medicaid and CHIP beneficiaries.

CMS is issuing this Request for Information (RFI) to obtain input on the design of the next generation of advanced primary care model(s). Advanced primary care is based on principles of the Patient Centered Medical Home and builds on the care delivery models employed in other CMS model tests, including the Comprehensive Primary Care initiative (click hyperlink for more information). Next generation model(s) for advanced primary care would seek to improve further the delivery of patient-centered care and population health and would align with the Secretary's goal to increase the use of alternative payment models. General topics of interest include:

1. Increased comprehensiveness of, and patient continuity with, primary care (i.e., care provided with greater depth and breadth and through longitudinal relationships between patients and primary care providers),

2. Care of patients with complex needs,

3. Closer connections between primary care and other clinical care ("the medical neighborhood") and community-based services,

4. Moving from encounter-based payment or encounter-based payment with care management fees towards population-based payments (PBPs) to support the infrastructure needed for advanced primary care, create incentives for innovation in care delivery, and promote accountability for costs and quality of

care, including consideration of appropriate mechanisms to assign beneficiaries to unique practices,

5. Mechanisms to support small primary care practices in the transformation to advanced primary care,

6. Advanced primary care within accountable care organizations (ACOs),

7. Multi-payer participation,

8. Performance measurement that is meaningful to beneficiaries and clinicians,

9. Matching documentation requirements to the goals of advanced primary care while protecting CMS program integrity, and

10. Use of health information technology (HIT), including electronic health records, data analytics, and population health tools, to support advanced primary care.

CMS seeks broad input from consumers and consumer organizations, health care providers, associations, purchasers and health plans, Medicaid agencies and other state offices, quality review organizations, social service providers, HIT vendors, and other stakeholders. Commenters are encouraged to provide the name of their organization and a contact person, mailing address, email address, and phone number in the following field; however, this information is not required as a condition of CMS's full consideration of your comment.

CMS may publicly post the comments received, or a summary thereof, so commenters should not share proprietary information. The information and questions in this RFI reflect ideas that CMS is considering, but it takes no position on whether any of the options discussed here or that may be raised by commenters in response to this RFI would be feasible or permissible.

SECTION I: INFORMATION REGARDING ADVANCED PRIMARY CARE MODEL CONCEPTS

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.

SECTION II: QUESTIONS

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.

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

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.

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

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)?

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

    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)?

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?

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.

    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?

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

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.

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

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.

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)?

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)?

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?

a. Should primary care practices within ACOs receive PBPs?

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

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

a. How can these issues be prevented or addressed?

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.

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.

SPECIAL NOTE TO RESPONDENTS: Whenever possible, respondents are asked to draw their responses from objective, empirical, and actionable evidence and to cite this evidence within their responses.

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY. This RFI is issued solely for information and planning purposes; it does not constitute a Request for Proposal, applications, proposal abstracts, or quotations. This RFI does not commit the Government to contract for any supplies or services or make a grant award. Further, CMS is not seeking proposals through this RFI and will not accept unsolicited proposals. Responders are advised that the U.S. Government will not pay for any information or administrative costs incurred in response to this RFI; all costs associated with responding to this RFI will be solely at the interested party's expense. Not responding to this RFI does not preclude participation in any future procurement, if conducted. It is the responsibility of the potential responders to monitor this RFI announcement for additional information pertaining to this request.

Please note that CMS will not respond to questions about the policy issues raised in this RFI. CMS may or may not choose to contact individual responders. Such communications would only serve to further clarify written responses. Contractor support personnel may be used to review RFI responses.

Responses to this notice are not offers and cannot be accepted by the Government to form a binding contract or issue a grant. Information obtained as a result of this RFI may be used by the Government for program planning on a non-attribution basis. Respondents should not include any information that might be considered proprietary or confidential. This RFI should not be construed as a commitment or authorization to incur cost for which payment would be required or sought. All submissions become Government property and will not be returned. CMS may publically post the comments received, or a summary thereof.