MSMS
MICHIGAN STATE MEDICAL SOCIETY

120 West Saginaw Street | East Lansing, Michigan 48823
517-337-1351 | msms@msms.org | www.msms.org

July 29, 2016

Phillip J. Bergquist
Manager, Policy and Strategic Initiatives
Michigan Department of Health and Human Services
333 S. Grand Ave.
Lansing, MI 48933

Dear Mr. Bergquist:

On behalf of the Michigan State Medical Society (MSMS) and the MSMS Executive Council of Physician Organizations, which represents 16,000 physicians and 12 partner organizations statewide, I write in response to the Michigan Department of Health and Human Services (MDHHS) *Concept Paper for Medicare Alignment in a Customized Patient-Centered Medical Home (PCMH) Model*.

MSMS embraces the movement away from fee-for-service (FFS) and shares the goals of MDHHS and CMS to increase the total percentage of health care services reimbursed under value-based contracts. We agree the PCMH model will play an integral role in the delivery system to achieve this goal and Michigan presents a unique opportunity due to the Blue Cross Blue Shield of Michigan's PCMH program, the largest of its kind in the United States, and the success of the Michigan Primary Care Transformation Project (MiPCT), a multi-payer demonstration with proven savings to Medicare.

We share the belief that the State Innovation Model (SIM) should build on these successes to continue the transformation of primary care practices into PCMHs, expand and sustain the use of team-based care models and grow the delivery of accountable care to Michigan patients. We applaud the effort to develop a stepwise approach for physicians and practices to move along a payment continuum toward these goals. However, we recognize a number of challenges within the details of this approach and write to recommend areas of opportunities for improvement.

Broadly, we recommend the following concepts be adopted:

1) **Physician organization should be recognized in all phases along the payment continuum as an empowering force behind PCMH transformation in Michigan.** Physician organizations provide practices with the infrastructure, education, and training to build the capabilities necessary to deliver accountable, patient-centered care. This fact is demonstrated by the agreed upon success of the BCBSM designation program and the MiPCT project. A single practice unit, particularly those in independent, private practice and located in rural or underserved areas, lack the operating margin and resources to make the investments needed for practice transformation on their own. We believe all practices eligible to participate in SIM should be required to participate with a physician organization and the role of the physician organization should be recognized.

2) **Simplicity should be a priority to allow for sustainability and growth**. While we support the need for evolutionary payment models that create a path to advance payment models, we are concerned about the complexity of the phases as defined in the concept paper. Physicians and their practices, especially those in independent private practice and located in rural or

underserved areas, do not transform quickly. One of the lessons learned in the MiPCT project was that three years was not long enough for practices to develop and solidify advanced PCMH capabilities like, care management. The timeframe provided for each payment model phase in the concept paper is too short and creates change for practices too rapidly year-to-year in a manner that threatens the success of the model.

3) **Risk-payment models should be compatible with other CMS payment model programs.** Michigan is a leader in adoption of the Accountable Care Organizations (ACOs) due to the core PCMH infrastructure developed over nearly a decade. We understand and support the need to enter into risk-based agreements as part of the custom option; however, this approach must be compatible with physician practices' participation in existing ACOs. Moreover, we are aware of pending applications by Michigan's two largest commercial payers to participate in CPC+ and if the applications are granted it will present an attractive model for consideration. We believe SIM has an opportunity to align with these programs more closely and will face significant challenges if physician practices must choose between SIM participation or participation in other CMS payment models.

MSMS wants to assist in the successful implementation of SIM and believes that if these broad concepts are adopted it will improve the expansion rate of the PCMH model. Additionally, we believe there are opportunities for improvement to the approach outlined in the concept paper. Specifically, we recommend the following changes to the modified SIM payment approach:

Interim Payment Model

We are concerned about the challenges presented in the interim payment model's decision to rely on the interim chronic and transitional care management codes. We do not believe practices are able to bill the chronic care code 99490 consistently enough to sustain their care management programs as developed under MiPCT. Calculations suggesting otherwise are built on levels of Medicare population outreach that has not been achieved and will be extremely difficult to achieve with the requirement of written patient consent and increase patient co-pay responsibility.

Moreover, we are concerned about the continued participation of commercial payers if the per-member-per-month (PMPM) commitments of Medicare and Medicaid under MiPCT are not maintained. The participation of Blue Cross Blue Shield of Michigan, Blue Care Network and Priority Health was reached based on similar investments by Medicare and Medicaid. We believe the removal of these investments seriously jeopardizes the continued participation of commercial payers.

We applaud the intent to continue Medicaid PMPM payments through 2017 but feel that in order to make the custom option viable we must also find a way to secure the PMPM practice transformation and care coordination payments provided by Medicare in 2017. MSMS offers its assistance in discussions with CMS regarding the importance of these payments and the need for the one year extension.

Phase 1 – Targeted Investment

We strongly support phase 1 as a mechanism to accelerate efforts to develop comprehensive primary care functions and become PCMH designated. We recognize phase 1 as the last chance for practices yet to adopt the PCMH model and offer our assistance as partners in engagement of these slow adopters. The criteria for engagement should be limited to those practices that are not PCMH designated and

have not adopted an electronic health record (EHR.) We also recommend an emphasis, if not exclusivity, for independent, private practices located in rural or underserved areas.

However, we believe phase 1 will be relevant to more practices than anticipated in the concept paper and require greater levels of investment than currently planned. As a result, we recommend the care coordination PMPM be added to the proposed practice transformation PMPM as it existed under MiPCT and similar to our recommendation for the interim payment model. Moreover, due to the investment necessary, particularly for EHR implementation, we recommend the ability for practices to remain in phase 1 up to two years instead of the proposed one-year limitation.

Phase 2 – Comprehensive Care Advancement

We support phase 2 as an evolution of MiPCT and earlier SIM phases as described in the concept paper with a practice transformation PMPM, tiered PMPM care management and at-risk performance payment. We agree the practice transformation funds should be targeted toward specific primary care capability advancements and especially those that align with the sharing of clinical data necessary for care management functions. These include, but are not limited to, engagement of all care team members in Michigan's Active Care Relationship Service (ACRS), statewide Admission, Discharge and Transfer (ADT) notifications, medication reconciliation and the exchange of electronic clinical quality data during the course of the demonstration, particularly as proposed under the Executive Council's Physician-Payer Quality Collaborative (PPQC).

Further, we recommend that any of the practice transformation and advancement of clinical information activities be eligible for participation in other CMS models under MACRA or existing ACOs. We also strongly recommend all practices be able to remain in phase 2 up to three years to improve consistency and reduce unnecessary complexities of the model.

Phase 3 – Delivery System Transformation

We see challenges in phase 3 in its compatibility with other CMS payment model programs. As mentioned earlier, we have a number of organizations operating or engaged with ACOs and interested in participation with CPC+. We believe phase 3 as proposed would create a tug-of-war between SIM participation and ACOs in a manner that threatens the success of each program. We recommend further assurances be gathered from CMS that physician practices could indeed participate in both before we support its adoption.

An alternative to the phase 3 as currently described may be to consider a natural progression of the tiered PMPM care management and at-risk performance payments in phase 2. We strongly recommend further thought and consideration of phase 3 before it is included in the PCMH custom option.

Phase 4 – Network Integration

We see a number of challenges to phase 4 that would make it difficult, if not impossible, to implement in a multi-payer environment. In fact, we have strong indications from commercial plans in Michigan that they would be unable or unwilling to participate in phase 4. Patients are too transient between plans and between primary care providers within the same plan to make this manageable to administer in a multi-payer environment. Additionally, a PCMH would not have the infrastructure necessary to unbundle an episodic payment to provide payment to specialists or other primary care partners without the assistance of physician organization or similarly structured entity.

As a result, we strongly recommend phase 4 be removed from the PCMH custom option. Instead, we recommend phase 4 be limited to the designated test regions and implemented in coordination with the identified Accountable Systems of Care (ASCs) and Community Health Innovation Regions (CHIRs).

Conclusion

MSMS shares the stated goals of the SIM PCMH custom option to expand value-based payment thru PCMH and team-based care models. We support the approach of a payment continuum to prepare physician practices for advance payment models. We believe the approach detailed in the concept paper will face challenges unless it formally recognizes the role of physician organizations in PCMH development, prioritizes simplicity throughout the payment continuum and remains compatible with other CMS payment models.

We strongly believe Michigan presents a unique opportunity to build on the lessons of MiPCT while constantly innovating toward more advanced payment models. Specifically, we recommend a limited continuation of the MiPCT practice transformation and care coordination PMPM to allow for consistency and growth, particularly for independent, private practice in rural or underserved areas. Similarly, we recommend a reduction of phases within the payment continuum and an extension of the participation timeline within each remaining phase. If the phases are adjusted accordingly to the recommendation, we could support a more aggressive evolution of the tiered care coordination PMPM and risk-based performance payments. Lastly, we strongly recommend the elimination of phase 4 from the PCMH model and suggest it be implemented within the designated test regions in coordination with identified ASCs and CHIRs. After many discussions with the Executive Council of Physician Organizations and the payer community we have concerns about SIM participation should the concept paper be submitted as written.

MSMS greatly appreciates the opportunity to comment on the PCMH custom option concept paper and wants to be a partner in its success. We recognize the important and difficult task faced by the SIM team as it prepares for implementation. We make ourselves available for any questions you might have and welcome the opportunity for further discussion.

Sincerely,

David M. Khrovsky, MD
President

c: Rebecca Blake, Senior Director, Health Care Delivery, MSMS
Tom Curtis, State Innovation Model Developmental Specialist, MDHHS
Elizabeth Hertel, Director of Policy and Legislative, MDHHS
Nick Lyon, Director, MDHHS
Joseph Neller, Director, Integrated Physician Advocacy, MSMS
Julie L. Novak, CEO, MSMS