

Patient-Centered
Primary Care
COLLABORATIVE

June 22, 2015

The Honorable Orrin Hatch
Senate Finance Committee
Washington, DC 20510

The Honorable Johnny Isakson
131 Russell Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Senate Finance Committee
Washington, DC 20510

The Honorable Mark Warner
475 Russell Senate Office Building
Washington, DC 20510

Dear Senators:

On behalf of the Patient-Centered Primary Care Collaborative - a diverse stakeholder group representing health care providers, patients and their families, and employers and purchasers - we write in response to your request for stakeholder recommendations on policies that will lead to the improved health of older Americans with chronic conditions. Because of their severe or multiple health conditions and functional limitations, patients with chronic conditions are more likely to go to hospitals, emergency rooms, and long-term care facilities, and need better care coordination and more supportive services to support them in their activities of daily living and ensure they do not "fall through the cracks."¹ We appreciate your leadership on this critical issue and encourage your Committee's support of policies that promote:

1. **Increased access to and support for advanced primary care** (consistent with the patient-centered medical homes) for patients with chronic illness in order to ensure appropriate and timely care coordination across the medical neighborhood;
2. **Increased linkages between clinical care and social supports** that are crucial to the well-being and function of those with chronic illness;
3. **Increased incentives that support patient and family engagement** in their care, especially in health care quality improvement efforts;
4. **Increased support for team-based interprofessional health professions workforce and training**, to include behavioral health and medication management.

Founded in 2006, the Collaborative promotes an effective and efficient health system built on a strong foundation of primary care and the patient-centered medical home (PCMH). Especially important for those with chronic illness, the PCMH model shares many attributes of the Chronic Care Model² and embraces the relationship between primary care providers and their patients, families, and care-givers; promotes authentic communication and patient engagement; and coordinates whole-person, compassionate, comprehensive, and continuous team-based care; all of which are crucial to achieving meaningful health system transformation that improves outcomes

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and lowers costs. Today, the Collaborative's membership represents more than 1,200 medical home stakeholders and supporters throughout the United States and we track more than 500 local, regional, state and national advanced primary initiatives on our PCMH Innovations map³.

As the Committee is aware, those with multiple chronic illnesses find accessing health care services in the U.S. intimidating, often difficult to navigate, disconnected, expensive and even unaffordable⁴ and for too many health care providers, the delivery of effective yet compassionate care feels harried, overregulated, and undervalued. For employers and policymakers, health care constitutes a significant expense without clear demonstration of the return on investment. The current system's fragmented, episodic, and volume-driven design is wreaking havoc on health care expenditures and the overall economy of our nation.⁵ Experts estimate that the overuse, underuse and misuse of health care resources is roughly 30% of the total U.S. health care spend;⁶ the equivalent of about \$2,000 per employee per year resulting in nearly 45 million avoidable sick days per year.⁷ As the Institute of Medicine recently noted, "more than one in four Americans has multiple (two or more) chronic illnesses (MCCs), and the prevalence and burden of chronic illness among the elderly and racial and ethnic minorities are notably disproportionate. Chronic disease has now emerged as a major public health problem, and it threatens not only population health, but also social and economic welfare."⁸ We believe that supporting primary care practices to embrace the tenets of advanced primary care, specifically patient-centered medical homes, is foundational to health system transformation that promotes better health outcomes in more a cost-effective manner for patients, providers, and payers/purchasers of health care services.

1. INCREASED ACCESS TO AND SUPPORT FOR ADVANCED PRIMARY CARE

We encourage the Committee to support expansion of existing programs for transformed primary care. Although the U.S. spent over 2.9 trillion dollars on health care in 2013,⁹ just four to seven percent of that total spend is dedicated to primary care.^{10,11,12} Despite this very modest dollar outlay, primary care visits in the U.S. account for more than half (55 percent) of physician office visits each year.¹³ Given that the delivery of primary care influences significant "downstream spending" in both hospital and specialty care settings,^{14, 15} enhanced primary care in the form of the patient-centered medical home (PCMH) can be a key foundational step to shifting the quality and cost of health care in America. In an interesting recent review of high performing primary care practices, study authors identify ten distinguishing features that fall into three categories -- each consistent with transformed primary care and relevant to patients with complex chronic health conditions: deeper patient relationships; broader interactions with the health care system; and a team-based approach to delivering care.¹⁶

Additional evidence for transformed primary care as a means to lower costs and improve quality continues to build¹⁷ especially when financial incentives are included. This month an important study regarding the patient-centered medical home (PCMH) model of care was published in JAMA Internal Medicine¹⁸ by the same RAND researcher who last year reported that the PCMH model was unsuccessful in delivering on the Triple Aim. In the more recent study, the authors suggest that several factors are important in achieving successful results from implementing advanced primary care, including: (1) payment incentives; (2) timely data at the point of care; (3) a focus on changing the culture and workflows of the practice; (4) fully implemented electronic health records; (5) using case management and other advanced PCMH capabilities, all of which are especially important when caring for patients who suffer from chronic illness.

- A. **Support for Primary Care Patient-Center Medical Homes within MACRA.** We encourage the Committee to support increased investment in transformed primary care via patient-centered medical homes as *The*

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Medicare Access and Chip Reauthorization Act (MACRA) is implemented. As you may know, the PCMH was included in both pathways of MACRA. In the Merit-based Incentive Payment System (MIPS) pathway, practices can maximize their clinical practice improvement activities score by becoming a PCMH, (one of a four part composite quality score that determines a practice's annual bonus or penalty payment, in addition to their fee-for-service payment). Under the Alternative Payment Model (APM) system, practices that are advanced PCMHs can qualify as an APM without having to take on two-sided risk arrangements. In either pathway, increased investment in PCMH practices are recognized as critical to advance health system transformation.

- B. **Emphasize Payment Reforms that move away from Fee-For-Service.** The majority of revenues received by primary care practices today are from fee-for-service (FFS) payments. In most cases, the payment models designed to support PCMH level care maintain FFS as a central feature and supplement those payments with additional fixed per beneficiary per month (PBPM/PMPM) payments. The costs of practicing comprehensive patient-centered primary care, however, are high. They include electronic health records, care coordinators/health coaches, population health management tools, practice coaching/facilitation, changing work flow, training, certification/recognition program fees, and other on-going quality improvement costs. Unfortunately, the revenues generated by the typical primary care practice are not sufficient or predictable enough to cover these costs. This is especially so for smaller practices who have little "reserve capacity" or flexibility to devote to new complex-need patients. Moreover, current payment models, even when coupled with modest PBPM payments, do not provide full compensation for the complete scope of services that do not have a "CPT code." These are critical clinical interventions that occur outside of a patient office visit and are an integral part of patient-centered primary care. For instance, following up with patients after a visit to ensure they filled their prescription and understand the dosage instructions.

To support the level of investment and predictable revenue stream required, and provide full compensation for the services delivered under a patient-centered care model, we encourage the Committee to support policies that accelerate the move away from fee-for-service payment to more comprehensive prospective primary care payment models. This increased investment in primary care holds the promise of bending the total cost curve by improving health while saving costs associated with unnecessary or avoidable ER visits, hospital visits or other care. That said, we must be mindful to not repeat the mistakes of the 1990s managed care capitation models which gave rise to concerns about limitation of care. New comprehensive payment models must include robust risk adjustment and be truly "value" based with portions of the total payment tied to achieving desired outcomes around patient quality, safety and satisfaction. Therefore, the Collaborative supports moving toward a risk-adjusted comprehensive primary care payment – with a commensurate shift away from the current fee-for-service (FFS) model -- to achieve the Triple Aim outcomes of better patient experience, lower cost, and better population health.

- C. **Consider expanding the Comprehensive Primary Care Initiative nationally.** We also encourage the Committee to support Centers for Medicare and Medicaid Services (CMS) Innovation Center programs that are demonstrating success in transforming primary care practices into PCMHs and subsequently improving health outcomes for patients with chronic conditions. Such is the case of the Comprehensive Primary Care (CPC) Initiative. The CPC is unique in that it brings together public and private payers to support primary care practices in transforming care delivery to include coordinating care with hospitals

and specialists, improving access, and supporting population health with new technologies. Participating primary care practices are provided technical assistance on quality improvement strategies and care management fees to support the costs of these non-visit-based services, with additional opportunities to share in total cost of care savings. In just the first year of this program, the results were more favorable than might be expected with reductions in hospitalizations and emergency room utilization generating nearly enough savings to offset the care management fees¹⁹. Evaluators anticipate that it may take 18 months to 3 years for practices to fully transform and to see the full effects on cost, service use, and quality. As the results continue to point toward cost savings and increased quality especially in the high-risk chronically ill populations, we encourage the Committee to consider expanding the CPC beyond the roughly 500 practices in seven regions and offer the program nationally.

- D. **Reauthorize the Primary Care Incentive Payment Program in Medicare and Extend Medicaid Pay Parity.** We encourage Congress to reauthorize the Medicare Primary Care Incentive Payment (PCIP) program and extend the Medicaid pay parity program by passing S.737, the *Ensuring Access to Primary Care for Women and Children Act* – as each provide needed support to primary care practices. Reducing payments to primary care at the same time those practices prepare for new payment methodologies created by MACRA is counter-productive and will make it more difficult for these clinicians to make the transformations required to successfully transition towards the value based payment models (e.g., PCMHs, ACOs, bundled payments). As Medicaid continues to grow, the demand for primary care will increase as well. Low reimbursement rates have historically been deterrents for health care providers to accept and treat Medicaid and some Medicare patients, as well as prevent medical students from entering into primary care specialties. Early evidence suggests that the Medicaid parity payment included in the Affordable Care Act (ACA) demonstrated improved access for Medicaid patients²⁰. A recent study suggests that medical home initiatives aimed at reducing emergency department use rely on sufficient access to Medicaid providers, pointing to both Medicaid parity and increased financial incentives as means to accomplish that policy goal²¹. We encourage the Committee to advocate for extension of PCIP and Medicaid Pay Parity as a means to support those practices caring for a disproportionate number of patients with chronic illness.
- E. **Coordinate Care for the Most Vulnerable with Chronic Illnesses.** A longstanding barrier to coordinating care for dually eligible Medicare and Medicaid enrollees has been the financial misalignment between the two programs. To better coordinate the care for this vulnerable population, the Collaborative supports the introduction of programs that will better align the financing of these two programs and integrate primary, acute, behavioral health, long-term services and community supports for dually eligible Medicare-Medicaid enrollees by adopting successful features from Medicare Advantage plans and Accountable Care Organizations. This includes conducting and regularly updating a comprehensive needs assessment and individualized care plan focused on the individual’s function and personal goals. This requires significant teamwork between the primary care practice team and those outside of the primary care setting (such as home health nurses, social workers, and caregivers) and a shift in paradigm from one focused on illness management to one focused on daily functions and wellness. One example of a promising care coordination model is found in S.1932 – the *Better Care, Lower Cost Act*, cosponsored by Senators Wyden and Isakson.

2. SUPPORT LINKAGES BETWEEN CLINICS AND COMMUNITIES

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Most primary care practices are still in the early stages of moving their care delivery model from one of caring for an individual to one of caring for communities. Embracing a population health perspective shifts from chronic illness management to include prevention and wellness. The Collaborative supports clinic-to-community partnerships that include the medical and social supports necessary to enhance health, with the PCMH serving as the patient's primary "hub" and coordinator of health care delivery. However, health and social service systems often have separate and distinct financing streams, delivery systems, professional training programs, eligibility rules, and terminology, according to AHRQ²².

These divisions further complicate the ability of primary care clinicians to manage the full range of services used by patients with complex care needs. Depending on their income and level of disability, these patients may or may not be eligible for Medicaid and other programs for the aged and disabled, which can provide services not covered by Medicare or traditional private insurance. A variety of community-based organizations, such as Area Agencies on Aging (AAAs) and community mental health programs, may provide access to needed resources for some patients with complex needs. Depending on the covered benefits and reimbursement policies of State Medicaid programs, including those provided through waivers, other services may be available to some patients. The fact that these support services are "siloed" by payer substantially increases the administrative burden on the practice that is trying to determine which patients are eligible for these services. This complexity challenges not only the primary care clinicians' ability to determine patient eligibility for services, but also the agencies' ability to interact effectively and efficiently with primary care clinicians.

The goals of a high-functioning PCMH include collaborating with these various "medical neighbors" and community and social supports. As the coordinator of care, PCMHs can direct the flow of information across and between clinicians and patients, to include specialists, hospitals, home health, long term care, and other clinical providers. In addition, PCMHs can link to non-clinical partners like community centers, faith-based organizations, schools, employers, public health agencies, YMCAs, and even Meals on Wheels. Working together, these organizations can actively promote care coordination, fitness, healthy behaviors, proper nutrition, as well as healthy environments and workplaces. To fully realize these goals requires a significant change in culture – by clinicians, patients, and communities – as all members of the care team will be challenged to assume new roles, responsibilities, and improved communication. We encourage the Committee to support the health and social needs of people living with chronic illness by developing and supporting linkages between health and social services across local, state, and national programs.

3. SUPPORT PATIENT AND FAMILY ENGAGEMENT

We encourage the Committee to support incentives for patient and family engagement, to include quality improvement efforts. Considerable effort is occurring to engage patients at the level of direct care, for example, by promoting shared decision-making, patient self-management of chronic illness, advanced care planning, and use of electronic health record patient portals. Maintaining independence and patient involvement in self-care is an important element in the care of complex-needs patients, as is including as core members of the care team the families of frail elders, patients at the end of life, and individuals with disabilities²³. We strongly support these efforts and encourage policies that further promote their development. Less progress has been made in engaging patients at other levels. Consumers are interested and beginning to demand more transparency about cost and quality, convenience and access, and new ways to engage providers outside of traditional office visits, such as telehealth, especially those in rural communities. Transparency and convenience is increasingly important for

Medicare beneficiaries with chronic conditions who must balance cost (out-of-pocket), quality, and convenience factors as they manage their illness. Few primary care practices have established patient advisory councils that involve patients as partners in working with clinicians and staff on practice improvement programs. Engaging and educating the public is critical to engaging those with chronic illness in their own care, and that of their community. The Committee can support patient and family engagement by expanding on current CMS efforts to make Medicare cost and quality information transparent to beneficiaries in both Medicare and Medicare Advantage plans; develop standards, certification, and incentives for shared-decision making for patients and practices, especially for chronic illnesses with strong evidence-based treatment guidelines (such as back pain, coronary artery disease, breast cancer, knee osteoarthritis); support reimbursement for advanced care planning discussions between clinicians, patients, and their families; incentivize providers to support strategies that increase adherence to medication regimens; and promote the use of Patient and Family Advisory Councils within Medicare.

4. SUPPORT INTERPROFESSIONAL TEAM BASED TRAINING

A team-based interprofessional workforce is critical to ensuring timely appropriate access to care and is a hallmark of the PCMH. Few health professionals working in isolation can meet the comprehensive needs of their community without a trusted team that includes patients and their family or caregivers. This is especially the case for those with chronic conditions who often suffer from depression or other behavioral health issues. Medication management is also a challenge given the need for multiple prescriptions that may change over time. Team-based care consists of several elements. One aspect is incorporating members with different skills into the medical home, such as health coaches, pharmacists, and behavioral health professionals. Another component is supporting every team member to be able to practice at the top of their license and skills. A final element is promoting teamwork, so that all members understand each other's roles and responsibilities and have regular communication regarding patient care goals with mutual accountability toward a shared care plan developed in partnership with the patient and their family or caregiver. As health care strives to realize the full potential of the PCMH and ensure access to care for all, we recognize the need to redesign clinical practice training around such principles as team-based care, improved compassionate partnerships with patients and families, and coordination of care across the medical neighborhood and community. Preparing future health professionals and the health workforce at-large to be skilled in related competencies and who can work effectively in interprofessional teams is vital for moving that redesign forward.

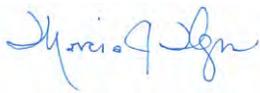
Most primary care clinicians have not received any formal training on quality improvement and practice redesign. For a primary care PCMH to perform optimally, providers must learn strategies to expand the care team to professionals who have typically not worked in primary care practices like behavioral health specialists, peer supporters, care coordinators, and health coaches. These strategies are particularly important when coordinating the care of individuals with chronic disease across the health care continuum. Health care providers must learn new ways to engage patients in their own care and identify and anticipate the needs of groups of patients, especially those who are at risk for hospitalization. There is also a need to expand interdisciplinary training programs working to train the incoming workforce on providing team-based care in the PCMH. We encourage the Committee to support interprofessional team-based health professions workforce training opportunities within Medicare, especially as it pertains to the needs of those with chronic illness. In addition, we encourage your support of the CMS Transforming Clinical Practices Initiative (TCPI) which will use lessons learned from both public and private primary care transformation efforts to offer a curriculum that will guide practices – especially small

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and medium sized ones -- on how the processes, culture change and leadership changes necessary to become a PCMH.

We appreciate this opportunity to share our recommendations regarding the needs of those with chronic illness. The PCPCC has played a leading and instrumental role as an educator/advocate, a convener, and a disseminator of information regarding advanced primary care and the medical home. We applaud the leadership of the Senate Finance Committee and believe that in addressing these four priority areas, we can realign and better engage advanced primary care as the solution for improving quality, health outcomes and lowering costs.

Sincerely,



Marci Nielsen, PhD, MPH
Chief Executive Officer
Patient-Centered Primary Care Collaborative

¹ Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services (2012) Coordinating Care for Adults With Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions. January. AHRQ Publication No. 12-0010

² Wagner's Chronic Care Model:

http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2

³ Primary Care and PCMH Innovations map <https://www.pcpcc.org/initiatives>

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