January 26, 2016

The Honorable Orrin Hatch
Chairman
Committee on Finance
United States Senate

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate

The Honorable Johnny Isakson
Committee on Finance
United States Senate

The Honorable Mark Warner
Committee on Finance
United States Senate

Dear Chairman Hatch, Ranking Member Wyden, Senators Isakson and Warner:

Thank you for releasing the Bipartisan Chronic Care Working Group Policy Options Document in December 2015. The Direct Primary Care Coalition represents physicians across America practicing high functioning, personal primary care. We share the committee's goals of increasing care coordination among individual providers across care settings; streamlining Medicare's payment systems to incentivize the appropriate level of care for beneficiaries living with chronic diseases; facilitating the delivery of high quality care, improving care transitions, and producing stronger patient outcomes in an overall effort that will reduce the growth in Medicare spending. In our comments, we will offer our thoughts on how CMS could improve care coordination in Medicare by giving each chronically ill beneficiary unrestrained access to a personal primary care physician (PCP) leading a team of professional care coordinators to getting a handle on the rapid spread of preventable chronic disease.

Direct Primary Care (DPC) is an innovative alternative payment model (APM) offering a membership-based payment model for primary care services in a medical home setting. DPC completely eliminates fee-for-service (FFS) payments in primary care, along with the undesired incentives that distort healthcare decision-making by rewarding volume over value. Patients and providers have a direct agreement that outlines the services covered by the practice, as well as the rights and responsibilities of the patient in the relationship. A flat fee, on average about $70 per month, is charged for primary care services. There is no additional billing to insurers for any services outlined in the direct agreement. Although some practices charge a small per-visit fee as a part of their agreement, there are no deductibles or co-pays.

Individuals, employers, insurers and other payers may pay DPC membership fees, but the direct agreements are typically between the doctor and patient regardless of who pays the fee. DPC agreements cover preventive and routine services like checkups, urgent care and chronic care management. Insurance still covers hospitalization and more expensive specialty care, but with appropriate access to primary care, utilization of insurance-covered services is significantly reduced. Since patients maintain a personal relationship with their physician, the DPC medical home is where they go for their healthcare needs—not the ER. In DPC we find that Primary care, operating as it should, can address up to 90% of a patient's healthcare needs. DPC benefits are currently being offered with Medicare Advantage (MA) and Medicaid managed care plans—but they are not permitted in FFS Medicare, which forces many PCPs practicing DPC to opt out of the Medicare program altogether.

DPC Medical Homes are among the most high-functioning value-based primary care models today. The American Academy of Family Physicians (AAFP) says "Direct primary care benefits patients by providing substantial savings and a greater degree of access to, and time with, physicians… while reducing the overhead and negative incentives associated with fee-for-service, third-party-payer billing." AAFP also correctly points out that "Direct primary care and concierge care are not synonymous. In practices offering concierge care, the patient typically pays a high retainer fee in addition to insurance premiums and other plan obligations (e.g., copays, out-of-pocket expenditures), and the practice continues to bill the patient's insurance carrier." DPC physicians have appropriately sized patient panels and patients spend more time with their personal physician—but not necessarily in the doctor's office. Patients communicate regularly with providers using appropriate technology platforms such as phone, secure text, email and Internet patient portals. The doctor-patient relationship is restored and empowered, enabling providers to resist the financial incentives that distort decision-making in FFS primary care.

State and Federal Law

Now operating in as many as 46 states and the District of Columbia, DPC practices around the country are improving healthcare while dramatically reducing costs for patients, families, businesses and governments. DPC has been defined in at least 13 state laws, and in Sec. 1301 (a) (3) of the Affordable Care Act (ACA) on the Treatment of Direct Primary Care Medical Homes.

The Primary Care Enhancement Act

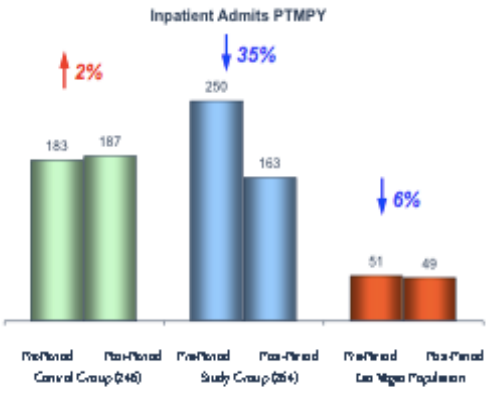
Senators Bill Cassidy (R-LA) and Maria Cantwell (D-WA) have introduced S. 1989, the Primary Care Enhancement Act, a bipartisan bill which proposes a Medicare demonstration in DPC resembling an Accountable Care Organization (ACO) with a revised financing model which emphasizes a flat, per member per month (PMPM) payment for primary care including chronic care management services, care transitions and care coordination. The legislation also clarifies provisions in the tax code with language that has been introduced previously in bills offered by the Chairman and others. ***Our primary ask of the working group is that this legislation be included in the legislative package being developed on chronic care for consideration later this year.***

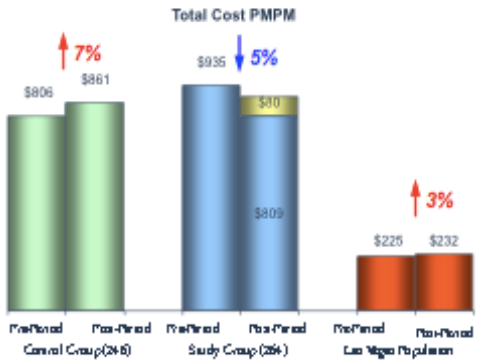
DPC Medical Homes = Improved Health Outcomes

DPC practices working with employers and unions around the country have demonstrated improved health outcomes and savings between 12 – 20 percent of the overall cost of care. The tables below illustrate this data from two of our members, Qliance, based in Seattle, and Iora Health, based in Boston. Iora is working with MA plans offered in 5 states by Humana and Tufts Health Plan. Qliance has a similar model working in Medicaid managed care with Coordinated Care, a Centene health plan. Both companies offer options for DPC in the exchanges.

	Per 1,000 Qliance patients	Per 1,000 Non-Qliance patients	Difference (Qliance vs. Other)	Annual Savings per patient
Hospital Inpatient days	100	250	-60%	$417
Specialist Visits	7,497	8,674	-14%	$436
Advanced Radiology	310	434	-29%	$82
Primary Care Visits	3,109	1,965	+58%	($251)
Savings Per Patient	---	---	---	$674
Total Savings per 1000 (after Qliance fees)				$684,000
% Saved Per Patient				20%

Qliance Data Sources*:* 2013 all-claims data (except prescription claims) from carriers for selected large employers; Qliance EMR data; Employer eligibility data. ***Claims Attribution:*** All claims incurred by Qliance patients prior to first Qliance visit were excluded; All employees with any interaction with Qliance included as our patients, even if the employee used another primary care provider (which is possible in some of the plan designs among clients); All claims incurred after any interaction with Qliance included, regardless of employee's intent to use Qliance as their primary care provider; All non-primary care provider visits included under "specialist" category (such as physical therapy, acupuncture, etc.) ***Population:*** Eligible members in employer-sponsored health plan; Employees only, to remove confounding factors from differences in dependent benefits structures and participation variances among clients.





Iora Health Data Summary: 2014 claims data from employers. Iora value based payment model doubles the typical 5% spend on primary care, plus an increasing up and downside share of savings on total spending. 4 to 4.5 star MA quality measures in less than a year + Net promoter scores above 90% Commercial practices show 37% drops in hospital admissions demonstrating a **12% drop in net total spend** relative to well-matched controls with equivalently sick populations v. MA. Iora operates 11 MA practices in 5 markets; with a total of 29 practices, 11 markets in 10 states.

Team Based Care

We applaud the Committee for making the move to team based care a priority for Medicare. DPC medical homes often work in a team-based environment with primary care physicians (PCPs) leading teams of nurse care coordinators, health coaches, dieticians, diabetes educators and other appropriate professionals. Examples are working well today in MA and Medicaid.

CMS Center for Innovation (CMMI) data shows high-functioning APMs improve care for individuals with multiple chronic conditions using care teams led by PCPs. Teams are assigned to a set number of beneficiaries with chronic conditions to coordinate care and provide care transitions. While the teams in these models are usually salaried, the PCPs operate in FFS as an ACO or Patient-Centered Medical Home providing bonus payments or shared savings on top of existing payments. It is expensive and complicated to administer; physicians and patients continue to struggle with the value equation of these models. In DPC, outside FFS, PCPs are far less concerned with the business of getting paid for their services and more attentive to patients. This often results in administrative staff being repurposed to help coordinate patient care—a far more rewarding career prospect than billing and coding. Existing quality measures typically used for ACOs are far better clinical indicators than detailed claims data in primary care and would negate much of the need for existing coding. There would be no co-pays or visit fees for the patient. Since there is no fee-for-service billing, there will be a significant administrative savings benefit over similar programs in Part B.

Few existing CMMI programs have shown substantial savings; however, a January 2015 RTI International Evaluation of the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration (P.224) showed that the program implemented in Vermont "Achieved a statistically significant reduction in total Medicare expenditures to generate a net savings of $9,241,486" in the first year equaling a return on Medicare's investment of $5.50 for every $1 invested. This program is very similar to DPC in that all team members are paid on a flat PMPM payment model—except for the PCPs. This evaluation indicates that there is a potential 5 to 1 return on investment for Medicare if such a program were scaled nationwide. We believe that advanced primary care programs would operate more efficiently if, in addition to care teams being paid in a salaried PMPM payment, the PCPs were also in a DPC payment model. Operating completely outside the normal claims driven environment, without the administrative burdens imposed by FFS, primary care would be able to operate at maximum efficiency and extend that ROI even further.

Technology and Telehealth

We are very pleased that the options paper highlights policies that would expand the reach of innovative technology and telehealth services. There is little doubt that the robust use of information technology and telehealth can help improve care coordination among providers in multiple care settings. DPC is a great incubator for the use of technology. One important outcome from an arrangement with a DPC medical home is that technology has enabled physicians to evolve from the "doctor visit" being the primary construct of the relationship between the PCP and the patient. In DPC, the physician is paid a flat fee to have a relationship with a patient—regardless of how many times the patient visits or how many procedures the office can code. Technology is therefore put to its best use case. Patient portals, telehealth,

patient health records (PHRs) and electronic health records (EHRs) are no longer used just to help physicians get paid; they are tools to help practice and patient coordinate care. Physicians encourage telehealth visits using patient-friendly web portals, secure text, email or phone for scheduling, routine questions, prescription refills and lab results— regular communications— leaving visits for diagnosis of more complicated conditions or to provide hands-on treatment. This helps work flow and makes the delivery of care and communication with the practice much more routine. As the options paper points out, Medicare beneficiaries currently receive telehealth services in a variety of settings. The historical impediment to using such patient-centered technology has been that physicians are not paid to use it without billing for a visit. The addition of CPT codes for care coordination and telehealth services has helped, but doesn't create a true use case for technology. While the codes help innovate around payment issues, they do little to push the envelope on innovation with the technology itself or its implementation in the field.

By taking the payment rationale away from the use of technology, doctors and care teams practicing DPC have innovated around how the technology is used within the limits of current privacy and licensure laws. And they have; remote monitoring imaging and use of telehealth is routine in DPC. Perhaps the greatest impediment to expanding telehealth services is the restriction on the use of these vital technologies across state lines due to licensure issues. Several pieces of legislation have been introduced that would allow Medicare to preempt some of these requirements so that patients and doctors can use health IT to communicate about chronic conditions in any setting regardless of where they are located. ***Legislation such as S. 1778, The TELE-MED Act, which permits Medicare providers licensed in a State to provide telehealth services to Medicare beneficiaries in other States should also be included in the package of reforms which the committee moves forward in the legislative process.***

Improving Quality for Medicare

The shift to high functioning value-based models like DPC, aided and driven by increased adoption of health IT, has helped reduce medical errors and improve quality. The use of IT will also help measure quality and use data to create a dynamic learning environment, which will allow Medicare to constantly re-evaluate what quality means, based in real time. We support the working group's recommendation requiring CMS to include measures that focus on the health outcomes of individuals with chronic disease. We also support the Working Group's recommending a GAO report on community-level measures on chronic care management to facilitate evaluation. We also encourage that a special emphasis be placed on identifying and facilitating the development of measures that capture health outcomes for people with multiple chronic conditions.

Sincerely,

Jay Keese,
Executive Director,
Direct Primary Care Coalition