Patient-Centered
Primary Care
COLLABORATIVE

January 26, 2016

The Honorable Orrin Hatch
Chairman, Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member, Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Johnny Isakson
131 Russell Senate Office Building
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 membership organization representing health care providers, patients and their families/caregivers, payers, employers and purchasers - we write in response to the Finance Committee's *Bipartisan Chronic Care Working Group Policy Options Document*, and your request for stakeholder feedback.

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 Model[1] 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 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 care initiatives on our Primary Care Innovations and PCMH Map. [2]

As we mentioned in our earlier letter to the Finance Committee's chronic care working group, 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."[3] 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.

We appreciate the bipartisan chronic care working group's leadership on this critical issue and commend its formation, which is tasked with developing innovative legislative solutions to advance chronic care reform in the Medicare program. As a multi-stakeholder organization, we provide our recommendations on several of the policy options included in your paper.

Policy under consideration: Addressing the need for behavioral health among chronically ill beneficiaries

> ***The working group is considering developing policies that improve the integration of care for individuals with a chronic disease combined with a behavioral health disorder. Policies would encourage care integration whether the beneficiary elects enrollment in traditional Medicare FFS, a Medicare FFS Alternative Payment Model, or a MA plan.***
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> - ***The working group is soliciting specific policy proposals to meet the goals stated above.***
> - ***The chronic care working group is also considering a recommendation that the Government Accountability Office (GAO) conduct a study on the current status of the integration of behavioral health and primary care among private sector Accountable Care Organizations (ACOs), public sector ACOs, and ACOs participating in the Medicare Shared Savings Program (MSSP), as well as private and public sector medical homes.***

The PCPCC strongly supports behavioral health integration (BHI) in which care is delivered by a practice team of primary care and behavioral health clinicians working together with patients, their families and caregivers. We are pleased that the chronic care working group is soliciting stakeholder input and reviewing policy proposals specific to improving the integration of care for individuals with a chronic disease combined with a behavioral health disorder.

A significant number of Medicare beneficiaries suffer from mental or behavioral health disorders (26%), such as Alzheimer's disease. For those under age 65 and eligible for Medicare because of their disability, 37% suffer from severe mental illness, such as bi-polar disorder or schizophrenia. More than half of all those who are dually eligible for Medicare and Medicaid have mental or cognitive impairments.[4] Co-morbidity for those having both

behavioral health and physical health disorders is the rule, rather than the exception with more than 68 percent of adults with a mental disorder having at least one medical condition.[5]

Properly addressing these needs requires robust care management services including extensive discussion, planning, and information-sharing between a primary care clinician and behavioral health specialists. As we voiced in our comments on the proposed CMS rule for the CY2016 Medicare Physician Fee Schedule, adding more CPT codes within the fee-for-service (FFS) payment structure perpetuates volume-based fragmentation and administrative burden on practices trying to integrate behavioral health into primary care. Ideally, we advocate a longer term solution that moves toward risk-adjusted comprehensive primary care payment with the goal of integrating behavioral health and medical services to enhance patient outcomes, as supported by scientific evidence.

As the working group reviews these proposed policy options, we ask that you consider two additional aspects of the policy's implementation: 1) the feasibility of each policy's implementation for practices with limited resources; and 2) how easily the policy can be scaled and spread depending on patient panel size, patient population health needs, and workforce capacity in various geographic regions.

The PCPCC also supports the working group's proposal to recommend that the Government Accountability Office (GAO) conduct a study on the current status of the integration of behavioral health and primary care among private sector accountable care organizations (ACOs), public sector ACOs, and ACOs participating in the Medicare Shared Savings Program (MSSP), as well as private and public sector medical homes. While there is a growing evidence base that associates models of behavioral health integration with reductions in health care costs and utilization, as well as improved quality of care, more research is needed to scale and spread these innovations in care delivery.[6,7] A GAO study assessing the current status of the integration of behavioral health services in primary care will not only help to identify where these activities are taking place, but also identify some of the best practices that will advance and promote further adoption of behavioral health integration in public and private sector ACOs and medical homes.

Policy Under Consideration: Ensuring Accurate Payment for Chronically Ill Individuals

> ***The chronic care working group is considering making changes to the CMS- HCC Risk Adjustment Model. Specifically these changes to the CMS-HCC Model would take into account the following:***
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> - ***Any changes in predicted costs associated with the total number of conditions of an individual beneficiary, including any cumulative impact of a large number of conditions;***
> - ***Any changes in predicted costs associated with the interaction between behavioral/mental health conditions with physical health conditions;***
> - ***The differences in costs associated with beneficiaries who are dually eligible for both Medicare and Medicaid through different eligibility pathways; and***

- ***The use of more than one year of data to establish a beneficiary's risk score.***

The chronic care working group is also considering a study to examine whether the use of functional status, as measured by activities of daily living or by other means, would improve the accuracy of risk-adjustment payments. The study could also examine the challenges in providing and reporting functional status information by MA plans, providers and/or by the CMS.

- ***The working group is soliciting feedback on what other potential changes to the HCC model should be considered.***
- ***The working group is also soliciting feedback on which changes, if any, should be differentially applied to CMS payment models, such as Medicare Advantage or Accountable Care Organizations.***

As ACOs and other value-based risk arrangements increasingly hold primary care practices financially accountable for the health of a given population, there are several key challenges for primary care practices, to include adequate payment, HIT capacity and interoperability, real-time access to data, financial sustainability, and appropriate risk-adjustment. We strongly support the working group's proposal to strengthen the current risk adjustment methods used to ensure that providers and plans are fairly paid for the costs they incur for providing care to chronically ill individuals.

Given the variability by practice, properly addressing the needs of chronically ill individuals requires enhanced reimbursement for critically important services in order to best serve these patients' needs. The PCPCC supports risk-adjustment that includes non-medical factors, especially those that have a significant impact on health outcomes (i.e. demographic and health history of those who actually enroll in the plan, severity of a beneficiary's illness and the accumulated effect of multiple diseases, as well as interactive effects). The PCPCC asks the working group to also consider adjustments based on location and adequacy of primary care services available in the local community (i.e. rural practices may need additional enhancements related to co-management with providers outside their community).

We support the working group's consideration of a study to examine whether the inclusion of functional status will increase the accuracy of the risk-adjustment payment. Patient-reported outcomes, like functional status can be essential components of assessing health care quality and value-based payments. The PCPCC supports the working group's consideration of the feasibility and use of functional status as part of the risk-adjustment payment.

Policy Under Consideration: Developing Quality Measures for Chronic Conditions

The chronic care working group is considering requiring that Centers for Medicare & Medicaid Services (CMS) include in its quality measures plan the development of measures that focus on the health care outcomes for individuals with chronic disease. Topic areas related to chronic conditions that the working group is specifically considering include:

- ***Patient and family engagement, including person-centered communication, care planning, and patient-reported measures;***
- ***Shared decision-making;***

- ***Care coordination, including care transitions and shared accountability within a care team;***
- ***Hospice and end-of-life care, including the process of eliciting and documenting individuals' goals, preferences, and values, quality of life, receipt of appropriate level of care, and family/caregiver experience of care;***
- ***Alzheimer's and dementia, including measures for family caregivers, outcomes, affordability, and engagement with the healthcare system or other community support systems;***
- ***Community-level measures, in areas such as obesity, diabetes and smoking prevalence.***

The working group is also considering recommending that Government Accountability Office (GAO) conduct a report on community-level measures as they relate to chronic care management. The report would discuss appropriate measures in this domain and provide recommendations for holding providers accountable to community-level measures, linking provider payment to these measures, and encouraging the use of these measures.

The PCPCC is encouraged by the working group's dedication to advancing patient-centered quality measures, and we agree with your assessment that the current quality measurement landscape does not sufficiently measure quality of care, particularly measures related to patient and family/caregiver engagement, patient experience, and community level measures of care.

Currently, considerable effort is underway to engage patients at the level of direct care. We strongly support measures that promote shared decision-making, patient self-management of chronic illness, advanced care planning, compassionate end-of-life care for patients and for family/caregivers, care coordination, and other measures of health that have meaning to patients (focused on function, wellness, and overall health status). We encourage policies that further promote and align measurement development and implementation, in partnership with patients and families.

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 for those in rural or underserved communities) and mobile technologies (that appeal to those who are interested in self-management and/or wellness). Transparency and convenience are increasingly important for Medicare beneficiaries with chronic conditions who must balance factors of cost (out-of-pocket), quality, and convenience. Additional measures that assess and measure these consumer and/or patient engagement measures are needed.

The goals of a high-functioning PCMH include collaborating with community and social supports to support the health and social needs of people living with chronic illness. 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 those, like Meals on Wheels, who provide nutrition and social support to those who are homebound. Working together, these organizations can actively promote care coordination, fitness, healthy behaviors, proper nutrition, chronic disease management, and peer support. Emerging data demonstrate that community-level engagement can promote improved patient outcomes.[8] However, community-level measures of health are limited, thus more study and evaluation is necessary in order to scale and spread and ensure appropriate payment of services.

Although there is a need for additional measurement development in many of these areas, standardization and alignment of performance measures is becoming increasingly valuable to providers. Under the current fractured payment system, primary care practices submit claims to many different health plans and payers, and they express growing concern about new and differing requirements across payers that create confusion, financial risk, and administrative burden on their care teams.[9] In a recent survey of family physicians, most reported submitting claims to seven or more payers (71 percent), with nearly four in 10 physicians currently submitting claims to more than 10 different payers (38 percent).[10] The overwhelming majority viewed lack of staff time as a barrier to implementing value-based care delivery (91 percent). Most agreed that the absence of coordinated data and metrics were barriers, with 75 percent citing a lack of uniform reports from payers, 75 percent mentioning lack of standardization of performance measures and metrics, and 63 percent reporting that the absence of timely data impacted their ability to improve care and reduce costs.[10]

We are pleased that the chronic care working group acknowledges the potential for these services to be tied to payment reform, and we support the working group's proposal for the GAO to conduct a report on community-level measures as they relate to chronic care management.

Policy Under Consideration: Encouraging Beneficiary Use of Chronic Care Management Services

> ***The chronic care working group is considering waiving the beneficiary co-payment associated with the current chronic care management code as well as the proposed high severity chronic care code described above.***
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> - ***The working group is soliciting input on the extent that waiving cost sharing would incentivize beneficiaries to receive these services, especially considering that many Medicare beneficiaries have supplemental Medigap policies or elect employer retiree coverage that provides supplemental coverage.***
> - ***The working group is soliciting feedback as to whether waiving cost sharing addresses the concern that beneficiaries may question CCM services that appear on summary of benefit notices because they do not involve a face-to-face physician encounter.***

The PCPCC is pleased to see that the chronic care working group is considering policy options that would waive the beneficiary co-payment associated with the current chronic care management code, as well as the proposed high severity chronic care code. Medicare

beneficiaries, especially those who are dually eligible or of limited means, should not be held financially responsible for care coordination activities. Care coordination is a core attribute of the PCMH model of care, but unfortunately the fee-for-service payment system often fails to adequately compensate providers who provide these services.

Currently, the majority of revenues received by primary care practices are in the form of fee-for-service payments. In most cases, the payment models designed to support PCMH-level care maintain fee-for-service as a central feature and supplement those payments with additional fixed per beneficiary per month (PBPM/PMPM) payments. Unfortunately, the revenues generated by the typical primary care practice are not sufficient or predictable enough to sustainably cover these costs. This is especially so for smaller practices who have little "reserve capacity" or flexibility to devote to new complex-need patients in need of care management. Moreover, current FFS payment models, even when coupled with modest PBPM payments, do not provide full compensation for the complete scope of services that are not paid for at all or are poorly compensated in primary care. These are critical clinical interventions that occur outside of a patient office visit and are an integral part of patient-centered primary care. For example, following up with a patient after a visit to ensure they filled their prescription and understand the dosage instructions may be covered under the CCM code, while paying for a consult with the clinical pharmacist or behavioral health specialist may not.

The PCPCC concedes that the chronic care management (CCM) code can be a short-term solution for some practices seeking reimbursement for these important services. However, health care providers continue to raise concerns about the number of administrative hurdles associated with the current fee-for-service payment system. Moreover, patients should be encouraged – not financially penalized – to use these services. Accordingly, the PCPCC supports elimination of cost-sharing for care management services.

Eliminating Barriers to Care Coordination under Accountable Care Organizations

> ***The chronic care working group is considering allowing ACOs in two-sided risk models to waive beneficiary cost sharing, such as co-payments, for items/services that treat a chronic condition or prevent the progression of a chronic disease.***
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> - ***The working group is soliciting feedback on whether the items/services eligible for reduction should be defined through rulemaking or be left to the discretion of the ACO.***
> - ***The working group is also soliciting feedback on the type of cost sharing that could be waived, such as copays, coinsurance, or deductibles.***
> - ***The working group is requesting input on the extent that waiving cost sharing would incentivize beneficiaries to receive these services, especially considering that many Medicare beneficiaries have supplemental Medigap policies or elect employer retiree coverage that provide supplemental coverage.***

The PCPCC also supports the working group's consideration of promoting policies that allow ACOs in two-sided risk models to waive beneficiary cost sharing, such as co-payments, for items/services that treat a chronic condition or prevent the progression of a chronic disease.

ACOs require a strong primary care strategy in order to sustain their goals for population health improvement and lower total cost of care. ACOs typically provide more primary care services (low cost care) and less acute care services (high cost care) in hospitals and other more resource intensive settings.[11] Moreover, when advanced primary care practices/PCMHs are aligned with the broader medical neighborhood and/or community supports (through ACOs or other value-based contracting arrangements, to include virtual arrangements), they too are better positioned to improve health outcomes, achieve shared savings, reduced administrative burden, and importantly improve patient care and satisfaction. With more than 750 ACOs currently in operation[12] and over 500 PCMH initiatives across the US,[13] these expanding delivery reforms work as a two-pronged strategy for health system reform that creates opportunities for innovation and can demonstrate impressive results.

Given this potential to improve patients' overall health care experience, enhance self-management of chronic illness, promote better health outcomes as well as improve patient access to care and preventive services, the PCPCC advocates for policies that minimize patient barriers to access, to include waiving co-payments and cost-sharing for primary care services within two-sided risk model ACOs.

Again, we commend the bipartisan chronic care working group's leadership on development of innovative legislative solutions to advance chronic care reform in the Medicare program, and we appreciate this opportunity to share our recommendations. If the PCPCC can be of service to you in these efforts, or if you need additional information, please do not hesitate to contact me.

Sincerely,

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1 Wagner's Chronic Care Model: http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2

2 Primary Care and PCMH Innovations map https://www.pcpcc.org/initiatives

3 Institute of Medicine (2012): Living Well with Chronic Illness: Public Health Action to Reduce Disability and Improve Functioning and Quality of Life.

4 Center for Medicare Advocacy. (2015). Medicare and mental health. Retrieved from: http://www.medicareadvocacy.org/medicare-and-mental-health/

[5] Druss, B.G., Reisinger Walker, E. (2011). Mental disorders and medical comorbidity. The Robert Wood Johnson Foundation. ISSN 2155-3718 Retrieved from: http://www.rwjf.org/en/library/research/2011/02/mental-disorders-and-medical-comorbidity.html

[6] Archer, J., Bower, P., Gilbody, S., Lovell, K., Richards, D., Gask, L., Dickens, C. & Coventry, P. (2012). Collaborative care for depression and anxiety problems. Cochrane Database Systems Review. 17;10:CD006525. doi: 10.1002/14651858.CD006525.pub2.

[7] Woltman et al, AJP, 2012: 169:790-784

[8] Vojta, D., Koehler, T.B., Longjohn, M., Lever, J.A., Caputo, N.F. (2013). A coordinated national model for Diabetes prevention. *American Journal of Preventive Medicine*. 44(4). Doi: http://dx.doi.org/10.1016/j.amepre.2012.12.018

[9] McGinnis, T. & Newman, J. (2014). Advances in multi-payer alignment: state approaches to aligning performance metrics across public and private payers. The Milbank Memorial Fund. Retrieved from: http://www.milbank.org/uploads/documents/MultiPayerHealthCare_WhitePaper_071014.pdf

[10] American Academy of Family Physicians. (2015). Data brief: 2015 value-based payment study. Retrieved from: http://www.aafp.org/dam/AAFP/documents/news/Data%20Brief-2015_Value%20Based_Payment.pdf

[11] McClellan, M.B., Mostashari, F., Colbert, J., Kocot, S.L., Brenner, R., Seidman, J., Monterastelli, M, & White, R. (2014). Adopting Accountable Care: An Implementation Guide for Physician Practices. The Brookings Institution. Retrieved from: http://www.brookings.edu/research/papers/2014/11/19-accountable-care-toolkit-physician-aco#recent_rr/

[12] Houston R, McGinnis T (2016). ACOs: Looking Back and Moving Forward. Center for Health Care Strategies. Retrieved from: http://www.chcs.org/resource/accountable-care-organizations-looking-back-moving-forward/

[13] Primary Care and PCMH Innovations map https://www.pcpcc.org/initiatives