CAFP
Colorado Academy of Family physicians

Monday, September 14, 2015

Bill Lindsay
Chair
Colorado Commission on Affordable Health Care

Dear Mr. Lindsay:

The Colorado Academy of Family Physicians (CAFP) is pleased to submit these comments to inform the work of the Colorado Commission on Affordable Health Care (Commission). CAFP represents 2,200 family physicians in the state. Recognizing the value of primary care, we strongly encourage the Commission to consider solutions that expand access to and the use of primary care for all Coloradans.

1. What do you think are the fundamental cost drivers and why?
    a. A 2012 report by the Bipartisan Policy Center, funded in part by the Robert Wood Johnson Foundation, analyzed some 13 health care cost drivers, many of which are likewise being considered by the Commission. Among its findings on what drives costs: a fee-for-service (FFS) payment system; a delivery system that emphasizes fragmented and specialized care rather than coordinated and preventive primary care; administrative burdens on providers, patients and payers; and high ratios of specialty physicians. It acknowledges that "drivers of health care costs are complex and multi-faceted."[1]

2. What are the barriers to reducing cost?
    a. Payment methodologies that hinder the start-up and sustainability of Patient-Centered Medical Homes (PCMH) present a significant barrier to reducing cost. In particular, FFS is an outdated payment system that incentivizes higher cost care. We need to drive consensus around payment models that support coordinated, team-based care, and we need to advance them more quickly. Blended payment models that employ per member per month (PMPM) payments can be appropriate models. We should ensure those payments cover care management activities in the context of a PCMH. Core activities that must be covered by this PMPM are:
        i. Non-physician staff time dedicated to care management
        ii. Patient education
        iii. Use of advanced technology to support care management
        iv. Physician time dedicated to care management
        v. Medication management
        vi. Population risk stratification and management
        vii. Integrated, coordinated care across the health care system

[1] What is Driving U.S. Health Spending? (2012)
http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf401339

You can access a complete description of these activities at http://www.aafp.org/about/policies/all/care-management.html

3. Can you list up to three things that you are doing to address cost that are unique?
    a. One emerging payment and delivery model is Direct Primary Care (DPC). Several practices in Colorado have begun working under this model, along with many more around the country. While the Affordable Care Act sought to emphasize preventive and other types of primary care, rising deductibles mean consumers have greater difficulty accessing those benefits that will keep them healthy. They pay for these services in their premiums, but often have no coverage until they have spent several thousand dollars.

       Under DPC, a practice collects a monthly fee from or on behalf of its patients. In return, the practice offers patients all their needed primary care services through email, on the phone or in the office, without any additional costs like copays or coinsurance. Commercial payers, including self-insured employers, are all candidates for coordinating with a DPC practice. This model streamlines administration for primary care physicians and enables patients to receive primary care without having to meet increasingly steep deductibles.

       Qliance, based in Washington, has successfully implemented DPC, including for Medicaid patients. A January 2015 study demonstrated DPC at Qliance saved 20% on claims due largely to reduced ER visits, specialist visits and hospitalizations.[2] DPC should still be offered in the context of a PCMH. A full description of DPC and specifically the Qliance model was described in a 2010 Health Affairs article titled *A Direct Primary Care Medical Home: The Qliance Experiment*: http://content.healthaffairs.org/content/29/5/959.full.

4. Is there any supporting data that demonstrates a reduction in cost?
    a. More comprehensive primary care is associated with lower costs and fewer hospitalizations.[3] The Colorado Multi-Payer PCMH Pilot demonstrated significant improvements to care and patient satisfaction, while Anthem realized a 14% reduction in costs.[4] The Patient-Centered Primary Care Collaborative comes out with an annual review of the literature on PCMHs and has found the model to be highly effective as the backbone of health care systems. The evidence base is growing regarding PCMHs and associated reductions in cost and inefficient

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[2] Qliance Study shows Monthly Fee Primary Care Saves 20 Percent on Claims http://stateofreform.com/news/industry/healthcare-providers/2015/01/qliance-study-shows-monthly-fee-primary-care-model-saves-20-percent-claims/

[3] Bazemore, A., Petterson, S., Peterson, L., & Phillips, R. (2015). More Comprehensive Care Among Family Physicians is Associated with Lower Costs and Fewer Hospitalizations. *The Annals of Family Medicine,* 206-213.

[4] Patient-Centered Primary Care Collaborative. https://www.pcpcc.org/initiative/colorado-multi-payer-patient-centered-medical-home-pilot

utilization.[5] In regards to DPC, some early evidence, particularly for Qliance, also shows reduced costs (see footnote 2).

5. What are the principal barriers to transparency?
    a. Several of our Colorado mountain communities now have the highest health insurance premiums in the nation. Health insurance premiums are based on the unit costs of providing care in that region. Insurance premiums will continue to rise and outpace inflation so long as medical costs continue to rise. Consumers need more information to make value based purchasing decisions in health care. Transparency in health insurance pricing, and consumer cost sharing, would go a long way to make insurance more accessible, and hopefully more affordable. Consumer confusion drives up the cost of health care because health plans are not easy for patients to understand. This leads to increased time spent by the physician handling insurance questions and issues, procedures that are not covered by the consumers' plans, and ultimately unpaid medical bills.

6. What would you change to make things better related to cost?
    a. Colorado should increase the number of family physicians, in the right places. Having a greater number of family physicians is associated with significant reductions in hospital readmissions and cost savings.[6] A recent report by the Colorado Commission on Family Medicine also offers 14 recommendations to increase training and retention of family physicians in rural and underserved areas.[7] These recommendations should be fully implemented to ensure we have an adequate primary care workforce. That workforce will ensure a delivery system that is centered around primary care can be achieved, along with the Triple Aim.
    b. We must accelerate the transition away from FFS and toward a payment system that fully compensates providers to work in a PCMH and do those activities we know make patients healthier (including supporting coordination and case management services).

Should you have any questions, please feel free to contact Ryan Biehle, CAFP Director of Policy and Government Relations, at Ryan@Coloradoafp.org or 303-696-6655.

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[5] Patient-Centered Primary Care Collaborative https://www.pcpcc.org/resource/patient-centered-medical-homes-impact-cost-and-quality

[6] Robert Graham Center Policy One-Pager. http://www.aafp.org/afp/2011/0501/p1054.html

[7] Family Medicine Education in Colorado http://cofmr.org/wp-content/uploads/2015/02/Report-to-Legislature-SB14-144.pdf