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Thursday, December 10, 2015

Bill Lindsay
Chair
Colorado Commission on Affordable Health Care

Dear Mr. Lindsay:

Please accept these comments on behalf of the Colorado Academy of Family Physicians. We greatly appreciate the extensive work of the Colorado Commission on Affordable Health Care (Commission) regarding payment and delivery reform. While we are generally supportive of the draft recommendations on this topic, we urge the Commission to include several other considerations:

1. **Broaden the draft recommendations to include the commercial market**
   Current draft recommendations are limited solely to public payers and plans covering state employees. However, it is important that all payers move toward a value-oriented payment system. Hence, we urge the Commission to expand the current recommendations to encompass the commercial markets.

2. **Set a state target for system-wide spending on primary care**
   We recommend the Commission set a concrete target for system-wide spending on primary care.

   Consensus exists within the literature on the value of primary care as a linchpin in the effort to achieve the Triple Aim. Numerous studies have shown increased investments in primary care improve quality and outcomes, and reduce costs. Estimates of appropriate spending vary, but an appropriate level could be determined for a Colorado target. Phillips and Bazemore suggest increasing primary care spending to 10-12% of total health care spending would move us toward better health outcomes that are comparable to other countries.[1]

   In 2008, 5.9% of health care dollars spent in Rhode Island by commercial plans were on primary care. After setting a target of 10.9% in 2008, the state has made tremendous progress as primary care spending rose to 9.1% of medical payments in 2012. **During this period primary care spending rose 37% while total medical expenditures declined by 14%.**[2]

   Such a target would not only specify the shift that must take place, but would help catalyze the movement toward integrated care in a Patient-Centered Medical Home (PCMH) setting by providing the appropriate reform incentives. Shifting spending toward primary care would accelerate payment reforms, as has occurred in Rhode Island, where 34% of commercial primary care payments are

[1] Phillips, R.L. and Bazemore, A.W. (2010). Primary Care and Why it Matters for U.S. Health System Reform. *Health Affairs. 29*(5), 806-810. doi: 10.1377/hlthaff.2010.0020
[2] Primary Care Spending in Rhode Island (January 2014). *Office of the Health Insurance Commissioner, Rhode Island.* http://www.ohic.ri.gov/documents/Primary-Care-Spending-generalprimary-care-Jan-2014.pdf

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value-based, up significantly from 2008. In addition, enhanced spending would support a necessary, robust primary care system while increasing incentives to bolster primary care provider supply.

3. **Encourage the availability of Direct Primary Care as delivery model option**
   Direct Primary Care (DPC) is an emerging delivery model that emphasizes primary care as a means to keeping patients healthy and avoiding higher cost care. DPC maintains the principles of the PCMH. Simultaneously, it reduces barriers to high value care that is increasingly out of reach with rising deductibles and other consumer cost sharing. 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. Patients would maintain a traditional insurance plan for specialty and emergency care, though increased access to primary care in many cases reduces the need for these services.

   As Washington State has seen success in extending DPC products to Medicaid clients, we urge the Commission to consider a recommendation to promote DPC as a viable alternative delivery model and to explore DPC through a pilot program in Medicaid.

4. **Increased funding for implementing and sustaining a PCMH**
   Colorado has made great strides expanding the number of patients in a PCMH. However, payment reform has not kept pace to cover the costs and fully realize the benefits of the PCMH model for all patients and clinicians. A recent study identified the costs associated with maintaining a PCMH. It shows minimum costs associated with PCMH activities are $105,000 per clinician FTE. These calculations do not include startup costs for a PCMH, nor do they include the value-added from care provided under a PCMH model.[3] PMPM payments by Medicare in the Comprehensive Primary Care Initiative average $20 per beneficiary. However, the payments are risk stratified and can range up to $40 PMPM.

   We urge the Commission to include a recommendation that PMPM payments be risk adjusted and raised to adequately cover the costs of PCMH activities, and that additional funds be identified to support startup costs for practice transformation.

Once again, thank you for your consideration. Should you have any further questions or comments, please feel free to reach out at any time.

Sincerely,

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[3] Magill, M.K. et al. (2015). The Cost of Sustaining a Patient-Centered Medical Home: Experience From 2 States. *Annals of Family Medicine 13*(5), 429-435. doi: 10.1370/afm.1851