



November 16, 2016

Health Care Payment Learning & Action Network
The MITRE Corporation
7525 Colshire Drive
McLean, VA 22102-7539

Submitted electronically at: <https://hcp-lan.org/pcpm-white-paper-submit-your-comments/>

Re: Primary Care Payment Models Draft White Paper

Dear Primary Care Payment Model Workgroup Members:

We appreciate the opportunity to provide feedback on the Health Care Payment Learning & Action Network's Draft White Paper on Primary Care Payment Models.

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1998, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. The Center for Consumer Engagement in Health Innovation focuses on health system transformation and bringing the consumer experience to the forefront of health. The Center works directly with consumer advocates to increase the skills and power they have to establish an effective voice at all levels of the health care system. We collaborate with innovative health plans, hospitals and providers to incorporate the consumer experience into the design of their systems of care. We work with state and federal policymakers to spur change that makes the health system more responsive to consumers, particularly those that are most vulnerable.

We appreciate the thoughtful approach the workgroup has taken to the paper and are supportive of the overall goal to put forth a payment model that recognizes the important role primary care providers play in moving toward a health system that values prevention, care coordination and patient-centered care. We especially appreciate the emphasis placed on the patient perspective, notably in Principle 6, as well as throughout the document, and the efforts of the workgroup to develop a white paper that aligns with the LAN's Principles for Patient- and Family-Centered Payment. We recognize that the workgroup is likely to receive a number of recommendations from diverse stakeholder perspectives and we hope that, as the group works to incorporate feedback, the emphasis on the patient perspective will remain intact.

We appreciate the opportunity to comment on the draft white paper and provide our suggestions with the goal of achieving a model for primary care payments that places the patient at the center. As the workgroup considers potential changes to the final document, we offer two general comments, followed by more specific comments related to individual recommendations.

Delivery Should Drive Payment Reform

Overall, the draft white paper seems to prioritize the need for payment reform over the need for improving the delivery of health care for patients. Rather than beginning the conversation with payment models and then adding recommendations to mitigate any potentially harmful impacts on patients, we believe the conversation should start with the question, "How can we deliver higher quality patient-centered care?" and recommendations on payment models should derive from there. Primary care, with its ability to address upstream factors of health and help prevent illness, certainly has the potential to drive down health care costs in the long term, but primary care itself is not the major driver of health care costs

currently. We are concerned that placing too much emphasis on financial risk, rather than focusing on desired improvements in care, could potentially harm patients. As the workgroup finalizes the white paper, we hope you will look at each recommendation through a lens that prioritizes needed delivery reforms and places the patient at the center.

Health Equity

We support an increased focus on vulnerable populations and an emphasis on the role primary care can play in reducing health disparities and achieving greater health equity. We understand that the workgroup is focused on creating a model that will serve all patients, but emphasizing health equity does not undermine this goal. In order to ensure that all patients are receiving high-quality care, it is vital that primary care providers are aware of the needs of the populations they are serving and disparities that exist within that population and are incentivized to address these specific needs and reduce those disparities. A one-size-fits-all model risks ignoring the needs of vulnerable patients and it is important that these concerns are at the forefront for payers and providers. We hope the workgroup will consider adding language to each of the principles that emphasizes the impact these recommendations will have on vulnerable and underserved populations.

Risk Adjustment (Recommendation 2 and Recommendation 10):

We support recommendation 2 that recognizes the greater degree of difficulty in caring for patients with complex needs and we applaud the workgroup for recognizing that payment adjustments should also account for the social, mental illness and substance use disorder needs of patients, as well as their physical health needs. We also recognize that in addition to appropriately compensating providers for their patient mix, payment models should not penalize providers who care for low-income, high-needs and complex patients. This means implementing performance measure strategies that recognize the increased difficulty of caring for patients with complex needs, without dis-incentivizing providers to make improvements that address health disparities in their practice. We appreciate the cautious tone the white paper takes on this issue and support the inclusion of stratification as one approach to navigating this challenge. We also caution that incentive schemes that reward only high relative performance without considering improvement or that are administered on a zero-sum basis are likely to have the perverse effect of directing financial resources away from where they are needed most.

Recommendation 11: Incentive payments in primary care will be based on an aligned set of comprehensive measures of primary care, rather than relying exclusively on a rigid set of disease-specific metrics.

We support recommendation 11 and strongly agree with the emphasis placed on patient-reported outcome measures and patient experience measures that go beyond looking at individual diseases and view the patient as a whole. We hope that the final paper will retain this language and ask the workgroup to also consider emphasizing the importance of engaging consumers in measure-development processes as well.

Recommendation 12: PCPMs will hold primary care practices accountable for the management of behavioral health and substance use services, because this recognizes the critical role that behavioral health plays in overall health, supports better integration between these services and primary care, and promotes shared accountability at the organizational and clinical levels.

We appreciate the focus on integrating services for mental illness and substance use into primary care. We believe this is essential for care of the whole person. We offer these suggestions for strengthening recommendation 12:

- We urge you to use the term mental illness or mental health, rather than behavioral health. Behavioral health is a vague term that means different things to different people. Using mental illness provides more clarity.

- In the first paragraph, there is a call-out about the importance of data sharing to integration. While this is indeed important, and can be challenging given federal restrictions on sharing of information about substance use treatment, the wording seems to suggest that it is the most important factor in integration. We suggest reworking the language to include other factors that are equally or more important, including basic cross-training of primary care providers in mental illness and substance use disorders and vice versa.
- We are concerned about the division of mental illness and substance use into two categories (mild-to-moderate versus severe) based solely on diagnosis, as well as providing two different models of care and payment for the two different categories. We believe that people across the spectrum of mental illness and substance use can be at a mild, moderate or severe stage, and that all can be treated in a fully integrated multidisciplinary practice. The current proposal appears to suggest only coordination, rather than integration for “severe” conditions, and to open the door to fragmentation of care by using a fee-for-service payment model in the cases of “severe” illness. We recommend rethinking this approach because we fear it may contribute to the continued siloing of treatment for mental illness and substance use disorders.

Recommendation 13: PCPMS will maximize the flexibility that primary care teams have to expend resources on coordination with community services, including direct support for community programs that demonstrably improve patient outcomes.


We are pleased to see the workgroup recognize the important role social and economic factors have on health outcomes and the potential primary care providers have to help address these issues. We support the inclusion of recommendation 13 and are especially pleased to see that the report moves beyond simply recommending screening and referrals by primary care providers and includes examples of how to pay for these services directly. While social and economic drivers of health are important for all patients, they are especially important for vulnerable and low-income populations and addressing these non-medical determinants could help reduce health disparities. We recommend that the workgroup include language in the final draft that emphasizes the importance of community service coordination for these populations and the potential impact on health disparities.

Recommendation 18: Primary care practices will need external coaching support and technical assistance to help them transition to new payment and delivery models.

We are glad to see that the white paper acknowledges that primary care practices will need coaching and technical assistance on, among other things, “methods to effectively partner with patients and families in care redesign.” The draft paper notes that payers and outside organizations will need to play a significant role in providing this assistance and we encourage the workgroup to consider adding language that points to patient and consumer advocacy groups as organizations well placed to provide such assistance. We also note that in addition to preparing providers, there is also a need to provide education to patients to prepare them to be active participants in these new models of care.

Thank you for the opportunity to comment on this important document. Please do not hesitate to contact me at ahwang@communitycatalyst.org should you have any questions.

Sincerely,



Ann Hwang, MD
Director, Center for Consumer Engagement in Health Innovation