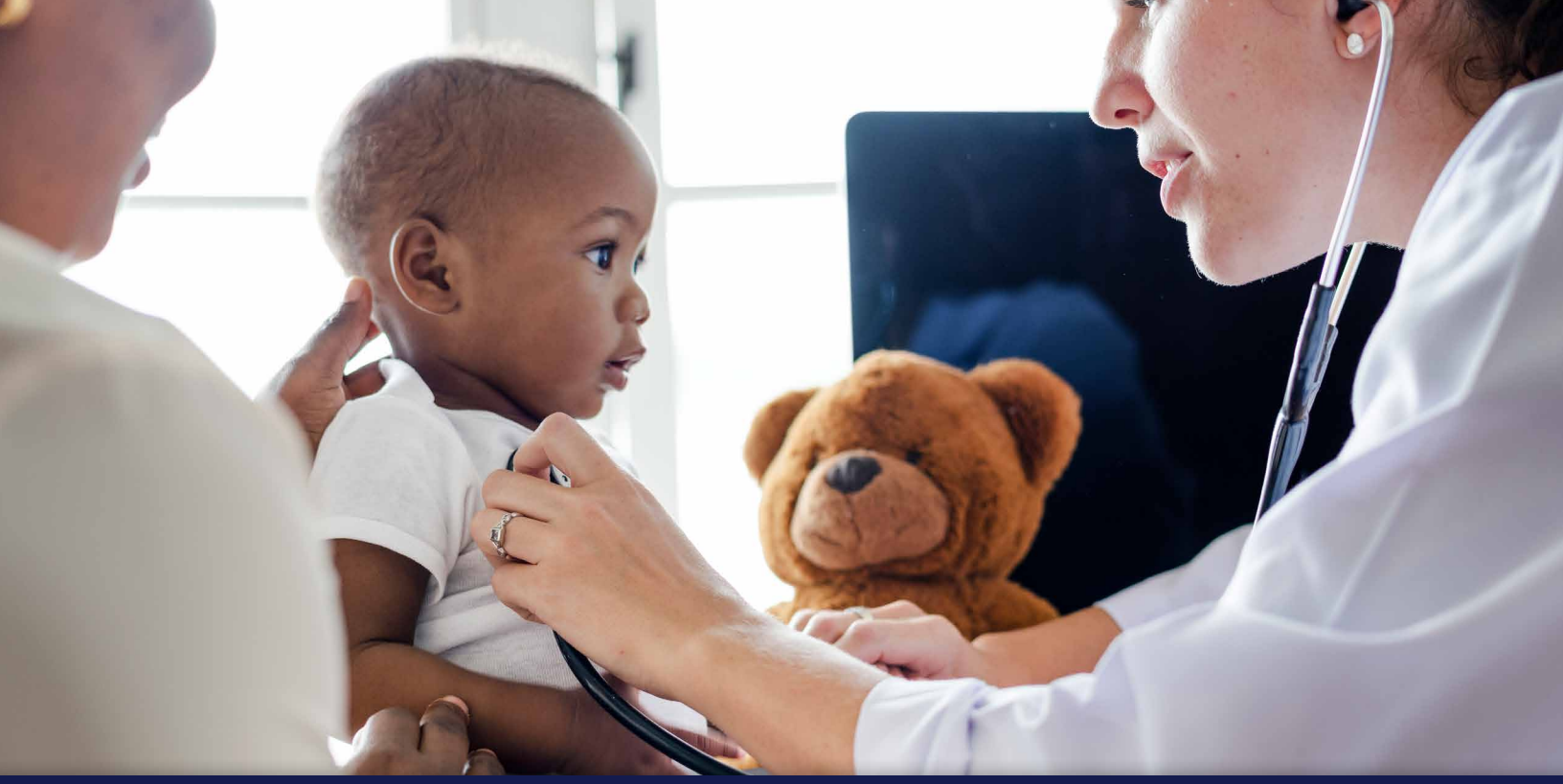


PRINCIPLES TO PROMOTE A HEALTH CARE SYSTEM GROUNDED IN *"Patient-First Care"*

UNITED STATES *of* CARE

People are losing trust in the health care system. Health care affordability remains the top concern for people across the country, with families increasingly delaying or skipping needed care as costs continue to rise. An incredibly complex system confuses patients, their caregivers, and health care providers alike, all the while failing to address existing health disparities and, even worse, sometimes reinforcing them.

Our nation's dependence on a costly fee-for-service system, in which providers are paid for the number of services they deliver instead of the quality of care they provide, is partly to blame. Volume-based payment tends to prioritize often-unnecessary high-cost, low-value care that may not lead to better health outcomes. At the same time, it often undervalues other forms of care, such as primary care, that have been associated with improved health outcomes and lower costs.

People deserve a system that delivers on the basic promise of affordable, accessible, quality health care. Policymakers should respond to people's real needs and continue to support efforts that shift toward patient-first care (PFC), often known as "value-based care" (VBC), instead of reinforcing the status quo with a failing fee-for-service system.

Why "Patient-First Care"?

Despite the broader shift in health care toward "value-based care", our listening research found that the phrase wasn't resonating with everyday people, who associate "value" with grocery store bargain brands. Instead, our emphasis on patient-first care underscores our commitment to promoting better, personalized care between people and their providers. The findings from this listening research were used to inform the creation of the principles found here, the latest example USofCare's innovative "people-centered policy design" that promotes policy solutions that respond to people's real, demonstrated health care needs.

What we've heard:

PEOPLE WANT A SHIFT TOWARDS PATIENT-FIRST CARE

A health care delivery system that puts people first not only improves health outcomes and lowers costs – it's what people want. Since early 2019, United States of Care (USofCare) has engaged in listening research with people across the country to understand their health care needs, including a recent focus on patient-first care. We found that, by a 4:1 margin, people favor a patient-first care model that ties provider payment to improved patient care and health outcomes instead of the current fragmented, disjointed system that prioritizes quantity over quality.

Given the state of the system, it's no wonder people think the status quo isn't working – it's not. To make matters worse, some models that move away from fee-for-service may even compound existing health disparities by penalizing providers that disproportionately care for certain populations, including people of color or people with low incomes. However, **when designed correctly, patient-first care models can elevate the patient voice in health care decision making alongside the voices of providers, payers, and other stakeholders in reducing disparities, promoting accountability, and creating a health care system that prioritizes affordable, personalized, and understandable care, regardless of patients' background or health status.**

What we've done:

PRINCIPLES TO ACHIEVE PATIENT-FIRST CARE

Following extensive stakeholder review, USofCare identified four major areas of focus, reviewed by providers, state and national advocates, regulators, and other health policy experts, that should guide the transition toward patient-first care. Federal and state policymakers are well-positioned to build upon existing efforts to shift towards a patient-first care system. Meaningful efforts to uplift and prioritize the patient experience must exist alongside other system-wide goals, such as cost-savings and efficiency, from model inception to provider payment to quality measurement.

We encourage federal policymakers to incorporate our principles into both new and existing payment models as well as through changes to status quo fee-for-service payment, such as through the Medicare physician fee schedule. Many of the principles can be adapted for state patient-first care models, but should take into account state-specific considerations that may differ from federal models.

1

Partner with people to incorporate their needs and perspectives into patient-first care design and delivery

Any patient-first care system should recognize people's health care experiences as the driving force behind policy development. Patients and caregivers should play a central role alongside their care team of providers, plans, and others in working together to create a patient-first care system that is driven by and fully meets patients' needs. **Policymakers can capture the patient and caregiver perspective by:**

Incorporating people's values and lived experiences into model development, implementation, and evaluation. Despite people's desire for personalized care, our current volume-based system rarely takes into account people's life experiences when providing services. The CMS Innovation Center's (CMMI) Strategy Refresh outlines CMMI's efforts and goals to engage with beneficiaries and caregivers. To build off this meaningful progress, it is critical that beneficiary and caregiver perspectives be fully incorporated alongside the voices of federal and state regulators, providers, and others, during the development, implementation, and evaluation of all models through patient and community advisory councils or other means.

- Outreach should incorporate the perspectives of underserved populations, such as groups based on race/ethnicity, language, sexual orientation/gender identity, disability status, income level, or other status, to ensure that these models also prioritize the needs of people who have historically not benefited from the health care system.
- Regulators should provide regular, easy-to-understand opportunities for the public to comment on proposed models and partner with community-based organizations to fully capture a diverse set of community perspectives.

Centering patients as partners in care decision-making. We know people want to be active partners with their providers in determining their care plan and that it often leads to improved patient outcomes. In a fee-for-service system that rewards volume, providers often lack the time during appointments to fully engage patients. Varying levels of health literacy and language barriers often lower levels of trust and only exacerbate these challenges. Patient-first care delivery should focus on giving providers the time and flexibility necessary to create shared decision-making opportunities with their patients in order to fully address their unique needs and ensure that their cultures, traditions, and preferences are respected.

Strengthening beneficiary education. People want to be able to understand their health care, but they often are not provided a clear understanding about how their care is delivered. All beneficiaries, whether or not they are enrolled in a patient-first care model, would benefit from greater education to understand the benefits of these arrangements, including how certain models are designed to reduce health disparities or increase access to primary care. Beneficiary notification, where applicable, should apply to both patient-first care models, such as certain accountable care organizations (ACOs), as well as regular fee-for-service payments so that all are held to the same standard. These measures would ensure beneficiaries and caregivers are provided with adequate information about their care arrangements and allow for more useful feedback

2

Realign financial incentives to ensure that providers are incentivized to deliver accountable care that improves health outcomes, quality, and equity

Today's fee-for-service payment model fails to put people first. True patient-first care involves shifting toward a delivery model that ties provider payment to patient care outcomes, instead of patient care volume. Efforts on both the federal level – through the Medicare Access and CHIP Reauthorization Act (MACRA) and CMMI – and the state level are designed to shift the incentive structure away from fee-for-service toward patient-first care models, with varying degrees of success. While the structure of these arrangements may vary, effective models recognize the need to restructure payments to providers to promote patient-first care. **To ensure provider participation, policymakers should ensure provider participation by:**

Promoting alternative payment models. Successful alternative payment models (APMs) should hold providers accountable for delivering high-quality care by tying provider payments to positive health outcomes, patient experiences, and other patient-first quality metrics, such as health equity measurements, and also reducing costs. Alternative payment models are structured to move away from volume-based payment, although some may retain elements of fee-for-service to allow the health care system to adapt to these new payment models, and many allow providers to share in some cost savings if health care costs drop below a predetermined threshold. These models should include adjustments or bonuses to incentivize care quality, reward certain outcomes, and address long-standing health equities, while also taking into account how new models may impact existing patient-first care arrangements.

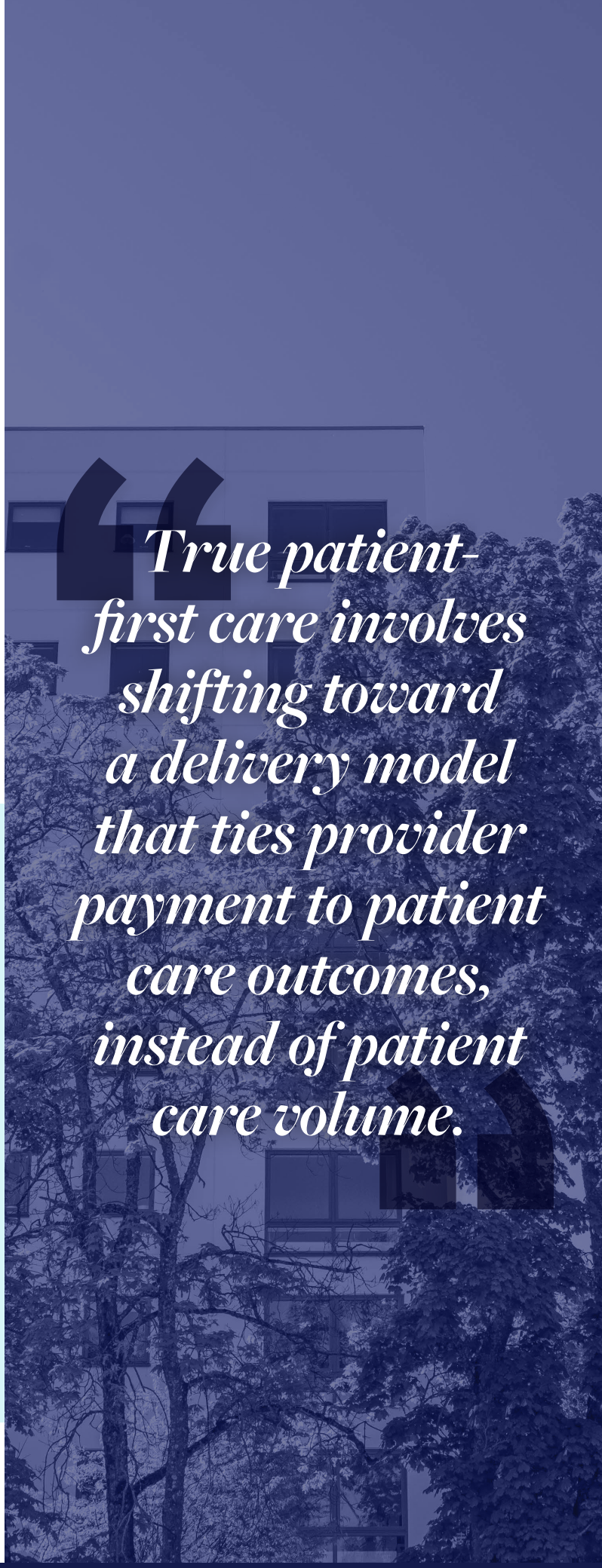
- Alternative payment models take many forms and may vary in terms of populations covered and services included. Some, such as bundled payments, including the upcoming Transforming Episode Accountability Model (TEAM) may be episodic in nature and facilitate care coordination and improved outcomes for one procedure, such as a surgery, and the immediate aftermath. Other models, such as capitated or prospective payments, including the new ACO Primary Care Flex Model, may be more comprehensive and involve providers receiving a predetermined payment per patient or patient population over a set period ahead of time. These up-front payments would guarantee providers some financial stability, incentivize participation, and ease these practices' transition toward patient-first care.

- Applying the capitation framework to primary care more broadly as part of a hybrid payment model, as recommended by a landmark report published by the National Academies of Sciences, Engineering, and Medicine, would pay primary care providers monthly for many common services, such as regular doctor's office visits, as well as care management services. This would allow them to increase the amount of time spent on delivering preventive care, coordinating care, or delivering other services to patients that may be undervalued or not reimbursed under fee-for-service.

2

Structuring risk to benefit patients. Many models involve some risk-sharing between plans and providers to allow them to keep revenue if certain improvements in care quality or costs are met or, depending on the risk structure, lose revenue if progress falls short. In the absence of patient-reported data, any successful risk-sharing arrangements should build on existing mechanisms, such as the ACO REACH model's Health Equity Benchmark Adjustment, that prioritize adjustments to account for differences in patients' health status, demographic background, or other social factor to ensure that providers care for patients of all backgrounds, regardless of health status or demographic profile. Additional safeguards, such as comprehensive data review and incorporation of social determinants of health, should be in place to ensure that providers aren't discouraged from caring for patients who are high risk or have complex conditions.

Considering mandatory provider participation. Mandating provider participation in certain patient-first care models could lead to the type of comprehensive health care transformation that improves health outcomes for all patients, preserves access to care for underserved populations, supports providers of all types, and allows for more comprehensive evaluations to identify what works and what doesn't. Any mandatory model should include limited exemptions or adequate resources for safety-net or independent providers and adequate preparation time for all providers to ensure they have sufficient resources to participate. All models should undergo a rigorous evaluation and data collection process prior to being made mandatory to ensure they meet a model's original goals, such as improving health outcomes and addressing health equity.



"True patient-first care involves shifting toward a delivery model that ties provider payment to patient care outcomes, instead of patient care volume.

3

Strengthen care delivery to encompass essential elements of whole-person care

How and what kind of care is delivered can mean the difference between a person seeking care or skipping it entirely. Patient-first care models should embrace a whole-person care focus that recognizes primary care as the foundation of an efficient and more effective health system and promotes care coordination and integration to satisfy a patient's physical, behavioral, social, and other health needs. **Policymakers should support policies to ensure that patients get the care they need when they need it by:**

Improving access to primary care and other forms of high-quality, cost-effective care ("high-value care"). It's critical that any patient-first care model centers access to primary care and other services, such as behavioral health visits, that improve outcomes at lower costs to patients. Models should incorporate value-based insurance design (VBID) principles, such as free maternity care visits, to ensure people have access to these services. Greater investment through primary care spend targets and more accurate valuation of primary care services through fee schedule changes can help reorient health care delivery toward a primary care system grounded in prevention and early detection to avoid the need for more costly care in emergency settings, while at the same time lowering costs for patients and improving health equity. Increased or bonus payments to providers who specialize in these forms of care, as well as some form of advance payment, can provide stability for providers, leading to a greater patient access to these services that have demonstrated benefits.

Enhancing coordinated care between care team members. Our listening research has shown that people favor models focused on increasing access to coordinated, patient-inclusive care over a disjointed fee-for-service model that rarely involves providers communicating with each other. These models should involve coordination and data sharing between providers, including primary care and specialty physicians, nurses, and behavioral health specialists, and support and care management staff, including case workers, care coordinators, and community health workers.

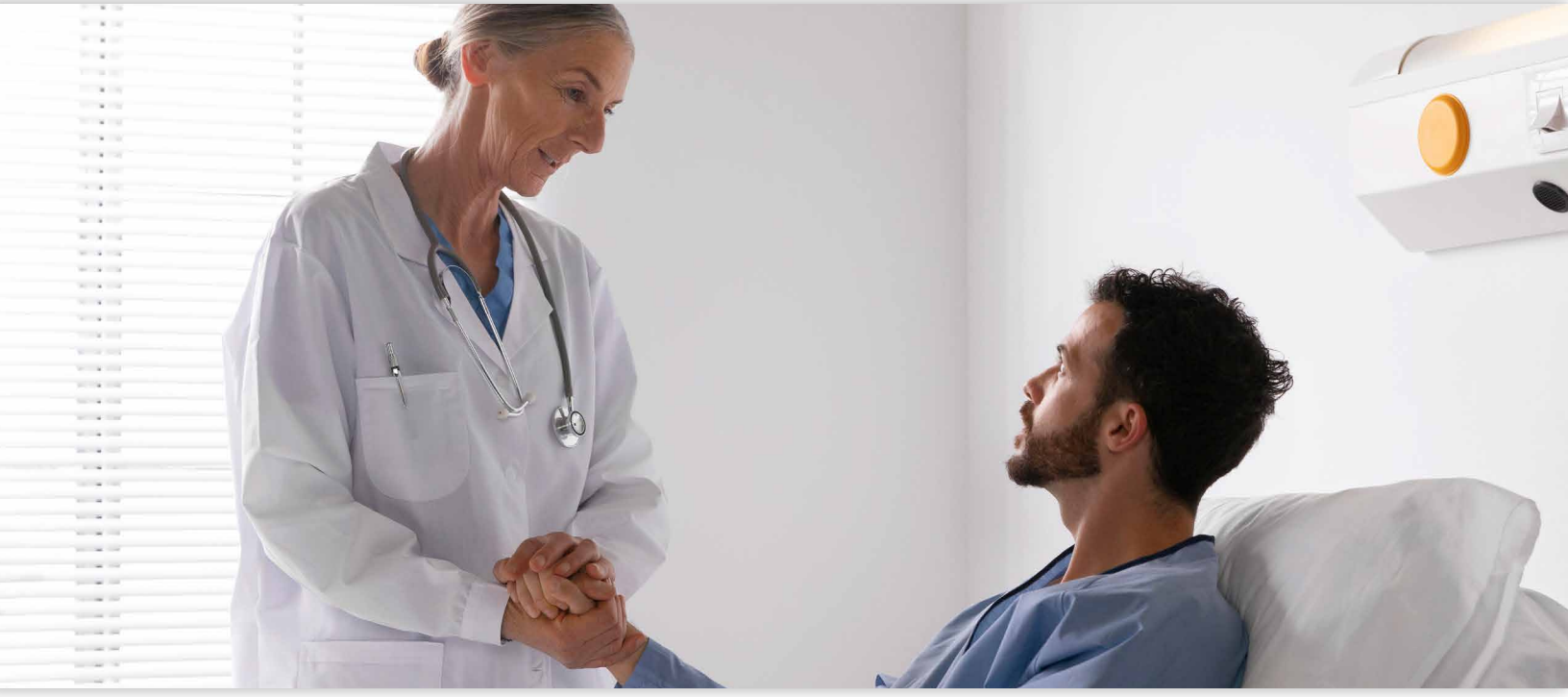
Incorporating the unique needs of patients and providers in underserved areas. Patient-first care should be structured to address long-standing inequities in access to care for patients, particularly for communities of color and others that have been neglected by the health care system. This can be done by, among other things, requiring providers to collect and report patient demographic data, implementing social needs screenings and referrals, or establishing specific risk adjustment methodologies designed to narrow, not further exacerbate, health disparities. Instead of basing payments to providers on historical spending patterns that may reflect long standing underinvestment in certain communities, models should increase resources, such as upfront infrastructure support for care transformation, to providers currently practicing in underserved communities to begin to redress decades of discriminatory policy choices.

4

Promote accountability within models to ensure that providers deliver quality care through patient-centric evaluation and reporting requirements.

Robust yet achievable patient-reported quality measures should be in place to ensure patient-first care is living up to its goal of making care better for all people. **Policymakers should do this by:**

Refining quality metrics. Successful patient-first care models require quality measurement and evaluation to assess their effectiveness in delivering quality patient care, facilitate meaningful comparisons across providers, and drive provider payment. Unfortunately, most quality metrics used to quantify provider performance often differ by payer or are too broad to effectively measure quality, leading to significant provider administrative burden and a patchwork of care standards that can adversely affect patient outcomes. Furthermore, many quality metrics may have little connection to the patient experience. To reduce provider burden and prioritize measures for improving patient care, patient-first care models should focus on adopting a core set of patient-reported quality measures across payers and populations that center both patient-reported outcomes and patient-reported experiences to fully capture the patient's perspective. The data collected from these metrics should be used to determine whether providers are achieving patient quality and health equity goals.



Acknowledgments

United States of Care would like to thank all of the organizations and individuals who collectively spent many hours responding to our questions and reviewing these principles. Specifically, we'd like to recognize Tim Gronniger, Jennifer Baron, Ashley Blackburn with Health Care for All Massachusetts, Alicia Camaliche with Families USA, Brandon Wilson with Community Catalyst, Larry McNeely with Primary Care Collaborative, and Spencer Carrucciu with Oxeon, as well as representatives from Accountable for Health, the American Heart Association, Health Care Transformation Task Force, and National Partnership for Women and Families, all of whom provided helpful guidance and feedback as we developed these principles. These principles would not be possible without them.