Mike Volz, MD – Talking points on payment and delivery system reform recommendations by the Commission on Affordable Health Care – Feb. 8, 2016

- Good afternoon, my name is Dr. Michael Volz. I'm in private practice in Denver specializing in allergy and immunology and I am the current president of the Colorado Medical Society.
- We have long supported the work of this commission. You are engaged in critically important work and one of the reasons that I am here today is to thank you for your service and your leadership in pursuit of finding ways for Coloradans individually and collectively to reduce the cost of health care while simultaneously improving the quality of that care. On behalf of the more than 7,500 physician members of CMS, I am also grateful for the opportunity to share some of our ideas regarding payment and delivery system reform.
- First off I want to acknowledge that we, like you, recognize the interconnected nature of any recommendations to fulfill your charge. Payment reforms are necessary but not sufficient to drive the changes that are needed. In addition, as you note, there is no one right to structure payment reforms and experimentation should be encouraged. Given that, we respectfully recommend that the commission not limit its payment reform recommendations to just the use of reference pricing or bundled payments. As we have shared in the past, it is critical that as many physicians in varied primary care and subspecialties like mine participate in alternate payment models in order to help spur the innovation and marketplace changes necessary. That's why we commended the work of Harold Miller to you that offers specific, value-based payment models, in addition to bundled payments, that should be pursued like payment for high-value service, condition-based payments, warrantied payments, episode payments and condition-based payments.
- The state should absolutely leverage the use of these models both within the state employee's purchasing program and Medicaid. But two payers aren't enough. I constantly hear the frustration from doctor colleagues across the state about how one plans requires that they do things one way while another requires them to do it another way. In the end nothing changes because everybody is too busy contorting themselves into different positions rather than focusing on patients and driving for cross-cutting improvements. I'm not sure if this number is correct because it may vary from one practice to another, but common sense tells me that until at least 40% of your patients are in alternate payment models, then it is very challenging for the practice to make the necessary investments and innovations to make and sustain the care delivery changes to support these models. My friend Dr. David Downs has this great saying that seems to sum things up pretty well here. He says that in order to drive better alignment and care we need to, "Standardize, streamline and make things clinically relevant." When it comes to payment reform the only way to live up to that saying and in turn harness the critical mass necessary for practices to change is through aligned all-payer approaches.

- Payment and delivery reforms must be focused on the needs of the patient, including their social determinants of health. That shouldn't be limited to just Medicaid as your recommendations suggest. Focusing those efforts also requires the use of meaningful, standardized performance measures. I applaud your support for public reporting to help drive this patient-centered care. As your transparency recommendations suggest these measures must focus on cost and quality, and they have to be actionable for both the patient and the provider. Claims data has its uses but we do not agree that claims data should be the exclusive source for public reporting. The limitations of these data are well documented and we encourage the use of other information including the use of clinical data, for example through the use of Qualified Clinical Data Registries that numerous physician specialty societies are developing.
- Last but not least we support switching your parking lot item regarding enhancing primary care reimbursement using value-based models to an actual recommendation. High performance primary care is the foundation upon which cost-effective, quality care rests. Models like the patient-centered medical home, which we strongly support, are proven to reduce costs and prevent unnecessary utilization. When coupled with all-payer approaches these models can drive incredible improvements in care for patients as well as increasing physician satisfaction. These models are difficult to sustain under a fee-for-service approach and that is also why we believe that the commission should recommend that continued funding for Medicaid evaluation and management reimbursement codes at parity with Medicare. This funding is critical in order to continue the momentum within the Medicaid Accountable Care Collaborative by individual practices and local systems of care through the Regional Care Collaborative Organizations. These delivery system changes take time and funding cuts threaten the progress to date to develop and sustain high performance primary care in Colorado.
- Thank you once again for the opportunity to provide feedback. We look forward to continuing our work together.