PBGH
PACIFIC BUSINESS GROUP ON HEALTH

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June 22, 2015

The Honorable Orrin Hatch
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
United States Senate
Washington, DC 20510

The Honorable Johnny Isakson
United States Senate
Washington, DC 20510

The Honorable Mark Warner
United States Senate
Washington, DC 20510

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

Thank you for the opportunity to provide comments to the Senate Finance Committee chronic care working group regarding policies that can lower costs and improve care for patients living with chronic conditions. The Pacific Business Group on Health (PBGH) is a non-profit organization that leverages the strength of its 60 members—who collectively spend $40 billion a year purchasing health care services for more than 10 million Americans—to drive improvements in quality and affordability across the U.S. health system.

Improving care for patients with chronic diseases has long been a priority for PBGH, its members, and virtually all other public and private sector purchasers of healthcare. As this committee and others have exhaustively noted, a significant proportion of health care expenditures are concentrated among chronically ill patients in both the Medicare and working-age adult population. Our general experience is no different—40 percent of a typical PBGH member's healthcare spending goes towards caring for the 15 percent of employees with multiple chronic conditions. Quality outcomes—particularly those related to care coordination and patient experience—are often substandard.

PBGH member companies have practical experience improving care for the chronically ill, which we detail below and use as the basis of several policy recommendations for the Medicare program. These strategies center on:

1. Creating provider performance measures that are meaningful and useful to chronically ill patients (e.g., functional status, patient experience, care coordination);
2. Strengthening alternative payment models that encourage providers to take accountability for the quality and total cost of care for chronically ill patients; and,
3. Using "smart" benefit designs that relieve the financial burden on chronically ill patients and encourage them to participate in effective care models.

All three have been tested by our members and shown to both improve quality and lower cost for some of their sickest employees and their families. Widespread adoption within Medicare can increase the value

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of federal health spending and effectuate positive change across the broader U.S. health system in which we all purchase and receive care.

I. What we're doing: Quality measurement, Payment reform, and Direct chronic care management

PBGH is very active in the development of robust quality measures that allow our members and their employees to see which providers are improving outcomes, using resources wisely, and delivering patient-centered care. Much of our recent work centers on the development and widespread deployment of patient-reported outcome measures, an important but often underutilized set of indicators that are especially useful in encouraging better care coordination and the efficient delivery of preventative services to the chronically ill.

Our members are also deeply engaged in the promotion of payment and delivery system reform initiatives that incentivize providers to improve outcomes while taking greater financial responsibility for patients with chronic conditions. Boeing is piloting a first-in-the-nation employer-driven accountable care organization initiative in Washington State. Walmart is the first private sector participant in a health home initiative for complex patients in Arkansas. Innovative medical home and accountable care programs like these can increase the receipt of high value preventative care and improve coordination across a range of medical and psycho-social services.

We also have experience working directly with providers to implement effective care management programs, including the Intensive Outpatient Care Program (IOCP) piloted by Boeing, PG&E, and CalPERS. IOCP utilizes embedded care coordinators who improve access to care, provide self-management tools, and help patients avoid unnecessary utilization. Under a CMMI Health Care Innovation Award, PBGH has since expanded the program to serve 14,000 Medicare beneficiaries through 23 participating delivery systems in five states. The model will soon by extended to enrollees in the California Medicaid program under the §2703 health homes program.

Program data over the past five years show that IOCP works. The Boeing pilot revealed a 20 percent decrease in claims cost, with participants enjoying a 28 percent reduction in hospital admissions, 56 percent reduction in missed workdays, and 16 percent improvement in mental health scores. Early data from the Medicare implementation show improvements in mental health and patient activation scores, and decreases in inpatient admissions and emergency department utilization.

II. What we've learned: Identify, Intervene, and Incentivize

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PBGH's experience in all three areas—quality measurement, payment reform, and direct care management—has generated insights into how to improve care and lower costs for patients with chronic conditions. First, cost-effective programs are built on effective identification of high-cost, high-risk patients. A hybrid method of prospective and retrospective identification using a mix of quantitative and qualitative methods is crucial for correctly identifying individuals who would most benefit from care management interventions. Further stratification based on utilization levels, severity of illness, and comorbidities like behavioral health can ensure that initiatives are effectively targeted.

Direct intervention strategies that improve the management of advanced illness or ongoing high-cost conditions return dividends to both employers and employees. Our work on IOCP and a review of other care management programs across the country shows that embedding care coordinators and other condition management programs in the provider setting can have a significant impact on both cost and quality, especially when coordination activities are augmented with interoperable information technology, social support services, and strong relationships between families and caregivers.

Finally, aligning financial incentives for both patients and providers is a powerful mechanism that encourages the provision and receipt of well-coordinated care. Our members use care management and patient-centered medical home payments, prospective and retrospective bundling, and other accountable care arrangements that reward providers for efficiently delivering high quality care. Similarly, introducing incentives—often described as "value-based insurance design" (VBID)—for patients to seek treatment from primary care doctors and accountable care systems by waiving co-pays and deductibles for chronic care management and other high value services has been a prudent and effective strategy.

III. Policy Recommendations: Improving chronic care in FFS, MA, and MSSP

Our long experience improving care for patients with chronic disease informs several policy recommendations for the Medicare program—increasing the value of federal spending in healthcare is a common, bipartisan interest that we all share. We are very supportive of the adoption of evidence-based approaches to chronic care management in Medicare, given that positive changes in payment and care delivery there often ripple out into the broader health system in which we all purchase and receive care.

Our general recommendations are three-fold:

1. Continue to develop provider performance measures that are meaningful and useful to chronically ill patients (e.g., functional status, patient experience, care coordination);

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2. Accelerate the adoption of meaningful alternative payment models that encourage providers to take accountability for the quality and total cost of care for chronically ill patients; and
3. Use "smart" benefit designs that relieve the financial burden on chronically ill patients and encourage them to participate in effective care models.

Comprehensive and effective reform requires implementing these strategies across the three distinct Medicare programs that now pay for care for beneficiaries with multiple chronic conditions—traditional fee-for-service (FFS), Medicare Advantage (MA), and the Medicare Shared Savings Program (MSSP). While all three have improved in recent years, policymakers need to continue the movement toward integrated payment and delivery through measure development, provider payment incentives, and value-based insurance design. To that end, we offer the following specific recommendations:

FFS

- Continue to develop physician payment codes for care coordination activities, but require doctors to provide ongoing care over a sustained period of time
- Expand and refine the new chronic care management payment to support more substantial payments to those caring for high-cost beneficiaries using proven models like IOCP
- Move away from "per visit" primary care billing and toward "per beneficiary" primary care payment
- Align readmission penalties among hospitals, post-acute care providers, skilled nursing facilities, and home health agencies

MA

- Allow all MA plans to tailor benefit packages for patients with chronic conditions (not just Special Needs Plans)—and add benefits like transportation and social services
- Implement MedPAC's recommendations regarding risk-adjustment so that plans aren't encouraged to avoid high-cost beneficiaries (two-years of diagnosis data, number of conditions, dual eligibility)

MSSP

- Move from retrospective to prospective attribution of patients so ACOs know where to focus care coordination efforts
- Encourage more ACOs to take on two-sided financial risk
- Provide regulatory relief from restrictions that were intended to prevent unnecessary treatment under traditional FFS Medicare
- Waive co-pays for patients visiting their ACO practitioners

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We look forward to continuing to work with this committee as it develops and implements policies that improve care and lower cost for chronically ill beneficiaries. Thank you again for the opportunity to provide comments on this important topic. Please contact me should you require any additional information or clarification.

Sincerely,

William E. Kramer
Executive Director for National Health Policy
Pacific Business Group on Health