



June 22, 2015

Senate Finance Committee Chronic Care Reform Workgroup
chronic_care@finance.senate.gov

Dear Senators:

On behalf of the University of Michigan's Institute for Healthcare Policy & Innovation (IHPI), I respectfully submit the following comments to the Senate Finance Committee Workgroup on Chronic Care Reform as it looks to develop solutions that improve health outcomes for Medicare patients with chronic conditions. IHPI is pleased to share our experience and research as the committee works toward developing policy measures to improve health outcomes. Our comments below focus on: value-based insurance design, ambulatory clinical pharmacists integrated in team-based care, Medicare's Hospital Value-Based Purchasing (HVBP) Program and rewarding hospitals for quality and costs of care, and flexible team configurations across patient types.

To put our comments in context, IHPI is one of the nation's leading university-based institutes of health services researchers evaluating how healthcare works and how it can be improved, and advising policy makers to inform change. Health services research applies the rigorous, methodical tools of scientific investigation to questions of effectiveness, access, value, affordability, quality and safety in healthcare. More than 460 University of Michigan researchers from across seventeen schools, centers, and institutes at the university (public health, medicine, nursing, social work, pharmacy, dentistry, public policy, law, business, and others) collaborate at IHPI on research studies and innovations in healthcare delivery and technology with a mission to enhance the health and well-being of local, national, and global populations. Together they hold more than \$500 million in active grants. Our researchers' interests are wide ranging: disparities, mental health, aging issues, children's health care, electronic health records, health insurance issues, quality measures, safety, value-based insurance design, injury prevention, opioid overdose, medication adherence, and so many other areas. Furthermore, we are closely linked to the University of Michigan Health System and the VA Ann Arbor Healthcare System. One of our newer and larger current studies involves twenty researchers and their teams who are evaluating six key domains of Michigan's "Healthy Michigan Plan" (Medicaid expansion), and includes faculty from our Business School, School of Public Health, Medical School, School of Social Work, and Institute for Social Research.

The following is a compilation of comments from several of our researchers who have had particular focus on Medicare and/or the question that was posed by your workgroup. If you would like to further discuss our comments on these important issues, please don't hesitate to reach out to Eileen Kostanecki, our Director of Government and External Relations for IHPI (202-554-0578 or ekostan@umich.edu), and we would be pleased to discuss them in more depth. If your workgroup holds regional roundtables we would also be happy to host such an event at our North Campus Research Complex in Ann Arbor.

Sincerely,

John Z. Ayanian, MD, MPP
Alice Hamilton Professor of Medicine
Director, Institute for Healthcare Policy and Innovation

IHPI Comments for the Senate Finance Committee Workgroup on Chronic Care Reform

Senate Workgroup Request for Comments on #1 and #3

1. Improvements to Medicare Advantage for patients living with multiple chronic conditions, and
3. Reforms to Medicare's current fee-for-service program that incentivize providers to coordinate care for patients living with chronic conditions

IHPI Comment: Consider Value-Based Insurance Design (V-BID)

One idea for the Senate Workgroup to consider is encouraging innovation in benefit design that is focused on providing Medicare enrollees access to health care services with high clinical value, a concept known as Value-Based Insurance Design (V-BID). This type of design involves lowering or eliminating beneficiary cost sharing in order to promote access to evidence-based, high-value medications and clinical services used to treat and manage chronic conditions. It could be used in Medicare Advantage or Medicare fee-for-service.

Enhancing access to services of high clinical value aimed at helping patients better manage chronic conditions leads to the avoidance of acute exacerbations, hospitalizations, and other adverse events and can positively affect health outcomes for many Americans.

V-BID innovation would not only help with the management of chronic conditions but also creates opportunities for greater overall alignment with payment and delivery system reform. There is increasing focus at the U.S. Department of Health and Human Services and in the marketplace to encourage and ensure that payments to providers incorporate concepts of value. These incentives are aimed at increasing accountability in the delivery system, incentivizing outcome-oriented care, and encouraging population health management. Yet the movement towards value in the payment and delivery system have not always had parallel movements in benefits and coverage design. A physician may be encouraged to provide high-value, evidence-based care, and his or her payments are tied to whether s/he has effectively managed a patient's chronic illness. Yet the high-value care may not be realized if the patient forgoes care prescribed by a physician if out-of-pocket costs are not aligned.

To pursue V-BID innovations in benefit design, the Workgroup may consider supporting a demonstration that would give Medicare Advantage plans flexibility to use V-BID to lower or eliminate beneficiary cost sharing in order to promote access to evidence-based, high-value medications and clinical services used to treat and manage chronic conditions. The Center for Medicare and Medicaid Innovation released a Request for Information on Health Plan Innovation Initiatives in October, 2014 and has noted interest in V-BID concepts. Two bipartisan bills have also been introduced in Congress to create a V-BID demonstration in Medicare Advantage: S.1396, *Value-Based Insurance Design Seniors Copayment Reduction Act of 2015*, sponsored by Senator Thune and Senator Stabenow, and H.R. 2570, *Strengthening Medicare Advantage through Innovation and Transparency for Seniors Act of 2015*, sponsored by Cong. Black and Blumenauer (which passed the House last week). Bringing a V-BID demonstration to fruition could provide Medicare enrollees with chronic conditions a coverage plan that could dramatically improve their care.

Senate Workgroup Request for Comments on #1, #4, #8

- 1. Improvements to Medicare Advantage for patients living with multiple chronic conditions, and**
- 4. The effective use, coordination, and cost of prescription drugs, and**
- 8. Ways to more effectively utilize primary care providers and care coordination teams in order to meet the goal of maximizing health care outcomes for Medicare patients living with chronic conditions.**

IHPI Comment: Consider Ambulatory Clinical Pharmacists Integrated in Team-Based Care

The Workgroup may want to consider the benefit of integrating ambulatory clinical pharmacists into team-based care to improve outcomes for people living with multiple chronic conditions. Ambulatory clinical pharmacists have been successfully integrated into the University of Michigan Health System (UMHS) for more than five years with great success. UMHS was also recently profiled as one of the top five Integrated Pharmacy Models in the nation, and has received several state and national awards. Furthermore, Blue Cross Blue Shield of Michigan, a major insurer in the state, recently funded a coordinating center to help replicate the UMHS model across the state.

Patients taking a high number of medications (polypharmacy) are at greater risk of having drug-related problems. These patients are often taking medications to manage their multiple medical and/or behavioral health conditions. Given the complexity of medication regimens and potential adverse events associated with polypharmacy, having health professionals such as clinical pharmacists with expertise in medication management as part of the integrated care team is critical. With clinical pharmacists reviewing all medications to ensure efficacy, safety, and cost-effective therapy as standard of care, patients needing better disease control, ongoing medication management, and adherence counseling will be identified more efficiently.

The UMHS model for team-based care utilizes clinical pharmacists to improve disease control and optimize medication-related outcomes. At UMHS, nine clinical pharmacists (equivalent to 4.9 FTE) are embedded in ambulatory care clinics as an integral member of the patient care team across 15 primary care sites. The clinical pharmacists provide disease management services for patients with diabetes, hypertension, and hyperlipidemia and comprehensive medication review for patients with medication related problems. Proactive outreach by clinical pharmacists who have a close relationship with a patient's physicians increased patient interest and engagement in the services. Having a full access to medical records and bi-directional communications with the providers is critical in providing high-quality care.

Additionally, while optimal medication use is a critical factor in producing positive outcomes in chronic conditions, only about 50% of patients take their medications as prescribed. One of the major barriers to optimal medication use and adherence is medication costs. Clinical pharmacists work closely with physicians and patients to help assess treatment burden vs needs, and devise affordable therapeutic plans.

Finally, under the UMHS model, clinical pharmacists complete assessments of cost saving opportunities including: generic switches, therapeutic interchanges, least expensive brand comparisons, combination pill options, therapeutic dose maximizations, pill splitting opportunities, discount programs, and other methods upon provider or patient request. These interventions can reduce patient out-of-pocket and payer medication costs, maintain therapeutic effectiveness and enhance medication adherence.

Senate Workgroup Request for Comments on #3

3. Reforms to Medicare's current fee-for-service program that incentivize providers to coordinate care for patients living with chronic conditions

IHPI Comment: Review and Consider Changing Medicare's Hospital Value-Based Purchasing (HVBP) Program: Reward Hospitals for both Quality and Costs of Care

One program the Senate Workgroup may be interested in reviewing, and potentially suggesting a change to, is the Medicare Hospital Value-Based Purchasing Program (HVBP). A group of University of Michigan health services researchers are completing an in depth study of the HVBP and found that implementing a minimum quality threshold in the HVBP program could eliminate the unintended consequence of paying bonuses to low-quality hospitals—thereby encouraging hospitals to improve quality of care for patients, particularly those with chronic conditions. Patients with multiple chronic conditions frequently use hospital services and are among the costliest patients in the fee-for-service Medicare program.

In an attempt to improve the value of hospital care, the Hospital Value-Based Purchasing Program was established by Section 3001(a) of the Affordable Care Act, and now applies to most U.S. acute care hospitals.

- In the first year of the program, bonuses and penalties worth up to 1.0% of a hospital's base Medicare Diagnosis-related Group (DRG) payments were linked solely to performance on quality (clinical processes and patient experience of care).
- In the second year of the program, the maximum incentive increased to 1.25%, and an outcomes domain that includes mortality rates was added.
- In the third and current year of the program, the maximum incentive increased to 1.5% and CMS added an efficiency domain consisting of performance on a 30-day episode-based spending measure: Medicare-Spending-per-Beneficiary (MSPB). The inclusion of an efficiency domain in HVBP is a major shift in CMS' approach to rewarding and penalizing hospitals, marking the first time that most U.S. hospitals have received financial incentives based on both the quality of care delivered and the cost of this care.

Although the HVBP program now aims to reward value (low cost and high quality), adding an efficiency domain may have had unintended consequences. Because hospitals that spend less on Medicare are more likely to receive bonuses, low-quality hospitals may be more likely to receive bonuses if they are also low cost. To address this question, University of Michigan researchers compared the distribution of hospital bonuses and penalties in the year before cost was included as a performance measure (FY 2014) to the distribution in the year after cost was included as a performance measure (FY 2015). They defined cost and quality performance categories according to CMS' approach for rewarding performance points.

As expected, low-cost hospitals (i.e., those that had lower MSPB scores than the mean of the bottom decile) became much more likely to receive bonuses (38% in FY 2014 vs. 100% in FY 2015). **However, low-quality hospitals (i.e., those that performed worse than the 50th percentile in quality) also became more likely to receive bonuses** (0% in FY 2014 vs. 17% in FY 2015).

These findings suggest that implementing a minimum quality threshold in the HVBP program could eliminate bonuses to low-quality hospitals, and could thereby encourage improvements in the quality of care for patients with chronic conditions admitted to hospitals.

Senate Workgroup Request for Comments on #8

8. **Ways to more effectively utilize primary care providers and care coordination teams in order to meet the goal of maximizing health care outcomes for Medicare patients living with chronic conditions.**

IHPI Comment: Consider Encouraging a Flexible Team Configuration Across Patient Classes

A model that the Workgroup may want to look at in more depth is a flexible team configuration across patient classes. Over the last five years, University of Michigan providers and researchers have developed and used a team configuration approach for different sets of patients with chronic conditions and have had positive results. What they found is that a stratified approach to build care teams that are most appropriate for particular patient groups demonstrated success at the University of Michigan Health System. This approach maximizes the extent to which providers practice “at the top of their license” to hold down costs while delivering high quality services. Stratification plays a central role in the care management model at the University of Michigan Health System (UMHS), and a key element is matching patients (and their caregivers) to the most appropriate care model within the practice.

Health care personnel essential to this stratified approach include a practice-based Primary Care Physician, Pharm D (Doctor of Pharmacy), Advance Practice Practitioners (Nurse Practitioner or Physician Assistant), Care Manager (RN and/or Social Worker), Panel Manager (Medical Assistant or equivalent), and Clerical Staff.

Below are examples of the main types of patients and care management teams that UMHS has used with demonstrated success. This model could be replicated elsewhere to achieve high quality care and potential cost savings.

Patient description	Team members	Care model
>= 65 years old, 0-1 conditions or impairments	Panel Manager, Advance Practice Practitioner	Proactive reminders, health behavior promotion, annual wellness visit
>=65 years old, 2+chronic conditions, no functional impairments	Advance Practice Practitioner, Pharm D, Physician	Physician visits with Advance Practice Practitioner, Pharm D follow-up—focus on disease self-management
>=65 years old, functional impairments (any cause)	Care Manager, Physician	Comprehensive assessment and management; case conferences