

U.S. Steel Tower  
600 Grant Street  
Suite 5500  
Pittsburgh, PA 15219  
412-434-1200

June 22, 2015

The Honorable Orrin Hatch  
Chairman  
Senate Finance Committee  
U.S. Senate  
Washington, D.C. 20510

The Honorable Ron Wyden  
Ranking Member  
Senate Finance Committee  
U.S. Senate  
Washington D.C. 20510

The Honorable Johnny Isakson  
Senate Finance Committee  
U.S. Senate  
Washington, D.C. 20510

The Honorable Mark R. Warner  
Senate Finance Committee  
U.S. Senate  
Washington, D.C. 20510

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

UPMC, on behalf of both its UPMC Provider System and the UPMC Insurance Services Division, which includes UPMC Health Plan, Inc., the UPMC *For Life* Medicare Plan, UPMC *for Kids* Children's Health Insurance Program (CHIP) product, UPMC *For You*, Inc. (a physical health managed-care organization (MCO)), and Community Care Behavioral Health Organization (a behavioral health MCO) (collectively, "UPMC") is pleased to submit the following comments in response to the United States Senate Committee on Finance (the Committee) request for comment.

First and foremost, we at UPMC enthusiastically support the bipartisan Commission as it seeks to improve the manner in which care is provided to millions of Medicare beneficiaries, particularly the nearly 45 percent of those beneficiaries grappling with four or more chronic conditions. We share the Committee's belief that better care coordination, appropriately tailored and aligned incentives, and new and innovative policies designed to improve overall care delivery, manage costs and foster improved outcomes will not only benefit beneficiaries, but also the nation as a whole as it actively seeks to stem the tide of rising health care costs.

While we recognize that improving the manner in which care is delivered to, and reimbursed for, Medicare beneficiaries will be complicated and will require an aligned, multi-faceted approach, we believe a focus on several areas will be particularly critical if meaningful change is to be achieved. First, as set forth more fully below, the continued and improved availability and use of

data is critical, particularly real-time, actionable data. In an increasingly complex world where data is generated and transmitted at astonishing volumes and speeds, the healthcare industry (like other industries) currently struggles to take full advantage of it. Making real-time, actionable clinical and other data available to providers, payors and members alike will improve care and improve outcomes. Across the country, providers and payors are increasingly using data to stratify risk, predict health outcomes and individualize treatment regimes. Building upon this momentum is among our top recommendations to the Committee.

Next, we are confident that, as the data mentioned above is collected and utilized to its fullest extent, care coordination, including coordination during transitions from one care setting or one provider to another, will improve. We believe that many of the current challenges to more comprehensive and collaborative care coordination efforts have their genesis in the industry's current inability to efficiently share information across mediums, systems and providers, particularly in real-time. We offer below several more comprehensive thoughts on this particular point for the Committee's consideration.

While enabling mechanisms that allow for the fundamental collection, distribution, and use of data are critical, care coordination that includes the use of real-time, usable data will only flourish when appropriate incentives are aligned and tailored for each situation and indeed, each beneficiary. Increasingly, health systems and payors are experimenting with and implementing innovative incentive programs geared toward those who deliver, pay for, or receive care. However, too often these incentives are of the "one-size-fits-all" variety, due in part to rules and regulations that in some cases require what is given to one, to be given to all. While well intended, we believe this approach is overly restrictive, and in many cases discourages the adoption of innovative, tailored incentives by dramatically increasing program costs and/or rendering effective incentive management impracticable due to the prescribed "total population." We firmly believe that using the expanse of available data to personalize incentives must be the next generation of incentive programming.

Personalizing medicine should not end with incentives. We believe that, just as one-size-fits-all incentives are inefficient, so too are restrictive care delivery systems and models; those limited to only traditional settings and services. Specifically, we think that limiting care delivery to hospitals, provider offices and other brick-and-mortar settings is short sighted. Rather, we believe that expanding care delivery to include home- and community-based settings, as well as increasing access to tele-health and remote treatment options, should be the wave of the future. We speak more specifically about this below.

Finally, we believe that an effective strategy can only be developed when the national discourse includes and addresses some of the more difficult and sensitive issues that face us. These include closely examining the role that personal responsibility must play if the epidemic of

individuals with multiple chronic conditions is going to be meaningfully impacted, as well as discussions about end-of-life decisions.

We offer for the Committee's consideration the following more specific comments and responses. Because we believe that our and other stakeholders' responses to the Committee's will likely generate additional questions and an ongoing iterative discourse on these very important issues, we are poised and ready to supplement our initial comments and/or engage in additional dialogue as requested.

**1. What improvements could be made to Medicare Advantage for patients living with multiple chronic conditions?**

As mentioned above, we believe that getting actionable, real-time data into the hands of providers, payors, beneficiaries, and their families (as appropriate) is critical to the delivery of effective care, particularly for those beneficiaries with multiple chronic conditions. Effective care coordination is wholly dependent upon such data, as is identifying and understanding individual risk factors, designing appropriate treatment protocols, and evaluating the efficacy of the chosen protocols in practice.

At the UPMC Insurance Services Division, the data collection process begins immediately upon enrollment with our request that beneficiaries complete comprehensive health risk assessments (HRAs). We have found that HRAs provide a wealth of valuable information about beneficiaries' present and potential future health, particularly in the absence or unavailability of claims and other data. We use HRA information to identify existing conditions, formulate likely areas of future risk (including at the condition level), contour individualized treatment and wellness recommendations for health improvement, and provide tailored educational and self-help tools and materials. The usefulness of HRA information is enhanced as historic or real-time lab results, medical and pharmacy claims and other information becomes available. Collectively, all information is used to develop individualized treatment, education, and management plans with the goal of ensuring that beneficiaries have access to both efficient care and care coordination resources; this type of unified information analysis and resource targeting is especially valuable for those with chronic conditions or those likely to develop them.

Unfortunately, there remain meaningful impediments to the effective and efficient exchange of reliable data; such exchange is necessary to realize the true potential for global data to improve the efficiency and efficacy of care coordination. Perhaps leading among these impediments are the multiple and disparate data and communication systems, many of which are simply not designed to allow for meaningful data sharing across systems. Despite advances in technology-solutions such as electronic medical records, much of the data collection and exchange between stakeholders today still flows through either a physical, paper-based process or through

disjointed electronic mediums. This not only delays the exchange of real-time data, but also increases the likelihood of errors with each transmission. While the challenges of information sharing within the healthcare industry have already entered the national discourse, meaningful solutions remain sorely lacking. We respectfully recommend that the Committee continue to work with stakeholders to continue to explore potential solutions. Doing so will contribute to the advancement of care coordination efforts and ultimately the improvement of health outcomes, particularly for those with chronic illnesses.

While care coordination is necessary for all patients, it is absolutely essential for the effective treatment and management of those individuals with multiple chronic conditions. At UPMC, our care coordination efforts have been driven by the establishment of patient-centered medical homes (PCMHs), among other things. These PCMHs integrate primary and specialty care delivery, and include not only physicians but other care providers such as pharmacists and psychologists as well. Each team member contributes to a beneficiary's specific, individualized treatment and wellness goals. Improved medication adherence, increased awareness of early warning signals of symptom escalation, and engagement in positive lifestyle changes to better manage chronic conditions are among the many focuses of the PCMH care team. Individualized data tracking and analytics allows the care team to develop targeted interventions and empower patients to take an active role in the prevention of unplanned, catastrophic and costly adverse health events.

At no time is care coordination more essential than during the transition from one care setting or one provider to another – a time during which the risk of costly adverse health events is often exacerbated. Of particularly high risk is a patient's transition from the hospital to home; a period during which an effective care coordination plan conditioned upon real-time data and information is essential to avoid or minimize readmission risk. UPMC has developed innovative transitional care strategies designed to minimize readmissions and has seen meaningful results. Specifically, UPMC increased its 5-day aftercare follow-up rates from 32% in 2011 to 36% in 2013 across all lines of business. Medicare in particular experienced a 5-day follow-up rate increase from 32% to 39%. As a result of increased follow-up, 30-day readmission rates decreased from 16% to 14% across all lines of business. These real world results provide a roadmap for a meaningful reduction in costs and unnecessary hospitalizations. We are happy to discuss our PCMH model further.

As mentioned above, also important to improved care coordination going forward is consideration of creative and innovative care delivery mechanisms. Among its initiatives, UPMC continues to explore the efficacy and cost-efficiency of alternate care settings, including home- and community-based services. UPMC's Staying-At-Home Program offers client-centered care coordination to older adults living in their own homes, assisted living facilities, or retirement communities. Among other services, the Staying-At-Home Program includes a post-

discharge visit by a nurse to a beneficiary's home, during which the nurse evaluates what the patient needs to maintain ongoing maximum independence, updates the patient's comprehensive health care diary, and organizes and reorders medications as needed.

In addition to the Staying-At-Home program, UPMC is actively pursuing the perfection of remote monitoring technology that collects daily weight and/or BMI or other data and triggers an almost immediate telehealth visit if concerns are identified. This technology has also allowed UPMC patients recovering from severe wounds to avoid unnecessary travel by instead allowing patients to take photos of their wounds and send those photos directly to providers who remotely monitor and evaluate the patient's condition, ensure proper healing, and/or to identify problems early.

Remote monitoring is also employed to assist in care coordination and monitoring for individuals identified at high risk for readmissions. Those with diabetes can transmit blood sugar levels and the weight; individuals with congestive heart failure transmit blood oxygen levels, blood pressure and other measures. At any time 250 individuals with chronic conditions participate in the UPMC remote monitoring program, and the program has seen proven positive outcomes. For example, last year only 12.9% of remotely monitored patients with congestive heart failure were readmitted to a hospital within 30 days of their initial hospitalization, compared with 20% of patients with the condition who did not participate. These meaningful, real-world reductions in readmission and improved outcomes demonstrate that telehealth strategies can genuinely impact healthcare delivery and finance going forward.

Finally, as stated above, we think it critical that we as an industry and as a nation confront the more sensitive issues facing us today. Nearly 25 percent of all Medicare spending is dedicated to individuals in their last year of life, which increases to nearly 30 percent for individuals in their last six months of life. The mere mention of statistics such as these at times prompts allegations that those tracking such statistics care more about costs than individuals. At UPMC, nothing could be further from the truth. We remain committed to meeting our patients' and beneficiaries' needs at all times, including at the end of life. We do think, however, that defensive medicine and the mere sensitivity surrounding discussions about end-of-life do sometimes result stunted discussions about reasonable treatment and/or non-treatment options. We believe the challenging and sensitive issues surrounding end-of-life decisions are best managed and addressed when a trusted care coordination team, along with the patient himself/herself and family members (if any and if appropriate) work together. We think this is a discussion that should and must occur if we are to improve healthcare delivery for all going forward.

Likewise, we think frank and open discussions with persons of all ages about health choices and personal responsibility will ultimately be necessary to reduce the epidemic of chronic disease in

the United States. Personal responsibility along with appropriate medical care, ongoing wellness interventions and health screenings will benefit all of us.

**2. What transformative policies can improve outcomes for patients living with chronic disease either through modifications to the current Medicare Shared Savings ACO Program, piloted alternate payment models (APMs) currently underway at CMS, or new APM structures?**

We at UPMC understand that change is difficult. Provider systems confronted with moving away from the long-standing fee-for-service model of care delivery – a model that simply rewarded more for more – are faced with a difficult task. UPMC was among those health systems that accepted the challenge early, leading to its development of an integrated delivery and finance system that promotes value-based rather than volume-based care; this transition was not without its challenges. UPMC’s success in moving from a fee-for-service, “quantity of treatment” driven payment model toward one conditioned upon value was realized only because we had buy-in at the highest levels of our organization on both the payor and provider side. Garnering requisite buy-in and successfully migrating away from volume-based payment methodologies can only be achieved when providers’ interests and goals are aligned with those paying for care. Over the past several years, UPMC has implemented various pay-for-performance, globalized payment and other shared savings models, all designed to prompt a reduction in unnecessary care in favor of rewarding better coordinated, high-quality care delivery.

Globalized payment and shared savings models have proven effective in improving care coordination, patient engagement, and increased preventive care delivery, while simultaneously promoting resource efficiency and prompting reductions in unnecessary utilization. By incentivizing providers for reductions in hospital readmissions, hospital-acquired infections and medical errors, we have been able to ensure the continued delivery of the highest quality care while eliminating unnecessary costs and waste. Again, as above, the increased availability and use of real-time data enhances these results by allowing payors and providers to collaborate on new and innovative payment models in ways not previously possible.

In addition to these new payment models, consistent reimbursement for telehealth visits and remote monitoring going forward will be essential in managing and driving down costs. While telehealth technology has matured dramatically in recent years, Medicare’s recognition of, and reimbursement for, its use has lagged. Nonetheless, these services have great potential to realize meaningful improvements in care accessibility, convenience, and quality; this potential should not be stifled because of historical program constructs that may be politically or operationally difficult to change. On the contrary, these services should be treated as the primary health care services that they truly are; not as merely adjunct or supplemental services.

**4. What improvements could be made to promote the effective and appropriate use, coordination, and cost of prescriptions drugs?**

First, the indispensable role that medications play in maintaining health, treating disease, and managing symptoms cannot be overstated. The clinical value of medications, however, is only realized when they are taken in accordance with prescribed regimens. Monitoring for such compliance is of utmost importance at UPMC and, like so much else, requires real-time information in order to be most effective; learning even a day late that a patient or beneficiary is not complying with medication use can have far-reaching consequences. Accordingly, as so often mentioned in our responses to other questions above and below, concerted efforts to continue laying the groundwork necessary for improved, real-time information sharing is critical.

Second, an individual will only continue to take medications as prescribed when potential adverse complications, side effects, and drug interactions are appropriately managed by a care-team. Pharmacists, of course, are well poised to address all of these potential adherence barriers. Historically, however, pharmacists have been relegated to a somewhat limited role on coordinated care teams. At UPMC, we prioritize and encourage the inclusion of pharmacists at all care levels not only to improve medication adherence, particularly in our PCMHs, but also to actively participate in overall treatment planning. Going forward, we believe remote monitoring and telehealth technologies can and should also be utilized to the greatest extent possible to assist pharmacists and the entire care team in impacting medication adherence and promoting beneficiaries' well-being.

No discussion about prescription medications in healthcare today would be complete without a mention of costs. Generic and specialty drug costs continue to skyrocket. A recent Kaiser Family Foundation poll found that 75% of Americans rank making prescription drugs affordable as their top health care priority; affordability is a top priority of UPMC and, we trust, of the Committee as well. State legislatures across the country, too, are engaged and many have proposed legislation that would impose transparency requirements on drug manufactures, including an obligation to disclose operational costs and profits, particularly for specialty drugs. We support and encourage continued discussion by the Committee regarding drug costs and welcome the opportunity to continue an iterative discussion in this regard.

**6. What strategies can be implemented to increase chronic care coordination in rural and frontier areas?**

With nearly 22% of Pennsylvanians living in areas considered to be "rural," providing and coordinating care in these areas is a continuing challenge that we at UPMC understand well. Primary care practice shortages, long travel times for routine or emergency care, and lack of access to after-hours care are just three of the numerous, well-documented challenges for those

living in rural areas. While predicting, preventing and treating illness in a coordinated manner are challenges in their own right, accomplishing these ends in areas where traditional care settings are few and far between presents an added layer of complexity. Unfortunately, the gaps in care resulting from access-related challenges put those living in rural areas at greater risk for chronic, yet often preventable conditions that could potentially be mitigated with proper monitoring and care coordination.

We support past efforts by the Administration and others to incentivize physicians and other providers to establish practices in rural areas. These efforts, while helpful, will nonetheless likely be inadequate to meaningfully reduce access issues, at least in the short term. Similarly, imposing health insurance provider network standards based merely upon “time and distance” does little, if anything, to address the underlying disparity of care availability in rural areas. Rather, we believe maximizing access to and payment for telehealth and remote monitoring technologies will be critical going forward. These technologies can not only bridge access gaps, but will also allow for the sharing of real-time information and facilitate greater care coordination for all, including those living in rural areas.

**7. What options encourage Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers?**

Empowering and incentivizing individuals to play a greater role in managing their health is a daunting challenge, yet is critical if we are to meaningfully impact the healthcare crisis facing our nation today. As discussed above, existing limitations to the manner in which incentives are chosen and distributed tend to stymie the realization of their optimum usefulness and efficacy. Again, we believe that creating a healthcare landscape in which tailored, targeted incentives are permissible will ultimately be far more effective in generating individual engagement and self-management.

At UPMC, we collaborate with individual members to identify the specific incentives, rewards, and even penalties most likely to garner positive results. This collaboration starts by first finding the means of communication through which each member prefers to interact. For some, only face-to-face or phone contacts will suffice; for others, mail, email or mobile texting are most impactful. Equally critical for effective engagement is the choice of behavior to be impacted. Incentivizing goals that are too large or too broad may be insufficient motivators for people to take the multiple small steps necessary to meaningfully impact change. Instead, linking financial rewards to smaller, achievable incremental steps may better engage individuals in self-management and lead to increased cooperation and collaboration with treating care teams.

UPMC also recently implemented its High Value Care for Kids program, a one-time payment reform program for children with medically complex conditions enrolled in the UPMC *for You*

(Medicaid) plan. Up to 100 families working with care coordinators were eligible for a \$500 prepaid debit card, which could be used to purchase both medical and non-medical items/services thought likely to impact the health of each participating child. Coupling this individual incentive with certain provider incentives allowed High Value Care for Kids to achieve savings of \$378 per member per month (PMPM) in the first year, and an additional \$147 PMPM in the second year. This is merely one example of our many innovative strategies to impact meaningful and lasting behavioral change; we are constantly striving to develop and implement cost- and quality-improving strategies that not only deliver real-world results, but also offer potential for translating positive impacts to broader programs and populations. We would be very pleased to discuss the High Value Care for Kids program and others directly with the Committee in the future.

Thank you for providing us the opportunity to comment upon these very important areas. We would be grateful for the opportunity to continue an iterative dialogue. If you would like to discuss any of these comments in greater detail, please contact Dan LaVallee, UPMC Health Plan Director of Health Policy, at [dvallee@upmc.edu](mailto:dvallee@upmc.edu)/412-454-5391 or Ryan Yuhas, UPMC Director of Federal Relations, at [ryanyuhas@upmc.edu](mailto:ryanyuhas@upmc.edu)/412-647-9444.

Respectfully Submitted,



Steven D. Shapiro, MD  
Executive Vice President, UPMC  
Chief Medical and Scientific Officer  
President, Health Services Division



Diane P. Holder  
Executive Vice President, UPMC  
President, Insurance Services Division  
President and CEO, UPMC Health Plan