PBGH
PACIFIC BUSINESS GROUP ON HEALTH

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January 26, 2016

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 65 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 virtually all 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.

Fortunately, we're doing something about it. In 2009, Boeing began working directly with providers to implement a care management initiative called the Intensive Outpatient Care Program (IOCP). The California Public Employees' Retirement System (CalPERS) and Pacific Gas and Electric Company (PG&E) quickly followed suit with an IOCP pilot in Northern California. Several of our members have begun directly contracting with providers and holding them accountable for the care they deliver to their sickest patients. We previously detailed these and other private-sector initiatives to you in a letter on June 22, 2015 and again during a meeting with your staff on October 13, 2015.

We are happy to provide additional information and data on these initiatives if it would help inform your discussions with the Congressional Budget Office (CBO) regarding the costs and savings associated with various care management payment and delivery reform approaches. Our feedback today, however, is limited to the specific Medicare policy options outlined in your December 15, 2015 document. Our long experience improving care for employees with chronic disease informs recommendations in five overlapping areas:

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1. **Improve physician payment for chronic care management (CCM) services.**
   - PBGH supports the addition of a new high-severity current procedural terminology (CPT) code, but simply adding more fee-for-service (FFS) codes is not a feasible long-term solution for effective CCM. CPT 99490 and any new code under consideration should not be made permanent, but rather strictly delimited as temporary stopgaps while the U.S. healthcare system continues its transition from Category 1 to Category 4 in the Learning and Action Network (LAN) Alternative Payment Method (APM) taxonomy.
   - Establish tight patient criteria and increase the payment level under the new high severity CCM CPT code so providers can do full case management for the sickest patients. Examples of this "tight criteria, high payment" approach abound: Anthem used 2+ chronic conditions in its Enhanced Personal Health Care program; PBGH used 2.5 times the average risk score for IOCP; a similar structure was implemented in the Comprehensive Primary Care initiative (CPCi). Mirroring the CPCi identification criteria would be consistent with the original Innovation Center charge to take successful demonstration projects and spread them widely.
   - Reduce the administrative billing and reporting requirements for CPT 99490 and the new high severity code under consideration. The prescriptive nature of the billing guidelines for 99490 limit the ability of provider organizations to recoup the cost of providing a broad array of care coordination services. Eliminate the patient-signed participation requirement in lieu of documentation that enhanced services have been discussed with the patient.
   - Allow the non-physician clinicians (NPCs) eligible to bill the 99490 code to use the high severity code under consideration; add registered nurses, social workers, and behavioral health staff. Recognition of behavioral health and licensed social worker roles in care coordination would help assure that psychosocial elements of the patients' needs are addressed as well as clinical indicators.
   - Refine risk-adjustment methodologies to ensure providers receive accurate payment for treating the sickest patients.
     - Explore changes to the CMS-HCC model to account for changes in predicted costs associated with the interaction between behavioral health conditions and physical health outcomes.
     - Launch an MA pilot that studies the impact of using Wennberg exogenous risk factors (community and self-reported health status, function) in the HCC.

2. **Use changes in benefit design to complement physician payment reform.**
   - Reduce barriers to care coordination by waiving the beneficiary co-pay for CPT 99490 and new CCM codes in FFS. Private and public sector experience with IOCP shows that additional physician payment for CCM services lowers PMPM costs even when beneficiary cost sharing is waived.

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- Allow two-sided ACOs to waive all cost sharing (including co-pays, co-insurance, and deductibles) for CCM services. Provide ACO's discretion to define applicable CCM services rather than rely on rulemaking given that two-sided risk provides a degree of protection against waste and unnecessary utilization.
- If patients voluntarily opt-in to an ACO, close the provider network to optimize care coordination and exchange of information. An open network creates potentially conflicting incentives if a patient has agreed to obtain services through an ACO-affiliated primary care physician.
- Prepayment of ACOs with assigned beneficiaries should be administered in conjunction with a defined network, the absence of which would deter organizations from pursuing two-sided risk.

3. **Facilitate the expansion of telehealth for CCM services.**
   - Eliminate the originating site requirement for two-sided ACOs entirely, as full risk provides a degree of protection against waste and unnecessary utilization.
   - Explore additional means to encourage the provision of telehealth services to chronically ill patients in all states, including those currently residing in areas with restrictive licensure and payment rules.

4. **Develop and publish robust quality measures (including patient-reported outcomes) for chronic conditions.**
   - Directing CMS to consider the implications of person-centered measures for individuals with chronic conditions is prudent, but drive a swifter and stronger movement toward patient-reported outcomes and other measures that use patient-generated health data. Measuring quality of life is especially important for those with comorbidities and for whom condition-specific measures cannot provide an adequate picture of the total quality of care received. Develop PROMs appropriate for individuals (or caregivers of individuals) with Alzheimer's, dementia, and other cognitive impairments.
   - Utilize existing channels such as the Health Care Transformation Task Force (HCTTF), LAN, and Center for Healthcare Transparency to accelerate adoption of community-level CCM accountability indicators. Collaborating with public and private stakeholders to design, test, and spread measures will be more effective in moving the market than commissioning a GAO report. This approach is consistent with planned PROM activities related to the CJR program and could be applied to others.

5. **Increase transparency of prescription drug pricing and utilization by chronically ill patients.**
   - We were disappointed the working group failed to include significant proposals related to increasing transparency of specialty pharmaceutical pricing and utilization, a major consideration when trying to improve value for the chronically ill. We encourage the

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committee to explore both immediate strategies (e.g., increasing transparency of drug spending through the medical benefit by using NCPDP codes) and longer-term solutions (e.g., publicizing and incorporating value-based pricing strategies) in future deliberations.

Elements of all five of these complementary strategies have been tested by our members and shown to both improve quality and lower cost for some of the sickest patients and their families. Widespread adoption within Medicare can increase the value of federal health spending and effectuate positive change across the broader U.S. health system in which we all purchase and receive care. 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

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