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The Honorable Orrin Hatch
Chairman
U.S. Senate
Committee on Finance
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
U.S. Senate
Committee on Finance
Washington, DC 20510

The Honorable Johnny Isakson
U.S. Senate
Washington, DC 20510

The Honorable Mark Warner
U.S. Senate
Washington, DC 20510

June 18, 2015

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

Priority Health is pleased to have the opportunity to respond to your request to submit examples of real world experience and data-driven evidence that will improve the care of Medicare beneficiaries with multiple chronic conditions. Priority Health is an award-winning, Michigan-based non-profit health plan nationally recognized for improving the health and lives of the people it serves. It continues to lead the industry in engaging members in their health, delivering effective health and disease management programs and working with physicians to improve health care outcomes and performance. We have included three examples, each of which is part of an overall solution to providing better care for patients with chronic conditions, but not a complete solution by itself.

Home-Based Care Initiatives

Introduction

A 2005 study by Johns Hopkins revealed that approximately 20% of adults age 75+ have 5 or more chronic conditions.[1] Older adults living with chronic conditions also have a high risk of functional limitations such as bathing, dressing and eating, and have higher rates of hospitalization, ER utilization, and use of home health care services than the average senior population. Adults with chronic conditions and functional limitations are 7 times more likely to be in the top 5% most costly to treat; more than twice the rate of those with chronic conditions alone[2].

[1] Johns Hopkins Bloomberg School of Public Health analysis of Medical Expenditure Panel Survey, 2005.

[2] Individuals living in the community with Chronic Conditions and Functional Limitations: A closer look Office of the Assistant Secretary for Planning and evaluations, United States Department of Health and Human Services, 2010.

The Problem

- Routine office-based care is not effective for the advanced, chronically ill, who often default to emergency room and inpatient settings, when much of this high-acuity utilization is avoidable
- Home healthcare is episodic and does not replace ongoing management of chronic conditions
- Telephonic RN case management is inadequate for advanced chronic care
- Delivery system care is fragmented and duplicative, driving high avoidable costs
- The chronically ill experience medical crises, cognitive decline and social isolation that alter their ability to care for themselves, resulting in increased utilization of avoidable health care services

The Solution

Home-based care delivers comprehensive medical care to this distinct population in their own homes. We have partnered with our own health system as well as several community-based organizations to build a transformative care model that features a multidisciplinary team specializing in care for patients with multiple chronic conditions.

We target patients with complex chronic disease and deliver comprehensive, longitudinal primary health care services to the home. A familiar, trusted care team holistically manages the patient's care, and total cost of care shifts away from high-cost, institution-based care toward lower-cost, home-based care. We are eliminating access barriers and creating long-term solutions for these patients.

Key characteristics of the model include:

- Care Team: Nurse Navigator, Social Worker, Volunteers
- Paramedic Check-ins (provision of care without transport; required approval from the State)
- 24x7 Rapid Response
- Physician Oversight
- Care Coordination with Primary Care and PH Care Management
- Life Plan (including Advance Care Planning) that stays with the patient across care settings

Opportunities for Savings & Benefits to Key Stakeholders

This innovative model of care enables us to improve on our delivery of the Triple Aim outcomes: lower costs, improved outcomes, and an exceptional patient experience. It is all about providing the right care, in the right place, at the right time.

- Investing early in the health of these patients reduces costs for avoidable and unnecessary care in the future
- Prudent, value-based shared decision-making with a trusted care team
- Patient (and caregivers) feel safe & supported in the home
- Reduced ER, inpatient, and SNF utilization due to 24x7 in-home support
- Patients at the center of a comprehensive care plan, rather than chasing care across a fragmented system

Experience to date

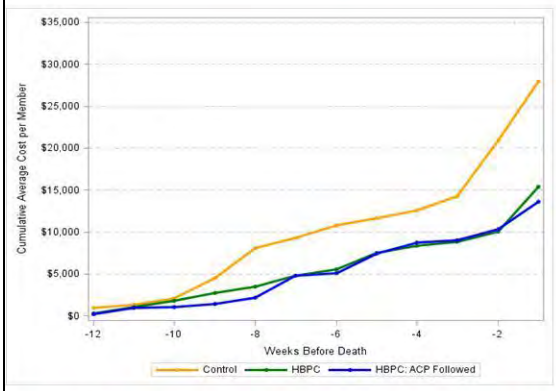
The home-based model of care not only offers efficient care to participating patients, it also provides them with an increased level of independence and dignity. It is well-aligned with Priority Health's commitment to improve the health and lives of the people it serves.

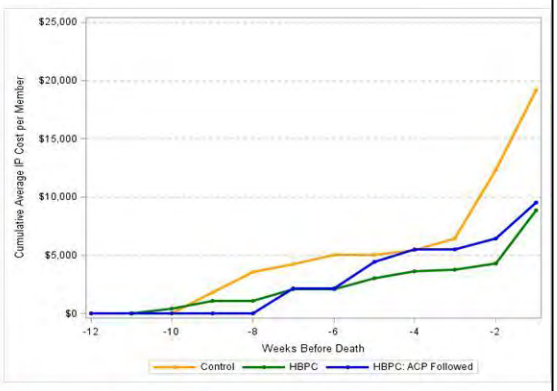
Results based on Sept. 2012-Sept. 2014 experience with the PH Medicare population:

Twenty four month savings results

	Total cost	RX cost	IP cost	OP cost	Prof cost	Other cost	Savings
HBPC	$39,738	$6,798 (17.11%)	$12,558 (31.60%)	$11,003 (27.69%)	$6,495 (16.34%)	$2,884 (5.75%)	**$8,620** $359 PMPM p=0.19
Control	$48,358	$8,600 (17.78%)	$19,859 (41.06%)	$8,422 (17.41%)	$9,275 (19.18%)	$2,201 (4.55%)	

Savings upon end-of-life





Total, IP costs in last 12 weeks of life (left, right)

- Total cost savings of approximately $15,000 are primarily driven by IP cost savings of approximately $10,000.

Next Step: Scaling the Solution

Priority Health is working to scale this model significantly in 2015-2016, with the support of our community partners in southwest Michigan, and other local care providers throughout the state. Key to this scaling is the ability to identify and engage the patients most appropriate for the program. Toward that end, we are using data from the first two years of program experience to refine our targeting and considering options for making this an "opt out" model for eligible patients.

Medication Therapy Management

Introduction

Inappropriate medication use results in over 1.5 million preventable adverse events annually, and accounts for an excess of $177 billion in morbidity and mortality. Nationally, more financial resources are used to manage adverse drug events than on the actual drugs themselves.

The Problem

Complex medication regimens create significant challenges for patients living with chronic illness, their caregivers, health care providers, and the health care system as a whole. Patients who have been hospitalized face additional challenges, often receiving new medications in the hospital. When they leave, they may not know how their new medications relate to those they were taking before, which they should continue taking, and which should be eliminated to avoid duplication or adverse reactions.

The Solution

Priority Health implemented a robust Medicare Medication Therapy Management (MTM) program in 2011, in partnership with OutcomesMTM. This program leverages pharmacists – an untapped resource on the care team – to help members get the best results from their medications.

OutcomesMTM uses a clinical rules engine to identify opportunities (e.g. gaps in care, medication non-adherence) for pharmacists, who engage patients to address drug-related problems and complete comprehensive medication reviews.

Opportunities for Savings & Benefits to Key Stakeholders

Via their work on the care team, pharmacists are helping to:

- Improve health outcomes for members with chronic illness
- Identify and resolve drug-related problems
- Protect patient safety
- Promote effective care transitions
- Reduce hospital admissions and readmissions
- Reduce the total cost of care
- Enhance the member's pharmacy experience

Experience to date

Results based on 2011-2013 experience with the PH Medicare population:

Savings by reason for MTM: 24 months

Reason	N Treatment	Pharma cost savings	SD Pharma cost savings	P-value
Complex drug therapy	2015	($8.11)	$16.23	0.62
Cost efficacy management	615	$63.45	$28.06	0.02
Needs therapy	239	($12.79)	$22.52	0.57
Suboptimal drug selection	306	($22.46)	$20.82	0.28
Underuse	1026	$4.78	$13.94	0.73

Overall pharma savings: $4.20 PMPM (sd $9.64, p = 0.66)

Reason	N Treatment	Total cost savings	SD Total cost savings	P-value
Complex drug therapy	2015	$109.08	$50.58	0.03
Cost efficacy management	615	$150.56	$73.87	0.04
Needs therapy	239	$168.83	$185.35	0.36
Suboptimal drug selection	306	($123.24)	$81.29	0.13
Underuse	1026	($36.79)	$71.83	0.61

Overall total savings: $65.99 (sd $34.05, p = 0.05)

Next Step: Program Expansion

In 2015, we are expanding the MTM solution in two ways:

- Initiating targeted outreach to the Commercial population
- Expanding MTM services within the provider office, to take advantage of the physician-pharmacist partnership within the Medical Home

Skilled Nursing Facility Outcomes Initiative

Introduction

Skilled Nursing Facilities (SNFs) can provide a critical bridge between the acute setting and home, facilitating the transition from one to the other for both patients and their caregivers. We want to ensure that Priority Health members are receiving the most appropriate post-acute care (PAC), in the right setting and with the right care plan, following every acute inpatient stay.

The Problem

Priority Health has historically had a very large SNF network, with wide variations in quality of care, cost per admission, and length of stay. We lacked data to understand how our SNFs compare to one another, and data to share with our members to help in shared decision-making regarding PAC. We also know that our SNFs, which are paid on a per diem basis, have had no financial incentive to strive for efficient, high-quality rehab care. Patients and providers were caught in a poorly designed system.

The Solution

In order to better manage our members' PAC experience, we have deployed the LiveSafe tool from naviHealth in our acute care and SNF settings. LiveSafe is a data-driven, patient-specific benchmarking tool that evaluates PAC options for a specific member and supports evidence-based decision-making.

- In the Acute Care Setting
    - Clinician (OT/PT) enters clinical and functional assessment data about the patient
    - Tool suggests most appropriate care setting (SNF vs. Home Health Care(HHC)), identifies readmission risk, and lists caregiver requirements for the patient
    - In the case of SNF, tool suggests expected length of stay
    - Tool provides data regarding quality of network SNFs, to inform shared decision-making
- In the SNF
    - Clinician (OT/PT) enters clinical and functional assessment data about the patient, upon admission and every 7 days thereafter
    - Tool estimates length of stay, based on patient-specific data

In both settings, LiveSafe data enhances the clinical team's decision-making; it does not replace or negate that team's critical thinking skills.

Opportunities for Savings & Benefits to Key Stakeholders

- PH savings resulting from:
    - Appropriate diversion from SNF to HHC
    - Reduction in SNF ALOS
- Patients & their families
    - Better information to help guide discussion with physicians about PAC options
    - Increased level of comfort & satisfaction with the care plan, as expectations are set early on in the acute care and SNF stays
- Acute Care Hospitals
    - Better management of transitions to post-acute care, to reduce acute care readmissions
- Skilled Nursing Facilities
    - Quantitative metrics demonstrate their quality of care to patients
    - Initiative lays groundwork for transitioning to an outcome-based model of care

Experience to date

We had a very successful first year of implementation in our SNFs (managing LOS), where we have partnered with our high-volume facilities by placing PH care managers on-site to integrate with their workflows. We have struggled more to integrate our process with the Acute Care facilities' discharge planning processes (for appropriate diversion to HHC), and are working to assess and improve that relationship in 2015.

Skilled Nursing Facility (SNF) - Cost and Utilization Metrics
A&I SNF Event Methodology / Medicare Members ONLY
--includes SNF admits through 1/31/2015--

rolling 12 months through January

	2012	2013	2014	2015	2015 +/-
Total PMPM	$28.68	$27.68	$27.16	$23.04	-15.6%
SNF Admits/1000	43.4	42.2	42.1	41.6	-3.5%
SNF ALOS	21.5	22.7	22.4	18.8	-14.1%
SNF Days/1000	934	956	941	780	-17.1%

Another metric we continue to monitor closely as the initiative progresses is our readmission rate, to ensure there are no negative consequences of the decreased LOS in the SNF.

Next Step: Creating a Preferred Partner Network

As we gather more data about our SNF network's performance, we will develop a preferred partner network of SNF providers. Partnering with high-performing organizations will benefit PH by increasing our volumes at higher-performing facilities that use the naviHealth tool to support an appropriate LOS. Likewise, those facilities will benefit by receiving a higher volume of PH admissions, in exchange for their partnership. Keeping in mind the Medicare requirements for access & availability, and always respecting patient choice, we are considering various options for using this tool / data to develop our preferred network.

Thank you again for this opportunity to provide you with information about our work with frail Medicare beneficiaries, and we look forward to working with you on this issue of mutual interest.

Sincerely,

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