Written Testimony

Prepared for the Senate Finance Committee's Hearing

entitled

"Examining Bipartisan Medicare Policies that Improve Care for Patients with Chronic Conditions"

Tuesday, May 16, 2017

Prepared by

John G. Lovelace
President, Government Programs and Individual *Advantage*
President, UPMC *for You*
UPMC Insurance Services Division,
UPMC Health Plan
University of Pittsburgh Medical Center
Pittsburgh, PA

Chairman Hatch, Ranking Member Wyden, Senator Casey, Senator Toomey, and members of the Committee,

On behalf of UPMC Health Plan and the over three million people we serve, primarily Pennsylvanians, thank you for the opportunity to testify today on S.870, the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017. We are proud to support this legislation and grateful for the opportunity to discuss the critical issues of care coordination and improved health care services for Medicare beneficiaries with chronic care needs.

By way of background, UPMC Health Plan and the integrated companies of the UPMC Insurance Services Division (collectively, "UPMC") are pleased to submit the following comments on Medicare policies that improve care for patients with chronic conditions, including those advanced by the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017 (S.870).

UPMC Health Plan and the UPMC Insurance Services Division are part of the University of Pittsburgh Medical Center health system (the "UPMC System"), an Integrated Delivery and Financing System (IDFS) that combines comprehensive provider-led clinical practice with a value-driven payer model to align payer-provider financial incentives and promote higher quality outcomes for patients. The UPMC System includes more than 25 hospitals, 600 affiliated physician and outpatient office sites, 3,600 employed physicians, and international clinical partnerships in 12 countries. UPMC System hospitals were recently named to the U.S. News & World Report Honor Roll of America's Best Hospitals, and are ranked nationally in 15 specialties. The UPMC System is also closely affiliated with the University of Pittsburgh, which has been among the top 10 recipients of National Institutes of Health research funding since 1998; in collaboration with the University's Schools of Health Sciences, the UPMC System provides ongoing education and training to nearly 1,800 medical residents and clinical fellows, as well as an average of 500 nurses per academic semester.

UPMC is pleased to offer a full range of commercial individual and group health insurance, Medicare Advantage (MA), Medicare Special Needs Plans (SNP), CHIP, Medicaid, behavioral health, dental, vision, employee assistance and workers' compensation coverage products. Our MA plan, UPMC *for Life*, serves approximately 160,000 members combined through the MA Part C/D and SNP programs. Through our Medicaid managed care organization, UPMC *for You*, we

provide coverage to more than 400,000 enrollees across 40 Pennsylvania counties, and our behavioral health managed care organization, Community Care Behavioral Health, manages mental health and substance abuse services for almost 1 million Medical Assistance enrollees in Pennsylvania. In January 2018, UPMC will expand its portfolio to include Pennsylvania's Community HealthChoices, a Managed Long-Term Services and Supports (MLTSS) program that is expected to serve more than 360,000 individuals who are disabled, placed in nursing homes, or dually eligible for Medicare and Medicaid. We will be rolling this program out across Pennsylvania through 2018 and will complete that roll out in 2019. Since beginning operations in 1996, UPMC's Insurance Services division has been recognized multiple times for its dedication to quality and the provision of outstanding customer services across its product lines, which collectively provide commercial or government programs coverage to more than 3 million members.

We thank Chairman Hatch, Ranking Member Wyden, and all the Members of the Senate Committee on Finance (the Committee) for the opportunity to comment on ways in which the Medicare program can improve care for patients with chronic illness. We applaud the Chronic Care Working Group's ongoing efforts to improve the quality and integrity of the Medicare program for those beneficiaries living with chronic conditions, and support the recent re-introduction of the CHRONIC Care Act in furtherance of those efforts. We previously submitted comments in response to the Working Group's 2015 chronic care "Policy Options" document (*see* January 29, 2016 letter), and we sincerely thank the Working Group for both their consideration of our input and their continued dedication to solving the challenges of serving chronically ill Medicare beneficiaries. 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 positively impact both Medicare beneficiaries and our nation's efforts to responsibly control the ever-escalating cost of medical care. It is with this support and shared belief in mind that we respectfully offer for the Committee's consideration the following comments.

I. Permanent Authorization for Medicare Special Needs Plans

Since their creation in 2003, Special Needs Plans (SNPs) have grown significantly and now provide targeted coverage and support to more than 2 million of the most vulnerable Medicare beneficiaries. While SNPs were originally established on a temporary basis, Congress has repeatedly recognized

the value of SNPs as part of the Medicare program, and has consistently found cause to extend authorization for SNPs over the past 14 years; today, there are more than 500 SNPs operating nationwide. The story of SNPs is one of success for both the Medicare program and the beneficiaries it serves, and the fundamentally individualized nature of SNP coverage means that every beneficiary enrolling in the program is likely to receive better tailored and more coordinated services than he or she would otherwise have in fee-for-service Medicare or the broader Medicare Advantage program. UPMC has long been committed to serving beneficiaries in Special Needs Plans (SNPs) by offering high quality, cost-effective SNP products that place a strong emphasis on care management and service coordination. UPMC currently provides coverage to more than 22,000 dually eligible Medicare members through UPMC *for Life* Dual, among the largest stand-alone 4-Star dual eligible SNPs (D-SNP) in the nation and the 17th largest D-SNP overall. We remain committed to continue serving the vulnerable SNP population, and we thank the sponsors of the CHRONIC Care Act for once again recognizing the critical importance and value of the SNP program.

Section 201 of the CHRONIC Care Act would permanently authorize I-SNPs, D-SNPs, and C-SNPs, and would impose certain additional conditions on SNP contracts to promote service integration and improve coordination. We enthusiastically support the permanent authorization of SNPs. Plans and States, and by extension beneficiaries, rely upon the continued availability of SNPs when planning for their future. States are particularly sensitive to uncertainty in funding or authorization for SNPs; the program integration that is necessary to truly realize the value and effectiveness of SNPs requires significant administrative effort and long-term investment in Medicare-Medicaid coordinating activities. Faced with uncertainty regarding continued authorization, some States undoubtedly place otherwise promising integration initiatives on the shelf for fear that they invest limited resources into constructs or models that could be invalidated in a few short years. The elimination of the historic uncertainty surrounding continued SNP authorization will improve stakeholder confidence, materially reduce the need for contingency planning, and is likely to encourage additional State activity and innovation related to Medicare-Medicaid integration; each of these results will further the ability of SNPs to reliably serve Medicare's most vulnerable beneficiaries now and in the future.

Equally important is that the CHRONIC Care Act takes a thoughtful and forward-looking approach to this significant policy change: the Act both establishes future

requirements to promote integration and provides flexibility to recognize that not all States may take the same approach, or move at the same pace, toward full integration of regulatory, financial, and delivery system structures between Medicare and Medicaid. We believe that both aspects of the Act's SNP authorization are important to ensure the continued quality and evolution of SNPs, while still providing States and Plans with the tools necessary to continue innovating for the benefit of SNP-eligible beneficiaries. We urge all members of Congress to support this policy as part of the CHRONIC Care Act.

II. Opportunities to Further Enhance the Delivery of Home and Community Based Services through SNPs

The provision and coordination of effective, high-quality medical care for seniors with multiple chronic conditions is increasingly complex and costly. While many beneficiaries with chronic conditions may be able to avoid or delay nursing home placement with appropriate home and community based services and supports (HCBS), coverage of these services has historically been limited. Over time, stakeholders have increasingly identified the positive outcomes associated with appropriate care delivered at home rather than in an institutional setting, and we appreciate the Committee's shared recognition of this premise. Promising programs like the Independence at Home (IAH) demonstration evince an important public commitment to pursue the potential savings and quality improvements that can be realized through the delivery of tailored, team-based primary care to beneficiaries in their homes.

III. Expanding Supplemental Benefits

The clinical practice of medicine is constantly evolving. This is true not only because of advances in clinical practice and technology, but also because medical science is increasingly recognizing that a "one size fits all" approach to medicine is not the most efficient method for delivering effective care. Similarly, our understanding of overall health, and how socioeconomic factors contribute to an individual's health in both positive and negative ways, continues to evolve and change. While clinical practice increasingly incorporates tailored or individualized care, the current capacity of our health care system to address social determinants of health is somewhat limited; this is often true even where an individual's providers, advocates, and payers agree about the adverse health effects of a patient's barriers to things like food, clothing, transportation, and social support. A prerequisite to effectively overcoming these barriers for

Medicare beneficiaries is the implementation of a financing structure that not only makes appropriate services available (some of these services are available through community and social service agencies today), but that actually makes them *accessible* for beneficiaries, whether through additional administrative coordination or through "linking" services like transportation and communication. Historically, Medicare's flexibility to address these issues has been constrained primarily by the program's "uniformity" requirement, which limits the ability of MA and SNP plans to offer beneficiaries tailored support services except where those services are made available to all members. Important initiatives like the CMS Value-Based Insurance Design (VBID) Model are beginning to incorporate more benefit flexibility regarding uniformity requirements, but we believe that there is still a significant opportunity to advance the concept of targeted, non-traditional services and supports for the benefit of a broader MA population.

We applaud the Committee's Chronic Care Working Group for formally recognizing one such opportunity in its 2015 "Options Paper," and we support the adoption of supplemental benefit flexibility as provided by Section 302 of the CHRONIC Care Act. This provision of the Act offers tremendous potential to positively impact not only the lives and overall health of chronically ill MA beneficiaries, but also long-term expenditures in the MA program, particularly with respect to avoidable acute care. The Act's approach to expanding allowable supplemental benefits for chronically ill MA beneficiaries provides critical authority for CMS to establish the details of implementation within well-considered statutory guidelines; it will promote a collaborative approach between CMS, MA plans, and other stakeholders. The Act's implementation date of 2020 provides for an appropriate implementation schedule, and it will likely allow implementation to be informed by early results from the current VBID Model demonstration. We look forward to working with CMS on this important initiative following the CHRONIC Care Act's enactment.

The CHRONIC Care Act's expansion of supplemental benefits is a significant step forward for the MA program, and we hope that CMS will continue to work with MA plans and stakeholders to provide maximal flexibility related to the provision of unique supplemental benefits as part of a beneficiary's individualized health care plan. While a risk-bearing ACO or MA plan today has financial incentives to efficiently and effectively manage a beneficiary's care, current Medicare rules create marked gaps in the ability of these entities to address social determinants of health that may be significantly contributing to a beneficiary's health and care utilization. For example, a beneficiary suffering

from COPD might repeatedly present to the emergency department for breathing difficulty during the summer. After exhausting medication and other clinical interventions, the beneficiary's primary care team or care manager might reasonably conclude that the most effective intervention is in fact a window air conditioning unit. While we recognize that this type of purchase is well outside the boundaries of traditional Medicare program reimbursement, the use of a risk bearing entity's rebate dollars in this scenario would be money well spent in support of beneficiary health and a reduction in emergency department utilization. We believe that this level of flexibility is appropriately balanced with CMS authority to adopt this approach exclusively in the future for risk-bearing entities without altering the existing MA bid structure, ACO cost methodology, fee-for-service reimbursement rules, or approved supplemental benefits. This approach would allow the Agency to collaborate with stakeholders and ensure that such flexibility is carefully implemented, subject to appropriate measurements of success, and designed in a manner that will only reduce, not increase, Medicare program costs.

IV. Telehealth Services

There is growing recognition among stakeholders that telehealth services have the potential to not only add convenience and increase patient access to care, but also to improve the overall quality of care, reduce delivery system inefficiencies, increase patient adherence and engagement, and ultimately reduce long-term costs in the Medicare program. Unfortunately, current law (SSA Section 1834(m)) narrowly limits the types of services for which the Medicare program will provide reimbursement. Even in the MA program, plans are disincentivized from offering telehealth services because they must either be paid for through rebate dollars or incorporated into an additional enrollee premium charge. Critical to any consideration of telehealth reimbursement in Medicare is the growing recognition of telehealth as a service setting or modality rather than a distinct service; patients access telehealth services in place of, rather than as a supplement to, similar face-to-face care. A 2014 analysis of UPMC's e-visit program, Anywhere Care, found no evidence that e-visits or other telehealth initiatives were additive to UPMC Health Plan members' care costs; in fact, data indicated that members who utilized an e-visit had a lower overall cost of care for the conditions treated than members who sought the same care in an emergency room, urgent care center, primary care office, or retail clinic. While we understand the caution with which policymakers have to date viewed changes in law that are necessary for broader Medicare coverage of telehealth, we applaud

the Working Group and the sponsors of the CHRONIC Care Act for recognizing the positive impact that telehealth is likely to have for Medicare beneficiaries.

With more than 20 distinct telehealth services available through UPMC providers, UPMC has and continues to be an ardent supporter of developing and utilizing innovative telehealth and remote monitoring technologies. Our current services include tele-primary care, tele stroke, tele dermatology, telepsychiatry, tele cardiology, remote specialty consultation, and both pre- and post-surgical care, among others. The availability of these services allows UPMC to rapidly deliver world class specialty care and comprehensive consultations to rural patients who may be several hours from the nearest specialty practice or clinic, nursing home residents who do not have 24/7 access to many types of care, and chronically ill patients living in home- and community-based settings for whom physical travel is often costly, complicated, and burdensome.

As an example, consider a medically complex rural nursing home resident with CHF and diabetes who is in need of a sophisticated gastrointestinal surgical procedure. Without access to telehealth services, this patient would likely spend a full day traveling to a major metro area for a pre-surgical consultation. Her trip will likely be coordinated with those of other residents, all of whom will spend hours on highways or in waiting rooms while trying not to significantly deviate from the necessary routine of their medication regime or blood sugar testing. A month later, she would repeat the process for her scheduled surgery. In the following weeks, she would spend at least another 2 full days travelling back and forth for follow-up care. This scenario is disruptive to the patient, increases the risk of complications due to the stress of extended post-surgical travel, and includes significant secondary costs for travel and associated patient support. By contrast, effective use of pre- and post-surgical telehealth services could have limited the patient to a single trip for surgery. In this way, telehealth can not only reduce the total cost of care, but also makes care like surgical procedures less disruptive, and in many ways less stressful, for patients. In addition to post-surgical follow-up care, UPMC's remote monitoring program tracks chronically ill patients who have been identified as "high risk" for inpatient readmissions. By example, the system tracks blood oxygen levels and blood pressure of patients with congestive heart failure (CHF) to facilitate rapid outreach and intervention in the event of any concerning clinical data. In 2014, the program reduced 30-day readmission rates for participating CHF patients by 7 percent when compared to non-participating CHF patients.

While UPMC and others have successfully implemented a host of telehealth services to support patients' physical health, the increased patient access associated with telehealth may be even more significant for mental and behavioral health issues, which disproportionately impact Medicaid-eligible members (and by extension, dual eligibles) who face additional structural and socioeconomic barriers to accessing care. UPMC's behavioral health managed care organization, Community Care Behavioral Health, recently implemented a pilot program to provide telepsychiatry services for Medicaid members in rural Pennsylvania. This program resulted in a 25% improvement for 30-day patient engagement, and a significant reduction in inpatient readmission rates for those patients who were able to access a telepsychiatry resource. Given the positive implications for quality and cost savings that we have seen through this and other telehealth initiatives, we believe that broader, more flexible reimbursement policies for telehealth have real promise to improve overall care costs, quality of care, and patient satisfaction across a range of both physical and behavioral health services.

We appreciate the Working Group's insightful recognition of telehealth's potential in their 2015 Policy Options document, and are encouraged by the inclusion of expanded telehealth services for Medicare Advantage as provided for by the CHRONIC Care Act. We support adoption of the Act's telehealth provisions, and we look forward to continuing to work with the Committee and with CMS to identify additional opportunities to employ cost-effective telehealth interventions in the future.

V. Value-Based Insurance Design

As you are aware, UPMC Health Plan is currently participating in the CMS Innovation Center's VBID Model. The nuances of VBID implementation may vary among participating plans, but the Model is fundamentally designed to leverage cost-sharing and other plan design elements in order to encourage enrollees' use of high-value clinical services. UPMC Health Plan has extensive experience implementing value-based and consumer-driven plan designs in commercial employer group coverage. Our experience with this approach in the commercial insurance market over a number of years has been positive, and our data from that experience demonstrates that a thoughtful combination of incentives and enrollee engagement efforts can be combined to produce meaningful cost savings. We are excited to partner with CMS in evaluating the expected positive impact of VBID for Medicare beneficiaries, and we look forward to continued collaboration as the Model demonstration period continues.

The VBID Model is currently operating in seven states, with three state expansion scheduled for 2018. Section 301 of the CHRONIC Care Act would expand the Model to every state by 2020. As stated above, we believe that the VBID Model holds significant promise of positive results in Medicare. We appreciate that the Committee and the Act's sponsors share our belief in the potential of VBID, and we support the Act's proposed expansion thereof. During the demonstration period, we will collectively have an opportunity to learn from this innovative initiative and to modify guidelines based on these findings.

VI. Conclusion

We again thank the Senate Finance Committee and the members of the Chronic Care Working Group for this opportunity and their consideration of their comments. We salute the Committee's continued pursuit of meaningful, cost-effective solutions designed to improve the Medicare program for beneficiaries with chronic conditions. We would be pleased to engage in further dialogue on this important topic and to provide additional information or data on our foregoing statements to support the Committee's efforts in this regard. We look forward to continued collaboration in the future.

John G. Lovelace
President
Government Programs and *Individual Advantage*
UPMC Health Plan