Senate Health Committee
Informational Hearing: Improving Performance and Aligning Incentives
in Commercial Health Insurance and Medi-Cal

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Testimony

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We would like to extend our appreciation to Senator Pan and members of the Committee for the opportunity to share information about innovative programs to improve health care quality and reduce costs, with a special focus on the needs of patients with chronic conditions.

The Pacific Business Group on Health (PBGH) is an organization consisting of 60 large employers and public agencies that purchase health benefits on behalf of their employees and beneficiaries. PBGH members collectively spend over $40 billion annually to purchase health benefits for over 10 million people. As a 501c3 not-for-profit public benefit organization, our mission is to be a change agent creating increased value in the healthcare system through purchaser collaboration, innovation, and action, and through the spread of best practices.

PBGH uses three core strategies to accomplish its goals.

- **Care redesign**. We provide technical assistance and training to hospitals and physicians on advanced primary care, practice transformation, behavioral health integration, team-based care, maternity care and other issues. This is accomplished primarily through the California Quality Collaborative as well as other specific grant-funded projects.
- **Payment reform**. We strongly support the movement from fee-for-service payments to value-based payments, which reward providers who are high performers on quality, patient experience and efficiency/costs.
- **Public Policy**. We support transparency and the development and wide use of meaningful measures of quality, patient experience and total cost of care. We can't improve what we can't measure. We also support price transparency and healthy competition among providers; people with chronic diseases need information to access high performing providers to assure optimal outcomes and affordability.

We applaud the Committee's interest in programs for patients with chronic conditions. The development of specialized systems of care or programs for "high needs/high cost" patients -- many of whom have multiple chronic conditions -- is warranted from a cost and quality standpoint.

- Forty percent of a typical large employer's health care spending goes towards caring for the fifteen percent of employees with multiple chronic conditions.
- Quality outcomes, particularly those related to care coordination and patient experience, are often sub-standard.

- Benefit designs, particularly those with traditional high deductible and coinsurance plans, often create a financial barrier to patients who need services to manage their chronic conditions.
- The services needed by patients with chronic diseases are often not discrete and compatible with traditional fee-for-service payment methods.

There are two points I would like to emphasize with regard to value-based care and payment models for patients with chronic conditions:

- **Primary care is essential**, and it needs to be strengthened across the state to meet the needs of those with chronic conditions. Advanced primary care models should be spread and scaled to improve quality and access and reduce costly health crises. Small practices can develop advanced care models, but many of them need technical support.
- **Behavioral health integration** is an important component of advanced primary care, and it is proven to improve outcomes, reduce costs, and improve clinician satisfaction. We need to promote care models that include behavioral health integration and measure outcomes, not process, e.g., whether patient symptoms are resolving or lessening.

I would like to describe one major PBGH program that has focused on the needs of high needs/high cost patients: the Intensive Outpatient Care Program (IOCP). The program was initiated by Boeing in the Seattle area, and the model was spread to other large purchasers in California and to multiple practice sites via a grant from the Center for Medicare & Medicaid Innovation (CMMI). Briefly, the IOCP model is based in primary care, and it usually involves an up-front payment to the providers for care coordination and management. The results have been outstanding: improved quality outcomes, reduced unnecessary emergency visits and readmissions, and lower total cost of care.

Based on our experience with IOCP and similar programs, we would like to offer a series of recommendations for purchasers as well as policy-makers.

For **purchasers**, i.e., large employers, state employee plans, and Medi-Cal, we believe the following are very important:

- **Align expectations for providers and health plans**. For example, all purchasers should use a consistent set of performance measures, payment models (although not the same *level* of payment), and quality standards. Many of our members have expressed support for Covered California's Attachment 7 and have incorporated elements of this into their own requirements of payers and in their direct ACO provider contracts
- **Use meaningful performance measures**. We should move toward fewer low-value measures and more meaningful measures that matter to patients and purchasers. A good example of a type of high-value measure is Patient-Reported Outcomes Measures (PROMS), which are used successfully in the UK and Sweden for specific procedures and conditions.

- **Pursue advanced payment models**, such as care management fees and rewards for improvement for those providers not ready to embrace full financial risk. In addition, long-term contracts and payment models can give providers a level of certainty to justify investment in advanced care models.
- **Include mental health services in benefit designs and provider contracts**. It is best to avoid carve outs; they add unnecessary complexity and detract from the care coordination that is especially important for many patients.
- **Assure comprehensive data collection and timely feeds** to support providers' care coordination and care management efforts

For **policy-makers** who want to improve care for patients with chronic conditions, we offer the following suggestions:

- **Strengthen primary care**. We urge you to consider setting a target portion of health insurance premiums that are paid for primary care; other states have done this and have achieved increased investments in primary care.
- **Endorse state public purchaser policies to increase use of value-based provider payment models.** We urge you to consider setting target portion of provider payments that are consider "advanced payment models" (APMs).
- **Support investment in improving the organization and delivery of care**. The state should consider offering support for training for advanced primary care practices and integration of behavioral health care.
- **Ensure that the state has the appropriate workforce to deliver comprehensive health care**. We urge you to consider modification of restrictive scope of practice laws, thereby enabling all providers to operate at the "top of their license".
- **Improve the data infrastructure**. The state should insist on the use of meaningful and useful performance measures. It should also consider requiring standardized claims and data reporting; this is especially important in light of the All-Payers Claims Database that the state is developing.

Thank you for the opportunity to share this information and these recommendations, and I would be happy to answer any questions you might have. After today's hearing, I can be reached at wkramer@pbgh.org or 503-679-8390.