



**National
Business
Group on
Health**

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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

October 12, 2010

Mr. Richard Gilfillan, M.D.
Acting Director
Performance Based Payment Policy Staff
Center for Medicare and Medicaid Innovation
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Dr. Gilfillan:

As President of The National Business Group on Health, I am writing to congratulate you and offer my wholehearted support for your recent appointment as Director of the Center for Medicare and Medicaid Innovation (CMI).

The National Business Group on Health (Business Group) represents approximately 297, primarily large, employers (including 64 of the Fortune 100) who voluntarily provide health care benefits and other health programs to over 50 million American employees, retirees, and their families.

The likelihood that patients will enjoy a higher quality and safer health care system is far greater with your leadership and experience improving health care quality and safety at the Geisinger Health System. The combination of your experience and knowledge combined with CMS Administrator Dr. Donald Berwick will be so powerful and help us make so many valuable innovations. As you know, the President cited Geisinger as an “island of excellence” and a model for how to improve health care nationwide “where high quality care is being provided at costs well below the national average” and recommended that “we need to make them the standard in our health care system.” We could not agree more.

CMS’ traditional demonstration process is unsustainable and does not move fast enough. **Accordingly, we are urging you to incorporate any “best practices” or “lessons learned” from the CMI into the entire Medicare program.** CMS should quickly analyze and use CMI results to identify and reward high-quality providers and services and penalize or require lower-quality providers to either improve or face reduced reimbursements.

Specifically, we recommend that the CMI:

- Create a learning network and clearing house of innovations with feedback loops for rapid learning;
- Use virtual subject matter teams for brainstorming and idea generation;
- Require reporting of results every 6 months, rather than annually, to increase focus and speed ideas forward;
- Include “disruptive” innovations to move the field along faster;
- Build channels for more rapid diffusion of positive results;
- Engage stakeholders, including those with considerable real-world experience (employers, plan administrators, etc.) in the topic (health care quality, payment reform, etc.) as advisors;
- Focus on CMS’ triple aims:
 - Better health care for patients;
 - Improved population health; and
 - Control of per-capita health care costs;
- Reduce overuse, underuse and misuse;
- Incorporate technology in the process of improving health care; and
- Use longitudinal studies to follow patients over time that were not treated correctly initially.

Too often, Medicare makes payments without regard to whether services are needed or are performed well. Recent studies estimate that under the current system up to 30% of Medicare spending may be for excessive and unnecessary care. In addition, the Dartmouth Atlas of Health Care’s most recent findings reveal wide variation in hospital care and outcomes for chronically ill Medicare patients. While cost is tied to quality or performance in most other industries, in health care, including in Medicare, the opposite tends to happen—we end up paying more for poor service and the additional health care needed to “correct” poor quality. Fortunately, Medicare is beginning to reverse this tendency by not paying for so-called “never events.”

We believe it is necessary for the financial future of Medicare, as well as for the quality and safety of care received by beneficiaries, for the federal government to harness its leverage as the largest purchaser of health care in the U.S. to move Medicare and all other payers towards paying for effective health care, quality and safety outcomes and away from continuing to pay based on units or volume of services. CMS should use CMI to build off the Value-Based Purchasing (VBP) program and move from a **passive payer** for health care to an **active purchaser**. By using its huge purchasing power to drive excellence in care delivery, especially through the new innovation center, Medicare is not only protecting and helping its beneficiaries but it will also make the health care delivery system in the U.S. better and safer for all Americans, all of whom will be beneficiaries once they turn 65 or disabled.

It is vital for the federal government to fully transition Medicare to a pay-for-performance system based on quality, safety and efficiency. As I’m sure you know well,

a recent study by CMS in *Health Affairs* reported that U.S. spending on health care is expected to double over the next decade. We are eager to work with to change the current system. In recent years, employers and other health care purchasers developed and adopted payment programs to reward quality in the health care system. As sponsors of health plans, employers currently use their flexibility, under ERISA, to innovate and close the gap between the quality of care that we have and the quality of care that we should have and need.

Many employers are already developing and implementing strategies aimed at improving the quality, safety and value of the health care they purchase and we stand ready to assist you as the CMI develops new payment models of care. Many Business Group members have taken the lead in promoting pay-for-performance, health care quality and transparency by participating in initiatives such as the Leapfrog Group Hospital Rewards Program, Bridges to Excellence and the pay-for-performance programs of the Integrated Healthcare Association to make true health care transparency and quality a reality.

We support many of the budget-neutral models called for under Section 3021 of the Affordable Care Act, including:

- Broadening payment and practice reform in primary care, including patient-centered medical home models for high-need applicable individuals and that address women's unique health care needs;
- Transitioning primary care practices away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment;
- Contracting directly with groups of providers of services and suppliers to promote innovative care delivery models;
- Utilizing geriatric assessments and comprehensive care plans to coordinate the care;
- Supporting care coordination for chronically ill applicable individuals at high risk of hospitalization through a health information technology-enabled provider network that includes care coordinators, a chronic disease registry, and home tele-health technology;
- Varying payment to physicians who order advanced diagnostic imaging services according to the physician's adherence to appropriateness criteria for the ordering of such services;
- Utilizing medication therapy management services;
- Assisting applicable individuals in making informed health care choices by paying providers of services and suppliers for using patient decision-support tools;
- Aligning nationally recognized, evidence-based guidelines of cancer care with payment incentives;
- Improving post-acute care through continuing care hospitals that offer inpatient rehabilitation, long-term care hospitals, and home health or skilled nursing care during an inpatient stay and the 30 days immediately following discharge;

- Facilitating inpatient care, including intensive care, of hospitalized applicable individuals at their local hospital through the use of electronic monitoring by specialists, including intensivists and critical care specialists based at integrated health systems; and
- Promoting greater efficiencies and timely access to outpatient services (such as outpatient physical therapy services) through models that do not require a physician or other health professional to refer the service or be involved in establishing the plan of care for the service.

In addition, with the clinical comparative effectiveness research conducted by the Agency for Healthcare Research and Quality (AHRQ), and the potential from the new Patient Centered Outcomes Research Institute (PORI), the federal government and its research partners are producing important information that will help eliminate inappropriate treatments and ensure that the government only pays for effective, high quality health care that works. It is important that the CMI, the public and private sectors act together to develop the research evidence base for treatment and coverage policies so that clinicians, policy-makers, and consumers are able to make decisions that improve the quality of care and quality of life.

Again, the National Business Group on Health offers our wholehearted congratulations on your recent appointment as Director of the CMI at CMS and we look forward to working with you as you implement the provisions of the Affordable Care Act. Please contact me or Steven Wojcik, the National Business Group on Health's Vice President of Public Policy, at (202) 585-1812, if you would like to discuss our comments in more detail.

Sincerely,



Helen Darling
President

cc: The Honorable Donald Berwick, M.D., Administrator, CMS