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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

November 20, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted electronically via: CMMI_NewDirection@cms.hhs.gov

RE: Centers for Medicare & Medicaid Services: Innovation Center New Direction

Dear Administrator Verma:

The National Business Group on Health (NBGH or the “Business Group”) appreciates the opportunity to comment on CMS’ Request for Information (RFI) on a potential new strategic direction for the Center for Medicare and Medicaid Innovation (CMMI or “Innovation Center”). **While we commend CMS for prioritizing the goal of fostering an affordable, accessible healthcare system that puts patients first, we strongly encourage the agency to stay the course on initiatives that are working well to reduce costs while improving quality, particularly alternative payment and delivery models. In fact, we believe that these two goals are complementary and equally important to achieving greater value for Medicare beneficiaries and all Americans.**

The National Business Group on Health represents 421 primarily large employers, including 73 of the Fortune 100, who voluntarily provide group health and other employee benefits to over 55 million American employees, retirees, and their families. Being mostly self-funded, our employer members as well as many other employers, have a vested interest in more effective, efficient health care. They promote health plan designs that encourage delivery of the right care at the right time and in the right place; emphasize health promotion and primary and preventive care; improve value while reducing the cost of care; and, deliver services to the highest level of customer satisfaction. Moreover, employers collectively recognize the importance of improving health care delivery to our economy as a whole and to the federal government’s long-term fiscal health.

NBGH continues to support the good work being conducted through CMMI, which is critical to leading Medicare and health care delivery in general to perform at higher levels that are also patient-centric. The Innovation Center has tested a number of payment models to restrain the growth in the cost of health care while also improving quality. The models have also sought to increase provider accountability for the care provided to a given population. They also move away from fee-for-service to

reward value through shared-savings and shared risk payment programs, bundled and/or episode-based payment arrangements, medical homes, and population-based payments.

Importantly, these models have been successful. The Medicare program has reported the success of a number of these programs. The most popular program, the Medicare Shared Savings Program (MSSP), which now has 480 Shared Savings Program ACOs and 9.0 million assigned beneficiaries in 50 states, Washington, D.C., and Puerto Rico¹, has saved more than \$400 million in each of the last two years and resulted in better care.² Another report by the agency noted preliminary results of some models in early stages of testing and found that, for example, in just one year, the Independence at Home Demonstration improved quality of care and saved \$3,000 per Medicare beneficiary on average³:

Perhaps the most significant aspect of these models is that they have changed the mindset of providers. In bundled payment models, as with other alternative payment and delivery models, participation is growing, with thousands of providers taking accountability for cost and quality of care, many for the first time. With the largest payer, CMS, taking the lead, complemented by private sector support for Alternative Payment Models (APMs), a unified effort across all payers has spurred providers to change the way they do business. Increasingly, providers are reducing their reliance on fee-for-service (FFS); changing the way they deliver care; focusing more on patient satisfaction; and developing infrastructure and expertise to function effectively using such models.

Our comments below focus on the following areas of the RFI where we believe CMS, through the Innovation Center, can continue to advance this good work:

- 1) Increasing participation in Advanced Alternative Payment Models (APMs)
- 2) Consumer-Directed Care & Market-Based Innovation Models
- 3) Prescription Drug Models
- 4) Mental and Behavioral Health Models
- 5) Comprehensive Primary Care Model

1) Increasing participation in Advanced Alternative Payment Models (APMs)

Staying at the forefront in supporting and promoting APMs, particularly advanced APMs in which providers share financial risk, is the most important way in which CMS can encourage more provider interest and commitment to APMs.

In addition to continuing to be a strong leader in this area, CMS can also increase provider participation in advanced APMs by reducing the administrative burden for providers by aligning with the private sector on quality metrics for measurement and reporting applicable to APMs. While reducing the administrative burden cuts across all providers, including those in FFS, there are some specific ways to reduce the administrative burden for APMs. NBGH has submitted previous comments with specific recommendations in this area.⁴ One example involves the use of registries. Registries, which are already

¹ All Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs) Fast Facts, January 2017. Accessed via: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/All-Starts-MSSP-ACO.pdf>

² Better Care. Smarter Spending. Healthier People: Improving Quality and Paying for What Works. CMS Newsroom. March 3, 2016. Accessed via: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-03-2.html>

³ Ibid.

⁴ National Business Group on Health comments to CMS re: Proposed Rule for the Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models (CMS-5517-P). June 27, 2016. Available: <https://www.businessgrouphealth.org/pub/?id=bf6616fa-782b-cb6e-2763-2a9afe77e2da>

in use by ACOs, are an important measure of performance for their constituents, including individual practices, sites and providers. Registries serve numerous functions, including adding to the evidence base for care improvement, informing participants on where they need to focus their organization's efforts, highlighting performance areas for improvement, and identifying which patients require interventions. In this way, registries are foundational to population health management. Eligible clinicians may use data they are already submitting to a clinical registry or to an ACO to satisfy their reporting requirements, thereby streamlining reporting requirements and easing the burden.

Additional opportunities to reduce the administrative burden associated with measurement and reporting should be sought by the agency. Another example, is the core measures collaborative, a joint effort of CMS, health plans, state representatives, employers, and providers to agree on a parsimonious set of meaningful, useful measures. The collaborative has agreed on a set of core measures for ACOs. To the extent that CMS aligns its ACO quality measures with this effort, it will help assure a standard, meaningful measure set and reduce the administrative burden for providers.

Apart from streamlining measurement and data reporting for APMs, a partnership between the Center for Health Policy at the Brookings Institution and the USC Schaeffer Center for Health Policy and Economics, has made specific recommendations in the following four general areas to advance provider participation in APMs, including advanced APMs, which we support:⁵

- Increase beneficiary engagement and alignment of financial incentives in all models
 - Change from beneficiary attribution to beneficiary enrollment
 - Implement actuarially neutral beneficiary financial incentives
 - Reform beneficiaries' financial incentives to allow for the creation of new Medigap plans that are specifically aligned with ACOs
- Improve design and implementation of bundled payments and their utility for systems of care
 - Allow bundled savings to accrue for person-level APM participants and providers
 - Prioritize areas of care to bundle based on each episode's variation in spending, administrative complexity, the number and differing types of providers involved, alignment of clinical and financial incentives, provider and infrastructure readiness, and the ability to expand nationally
- Make payments directly to organized systems of care, like accountable care organizations, so as to incorporate incentives for hospitals and other key providers into the financial incentives of the APM
 - Work with relevant policy makers to reform anti-kickback legislation to allow providers to steer patients to preferred external health care entities based upon their professional judgment and collaboration
 - Change the benchmarking process for APMs to establish earlier transitions from historical-based benchmarks to regional benchmarks
- Support the development and initial funding of the costly infrastructure needed to organize systems of care among providers

⁵ Steven M. Lieberman, Margaret Darling, and Paul B. Ginsburg. "4 recommendations to advance Medicare delivery system reform." February 10, 2017. Published on brookings.edu. Accessed November 15, 2017 via: <https://www.brookings.edu/blog/up-front/2017/02/10/4-recommendations-to-advance-medicare-delivery-system-reform/>

- CMS should organize a source of “working capital” that provides funds, management expertise, and technical expertise to providers, better supporting the development of systems of care like ACOs where they do not currently exist

Below, we offer additional opportunities for further CMS consideration to encourage participation in and to advance APM models:

Bundles and Centers of Excellence

In addition to the recommendations above from USC Schaeffer/Brookings on payment bundles, we recommend that CMS look at employer success in this area as a reason to continue strong CMS support for bundled payments. A couple of the programs previously promoted by CMMI — the Comprehensive Care for Joint Replacement Model or CJR model and the Cardiac Care Program — were projected to save \$294 million over three years and \$159 million over five years, respectively.⁶ By slowing their adoption and implementation, CMS is foregoing opportunities to improve care while also saving Medicare. **CMS should reconsider its commitment to testing bundled models through the Innovation Center.**

Employers are expanding the use of Centers of Excellence (COEs), which bundle payments and services for specific high cost, complex treatments to ensure that employees have access to the best care available and at lower cost. By increasing employees’ access to high quality care—and by helping them select providers who practice the best and most cost-effective care—employers are seeing significant improvements in quality, cost and satisfaction.

The following examples of effective care bundles through the Employers Centers of Excellence Network (ECEN) illustrate the success of this approach:

- 1) Lowe’s. The average Lowe’s associate with joint replacement surgery performed by one of the ECEN centers saved approximately \$3,300 in copayments and other fees as compared to those patients who received the same care under traditional insurance. In an analysis of 12 month’s experience, 100% of Lowe’s ECEN joint surgery patients reported that they would refer co-workers or family to the program for a similar surgery.⁷
- 2) Boeing. Data from The Boeing Company’s experience has shown similarly high employee satisfaction. Starting in fall 2014, Boeing began offering about 30,000 of its employees, retirees and their dependents the option of keeping their current health plan or choosing a new narrower network of facilities, as a way to move employees into a bundled arrangement. In exchange for choosing the smaller selection of providers, Boeing employees received a range of perks, such as same- or next-day appointments, online access to scheduling and test results, and lower costs in the form of smaller contributions from their paycheck or free generic prescription drugs.

⁶ Projections were prior to the agency’s announcement it would scale back the CJR program and cancel the Cardiac Care Program.

⁷ Why GE, Boeing, Lowe’s, and Walmart Are Directly Buying Health Care for Employees. Jonathan R. Slotkin, MD; Olivia A. Ross; M. Ruth Coleman; Jaewon Ryu, MD. Harvard Business Review, June 08, 2017. Accessed via: <https://hbr.org/2017/06/why-ge-boeing-lowes-and-walmart-are-directly-buying-health-care-for-employees>

- 3) Walmart. Through Company-Sponsored Centers of Excellence (CSOEs), Walmart helped employees and their families whose doctors diagnosed them with certain conditions and subsequently recommended surgery, by referring them to specific hospitals.⁸ While employees can always remain with the hospital of their own choosing, Walmart will pay all copays and travel expense for the patient and a companion, if they consult with one of the centers of excellence. Results:⁹
- About 40% of covered plan enrollees were originally told they needed a transplant, but were discovered to not need a transplant when sent to the CSOEs.
 - Avoiding a transplant saves money, but more importantly, it also saves heartache and suffering for those patients able to find less invasive alternatives.
 - A transplant is one of the most painful and difficult surgeries imaginable, and requires a lifetime of medical follow-up, including strong medications, many with serious side effects.

A recent survey found that care bundle adoption is at a critical turning point and have had positive results: 1) 31% of providers and 20% of employers have adopted the model; 2) about two-thirds of providers have improved quality and reduced costs through bundles; and, 3) the majority of consumer respondents found bundles easy to understand and appealing, selecting them over current coverage 62% of the time.¹⁰ The same survey also found that there is still a mismatch between provider activity and employer needs:¹¹

- Employers want to see greater financial impact and a wide variety of bundles, whereas hospitals have kept efforts small.
- Employers are more interested in using bundles for chronic conditions, whereas hospitals are almost exclusively offering bundles for a few acute conditions.

CMS should continue to explore bundles and COEs. To that end, CMS should expand its approach to bundles by broadening the variety of bundles, including bundles for chronic conditions, and increasing bundle transparency to beneficiaries.

Business Group Collaboration with the National Comprehensive Cancer Network® (NCCN)

Another opportune condition area ripe for CMMI to try innovative approaches is cancer. Today, more than ever before, employers are facing the growing impact of cancer in the workplace. This change is the result of several factors: an increased incidence of cancer among employees because of an aging workforce and delayed retirement; an increase in the number of employees assuming caregiving roles for family members; and reduced productivity during treatment and recovery for employees with cancer and for those caring for loved ones. With the rising direct and indirect costs associated with cancer, financial impacts also have increased. And the bewildering array of treatment options with varying levels of benefit and quality makes it all the more important to adopt a comprehensive, patient-centered approach.

To address these important concerns, NBGH and NCCN partnered to:

⁸ Cracking Health Costs: How to Cut Your Company's Health Costs and Provide Employees Better Care. Tom Emerick; Al Lewis. ISBN: 978-1-118-63648-0 (cloth).

⁹ Ibid.

¹⁰ Strategy& Annual Bundles Survey: 2015/2016 Results: Hospitals, Employers, and Consumers. Strategy& | PwC, accessed via: <https://www.strategyand.pwc.com/media/file/Annual-Bundles-Survey-2015-2016-Results.pdf> on November 6, 2017.

¹¹ Ibid.

- Develop a comprehensive approach to cancer care with a focus on evidence-driven, accountable and personalized care;
- Increase standardization and integration of cancer care across an employer's programs, providers, and geography; and,
- Support quality improvement, tools and processes for employers to aid in evaluation of the effectiveness of these services.

The collaboration between NBGH and NCCN focused on a comprehensive benefits plan for cancer treatment, rooted in the following strategies:

- Providing access to evidence-based information about cancer;
- Motivating and rewarding employees and dependents who adopt and maintain healthy behaviors that can help reduce the risk of cancer;
- Encouraging compliance with recommended cancer screenings;
- Supporting individuals during treatment for and recovery from cancer or at end of life through appropriate medical, pharmacy, behavioral health and other benefits;
- Empowering individuals to become knowledgeable and engaged participants in their health and health care;
- Supporting employees who are caregivers for a loved one with cancer;
- Providing resources to help managers and employees cope with a co-worker's cancer;
- Retaining talented employees and optimizing productivity during cancer treatment and recovery or while employees are providing care to a loved one;
- Managing disability and leave benefits; and
- Developing evidence-based requests for proposals for vendors related to cancer in the workplace.

CMS should consider implementing or building a comprehensive cancer management program that provides navigation, second opinion and decision-support services. A model similar to the one developed through NBGH's collaboration with NCCN should be tested through CMMI. For additional information, we recommend that CMS review the following resources: [An Employer's Guide to Cancer Treatment and Prevention](#), [An Employer's Guide to Cancer Treatment and Prevention, Tool 2: Plan Design & Assessment](#), and [Employer's Companion Guide to the Cancer Benefits and Resource Guide](#).

2) Consumer-Directed Care and Market-Based Innovation

CMS should continue implementing transparency tools that provide meaningful information on price and quality for beneficiaries. Publicly disclosing information about the price and quality of care at the provider and facility levels will enable beneficiaries to use this information to make more informed decisions about healthcare and become better consumers of health care. This is an important initiative for the agency to consider because research suggests that helping consumers make well-informed decisions can lead to higher quality of care, greater patient satisfaction, and a far better use of the nation's health care resources than would otherwise be the case.¹² But consumer tools to shop for

¹² Steinberg, Caroline; Dentzer, Susan. "Transparency in Health Care A Priority Roadmap for Consumer Engagement." The Network for Excellence in Health Innovation (NEHI). June 2017. Accessed September 14, 2017 via: http://www.nehi.net/writable/publication_files/file/nehi_transparency_report.pdf

health care are only as good as the data that power them. Currently, the tools are limited by insufficient, unclear and difficult-to-interpret data on the quality of providers and the prices they charge. Employers recognize the value of these tools. Almost 72% of employers responding to the annual National Business Group on Health Plan Design survey, Large Employers' Plan Design Changes, offer online transparency tools to their employees either through their health plans or a third-party vendor. The tools provide plan members with meaningful information to choose health care based on quality, value and personal preference. **CMS should empower beneficiaries similarly, as transparency tools encourage smarter shopping and are consistent with the overall aim of “a better, smarter Medicare for healthier people.”**

In addition, the adoption of Consumer-Directed Health Plans (CDHPs) continues to increase among large employers, innovating the market in a manner that is already driving consumer-directed approaches to health care:

- In 2018, 90% of employers will offer at least one CDHP, up significantly from 84% in 2017.
- Another 7% are considering offering a CDHP by 2020.
- In addition, the percentage of employers who will offer only CDHPs to their employees has increased, from 35% in 2017 to 39% in 2018.
- Among employers offering a CDHP as an option, the median participation rate in the CDHP is 28%.
- While CDHPs are now offered by most large employers, not all CDHPs are the same. The most common design is a high-deductible health plan (HDHP) paired with an HSA. This design is offered by 80% of employers with any type of CDHP—down from 92% in 2017.

CMS should lean on the models presented by large employers, as it considers ways to increase consumerism and work with all relevant policy makers to expand efforts to increase the amount of health care price information available to consumers and promote the availability of more complete cost information. Additionally, we encourage CMS to continue to pursue other outside-of-the-box models that would promote consumerism in areas where high value care is needed most. For example, we strongly support the Value-Based Insurance Design (VBID) model that CMS rolled out through CMMI in January of this year, which will test methods that reduce cost-sharing and/or offer additional services to targeted enrollees with chronic conditions.¹³

Given that estimates suggest that chronic conditions cost the Medicare program up to 75% of its total budget¹⁴, there is a great deal of opportunity for the program to sharpen its focus on these high prevalent and often overlapping illnesses, both to reduce cost and improve patient outcomes. Other efforts should similarly focus on: 1) reducing cost-sharing for high value services; 2) reducing cost sharing for high-value providers; 3) reducing cost sharing for enrollees participating in disease management or related programs; and, 4) coverage of additional supplemental benefits.

3) Prescription Drug Models

Along with the public sector, large employers are increasingly concerned about the fast and ever-growing proportion of their overall health care spend for prescription drugs. As an example, in 2014,

¹³ <https://innovation.cms.gov/initiatives/VBID/>

¹⁴ Medicare & Medicaid Research Review. 2013: Volume 3 (2). “Medicare Payments: How Much Do Chronic Conditions Matter?” Accessed November 16, 2017 via: https://www.cms.gov/mmrr/Downloads/MMRR2013_003_02_b02.pdf

only 6% of employers indicated that specialty pharmacy was the highest driver of health care costs. This year, 26% of employers said it is the highest driver, and 80% cite it as one of the top three drivers. As a result, employers have implemented various tactics to help combat rising costs. Two-thirds of employers indicated that pharmacy management techniques are their most effective tools for controlling rising health care costs. As noted above, many employers have reported that implementing CDHPs as an option or going full replacement was one of their most effective tactics, to encourage more robust consumerism for prescription drugs. Tactics such as increasing employee cost sharing were ranked lower this year, while tactics such as high-touch health concierge or navigator services were ranked higher.

However, tinkering with plan design, and/or implementing utilization management tactics are not enough to control spiraling drug costs. Thus, employers have begun to focus on more innovative payment models for prescription drugs, which may move the needle to paying for value. Below are examples of areas large employers are exploring, either with their Third Party Administrators (TPAs), Pharmacy Benefit Managers (PBMs), or through direct contracting with manufacturers. **CMS should explore these models as part of its strategic direction for the Innovation Center.**

Risk-sharing agreements based on outcomes

The attractiveness of these arrangements are manifold, including creating a win-win situation for both manufacturers and payers—employers, insurers, and plan participants align incentives for appropriate, evidence-based use of expensive specialty pharmacy products. **CMS should, through the Innovation Center and other avenues, continue to explore ways to bring risk-sharing agreements to fruition, including by exploring public policy barriers that exist to inhibit the proliferation of risk-sharing agreements.**

A compilation of risk-sharing agreements uncovered numerous studies that report strong results in the U.S. from value-based insurance design programs.¹⁵ Excerpted examples from this research include:

- 1) Novartis employees realized cost savings in a value-based insurance design program for asthma, hypertension, and diabetes medication. After three years, hypertension medication compliance increased 9.4 percent (use rose five percent per program participant, on average).
- 2) Pitney Bowes employees realized cost savings (the program produced some savings for the company) in a diabetes and asthma value-based insurance design program where predictive modeling was used to determine which employees should be in a chronic disease management program providing the most favorable (tier1) access to the right medication. As a result, diabetes medication compliance increased (by 13 percent among fixed-combination oral diabetes medication users) after three years, program participants relied less on asthma rescue therapy (declined 18 percent) after five years, and emergency room visits declined (decreased 26 percent for diabetes and 22 percent for asthma program participants) after five years.
- 3) In an analysis using data from Thomson Reuters' Advantage Suite, a diabetes pharmacy program combining value-based insurance design and disease management produced

¹⁵ "Value-based pricing for pharmaceuticals: Implications of the shift from volume to value." 2012. Available at http://www.converge-health.com/sites/default/files/uploads/resources/white-papers/valuebasedpricingpharma_060412.pdf. Accessed May 3, 2016.

increased compliance of 3.7 percentage points with prescription medications and adherence to diabetes guidelines in the program’s first year. Over three years, the program saw a return on investment of \$1.33 for every dollar spent.

Indication-based pricing

With multi-indication drugs on the rise, many of which are high-priced specialty drugs, employers are eager to consider options through which pricing can better reflect differential benefit by indication, and we encourage CMS to do so. In March 2016, the Institute for Economic and Clinical Review (ICER) released a white paper¹⁶ that detailed various models of indications-based pricing for pharmaceutical drugs, outlined the risks and benefits of these models for both payers and manufacturers, and made specific policy recommendations for how these types of agreements could be implemented. **In particular, three major models of indication-specific pricing were described, which could be considered by CMS for pilot testing through the Innovation Center:**

1. Distinct product differentiation, authorized and marketed under different brand names with different prices
2. No brand differentiation, distinct, separate discounts are applied for each indication
3. No brand differentiation, a single “weighted-average” price is developed using estimates of indication use across the population, with possible retrospective reconciliation through rebates based upon actual use

The white paper specifically contemplates indication-specific pricing within Medicare Part B could work:

If indication-specific pricing were applied to physician-administered drugs under the current buy and bill model, the reimbursement levels might not be sufficient to cover the acquisition cost of the drug for some indications. For example, consider a situation in which the average sales price of a drug with two indications is \$750, and therefore the physician reimbursement for use of this drug for either indication would be ASP + 4.3%, or \$782.25. However, if indication-specific pricing were being applied, the physician acquisition cost for the drug could be set at \$500 for indication A and \$1,000 for indication B. Under such a scenario the Medicare reimbursement of ASP + 4.3% (\$782.25) easily covers the acquisition cost for the drug when used for indication A, but the physician would lose money when using the drug for indication B, even though use for indication B represents a higher clinical value (thus the higher price).

Though there may be substantial implementation challenges to indication-specific pricing policies, we had been encouraged by CMS’s willingness to pilot this tool through the Medicare Part B program, in the “Part B Demo,” which was shelved earlier last month. We recognize that there were serious concerns from various stakeholders with the proposed Phase I of the Part B Demo, but had been encouraged by CMS’s willingness to consider additional payments models for prescription drugs. **We recommend that CMS revisit the portion of the Part B Demo that had been focused on alternative payment models for prescription drugs in Phase II of the**

¹⁶ “Indication-Specific Pricing of Pharmaceuticals in The United States Health Care System.” March 2016. Steven D. Pearson, MD, MSc FRCP, et.al. Available at http://icer-review.org/wp-content/uploads/2015/03/Final-Report-2015-ICER-Policy-Summit-on-Indication-specific-Pricing-March-2016_revised-icons-002.pdf. Accessed May 3, 2016.

Demo. Through this process, we recommend that CMS also maintain an open dialog with employers and other payers, as well as manufacturers and providers to identify opportunities for additional changes needed to promote indication-specific pricing agreements.

Reference Pricing

Specific to prescription drugs, employers have long relied on reference pricing, particularly when generic alternatives to more expensive brand medications are available. As CMMI contemplates its new strategic direction, we encourage consideration of reference pricing policies for pharmaceuticals as well as for other easily commoditized, standardized services that beneficiaries can easily shop for and compare prices. One potential academic resource for reference is an article in the *Northwestern Journal of International Law and Business*, which synthesized 16 studies describing 9 reference-pricing policies from 6 countries. The synthesis found that reference pricing led to decreases in drug prices and increases in utilization of targeted medications, while also reducing payer and patient expenditures. The synthesis further suggested there was no increase in the use of medical services, such as physician office visits and hospitalization.

Below are both public and private examples from which CMS could obtain additional information to inform the rule-making process around reference pricing:

CalPERS

A 2013 study evaluated the impact of reference pricing on the use of and prices paid for knee and hip replacement surgery by members of the California Public Employees' Retirement System (CalPERS), the country's second largest purchaser of health benefits. The reference-pricing program saved CalPERS an estimated \$5.5 million over two years, with most of the savings attributed to providers lowering their prices to meet the reference price.

Kroger

Cincinnati-based retailer Kroger Co. experienced a \$4.3 million in company savings in 2012 after implementing reference pricing for prescription medication, and an additional more than \$1.7 million in savings the following year. The program focuses on educating employees about the price variation in certain medical services and prescription medications. Kroger describes its model as being focused on two objectives: 1) to improve health and 2) reduce costs.

4) Mental and Behavioral Health Models

Behavioral health is a growing area of focus among employers and companies are making attempts to improve access and reduce the stigma associated with behavioral health treatment:

- 56% of companies will offer tele behavioral health in 2018, more than a 50% increase in the number of companies providing it this year.
- 20% of companies will offer self-directed online cognitive behavioral therapy in 2018, up from 8% this year.

- Many large employers will offer manager and employee training to help build broader awareness and sensitivity to help employees recognize behavioral health issues in the workforce and provide tips on how to reach out to their colleagues and direct them to appropriate resources.
- In addition, 18% of employers will hold anti-stigma campaigns for behavioral health conditions.

In January 2017, the Business Group convened a meeting of large employers focused on highlighting strategies that employers can use to connect their employees to high-quality mental health care and promote positive emotional wellbeing in the workplace.

According to a spot survey conducted at the event, depression is the primary mental health condition employers are focused on. Depression is the leading cause of disability worldwide. And, people who have a chronic disease with comorbid depression have \$6,720 more in average yearly medical expenses than those without depression.¹⁷ The top barrier to getting people to appropriate behavioral health care remains stigma associated with seeking treatment. Access is also a key barrier. People often struggle to find providers who are taking on new patients. They also run up against a confusing insurance system, which they often need help navigating.

There is no silver bullet to this issue, but more must be done to address stigma and access concerns in both the public and private sectors. Additionally, employers are using new technologies and “big data,” as well as improving their understanding of evidence-based approaches to emotional well-being, which may be of relevance to the Innovation Center. Innovative companies are stepping in to provide tools for consumers. These tools can help build resilience through stress self-management techniques, provide tips for sleeping better and coping with stressors, and offer ways to access necessary care. For example, several start-ups are partnering with employers to provide mobile technologies that enable patients to do Cognitive Behavioral Therapy (CBT) online in their homes, removing barriers like stigma and inadequate provider networks.

5) Comprehensive Primary Care Model

The Comprehensive Primary Care Plus (PCP+) model, a public-private partnership to strengthen primary care through payment and delivery transformation and support for infrastructure to improve quality, boost care coordination and care management, reduce unnecessary services, and lower costs for Medicare and beneficiaries, builds upon positive results of the CPC model that ended in 2016. CPC covered over 400,000 people in Medicare and Medicaid and over 800,000 people with private insurance and improved patient satisfaction, reduced emergency department visits, and had no adverse impact on quality overall though it did improve quality of care for diabetes patients.

CPC+ promises to provide more information on what works and what improvements are needed in the primary care medical home models to increase patient-centeredness of care, improve care management for chronic conditions, increase care coordination across providers and settings of care, and are a key element of the move to population health management to prevent hospitalizations and higher downstream costs for people with chronic conditions.

¹⁷ Druss B, Reisinger Walker E. Mental disorders and medical comorbidity. The Synthesis Project. Robert Wood Johnson Foundation. Accessed February 23, 2017. http://www.integration.samhsa.gov/workforce/mental_disorders_and_medical_comorbidity.pdf.

CPC+ and other innovations in delivery and payment that focus on patient-centered primary care are key areas that CMMI should continue to focus on in the future to align payment and transform delivery to put patients first, improve quality and affordability, and reduce costs for Medicare and its beneficiaries.

In closing, we commend the agency for continuing to seek opportunities to refine payment and delivery reform, leveraging the Innovation Center as a lab of change in the status quo. We are eager to be a resource to CMS and willing to offer our perspective on areas where employers have embraced transformative innovations that may serve as learning opportunities for CMMI. Finally, we look forward to continued partnership as the agency works to transform the nation's health care system into one that is renowned for high-quality and high-value care, through improvement initiatives which pursue a broader system of linked goals. Again, thank you for the opportunity to comment. Please contact me or Steven Wojcik, the National Business Group on Health's Vice President of Public Policy, at (202) 558-3012, if you want to discuss our comments in further detail.

Sincerely,

A handwritten signature in black ink that reads "Brian Marcotte". The signature is written in a cursive, flowing style with a long horizontal tail on the final letter.

Brian Marcotte
President and CEO