PBGH
PACIFIC BUSINESS GROUP ON HEALTH

575 Market St. Ste. 600
SAN FRANCISCO, CA 94105
PBGH.ORG

OFFICE 415.281.8660
FACSIMILE 415.520.0927

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Lew Sandy, MD
Clinical Episode Payment Workgroup
Health Care Payment Learning and Action Network
PaymentNetwork@MITRE.org

Dear Dr. Sandy:

Thank you for the opportunity to comment on the clinical episode payment (CEP) workgroup's paper on episode-based payment interventions and recommendations for coronary artery disease (CAD). The Pacific Business Group on Health (PBGH) is a non-profit membership organization that leverages the strength of 65 public agencies and private employers to drive improvements in quality and affordability across the U.S. health system. Collectively, we spend $40 billion a year purchasing health care services for more than 10 million Americans.

A patient-centered, outcomes-based approach to managing CAD aligns with PBGH's mission to lower health care spending while improving quality of care. Several of our members—including Boeing, Lowes, and Walmart—have direct experience sponsoring programs that include episode-based pricing for cardiac care. The overarching goal of these programs is appropriate utilization of acute interventions (e.g., PCI, CABG) and expensive testing (e.g., stress tests), and accountability for effective symptom management including low incidence of acute myocardial infarction (AMI). It is this set of goals and our members' direct experience that informs our feedback today.

Specific recommendations for improving the CEP CAD recommendations are five-fold:

1. **Explicitly prioritize reduction of PCI and CABG.** The paper provides general language about the need to delivering the right care at the right time, and reduce unwarranted variation in care. While important, we urge the workgroup to set a more explicit goal regarding the relative volume of PCI and CABG surgeries, and then discuss distinct levers to achieve it such as increased use of shared decision making and decision support aids (discussed below). As currently written, the CEP recommendations presume that optimal medication management might address such variation. Our experience suggests this is necessary but not sufficient.

2. **Revise the episode price methodology.** The workgroup's endorsement of an episode price based on a provider's historical costs or the region's average costs is inconsistent with the workgroup and broader LAN goal of implementing innovative payment models. Current practice patterns should not be used to set a total cost for care, as widespread evidence points

to unnecessary care and variations that result from this payment approach.[1] The recommendation that the episode price should strike a balance between provider-specific and multi-provider/regional utilization history does not take into account an important concern that the overall baseline for these services is too high (see Appendix of this letter regarding the growth in service sites relative to the incidence of AMI). Reliance on historical data tends to reinforce supply-side driven utilization patterns and variation that exists today.

Instead, we recommend providers bid their episode price, which would help meet the workgroup's goal of encouraging competition among providers to achieve the best outcomes for the lowest cost.

3. **Adequately address comorbidities and appropriateness of care**. While the workgroup mentions that patients with CAD often experience comorbidities like diabetes and obesity, the paper does not explicitly explain how these comorbidities will be addressed in the episode payment model, beyond acknowledging that comorbidities will make it difficult to define the core services for CAD and suggesting core services are limited to those with a CAD-related diagnosis code. The paper should also clearly define what constitutes appropriate care and ensure this definition represents a suitable threshold. Our experience implementing episode payments for both cardiac and other health conditions shows that care sought by a patient or physician is not always determined to be appropriate and in some cases is deemed unnecessary. Patients and payers may not know if the provider was withholding necessary procedures; conversely, it would be difficult for sub-episode payments for PCI or CABG to be set without encouraging utilization. The workgroup should consider this in their recommendations.

4. **Support patient engagement and shared decision-making**. We support the use of patient-centered tools including the ACC Framingham and Reynolds Atherosclerosis CV Disease Risk Calculators. We strongly support recommendations for inclusion of shared decision making tools for PCI and CABG such as from the Foundation for Informed Medical Decision Making (FIMDM) and others. These tools should take into account patient expectations and outcome goals, risk tolerance, understanding of recovery process, treatment options and consideration of stage of disease progression.

5. **Prioritize recommended metrics.** We recommend inclusion of ACCF/AHA/AMA-endorsed measures for CAD and hypertension, which include both symptom management

[1] In a study based on a National Cardiovascular Data Registry Review, it was found that 12% of PCIs were classified as inappropriate among cases with non-acute indications, with substantial variation across hospitals. See Paul S. Chan, MD, MSc, Manesh R. Patel, MD, Lloyd W. Klein, MD, et al. Appropriate Use Criteria for Coronary Revascularization and Trends in Utilization, Patient Selection, and Appropriateness of Percutaneous Coronary Intervention JAMA. 2015;314(19):2045-2053. doi:10.1001/jama.2015.13764.

and symptom assessment.[2] We encourage use of Seattle Angina Questionnaire or similar PRO for this population to address key areas of importance to patients, including reduction of symptom burden and improvement in quality of life. Condition reimbursement on reporting (and ultimately improving) recommended measures and patient-reported outcomes.

Finally, our members would benefit from a concrete action guide outlining the steps they can take as private employers and public agencies to facilitate the adoption of a clinical episode payment model for CAD.

Thank you again for the opportunity to provide feedback to the CEP workgroup on this important framework document. We look forward to continuing to engage public and private purchasers in the workgroup's activities, and continue to strongly support LAN's broader effort to increase value across the U.S. health system.

Please contact me should you require any additional information or clarification.

Sincerely,

David Lansky, PhD
President and CEO

[2] Joseph Drozda, Jr, MD, FACC, Joseph V. Messer, MD, MACC, FAHA, FACP, John Spertus, MD, MPH, FACC, FAHA, et al., "ACCF/AHA/AMA–PCPI 2011 Performance Measures for Adults With Coronary Artery Disease and Hypertension A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Performance Measures and the American Medical Association–Physician Consortium for Performance Improvement," Circulation. 2011;124:248 –270.

Appendix – State PCI Ratios

Growth in Percutaneous Coronary Intervention Capacity Relative to Population and Disease Prevalence

State	MI Prevalence Rate (Per 1000 Persons)	PCI Centers Per 1000 Square Mile	PCI Centers Per 1 MM Capita
AK	42	0.6	5.7
AL	49	74.4	8.3
AR	47	47.0	8.7
AZ	42	41.2	7.1
CA	34	100.8	4.5
CO	32	31.7	6.6
CT	28	324.7	5.1
DC	21	7316.4	8.3
DE	39	200.9	5.6
FL	42	188.6	6.7
GA	40	104.3	6.3
HI	26	82.3	6.9
IA	37	39.1	7.3
ID	36	10.8	5.8
IL	36	167.5	7.5
IN	47	162.0	9.2
KS	35	28.0	8.2
KY	56	94.0	8.8
LA	42	100.3	11.6
MA	37	350.6	5.6
MD	34	249.9	5.4
ME	39	31.1	8.3
MI	41	61.0	5.9
MN	28	21.9	3.6
MO	40	73.2	8.5
MS	46	49.6	8.1
MT	37	6.1	9.2
NC	42	102.2	5.9
ND	35	8.5	9.3
NE	31	22.0	9.5
NH	33	117.6	8.3
NJ	34	665.0	6.7
NM	34	9.9	6.0
NV	51	16.3	6.8
NY	32	139.3	3.9
OH	40	205.2	8.0
OK	49	44.4	8.4
OR	38	21.3	5.5
PA	39	191.1	7.0
RI	36	388.3	5.7
SC	42	99.9	7.0
SD	36	9.1	8.6
TN	43	121.0	8.1
TX	34	60.7	6.6
UT	32	17.7	5.4
VA	37	98.2	5.3
VT	33	20.8	3.2
WA	30	49.1	5.3
WI	32	61.1	7.1
WV	56	90.8	12.1
WY	32	2.0	3.7

James R. Langabeer, PhD, Timothy D. Henry, MD, Dean J. Kereiakes, MD, et al.; J Am Heart Assoc. October 28, 2013
doi: 10.1161/JAHA.113.000370