



June 1, 2009

The President
The White House
Washington, D.C. 20500

Dear Mr. President:

Four weeks ago we came together, representing six different sectors of the health care industry, and pledged: *As restructuring takes hold and the population's health improves over the coming decade, we will do our part to achieve your Administration's goal of decreasing by 1.5 percentage points the annual health care spending growth rate – saving \$2 trillion or more.*

Since then, we have been working hard on how to help achieve that goal. We have convened seven all-day meetings and multiple conference calls to discuss what we can contribute, both individually and collectively, to help achieve that challenging goal.

We have made solid progress. Individually and together, our organizations have developed initiatives that will help move the nation toward achieving the Administration's goal and we intend to keep working. Our organizations will now pursue these initiatives which, together, will help transform the U.S. health care system.

The attached documents describe each sector's commitments, which will have significant and lasting financial impact over time. Each group has identified changes in its sector that will reduce costs, strengthen quality and improve access to care through the following key areas:

- **Utilization of care:** Providing clinicians and other providers with the tools to address utilization and to improve quality and safety will help ensure that patients receive the right care at the right time in the right setting and will lower costs.
- **Cost of doing business:** Innovative approaches to reducing the growing costs of providing health care services are essential and will benefit all stakeholders in the health care system.
- **Administrative simplification:** Streamlining the claims processing system will allow clinicians and other personnel to spend less time and fewer resources on paperwork, lowering costs for everyone.
- **Chronic care:** We are identifying significant opportunities to better manage chronic disease, which accounts for 75% of overall health care spending. We are also looking at more effective approaches to health promotion and disease prevention, with a special focus on obesity.

Some of these proposals can be achieved under current law. The success of others will depend upon good public policy.

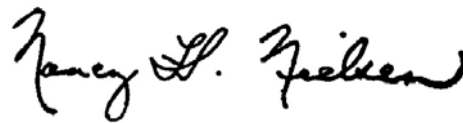
We are committed to doing our part to make the system more affordable and effective for the nation. Our initiatives demonstrate that commitment, and we will work very hard to see them implemented. We can and will work together, and with other key sectors of the health care community, to identify further reform opportunities.

We will continue to work with you, the Congress and other stakeholders to make reform a reality.

Sincerely,



Stephen J. Ubl
President and CEO
Advanced Medical Technology Association



Nancy H. Nielsen, MD
President
American Medical Association



Karen Ignagni
President and CEO
America's Health Insurance Plans



Billy Tauzin
President and CEO
Pharmaceutical Research and Manufacturers of America



Rich Umbdenstock
President and CEO
American Hospital Association



Dennis Rivera
Chair, SEIU Healthcare
Service Employees International Union

Cost Savings Estimates

The literature provides estimates of the potential savings for some, but not all of the proposed initiatives. Based on the literature, the potential savings could be:

- **Utilization of Care:** \$150 - \$180 billion
- **Chronic Care:** \$350 - \$850 billion
- **Administrative Simplification and Cost of Doing Business:** \$500 - \$700 billion

Achieving these system-wide cost reductions will require collaboration and good public policy.

The sources for the above estimates are included in the attachments to the June 1st letter.



AdvaMed

Advanced Medical Technology Association

Medical Technology Industry Initiatives

The Advanced Medical Technology Association represents manufacturers of medical devices and diagnostics. Our members account for 90 percent of the devices and diagnostics sold in the U.S. and 50 percent of the products sold worldwide. Our industry is highly competitive. Over the last 18 years, medical device and diagnostic prices have increased only one-quarter as fast, on average, as other medical prices and one-half as fast as the general consumer price index (CPI).

While the direct cost of these products is a relatively small and stable proportion of national health expenditures (approximately 6 percent), devices and diagnostics are an integral part of medical practice and utilization of health care services and play a key role in preventing, treating and curing disease. Since the key decisions about the use of devices and diagnostics are ultimately made by health care providers, changes in medical practice, in the incentives in the health care system, and in the management and prevention of disease will all have significant effects on utilization of our products.

In addition to the initiatives described below, we also support a number of broader structural changes in the reimbursement and delivery system designed to encourage quality and efficiency that will affect our industry and that we anticipate will substantially reduce health care costs. Among these are a substantially expanded federally supported comparative effectiveness research effort as embodied in the Baucus-Conrad bill and establishment of payment systems that reward providers for the quality and efficiency of care provided.

AdvaMed also is committed to supporting an expanded national commitment to health promotion and disease prevention and to fundamentally restructuring our health care system to provide improved management and treatment of chronic disease. The Milken Foundation has estimated that the difference between our current national trajectory on chronic disease and an alternative path that combines better management with enhanced prevention and technological progress could save the nation more than \$1 trillion annually by 2023.

Finally, the products our industry creates meet clinical needs and extend and enhance lives. Many of them also reduce costs by making it possible to diagnose disease promptly and to cure it more efficiently and effectively.

For example, new diagnostic tests can correctly identify diseases in minutes that once took hours or days to correctly diagnose and are the key to more efficient drug development and targeting. New imaging techniques also can lead to earlier and more accurate diagnosis and replace more invasive procedures. Implantable orthopedic products give the gift of mobility and result not only in better quality of life, but in greater productivity and reduced institutionalization. Device driven innovations in cardiology have contributed to a 50 percent reduction in deaths from heart disease over the period 1980-2000 and kept people active and contributing members of society who would otherwise be dead or disabled. Continued medical progress depends to a significant degree on continued innovation in medical devices and diagnostics.

Initiative #1: Assist in development of quality metrics to improve the role that AdvaMed member companies' technologies play in treating and managing disease.

The AMA convened Physician Consortium for Performance Improvement (PCPI) has identified priorities for targeted measure development to assure appropriateness of care, focusing on areas where there is particular concern about overuse. The device industry believes that the goal of health care delivery must be the right care for the right patient at the right time. Both failure to provide appropriate treatment and provision of inappropriate treatment raise costs and lower quality. The industry commits to working cooperatively with the AMA and the PCPI to contribute its expertise to development of these measures.

To achieve this objective, we will:

- Encourage physicians who have expert knowledge of medical devices to participate in the PCPI and its workgroups;
- Organize our industry sectors to assure full input of our scientific and medical knowledge and expertise in measurement development for device-intensive procedures.

Initiative #2: Reduce medical errors and avoidable injuries

The Institute of Medicine's landmark 1999 study found that as many as 100,000 patients may die annually as a result of in-hospital medical errors and that these errors cost \$38 billion annually. At today's medical costs, the financial toll of medical errors would be \$75 billion. Errors in the outpatient setting add additional costs.

While the proportion is unknown, it is reasonable to assume that some portion of medical errors involves improper use of medical devices and that application of technology to the processes of care could reduce other errors. The device industry commits to launching a three-pronged initiative to reduce medical errors and enhance patient safety.

(1) Human factors and devices. Dr. Peter Pronovost of Johns Hopkins is spearheading a public-private partnership to reduce medical errors. This effort is modeled on the CAST work in the aircraft industry. CAST brought stakeholders together in an effort to reduce the frequency of airplane crashes. Thus far, they have been extremely successful, using a combination of procedural and technological fixes. Dr. Pronovost has successfully reduced the frequency of errors in ICUs through a checklist approach to reducing human errors modeled on procedures used in the airline industry.

A similar approach to other areas of health care with all parties participating can produce significant improvements in patient safety, which leads not only to lower costs but to better care. The medical device industry will engage with Dr. Pronovost's or similar efforts in several ways. We will bring the expertise and experience of our companies to bear in advancing research in identifying medical devices for which modified design or design consistency can reduce human errors and we will encourage companies to make appropriate changes.

An example of this approach occurred years ago in the design of anesthesiology equipment where a simple change in design of all products that assured that the hose to deliver oxygen could only attach to the outlet for oxygen and the hose for anesthesia

could only attach to outlet for anesthesia had an important impact in reducing fatal errors. In addition, device companies can design products that produce software controlled monitoring systems to supplement checklist procedures designed to reduce human error.

(2) Education and awareness. AdvaMed will launch an intensive education and awareness program to encourage our member companies to accelerate and intensify their risk management and human factors programs in product design. We will especially focus these efforts on smaller companies that may lack internal expertise in this specialized area.

(3) Joint Commission. The Joint Commission (TJC) has embarked on an effort to improve safety and quality of care that goes beyond its traditional role of setting of standards for care and monitoring compliance with these standards. The Joint Commission is investing in a new initiative (1) to identify areas where significant quality and safety issues exist in the delivery of health care, and (2) to recommend solutions, strategies, and interventions that will improve safety and quality and at the same time yield savings in health care spending. AdvaMed will work with the Joint Commission in both of these efforts, engaging its companies' medical directors and technology design scientists in the process. Solutions will involve finding efficiencies for health care organizations that will be both reliable and sustainable over time. The first area the Joint Commission has identified for action is hand hygiene. Another area under consideration for future initiatives where device companies have special expertise is infection control more broadly defined.



AHIP's Submission on Behalf of the Health Insurance Industry

AHIP members, in conjunction with the Blue Cross Blue Shield Association, are fully engaged in broad, long-term efforts to improve quality, simplify the process of obtaining and delivering care, and improving value for all those who purchase it.

The initiatives outlined below will help our nation transition to a fully integrated, 21st century health care system that utilizes the benefits of health information technology, rewards quality and value, and empowers patients to more effectively engage in the health care system. These efforts, combined with the work being done by other stakeholders, can help put our health care system on a sustainable path.

ADMINISTRATIVE SIMPLIFICATION

Current situation:

There is currently a lack of uniformity for providers who face administrative challenges created by having business contracts with multiple health insurance plans, each with different telephone numbers, codes, fax numbers, and varying forms and administrative processes.

Proposed reforms:

The health insurance industry is proposing a comprehensive overhaul of administrative processes to standardize and automate five key functions—claims submissions, eligibility, claims status, payment, and remittance. The move to fully automating and standardizing administrative transactions will be a watershed event, allowing physicians, hospitals, and other health care providers to reduce their administrative costs substantially. The effect throughout the health care industry will be similar to the effect of ATMs being introduced throughout the banking system.¹

¹ Third party sources that provide insight into the range of savings that could be achieved if these proposals are implemented across the health care system, including: L.P. Caslino, S. Nicholson, D.N. Gans et al., "What Does it Cost Physician Practices to Interact with Health Insurance Plans?" *Health Affairs* Web Exclusive, May 14, 2009, w533-w543. James G. Kahn, Richard Kronick, Mary Kreger and David N. Gans, "The Cost Of Health Insurance Administration In California: Estimates For Insurers, Physicians, And Hospitals" *Health Affairs* Web, 2005. 24 (6), 1629-1639. Andis Robeznieks, "Adding up the costs" *Modern Healthcare*. May 18, 2009, <http://www.modernhealthcare.com/apps/pbcs.dll/search?Category=Search> Retrieved June 1, 2009.

We are *not* recommending a voluntary effort, but rather that HHS require the adoption of the CAQH Committee on Operating Rules for Information Exchange (CORE). CORE has been developed as part of a multi-stakeholder effort comprised of plans, providers, and suppliers. The goal is to eliminate costly variation and promote uniformity and clarity in the way that information is exchanged between health plans, doctors, and hospitals.

The administrative simplification provisions of HIPAA should be updated and expanded to:

- Direct the Secretary of HHS to utilize and coordinate the work of existing entities, both private and public, including ONCHIT, OESS, NCVHS and CAQH, and adopt a set of comprehensive and robust standards for codes and implementation specifications.
- Require the Secretary to establish a collaborative process to develop common operating rules for all administrative transactions, including the standards in HIPAA that will address: requirements for data content using available and established national standards; infrastructure requirements for streamlining data flow; and policies pertaining to the rights and responsibilities of the entities transmitting data.
- Establish a multi-stakeholder national task force to develop a process similar to the national Correct Coding Initiative (NCCI) to address correct coding for all populations and health care services covered by public programs and private insurers; make recommendations regarding timely adoption of claims coding updates, i.e. ICD, CPT, HCPCS; and recommend uniform prompt pay requirements across all states.

As part of health reform, we are supporting comprehensive reform of market rules. We support uniform federal guidelines operationalized at the state level and the creation of portals to make it easier for individuals and small businesses to evaluate and purchase coverage. This will simplify the system and reduce administrative costs.

We have advocated that each state provide a list of all insurance plans available to individuals and small employers. There would be comparative information in a common format on benefits, price, and quality features to enable individuals and small businesses to comparatively shop for coverage and determine whether they are eligible for subsidies.

BRINGING SIMPLIFICATION SOLUTIONS TO PHYSICIANS NOW THROUGH THE LAUNCH OF COMMON WEB PORTALS

Current situation:

Physicians typically care for patients covered by multiple health insurers in any geographic area. There is a wide variation in the processes used to carry out common office tasks, such as verifying a patient's insurance and submitting/receiving payment, and in the way insurers and physicians exchange the information needed to run medical practices on a day-to-day basis.

Health plan initiative:

The health insurance industry is preparing to launch a major effort that will make common administrative tasks in physician offices simpler, more efficient, and less expensive. Beginning with pilot tests in Ohio and New Jersey that will inform a national strategy, our community is establishing web portals that will allow physicians to conduct business with insurers throughout a region or state at one website, reducing the need to visit multiple websites and/or spend hours on the phone. Common web portals will virtually eliminate paperwork, improve efficiency through the system, and yield significant savings.

Expansion to include government programs:

AHIP is recommending that the Department of Health and Human Services work with the private sector to implement these demonstration projects across all payers, private and public, to test advanced administrative connectivity to providers through web portals and other business-to-business technology for both the electronic transaction of administrative data in phase I and clinical data exchange in phase II.

AGGREGATING PHYSICIAN PERFORMANCE DATA

Current situation:

Stakeholders from across the health care system support the principle that measuring and reporting on quality are fundamental building blocks for achieving the goals of reform – improved quality, improved access, and improved value. Physicians have raised concerns about that lack of uniformity and consistency in how their performance is evaluated. Currently, physician performance is measured by individual health plans and public programs that utilize different sets of measures and look at only a subset of patients.

Health plan initiative:

Public sector and private sector data will be combined using common measures and common methods to arrive at a more complete and accurate picture of the quality of care providers deliver. Using consistent measures endorsed by the National Quality Forum, and in conjunction with local physicians, this project will compile data for 12 important measures of physician performance, and give physicians the ability to evaluate and comment on the data and communicate results to consumers. This approach will be tested

in two pilot communities in 2009 to advance a nationally-consistent data aggregation strategy.

IMPROVING HEALTH LITERACY

Current situation:

Health literacy is the ability to understand and act on the medical information and instructions we are given. Almost half of all Americans lack the skills needed to navigate the health care system and engage meaningfully in their own health care. A 2007 study from the School of Business at the University of Connecticut estimates that low health literacy costs the health care system between \$106 and \$238 billion annually.

Health plan initiative:

Working with researchers at Emory University, our community has launched a groundbreaking effort, now in pilot testing, that will allow health plans to assess their health literacy across their organizations and to build targeted health literacy programs. This will be the first such tool that makes it possible for a health care organization to conduct such a company-wide assessment.

EMPOWERING CONSUMERS THROUGH THE USE OF PERSONAL HEALTH RECORDS

Current situation:

About half of all Americans live with at least one chronic medical condition, and chronic disease accounts for more than 75% of the nation's health care costs. In addition, personal health information needed for clinical decision making is often dispersed piecemeal among a number of physicians, hospitals, pharmacies, and other health care providers. This lack of coordination within the health care system results in preventable medical errors, duplication of tests and procedures, and the delivery of inefficient and inappropriate care.

Health plan initiative:

Consumers, especially those with chronic conditions, will have greater access to the information they need to optimize their health and health care as the result of the personal health record (PHR) model developed by AHIP and BCBSA in a coordinated effort. Our community has identified common elements that should be included in PHRs and has tested mechanisms to transfer PHRs when consumers change coverage and plans of care.

The Center for Information Technology Leadership estimates that the adoption of health plan PHRs could save as much as \$11 billion annually.

American Hospital Association



The American Hospital Association (AHA) is working to fulfill the hospital field's commitment to develop concrete ideas to achieve the Administration's cost containment goals. The following document presents specific actions that can be taken in the immediate term, as well as longer-term initiatives, to bend the cost curve. It also includes actions that can be taken to collaborate with other stakeholders. Some of these initiatives would be further enabled by public policy changes, changes that the AHA will continue to pursue on Capitol Hill.

The document is divided as follows:

- I. Immediate Cost Savings Initiatives
- II. Longer-Term Initiatives
- III. Cross-Stakeholder Initiatives

I. Immediate Cost Savings Initiatives

Containing health care costs is a complex undertaking that will require the cooperation of various stakeholders, and broad-based action across both the private and public sectors.

The nation's hospitals firmly believe that ensuring access to quality, affordable coverage for every American is a key first step. As the Commonwealth Fund noted in its 2007 Annual Report, "If everyone in the U.S. had health insurance coverage, the possible cumulative health system savings could amount to more than \$1.5 trillion over 10 years. Rather than national health expenditures rising from 16% of GDP to 20% by 2017 – as is currently projected – spending could be held to 18.5% of GDP."

While America's hospitals continue to advocate for coverage for all, paid for by all – a key pillar of our *Health for Life: Better Health. Better Health Care.* framework for overall health system reform – there are immediate steps hospitals are taking to contain costs. Many of these steps have been tested and adopted by hospitals and health systems in partnership with their national, state, regional and metropolitan hospital associations and have shown great promise for improving quality and reducing costs across the board. Other strategies flow from our recent work with strategic partners such as the Agency for Healthcare Research and Quality (AHRQ).

On behalf of America's hospitals, the AHA will work in conjunction with our hospital association partners, as well as other stakeholders such as the Institute for Healthcare Improvement (IHI), to design and implement the *Hospitals in Pursuit of Excellence* campaign. The goals of this campaign will be to:

- Facilitate hospital and health system performance improvements that have meaningful quality improvement and associated cost savings;
- Further the use of known best practices, initially in the areas of infection prevention and patient safety and expanding over time into other areas;

American Hospital Association



- Facilitate the sharing of best practices among hospitals, health systems and national, state, regional and metropolitan hospital associations; and
- Demonstrate the commitment of the hospital field to achieve these improvements.

Hospitals in Pursuit of Excellence Campaign	
1. Reduce surgical infections and complications ⁱⁱ	Promote adoption of the World Health Organization (WHO) Surgical Safety Checklist to enable teams to implement critical safety steps. AHA has co-sponsored with IHI a webinar to encourage hospitals to test an adaption of the checklist and will accelerate sharing and learning among hospitals.
2. Reduce central line-associated blood stream infections (CLABSI) ⁱⁱⁱ	Promote best practice strategies to reduce central line-associated blood stream infections through reliable implementation of infection prevention and monitoring strategies. In conjunction with AHRQ, AHA has been working with multiple states and hospitals to spread best practices in implementing a culture of safety and teamwork and accelerating the elimination of CLABSI.
3. Reduce methicillin-resistant Staphylococcus aureus (MRSA) ^{iv}	Promote best practices in screening, hand hygiene and contact precautions to prevent the spread of MRSA. AHA and several health systems are collaborating with The Joint Commission on a broad ranging, new initiative to improve patient safety and reduce preventable complications, starting with an effort on hand hygiene.
4. Reduce clostridium difficile infections (c diff) ^v	Promote best practices in screening, hand hygiene and contact precautions to prevent the spread of c diff. AHA and several health systems are collaborating with The Joint Commission on a broad ranging, new initiative to improve patient safety and reduce preventable complications, starting with an effort on hand hygiene.
5. Reduce ventilator-associated pneumonia (VAP) ^{vi}	Promote the spread of reliably tested best practices for patients receiving mechanical ventilation.
6. Reduce catheter-associated urinary tract infections ^{vii}	Promote best practices in the appropriate use, insertion and care of catheters to minimize urinary tract infections.
7. Reduce adverse drug events from high-hazard medications (e.g., anticoagulants, narcotics, opiates, insulin, sedatives) ^{viii}	Promote best practices in the prevention of adverse drug events focused on high-hazard medications by using standardized protocols, adequate monitoring and increased patient and family education.
8. Reduce pressure ulcers ^{ix}	Promote best practices in helping hospitals assess the risk of a hospital-acquired pressure ulcer, daily skin inspection and optimizing prevention.

II. Longer-Term Hospital Initiatives

In addition to the aforementioned immediate opportunities, hospitals will continue to increase their engagement in a number of longer-term initiatives. The *Hospitals in Pursuit of Excellence*

American Hospital Association



campaign will help promote these initiatives as the evidence, tools and nationally endorsed measures for these opportunities develop:

- Improving Care Coordination – Focus in particular on the discharge process and care transitions.
- Implementing Health Information Technology (HIT) – Focus on leadership and clinical strategies to effectively implement HIT.
- Promoting Efficient Resource Utilization – Promote palliative and hospice care through the use of advanced directives and best practices.
- Preventing Patient Falls – Further the implementation of effective fall prevention programs and use of fall risk assessment tools.
- Improving Perinatal Care – Promote best practices to improve perinatal care and reduce birth trauma and complications.
- Reducing Supply Costs – Create a more efficient and transparent purchasing environment, including greater alignment of hospital and physician incentives, greater product standardization and other measures.

III. Cross-Stakeholder Initiatives

The hospital field is committed to continuing its work with health plans, physicians and other stakeholders to achieve a more efficient, effective and coordinated health care system. The future vision of such a system includes simplified and standardized public and commercial insurance processing systems, reducing the need to practice defensive medicine and enhancing the ability of practitioners and providers to integrate clinically to improve quality of care.

i The Commonwealth Fund. Annual Report. 2007.

http://www.commonwealthfund.org/usr_doc/site_docs/annualreports/2007/AR2007.pdf.

ii Centers for Disease Control and Prevention. Scott, DR, The Direct Medical Costs of Healthcare-Associated Infections in U.S. Hospitals and the Benefits of Prevention. March 2009. http://www.cdc.gov/ncidod/dhqp/pdf/Scott_CostPaper.pdf.

iii *ibid*

iv <http://www.infectioncontrolday.com/hotnews/55h168584264313.html>.

v Centers for Disease Control and Prevention. Scott, DR, The Direct Medical Costs of Healthcare-Associated Infections in U.S. Hospitals and the Benefits of Prevention. March 2009. http://www.cdc.gov/ncidod/dhqp/pdf/Scott_CostPaper.pdf.

vi *ibid*

vii *ibid*

viii Committee on Identifying and Preventing Medication Errors. Aspden P, Wolcott J, Bootman JL, Cronenwett LR, Editors. *Preventing Medication Errors: Quality Chasm Series*. Washington, DC: National Academies Press; July 2006.

ix Reddy M, Gill SS, Rochon PA. Preventing pressure ulcers: A systematic review. *JAMA*. 2006;296:974-984.



Medicine's Efforts to Address Utilization of Care

Background

The AMA-convened Physician Consortium for Performance Improvement (PCPI) develops evidence based measures that capture variations in care and inform efforts to improve the quality of care and the appropriate utilization of health care services and treatments. The measures are developed by expert work groups including practicing physicians, health care professionals, patients, representatives of health plans, and others. All measures are reviewed by the PCPI membership, which includes more than 100 national specialty societies, state medical associations, ABMS and member boards, Council on Medical Specialty Societies, and 13 health care professional organizations, as well as CMS, AHRQ, a Consumer/Purchaser Advisory Panel, private health plans, and other organizations.

Improve Care Transitions to Avoid Hospital Readmissions

To reduce hospital readmissions within 30 days of initial discharge, the PCPI, the American Board of Internal Medicine Foundation, the American College of Physicians and the Society of Hospital Medicine has developed a set of measures to improve care transitions from hospitals to other settings. These measures focus on medication guidance for patients prior to discharge, care transition records for patients prior to hospital discharge and timely transmission of medical information to physicians serving the patient following hospital discharge. The Care Transitions measures have been submitted to the National Quality Forum for review.

Simultaneously, the AMA is undertaking development of an electronic care transition tool that will facilitate the transfer of information between hospitals and primary care doctors, emergency departments and primary care doctors. We are currently in discussions with HIT entities and healthcare systems to adopt the format. We are also developing a strategy to partner with other entities in a campaign to improve care transitions in order to improve quality, reduce redundant testing, and improve the efficiency of care processes to be rolled out in 2010.

Significance: Studies project substantial savings from reducing hospital readmissions.

Efforts to Reduce Unnecessary Utilization

The PCPI initiated work in 2009 to address concerns about the overuse of certain services or procedures. Topics were selected based on priorities established by the Institute of Medicine, the National Quality Forum, the National Priority Partners and the PCPI. Selection criteria include high variation, high volume and high cost, availability of relevant guidelines, and the potential for improving quality and efficiency of care.

The PCPI selected the following topics for development of overuse measures this year:

- Surgical and non-surgical management of back pain

Significance: A major health plan reported that nearly 20% of plan members' spine surgery occurred within the first 6 weeks of symptoms, which is not consistent with guidelines. The volume of spinal fusion surgery has increased significantly. Eliminating unwarranted variations in treatment will produce substantial savings.

- Percutaneous Coronary Intervention (PCI) (encompasses a variety of procedures) for Chronic Stable Coronary Artery Disease

Significance: Studies project large potential savings from adhering to evidence based guidelines for coronary artery disease.

- Maternity Care: Induction of labor/Caesarean Sections

Significance: There has been a substantial increase in the rate of elective induction of labor. Practice patterns are not always consistent with ACOG guidelines. Expenses related to c-section births account for 45% of the more than \$79 billion in annual hospital charges attributed to childbirth in the U.S. annually.

- Sinusitis: Antibiotic prescriptions and sinus radiography

Significance: Antibiotics for sinusitis account for 21 percent of all antibiotic prescriptions for adults and 9 percent for children. More than 1 in 5 antibiotic courses for adults are for sinusitis. Sinusitis is the fifth most common diagnosis for which an antibiotic is prescribed. Overuse of antibiotics for respiratory and sinus infections is an increasing problem, with potential savings of \$525 million to \$1.1 billion (New England Healthcare Institute).

PCPI will develop measures for diagnostic imaging, examples include:

- CT angiography for pulmonary embolism
- MRI of the knee
- MRI of the shoulder
- CT or MRI of the head
- Stress Echocardiography
- SPECT MPI

Significance: Although their growth has moderated significantly since implementation of the Deficit Reduction Act of 2005, Medicare payments for physician imaging services increased from \$7 billion to \$14 billion between 2000 and 2006. This represented a 13 percent annual increase in spending for these services, versus an 8 percent increase in all Medicare physician-billed services over the 2000 to 2006 time period. For a 10 year period from 1997 to 2006, a large private insurer saw CT utilization per enrollee increase 14 percent per year, and MRI increase 26 percent per year. Specialty societies, PCPI members, health plans and government agencies have identified diagnostic imaging as an important area for developing measures of overuse given the rising costs, increased volume and numerous published articles on the topic.

Note: A significant portion of higher level imaging is driven by the fear of potential lawsuits, commonly referred to as defensive medicine. There is extensive literature indicating that defensive medicine adds tens of billions of dollars in health care spending. Physicians who adhere to evidenced based best practice guidelines are not protected from lawsuits in our current

liability system. Congress needs to enact liability protections for physicians who adhere to best practice guidelines and fund state demonstration projects to test alternative reforms such as health courts, administrative compensation systems and early offer initiatives.

Medication Reconciliation

The AMA has initiated a multi-pronged effort to reconcile multiple prescriptions for individual patients treated by different physicians. This program of medication reconciliation is designed to avoid potential adverse events and inappropriate prescriptions. A prototype electronic version of the medication reconciliation card is undergoing beta-testing. A second version will be tested in early July. The AMA is completing a strategy to make the electronic version available to employers, health systems and physicians available by the end of 2010.

Significance: Literature reviews project potential annual savings of \$3 billion.

The initiatives by physician groups outlined above represent current activities. This portfolio will be expanded in the years ahead to reduce the rate of growth in total health care spending.

Biopharmaceutical Sector and Bending the Cost Curve

Medicines have already begun to play a key role in bending the cost curve in the U.S. For example, IMS Health reports that in 2008, spending for prescription medicines grew by just 1.3% over 2007 – the lowest rate since 1961. In 2009, IMS projects that the U.S. market for prescription medicines will contract, declining 1-2% *below* 2008 levels. Going forward till 2014, IMS projects annual growth rate for prescription medicines to remain essentially flat.¹ Between 2008 and 2009, CMS’s Office of the Actuary reduced its 10-year forecast of total drug spending by 14% or \$515 billion.² Declining cost trends have been driven by several factors. For example, generic use rate in the U.S. is now at 72 percent – up from 43 percent in 1996 – and is expected to further increase over the next several years as additional brand prescriptions come off patent. Since 2007, over 130,000 global biopharmaceutical job losses have been announced.

Investments in Public Health and Reforming the Delivery System

As recognized in the coalition’s May 11 letter, “Billions in savings can be achieved through a large-scale national effort of health promotion and disease prevention to reduce the prevalence of chronic disease and poor health status, which leads to unnecessary sickness and higher health health costs.” PhRMA supports moving forward with significant public health initiatives to reduce the need for health services, including medicines. The importance of substantial public health and primary prevention initiatives to bending the cost curve is evident in the projection by David Cutler and colleagues finding that reducing obesity to levels seen in the 1980s would achieve savings of over \$1 trillion in Medicare alone over the next 25 years.³ Likewise, the importance of public health and primary prevention initiatives to bending the cost curve is evident in the doubling of the number of new diabetes cases in the U.S. over the last decade. Individuals with diabetes have average health spending that is about 4 times the level of individuals without diabetes, indicating the impact increasing incidence has on health costs. It is also evident in the impact diabetes has on other conditions. For example, according to research, “Cardiovascular disease in the setting of diabetes is more premature, relentless and recurrent, despite aggressive therapies and interventions...Chronic kidney disease is also accelerated by diabetes, which, in turn, hastens the pace of hypertension, atherosclerosis, and heart failure.”⁴

To help achieve savings, PhRMA also supports a series of policy changes that will support delivery of less fragmented, better coordinated, more efficient and higher quality care. As stated in the coalition’s May 11 letter, encouraging coordinated care, adherence to evidence-based best practices, implementing proven clinical prevention strategies, and aligning quality and efficiency incentives are key to achieving a more sustainable and stable health system. How medicines are used is determined by our health care system; the array of changes to improve the delivery system will significantly affect use of medicines, reducing overuse, underuse and misuse and allowing patients and society to achieve their full therapeutic value.

1 IMS Press Release, “IMS Health Reports U.S. Prescription Sales Grew 1.3 Percent in 2008 to \$291 Billion,” March 19, 2009.

2 A. Sisko et al., “Health Spending Projections Through 2018: Recession Effects Add Uncertainty to the Outlook,” Health Affairs, February 2009.

3 D. Goldman et al., “The Value of Elderly Disease Prevention, 2006, available at: http://www.bepress.com/fhep/biomedical_research/1.

4 M.L. Weisfeldt and S. J. Zieman, “Advances in the Prevention and Treatment of Cardiovascular Disease,” Health Affairs, January/February 2007.

Better use of medicines driven by delivery system changes can have a central role in further bending the cost curve, as well as helping achieve better health outcomes.⁵ For example, better use of medicines can save lives, decrease utilization of other health care services, enhance productivity and save money. A large and growing body of data shows that proper use of medicines can keep patients with chronic illnesses healthy, slow disease progression and minimize costly hospitalizations. Although medicines play a central role in effective treatment, in today's health care system they often are not used well – meaning foregone opportunities for better health and cost savings. For instance, David Cutler and colleagues have reported that use of antihypertensive medicines prevented 833,000 hospitalizations in 2002 alone.⁶ Cutler notes that we have achieved only half the health gains available against hypertension. He projects that if all untreated patients with Stage I or II hypertension had been treated and achieved normal blood pressure, an additional 89,000 excess premature deaths from major cardiovascular disease could have been avoided in 2001 and 420,000 hospitalizations for stroke and myocardial infarction avoided in 2002. University of Maryland School of Pharmacy researcher Bruce Stuart reports that each additional prescription used nets Medicare a savings of \$57 in reduced hospital stays.⁷ A recent Agency for Health care Research and Quality (AHRQ)-sponsored study found that a discharge nurse and pharmacist working to coordinate hospital discharges and educate patients on the use of discharge medications significantly reduced unnecessary and costly hospital readmissions relative to the usual standard of care.⁸

Use of prescription medicines is often determined by incentives that drive the health care delivery system. Realigning incentives to consistently deliver high quality care will therefore significantly affect use of medicines, reducing overuse, misuse and underuse. Therefore, PhRMA supports:

- **Development and use of performance measures to drive quality and promote better, more efficient care.** PhRMA supports public reporting of performance measures to aid in decision-making by patients and payers, and the need to move toward performance-based payment for providers based on sound clinical, evidence-based quality measures that are developed and endorsed by professional consensus. These programs should reward health care practitioners for delivering and improving care consistent with consensus-based quality standards while recognizing the need to individualize treatment. For example, measurement of appropriate evidence-based processes (e.g., hemoglobin A1c test administered to patients with diabetes) and expected outcomes (e.g., control of blood glucose as demonstrated by hemoglobin A1c<8% in patients with diabetes) are typical means or measures of evaluating the effectiveness of a quality improvement initiative. Adoption of well-designed performance measures can help to ensure that patients are receiving the right types of

5 Full a full description of studies concerning cost-offsets related to medication use and the importance of adherence in improving health and lowering cost, see: "Just What the Doctor Ordered: Taking Medicines as Prescribed Can Improve Health and Lower Costs," and "Medicines Play a Key Role in Improving Health While Reducing Avoidable Costs," available at www.phrma.org.

6 D. Cutler et al., "The Value of Antihypertensive Drugs: A Perspective on Medical Innovation," Health Affairs, January/February 2007.

7 B. Stuart et al., "Assessing the Impact of Drug Use on Hospital Costs," Health Services Research, February 2009.

8 B.W. Jack et al., "A Reengineered Hospital Discharge Program to Decrease Rehospitalization," Annals of Internal Medicine, February 2009.

treatment, including pharmacotherapy, for a given condition and that patients are actually following the treatment regimens to achieve desired health outcomes.

The importance to bending the curve of creating a system that better supports quality, efficient care is evident in current treatment patterns for diabetes, hypertension and high cholesterol. Of the 24 million Americans with diabetes, 6 million are undiagnosed, 3 million are untreated and 9 million are treated, but not well controlled.⁹ According to research by David Cutler, among those with hypertension, 24% are unaware, 11% are aware but not treated, 34% are treated but not controlled and 31% are controlled. Further, Cutler's research finds that of those Americans with high cholesterol, 37% are unaware, 22% are aware but not treated, 16% are treated and not controlled and 25% are controlled.¹⁰

One important aspect of performance measurement development is improving adherence to physician-directed treatment. Poor adherence to needed medicines is one of the central reasons that patients with chronic illnesses often do not achieve optimal outcomes and suffer illnesses and costs that could have been avoided. Research estimates the cost of non-adherence at \$100 billion to \$300 billion annually, including costs from avoidable hospitalizations, nursing home admissions, and premature deaths.¹¹ Many of the human and economic costs associated with non-adherence can be avoided, making improving patient adherence one of the best opportunities to get better results and greater value from our health care system. For example, one study reports that people with diabetes who took their diabetes medicines less than 60 percent of the time were 3.6 times more likely to be hospitalized than those who followed their prescribed treatment.¹² Another study found that better adherence to medicines among patients with diabetes, high cholesterol, and high blood pressure has been shown to reduce total health care costs by \$4 to \$7 for every additional dollar spent on medicines.¹³ Even if performance measurement only addresses a small portion of non-adherence, there are significant opportunities to save tens of billions of dollars in the health care system.

- **Expanded use of medication therapy management (MTM) to address polypharmacy, reduce medication errors and inappropriate use, and achieve better clinical outcomes at lower cost.** MTM is an important mechanism for evaluating a beneficiary's multiple conditions and prescribed medicines to ensure that their treatment and care are appropriately coordinated and managed. The pharmaceutical sector and other partners in the health care system have been supporting development of MTM models to identify models that can work to improve care and lower costs. A program originated in Asheville, North Carolina (the Asheville Project) has since been expanded based upon its success. The expanded program, known as the Diabetes Ten City Challenge (DTCC), is sponsored by the APhA Foundation

9 See, "Pitfalls & Opportunities in Diabetes Prevention & Care," PhRMA.

10 D. Cutler, "Improving Chronic Care Management," Presentation at Alliance for Health Reform Briefing, March 28, 2008.

11 L Osterberg and T Blaschke, "Adherence to Medication," *New England Journal of Medicine* 2005;353:487-97 and M.R. DiMatteo, "Variation in Patients' Adherence to Medical Recommendations: A Quantitative Review of 50 Years of Research," *Medical Care*, March 2004.

12 D.T. Lau and D.P. Nau, "Oral Antihyperglycemic Medication Nonadherence and Subsequent Hospitalization Among Individuals with Type 2 Diabetes," *Diabetes Care* 2004;27(9):2149-53.

13 M.C. Sokol, et al., "Impact of Medication Adherence on Hospitalization Risk and Healthcare Cost," *Medical Care*, June 2005.

with support from GlaxoSmithKline, and is a voluntary health benefit involving waiver of co-pays for diabetes medications and supplies. The program also involves helping people better manage their diabetes on a day to day basis with the help of a specially-trained pharmacist "coach".

Today, 30 employers and hundreds of local pharmacists in ten cities are working together to help people manage their diabetes. In addition, as a result of a partnership with Mirixa Corporation announced in 2009, the DTCC model of collaborative care is now available to employers nationwide through HealthMapRx. The program has established a proven track record in improving care and lowering costs. A report published in the May/June 2009 issue of the *Journal of the American Pharmacists Association* (JAPhA) documents the economic and clinical benefits for employers and participants. According to the research, employers realized an average annual savings of almost \$1,100 in total health care costs per patient when compared to projected costs if the DTCC had not been implemented and participants saved an average of almost \$600 per year. Participants also improved in all of the recognized standards for diabetes care, including decreases in A1c, LDL cholesterol and blood pressure; and increases in current flu vaccinations and foot and eye exams. Given the significant economic and societal impact of diabetes, the DTCC represents a promising model in designing a patient-centered health benefit, one that improves outcomes for patients and manages costs for everyone involved. Another program, also part of the original Asheville program, focused on managing of cardiovascular disease. The program decreased cardiovascular-related medical costs from 31 percent of total health care costs to 19 percent during a six-year study period while increasing the use of cardiovascular medicines nearly threefold. The program also resulted in a 50 percent decrease in the risk of a hospitalization or an emergency room visit due to a cardiovascular event.¹⁴ Both the DTCC and cardiovascular model are illustrative of the types of models that can help reform our system.

In addition to the models being sponsored by the pharmaceutical industry and APhA, the Medicare Modernization Act required that Part D plans have MTM programs that ensure that covered Part D drugs prescribed to targeted beneficiaries¹⁵ are appropriately utilized to optimize health outcomes and reduce the risk of adverse events. Many targeted beneficiaries have complex medication regimens, which makes MTM important to ensure that their chronic conditions are managed appropriately and that optimal health outcomes are achieved. While CMS has taken helpful steps to improve consistency and performance among MTM programs, additional changes could further enhance results. PhRMA supports establishment of clear requirements, development of a quality-based payment program that recognizes achievement of performance targets, targeting beneficiaries for MTM services based on total Medicare costs (rather than just drug costs), and testing of approaches, including financial incentives, to improve active patient engagement in MTM programs. Continued efforts to establish clear, rigorous requirements and a quality-based payment program that recognizes achievement of performance targets will help improve health outcomes, particularly for beneficiaries with chronic conditions, and also presents opportunities to save the health care system money by ensuring appropriate use of medicines.

14 B. Bunting et al., "The Asheville Project: Clinical and Economic Outcomes of a Community-based Long-term Medication Therapy Management Program for Hypertension and Dyslipidemia," *Journal of the American Pharmaceutical Association*, January/February 2008.

15 Targeted beneficiaries are those patients who have multiple chronic diseases, take multiple medications, or reach an established spending threshold.

- **Development of an abbreviated regulatory approval pathway for biosimilars that assures patient safety, increases competition, and provides responsible incentives for the R&D investment needed** (including patent protection and at least 14 years of data protection). Biologics are revolutionizing health care with effective, targeted therapies for many devastating diseases such as cancer, Alzheimer's, and Parkinson's and will be critical in achieving the President's goal of retiring words like 'terminal' and 'incurable' from our vocabulary. As of 2008, more than 300 biologics have been approved by the FDA and 633 biotechnology medicines were in development, including more than 250 for various cancers.¹⁶

Strengthening the Evidence Base

- **Well-designed comparative clinical effectiveness research (CER) as an important tool to support good decision-making in health care.** The Baucus-Conrad bill introduced in the last Congress is a good basis from which to establish policy in this area. Strengthening the evidence base for clinical decisions and decisions about how care can be organized so that patients receive the best possible care should be an important element of health care reform. CER can help inform the policy- and population-level decisions already being made in the health care system through existing processes. CER efforts at all levels should help inform and support decisions made by patients and providers. Empowering patients and physicians with high quality information on the full range of available treatment options and health services will help ensure that our health system efficiently delivers the best possible results for all patients.
- **Support the release of Part D data to facilitate research on effective care.** PhRMA supports release of additional Part D data, including plan identifiers, plan-level benefit design and formulary data (while, as CMS recognizes, protecting proprietary information, such as rebates, important to the competitiveness of the market). This would be useful to support research on patterns of care (especially when linked with Medicare A and B data), the impact of alternative benefit designs on adherence and clinical outcomes, and can help improve care for dual eligible beneficiaries. CMS should also make available an expanded number of performance measures developed and endorsed by a multi-stakeholder consensus process.

Drug Development

As stated in the coalition's May 11 letter, "the proper approach to achieve and sustain reduced cost growth is one that will ... encourage the advancement of medical treatments, approaches and science", among other factors. An example is of innovation's importance in achieving this goal is found in Alzheimer's Disease. Today, Medicare beneficiaries with Alzheimer's disease account for 34% of Medicare spending, even though they constitute only 12.8% of the

¹⁶ Biotechnology Research Continues to Bolster Arsenal Against Disease with 633 Medicines in Development." Accessed at: <http://www.phrma.org/images/110308%20biotech%202008.pdf> on May 8, 2009.

population age 65 and older. According to a study by the Lewin Group¹⁷, commissioned by the Alzheimer's Association, Medicare and Medicaid costs can be reduced by slowing the onset and progression of Alzheimer's disease. This could achieve annual Medicare savings of \$51 billion by 2015, \$126 billion by 2025, and \$444 billion by 2050. Annual savings in Medicaid spending on nursing home care would also be significant – \$10 billion in 2015, \$23 billion by 2025, and \$70 billion by 2050. Today, biopharmaceutical companies have 67 medicines in development for the treatment of Alzheimer's.

➤ **Initiatives to improve the efficiency of drug development.**

The cost and challenges of new drug development continue to increase as the disease areas targeted for new drugs are more complicated, our understanding of them is less complete, and as clinical trial and post-approval requirements increase.¹⁸ The biopharmaceutical research sector is continually retooling to seek more efficient drug development and to exploit new scientific opportunities. Companies' efforts to improve the development process have been especially intensive in recent years. There are a number of initiatives that can complement this ongoing intensive work throughout the sector. These initiatives, many of them broadly collected under FDA's Critical Path Initiative, include:

- Expanding the development and utilization of biomarkers through public-private partnerships, such as the Biomarkers Consortium;
- Encouraging the development and use of new trial designs (such as adaptive designs and designs for targeted populations and sub-populations based on genetic markers or specifically defined and measured disease states);
- Encouraging incorporation of standard of care real world data for illustrating novel treatment benefit; and
- Fostering better utilization of post-approval methods for further elucidation of benefit and risk.

➤ **Acceleration of the development and adoption of personalized medicine.** Incorporating personalized medicine into the fabric of the healthcare system can help resolve embedded inefficiencies, such as trial-and-error dosing, poor adherence to therapy, avoidable hospitalizations, late diagnoses, and care that is reactive rather than proactive preventative therapy. Moreover, personalized medicine offers better targeting of therapies to those who can benefit from their use by allowing the best matching of a patient and a medicine. For example, economists at the FDA have estimated that the use of a genetic test to properly dose the blood thinner warfarin could prevent 17,000 strokes and 85,000 “serious bleeding events” each year and avoid as much as 43,000 visits to the emergency room.¹⁹ If the 2 million people that start taking warfarin each year were to be tested at a cost of \$125 to \$500 per patient, the overall cost savings to the healthcare system would be \$1.1 billion

17 “Saving Lives. Saving Money. Dividends for Americans Investing in Alzheimer's Research,” The Lewin Group, March 2005, Prepared for the Alzheimer's Association.

18 Tufts University Center for the Study of Drug Development, Growing Protocol Design Complexity Stresses Investigators, Volunteers, Tufts Impact Report (Jan./Feb. 2008), available at http://csdd.tufts.edu/_documents/www/Doc_309_65_893.pdf.

19 McWilliam A, Lutter R, Nardinelli C. Health Care Savings from Personalizing Medicine Using Genetic Testing: The Case of Warfarin. 2006 AEI-Brookings Joint Center; (Available online at: <http://aei-brookings.org/publications/abstract.php?pid=1127>)

annually. In addition, studies have found that hundreds of millions of dollars can be saved by targeting cancer therapies based on specific genetic mutations. Through public-private partnership efforts such as the Biomarkers Consortium and C-PATH Institute, industry, academia and government can facilitate the evolution of the regulatory framework needed to support the full development of personalized medicine.

Companies are working intensively to advance personalized medicine. This work's potential for improved patient outcomes and health care value can be supported by taking additional steps, such as including consideration of personalized medicine in the HIT infrastructure and codifying the HHS Personalized Health Care Initiative.

Expanding Access to Comprehensive and Competitive Prescription Drug Coverage

- **Assuring all Americans access to good prescription drug coverage – resulting in negotiated savings for 47 million more Americans.** Approximately 47 million Americans are wholly uninsured - these individuals typically pay undiscounted retail prices at the pharmacy counter. We support each and every one of these 47 million individuals gaining insurance coverage that will include negotiation of savings on prescription drug prices. The largest U.S. purchasers, such as PBMs, each negotiate for over 700 million prescriptions on behalf of tens of millions of individuals. This allows them to achieve significant savings off retail prices for the people they cover.



SEIU's Submission: Proposals to Bend the Cost Curve
June 1, 2009

SEIU recognizes that bending the cost curve will involve major changes in the operations of healthcare institutions and these changes will have a major impact on our more than one million healthcare members. Reducing unnecessary procedures, replacing paperwork with electronic medical records, using health IT to improve work flow and shifting the emphasis to prevention will allow our members to spend more time with their patients providing the right care at the right time in the right setting. We understand that creating a more efficient healthcare delivery system requires a strong partnership among organized labor, hospitals, and physicians.

We also understand that a more efficient delivery system requires realignment of the workforce—and in some cases, a reduced workforce. Fewer workers handling charts, but more workers engaged in prevention. Less time spent on redundant tests and imaging but more time on educating patients on wellness. The dislocation will be difficult; change always is. While we must create pathways for our healthcare workforce to retrain and upgrade for the new jobs and new opportunities, we cannot be afraid of the new face of healthcare. SEIU stands ready to help our provider partners in developing the best trained and prepared workforce.

Our readiness to move forward is best judged by steps we have already taken in major restructurings of the delivery system. SEIU actively supported the efforts of New York State's Berger Commission to "right size" the acute and long term care sectors. The Commission made 57 mandatory recommendations, affecting 81 acute care and long-term care facilities. The acute care recommendations reconfigured 57 hospitals or one-quarter of all hospitals in the State—with nine facilities being closed. Collectively, the Commission sought to reduce inpatient capacity by almost 4,200 beds.

In addition, the Commission's long-term care recommendations called for downsizing or closing nursing homes targeting nursing bed reductions of approximately 3,000. In addition, the long-term care recommendations contemplated creating more than 1,000 new non-institutional slots. It is estimated that the capacity reduction outlined by Berger Commission would cut 23,400 hospital and nursing home jobs in New York State.

Our twelve-year long engagement in the Kaiser Labor Management Partnership helped Kaiser to move from a \$250 million dollar loss in 1996 to a position of market leadership. The 55,000 union members within the Kaiser system have supported and implemented the host of work process and technological changes that has moved Kaiser into a position of being recognized as one of the premier healthcare delivery system in the country. SEIU has been Kaiser's strongest partner in this process.

Today, SEIU is involved in a host of pilots and demonstrations around the country on cost reductions. For example, our public employee members in California receive their health benefits through CalPERS. CalPERS has undertaken a pilot program designed to improve health care quality, enhance service, and reduce costs. CalPERS will partner with Blue Shield of California, Catholic Healthcare West (CHW), and Hill Physicians Medical Group to implement the pilot starting January 2010. SEIU also represents most of the healthcare workers at Catholic Healthcare West. The program will create an integrated health care model that aligns incentives among our public employee members, the health plan, hospital system, and medical group. The providers have also agreed to be at financial risk should the pilot's cost reduction goals fall short of expectations. All SEIU/CalPERS members who live or work in Sacramento, Placer, and El Dorado counties are eligible for the pilot program, even if they are currently enrolled in one of the other CalPERS health plans. Blue Shield anticipates that the 12-month pilot will succeed in keeping the 2010 total cost of health care trend flat (or negative) as compared to the 2009 projected cost of health care in the targeted three county region.

SEIU was an aggressive supporter of President Obama's \$30 billion healthcare information technology commitment in the American Recovery and Reinvestment Act. We understood its importance as a down payment on healthcare reform and we understood that without significant modernization of the delivery system we could not afford to expand coverage. We also understand that any modernization will change the way our members deliver care and will dislocate many workers from their current jobs. The 2005 Rand study estimated a \$70 billion savings from full implementation of health IT. Most of the savings comes from re-engineered work flow leading to a 10% reduction in average length of stay. Building on the Rand study, SEIU calculates the job loss from full implementation of health IT to be roughly 630,000.

SEIU's specific initiatives (see below) are directed at the primary and long term care sectors. We believe these initiatives can make a significant impact on shifting America on to a path of affordable healthcare. We are also firmly committed to working with our hospital and physician partners to create the most flexible, responsive and efficient healthcare workforce in the world.

Initiative A. - Expanding Home and Community Based Services

Definition/description: Our long-term care system provides the most expensive care in the least desirable setting – not occasionally, but as a matter of default. While long-term services and supports are not the driver of Medicaid spending, the demographic changes over the next two decades present a challenge for state budgets that demands our attention. Resetting our long-term care system is also crucial if we are to have the infrastructure necessary for truly integrated Medicare and Medicaid covered services.

We know that consumers strongly prefer home and community based services (HCBS) over care in an institution. We also know that the average total public expenditure on a recipient of HCBS waiver services who is nursing home eligible is approximately \$44,000/year less than for a person receiving institutional services. State Medicaid programs can support approximately three adults with physical disabilities in the community for every one person in a nursing facility.

While it is clear that a well-developed HCBS program can limit institutional costs and help states moderate the cost of Medicaid spending overall, most states need additional federal resources to pursue such a strategy. The theory behind this proposal is to provide states with temporarily increased federal matching payments for HCBS expenditures, based on the degree of system imbalance. Our initial thoughts are that the proposal would be structured as follows:

- States where less than 25% of LTC spending is devoted to HCBS would receive a five percentage point boost in federal matching rates for HCBS; and
- States where HCBS spending makes up between 25% and 49.9% of LTC spending would receive a two percentage point boost in federal matching rates for HCBS.

In exchange, for the higher FMAP, states would agree to adopt certain structural reforms in the administration of their Medicaid program. State level experience shows that success on containing costs depends on nursing home diversion, which in turn depends on whether a state has adopted the programmatic and structural changes needed for this more person-centered approach. The federal government can use the Real Choices Systems Change Grants or the Medicaid Transformation Grants to obtain both technical and financial assistance in implementing the structural changes that reinforce a program of diversion and increased consumer choice:

- Mission statement of a community based long term care system that allows beneficiaries to receive services in a setting of their own choosing.
- Consolidated program administration/budget authority.
- Presumptive eligibility.
- Case management.
- Uniform assessment.
- Single entry point.
- Nursing home conversion programs.
- Collection of encounter and other data needed for more accurate budgeting and for development of quality standards.
- Adoption of federal quality measures.

At the same time, states would develop and implement more aggressive nursing home diversion program. States would be free to increase diversion through either waivers or state plan amendments permitted under the new 1915(i) waiver, amended to increase income eligibility and expand the scope of services.

There are possible variations to this proposal. States that are balanced could receive an FMAP increase as well, perhaps the one percentage point suggested by Senate Finance Committee (this adds costs). The increased FMAP can be applied to new HCBS cases (this reduces costs significantly in the early years, but is difficult to administer, especially in the out-years).

Estimated Impact: Our model demonstrates that an across the board FMAP increase combined with an ambitious yet realistic goal of increasing nursing home diversion by 3 percentage points annually yields net savings for the health care system of \$43 billion (\$26 billion in net federal savings and \$16 billion in net state savings) over ten years. These savings are calculated based on current population growth, utilization and disability rates.

Initiative B – Medicare and Medicaid Chronic Care and Prevention

Definition/description: Medicare and Medicaid Chronic Care and Prevention using community health teams. This initiative would develop coordinated care within the traditional fee-for-service Medicare program. Community health teams—are comprised of care coordinators, nurse practitioners, social and mental health workers, nutritionist among other providers. The CHTs would work closely with primary care physicians to manage and execute care plans developed by the physician. Each patient would receive a care plan—those that are healthy, at risk (overweight, pre-diabetic, and those with chronic disease). The CHTs would work with these patients to provide primary preventive services (diet, exercise, nutrition counseling) and coordinate care for chronically ill patients. These teams would provide transitional care for patients (as they enter a hospital, nursing home) and work closely with patients at home and in the community. The initiative would allow other payers such as Medicaid, CHIP, private health plans and self-insured employers to contract with the teams to prevent disease and manage patients with chronic health care conditions.

Estimated Impact: Likely substantial. The functions performed by the CHTs incorporate the functions (transitional care, close integration of care coordination and the physicians' office) that have been shown empirically to reduce costs—on net on the order of 4 to 8 percent.

Initiative C - Post Acute Care Payment Reform

Definition/description: In the summer of 2009, 200 nursing homes across four states will begin participating in a three-year Medicare Nursing Home Value Based Purchasing Demonstration that will provide incentive payments to high-performing and rapidly-improving nursing homes. Facilities will receive quality scores based on their staffing levels, staff turnover rates, rates of potentially avoidable rehospitalizations, quality measure outcomes and performance on state inspection surveys. The Demonstration will allocate 80% of any Medicare savings above a 2.3%

savings threshold to qualifying skilled nursing facilities. (Incentive payments are capped at 5% of total Medicare expenditures.) Medicare retains any savings below the 2.3% threshold and a portion of the savings beyond the 2.3% threshold. This option proposes to expand the program nationwide beginning in Fiscal Year 2013.

Estimated Impact: SEIU's estimate assumes savings of 2.3% of total annual Medicare nursing home spending or \$6 billion. Most of the savings to come from reduced rehospitalizations.