PIPC Partnership to Improve Patient Care

October 10, 2014

Mr. Glenn Hackbarth, J.D., M.A.
Chairman
Medicare Payment Advisory Commission
425 I Street, N.W. Suite 701
Washington, DC 20001

Dear Chairman Hackbarth:

The Partnership to Improve Patient Care (PIPC) is a diverse coalition of over 40 organizations representing patients, healthcare providers, research institutions and medical research companies. Since its founding, PIPC has been at the forefront of patient-centeredness in comparative effectiveness research (CER) – both its generation at PCORI and translation into patient care. Having driven the concept of patient-centeredness in the conduct of research, PIPC looks forward to bringing the patient voice to the discussion of how to advance patient-centered principles in an evolving health care system.

My comments are in response to a recent session of the Medicare Payment Advisory Commission (MedPAC) on developing payment policy based on the use of clinical evidence, with specific focus on reinstating the least costly alternative (LCA) policy to Medicare Part B drugs and biologicals. PIPC is deeply concerned with the Commission's support for this proposal, which would allow for cost-based determinations of patient treatment options. PIPC fought hard for patient protections in the Affordable Care Act that ensure CMS does not misuse clinical CER to impose "one-size-fits-all" coverage or payment policies. LCA would undercut these protections and prevent doctors and patients from making informed decisions about the treatment option that is best for the individual patient. Therefore, we urge MedPAC not to move forward in recommending new LCA authority for CMS.

Many of these concerns were echoed by Commissioners who noted that the policy could prevent beneficiaries from accessing medications that are medically necessary, and that even application of an appeals process for such a system would likely be burdensome, costly, and delay patients' timely access to the most appropriate therapies. Others acknowledged that the current evidence base is not sufficient to assess clinical equivalency between therapies or to reconcile an LCA standard with the emerging field of personalized medicine and patient-centered care. Unfortunately, despite these concerns with the LCA policy, many Commissioners expressed support for the policy, and suggested that Medicare Advantage plans and other private payers have effectively implemented such strategies.

PIPC agrees that CER, when used appropriately, can provide patients and providers with unbiased, objective information to support good decision-making that will lead to better health care quality and, ultimately, lower overall health care costs. However, imposing policies like LCA that rely on broad judgments of comparative effectiveness of treatments will overlook important differences in the way individual patients respond to treatment and create barriers to

access to the range of treatment options needed to tailor care to their individual needs and preferences.

As noted during the Commission's discussion, application of LCA raises barriers to advancing the goals of efficient care delivery and high quality patient care. We strongly recommend that, instead of pursuing LCA, MedPAC should focus on delivery reforms that activate patients, engage patients, and support shared decision-making between patients and physicians. We believe that solutions that center on the patient are the best approach to improving overall health care efficiency and quality. We already know that engaged and active patients are more compliant with their treatment protocol because they are given a meaningful role in defining the care that is best for them. Engaged patients fill prescriptions and take them, they make appointments with rehabilitation specialists, and they go in for their follow-up appointments. We also know that meaningful patient engagement requires that patients trust in the system and their care providers, embrace the principles of shared decision-making, and recognize the benefits of being activated. Policies such as LCA will undermine efforts to engage and activate patients in their own care, because it precludes them from having choice and control over their own health care. The LCA policy also undermines efforts undertaken by the medical profession to evaluate the range of treatments available to patients in support of individual treatment decision-making. An example of this is the proliferation of physician clinical outcomes data registries.

Anticipating that a sole focus on cost containment without consideration for individualized patient care could undermine progress toward a patient-centered health system, PIPC developed a White Paper on *Building a Patient-Centered Health System: A Patient-Centered Approach to Developing Alternative Payment Models – and the Foundation on Which They are Built*. Work to shift from health care payment based on volume to "value-based" models has taken hold, in part due to broad cost-containment pressure and in part due to the expansion of value-based payment policy via the Affordable Care Act (ACA). As these policies seek to define and reward value, apply evidence of comparative clinical and economic value, and reshape physician decision-making, they hold significant implications for the patient-centeredness movement, and the related issues of patient access and the physician-patient relationship. As part of our ongoing commitment to patient-centeredness in health care, PIPC developed this White Paper to highlight some of the most important opportunities and issues to address in translating principles of patient-centeredness into value-based payment.

Our final recommendations center on three principles. First, we advocate giving a voice to patients. Achieving this goal centers on process and governance at various levels of design and implementation of a payment system whereby patients have an opportunity to provide input on what it means for care to be centered on the patient. Second, patients should have choice. One of the core concepts behind patient-centered outcomes research is generating evidence that matters to patients and helping them and their caregivers apply it to their unique needs and preferences. This concept must carry through to new payment models as well, allowing patients to tailor optimal care based on the range of available options. Third, we should be advancing value for patients. As new payment models seek to make providers accountable for value,

providers should account for value to the patient. This means that cost and quality incentives incorporate or prioritize patient preference or value from the patient perspective, at a population and individual decision-making level.

As the Commission moves forward in their deliberations to improve outcomes and reduce costs in the Medicare program, PIPC hopes that you will pursue policies that activate patients and lead to long-term health improvements, rather than focusing on those that could threaten to jeopardize the nature of the doctor-patient relationship. Instead of undermining the application of patient-centeredness criteria with LCA policies, MedPAC could be advancing patient-centeredness as we build a health care data infrastructure, conduct CER, develop shared decision-making tools, and improve quality measurement. The Commission is understandably frustrated that the tools for a patient-centered health system seem to be lacking, but the answer is not to shift gears and advance LCA policies. The answer is to strengthen the health care infrastructure to support patient-centered payment and delivery models.

We appreciate this opportunity to provide input on this important topic and look forward to working with you in developing payment policies that are patient-centered, provide high-quality care, and improve health outcomes.

Sincerely,

Tony Coelho