Health Care Cabinet DRAFT recommendations

Comments on text in **Pdf pages 1-24***

01 12 2018

Velandy Manohar, MD

Medical Director, Aware Recovery Care

President, In Home Addiction Treatment PC

Sections:

A.

Overview: Page 1:

I endorse these 6 recommendations.

I am attaching a document that addresses the tasks involved in implementing these recommendations with respect to health care quality, costs, efficiency, transparency, health care outcomes. I want to urge the HCC to consider the adoption of Choosing Wisely recommendations, ensure the Federal Law that are the CLAS Standards are adopted and implemented universally and no effort is spared to augment Health literacy progressively strengthening the role of the consumer as an effective partner in health promotion and in substantially reduce the prevalence of the top five disorders which accounts of 2/3rds of deaths in the United states of America among Americans under 80 namely Heart Disease, Cancer, Stroke, Chronic Lower Respiratory Diseases like Asthma, Emphysema, and Accidental deaths including Overdose deaths in 2014 per CDC.

One of the reasons I support the recommendations that will enhance engagement, educate and empower consumers of care because an informed can help to make a serious impact over time in reducing the death rates from these five disorders. The CDC states 30 % of Cardio-Vascular diseases, 15% of cancer Deaths, 28% Stroke Deaths, 36% Chronic Lower Respiratory Disorders, and 43% of Accidental Deaths were PREVENTABLE.

I am hopeful that these efforts delineated in Health Care Cabinet can be helpful to improve the steady but inadequate/ insufficient declines in deaths in 3 of the 5 disorders e.g. a mere 4 % decline in Cardio-Vascular disorders, 11% decrease in Stroke related deaths, and reverse the tragically increased rates of overdose deaths [Currently 1,200 Americans die from overdoses.] Deaths from preventable deaths from unintentional injuries increased by 23%, Deaths from Chronic Lower Respiratory disorders increased by 1%, There is heartening 25% reduction in cancer related deaths largely due to 12% age adjusted death rate from Lung Cancer. Implementation of Health promotion campaigns, Choosing Wisely recommendations and thoughtful utilization of health maintenance strategies especially during last years of life.

Section: Major New State Drug Cost Laws or Passed Bills

Page 3:

a. **CA SB 17 [Passed]**

Item i: Would be very important to include in any Legislation we enact to protect the health well- being and safeguard the pocketbooks of CT residents.

b. **Nevada SB 539.** Law Passed. Diabetes Drug Transparency.

Items i-vii are all very essential elements of legislation

Page 5

Vermont Act 165:

Components of the Bill- i-iii are important to enact to help contain HC costs.

Pages 7-10

Draft Recommendations:

Priority Recommendations:

1. Legislative

Sections a, b, c, and d contain powerful, necessary legislative remedies that can help to achieve the goal of Containing Health Care Costs.

Page 10:

2. Administrative

Paragraph A -1 is the real grist for the mill. This provides the crucial data and emphasizes the importance of containing prescription drug costs- I want to point out the importance of adopting Choosing Wisely recommendations, universally implementing the CLAS standards and doing all that is necessary to substantially improve Health Literacy and successfully reverse the increasing rates of death from Chronic Lower Respiratory diseases and especially deaths due to unintentional injuries deaths due to Over doses and substantially increase the rate of decline of deaths from Heart disease, Stroke and Cancer.

Page 12:

2.Administrative

b. i. The Data set is very helpful to develop strategies to improve health outcomes and cost-effectiveness

b. ii I fully endorse this recommendation- Over decades I have worked with Pharmacist to help patients to get the most from the medication regimen.

Page 13

Other Legislative recommendations:

3.a. I and ii are absolutely necessary to achieve the stated goals.

3. b. I am very supportive of clearly defining the Fiduciary Responsibility of PBMs.

Page 14

Fully Endorse these excellent and necessary recommendations c and d

Page 15:

Recommendations e and f are essential to the achievement of our common goals: Physicians, Prescribers, APRNs, Pas, Consumers, Insurance Companies, PBMs, Pharmacists

Page 16

I fully endorse the recommendation to assure Transparency of PBM

Page 17

Item h. This section has important requirement especially the appeals process.

Page 18

Item b. This would be an important cost saving strategy to expand access to the State employee contract to private sector entities. This can greatly increase bargaining power to negotiate costs

Page 19

Item J. **This is an absolutely necessary component for a successful cost containment strategy empower consumers to make real time decisions.**

Item K and L are necessary components for building an effective and efficient operational system that can add value every day week in and week out which can accrue incremental gains in Cost savings.

Page 20

Item m: **I enthusiastically support the recommendations m 1,2,3**

Page 21

Ii] This a MUST happen change in process. <u>The State Plan needs to move from evaluations of PBM vendors based primarily on potentially pharmacy savings</u>- primarily rebate savings and pharmacy network discounts <u>to one that is focused on primarily reducing overall medical costs and improving patient outcomes.</u>

I am glad to have the information in [1] and [2]

Page 21

<u>Items n and o are important in the future development of effective strategies to contain costs.</u>

Page 22

Items p and q are necessary to work on Value Based Insurance Design.

Item q. As a part of the mandate … the SIM VBID consortium should consider promoting formulary designs that focus on value by tying formulary placement <u>TO VALUE, not REBATE size:</u>

Items: i-v are crucial and must be implemented.

Page 23

Item r: This is an interesting proposal I have concerns.

Item s: This also an interesting proposal. I have my concerns.

Please review my comments on the 26 Items in the Executive Summary provide by Stephen R. Smith, MD, MPH, Professor Emeritus of Family Medicine, Warren Alpert Medical School of Brown University to assist the members of the National Physicians Alliance of CT to better understand the "**Recommendations of the Health Care Cabinet to Restrain the Costs of Prescription Drugs"**

Executive Summary of Recommendations of the Health Care Cabinet to Restrain the Costs of Prescription Drugs

Annotated with my responses: [Emphasis and comments added]

Velandy Manohar, MD
Medical Director, Aware Recovery Care
President, In Home Addiction Treatment PC

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1. **Create a Drug Review Board to identify unjustified price increases for prescription drugs and refer those to the Attorney General as unfair trade practices.**
2. **Publicly disclose funding to patient advocacy groups by industry.**
3. **Require pharmacy benefit managers (PBMs) to cooperate with audits**.
4. Base coinsurance and deductibles on **negotiated price of drugs rather than the list price.**
5. Require more detailed information on the impact of prescription drug price increases on health insurance premiums.
6. **Expand quality measures to include conversations between providers and patients about drug prices, barriers, medication adherence, and the clinical value of each prescription**.
7. Build comparative effectiveness reports about drugs into office workflow.
8. **Make cost-sharing information on drugs available online.**
9. Require PBMs to always act in the best interest of the plan sponsor rather than their own best interests. [How do we legislate these aspirational goals? VM]
10. Explore state-administered loan programs that allow patients to spread the up-front costs of drugs over the entire year.
11. **Require facilities to publicly post industry payments to providers in their facilities.**
12. Set maximums for cost-sharing for drugs to $250/mo. ($500 for bronze plans).
13. **Limit manufacturer coupons for drugs to only when lower-priced drugs are not available.** *[I am in partial dissent because there are times in my practice and for instance in my situation were the lower priced drugs for one of my health issues are intolerable. I recommend the availability of manufacturers coupons for an individual patient be based on medical attestation that personalized therapeutics requires a specific drug that is unaffordable but is expected to yield the best results and is both tolerable and safe based on peer reviewed literature. I used to personally or request the help of staff to guide patients as they fill in the necessary*

medical information on line to get the coupons for patients who had coverage, but co-payments were high, incomes low and there was high risk of non-compliance and adverse health consequences accruing to the patient and the family. [because of the side effects of the lower tier covered or cheaper drugs and efficacy issues] VM]

14. PBMs **must not** reimburse pharmacies less than the reasonable cost incurred by the pharmacy. [I question this language in this context. ***How do we legislate aspirational goal****? We can all hope that this doesn't occur.VM*]

15. Explore expanding access to the state employee pharmacy contract to the private sector.

16. **Provide consumer education about drugs and nonpharmacological approaches to health**. [*These are benefits that accrue to patients with the adoption of Integrated medical treatments is well documented. These are likely to adopted and utilized widely if value based purchasing process dictated by the CMS considers as proposed MedPAC: Clinical Excellence, Quality of treatment experience and Value-added services*]

17. **Promote the availability of existing resources to allow comparison shopping for drugs**. *[I want to interject -this cannot be freely espoused unless there are well established mechanisms to check these drugs are indeed comparable and verify the source of the Drugs,* ***the veracity about the labeling, its safety and reliability. VM***]

18. Evaluate the benefits of value-based drug contracts being pursued by other states.

19. Evaluate effects of more stringent prior authorizations or exclusions in Medicaid.

20. Ensure that the state employee plan links its drug formulary **to clinical value of drugs rather than just the size of a rebate. [***Here again. Recommend the public be made aware of the comparability of drugs that is supported by rebate in terms of the country of manufacture and veracity about the labeling, its safety and reliability. VM]*

21. Consider using Medicaid expertise rather than a PBM to create formulary for the state employee plan. *[To ensure mechanisms are put in pace and implemented to assure veracity of the labelling, safety and reliability. VM*

22. The All-Payer Cost Database (APCD) **should be available to policy makers to analyze out-of-pocket cost trends.**

23. Evaluate the risks and benefits of lower deductibles and out-of-pocket maximums for drugs and elimination of any copays for asthma, hypertension, diabetes, hyperlipidemia, and possibly heart failure and chronic obstructive lung disease.

24. Promote formulary designs based on clinical value.

25. Investigate allowing importation of drugs from Canada. [**A word of caution**. *The fact we proximate source of the drugs is Canada doesn't mean that these imported drugs presumably cheaper drugs are safe and the labeling is truthful, the product in the package is safe and reliably effective. It is vital no drugs are imported that have not been approved for use in the United States by the FDA or contain additives and vehicles etc. that are determined to be safe and effective by the FDA. VM]*

26. Explore a public utility model for regulating drug prices.

[I am opposed to this because this will make the process of pricing and contracting much more political and problematic and greatly reduce competition between Pharmaceutical Manufacturers, PBMS and Health Care Insurance Companies to promote their products for alleviating the symptoms and disabilities of these major chronic progressive deadly illnesses. Especially since many HC Insurance Companies are buying up PBMs and the pharmacies connected to the PBMs operate Clinics that provide an increasing array of services.VM]

As we move forward in this process I behoove us to keep the developments at the federal level with respect to value based purchasing programs. VM

"Becker's Hospital CFO report
Med PAC votes to kill MIPS, recommends alternative program VVP
Written by Ayla Ellison (Twitter | Google+) **| January 12, 2018**

The Medicare Payment Advisory Commission, a federal group tasked to advise Congress on Medicare, voted 14-2 on Thursday in favor of recommending Congress eliminate the Merit-based Incentive Payment System.

MIPS will not succeed in helping beneficiaries choose clinicians, helping clinicians change practice patterns to improve value or helping the Medicare program to reward clinicians on value," the presentation read.

Med PAC commissioners in support of axing MIPS cite the financial burden on physicians to comply with reporting requirements and issues with the metrics.

On Thursday, the commissioners recommended replacing MIPS with a new model, the **Voluntary Value Program**. **The VVP** would include an across-the-board withhold for all fee schedule payments, and **performance would be assessed using uniform measures across three categories: clinical quality, patient experience and value-added services**.

Commissioners in favor of the new program said it would better prepare physicians to participate in the Medicare and CHIP Reauthorization Act's other track, Advanced Alternative Payment Models."

http://www.choosingwisely.org/doctor-patient-lists/

Consumer Reports has been in Charge of the CW campaign.
Choosing Wisely
Originally started as Initiative of the ABIM
View over 500 Specialty Society recommendations
Access Information for Providers and Patients.
Share information by text, email or social media

Lists

The *Choosing Wisely* lists were created by national medical specialty societies and represent specific, evidence-based recommendations clinicians and patients should discuss. Each list provides information on when tests and procedures may be appropriate, as well as the methodology used in its creation.

In collaboration with the partner organizations, Consumer Reports has created resources for consumers and providers to engage in these important conversations about the overuse of medical tests and procedures that provide little benefit and in some cases harm.

Choosing Wisely recommendations should not be used to establish coverage decisions or exclusions. Rather, they are meant to spur conversation about what is appropriate and necessary treatment. As each patient situation is unique, providers and patients should use the recommendations as guidelines to determine an appropriate treatment plan together.

For Clinicians
Specialty society lists of things clinicians and patients should question

For Patients
Patient-friendly resources from specialty societies and Consumer Reports

https://www.consumerreports.org/doctors/questions-to-ask-your-doctor/

Consumer Reports

5 Questions You Need to Ask Your Doctor
That can help you avoid unnecessary tests, medications, and procedures
By David Ansley

June 01, 2016

Before you get any test or treatment, ask your doctor these five questions. Why? Because some medical tests, medications, and procedures may not be right for you. A conversation with your doctor helps you avoid unnecessary, duplicative, or overly risky care.

What to Ask

1. Do I really need this test or procedure?

2. What are the risks and side effects?

3. Are there simpler, safer options?

4. What happens if I don't do anything?

5. How much does it cost, and will my insurance pay for it?

One Woman's Story About Asking Questions

After years of receiving antibiotics for her bronchitis, Mary H. learned a very painful lesson. Now she knows the questions she should have asked about her treatment options.

We'll Send You a Copy

To get a free copy of the 5 Questions to Ask Your Doctor wallet card, send an email to healthimpact@cr.consumer.org with your name and address.

More About Choosing Wisely

For details about needed (and unneeded) care in more than 100 situations, here is more information about the Choosing Wisely campaign.

Considerations that need to reviewed and addressed as we move forward on coordinating / integrating the priorities of the CAB/SIM and the CWCC and Consumer Reports.

Velandy Manohar, MD.

Medical Director Aware Recovery Care, North Haven, CT. President, In Home Addiction Treatment PC.

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I.

A. It would be to benefit of all 4 groups of vital Stakeholders [listed below if the CT SIM DPH, DMHAS work closely with CCWC to both eliminate Racial and Ethnic Disparities and achieve the Quadruple AIM:

<u>These are National Priorities.</u>

1. **Improving the patient experience of care** (including Quality [Added Value to Person's life] and Personal satisfaction with Treatment Experience);
2. **Improving the health of populations**; and
3. **Reducing the per capita cost of health care**.
4. **Care Team Wellbeing and eliminating Staff burnout**

B. <u>The four stakeholders stated by CWCC are:</u>

1. Practitioners and Health Systems
2. Patients and Community Organizations
3. Educational Institutions for Training Health Care Professionals
4. Employers and Payers

II.

A. Choosing Wisely Campaign: Thoughts on Implementation

In my opinion the Primary purpose of the Choosing Wisely Campaign is to inculcate patients, clinical staff and health care administrators to create environments conducive to '<u>why'</u> questions that can foster autonomy of our patients in determining the choices they wish to make to pursue specific treatment goals or not.

For this to happen <u>a tripod of structures</u> must be built, updated and maintained to help achieve the Quadruple Aim namely:

1. Meeting or exceeding the applicable provisions of: Title VI of the Civil Rights Act of 1964, 42 U.S.C. §2000d, 45 C.F.R and Standards 4, 5, 6, and 7 are based on Title VI of the Civil Rights Act of 1964 (Title VI) with respect to services for limited English proficient (LEP) individuals

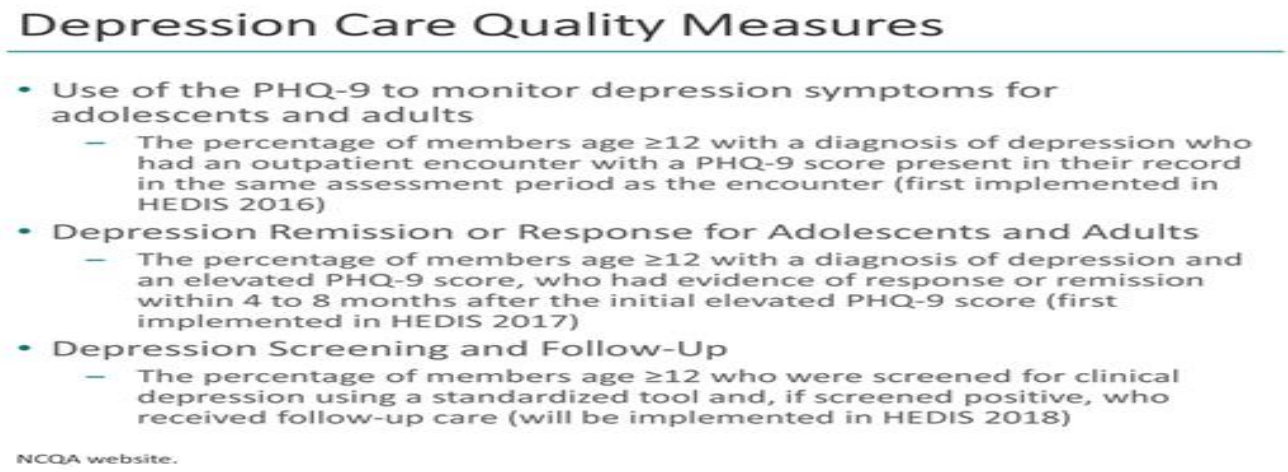
2. Adopting and implementing efforts to remediate Low Health Literacy and its detrimental impact on people's lives and HC costs including Ask Me 3

3. Promoting patient autonomy and strengthening their role in Clinical Decision- Making Process which can have well documented benefits by adopting and implementing the Choosing Wisely campaign among the four chief stakeholders: Practitioners and Health Systems, Patients and Community Organizations, Educational Institutions for Training Health Care Professionals and finally Employers and Payers.

III. Possible Evaluation Formats to assess efficacy and efficiency of the Choosing Wisely Recommendations: At least two can be reviewed

A. **Choosing Wisely Principles and the Use of Anti-Psychotic Medications: APA recommendations.** It will especially useful to select for **review individuals above age of 65 who were treated with Anti-Psychotics** while implementing Choosing Wisely recommendations.
In coordination with the **American Board of Internal Medicine**, the APA proposes five recommendations for physicians and patients. The list was compiled by members of the Council on Research and Quality Care.[16] The APA places a primary focus on **antipsychotic** medications. [Please review previously provided information. VM]

B. AHRQ- National Health Care Quality and Disparities Report:
AHRQ analyses 179 HEDIS measures and produces Annual Report:
Allows comparisons of Insurance Plans Nationwide. It should be possible to use data from HEDIS measures for depression or any other chronic disorder to determine if Plans that incentivize the implementation of the Choosing Wisely recommendations will report more positive outcomes than comparable plans providing Behavioral Health care. I selected Depression because MDD is Globally the 4th leading cause of disability and much work has been done on analyzing efficacy and efficiency of different treatment measures.



I am providing excerpts from two important documents to provide a broader National perspective to be able to be understand the complexities of assessing and managing costs while adding value:

1. **What Is Value in Health Care?**

   Michael E. Porter, Ph.D. N Engl J Med 2010; 363:2477-2481December 23, 2010DOI: 10.1056/NEJMp1011024

   Two framework papers that develop the concepts outlined in this article, "Value in Health Care" and "Measuring Health Outcomes," are available as Supplementary Appendixes.

"**Measuring, reporting, and comparing outcomes are perhaps the most important steps toward rapidly improving outcomes and making good choices about reducing costs**.4 Systematic, rigorous outcome measurement remains rare, but a growing number of examples of comprehensive outcome measurement provide evidence of its feasibility and impact.

Determining the group of relevant outcomes to measure for any medical condition (or patient population in the context of primary care) should follow several principles.

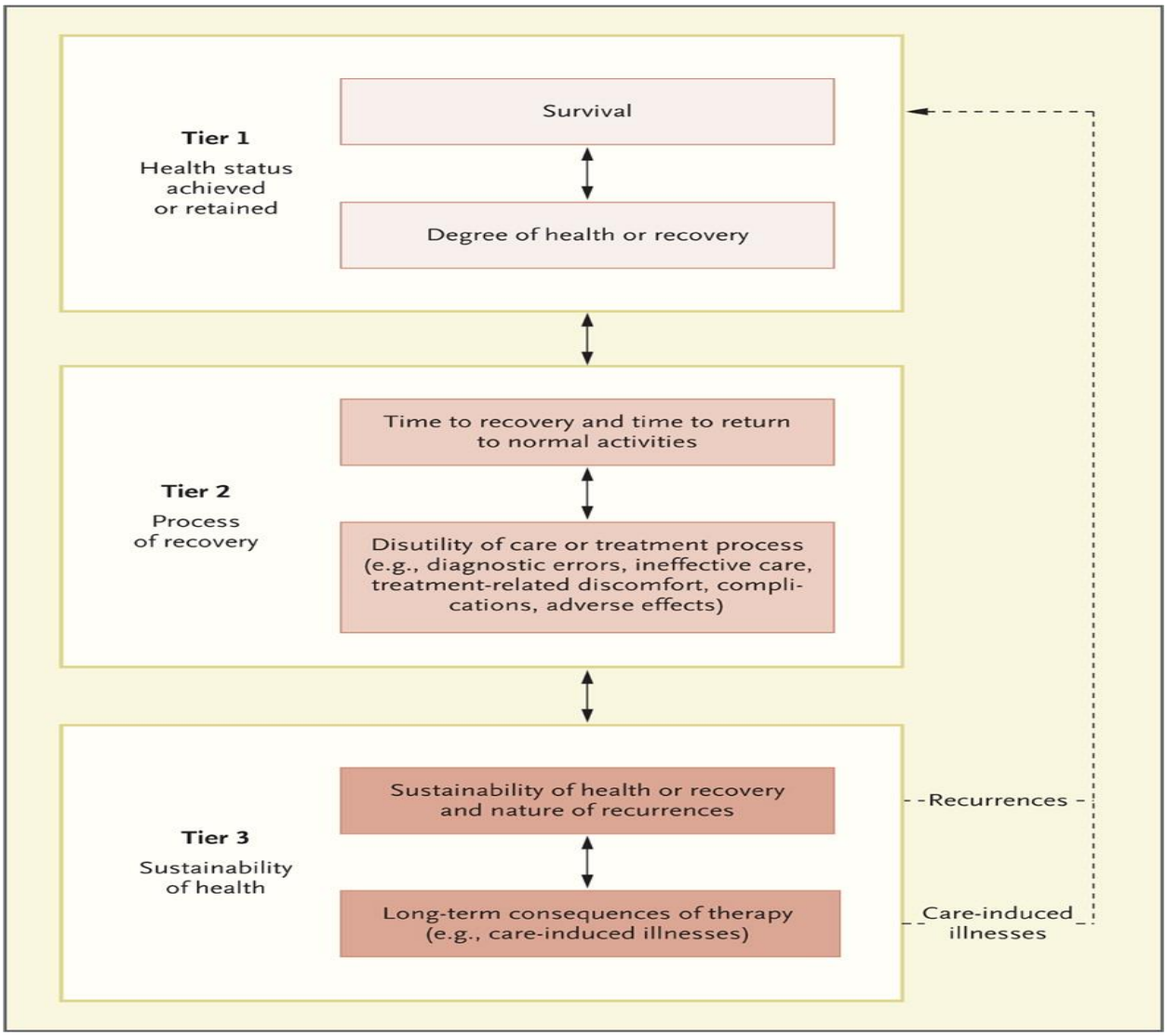
Outcomes should include:

a. **the health circumstances most relevant to patients.**
b. **They should cover both near-term and longer-term health,**
c. **addressing a period long enough to encompass the ultimate results of care.**
d. **And outcome measurement should include sufficient measurement of risk factors**
e. **or initial conditions to allow for risk adjustment.**

Multiple outcomes collectively define success. **The complexity of medicine means that competing outcomes (e.g., near-term safety versus long-term functionality) must often be weighed against each other.**

The outcomes for any medical condition can be arrayed in a three-tiered hierarchy (see FIGURE 1] The Outcome Measures Hierarchy.), in which the top tier is generally the most important and lower-tier outcomes involve a progression of results contingent on success at the

higher tiers. Each tier of the framework contains two levels, each involving one or more distinct outcome dimensions. For each dimension, success is measured with the use of one or more specific metrics.

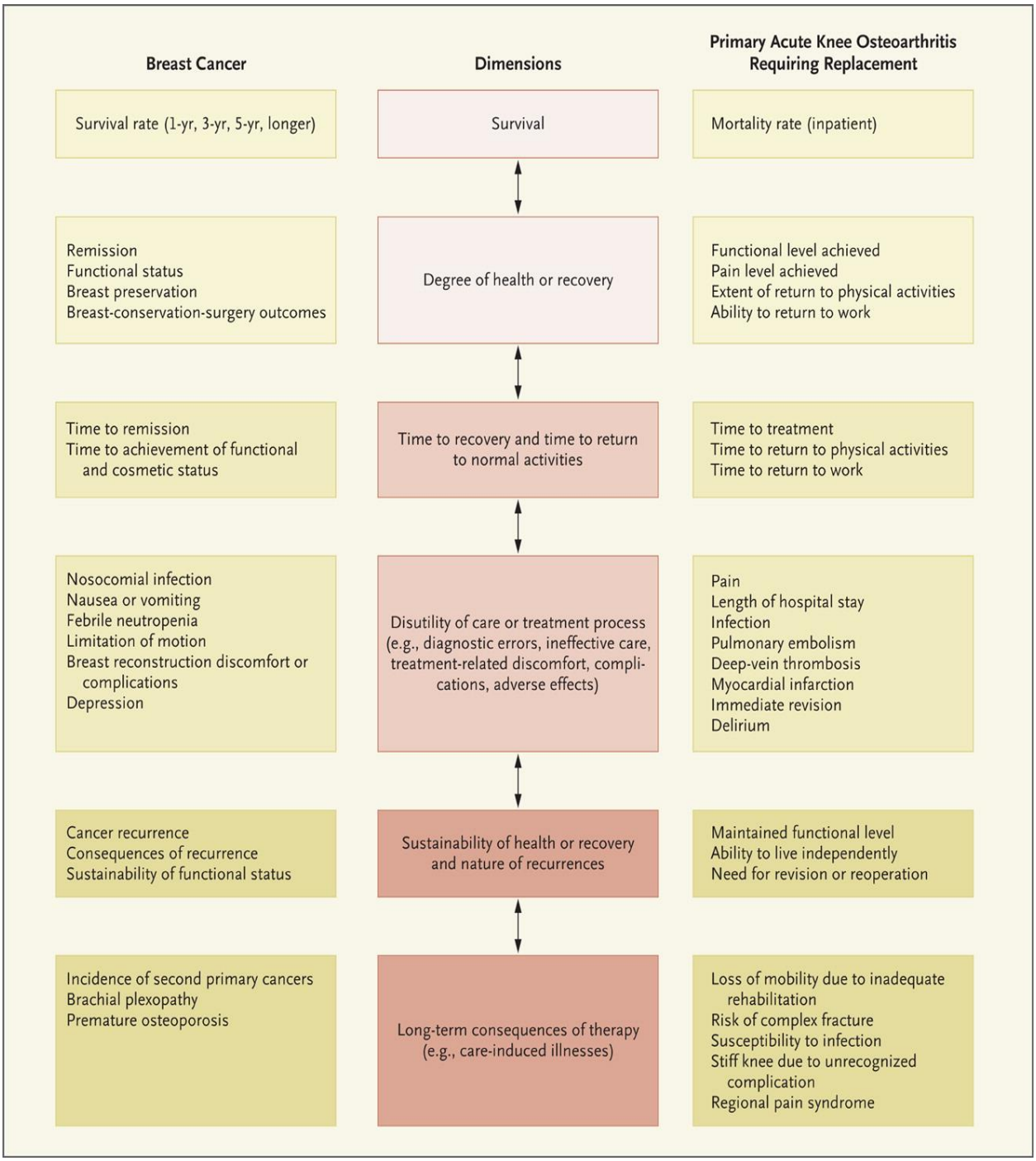


2. Michigan Medicine, University of Medicine, JUNE 15, 2016

Four paths to the end of life -- one far more expensive than others -- emerge in new Medicare study

Results conflict with popular ideas about where most dollars are spent in the last year of life – and where potential cost savings might lie

ANN ARBOR, Mich. — Last-ditch, high-tech heroic treatments. Days in the hospital intensive care unit. You might think this is what makes dying in America so expensive – and that it's where we should focus efforts to spend the nation's healthcare dollars more wisely.[? Role of Choosing Wisely principles. VM]



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ANN ARBOR, Mich. — Last-ditch, high-tech heroic treatments. Days in the hospital intensive care unit. You might think this is what makes dying in America so expensive – and that it's where we should focus efforts to spend the nation's healthcare dollars more wisely. [? Role of Choosing Wisely principles in altering the course of two or three of the four paths. VM]

But a new study finds(link is external) that for nearly half of older Americans, the pattern of high spending on healthcare was already in motion a full year before they died.

That's thanks to the care they received for their multiple chronic health conditions -- including many doctor visits and regular hospital stays over the year, not just in their final days.

As a result, the study shows, the last year of life for this large group of seniors costs the Medicare system five times as much as the care received by the much smaller group of seniors who have a sudden burst of very expensive care in their last few weeks of life. The findings have clear implications for efforts to improve care, and contain the growth of costs, at the end of life.

The study shows four clear patterns of end-of-life spending, newly identified through an analysis of Medicare data by team led by University of Michigan researchers. They have published their findings in *Health Affairs*.

Lead author Matthew A. Davis, Ph.D., M.P.H., an assistant professor at the U-M School of Nursing and member of the U-M Institute for Healthcare Policy and Innovation(link is external), says the findings surprised him and his colleagues from the U-M Medical School and School of Public Health, and The Dartmouth Institute for Health Policy and Clinical Practice.

"We were expecting to find the most common pattern to be explosive healthcare spending in the final months of life. In fact, only 12 percent of older adults in our study showed this 'late rise' pattern of healthcare spending," he says.

"Our research points to having to do a better job taking care of people who have multiple chronic conditions in a way that maintains or improves the quality of care they receive, but with cost in mind," he continues. "This also suggests that if we focus purely on care for those with a poor prognosis, we won't be able to contain the growth of health costs that you might anticipate."

The team named the four patterns of end-of-life healthcare spending:

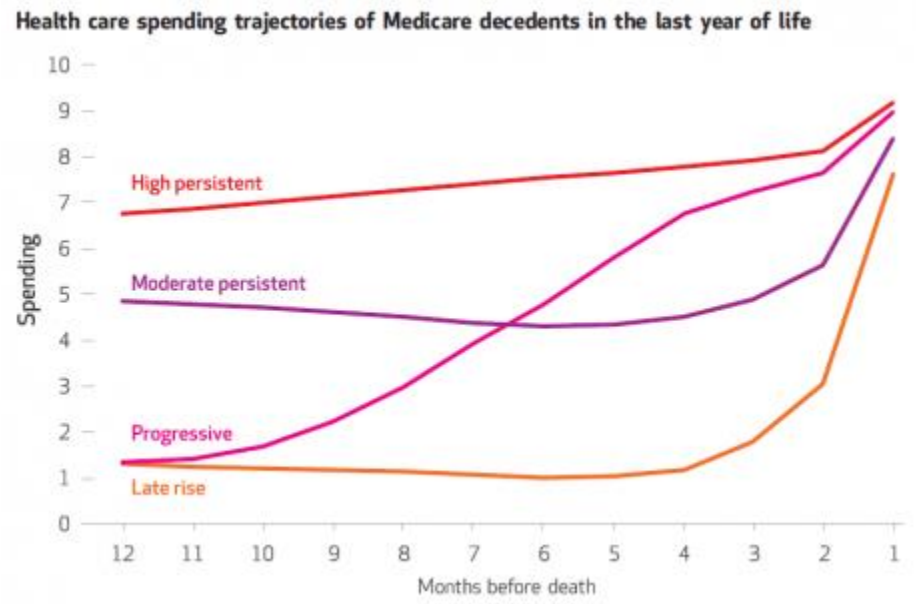
a. High persistent: This group made up nearly half of the Medicare participants studied and had high (and slightly rising) spending throughout the final year of life.

In the last year of life, their care cost Medicare around $59,394 (the median value), and they had twice as many outpatient visits to medical specialists as other groups. They also were more likely to spend time in hospitals and skilled nursing facilities, and more likely to get treated using life-prolonging treatments: a respirator, dialysis or a feeding tube.

b. Moderate Persistent – This group made up 29 percent of the patients studied. Their final year started with moderately high amounts of spending, then it dipped down for a while, and then went up in the last few months of life. Their care cost about $18,408 in that final year.

c. Progressive – This group only accounted for 10 percent of the patients, but had the second-highest costs, with a median of $37,036. These individuals had very low spending at the start of their last year of life, but it rose steadily, in a straight line, throughout the last year of life. This group was also the most likely to use hospice care, perhaps because they and their families and physicians had a good sense that they did not have long to live.

d. Late Rise – With just $11,166 in median health care costs in their final year, this group made up only 12 percent of the total group. They had very low health spending up until a few months before they died, far lower numbers of physician visits and hospital stays, and no or few chronic conditions. They were more likely to die during a hospital stay that included time in an ICU and had the second-highest use of life-prolonging treatments.



Medicare deaths divided sharply into four categories based on healthcare spending in the last year of life.

There were no clear differences in the healthcare spending patterns when the researchers compared people who had specific major diseases such as cancer, cardiovascular disease and organ failure. Instead, the driving force behind the spending pattern that each person followed appeared to be based on the number of different health conditions he or she had.

Davis and his colleagues used 2011-2012 data from the Centers for Medicare and Medicaid Services. The data were from nearly 100,000 randomly sampled traditional Medicare participants who died in 2012. They drew their sample from data on nearly 1.3 million Americans aged 66 to 99 who died during the period studied.

The study did not account for prescription drug and out-of-pocket spending, nor data on seniors enrolled in Medicare Advantage plans managed by private companies. *Another recent U-M study found that Medicare Advantage participants tend to be healthier in their last year of life than those in traditional fee-for-service Medicare.*

The study period coincided with the early stages of the "population health" movement, which has increased since that time. Medicare, through programs such as Accountable Care Organizations, is incentivizing doctors' groups and hospitals to improve care and the patient experience while containing cost growth, by offering them extra payment if they achieve goals across a broad swath of patients enrolled in traditional Medicare.

This has led to care management programs and efforts to support patients between doctor visits or when new issues crop up, which may help with the complex patients who had the highest spending rates in the new study.

In addition to Davis, the study's authors include Julie P.W. Bynum at Dartmouth and U-M's Brahmajee Nallamothu, M.D., M.P.H., and Mousumi Banerjee, Ph.D., M.S., who are both also members of IHPI. The study was funded by the National Institute on Aging at the National Institutes of Health (AG019783) and NIH grant AT006162. Reference: *Health Affairs* 35, No. 7, DOI:10.1377/hlthaff.2015.1419 http://content.healthaffairs.org/lookup/doi/10.1377/hlthaff.2015.1419