



June 22, 2015

The Honorable Orrin Hatch
Chairman
United States Senate Committee on
Finance
104 Hart Senate Office Building
Washington DC 20510

The Honorable Ron Wyden
Ranking Member
United States Senate Committee on
Finance
221 Dirksen Senate Office Building
Washington DC 20510

The Honorable Johnny Isakson
United States Senate Committee on
Finance
131 Russell Senate Office Building
Washington DC 20510

The Honorable Mark Warner
United States Senate Committee on
Finance
475 Russell Senate Office Building
Washington DC 20510

Re: Chronic Care Solutions

Mr. Chairman, Senator Wyden, Senator Isakson and Senator Warner:

On behalf of Cambia Health Solutions, thank you for this important opportunity to provide input on improving health incomes for Medicare patients with chronic conditions. As a total health solutions company, our organization offers a unique perspective to examine the current state of the industry. Our deep roots in the health insurance industry are well complemented by our innovative, consumer-focused portfolio of Direct Health Solutions companies. Through our corporate foundation, we seek to improve access to quality care, reduce cost and promote consumer engagement for vulnerable populations.

These three components of the Cambia family work separately but in tandem toward the same goal, represented in our Cause: *"To serve as a catalyst to transform health care, creating a person-focused and economically sustainable system."* The response that follows is comprised of information from individuals in our health care division, the Direct Health Solutions team and officers from the foundation. I am proud to be a part of this conversation and to offer insight from my colleagues, all of whom are experts in their fields.

Finally, I applaud this bipartisan and collaborative effort to seek better outcomes for those living with serious and life-limiting illnesses. Our country needs the kind of robust



bipartisan leadership that is demonstrated by your request for comments. Thank you for your dedication to improving the life and health of our nation's citizens.

To that end, I welcome your questions and any opportunity to be a resource.

Sincerely,

A handwritten signature in black ink that reads "Bruce C. Smith MD". The signature is written in a cursive style with a clear, legible font.

Bruce Smith, MD, FACP
Executive Medical Director, Government Programs
Cambia Health Solutions
206-332-5142

Improvements and reforms to Medicare and Medicare Advantage

Medicare and Medicare Advantage cover our country's most vulnerable citizens, protecting patients at a time when they are most likely to need coordinated health care services. However, the current system falls short of addressing the reality of multiple chronic conditions that so many individuals live with, particularly at end-of-life.

One area for reform is to the Medicare Hospice Benefit where the capacity exists for significant impact, especially for patients living with multiple chronic conditions. The Medicare Hospice Benefit uniquely defines "hospice" in the US as restricted to a person's final 6 months of projected life and requires they agree to forego "curative" therapies. This is not the case in the rest of the world. These restrictions lead many Medicare beneficiaries to delay enrollment in hospice until the last week or two of life. There are clear benefits to removing the requirement to relinquish curative care and moving toward a more comprehensive, all-inclusive program incorporating palliative care practices concurrently with curative care long before the patient is actively dying. Allowing earlier access to specialty-level palliative and hospice medical care and support programs such as wraparound care management, psycho-social support, and goals of care discussions that are the hallmark of a hospice program lead to higher quality of life for both the patient and their families as well as lower overall costs of care. The current hospice payment model would require restructuring but there are examples that currently exist, such as the graded payment model suggested by MedPAC in recent years. Moving from a flat, per-diem rate to a graduated system would better align with actual services rendered and allow for more flexibility in terms of eligibility criteria.

Another opportunity for reform is revision to the Medicare Advantage payment model. The current Risk-Adjusted payment model recognizes each chronic condition with a Risk Index HCC score, but if a patient has many chronic conditions the codes are simply additive. In reality, as people develop multiple chronic conditions the complexity of their care more closely follows a geometric progression than an arithmetic one. To account for care coordination and care management as patients' needs become increasingly complex, CMS should consider revising the HCC payment methodology to provide some multiplier or sequential add-on reimbursement that would be triggered by and tied to the presence of multiple individual chronic conditions.

Lastly, the recently proposed Care Planning Act of 2015 would allow for reimbursement to providers for goals-of-care conversations with Medicare patients. These conversations are shown to vastly improve quality of life for patient, family and provider, by clearly articulating treatment goals in the event of serious illness.

Telehealth and remote monitoring technology

Today's opportunities to increase access to care are pervasive with significant advances in technology. Telehealth and remote monitoring technology are both concepts that until only recently were laden with barriers. While traditionally health care only existed within



brick and mortar buildings, providers are now able to reach patients wherever they are receiving care, whether that is in the home, at a long term living facility or in a hospital bed.

New developments in this field include the ability for informed, virtual visits, providing care outside of the four walls of a facility. Incorporating video conferencing into care planning not only allows patients to access providers without unsettling routines – it also provides face-to-face contact for patients who are at increased risk of isolation. The benefits to virtual visits are profound for those living with chronic illnesses when transportation can be painful and disruptive.

Additionally, the advent of consumer-oriented remote monitoring technology allows for tracking of vitals and for a care team to provide instant medical interventions as soon as an abnormality is detected. For example, if a patient’s blood pressure goes outside of the normal range, a nurse practitioner can be alerted and pick up the phone to check in or send a practitioner to the patient.

The virtual visit model, coupled with accessible monitoring devices, provides for actual visual interactions and treatment via video, and can be particularly helpful in post-discharge planning and managing of patients outside of a clinical setting.

Through this type of technology, there is opportunity to improve family engagement as well. A company within the Cambia portfolio of direct health solution investments called “Lively” demonstrates how remote technology can be effectively used to allow seniors to live autonomously for longer. Lively’s in-home sensors analyze behaviors through motion detection and alerts long distant caregivers in the event of an abnormality.

Care coordination in rural and frontier areas

Through our foundation’s Transforming Health Care funding program, over \$3 million in investments have been made over the past two years to target vulnerable populations and increase quality of life while reducing cost. Grants to coordinate chronic care teams in rural and frontier areas has been a vital component of this work, particularly in Utah and Idaho. These states experience significant challenges within vast rural and frontier geographic areas. Telehealth and remote monitoring technology is a critical component to coordinating care in these areas.

Although care coordination has long existed as a model, particularly with respect to managing chronic conditions such as diabetes, it has not been as commonly employed across diagnostic boundaries to target a group defined by the intersection of complex social and medical needs. We are gaining a body of knowledge that chronic care coordination in rural and frontier areas is maximized when coordination brings together medical and social models of patient-centered care. Strategies that have promising results include those that:

- Utilize a hub and spoke model of care with emphasis on the spokes. Increasingly, patients must have access to web and smart phone based resources as initial spokes combined with peer support groups to support and help manage chronic conditions. A hub and its resources should look to be minimized for those where acute care is vital.
- The co-existing behavioral health needs of chronic medical care patients should not be underestimated. Projects such as [Utah Smart Care](#) are utilizing e-health technology platforms to help care teams provide more detailed risk stratifications while deploying resources where and when they are needed. This is particularly vital in frontier areas where in-person visits much be managed carefully.
- Expanding the primary care and disease management role of first responders in rural and frontier areas is a resource that should be further developed.
- Patient engagement between visits is essential. Follow-up with virtual technology can provide a continuum of care between necessary in-person visits. Tools such as [Open Notes](#) allow providers, patients, and their families/caregivers to have more meaningful interactions during and between visits.