



June 22, 2015

Delivered via email: chronic_care@finance.senate.gov

The Honorable Orrin G. Hatch
Chairman
Senate Finance Committee
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden:

CenseoHealth (Censeo) appreciates the opportunity to provide feedback on the Senate Finance Committee's May 22, 2015 request for recommendations on real-world experience and data-driven evidence that will improve care for Medicare beneficiaries with chronic conditions. As the Committee recognizes, chronic care is a significant issue for the health care system as a whole and for the Medicare program in particular. According to the Bipartisan Policy Center, chronic disease treatment accounts for 86 percent of U.S. health care costs and affects 50 percent of the U.S. population.¹ The number of people over age 85 with multiple chronic conditions will rise to nine million by 2030, more than doubling from 4.2 million. Further, beneficiaries with five or more chronic conditions represent the fastest growing segment of the Medicare population.²

We believe that our extensive experience with physician house calls in the Medicare population offers valuable lessons on how Medicare can improve care for beneficiaries with chronic conditions. Our program in particular meets the Committee's three bipartisan goals of:

- (1) Increasing care coordination;
- (2) Streamlining current payment systems to incentivize the appropriate level of care for patients living with chronic disease; and
- (3) Facilitating the delivery of high quality care, increased program efficiency, improved care transitions, better patient outcomes and reduced Medicare spending.

¹ Bipartisan Policy Center, "A Prevention Prescription for Improving Health and Health Care in America," May 2015. <http://bipartisanpolicy.org/wp-content/uploads/2015/05/BPC-Prevention-Prescription-Report.pdfm>.

² Rauch, Jonathan, "Opportunity Knocks at Home: How Home-Based Primary Care Offers a Win-Win for U.S. Health Care," Governance Studies at Brookings, Dec. 2013, http://www.brookings.edu/~media/research/files/papers/2013/12/05-home-based-primary-care-rauch/rauch_latelifecare.pdf

GENERAL COMMENTS

CenseoHealth

Serving plans with a combined enrollment of over 6.5 million Medicare Advantage (MA) members, Censeo changes the way health care organizations interact with their members by providing care consultations and ancillary services in a home setting. The core of our service is a physician house call that we conduct on behalf of MA health plans and physician groups. Over the course of approximately one hour, our physicians conduct a comprehensive evaluation of the member's health, family history, living arrangements and medication use, as well as a frailty assessment, depression screening and much more. Our physicians perform comprehensive histories and physicals, as well as various other needed health assessments (e.g., cholesterol check, hemoglobin checks, etc.). Our assessments identify gaps in care, and take a snapshot of beneficiaries' health status, including potential risks and case management opportunities.

These insights are shared with the member, his/her primary care provider (PCP) (when possible), and the health plan, often resulting in care planning and enrollment in care/case management programs. In addition to these evaluations, our physicians have also triaged services for an acute and/or life-threatening patient need (e.g., 911 calls) for many members at the point of care. Our findings help enhance member engagement, improve quality ratings and reduce overall health care costs.

Our data shows that in-home assessments lead to significant reductions in emergency room (ER) visits and hospital admissions. Members identified as "low engagement" (no primary care encounter in the 6 months prior to the home visit) are twice as likely to go to their physician after receiving our house call. Censeo has also seen significant improvements in beneficiary health for chronic conditions when comparing 100 days pre-Censeo physician visit with 100 days post-visit, including:

- A 17 percent increase in congestive heart failure (CHF) treatment;
- An 11 percent increase in dementia treatment;
- A 26 percent increase in depression treatment;
- A 25 percent increase in diabetes treatment;
- A 29 percent increase in glaucoma treatment; and
- A 38 percent increase in hypertension treatment.

Evidence of Efficacy for Physician House Calls Generally

As our experience illustrates, physician house calls can play a key role in reining in health care costs and improving care for patients with chronic conditions. House calls used to be the norm in American health care. In 1930, house calls accounted for 40 percent of physician interactions. While physician house calls are generally infrequent today, in 2010, about 4,000 physicians conducted more than two million house calls.³ However, according to a 2013 American Academy of Family Physicians' survey, only 13

³ Emanuel, Ezekiel, "Hi, It's Your Doctor," *New York Times*, Sept. 5, 2013. <http://opinionator.blogs.nytimes.com/2013/09/05/hi-its-your-doctor/>.

percent of family physicians made regular house calls in 2013, and only three percent made more than two per week.⁴

Despite their underuse, there is growing evidence that house calls improve care and save money. A 2011 Avalere Health study found that health care at home improved outcomes and saved \$2.8 billion among patients with diabetes, CHF and chronic obstructive pulmonary disorder. A 2009 study found that expanding access to home health care for chronic disease patients could save a projected \$30 billion.⁵

House calls allow providers to instruct patients on how to best care for themselves in a way that an office visit cannot. House calls are also immensely beneficially for frail Medicare beneficiaries who find it challenging to travel to physician offices, and attempt to avoid hospitalization and bring care to the patient rather than forcing the patient to travel to care. Even among the elderly, at least 30 percent of hospitalizations are potentially avoidable.⁶ "Seeing a person in his or her daily environment can give a far richer view of the person's capabilities, needs and vulnerabilities... For the frail population, in many cases the home is a safer environment than the hospital."⁷

Our Experience

Censeo's experience is consistent with the literature on physician house calls generally. We have found that our home physician visits often reveal vital information about the patient that can only be gathered in the home (e.g. fall risk, an empty refrigerator, etc.) or through an extended visit (e.g. some patients may be reluctant to speak about depression or substance abuse and, as a result, these conditions may go undetected in a shorter visit with the patient's PCP.) In all, we collect over 300 clinically relevant data elements during each patient visit, the vast majority of which are used by the plan and/or providers to drive quality programs, care coordination and wellness initiatives. Our physicians are trained to focus only on accurate diagnoses.

RESPONSES TO SPECIFIC REQUESTS FOR FEEDBACK

1. Improvements to MA for patients living with multiple chronic conditions;

As the Committee states, 30 percent of Medicare beneficiaries are enrolled in MA plans today. We agree that "private sector health insurers have extensive experience in using disease management and care coordination tools to effectively target and better engage patients that have chronic conditions." Indeed, MA plans are incentivized to overcome the silos of Medicare fee-for-service. As Mark Miller of MedPAC observed in

⁴ Miller, Anna Medaris. "Is the House Call Doctor Coming Back?" *U.S. New & World Report*, April 14, 2015. <http://health.usnews.com/health-news/patient-advice/articles/2015/04/14/is-the-house-call-doctor-coming-back>.

⁵ Fleming, Michael, "Why Health Care Should Bring Back the House Call," *Harvard Business Review*, May 15, 2013, <https://hbr.org/2013/05/why-healthcare-should-bring-ba>.

⁶ Fain, Mindy, "Want better healthcare? Have doctors make house calls," *Los Angeles Times*, June 4, 2014, <http://www.latimes.com/opinion/op-ed/la-oe-fain-healthcare-house-calls-20140605-story.html>

⁷ Rauch, Jonathan, "Opportunity Knocks at Home."

recent testimony to the Committee, “[p]rivate plans have greater incentives to innovate and use care-management techniques that fill potential caps in care delivery.” MA plans also cap out-of-pocket beneficiary spending, which benefits sicker patients (i.e., those with greater chronic care needs).⁸

Currently, Medicare pays for most inpatient services, but outside of demonstration programs, reimburses only for post-acute rather than chronic home care. It does not cover travel time, travel expenses, conferences and coordination with family or caregivers or coordination between medical providers.⁹ By contrast, the structure of MA – when adequately resourced – allows for precisely these services.

Adequate payment to MA plans is essential so as to ensure plan viability and integral downstream services such as home visits. Although MA home visits are fairly new, they have quickly become an essential tool for health plans and providers to learn more about beneficiaries and act on that knowledge. As noted by CMS, best in class in-home visits often go well beyond the typical internet or phone-based Health Risk Assessments (HRAs) sent to enrollees upon enrollment into MA and/or annually. In many cases, our visit is the member’s only contact with primary care that year—giving the health plan yet another tool to engage with a member who may be outside the traditional system for some reason.

2. *Transformative policies that improve outcomes for patients living with chronic diseases either through modifications to the current Medicare Shared Savings ACO Program, piloted alternative payment models (APMs) currently underway at CMS, or by proposing new APM structures;*

Over the past several years, care in the home has been increasingly viewed as an important part of improving quality and reducing medical costs in our health care system. Based on our experience, Censeo believes strongly in the value of physician home visits to Medicare beneficiaries and is pleased to see recognition of its potential in new Medicare programs.

For instance, as you know, the Affordable Care Act created the Independence at Home (IAH) demonstration project, which launched in 2012. Fourteen primary care practices and three consortia of physician practices are participating for three years. Early results, released on June 18, 2015, indicated that participants saved \$25 million and improved quality on at least half of the program’s quality measures during the first performance year.

Additionally, some Medicare ACOs have had a house calls program, including an ACO that saved \$3.5 million in its first year.¹⁰ Importantly, CMS also recently indicated that ACOs participating in the new Next Generation ACO model will be allowed to provide

⁸ Miller, Mark E. Executive Director, Medicare Payment Advisory Commission, Statement to the Senate Finance Committee, “Improving Care for Medicare Beneficiaries with Chronic Conditions,” May 14, 2015. <http://www.medpac.gov/documents/congressional-testimony/testimony-improving-care-for-beneficiaries-with-chronic-conditions-%28senate-finance%29.pdf?sfvrsn=0>

⁹ Rauch, Jonathan, “Opportunity Knocks at Home.”

¹⁰ Brino *ibid.*

post-discharge home visits as part of this new program.

3. *Reforms to Medicare's current fee-for-service program that incentivizes providers to coordinate care for patients living with chronic conditions;*

Censeo's experience has been largely with MA and, to a lesser extent, with Medicaid managed care and Medicare ACOs. We note that as indicated above, there is a growing body of literature on the value of physician home visits in improving care for patients with chronic conditions. For instance, a 2014 study in the *Journal of the American Geriatrics Society* compared Medicare beneficiaries who received home-based primary care to matched case controls, and found that a home-based primary care model led to 17 percent lower total Medicare costs over a mean of two years, while achieving similar mortality rates. The home visits achieved these savings by shifting usage from inpatient and specialty care to community-based and generalist care.¹¹

The Committee may wish to consider how best to incorporate these findings into the traditional fee-for-service program. However, it may be easier to focus instead on ensuring adequate MA reimbursement so that MA plans – which already have incentives to build in care coordination — can remain strong and grow.

4. *The effective use, coordination, and cost of prescription drugs;*

Appropriate prescription drug use is a vitally important issue. According to an article in the *American Family Physician*, approximately 14 to 50 percent of older patients experience medication discrepancies, which are associated with increased rates of rehospitalization.¹² Censeo integrates comprehensive medication review into our home visits. Our review strives to increase member understandings of their prescriptions and over-the-counter medications to empower the member to self-manage medications and health conditions. After the assessment, we generate a medication action plan.

5. *Ideas to effectively use or improve the use of telehealth and remote monitoring technology;*

A 2013 Harvard Business Review article on home care recommended that more home care should include innovative technology that can aid in coordinating care in real time such as point-of-care laptops, telemonitoring devices and internet portals that allow all providers to share patients' information.¹³ Censeo uses a tablet-based electronic data collection tool that is designed to allow precisely such sharing. We believe that, while telehealth and remote monitoring may be helpful, they should complement rather than serve as a substitute for in-home, extensive physician visits.

¹¹ De Jonge, K. Eric, Jamshed, Namirah, Gilden, San *et al*, "Effects of Home-Based Primary Care on Medical Costs in High Risk Elders," *Journal of the American Geriatrics Society*, Oct. 2014. Vol. 62, No. 10, 1821-1831.

¹² Unwin, Brian K. and Paul E. Tatum, "House Calls," *American Family Physician*, Vol. 83, No. 8, pages 925-931, April 15, 2011.

¹³ Fleming, Michael. "Why Health Care Should Bring Back the House Call."

6. *Strategies to increase chronic care coordination in rural and frontier areas;*

Rural MA and other prepaid plan enrollment in March 2014 was nearly 1.95 million, or 20.3 percent of all rural Medicare beneficiaries, an increase of more than 216,000 from March 2013.¹⁴ We are pleased that MA plans have seen growth in rural areas in both PPOs and HMOs, and strongly believe that MA plans can play a key role in care coordination in both rural and urban areas. Indeed, our experience has shown that a higher percentage of Medicare beneficiaries in rural and other underserved markets do not have PCPs. Censeo has over 5,000 credentialed physicians in our network who are licensed in all 50 states so our home-based care assessment model can work in rural areas.

7. *Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers; and*

Censeo has found sharing the results of our in-depth home assessment with MA beneficiaries to be very powerful. As noted above, over the course of approximately one hour visit, our physicians conduct a comprehensive evaluation of the member's health, delve into family history, living arrangements and medication use, as well as conduct a frailty assessment, depression screening and much more. We therefore believe that greater adaption of such best-in-class home care visits in Medicare would help advance patient engagement.

8. *Ways to more effectively utilize PCPs and care coordination teams in order to meet the goals of maximizing health care outcomes for Medicare patients living with chronic conditions.*

Our home visit program is designed to maximize PCP involvement and care coordination. To ensure that the home visit is seamlessly integrated into the patient's overall health care plan, we have implemented a robust follow-up program connecting the patient back to their PCP. Of course, this can only be implemented in cases where the patient has one. 15 percent of the patients seen by Censeo physicians have had no other contact with the primary care system in a given year. If there is no PCP, we collect the information of the provider who is performing the majority of the patient's care and send follow-up information to that physician. Additionally, many of our clients have us generate a referral to an internal plan program to get the beneficiary signed up for a PCP.

In cases where there is a PCP, following every visit, our physicians create a recommended treatment plan for the patient, and share those recommendations with the patient, the patient's PCP and the plan. All information gleaned from the evaluation is converted to "flat" data files, meaning this information can be loaded into electronic medical records, case management software, etc. at the discretion of the plan and providers. Furthermore, because our model is to send physicians into the home (rather than another type of provider), we establish a strong working relationship with our patients' PCPs, almost all of whom are accustomed to working with other physicians.

¹⁴ Kemper, Leah; Barker, Abigail and McBride, Timothy, *et al*, "2014: Rural Medicare Advantage Enrollment Update," RUPRI Center for Rural Health Policy Analysis Rural Policy Brief, Brief No. 2015-1 January 2015, Brief No. 2015-1 January 2015.

CONCLUSION

Home visiting programs significantly advance the care of Medicare beneficiaries with chronic conditions, improving care, care coordination and beneficiary engagement, thereby meeting the Committee's goals. This type of home care program should be supported and built upon by the Committee for the benefit of all Medicare beneficiaries.

Thank you for considering our feedback. We welcome the opportunity to collaborate with the Committee as it works to improve chronic care in Medicare. Should you have questions about this response, please do not hesitate to contact me at ngoldstein@censeohealth.com or 202-390-2258.

Sincerely,

Nathan Goldstein
Chief Strategy Officer