



June 22, 2015

The Honorable Orrin Hatch
Finance Committee, Chairman
SD-219 Dirksen Senate Office Building
Washington, DC 20510-6200

The Honorable Ron Wyden
Finance Committee, Ranking Member
SD-219 Dirksen Senate Office Building
Washington, DC 2510-6200

The Honorable Johnny Isakson
Finance Committee, Member
SR-131 Russell Senate Office Building
Washington, DC 20510-1008

The Honorable Mark Warner
Finance Committee, Member
SR-475 Russell Senate Office Building
Washington, DC 20510-4605

Dear Senators:

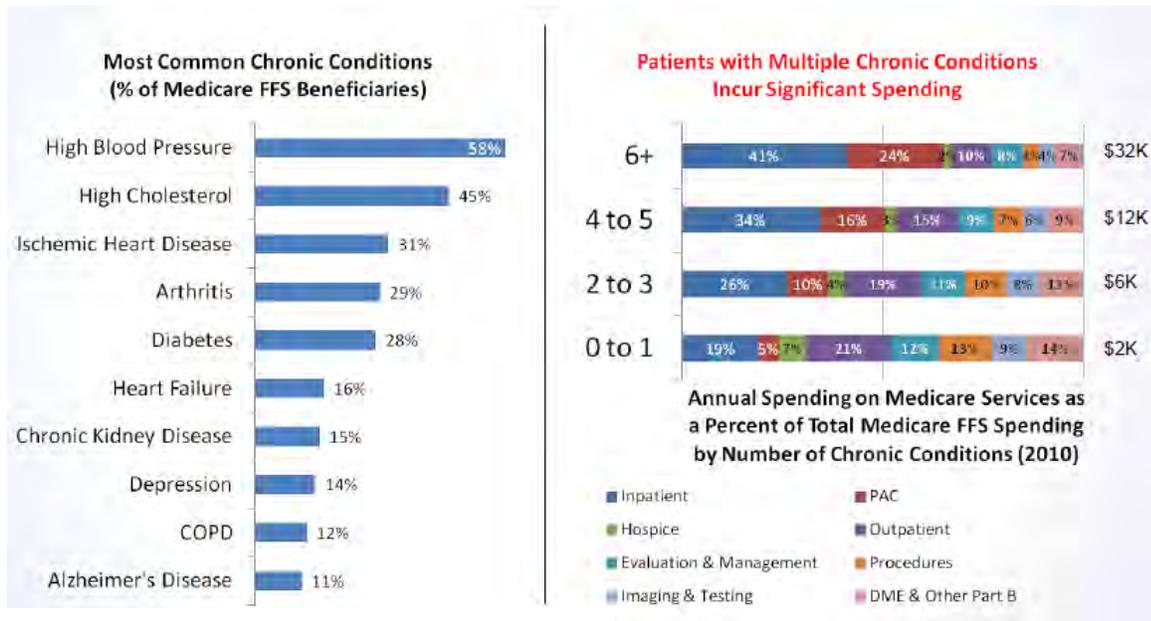
On behalf of Kindred Healthcare and all of our dedicated teammates, thank you for the opportunity to provide comments on how our nation can improve care and coordination for Medicare beneficiaries living with chronic health conditions.

Kindred's care approach is to provide quality, coordinated care for patients when they need it, in the most appropriate setting through an entire episode. Our national presence and full continuum of integrated care locations provides significant opportunity for people to access the right care and services to support recovery and wellness. Kindred is the largest provider of integrated care for people with chronic care in the nation, with 102,600 dedicated employees providing care annually to more than one million people in 2,787 locations in 47 states, including 97 transitional care hospitals, 16 inpatient rehabilitation hospitals, 90 nursing and rehabilitation centers, 21 sub-acute units, 664 Kindred at Home home health, hospice and non-medical home care sites of service, 100 inpatient rehabilitation units (hospital-based) and over 30,000 rehabilitation therapists providing restorative care in 1,799 non-affiliated sites of service. Simply put, over the last few years we have dedicated ourselves to building a platform for population health management through our continuum of care from hospital to home. As described below, we are striving to provide patient-centered, integrated care to improve care, improve patient experience, and reduce costs. Our focus is on chronically ill people who desperately need this integrated care, and whose health care costs to our nation are disproportionate to their numbers.

The Need For Chronic Care Management

Increasingly, Medicare beneficiaries suffer from multiple chronic illnesses. More than two-thirds of the current 54 million beneficiaries have two or more chronic conditions, and 14 percent have six or more chronic conditions. Those beneficiaries with six or more illnesses accounted for 46 percent of all Medicare spending in 2010. Additionally, the Centers for Disease Control and Prevention (CDC) reports that individuals aged 45-64 are increasingly living with multiple chronic conditions.

The aging population and rapid increase in the number of chronically ill and medically complex people presents a significant challenge for caregivers, care managers and payors alike. Of the 1.9 million Medicare hospital readmissions in 2010, beneficiaries with two or more chronic conditions accounted for 98% of these readmissions. This trend underscores the need for change in healthcare – as healthcare providers, we cannot continue to focus on individual disease interventions, rather we must look to treat the entire patient.



Source: Chronic Conditions Among Medicare Beneficiaries, Chartbook: 2012

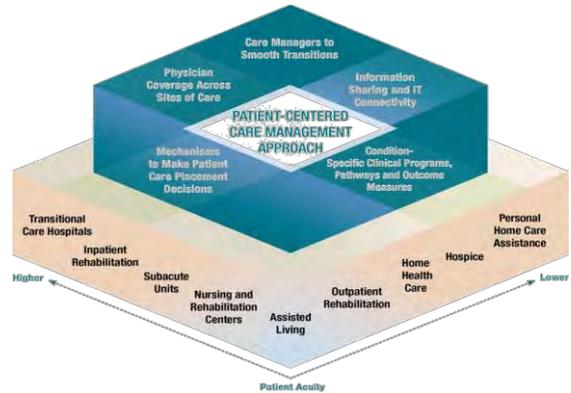
Consistent with national demographics, clinicians in Kindred care settings across the continuum are increasingly caring for patients living with multiple chronic conditions. Because they suffer from several ongoing illnesses, these patients present additional challenges in treating their primary – often unrelated – care needs. In order to best meet patient need and deliver medical and rehabilitative care that best supports recovery and return home, Kindred has significantly expanded our care management capabilities as we test innovative approaches to care such as bundled payments and shared savings. Simultaneously, we have been promoting post-acute care payment and delivery reforms that encourage accountability, incentivize quality outcomes and produce savings to Medicare. We appreciate this opportunity to discuss these parallel efforts.

Kindred: Building a Platform for Population Health, Care Management & Innovative Approaches to Patient-Centered Care

As we pursue strategies to address patient-centered care management for the highest risk consumers, we must test models and multi-dimensional opportunities to provide effective care management that improves quality outcomes while reducing the overall cost of care. In order to support recovery and wellness for our patients, Kindred has developed clinical expertise and capabilities across the continuum to deliver the right care in the right setting across an entire episode. Our priority is to provide the care interventions and services that allow individuals to stay in the comfort of their home or community – and avoid a costly hospital stay or emergency room visit. But when an individual does need ongoing care support and rehabilitation after a hospital admission, Kindred has an integrated continuum of post-acute care settings and services, which serve to manage and coordinate patient care in the most appropriate setting according to clinical needs.

Our approach to integrated care for chronically ill people is driven by five evidence-based core capabilities necessary to meet the unique needs of each patient. We believe that policy should actively seek to support and expand these key enablers through payment policy and innovative demonstration projects:

- Physician coverage across sites of care
- Care managers to smooth transitions
- Information sharing and IT connectivity
- Condition-specific clinical programs, pathways and outcome measures
- Mechanisms to make care placement decisions



Partnerships to support coordination

The Centers for Medicare and Medicaid Services’ (CMS’) Center for Medicare and Medicaid Innovation (CMMI) continues to test programs that strive to encourage care coordination with the goal of producing improved outcomes and Medicare savings. Accountable Care Organizations (ACO), Medical Homes, and the Bundled Payment for Care Improvement (BPCI) Initiative are some of the innovative approaches that are intended to coordinate care for Medicare’s most at risk patients – including those with several chronic conditions. While these demonstrations are showing promising signs, it is unclear if the models are sustainable, if they will improve outcomes for patients with chronic conditions, or if they will generate savings to the Medicare program.

Kindred is currently participating in some of the CMMI supported models, including Model Three of the CMS BPCI Demonstration. As a convener for two long-term care hospitals, one skilled nursing facility, and one sub-acute unit, Kindred is managing a 60-day episode for seven conditions including COPD, CHF, major joint replacement of the lower extremity, among others. Additionally, in 2014 Kindred became an owner and strategic partner in the Silver State Medicare Shared Savings Program ACO, which covers the lives of 15,000 Medicare fee-for-service beneficiaries in Southern Nevada. This ACO is co-owned and managed by Kindred in collaboration with approximately 150 primary care physicians. Unfortunately, as noted below, Kindred’s experience to date is that these demonstration approaches, while worth testing, may not be designed to produce the clinical and financial results that are needed specifically for the chronically ill population.

Home-based Primary Care

Kindred established Kindred House Calls in order to provide high-quality physician-based house call services to patients who are at high risk for hospitalization and cannot easily access traditional outpatient services – enabling patients to stay at home. Through our tailored medical care, we are delivering improved clinical outcomes, preventing emergency room visits and hospital stays, and creating positive patient experiences.

In 2014, Kindred House Calls served a high-risk population, typically about 86 years of age, with an average of 20 diagnoses, and seven chronic conditions at risk for exacerbation. A Medicare cost data pilot project found that the **group's care was associated with significant cost savings over traditional care models, and for the seventh year in a row achieved a 30-day readmission rate below 7%**. These outcomes are consistent with the strong results from the first performance year of the Independence at Home Demonstration. CMS recently announced that the participants saved more than \$25 million to the Medicare program in that first year, while also providing higher quality care to chronically ill patients.

Kindred House Calls currently operates in four states – Colorado, Ohio, Texas, and Washington – with 70 physicians and nurse practitioners.

Care Transitions Program

Kindred's Care Transitions Program is a quality improvement program designed for patients who have complex medical conditions and are highest risk. The Care Transitions Manager does not replace any member of the care team, but rather works collaboratively with the team and serves as an additional educational resource to engage patients and caregivers and help them understand disease processes, care plans, medications and follow up care. The program begins when a patient is admitted to a Kindred site of care and continues throughout their stay across Kindred locations and their return to community – concluding 35 days post discharge.

In 2014, the Care Transitions Program in pilot testing **achieved a low 30-day hospital readmission rate of 6.1%**, and 93% of patients kept their scheduled follow up appointment with their primary care physician within 7 days of discharge. It should be noted that Kindred does not get paid for care transition services today. Policy should support these types of interventions that have been demonstrated to improve care and reduce costs.

24/7 Decision Support

Recognizing the difficulties that patients, families, and loved ones face in navigating the complex and confusing healthcare system when dealing with tough medical decisions, Kindred set-up a toll-free resource (1.866.KINDRED) and dedicated [online site](#) for consumers to talk with Registered Nurses so that they may make informed care decisions. In addition to helping find the best care solutions for a patient after a hospital stay, our nurses answer tough questions about insurance or Medicare coverage and detail the care options available to consumers in their local community.

Policies to Support Innovative Care Solutions

We continue to test these, and other, innovative approaches to better manage care for our patients as we seek to deliver population health. However, the current Medicare Fee For Service structure is at odds with our efforts. We support policy approaches, such as the *Better Care, Lower Cost Act*, which removes some of the barriers that exist and limit our ability as providers to expand our innovative care models. We also support the framework in the Wyden, Isakson, Paulsen, Welch legislation as it encourages and incentivizes innovative chronic care delivery. The bill recognizes that to best address chronic care, we should have mechanisms in place to identify patients that are at greatest risk and provide targeted preventative interventions to support wellness, and stave off the development of chronic conditions.

Post-Acute Care Reform to Support Chronic Care Management

Kindred has long supported a reformed post-acute delivery and payment system that encourages accountability, incentivizes quality outcomes and produces savings to Medicare. A new patient-centered payment and delivery system should be based upon patient need and reward the provision of appropriate interventions that enable recovery and return home.

As we detailed in our “[Blueprint for Post-Acute Care Reform](#),” that we submitted to Congress in August 2013, there are four principles for achieving such reform:

- 1) Recognize that each post-acute provider offers a unique value and plays an important role;
- 2) Prioritize policies in the near term that simultaneously support integrated care and achieve budget savings;
- 3) Remove barriers to integrated care by modifying or eliminating fee-for-service rules that thwart innovation and reform; and
- 4) Support innovation and build a bridge to the future through incremental reform.

The successful replacement of the troubled Sustainable Growth Rate (SGR) system for physician reimbursements provides an opportunity for providers and policymakers to work together toward sustainable PAC reform that better supports patients with chronic care conditions. We are hopeful that moving away from annual SGR patches, will provide relief from blunt cuts as pay-fors – in terms of market basket cuts and extension of the sequester – and move toward nuanced payment reforms. Given the opportunity to advance post-acute payment and delivery reforms, which should include incentives for chronic care management, we believe that the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) provides an appropriate framework and timeline for implementing a restructured system.

Next Steps in Promoting Coordinated Care

While we support the *Better Care, Lower Cost Act* and its approach to remove some regulatory barriers to coordinated care for patients most at risk of living with chronic conditions, we believe there are additional steps that can be pursued. Under the current model three BPCI model, participants are only allowed two waivers. In order to more effectively incentivize providers to take part in the demonstration and to advance the concept of bundling on a greater scale, policymakers should also consider waiving additional regulatory restrictions such as the Skilled Nursing Facility 3-day stay, co-location of post-acute care provider types, the Long-term Acute Care Hospital 25-day length of stay requirement, the Inpatient Rehabilitation Facility 60 percent rule, restrictions for referring beneficiaries to post-acute care settings, and restrictions on information sharing between institutional post-acute and home health providers.

Waiving these regulatory restrictions will furnish providers with additional flexibility to treat patients in the most clinically appropriate and cost-effective setting for the appropriate length of time. With the appropriate reporting requirements and financial incentives in place to ensure high quality clinically appropriate care, these regulatory restrictions are unnecessary and impede the ability of providers to fully innovate or reform health delivery systems.

Additionally, with the development of our Kindred at Home offering featuring home-based primary care services, it is understandable that **we support the CMMI Independence at Home demonstration project.** We believe that with physicians and nurse practitioners delivering care services to patients with – or at high risk of developing – multiple chronic conditions at home, we are able to prevent much more costly interventions in a hospital or other post-acute settings.

We were pleased that the Senate voted to approve the *Medicare Independence at Home Medical Practice Demonstration Improvement Act of 2015* (S. 971) earlier this year, which would extend the demonstration by an additional two years. We believe that the extended time frame will provide more conclusive data to support the value of the Independence at Home effort, and identify areas where the program could be improved. However, we support the idea of expanding the pool of only 17 participating practices and consortia to other entities who meet the criteria. Having a larger pool of participating practices will more clearly identify geographic differences, and will take the next step in incentivizing chronic care management at home for a greater number of patients.

Additional Policy Considerations

In trying to solve to the problem of a rapidly aging population living with multiple chronic conditions, there are significant issues we must consider. In addition to the policy recommendations above, we believe that as you pursue a bipartisan legislative solution to chronic care management, the following must be part of the discussion:

- How do we accelerate change today in Fee-For-Service Medicare and Medicare Advantage?
- How can we adapt current alternate payment models to address needs of chronically ill beneficiaries?
 - How do you address issues of scalability to a national framework?
 - How can we address the fragmented nature of provider community?
 - How do you align financial incentives?
 - What changes need to be made to address mixed results from demonstrations?
- What is the role of expanding Medicare Advantage (i.e., C-SNPs or D-SNPs)?
- What opportunities exist to improve care coordination through transitional care coordinators, patient navigators, etc., but limit redundancy and overlap?
- How do we accelerate adoption of readmissions programs for all providers and payers?
- How can we invest in palliative care?
- How can we invest in home-based primary care for patients with multiple chronic conditions (fully operationalize the Independence at Home Demonstration)?

The development of this chronic care working group is an important first step in addressing these considerations and developing policy proposals that serve to best meet the needs of a difficult to treat population, improve clinical outcomes, and provide programmatic savings by preventing hospitalizations and supporting wellness at home.

Chronic Care Management Concepts

In response to this workgroup's request for stakeholder comment and input on policies that may enhance the care and management of chronically ill individuals, Kindred has begun developing new concepts, which we believe contribute positively to the discussion. While these ideas are still in their infancy, we wanted to take this opportunity to share three broad-brush concepts.

CONCEPT 1: Advance Integrated Chronic and Population Health-Based Care with a Home Health Model

This concept was based on the fact that at this time, home health care providers serve some of the most vulnerable Medicare beneficiaries – with an average of 3 chronic conditions and at least 3 functional limitations.

The general idea would be to develop a voluntary program – not a demonstration – that enables eligible providers, including home health, to manage this complex population within a population health model. This Advanced Integrated Patient-Centric Model would focus on managing chronic conditions and utilization through a holistic approach to patient care, including greater emphasis on caring for patients' in their own homes. Through a new alternative monthly payment model, participating providers would manage the total cost of Medicare-covered care (excluding Medicare Part D) to the beneficiary. Beneficiaries that opt in to the program would have limited cost-sharing to encourage utilization of the highest quality care and services.

Participating providers would be required to have several key capabilities, including: transition managers; IT infrastructure to enable communication across sites of care; physician coverage; the ability to track, measure and report patient outcomes; and condition-specific clinical protocols. The use of palliative care, in concert with the curative medical care delivered across post-acute settings, could further be encouraged to drive better coordination for patients with chronic conditions.

By aligning resources to deliver patient-centered population health, primarily in the home or community, participating providers will provide enhanced monitoring, service coordination, and prevent the exacerbation of chronic conditions – thereby preventing hospitalizations and creating savings to Medicare.

CONCEPT 2: Promote “Next Generation” Prospective Bundling and Care Integration Programs

After several years of participating in the BPCI program, we believe there may be approaches that take into account “lessons learned” and build the next generation prospective bundling program. Under this concept, a bundling program would no longer rely on traditional fee-for-service payments with a retrospective reconciliation, as the current BPCI program does. A prospective, rather than retrospective, payment model would address the concerns of providers participating in BPCI that the current financial structure limits the ability to invest in high-value services that are not reimbursed by Medicare. It would also enable innovative approaches to care that are currently not allowed under fee-for-service.

One idea under this approach would be to allow participating post-acute care settings to accept prospective, fixed payments for managing care of certain patients over a 90-day episode. The bundle-payment could be used across several different post-acute episode scenarios – such as a long-term acute hospital/skilled nursing bundle, or an inpatient rehabilitation facility/skilled nursing facility/home health bundle. The development of such a concept would build on existing BPCI parameters, and could easily be aligned with the new cross-cutting quality metrics and timeline for the IMPACT act.

We believe that a prospective payment would encourage greater provider participation in the program, and contribute to new innovations in delivering high quality, accountable care for the difficult to treat chronically ill population.

CONCEPT 3: Advance Silo-Specific Reforms that Pave Way to Broader, More Integrated Care Models

We believe there are also opportunities to make smaller, more incremental reforms to the current silo-specific Medicare payment and delivery system that would positively contribute to future integrated care models. Take for example the fact that the current prospective payment system for Medicare-covered skilled nursing facility (SNF) care does not reimburse adequately for more complex medical cases such as patients with chronic care needs on top of more-acute medical needs. More specifically, under the current Resource Utilization Group (RUG) payment system, SNFs report the nursing-intensity level required for patient care, but it is not used to calculate payments.

One idea worth consideration to better target services to a chronic care patient, would be to update the nursing component of the RUG payment to base it on nursing intensity. The therapy and non-therapy ancillary components would remain the same under such a system. As CMS recalculates the RUG payment under such a model, it would result in reimbursements that more accurately reflect true nursing needs.

We would look forward to collaborating with this working group, and your staff, to further model these ideas and build upon these concepts to create programs that are operational, sustainable, drive quality outcomes and better manage chronic care patients.

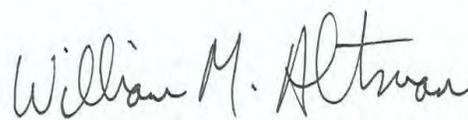
Over the course of the past several years, we have transformed Kindred – our operations and capabilities – in order to deliver care where and when people need it most. We are proud of our dedicated caregivers and their ability to continually drive performance that exceeds national benchmarks in key clinical and quality measures. Year over year reduction in hospital readmissions and reduced lengths of stay highlight our commitment to put in place solutions that help provide savings to the Medicare program.

We look forward to working with the Finance Committee’s chronic care working group and staff to share Kindred’s experiences to help improve patient centered care management for patients that often suffer from multiple chronic conditions. Additionally, we are committed to working with all stakeholders in order to advance progressive post-acute care reform to ensure the delivery of high quality and efficient care that Medicare beneficiaries deserve. By working together, we will make healthcare better for everyone.

Sincerely,

A handwritten signature in black ink, appearing to read "Ben Breier". The signature is stylized with large, flowing letters.

Benjamin A. Breier
President and CEO

A handwritten signature in black ink, appearing to read "William M. Altman". The signature is written in a cursive style.

William M. Altman
Executive Vice President, Strategy, Policy, Integrated Care