

PHILIPS

Transmitted via email to chronic_care@finance.senate.gov

January 26, 2016

The Honorable Orrin Hatch, Chairman
The Honorable Ron Wyden, Ranking Member
The Honorable Johnny Isakson
The Honorable Mark Warner
United States Senate
Committee on Finance
SD-219
Washington, D.C. 20510

Chairman Hatch, Ranking Member Wyden, and Senators Isakson and Warner:

Please find attached Philips' comments in response to the December 2015 Bipartisan Chronic Care Working Group's Policy Options Document on how to improve care for Medicare patients with chronic conditions.

If you have any questions or are interested in exploring any of the topics or recommendations contained herein, please feel free to contact me at: David.Shoultz@philips.com, or by phone at: (202) 997-5023 (mobile).

Sincerely,



David Shoultz
Federal Government Affairs and Policy
Philips Healthcare



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Philips would like to commend you for all of the thought and effort involved in the issuance of the Bipartisan Chronic Care Working Group (CCWG) Policy Options Document (the “Options Document”) dated December 2015. Thank you for this opportunity to share our thoughts.

As indicated in our June 2015 submission, Philips has extensive experience in partnering with providers to manage patients with multiple chronic conditions. Specifically, as described at greater length in Attachment A, Philips’ **Intensive Ambulatory Care (eIAC) Program** partners with providers to manage high-risk patients with multiple chronic conditions (MCCs) in the home using a telehealth-enabled program that combines “high tech” technology and “high touch” services to address the very special needs of those most severely impacted by multiple serious and complex chronic conditions (the “Severely Debilitated MCC population” or SD-MCC).¹ Data from a pilot program involving Philips’ partnership with Banner Health (Phoenix, AZ) indicate that the eIAC program has the potential to result in cost reductions in the range of

¹ For the purposes of these comments, the SD-MCC patient population is defined as those with:

- Four or more chronic illnesses (including depression and anxiety);
- Three or more hospital admissions in last 12 months;
- Living at home and/or recently discharged from long term care facility; and
- 10 or more prescription medications

27%, reductions in acute and long-term care of 32%, and reductions in hospitalization in the range of 45%.

Our experience suggests that, for this high-cost SD-MCC population, achieving the CCWG's objectives requires highly specialized high tech/high touch team-based programs with set-up and operational costs not reflected in the Medicare Advantage capitated payment amounts or Accountable Care Organization shared savings calculations, and benefit categories not reflected under the Medicare fee-for-service program, or the Medicare Advantage program. For these reasons, these comments focus primarily on CCWG's proposed policy options related to the Medicare Advantage (MA) and Accountable Care Organization (ACO) programs. Specifically:

- *We support the proposed changes to the Medicare Advantage (MA) program to make the SD-MCC population more attractive to MA Plans and to make MA plans more attractive to these patients. We are especially supportive of the CCWG's focus on Chronic Condition Special Needs Plans (CC-SNPs), and believe that such plans have considerable potential to achieve quality improvement and costs savings for the SD-MCC population.*
- *We support the proposed changes in the ACO program, but believe that they will not meet the needs of the SD-MCC population, especially with respect to coverage for telehealth services.*
- *We do not believe that the changes in the Medicare Fee for Service (FFS) program outlined in the Options Document are likely to substantially improve the quality of care or reduce the costs of the SD-MCC population, unless Chronic Care Management (CCM) fees are sharply graduated to provide substantial monthly payments for this narrow sector of the patient population, benefits are strictly limited based on patient selection criteria described below, and participation is limited to providers that meet the qualifications set forth below expanded to include all necessary clinical and non-clinical providers comprising the care team.*

With regard to the specific policy proposals included in the Options Document, Philips offers the following comments:

I. Proposals Related to Improvements to MA Plans for the SD-MCC Population.

The Options Document includes a number of provisions whose purpose is to improve MA plans for patients living with multiple chronic conditions and to make MA plans more attractive to this patient population, including:

- Providing MA enrollees with Hospice Benefits
- Allowing End Stage Renal Disease beneficiaries to choose a MA Plan
- Providing continued access to MA Special Needs Plans (SNPs) for vulnerable populations by making SNPs a permanent part of the MA program.

- Allowing MA plans to offer additional supplemental benefits, to reduce cost sharing for select items and services, to tailor provider networks to include providers focused on this population; and to provide tailored care improvement and/or wellness programs, and to offer a wider array of supplemental benefits, including not only medical but also non-medical, social services; and to include certain telehealth services in MA Plans' annual bid amounts.

Based on the number and depth of the proposals included in the Options Document that address improvements in the MA Plans for those with multiple chronic conditions, it appears that the CCWG views MA Plans as a major component of the solution for Medicare patients with chronic conditions. We agree, and strongly support all of these proposals.² We especially support the proposal in the Options Document to permit a MA Plan to include certain telehealth services in its annual bid amount.

The Options Document specifically solicits feedback on whether the telehealth services provided by the plan be limited to those allowed under the traditional Medicare program and which additional telehealth services should be permitted, if any. We strongly urge the CCWG not to limit the telehealth services allowed to those that are currently covered under the Medicare Fee For Service (FFS) program.

Coverage of telehealth under Medicare FFS is extremely limited both in terms of geographical limits and in terms of originating site requirements. It is especially troublesome that the current FFS telehealth coverage does not extend to services provided in the patient's home, and home-based services are critical for those with complex MCCs. Our experience with Banner suggests that providing telehealth and other support services to the SD-MCC population in the home is key to improving care and achieving cost savings.

Current coverage is also limited to services that substitute for face to face interventions, a limitation that is especially ill suited for those with complex MCCs, since success in managing this patient population is highly dependent on close daily monitoring to identify potential signs of deterioration through both human (high touch) and technological (high tech) means.

For these reasons, we urge the CCWG to authorize MA Plans to include telehealth services meeting the following definition to be included in their bids:

Telehealth is the use of remote sensors, communications and data processing technologies that focus on the patient/person and involves dynamic interaction with providers in real-time or near real-time resulting in improved clinical outcomes, lower costs and greater satisfaction. Telehealth technologies include bi-directional audio/video, physiologic and behavioral monitoring, engagement prompts and point-of-care testing. Telehealth programs utilize remote teams of physicians, nurses,

² We especially support the proposal to authorize MA Plans to provide social services and other "non-medical" support to this patient population. The provision of these services (including especially the provision of a "health coach") is critical.

pharmacists, social workers and health coaches supported by this enabling technology to provide the highest quality health care.

While Philips supports the MA Plan modifications included in the Options Document, we are concerned that so long as HCC risk adjustment model under-predicts high cost, complex individuals, it may be difficult to successfully encourage most MA plans to seek out this patient population. For this reason, pending the implementation of improvements in the HCC risk adjustment formula, we urge the CCWG to focus heavily on improvements in the Chronic Condition Special Needs Plans (CC-SNPs), which we believe have great potential to improve the care provided to this patient population.

In this regard, we urge the CCWG to consider incorporating in CC-SNPs a number of the features of the Better Care Plans (BCPs) envisioned in legislation introduced in 2014, the *Better Care Lower Cost Act* (S.1932). Under this model, CC-SNPs would be responsible for the full continuum of care (other than long term care) for enrollees. Cost-sharing for enrollees could be varied from standard cost sharing requirements. The provision of a broad range of services (including non-medical services such as social services and health coaches, and innovative telehealth technology) would be required and would be included in CC-SNP bids. Team-based care (including counseling), with the team run by a physician who has advanced training in managing multi-morbid, complex patients, likewise would be required.

The capitated rates to be paid to CC-SNPs would be carefully constructed using a combination of Medicare claims data and the documented costs of caring for this patient population. Only SD MCC patients would be eligible for coverage through a CC-SNP.

II. Proposals related to the Improvement of Accountable Care Organizations (ACOs) for patients living with multiple chronic conditions.

The Options Document includes a number of proposals to improve the structure and operation of ACOs to better serve the needs for patients living with multiple chronic conditions. These proposals include:

- Waiving the geographic restrictions on coverage of telehealth for two sided risk ACOs;
- Clarifying that two sided risk ACOs may provide (at their own cost) social services, transportation and remote monitoring;
- Authorizing assignment of beneficiaries to certain ACOs on a prospective basis; and
- Authorizing waivers of copayment requirements for beneficiaries with chronic conditions in two-sided risk ACOs.

While we most certainly support the CCWG's proposal to lift the geographic and originating site restrictions on coverage of telehealth for two-sided risk ACOs, we are concerned about the July 29, 2015 conclusion of the Congressional Budget Office, which appears to suggest that coverage should be limited to telehealth services that substitute for existing clinical services because increasing telehealth service access beyond this limited definition “[is] estimated to increase Medicare program costs.”

The e-IAC experience is unequivocally inconsistent with this conclusion. In its third Performance Year as a Pioneer Accountable Care Organization, Banner returned more than \$29 million in savings over the predicted financial benchmark, while at the same time improving its quality score by nearly 10 percent over the previous year. Banner credits much of this success to its iCare program, which encompasses all telehealth programs including the eICU and the IAC programs.

For the SD-MCC population in particular, the greatest cost reductions will be realized by caring for patients outside of the hospital settings. Yet, current home care coverage is not designed to care for persistently high cost patients who might otherwise be in and out of the hospital. Telehealth technologies that provide not only remote monitoring but also use of two-way audio visual communication and that supplement but do not substitute for face to face services have the potential to fill the gap, especially for the SD-MCC patient population.

We would also urge the CCWG to consider mandating the establishment of a new type of “Advance Payment” ACO focused exclusively on the SD-MCC population, which provides for a prospective assignment process, increased shared savings, quality measures that focus on reduction in hospitalization and other quality measures especially relevant to this patient population, and advance payment for investments in bi-directional telehealth technology with the capability of enabling patients to monitor and track their progress.

III. Proposals related to the Improvement of Medicare’s FFS Program for the SD-MCC Patient Population.

The Options Document includes a number of provisions to improve Medicare’s current fee-for-service program for patients living with multiple chronic conditions. These include:

- Establishing a New “Complex” Care Management Code under the Physician Fee Schedule;
- Addressing the Need for Behavioral Health Among Chronically Ill Beneficiaries; and
- Eliminating geographic restrictions on telehealth for the narrow purpose of promptly identifying and diagnosing strokes, thereby facilitating access to telehealth services in urban areas.

We support these proposals; however, based on our experience with this patient population through the eIAC, we believe that considerably bolder steps are necessary. For example, the per patient costs involved in eIAC substantially exceed the amounts payable for the current care management code and the amounts that we anticipate would be established for a new complex care management code under the current Physician Fee Schedule methodology, Incremental improvements in payment for “complex” CCM may result in increased payment for primary care services, but is unlikely to appreciably improve the quality or reduce the costs of caring for SD-MCC Medicare beneficiaries.

For the purposes of determining eligibility for complex CCM payment for the SD-MCC population, we suggest that the SD-MCC patient criteria be defined as follows:

- Four or more chronic illnesses (including depression and anxiety)
- Three or more hospital admissions in last 12 months
- Lives at home and/or recently discharged from long term care facility
- 10 or more prescription medications

In order to receive payment, an eligible SD-MCC provider should be required to meet the following criteria:

- Geriatrician Physician- led team that includes:
 - Nurses with critical thinking skills (more than 5 years ICU or Emergency Department experience)
 - Pharmacist
 - Social worker led health coach team
- Daily assessment of physiologic data and symptoms
- Tablet with
 - Bi-directional audio/video
 - Capability for patients to track their own metrics
 - Task reminders

In other words, in order to address the cost and quality issues raised by the SD-MCC patient population in the context of Medicare's fee-for service program, we urge the CCWG to establish a new category of supplier for entities dedicated to the management of the SD-MCC population, and to institute a monthly CCM fee that, unlike the CCM payment currently payable to physicians, takes into account the full costs of providing necessary team based care and access to the advanced telehealth technologies.

IV. Establishing quality measures for individuals with chronic diseases.

We support the CCWG's emphasis on developing special quality measures for those with chronic conditions. For the SD MCC population, however, we urge CCWG to ensure that administrative burdens are minimized. For this patient group in particular, the time of physicians and non-physician professionals is best spent in the provision of patient care either in person or remotely. Any quality measures that are established should reflect emerging standards of care for this patient population. We recommend that for the SD MCC population described above, the following five quality measures be used, regardless of whether payment is made based on a capitated (MA or CC-SNP), ACO, or fee for service basis:

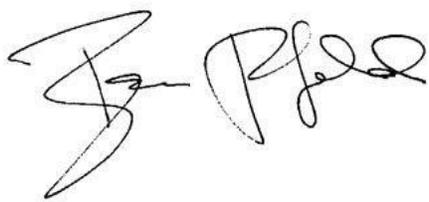
- Three or fewer consultants requesting reimbursement
- Palliative care discussion documented
- Two or fewer hospital admissions
- 25% reduction in prescription medications
- More than 25% reduction in costs from base year

V. Other Proposals Included in the Options Document

The Options Document includes a number of other proposals, including increasing CMMI transparency. Philips supports modifications of the governing law that would require CMMI to afford greater transparency regarding the implementation of new models of care and demonstration projects.

We would be happy to provide additional feedback to the Committee on this critical topic, and hope that the Committee finds these comments helpful. If the Committee has any questions or if we can be of any additional assistance, please do not hesitate to contact me at Brian.Rosenfeld@philips.com, or David Shoultz, Philips Healthcare, Government Affairs and Policy at brian.rosenfeld@philips.com, or Dave Shoultz at (202) 962-8556 or David.Shoultz@philips.com.

Sincerely yours,

A handwritten signature in black ink, appearing to read "Brian Rosenfeld". The signature is stylized and cursive.

Brian Rosenfeld, MD
Vice-President and Chief Medical Officer
Philips Healthcare, Hospital to Home

Attachment A

Philips' Experience in Partnering with Providers to Manage Patients with Chronic Conditions

While Philips provides health care products and services that span the health continuum³, it is our experience in the provision of a complete range of comprehensive telehealth programs that is most germane to the work of the Committee. Philips believes that coordinated telehealth programs are among the most cost-effective solutions to systematically manage patient populations with ongoing needs, particularly those with medically complex and/or chronic conditions. Philips' telehealth programs are designed to enable providers to coordinate care across the continuum for patients ranging from those who require chronic management to patients with complex, high-risk conditions requiring acute intervention;⁴ however, the telehealth program likely to be of greatest relevance to the work of the committee is the **Intensive Ambulatory Care (eIAC) Program**, through which Philips partners with providers to manage high-risk patients with multiple chronic conditions in the home.

eIAC: Background

Telehealth technologies have undergone a transformation that has created new capabilities that are not currently reflected in public policy. Telehealth has largely been understood and paid for under Medicare as either a one-for-one replacement for a visit to a physician's office, whether it is a primary care physician or a physician specialist, or a means by which a provider can remotely monitor certain physiological parameters for a patient.

However, changes to and enhancements of telehealth technologies are fundamentally altering the way care can be delivered to certain populations. These changes are permitting providers with new capabilities to address population health in ways that have not been possible in the past. Interestingly, the application of these new technological capabilities has revealed a need for new or previously underutilized members of the care teams to become involved in the management of certain health populations. Our comments will touch more on this observation later.

These changes to and enhancements of telehealth technologies are creating opportunities for collaboration among providers at unprecedented levels, facilitating interaction with patients and enabling care teams to anticipate patient needs before they escalate beyond certain thresholds

³ Our service lines include imaging, patient monitoring, and cardiac care systems; medical alert systems; sleep management and respiratory solutions; and healthcare informatics solutions and services.

⁴ Philips telehealth programs include the Remote Intensive Care Program (eICU®), a comprehensive technology and clinical reengineering program that enables health care professionals from a centralized telehealth center to provide around-the-clock care for critically ill patients; eAcute Program, which is modeled after the eICU, and monitors high-risk hospitalized patients on medical-surgical floors to prevent avoidable complications, and eConsultant program, which provides remote management services to Skilled Nursing Facilities (SNFs) and emergency department (ED) consults for telestroke, telepsych and trauma triage.

leading to more expensive levels. Furthermore, these technologies can and do optimize patient engagement and greater self-care.

The eIAC Program is a telehealth-enabled program that uses “high tech” technology and “high touch” services to address the special needs of complex patients who comprise approximately 5% of patients yet utilize almost 50% of healthcare resources.⁵

The “high tech” component of the program includes:

- In-home devices measure blood pressure, heart rate, body weight, and track symptoms and can also be used to measure lab tests, and medication use.
- Sophisticated algorithms monitor these data continuously and flag problems for the eIAC care team.
- During the on-boarding process patients are evaluated for psycho-social needs and categorized into different personality “behavioral phenotypes” that are used by the team to help personalize their messaging.
- Every patient receives a specially designed Personal Health Tablet (PHT) so they can communicate with the eIAC team through two-way audio-video software and email.
- The PHT also delivers educational videos and surveys in the home.

The “high touch” component of the program includes:

- Assignment of a personal Health Coach to help each patient manage his or her health and to deal with their psycho-social needs. These specially trained individuals go to the patient’s home, as needed, and help with a variety of tasks such as providing emotional support and helping patients master the many tasks required to keep themselves healthy.
- The assignment of a team “quarterback” who keeps the work assignments flowing.
- Patient status is monitored on a daily basis and the care team can change and prescribe medications, arrange for home health services or a visit by their Health Coach, and refer patients to their PCP’s office for tests and other urgent services.
- The care team responds to issues that are often considered non-clinical, such as transportation, nutrition, and social support.

The eIAC Health Coaches utilize software that identifies what social services a patient is eligible for, facilitates access to those services, and escalates to a Social Worker as needed

⁵ Stanton, MW. The High Concentration of U.S. Health Care Expenditures. Rockville, MD: Agency for Healthcare Research and Quality; 2006. Research in Action Issue No. 19.
<http://www.ahrq.gov/research/findings/factsheets/costs/expriach>. Accessed September 15, 2011.