



VIA ELECTRONIC MAIL

June 19, 2015

Senator Orrin Hatch, Chairman
Senator Ron Wyden, Ranking Member
Senator Johnny Isakson, Chronic Care Working Group Co-Chairman
Senator Mark R. Warner, Chronic Care Working Group Co-Chairman
United States Senate Committee on Finance
Washington, DC 20510-6200

RE: A Pathway to Improving Care for Medicare Patients with Chronic Conditions

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

RML Specialty Hospital (RML) is pleased to have the opportunity to present our thoughts on ways to improve care for Medicare patients with chronic conditions to the United States Senate Committee on Finance's Chronic Care Working Group (Working Group). We are very supportive of the Working Group's initiative to explore alternative policy options to improve care for this vulnerable population and appreciate your thoughtful consideration of our ideas and suggestions.

RML is a freestanding hospital (with two locations in the Chicago metropolitan area) licensed in the State of Illinois and recognized by Medicare as a long-term acute care hospital (LTCH). RML is a 501(c)(3) not-for-profit limited partnership, whose current limited partners are Loyola University Medical Center and the Advocate Healthcare Network. RML's clinical focus is on ventilator weaning (respiratory), complex medical, and wound services. Due to our focus on these three programs, RML has historically maintained a very high case-mix level and most of our patients suffer from multiple chronic conditions, including chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), depressive disorders, diabetes, end-stage renal disease (ESRD), hypertension, and obesity. Patients are referred to us from approximately 65 short-term acute care hospitals (STCHs) in Illinois, more than 80% of our patients are transferred from intensive care, critical care, burn, and step-down units, and more than 50% of our patients are Medicare beneficiaries (with a further 25+% being Medicaid beneficiaries).

Over the past several years, we have completed a number of in-depth data studies of high-acuity patient stays at STCHs in the Chicago metropolitan area, as well as extensively analyzed the post-acute patterns of care and total episode costs for a subset of such patients who were Medicare beneficiaries. These studies have demonstrated that STCH lengths-of-stay for similarly acute patients vary greatly both between and within STCHs, that such lengths-of-stay are often unnecessarily long, that such patients transfer back and forth between provider types frequently during their post-acute care (PAC) episodes (both up and down the acuity scale), and that the first stop in any such patient's PAC episode accounts for only a fraction of the total PAC cost incurred to treat them. Based on these analyses, as well as our own experience as an LTCH since 1997, we have come to realize that chronically, critically ill (CCI) patients with catastrophic or acute illnesses and injuries complicated by complex or multiple co-morbidities are often not identified as such in a timely manner (resulting in unnecessarily long STCH lengths of stay) and that the long-term PAC required to treat such patients is rarely coordinated in an efficient and effective manner (resulting in unnecessary health care costs being incurred and an

increased incidence of clinical complications). This is true even in cases where private sector health insurance and/or STCH-led disease management and care coordination programs exist, due to the unique and complex needs of the CCI population. We believe that earlier identification of such CCI patients in the STCH setting, followed by better coordination of the specialized care provided to them by PAC providers, would considerably improve high-acuity patient outcomes and measurably reduce overall health care costs.

To test our belief and pursue those objectives, we developed and submitted a grant proposal to the Center for Medicare & Medicaid Innovation (CMMI) in mid-2013. Our proposed service delivery model would have expanded and enhanced utilization of the CARE Tool to better and more quickly identify CCI patients in the STCH setting and pioneered the use of a new CCI Care Coordination Team to then follow each such high-acuity patient from the referring STCH through his/her entire PAC episode. This new team would have been led by physicians skilled in the treatment of CCI patients, who would have designed a post-acute Continuing Care Plan for each participating patient, monitored such patients' progress across PAC settings, liaised with other PAC providers, provided final authority on PAC medical decisions (in collaboration with patients' primary care physicians), and ensured patient safety. Although we were not selected by CMMI to receive such grant in 2013 to test our proposed new service delivery model, we still believe in its validity and were recently successful in securing approval from our Board of Directors to self-fund a smaller, less intervention-oriented version of our proposed study over the next twelve months. The focus of our near-term efforts will now be to better ascertain from our CCI patients which long-term quality and outcome measures are of most importance to them (via patient engagement activities), to align such measures across all post-acute settings in which our patients typically receive care, to develop and implement a scaleable means to track (and transfer, as applicable) patient-related data across settings, and to establish benchmarks against which we will measure future performance.

We strongly encourage the Working Group to consider implementing a new policy (or policies) to enable the development and testing of new dedicated, long-term PAC coordination programs by specialized/qualified organizations for CCI patients. Further, one such program to be tested should include the piloting of a new alternative payment model that would include: (1) a fixed, per-patient care management fee; and, (2) a variable, value-based supplemental payment (to be shared among participating PAC providers), based on total cost savings and improved outcomes (as measured consistently across settings by, again, expanded and enhanced used of the CARE Tool) achieved over a pre-defined, long-term period of care (such as 180 or 365 days).

We appreciate the opportunity to present our ideas and suggestions on ways to achieve the triple aim of better care, better health, and lower costs for Medicare patients with chronic conditions and are available and eager to explore these issues in more detail. If we can be of further assistance, please do not hesitate to call upon us.

Sincerely,



James R. Prister
President and Chief Executive Officer
RML Specialty Hospital