Adventist
HEALTH SYSTEM

June 22, 2015

VIA ELECTRONIC MAIL

The Honorable Orrin Hatch
U.S. Senate
104 Hart Senate Office Building
Washington, DC 20510

The Honorable Johnny Isakson
U.S. Senate
131 Russell Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
U.S. Senate
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
U.S. Senate
475 Russell Senate Office Building
Washington, DC 205

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

Adventist Health System (AHS) appreciates the effort that you are undertaking to seek solutions and improvements in both the cost and the quality of care provided to Medicare beneficiaries who are faced with chronic care conditions.

Our organization includes 44 hospital campuses located across 10 states and comprises more than 8,000 licensed beds. AHS provides inpatient, outpatient and emergency room care for four million patient visits each year. We are also a member of the Adventist Health Policy Association, which represents a total of 80 hospitals across the U.S.

Our comments are focused on the following issue areas highlighted in your letter:

- Policies to improve patient outcomes through modifying and existing Alternative Payment Models (APMs)
- Reforms to Fee-For-Service (FFS) that incentivize providers to coordinate care
- The effective use or improvement of telehealth and remote monitoring technology
- Empowering patients to play a greater role in managing their health

The Impact of Chronic Disease on Medicare

As highlighted in your letter, the impact of chronic disease on the Medicare program, and those it serves, is staggering. The added complexity is that chronic disease in itself is an intricate and difficult area of medicine to address. Most major chronic diseases worsen over time even if both optimal medical management and patient compliance occurs. This is due to complications associated with aging as well as the fact that health professionals can rarely “arrest” chronic diseases (although we may be able to slow the rate of progression) with our current level of knowledge. Examples of such predominantly inexorable progressive diseases include Type 2 Diabetes, atherosclerosis, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), osteoarthritis, obesity and chronic kidney diseases. Only a relatively few chronic diseases can be arrested in their tracks with our current knowledge.

Educational levels and most socio-demographic factors are inconsistently correlated with compliance of treatment. However, educational levels, family structure, socio-demographic factors and income level all very strongly and consistently correlate with the prevalence of chronic disease and the outcome of chronic diseases (i.e. better levels of education, family structure, social status and income strongly correlate with lower chronic disease prevalence). Certainly, these factors must be accounted for as we work to provide effective chronic care management and develop payment models that facilitate this.

Transformative Policies to Improve Patient Outcomes

The general nature of chronic disease is that the severity becomes more intense or debilitating over time (for example CHF and arthritis). Therefore the development of payment structures, as well as the metrics to evaluate effectiveness, must take into consideration the stratification of the complexity and progress of the chronic disease, as well as the age cohort of the population. With this in mind, we recommend that the legislation spearheaded by the working group articulate parameters that will help establish priorities in the management of specific chronic conditions. Such parameters could include: the total cost of the chronic disease, the total numbers of people affected by the disease, the per capita costs of the disease, the degree of disability caused by disease, when multiple conditions are present the impact of different configurations of those diseases upon cost and disability, the age cohort of the patient and other relevant factors.

As noted earlier, chronic disease can only be ameliorated, or arrested in some cases, but not eliminated with the current state of medical knowledge. Therefore when measuring improvement in outcomes this will manifest itself outside of just disease symptoms. For example, improved outcomes can be inferred from decreased ER visits, increased patient activity, decreased pharmacological usage and patient self-reports on improved outlook on life. In order to create truly transformative policies that improve patient outcomes, policies must take this into consideration so that existing, and future, APMs account and reward for meaningful outcomes.

As stated in your letter, Medicare Payment Advisory Committee (MedPAC) data highlights the significant impact of chronic disease on the Medicare program. As you noted, in 2010 more than two-thirds of Medicare beneficiaries had multiple chronic conditions and 14 percent of beneficiaries had six or more chronic conditions. Beneficiaries with six or more chronic conditions accounted for 46 percent of all Medicare spending in 2010.

We believe that payment models, specifically bundled payment, should account for this significant impact that chronic disease has on the Medicare program and take into account the impact of having varying numbers of chronic diseases. Specifically, a restructuring of the bundle payment should have two primary goals:

1. To achieve whatever efficiencies can be attained with the chronic care patient in today's timeframe.
2. To decrease the increasing cost of caring for a chronic care patient over time.

This would require a restructuring of the, or creation of an alternative, bundled payment structure around disease category and adjusted for relevant Socioeconomic Status (SES)[1] as well as the presence of the number of chronic diseases. Specifically, the bundle would need to be set based on which chronic conditions are present due to the interactions of co-morbidities. Projected resource use based upon historic patterns of consumption at different age tiers should also be calculated. As a means of engaging

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[1] A study in *Circulation: Cardiovascular Quality and Outcomes* in 2014 demonstrated that among patients with heart failure, neighborhood SES was significant associated with 6-month all-cause readmission.

patients and incentivizing them to take greater control in managing their health, a bonus pool could be created using the difference of actual resource consumption versus predicted consumption over a three-year time frame. This time frame allows for changes in behavior to take affect and gives incentive to the physician or other caregiver to retain the difficult patient. If certain metrics are attained then the provider can participate in the bonus pool and a portion of the bonus pool would be shared with the patients adhering to care management.

In order to accelerate learning, and to achieve maximum results, we recommend that demonstration projects utilizing this suggested modification to bundled payment be initiated under the work group's future legislation. Within these demonstration projects, participating facilities and providers should be required to provide information on their approach to managing chronic disease. Outcomes can be quantified such as reduced hospital visits and reduction in pain scores. Additional metrics should be identified through partnership with the Centers for Disease Control and Prevention (CDC). Reported outcomes can be pulled together as a catalog for best practices for use by future providers as the program expands. In this way there can be a continuous development of knowledge and success so that from the learnings of the demonstration projects there can be an enhancement in chronic care management with the subsequent decrease in cost and decrease in debilitation.

Attention must also be given to the governing regulations that have an impact on the ability to coordinate chronic care within a bundled payment model. If a provider is receiving a bundle to provide a certain level of care, that provider is assuming financial risk. Inherent in that assumption of risk will be a strong *disincentive* to both over treat and over refer. Also, it is inherent in a risk model that there be some form of financial incentive or compensation for the reduction of costs or the improvement in quality, however defined. There must be a vehicle for the moving of that money from one party to another based upon the attainment of certain predetermined expectations and goals. Absent a waiver, as has occurred under the Accountable Care Organizations (ACOs) and Bundled Payments for Care Improvement (BPCIs), the current regulatory environment inhibits the effective implementation of the bundled payment to achieve the desired results. Under the current structure, Medicare would be fixing its cost through a set fee but would be creating a situation where there is no practical ability to attain the gains in efficiency and outcome that would be desired from the implementation of such a payment structure. The simple use of waivers will not result in maximum creativity of systems redesign. As has occurred under the ACO program, the creativity on care improvement is limited by the defined parameters in the rule. Given the high costs involved with chronic care and the lack of historic focus upon this area, the structures established must allow for maximum inventiveness from community to community.

A more subtle regulatory problem exists with the Conditions of Participation (CoP) under Medicare where in a patient is allowed total and absolute free choice of their provider. Under a bundle, or other risk bearing payment, there has to be some method that allows the physician or other medical professional or medical institution to direct the patient to an additional provider who is aligned with the quality and financial goals under the bundled payment. Otherwise the provider is bearing a risk over which he or she will have only limited control. At the very least, the provider should be allowed to present objective quality data on the other providers the patient may choose and be able to tell the patient which of these providers are in a working relationship designed to enhanced the patient's care.

AHS' flagship hospital, Florida Hospital Orlando in Orlando, Florida, is currently participating in the BPCI initiative under a Model 4 demonstration pilot. In our comments to the Centers for Medicare and Medicaid Services (CMS) on the Fiscal Year (FY) 2016 Inpatient Prospective Payment System (IPPS) proposed rule, in response to their solicitation for feedback on the BPCI initiative, we shared that in our experience there are significant differences in quality, efficiency and cost between post-acute providers.

Furthermore, this has had a direct impact on readmission rates. While hospitals and physicians cannot rely on cost alone for determinations of post-acute placement, they must have the ability to direct patients to cooperative and participatory providers who are well-positioned to make the bundled payment experience maximally effective from a quality and financial standpoint. By providing patients with objective and meaningful quality data regarding the post-acute facilities available for their choosing, patients can be empowered to make the best decisions for their health.

Fee-For-Service Incentives to Coordinate Care

The working group notes that traditional FFS is increasing its focus on chronic care as evident by the implementation of new billing codes in the Physician Fee Schedule and by studying APMs. While the addition of these billing codes is a step in the right direction, this is limited to non-face-to-face care coordination services. A potential solution is to create an add-on payment, in addition to the FFS payment, on a per capita basis. This approach is similar to that outlined in the *Advancing Care for Exceptional (ACE) Kids Act of 2015*. The *ACE Kids Act* focuses on children with medically complex conditions. Providers participating in the Medicaid Children's Care Coordination (MCCC) Program for Children with Complex Conditions would receive a FFS payment as well as a per capita care coordination payment for expenditures for items and services furnished to eligible children enrolled in the program. This add-on payment would be temporary, occurring over the first two years of an overall five-year transition from FFS to a risk-based payment model.

We believe that this transitioned approach can also be utilized to coordinate care for Medicare patients suffering from multiple chronic conditions. This would start as a supplemental add-on and, over time, phase into an APM. To account for the provision of care coordination services, physicians would be required to document in the patient record the exact nature of the care coordination undertaken. Additionally, modifications to the Physician Fee Schedule could be made to place emphasis on preventative or ameliorative interventions. For example, the FFS model could incorporate payment for services designed to detect diseases early on.

Empowering Patients

In perhaps no other area of health care does the patient play a more important role in the long-term costs and outcomes related to their condition. Unlike acute-care, where the follow-up and amount of involvement by the patient is very time-limited, chronic care requires extensive cooperation and compliance by the patient for there to be successful and cost efficient outcomes. Any approach to a more comprehensive efficient and effective management of chronic care has to account for this very important variable.

In order to construct payment systems and approaches that facilitate the empowerment of patients to play a greater role in managing their health, and meaningfully engaging with their health care providers, we recommend that future legislation the working group develops focuses on the following:

- The importance of the patient and the patient participation.
- The development of educational approaches with the patient.
- The development of appropriate incentives for the patient to be cooperative and compliant in their role of managing their condition.

In order to facilitate such involvement on the part of the patient, it may be necessary to take a fresh look at some of the barriers that exist within our current regulatory environment. We have seen some indication that this is being done. In the Office of Inspector General's (OIG) proposed rule last year, entitled "Medicare and State Health Care Programs: Fraud and Abuse; Revisions to Safe Harbors under the Anti-Kickback Statute, and Civil Monetary Penalty Rules Regarding Beneficiary Inducements and

Gainsharing" a section was dedicated to the development of safe harbors in the provision of local transportation.

The OIG proposed that free or discounted local transportation services be available only to established patients and not new patients. While we requested clarification on the definition of "established patient" we recognize, and are encouraged by the inclusion of this, that local transportation plays a critical role in a patient's ability to receive care. One of the greatest needs for free transportation at AHS facilities derives from individuals who have been brought to the Emergency Department (ED) via ambulance and do not have transportation to get back home or, in the case of some individuals, back to a group home or homeless shelter. Also, these same individuals may be admitted to inpatient units for specialized care and upon discharge do not have transportation home.

Moreover, we commented to the OIG that we support the ability to provide shuttle services to neighborhoods served by the hospital and that this service should have few, if any, restrictions when provided within 30 days of a hospitalization or within seven days of an ED visit (provided that there is a written order documenting the need for the follow up visit either post inpatient discharge or post ED visit). Ensuring that a patient has the ability to access care and follow up is a significant step in empowering patients to play a greater role in managing their health. There needs to be a readdressing of the overall regulatory models as Medicare goes from FFS to more risk based models to determine what aspects of Stark Law, the Anti-Kickback rules and the Medicare CoP are still relevant in the changed reimbursement world.

The degree to which a patient is empowered to take greater control of their health is inextricably linked to access to care. Therefore, promoting access to health care is critical. As patient involvement is one of the critical factors in the successful management of chronic conditions it would seem almost axiomatic that there has to be adjustment for social economic issues of the population being treated. It is assumed that a higher educated population has a higher probability of being compliant, (although the data is inconsistent), and being able to follow the long-term management regimen for their disease than a population that is ill educated. Also if a population has a greater social support structure there is a higher probability of compliance for management than if there are no such resources available to a different population. Given what has occurred under the *Affordable Care Act* (ACA) on the lack of adjustment on outcome measures to account for the impact of social economic variables, we think it is important that this bill clearly state that such factors will be included in whatever ultimate system is implemented by the Department of Health and Human Services (HHS)/CMS.

Telehealth and Remote Monitoring Technology

Remote monitoring technology and telehealth are essential to chronic care disease management. In the OIG proposed rule abovementioned, it was purported that by giving patients items that are necessary for recording and reporting health data, such as blood pressure cuffs or scales, would promote access to care. This is because the recording and reporting of health data increases the patient's ability to obtain medically necessary care. Additionally, this provides caregivers the knowledge necessary to manage a patient's care, even after they have left the hospital. We believe that items that are part of ongoing monitoring and a defined plan to lower readmissions or overall cost of care should be permitted and not be perceived as a beneficiary inducement that is likely to influence the selection of providers, practitioners or suppliers. Particularly when the provider is at financial risk for the patient care, greater latitude should be put in place to enable providers to utilize telehealth and remote monitoring technology amongst their population. As part of the overall effort to accelerate learning, there should be a sharing of telehealth applications so that the application of this potentially cost effective approach can be more widely and timely shared.

On behalf of Adventist health system I appreciate the opportunity to provide input as you develop legislation addressing chronic care. We look forward to seeing the initial draft and have the opportunity provide further comment.

Sincerely,

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