Cleveland Clinic

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The Honorable Orrin Hatch
Chairman
United State Senate Committee on Finance
104 Hart Senate Office Building,
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
United States Senate Committee on Finance
221 Dirksen Building,
Washington, DC 20002

Dear Chairman Hatch and Ranking Member Wyden,

Cleveland Clinic (CC) is a not-for-profit, integrated healthcare system dedicated to patient care, teaching and research. Our health system is comprised of a main campus, eight community hospitals, and 18 family health centers with over 3,000 salaried physicians and scientists. Last year, our system had more than five million patient visits and over 150,000 hospital admissions. We appreciate the dedication the Senate Finance Committee has brought to focus on improving care for Medicare Patients with Chronic Conditions and the formation of the bipartisan, full Finance Committee chronic care working group. Your leadership in this effort will be critical to paving the way for improved care for patients with chronic disease both inside and outside the Medicare program. We are grateful for the opportunity to provide input to the Committee on this important topic and look forward to meaningful dialog on the issues raised. The following are the comments of Cleveland Clinic in respect to the needs of the health care system and its beneficiaries with respect to chronic disease care and management.

It is a reality today that nearly 97 percent of all patients entering the Medicare system have at least one chronic condition. This necessarily means that care of chronically ill Medicare patient must start well before they reach age 65. While the Committee has asked specifically for comments on how to improve the Medicare system to better diagnose, treat and manage chronic diseases, we cannot help but note that, by age 65, most opportunities for chronic disease prevention have long passed. As the Committee looks at care of chronic diseases, we urge that it also consider and address the issue of transitions from commercial insurance plans to Medicare and that often, the best way for Medicare to save money on management of chronic conditions may reside in its interactions with future beneficiaries 10, 15 or 20 years prior to entry into the system.

In thinking about how best to address the questions of the Committee, we reached out to the group with the most experience in chronic care management: our care coordinators and care management

specialists. As a result, we have not commented on each question individually; instead, we have chosen to use examples they provided from our own patients to highlight specific needs and to use those to suggest potential reforms and changes to the Medicare system to better serve these beneficiaries and control costs.

1. **The Medicare Advantage Program has improved the health and lives of countless patients with chronic disease. However, patients can become caught in the middle of competing cost-reducing measures. Further, the business cycle often inhibits care from happening in the right time and right place to optimize both outcomes and savings.**

Patient Example: A Medicare Advantage Plan member and came into our emergency department after a fall. She had atrial fibrillation and was recently discharged from our hospital with dizziness. At age eighty five, she lived alone with a daughter living out of state and a son living about 100 miles south of her home. She suffered no fractures but was in pain and was significantly bruised due to her anticoagulant therapy, Coumadin. A fall at home is not a reason to admit a patient to an acute care facility; however, she was at significant risk for another fall and a possible internal bleed due to her Coumadin therapy. The optimal plan for the patient would be a direct admission from the Emergency Department to a Skilled Nursing Facility (SNF). She would qualify for a skilled level of care according to the Medicare guidelines and her Medicare Advantage benefits; however the health plan as the gatekeeper would not allow this transfer without prior approval. At 2100 local time, there was no mechanism to submit a request from her carrier for an admission to a SNF. Therefore, she was placed in observation status with the plan to request an authorization for a SNF from the health plan. The case manager asked the physician to order Physical Therapy and Occupational Therapy assessments to provide the health plan with the necessary information to approve the SNF admission. The request for SNF, with recommended therapies was sent to the health plan at 1300 on Day One of observation status. The health plan reserves the right to take up to 72 hours to make a decision to allow the patient to move to SNF, and in this case, denied the patient access to SNF after 36 hours – mid-way through Day Two of observation status -- stating the patient could receive her therapy at home.

The case manager contacted both children who stated that they were unable to relocate to care for her at home, and further, that the patient could not privately pay for a SNF. They requested the case manager apply for Medicaid. The case manager submitted the application on behalf of the patient and the approval was granted by the county Medicaid office in 28 hours…now Day Three of observation status.

The patient had, at this point, been in the acute care hospital in observation status under her Medicare Part B benefit for three days without the need for hospitalization. The case manager and the interdisciplinary team spent time and energy attempting to advocate for the patient so she could access her SNF benefits. The health care plan's pre-certification team, under the auspices of

working to decrease costs, had disallowed the patient to transfer to SNF because it was felt the patient could receive therapy at home. The family could not support the patient at home and she could not afford to pay for private SNF or home care. She eventually moved to SNF after three acute hospital days under observation status. Her SNF stay was covered under the benefit of the Medicaid government program. In practice, tis transfer could have taken place three days earlier, saving money for the patient, for Medicaid and ultimately for Medicare.

Under the current system, The Medicare Advantage health plan gets to claim that this case is a net cost saving. However, at best, this represents a cost shifting between the government payers. Our patient's story is not unusual; while Case Management is integral to effective care coordination, much of the time and energy spent by the case manager is spent overcoming artificial administrative barriers to patient's access to care.

Recommendation: A collaborative relationship between health plans and the health system would allow the patient to receive the right care, at the right time and in the right place, by allowing health systems to "make the call" to place a patient into an appropriate care setting presumptively. It would provide the case manager the necessary time to work with high risk chronically ill patients and to assist them in self-management of their disease.

2. **Socio-Demographic Status needs to be a determinant for admit to care coordination programs, and Care Management needs to coordinated at the family unit level. This is especially important for rural or underserved areas.**

Patient Example: A 75 year old married male patient with >5 co-morbid conditions was being followed in our chronic care clinic for congestive heart failure. The patient resided 26 miles away from our clinic. After several months of visits with poor adherence to the care plan, the patient confided that he was illiterate and relied on his wife for help with his medications. Unfortunately, the wife was diagnosed with cancer and was undergoing treatment, which resulted in her developing diabetes. Despite diligent adherence on her part, her blood sugar was under poor control. Because she and her husband presented together for one of his follow up appointments, her care manager was able to test her on site, and get her a same-day referral to endocrinology. Because care management was centralized for the family, the team was able to avoid an unnecessary readmission for this patient.

Unfortunately, this sort of family- and community-centered care coordination is rare, and the lines between patient educators and care managers remain poorly defined and as a result, can fail to meet the needs of patients and their communities.

Recommendation: Care coordination roles (e.g. care coordinators, patient educators, social workers, care navigators) need to be clearly defined and proper harmonization of job titles, duties, and requirements need to be embraced by those providing and paying for the services.

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To be effective, patient care coordination needs to encompass not just the totality of the patient, but the totality of the patient's care environment. We call on the Work Group to require this harmonization of Care Management roles, review and adjust funding of care management at the community level and properly resource training programs to develop fully-functional teams.

We wish, additionally, to lend our support to the call issued by the Healthcare Leadership Council (HLC) to form a *Community-Based Institutional Special Needs Plan (CBI-SNP)* to provide targeted community-based, long-term services and support (LTSS) to low-income Medicare beneficiaries who are functionally impaired. These individuals need daily care, but have neither the resources nor the desire to enter into long-term nursing facilities. Enabling these seniors to remain in the community could significantly improve their quality of life while simultaneously delivering savings to both states and the federal government. Senators Chuck Grassley (R-IA) and Ben Cardin (D-MD) have introduced legislation to this effect, "The Community Based Independence for Seniors Act" (S.704). Cleveland Clinic believes it is this sort of community-based intervention that serves the triple aim of improving the quality of life for beneficiaries, reducing costs, and

3. **Managing Pediatric Patients with chronic illnesses: While Medicare Advantage plans have done a good job of incentivizing care coordination for traditional Medicare beneficiaries, there is little to meet the needs of high-utilizer, "non-traditional" higher risk recipients, including disabled and medically-complex children. These high risk beneficiaries can be served, in part, by Special Needs Plans (SNPs) that are demographic or diagnosis-specific. These SNPs do not, however, fully address the needs of pediatric patients who often need a highly-specialized team of providers to manage their chronic conditions.**

Patient Example: Since June 2009, Cleveland Clinic Children's has maintained a multi-disciplinary clinic to address the needs of children with severe and chronic health issues surrounding airway maintenance, digestive health, voice, and swallowing. The team includes Pediatric Otolaryngology, Pediatric Pulmonary, Pediatric Gastroenterology, Pediatric Speech Language Pathologist, Pediatric Dietitian, Pediatric Social Work, a and Pediatric Developmental and Rehabilitation physician. The multi-disciplinary team approach is to serve as a convenient patient centered appointment for these children with special needs. The overwhelming majority of children in this clinic have tracheostomy+/-ventilator dependence, feeding tubes, and wheelchairs. Children visit the clinic on average 3 times per year.

<u>OUTCOME RESULTS ON IN-PATIENT HOSPITALIZATIONS FOR CHILDREN OF PCAVS in 2014:</u>

Total number of active patients: 137
Total number of admissions for all patients: 452

Average length of in-patient stay for patients: 12.3 days
Total number of admissions prior to PCAVS: 296
Total number of admissions after initiation of PCAVS: 156
Mean number of admissions prior to PCAVS per patient: 2.2
Mean number of admissions after initiation of PCAVS per patient: 1.1
On average, we demonstrated an ability to decrease hospitalization per patient by 2 weeks.

Recommendation: Payment models need to be encouraged that not only incentivize primary care coordination for these patients, but which incentivize specialists to coordinate their efforts with a team-based approach to care, including coordinating appointments and interactions with family and community caregivers. Much like the results seen in the CMMI Bundled Payment pilot programs, shared risk and reward around managing highest risk patients and patients with unique needs has the potential to both improve outcomes and reduce costs for pediatric patients.

Thank you for conducting a thoughtful process that allows us to provide input on such important issues and for your consideration of this information. Should you need any further information, please don't hesitate to contact me.

Sincerely,

Elizabeth Sump
Senior Director, Health Policy
The Cleveland Clinic