Mercy Health System

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June 19, 2015

Submitted electrically to: chronic_care@finance.senate.gov

United States Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200

RE: *Improving Care for Medicare Patients with Chronic Conditions*

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

Pursuant to your letter of May 22, 2015 requesting recommendations from health care stakeholders to improve how care can be delivered to Medicare beneficiaries who suffer from chronic illnesses. As you note in your letter, the treatment of chronic illnesses accounts for a substantial portion of Medicare spending and left unresolved the situation will only worsen.

Mercy Health System is a mission-driven regional health ministry focused on improving the health of our communities and each person we serve. As part of Trinity Health, we have a special concern for persons who are poor and disadvantaged. Mercy's health ministry is located primarily in southeastern Pennsylvania and includes 4 acute care hospitals, a regional home health organization, as well as ambulatory and physician network providers. Mercy's hospitals serve primarily a disproportionate share population, with the majority of our patients who are insured covered by a government health program. Mercy has a long tradition in community health management. This includes an expanding PACE (Program of All-inclusive Care for the Elderly) organization that helps people who qualify for Medicare and Medicaid to meet their health care needs in the community and an interest in a large Medicaid managed care program in Pennsylvania. Additionally, Mercy has begun to implement an accountable care organization regionally to further its population health capabilities.

We applaud the Committee's interest in addressing care coordination issues around persons who suffer from multiple chronic conditions. Multiple chronic conditions have been defined by the U.S. Department of Health and Human Services as beneficiaries having two or more chronic conditions. Chronic diseases are non-communicable illnesses that are prolonged in duration, do not resolve spontaneously and are rarely cured completely. Two thirds of Medicare beneficiaries have had multiple chronic conditions. As of 2010, the most common chronic conditions among Medicare beneficiaries were high blood pressure, high cholesterol, heart disease, arthritis and diabetes. High blood pressure is the most common chronic condition across men and women of all age groups. Multiple chronic

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conditions increase with age. Instances of high blood pressure, high cholesterol, arthritis and ischemic heart disease are higher for those beneficiaries age 65 and older. Based on 2010 data, 14% of Medicare beneficiaries have 6 or more chronic conditions. Diabetes affects beneficiaries older and younger than age 65 at comparable rates.

Women are more likely than men to have multiple chronic conditions. Based on 2010 data, female beneficiaries are more likely to have the chronic conditions of high blood pressure and high cholesterol than male beneficiaries. Significantly, beneficiaries of African American and Hispanic backgrounds have the highest prevalence of 6 or more chronic conditions. Dual-eligible beneficiaries were more likely to have multiple chronic conditions. As of 2010, 72% of dual-eligible beneficiaries had two or more chronic conditions.

Moreover, while chronic conditions are more prevalent among aged beneficiaries, depression was more common for disabled beneficiaries. Beneficiaries who are less than 65 years of age but primarily disabled were 2.3 times more likely to suffer from depression.

As the number of chronic conditions increase, so does utilization of health care services. Beneficiaries with 6 or more chronic conditions have hospital readmission rates approximately 30% higher than the national readmission rate for fee-for-service beneficiaries. According to the 2010 U.S. Department of Health and Human Services Chronic Care study, beneficiaries with multiple chronic conditions were more likely to be hospitalized and had more hospitalizations during the year. Only 4% of beneficiaries with no or one chronic condition were hospitalized during the year while almost two-thirds of beneficiaries with 6 or more chronic conditions were hospitalized on average during the year. As such, we believe consideration should be given to waiving or modifying hospital readmission penalties for chronic patients who have high readmission risk scores.

According to the Chronic Conditions among Medicare Beneficiaries Chartbook, 2012 edition, beneficiaries with multiple chronic conditions were high users of home health services. Moreover, there is a direct correlation between the increase in the number of chronic conditions and increases in utilization in post-acute care services.

We appreciate the increasing attention being paid by Medicare to chronic care management. The CY 2015 Medicare Physician Fee Schedule (PFS) includes separate payments for non-face-to-face care management and coordination services. While these payments are subject to certain exclusions and limitations, providing compensation for these important activities in a positive step in addressing care for patients with chronic conditions. There are also additional opportunities in both the Medicare fee-for-service and population health payment programs to create a system of aligned incentives that reward the quality of services not focused on per treatment activities. In order to promote chronic condition management, especially among vulnerable populations, the Medicare program should consider options that allow providers of at-risk patients with chronic conditions to waive or reduce copays and deductibles for office visits. Other opportunities include consideration for reimbursement programs for Advance Care Planning (Advance Directive, POLST).

Mercy's PACE program has had marked success in reducing medications for chronically ill patients. Incentives could be developed for providers to work with patients with chronic conditions to

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reduce dependence upon multiple medications. For instance, Medicare could develop initiatives to reimburse Clinical Pharmacy consults for patients on 10 or more medications. Expansion of successful care management programs like PACE and coordination with clinical pharmacy programs may yield substantial results in reducing medication dependency in patients with chronic conditions.

Other options to promote care management could include waiving the three day qualifying hospital stay requirement for patients with chronic conditions who require inpatient rehabilitation in a skilled nursing facility.

Mercy has specific service lines that care for individuals with behavioral health disorders and as such has tremendous experience in this area. Mental health disorders are conditions that disrupt a person's thinking, feeling, mood and daily functioning. Like most chronic conditions, mental health disorders are treatable. Many associations exist between mental illnesses and other chronic diseases such as cardiovascular disease, asthma and diabetes. Since there are specific strategies to effectively treat behavioral health conditions, behavioral health should have categorical recognition as a chronic condition.

As Medicare implements alternative payment strategies, Mercy would suggest promotion of tele-health consults for chronically ill patients, especially those who are homebound. Specific payment methodologies could Payment for e-visits, tele-visits, and technology platforms which enable chronic disease self-management. Other population health program and payment methodologies may also be helpful in managing the care of patients with multiple chronic illnesses, promoting better health and reducing costs. These include potentially reimbursing for nursing Care Management and health coaching to offset investment in resources required to move toward population health models as well as implementing group visit and peer networking opportunities to promote health decision sharing.

Once again, we appreciate the opportunity to present proposals concerning the improvement of care and reducing of costs associated with the treatment of individuals with chronic care conditions.

Sincerely,

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