PHILIPS

Transmitted via email to chronic_care@finance.senate.gov

June 22, 2015

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 the comments of Philips in response to your May 22, 2015 letter to stakeholders soliciting the best ideas on how to improve care for Medicare patients with chronic conditions.

We appreciate your consideration, and should 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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Chairman Hatch, Ranking Member Wyden, and Senators Isakson and Warner:

Philips would like to commend you for your May 22nd letter to stakeholders soliciting the best ideas on how to improve care for Medicare patients with chronic conditions. Addressing the challenges of our citizens with chronic conditions is a daunting but critical national priority. As you highlight in your letter the impact, in terms of cost, on our healthcare system is staggering, but the human toll on those with these conditions is equally staggering. And as you further note, the passage of time will only see this situation deteriorate. Thank you for this opportunity to share our thoughts based on our extensive experience.

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

While Philips provides health care products and services that span the health continuum[1], 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;[2]

[1] 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.

[2] 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

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 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.[3]

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:

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to Skilled Nursing Facilities (SNFs) and emergency department (ED) consults for telestroke, telepsych and trauma triage.

[3] 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.

- 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

e-IAC: Cost Reductions

Recently released data from a pilot program involving Philips' partnership with Banner Health (Phoenix, AZ) documents the effectiveness of this "high tech/high touch" system of managing patients with multiple chronic conditions. Results of the pilot program indicate that this approach has the potential to result in cost reductions in the range of 27%, reductions in acute and long-term care of 32%, and reductions in hospitalization in the range of 45%.

e-IAC: Peer Review Literature Support

The most recent and largest study of the potential impact of telemedicine in the management of patients with chronic conditions, titled "The Empirical Foundations of Telemedicine Interventions for Chronic Disease Management", was published in *TELEMEDICINE and e-HEALTH* in September, 2014. The study, authored by 23 experts in the area of Telemedicine, reviewed the use of telemedicine for the remote care of patients in the home for CHF, COPD, and stroke. The economic effects of telehealth interventions were measured or examined in two ways: (1) changes in rates or volumes of hospital admissions, re-admissions, length of stay, and/or emergency department visits and (2) cost-benefit analysis and cost-effectiveness analysis of telehealth in terms of specified outcomes. In both instances and with few exceptions, the evidence supported the economic benefits of telehealth compared with usual care among patients with CHF, stroke, and COPD. Based on the 71 studies that met applicable inclusion criteria, the experts concluded that:

> [T]he preponderance of the evidence produced by telemonitoring studies points to significant trends in reducing hospitalization and emergency department visits and preventing and/or limiting illness severity and episodes, resulting in improved health outcomes.

General Observations: Lessons Learned

Our experience in partnering with health care providers in the context of the eIAC program has taught us a number of important lessons that we hope the Committee will find helpful.

First, the complexity of identifying the patients whose condition is sufficiently serious to warrant this level of patient support should not be underestimated; however, accurate patient identification is key to success. Even among those patients with chronic conditions, there is substantial variation in the level and intensity of support required, and a patient's health care claims history alone may be insufficient to ensure that relatively resource intensive high tech/high touch programs are targeted to a patient population that is

truly in need of this level of support. Accurate identification of the target population, and possibly tiering of the target population in a manner that gears the intensity of support to the clinical and psycho-social needs, requires specialized expertise and experience, and there is a "learning curve".

Second, and along a related line, because of the complexity of identifying the appropriate patient population and managing care once the right patients are accurately identified, we believe that care should be overseen by individuals who specialize in this patient population. To the extent that the care of this patient population is provided by providers that also provide care to others, consideration should be given to requiring the establishment of highly specialized divisions or designated personnel charged solely with managing these highly vulnerable patients.

Third, managing the health care needs of this patient population is likely to be only partially successful if it is conceptualized solely in clinical terms and delivered solely through traditional health care providers. In fact, this patient population tends to have a broad array of behavioral, social, and financial needs that must be addressed for clinical interventions to be successful and for positive health care outcomes to be attained and maintained. Generally, many patients in this population are not only underserved by the medical community, but also socially isolated, psychologically fragile (often depressed), and financially strained. The provision of adequate psychosocial supports, including mental health services, case management, and social work support is critical for effective (and cost effective) patient management.

Fourth, this patient population is most effectively treated by regimens that are both high tech and high touch. While these patients may not be technically "homebound", their conditions generally keep them at home, and more isolated than others with less serious medical conditions. As such, remote monitoring through technologically sophisticated devices and integrated care networks is critical. At the same time, technology alone is not likely to be successful without the continuous involvement of specialized and sympathetic caregivers, caseworkers and advocates (who need not be clinically trained as nurses or physicians). The cost savings and improved care that have occurred in this program come from early identification of clinical deterioration of patients in this population and the ability to rapidly escalate interventions to halt the deterioration to restore the patient's health before other more costly and severe interventions are required.

Fifth, population management for patients with multiple chronic conditions will be hampered until progress is made on the widespread interoperability of Electronic Health Records (EHRs) and other patient data. Collaboration and communication is central to population health management. These are some of the most powerful capabilities being unleashed by the new telehealth technologies and combinations. But critical patient information resides in EHRs, and until that information can be freely and easily accessed the full aspirations for improved care at lower cost for these populations of patients with multiple chronic conditions will go unmet. To enable the best care at the lowest cost, all patient health information is critical, including information from payers, pharmacies and other healthcare providers such as skilled nursing facilities.

There are technology developers including Philips who are working assiduously to develop a secure, open, public platform that will collect, store and make assessable all patient data (i.e., the HealthSuite Digital Platform (HSDP)). The data will be available via a public application programing interface (API), for an open eco system of application developers to build innovative applications that can enable providers and patients to facilitate their care. But until that happens we are concerned that some policymakers are treating policies aimed at improving care for patients with multiple chronic conditions and the issue of EHR interoperability in separate policy silos. So, we urge the Committee to recognize that this issue of EHR interoperability is bound together with your interest in improving care for patients with multiple chronic care conditions and to address these issues together.

We believe that programs that are built around these principles—specialized, team-based, high-tech/high touch, programs that consider these patients' psychological, behavioral, and social needs as well as clinical concerns-- are most likely to be successful in improving outcomes and reducing costs.

Responses to the Committee's Specific Requests for Information

1. **Improvements to Medicare Advantage (MA) for patients living with multiple chronic conditions**;

   Before determining whether and to what extent changes should be made to MA to accommodate this special patient population, we urge the Committee to conduct fact finding into a number of key issues. For example, an alternative to encouraging general MA plans to serve this population would focus on encouraging the establishment of specialized MA plans to address the needs of this group. The Medicare Act already authorizes MA Special Needs Plans, which are specifically formed to serve patients with chronic conditions; however, few have been established at this stage. What is the Medicare Program's experience with these plans, and how could the law be changed to encourage their establishment?

2. **Transformative policies that improve outcomes for patients living with chronic diseases either through modifications to the current Medicare Shared Savings ACO Program, piloted alternate payment models (APMs) currently underway at CMS, or by proposing new APM structures**;

   Alternative payment models such as Accountable Care Organizations (ACOs), medical homes, and bundled payments were designed to address the lack of coordination and to create incentives for providers to work together to ensure better outcomes and cost savings. While there is opportunity to reduce costs and/or improve outcomes with better care coordination, there are limitations to current approaches and payment systems. It has long been recognized that "many of the challenges inherent in living with a chronic condition are common across many chronic diseases and involve day-to-day problem solving. Such challenges include management of emotions (e.g., discouragement, fear, and depression); medication use and side effects; adherence to diet and physical activity regimes; and communication with health-care providers."[4]

   Furthermore, although the greatest cost reductions will be realized by caring for patients outside of the hospital settings, current home care is traditionally not designed to care for persistently high cost patients who might otherwise be in and out of the hospital.

   To address these issues, we suggest an approach that incorporates some of the provisions of the 2014 *Better Care, Lower Cost Ac*t (S. 1932) sponsored by Senators Ron Wyden and Johnny Isakson. That proposed legislation addressed some fundamental issues in caring for this patient population and serves as a good start in addressing their needs, while addressing the limitations of the current alternative payment models, particularly ACOs. However, there also are some gaps in that legislation that we would like to address.

   The proposed *Better Care, Lower Cost Act* would enable providers to target patients with chronic and other medically complex conditions. Under this concept, "Better Care Plans" (BCPs) would

[4] *Managing Multiple Chronic Conditions: A Strategic Framework for Improving Health Outcomes and Quality of Life* Anand K. Parekh, MD, MPH,[a] Richard A. Goodman, MD, JD, MPH,[a,b] Catherine Gordon, RN, MBA ,[c] Howard K. Koh, MD, MPH,[a] and The HHS Interagency Workgroup on Multiple Chronic Conditions; Public Health Rep. 2011 Jul-Aug; 126(4): 460–471

be created to provide coordinated care to Medicare patients with complex medical (including chronic conditions). Qualified BCPs would be responsible for the full continuum of care (other than long term care) for enrollees. Cost–sharing for BCP enrollees is varied from standard cost sharing requirements to incentivize the use of high-value, high-quality services that have been clinically proven to benefit those with complex medical needs.

S. 1932 also encourages the appropriate use of technologies that enhance communication between patients, providers and communities of care such as telehealth, remote patient monitoring, Smartphone applications, and other enabling technologies that promote patient engagement and self-care while maintaining patient safety.

While this proposal begins to deal with the issues of caring for high-cost patients, we believe that the approach in S. 1932 from the last Congress could be enhanced by:

- Including additional team members that are not addressed in the S. 1932 legislation, which is limited to "healthcare" professionals only. For example, our experience is that the inclusion of social workers and health coaches is critical.

- Requiring that the remote care team be run by a primary care physician who has advanced training and wishes to manage only multi-morbid, complex patients. By utilizing this type of physician, the day-to-day care is more tightly managed and the need for sub-specialty consultants is substantially reduced along with the attendant costs.

- Utilizing patient behavioral phenotypes as a structured approach to personalize care and enable all providers, but particularly the social workers and health coaches, to provide counseling and information to each patient in a way "that they are designed to accept and understand this information". Patient phenotypes are categories that use psychological and sociological tools to identify and categorize how patients and their social networks interact to best receive information and modify their behaviors.

- Utilizing innovative technology like 1) point of care testing such as white blood cell counters, so that patients can be more fully evaluated in their home, avoiding unnecessary ED visits and 2) a patient portal that enables bi-directional audio/video, patient tracking of their physiologic parameters and accomplishments towards structured goals, educational materials and daily tasks, and a family app that promotes greater self-care.

- Mandating the use of telehealth solutions modeled after well-documented eICU and eHospital care models that are integral to managing a patient population with ongoing needs. While providers are "encouraged" to use these solutions in S. 1932, the upfront investment costs to implement these programs are not addressed, nor are they recognized because provider payments are based solely on historical claims data. Given that many of the telehealth solutions required to implement a program such as this are innovative, the costs to administer the programs would not be reflected in the claims data. Therefore, to incent providers to take the risk of establishing this alternative chronic care program an increased savings share should be available to those BCPs that invest in this technology. Based on experience with similar programs (e.g. Banner Health/Philips partnership), teams focused on caring for this population need to be dedicated solely to these patients to ensure appropriate focus, consistency of management approach and thorough follow through. Clinical workflows need to address how to handle each clinical scenario (escalations, emergencies, psychosocial/compliance) with the appropriate processes,

workflow guides and training materials developed to ensure desired clinical and economic outcomes.

- The establishment of BCPs should be encouraged in all geographic locations, not just those not served by ACOs because not all ACOs are organized to care for the unique needs of this population.

Under this proposal, BCP payments would be capitated, with payments determined using claims data, for a group of beneficiaries who have similar health risk characteristics, and have sought care in the same county, multi-county, or State-level to the population the qualified BCP is tasked with serving. Also, the payments would be risk-adjusted for health status. The legislation includes a risk-sharing provision; however, it is unclear to us how this element of the payment methodology would work.

Another option that might be considered is the payment model used in the Independence at Home demonstration: Under this model, to incent providers to take the risk of establishing this alternative chronic care program there should be a post hoc shared savings incentive payment to providers following the first year of the program (and every year thereafter) so that when there are savings in excess of the first 5% of cost savings (comparing the projected total cost of a patient that is not part of this program from the actual costs of a patient in the program) the provider receives 80% of the savings in terms of an annual lump-sum payment from CMS. We urge the Committee to review this option closely when the results of the IAH demonstration are released.

Based on our experience, regardless of whether a partial capitation model or shared savings model is utilized in the short term, in the long term, full capitation should be the goal.

3. **Reforms to Medicare's current fee-for-service program that incentivize providers to coordinate care for patients living with chronic conditions**;

We are aware that CMS has recently adopted policies that provide for coverage of transitional and chronic care management services, and we commend CMS for moving in this direction. However, based on our experience with this patient population through the eIAC, we do not believe that, in light of the limited payment associated with these services, this expansion in coverage is likely to appreciably improve the quality of care provided to these patients or reduce costs. For example, the per patient costs involved in eIAC exceed $400 per month, while the per patient per month allowance for CCM under fee for service Medicare is currently about $40-50 per patient per month, and is available only to physicians and not to disease management or other entities.

In order to address the cost and quality issues raised by this patient population in the context of Medicare's fee-for service program, significantly bolder steps would be necessary. In particular, we urge the Committee to consider the following options:

- Eliminating the originating site and geographic restrictions on coverage for telehealth for patients with chronic conditions and modifying coverage criteria to facilitate coverage of "enabling" telehealth technologies and not just those that serve as one-to-one replacements for in-person care;

- Establishing a new category of supplier for entities dedicated to the management of patients with multiple chronic conditions and establishing a monthly management fee

payment 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 necessary telehealth technologies.

- Facilitating the establishment of hospital programs dedicated to this patient population by establishing special conditions of participation for hospital-based care coordination programs and providing cost pass through payment for the initial capital expenditures necessary to establish such programs. (Please note, for example, that hospital Transplant Centers have specific conditions of participation and that some transplant costs are reimbursed by Medicare on a cost pass-through basis. Similar treatment could be afforded for hospital chronic care management programs.)

4. **The effective use, coordination, and cost of prescription drug**s;

Philips is not in a position to comment on this aspect of care management for patients with multiple chronic conditions.

5. **Ideas to effectively use or improve the use of telehealth and remote monitoring technology**;

As discussed above, we believe that telehealth and remote monitoring technologies are most appropriately viewed as enabling technologies utilized to wrap around the provision of services (including medical, psychosocial and other support) services to the patient and to facilitate care coordination. Along these lines, Philips defines telehealth as:

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

Unfortunately, Medicare definitions, as reflected in current telehealth coverage rules, conceptualizes telehealth very differently: Under this view, telehealth is basically limited to the remote provision of services that would be covered if provided in-person. We strongly believe that this definition of telehealth is outmoded and that the provision of telehealth services, and the integration of telehealth services with clinical, psychosocial and other supportive services, should be viewed as an essential service for any new APM or fee-for service delivery system focused on patients with multiple chronic conditions.

6. **Strategies to increase chronic care coordination in rural and frontier areas**

We urge the Committee to consider the following strategies to increase chronic care coordination in rural and frontier areas:

- Promote the use of telehealth technologies that are enabling new ways of care coordination for patients with multiple chronic conditions. A powerful benefit is the scalability of these kinds of telehealth programs to reach more patients and reduce the

barriers caused by distance through a more efficient care delivery system. These technologies enable and extend the reach of providers already stretched thin.

- Draw from successful state telehealth programs that already have demonstrated success with patients in rural areas as models for Federal programs, including payment methodologies, such as the Center for Telehealth at the University of Mississippi Medical Center (www.umc.edu/telehealth)

- Provide mechanisms for additional reimbursement incentives for programs serving rural and frontier area patient populations to encourage outreach to these areas and to cover the additional costs of providing in-home visits (e.g. higher share of the savings, subsidies for start-up costs of technology and infrastructure).

- Allow for additional regulatory flexibility and "fast track" approval of BCMs, IAH plans or other models that focus on chronic care patients in rural and frontier areas.

7. **Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their healthcare providers**;

   We have found in the context of eIAC that the use of bidirectional audio-video is critical to engaging this patient population in managing their own healthcare, insofar as it provides near real-time access to the patient's support team. We also believe that the use of coaches, as described above, is important to ensuring that patients follow through on medication management and other critical aspects of self-care. Using the behavioral phenotypes described earlier in our comments, we also believe that it is important to conduct an initial assessment of the patient's relationship with his or her family, since family interactions may serve as either a positive or negative force in the patient's life and health. .

8. **Ways to more effectively utilize primary care providers and care coordination teams in order to meet the goal of maximizing health care outcomes for Medicare patients living with chronic conditions**.

   As discussed above, we believe that a team-based approach is critical to the management of this patient population. In particular, the role of the coach, social worker and pharmacist is essential. While we initially thought that the eIAC would minimize or eliminate the role of the patient's primary care physician, we learned that the inclusion and active participation of the patient's primary care physician is extremely important in obtaining and maintaining patient trust.

We would be delighted 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 David.Shoultz@philips.com.

Sincerely yours,

Brian Rosenfeld, MD
Vice-President and Chief Medical Officer
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