School of Medicine
TEMPLE UNIVERSITY

Larry R. Kaiser, MD, Dean
Senior Executive VP, Health Sciences
President and CEO
Temple University Health System

3500 N. Broad Street
Medical Education Research Building
Suite 1141
Philadelphia, PA 19140

phone 215-707-8773
fax 215-707-8431
e-mail larry.kaiser@tuhs.temple.edu
web www.temple.edu/medicine

June 22, 2015

The Honorable Orin G. Hatch, Chairman
The Honorable Ron Wyden, Ranking Member
The Honorable Johnny Isakson
The Honorable Mark R. Warner
United States Senate
Committee on Finance
Washington, DC 201510-6200

Submitted electronically via chronic_care@finance.senate.gov.

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

We are pleased that the United States Senate Committee on Finance is looking to develop solutions that improve health outcomes for Medicare patients with chronic conditions. Thank you for the opportunity to offer ideas that will help lead to bipartisan legislation for introduction and mark-up later this year. We discuss our concepts more fully below. Initially, however, I provide background on the Temple University Health System, and the vulnerable communities we serve.

About Temple Health

Temple University Health System (TUHS), as the sole member of its affiliated hospitals and physician practices, provides access to sites, programs, and other resources to carry out a broad array of services. We take great pride in our comprehensive efforts to improve the health and quality of living in North Philadelphia and the Southeast Pennsylvania region.

TUHS consists of three hospitals: Temple University Hospital (TUH), the chief clinical teaching arm of the Temple University School of Medicine; Jeanes Hospital, and the American Oncologic Hospital, also known as the Hospital of the Fox Chase Cancer Center (FCCC). TUHS also includes Temple Physicians, Inc., our network of about 110 community-based physicians in about 48 practice sites and the Temple University School of Medicine faculty practice plan, which includes about 400 faculty members. All Temple physicians, whether faculty or community-based, care for patients covered by Medicare and Medicaid in the inpatient and outpatient settings. The Temple Center for Population Health supports the chronic disease management and other health improvement programs for our hospitals and physician groups.

TUH was founded in 1892 as "Samaritan Hospital," with the mission of caring for patients with limited incomes and ensuring access to medical care in its surrounding

neighborhoods. Today, TUH is a 714-bed non-profit acute care hospital that provides a comprehensive range of medical services to its North Philadelphia community, and a broad spectrum of secondary, tertiary, and quaternary care to patients throughout Southeastern Pennsylvania.

Our services are especially important in the diverse, economically challenged neighborhood of TUH, where about 84% of our inpatients are covered by government programs: about 33% by Medicare and 51% by Medicaid. Patients dually eligible for both Medicare and Medicaid comprise about 20% of our inpatient base. Approximately 42% of our inpatient cases include a behavioral health diagnosis.

TUH also serves as a critical access point for vital public health services. Last year we handled more than 130,000 patients in our Emergency Department; 11,000 patients in our Psychiatric Crisis Response Center; 2,100 discharges from our inpatient Behavioral Health unit; 700 victims of gun and stab violence in our Trauma Unit, the highest number in Pennsylvania; and more than 300 patients in our Burn Center. We delivered about 3,100 babies, of whom 90% were covered by Medicaid.

TUH is located in a federally designated *Medically Underserved Area.* Within our service area, about 35% of individuals live below the federal poverty level; about 67% have achieved a high school education level or less; about 51% of individuals identify as Black, and about 26% as Hispanic.

About our North Philadelphia Community

According to the 2014 Community Health Improvement Plan of the Philadelphia Department of Public Health, rates of diabetes, hypertension, asthma, hospitalizations, adults with mental health conditions are increasing steadily in our area. The infant mortality rate is among the highest in the nation. The Plan specifically states:

> Neighborhoods with large racial/ethnic minority populations-***particularly in North and Lower North Philadelphia***-have the poorest health outcomes across a range of issues, including poverty, educational attainment, premature death, teen births, breast cancer screening, rat complaints, and homicide. (Emphasis added)

Furthermore, the County Health Rankings and Roadmaps reported annually by the Robert Wood Johnson Foundation rank Philadelphia 67th of 67 counties in the Commonwealth of Pennsylvania both in terms of health outcomes (duration and quality of life) and health factors (behaviors, clinical care, socio-economic issues and physical environment).

Similarly, the 2013 Community Health Needs Assessment of Temple University Hospital (CHNA), conducted by the Public Health Management Corporation, identifies numerous unmet needs in our service area.

- 27% of adults are in fair or poor health, higher than that 16.8% statewide average.
- More than 37.8% of adults were diagnosed with high blood pressure.

- 18.9% of adults were diagnosed with diabetes.
- 38.2% of adults are obese, and 29.9% are overweight.
- 24.4% of adults were diagnosed with a mental health condition, representing 84,300 adults. Of those with a mental condition, 34.1% are not receiving treatment.

The CHNA further noted several health need deficiencies, including access to the following health services: primary and preventative care; mental health services, prescription coverage and dental care; heart disease and cancer management programs; smoking prevention, interventions, and cessation programs; and, education about healthy lifestyles and disease management. The CHNA also identified significant language and cultural barriers facing the communities we serve.

Ideas to Improve Health Outcome for Medicare Patients with Chronic Conditions

TUHS is proud of our rich history caring for our medically complex and socio-economically disadvantaged community. Based on our experiences, we offer the below ideas that we believe will help achieve the Committee's goals of increasing care coordination among providers who treat patients with chronic disease; streamlining Medicare's payment systems to incentivize the appropriate level of care for these patients; and, improving delivery of high quality care, patient outcomes, care transitions and program efficiency while reducing the growth in Medicare spending.

I. Improvements to Medicare Advantage for patients living with multiple chronic conditions. Section 1853(a)(1)(C) of the Social Security Act provides for demographic adjustment, including adjustment for health status, in payments to Medicare+Choice organizations, with respect to individuals covered by Medicare+Choice on a per-member-per-month basis. We suggest that this risk-adjustment be improved by revising the risk-adjustment system to account for chronic conditions and other factors. Specifically, we suggest that a risk score, with respect to an individual, take into account the number of chronic conditions for which the individual has been diagnosed.

II. Transformative policies that improve outcomes for patients living with chronic diseases through Alternative Payment Models. We recommend that the Committee consider changes in care delivery models under the Program for All-Inclusive Care for the Elderly (PACE) and consider expansion of the "Health Home" care delivery model.

With respect to PACE, we suggest that the Committee expand its focus beyond the aim of avoiding institutional living to include coordination of both primary and specialty care beyond a single location, and that PACE organizations (POs) be empowered to manage medical and social services throughout the continuum of care. We also suggest that PACE Guidelines be revised to enable more than one PO in a specific geographic area to increase beneficiary choice.

With respect to Health Homes, current law provides states with an option to provide coordinated care through Health Homes for individuals with chronic conditions. We suggest that this program be expanded to allow provider organizations to apply directly to the Centers for Medicare and Medicaid Innovation to achieve recognition as a Health Home, and that the program include a financing model that will assure that providers and collaborating community organizations receive adequate reimbursement for the medical care and social supports they provide.

III. Reforms to Medicare's current fee-for-service program that incentivize providers to coordinate care for patients living with chronic conditions. We suggest that the Committee establish an incentive program to encourage beneficiary and provider engagement, either using a point system that reduces co-pays or deductibles at prescribed intervals, or a financial award that incents patients to achieve goals such as completion of annual wellness visits, screening evaluations, medication adherence, and achieving care plan goals.

We also suggest that the Committee consider a change in anti-kickback rules that preclude the use of provider-supported transportation. Transportation has proven to be a major access barrier to healthcare resources. Public transportation, especially for those with physical disabilities, is often unreliable, resulting in a high rate of failed follow-up appointments. Ultimately, transportation issues result in a high incidence of low acuity emergency department utilization and subsequent potentially preventable inpatient admissions.

IV. The effective use, coordination, and cost of prescription drugs. We ask that the Committee consider the establishment of a threshold in medication coverage, for multiple chronic conditions, that provides for continuous pharmacy coverage with low co-pays to promote adherence to medication therapy management.

We also suggest that the Committee consider a financing mechanism that would support medication therapy management by physicians and advanced practice professionals. Currently, pharmacists are the only professional group reimbursed for medication therapy management. Thus, there is no incentive for primary care providers to deliver this service.

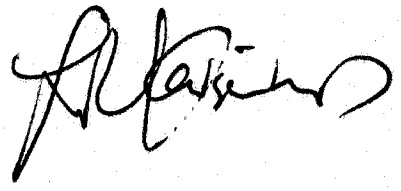
V. Ideas to effectively use or improve telehealth and remote monitoring technology. We suggest that the Committee consider the establishment of funding for an innovative care coordination program using remote monitoring technology that will focus on medical and non-medical beneficiary needs. We believe that a care coordination model involving Area Agencies on Aging, hospitals, physicians and other service providers will improve medical and social support, reduce care redundancy and improve efficiency.

We also suggest that the Committee consider the establishment of a metric driven cost sharing model for the application of telehealth technology. This model would focus on key diagnostic categories such as congestive heart failure, chronic obstructive pulmonary disease and diabetes.

VI. Ways to establish equity in hospital readmissions. We strongly urge the Committee to include in its legislation provisions that direct the HHS Secretary to incorporate sociodemographic adjustment into the readmissions program. We also recommend that the Secretary be directed to use the proportion of dual-eligible patients as a risk adjuster. Furthermore, we recommend that the Secretary be directed to exclude from the hospital readmissions program patients whose diagnoses often lead to frequent readmissions, such as transplant, burn, trauma, psychosis and substance abuse. Such changes to the hospital readmissions program will help ensure that hospitals caring for vulnerable populations are not unfairly penalized, which would ultimately restrict care for disadvantaged populations.

Thank you for your leadership on this important healthcare issue and for providing us with the opportunity to comment. We look forward to continuing our work with the Senate Committee on Finance as you develop reforms to improve the Medicare program. Should you wish to discuss any of these ideas, feel free to contact me directly or through Katherine Levins at Katherine.Levins@tuhs.temple.edu or via phone 215-707-4851.

Sincerely,



Larry R. Kaiser, MD

CC: The Honorable Robert P. Casey
The Honorable Patrick J. Toomey