UPMC LIFE CHANGING MEDICINE UPMC HEALTH PLAN

January 29, 2016

The Honorable Orrin Hatch
Chairman
Senate Finance Committee
U.S. Senate
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
U.S. Senate
Washington D.C. 20510

The Honorable Johnny Isakson
Senate Finance Committee
U.S. Senate
Washington, D.C. 20510

The Honorable Mark R. Warner
Senate Finance Committee
U.S. Senate
Washington, D.C. 20510

Submitted electronically via chronic_care@finance.senate.gov

Re: United States Senate Committee on Finance Bipartisan Chronic Care Working Group Policy Options Document

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

UPMC, on behalf of both its UPMC Provider System and the UPMC Insurance Services Division, which includes UPMC Health Plan, Inc., the UPMC *for Life* Medicare Plan, UPMC *for Kids* Children's Health Insurance Program (CHIP) product, UPMC *for You*, Inc. (a physical health managed-care organization (MCO)), and Community Care Behavioral Health Organization (a behavioral health MCO) (collectively, "UPMC"), is pleased to submit the following comments in response to the United States Senate Committee on Finance (the Committee) request for comment regarding the Bipartisan Chronic Care Working Group's (the "Working Group") Policy Options Document.

First and foremost, we at UPMC enthusiastically support the Committee's bipartisan Working Group as it seeks to improve the manner in which care is provided to millions of Medicare beneficiaries, particularly the nearly 45 percent of those beneficiaries grappling with 4 or more chronic conditions. We share the Committee's belief that better care coordination, appropriately tailored and aligned incentives, and new and innovative policies designed to improve overall care delivery, manage costs and foster improved outcomes will not only benefit beneficiaries, but also the nation as a whole as it grapples with the ever escalating cost of medical care.

We appreciated the opportunity to respond to the Working Group's initial letter from May 2015 that formally invited all interested stakeholders to submit their ideas, based on real-world

experience and data-driven evidence, on ways to improve outcomes for vulnerable Medicare beneficiaries living with multiple chronic conditions. We are grateful for the Working Group's open and transparent manner in reviewing stakeholder input, identifying policy goals, and ultimately formulating policy options. We share in the Committee's urgency and challenging task to ultimately develop and implement policies designed to improve disease management, streamline care coordination, and improve quality while reducing Medicare costs. While we agree that there are no easy answers, we believe that the Working Group's effort to develop these policy options will further frame, identify, and implement effective strategies to better care for those Medicare beneficiaries with multiple chronic conditions.

As the Working Group seeks to develop a more finite list of policy options to guide the Committee in producing a bipartisan legislative product, we offer the following comments and recommendations regarding specific policy options.

Receiving High Quality Care in the Home

Policy Option: Expanding the Independence at Home Model of Care

The Working Group is considering expanding the current Independence at Home (IAH) Demonstration into a permanent nationwide program and is soliciting feedback on specific modifications to the Demonstration that would encourage additional provider practices to choose to participate. First and foremost, UPMC supports the IAH Demonstration that is currently testing a delivery and payment incentive model that uses home-based primary care teams designed to improve health outcomes and reduce expenditures for Medicare beneficiaries with multiple chronic conditions. In fact, we note that the IAH Demonstration is estimated to curb Medicare spending by as much as $34 billion over ten years, according to the American Academy of Home Care Medicine.

Here at UPMC, we take pride in our integrated delivery and financing system that provides highly coordinated, team-based care focused on value rather than volume. Similar to the tenets of IAH, we have over twenty years of experience in implementing care and resource coordination for elderly persons with chronic conditions through our Staying-At-Home (SAH) model, a collaborative approach between UPMC Senior Services and UPMC Health Plan. However, the one notable difference between IAH and UPMC's SAH is that IAH is physician-led and incorporates the home-based participation by physicians and nurse practitioners. Both programs do include interdisciplinary teams, including pharmacists, social workers, and other staff. While SAH is implemented with medical direction and oversight, it relies more heavily on registered nurses and social workers. Both programs focus on extending primary care at home through inter-professional teams, but SAH also focuses on providing a broader array of services to meet

physical and psycho-social needs such as functionality, advance care planning, and medication management. For example, under SAH, a post-discharge visit to a participant's home may include a social worker helping an individual connect with community support services or a nurse creating and updating a detailed medication list. Research confirms that SAH produced savings as well as positive health outcomes, similar to those achieved through IAH. In fact, according to a study by researchers from the University of Pittsburgh in the Journal of Applied Gerontology, SAH participants were significantly *less likely* than non-SAH participants to visit the emergency department, experience unscheduled hospital stays, report negative health conditions, and move to a nursing home. SAH participants were also significantly *more likely* than non-participants to visit the dentist, report improvements in health, and use health services provided outside of hospital settings. Further, the study found that the SAH program saved approximately $210,000 over two and a half years for about 730 SAH participants and also prevented 21 emergency room admissions and 20 hospital stays for every 100 SAH participants.[1] We believe that SAH has also successfully integrated more substantially with hospital-based care and traditional post-acute models of care to ultimately assure effective care transitions and identify the appropriate patient-base for the intervention. Finally, UPMC has established strong working relationships within the SAH model, such as partnering with subsidized senior high-rises, which adds depth to the program through leveraging existing support structures in the larger community.

We enthusiastically support expanding the IAH model nationwide, but respectfully suggest that the Working Group consider potential modifications to permit flexibility in the composition of care teams as well as the integration of navigation toward community supportive services. We believe that broadening these specifications will encourage additional healthcare providers to participate while still ensuring the aforementioned cost savings and desired outcomes of the IAH primary care physician-led model. Finally, we suggest that the Working Group consider implementing a comparative effectiveness evaluation of the different "At-Home" models as a part of the demonstration to further understand and share best practices.[2]

Advancing Team-Based Care

Policy Option: Providing Medicare Advantage Beneficiaries with Hospice Benefits

The Working Group is considering requiring Medicare Advantage (MA) plans to offer the full scope of the hospice benefit, including the required care team and written care plan, as is currently provided under original Medicare. First and foremost, we believe that providing palliative services in the earlier stages of a terminal diagnosis and hospice services in the latter

[1] Service-Enriched Housing: The Staying at Home Program. Journal of Applied Gerontology. July 2014.
[2] For more information on UPMC's SAH and to watch a testimonial, please visit: http://community.upmc.com/?p=2321

stages are vitally important in facilitating quality of care, pain management, and symptom relief. In fact, a 2013 Health Affairs study demonstrated that "hospice is associated with reductions in symptom distress, improved outcomes for caregivers, and high patient and family satisfaction…while also indicat[ing] that continuous hospice use reduces the use of hospital-based services—including emergency department visits and intensive care unit stays—and the likelihood of death in the hospital." The study also found that timely referrals to hospice providers resulted in lower Medicare costs for individuals enrolled in hospice for at least three months, as compared to individuals who did not enroll in hospice early. Even with the aforementioned benefits and the fact that two-thirds of all Medicare beneficiaries prefer to die at home, the majority still die in intensive care units and hospital settings, while likely not receiving hospice care.[3] This often results in "seriously ill patients and their families receiv[ing] suboptimal care, characterized by untreated pain and physical symptoms, spiritual and emotional distress, high family caregiving burdens, and unnecessary or unwanted treatments inconsistent with their previously stated wishes and goals for care."[4] We believe that the genesis of these unintended outcomes and their corresponding solutions is two-fold and depend upon enrollment in MA.

First, the current hospice eligibility criteria often constrain individuals from seeking hospice care. Medicare Part A provides coverage for hospice care if a beneficiary has been certified as having a life expectancy of six months or less and has accepted and signed an agreement choosing palliative care instead of curative treatment. This can be an exceedingly difficult or nearly impossible choice for any individual to make without considerable thought and consultation with professional and family caregivers. Dr. David J. Cassarett, Director of Hospice and Palliative Care at the University of Pennsylvania Health System, accurately portrays the effect of the aforementioned criteria as "[individuals] are required to make a tradeoff, many terminally ill patients receive aggressive treatment without any palliative care until they enroll in hospice, and then often die within one week of enrolling."[5] Research confirms that the median hospice length of stay was only about 17 days in 2014.[6] CMS has therefore since recognized this issue and developed the Medicare Care Choice Model Demonstration as a potential solution. This demonstration project is currently testing a new option *for certain Medicare Fee-For-Service (FFS) beneficiaries only* to receive palliative and hospice care services from selected providers while concurrently receiving curative care treatment, at the individual and provider's discretion.

[3] Improving End of Life Care. Pew Charitable Trusts. May 2015.
[4] Kelly, Amy S., et al. Hospice Enrollment Saves Money For Medicare And Improves Care Quality Across A Number Of Different Lengths-Of-Stay. Health Affairs. March 2013.
[5] Reinventing Hospice. Managed Care Magazine. March 2014.
[6] Facts and Figures: Hospice Care in America. National Hospice and Palliative Care Organization. 2015.

Second, the enrollment criteria remain even more difficult for MA beneficiaries to receive hospice care. Under current law, MA beneficiaries may elect to use hospice, but are either required to disenroll completely from MA or receive hospice services from original Medicare with the remaining services provided by their MA plan. As a result, according to the Medicare Payment Advisory Commission (MedPAC), only about 50 percent of critically-ill MA beneficiaries elected to receive hospice care in 2011, and most of them very close to the end of life. As the Working Group mentions, even for the MA beneficiary who goes through the trouble of enrolling in FFS hospice care, they too often receive fragmented care requiring them to find new providers and even switch out their beds, bedside commodes, and oxygen tanks among other durable medical equipment, all during the final days of life. Requiring that MA plans provide the hospice benefit would undoubtedly work to avoid the aforementioned disruption in care while also advancing palliative care consultations and services, especially in the most vulnerable and difficult circumstances.[7] Further, this policy option would enable MA beneficiaries access to concurrent care – *in the same manner as the Medicare Care Choice Model does for FFS beneficiaries* – with an emphasis on advance care planning, better and earlier access to palliative and hospice care while at the same time facilitating clinically appropriate curative treatment at the individual and provider's discretion. We therefore wholeheartedly support the Working Group's policy option to allow MA plans the ability to offer the hospice benefit that is now provided under original Medicare.

<u>Policy Option: Providing Continued Access to Medicare Advantage Special Needs Plans for Vulnerable Populations</u>

The Working Group is considering either a long term extension or a permanent authorization of Special Needs Plans (SNPs), including SNPs that enroll beneficiaries in need of institutional level of care (I-SNPs), SNPs that enroll beneficiaries with certain chronic disease (C-SNPs), and, most notably, SNPs that enroll beneficiaries eligible for both Medicare and Medicaid (D-SNPs).

Here at UPMC, over 21,000 of our Medicare members are enrolled in the UPMC *for Life* Dual, a 4-Star plan, and the 17th largest dual-eligible SNP in the nation. As you know, dual-eligibles make up nearly 85 percent of SNP beneficiaries nationally and are among the highest risk Medicare beneficiaries.[8] They are more likely to require long-term care (both institutional and in community settings), experience poverty and homelessness, and live with chronic, complex and costly health care conditions. Further, MedPAC estimated that while dual-eligibles make up nearly 20 percent of Medicare enrollment and 14 percent of Medicaid enrollment, they account for nearly 34 percent of total spending in both programs. Dual-eligibles are also more likely to

[7] Spettell, Claire M., et al. A Comprehensive Case Management Program To Improve Palliative Care. Journal of Palliative Medicine. November 2009.
[8] SNP Alliance Estimate Based on Data from MedPAC Annual Reports to Congress.

have three or more chronic conditions, a cognitive or mental impairment, and live with one or more functional impairments in activities of daily living. Finally, the Kaiser Family Foundation found that dual-eligibles were more likely to have at least one hospitalization (25 percent versus 16 percent) as well as visit an emergency room (44 percent versus 24 percent) than were their non dual-eligible counterparts.[9]

With that said, UPMC is and has long been committed to serving these beneficiaries by offering high-quality, cost-effective SNP products that place a strong emphasis on care management and coordination. Our success, like that of other D-SNPs nationally, has outperformed FFS in both quality and cost. SNPs are not only best positioned to provide this care, but also to identify and manage its interplay with complicating psycho-social and socio-economic factors. With the recently proposed CMS-HCC risk adjustment model changes, CMS affirmed its commitment to preserving the viability of SNPs; and therefore, a permanent authorization is the next logical step towards ensuring that SNPs maintain the ability to meet the complex needs of the frail, disabled, and chronically-ill.

Further, we believe that a permanent authorization of SNPs will encourage states that have not yet done so to move towards full integration of regulatory, financial, and delivery system structures between Medicare and Medicaid. The benefits of full integration are clear; however, individual states maintain the authority to make this decision. As a high-performing D-SNP sponsor, we have concerns with the Working Group's potential requirement that all D-SNPs offer fully integrated benefits without taking into account a state's current dynamic. While we agree that full integration is preferred, without requiring state Medicaid programs to take action, many D-SNPs nationally will be forced to close, denying the proven benefits that D-SNPs offer even without integration with the Medicaid program.

Instead of forcing full integration as a D-SNP requirement, we respectfully suggest the Working Group further engage the Center for Medicare & Medicaid Services (CMS) Medicare-Medicaid Coordination Office's (MMCO) existing efforts to advance integration, identify the existing barriers, and grant the MMCO authority to do the following: 1) create a master plan for advancing integration, including financial incentives, for states that have yet to do so; 2) establish and maintain an internal federal-state structure for communication on dual integration issues; and, 3) increase the use of aligned and administratively efficient Medicare and Medicaid program requirements such as marketing and member materials, appeals and grievances, and performance measurement.

[9] A Primer on Medicare: Key Facts About the Medicare Program and the People it Covers. Kaiser Family Foundation. March 2015.

Addressing the Need for Behavioral Health among Chronically Ill Beneficiaries

The Working Group is considering developing policies that improve integration of care for individuals with a chronic condition combined with a behavioral health disorder. Here at UPMC, we provide managed Medicaid-funded behavioral health services to over 900,000 Medicaid beneficiaries through our Community Care Behavioral Health Organization (Community Care), the largest non-profit behavioral health managed care organization in the nation. Community Care has helped to develop a broad range of community-based programs focused upon minimizing institutional care and maximizing family and community support and recovery. Our approach includes the development of a health home in behavioral health agencies based on a person-centered system of care that includes an individualized care plan and self-management strategies, as well as an emphasis on relevant physical health factors and overall wellness. We therefore see first-hand the need for the integration and coordination of physical, behavioral, and supportive services.

We agree with the Working Group that behavioral health problems may often hinder the successful management of physical health chronic conditions, and vice versa, and can be particularly challenging for Medicare beneficiaries, who are often at greater risk for mental and cognitive disorders like Alzheimer's and dementia. Successful integration is even more important for dual-eligible beneficiaries who, as discussed above, often have multiple chronic conditions and are more likely to suffer from mental and cognitive disorders (more than half of all dual-eligibles have mental or cognitive impairments).[10] To that end, the Affordable Care Act (ACA) took important steps towards incentivizing integration of behavioral and physical health services for Medicare beneficiaries by working to close the payment gap through instituting parity for outpatient mental health services as well as increasing access to preventive services such as an annual screening for depression, at no cost to beneficiaries.

However, there are still significant barriers to further integration. First, the payment gap persists in certain areas such as the outdated requirement that a particular Medicare provider can be paid only for one service, administered on a single date, even if two services were administered – e.g., a physical health and behavioral health service. We therefore encourage the Working Group to consider eliminating this requirement as it serves to disincentivize the provision of integrated behavioral health services – especially those services provided in a primary care setting – if there is no adequate compensation. Secondly, Medicare covers mental health services provided by a limited set of providers including psychiatrists or other doctors, clinical psychologists, clinical social workers, clinical nurse specialists, nurse practitioners and physician assistants. However, states often license and credential additional types of highly trained and certified providers such as mental health and professional clinical counselors to best serve the needs of their residents.

[10] The Kaiser Family Foundation. Medicare's Role for Dual Eligible Beneficiaries. April 2012.

We therefore suggest that the Working Group encourage CMS to revisit the process as to which types of providers are allowed to provide behavioral health services consistent with the most current licensing and credentialing practices. Finally, we believe that the most impactful behavioral health care is not simply treating a mental or cognitive disorder, but is the ability to assess the interaction and interplay between treatment plans for both physical and mental health chronic conditions. Much like what we are able to do for our Medicaid members at Community Care and UPMC *for You*, we encourage the Working Group to consider policies that incentivize integration of physical and behavioral health care for Medicare beneficiaries such as payment incentives for primary care physicians to complete behavioral health assessments and/or pay-for-performance initiatives tied to effective behavioral health treatment, appropriate specialist follow-up care, and effective management of psychiatric medication.

Expanding Innovation and Technology

Policy Options: Adapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage Beneficiaries & Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Beneficiaries

The Working Group is considering giving MA plans the flexibility to establish a benefit structure that varies based on chronic conditions of individual beneficiaries. The Working Group is also considering allowing MA plans to offer a wider array of supplemental benefits than they do today. A wide-range of non-medical or social factors, such as nutrition, are important contributors to the health and costs of chronically-ill individuals, yet many of these services are not permitted to be offered by MA plans as supplemental benefits. We agree with the Working Group that allowing MA plans to specifically tailor their benefit design and incorporate additional supplemental benefits to meet the needs of chronically ill individuals will help improve management of chronic disease and/or prevent the progression of these diseases. We wholeheartedly support both of the aforementioned policy options and believe it reasonable to potentially require for a plan to be afforded this flexibility in benefit design and provision of supplemental benefits, that it meet and maintain a certain Star Rating threshold – perhaps a 4-Star Rating.

Finally, we note that CMS recently began the Value-Based Insurance Design (VBID) Model as an opportunity for MA plans to institute the aforementioned flexibility in benefit design and provision of supplemental benefits. UPMC Health Plan and other issuers in seven states have submitted applications for consideration and we are more than willing to discuss our potential model and benefit design changes if the Working Group so desires.

Policy Option: Increasing Convenience for MA Beneficiaries through Telehealth

Currently, the Medicare program recognizes and pays for only certain Part B telehealth services while beneficiaries are only eligible for these services if they are provided at a medical facility in a rural area. Further, any use of telehealth services beyond the narrowly defined original Medicare telehealth benefit must be a supplemental benefit in the MA program. As a supplemental benefit, an MA plan must use a portion of its rebate dollars or charge the enrollee an additional premium to provide the service. These circumstances often disincentivize the offering of telehealth services. The Working Group is therefore considering permitting MA plans to include certain telehealth services in its annual bid amount. We wholeheartedly agree with the Working Group in that telehealth technology should not be considered an additional benefit, but rather an alternative mode of care delivery of mandatory benefits to an enrollee. In fact, we see great value in utilizing telehealth technology as it has proven effective in promoting quality and reducing costs.

Here at UPMC, we continue to test telehealth and remote monitoring techniques that are proving to be effective modes of delivery that facilitate patient engagement and coordination of services across multiple settings. Notably, we are actively utilizing technology that collects daily weight and/or BMI data and then triggers an almost immediate telehealth visit if concerns are identified. As a health system, we are increasingly using remote monitoring to assist in care coordination and monitoring for individuals identified at high risk for readmissions; for example, blood oxygen levels and blood pressure of patients with congestive heart failure can be monitored. At any time, 250 individuals with chronic conditions participate in the UPMC remote monitoring program, and the program has seen proven positive outcomes. In 2014, only 12.9 percent of remotely monitored patients with congestive heart failure were readmitted to a hospital within 30 days of their initial hospitalization, compared with 20 percent of patients with the condition who did not participate. Further, recent research has studied the impact of telehealth interventions on hospitalization rates for nursing home patients, a population with multiple chronic conditions and a high risk of potentially avoidable complications and hospitalizations. A 2014 Health Affairs study confirmed that telehealth coverage reduced hospitalizations by 11.3 percent, representing an average savings of $151,000 among nursing homes engaged in telehealth as compared to those that were not.[11] Moreover, the advantages associated with the use of telemedicine in nursing homes is not limited to rural settings, as the absence of 24/7 on-site medical services is true across all nursing home settings. These meaningful, real-world reductions in hospitalizations, readmissions, and costs along with improved outcomes demonstrate that

[11] Grabowksi, David. C and O'Malley, A James. Use of Telemedicine Can Reduce Hospitalizations of Nursing Home Residents and Generate Savings for Medicare. Health Affairs. February 2014.

telehealth strategies can genuinely impact the delivery and financing of healthcare, especially for those individuals with multiple chronic conditions.

We believe that the ability to include telehealth services in our annual bid amount, while also not limiting the services allowed to those currently permitted by FFS, will better facilitate the provision of high-quality, cost effective services to our MA members. By way of example, allowing a telehealth visit to satisfy the face-to-face requirement for the advance care planning CPT codes 99497 and 99498 could prove beneficial to beneficiaries, providers, and the MA plan. Finally, we believe that eliminating the geographic and originating site restrictions will also go a long way in incentivizing the use of telehealth services for all Medicare beneficiaries, and not just a certain subset in specific geographic locations.

Thank you for providing us the opportunity to comment on these policy options. We would be grateful for the opportunity to continue an iterative dialogue.

Respectfully Submitted,

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