Re: 2016 Inpatient Prospective Payment System Proposed Rule (Proposed Rule); Potential Expansion of Bundled Payments for Care Improvement Initiative (BPCI)

On behalf of Philips Health Systems (Philips), I am pleased to have this opportunity to comment on the Proposed Rule's solicitation of comments on the possibility of expanding the BPCI, a demonstration program currently conducted by CMS' Center for Medicare and Medicaid Innovation (CMMI). Philips provides solutions that span the health continuum, including imaging, patient monitoring, and cardiac care systems; medical alert systems; sleep management and respiratory solutions; healthcare informatics solutions and services; and, pertinent to the Proposed Rule, a complete range of comprehensive telehealth programs.

Philips supports efforts to reform the health care delivery system to facilitate the provision of high quality, cost effective health care services to Medicare beneficiaries. We understand that, at this stage, CMS has not yet issued a proposed rule that would expand BPCI; rather, the agency is soliciting comments regarding whether the program should be expanded, and if so, how. We are hopeful that the time is therefore right for Philips to provide input with respect to the critical role that telehealth could play in this potentially transformative effort.

The Role of Telehealth in Achieving Cost Savings and Quality Improvement

Philips' telehealth programs are designed to enable providers to scale their efforts and coordinate care across the continuum for patients ranging from those who require readmission reduction to chronic disease management to patients with complex, high-risk conditions requiring acute intervention. The programs most relevant to the potential expansion of the BPCI[1] as described in the proposed rule include:

- **Remote Intensive Care Program (eICU)** – A comprehensive technology and clinical reengineering program that enables a relatively few health care professionals from a centralized telehealth center to providing around-the-clock care for critically ill patients. With critical care costs in the U.S. totaling roughly $80-$100 billion per year, research published in the December, 2013 issue of CHEST Journal's **Online First**[2] examined the impact of Philips' eICU program on nearly 120,000 critical care patients across 56 intensive care units (ICUs), 32 hospitals and 19 health systems over a five-year period. The study demonstrated substantial reductions in mortality and length of stay. In fact, patients were discharged from the ICU 20% faster and discharged from the hospital 15% sooner than patients not monitored under an eICU program. Furthermore, a study from the University of Massachusetts demonstrated that more patients were

[1] Another extremely promising telehealth program offered by Philips is the eIAC program, a program that manages high-risk patients with multiple chronic conditions in the home. A recent pilot has demonstrated that this program is highly effective in reducing hospital admissions and other health care costs. See http://ycharts.com/news/story/PRN-NE97054. However, this program is focused on the provision of high tech and "high touch" services to ambulatory patients, and is not as relevant to the issues surrounding the potential expansion of BPCI, since all of the BPCI models involve episode-based payments for patients undergoing hospitalization.

[2] *"A Multi-Center Study of ICU Telemedicine Reengineering of Adult Critical Care," Craig M. Lily, M.D., Professor of Medicine, Anesthesiology and Surgery at the University of Massachusetts and Director of the eICU Program at UMass Memorial Medical Center.*

discharged to their home as opposed to hospice, LTACH or Skilled Nursing locations (Lilly JAMA article).

- **eAcute Program** – Modeled after the eICU Program, this program monitors high-risk hospitalized patients on medical-surgical floors to prevent avoidable complications. Results of the eAcute pilots have shown a 17% reduction in cost/case, a 36% reduction in falls, and a 17% reduction in average length of stay.

- **eConsultant** - This program provides remote management services and emergency department (ED) consults for telestroke, telepsych and trauma triage. Telestroke has already been demonstrated to increase thrombolytic treatment and reduce the disease burden to patients and society. Telepsych enables more rapid evaluation and treatment to more patients across any geography and trauma triage enables a centralized trauma surgeon to determine which patients need to be transferred by costly air transport, less expensive ambulance and which patients can remain at the local hospital and cared for by the eICU care team.

- **Bedside Skilled Nursing Facility (eSNF) Program**: This program provides consultative care to SNFs based on defined criteria on demand. Early results show a 25-30% reduction in emergency department transfers.

While each of these programs has the potential to reduce costs and improve quality for the patient populations targeted by BPCI (those Medicare patients admitted for inpatient hospital stays), Medicare's current fee for service payment methodologies create financial disincentives to the adoption of these systems. Any cost reductions achieved by hospitals for inpatient and post-discharge episodes of care through the use of these and other innovative health technologies inure are not shared by the institutions involved. In light of the substantial capital and operational start-up costs involved in implementing these types of programs, a broad array of payment changes that enable hospitals and related institutions to share in the savings achieved –including but not limited to BPCI—should be considered to remove this financial obstacle to the adoption of new and innovative approaches to quality improvement and cost reduction.

Responses to CMS Solicitation of Comments on Potential Expansion of the BPCI

The Proposed Rule solicits comments on potential expansion of the BPCI, including the following:

- ***The breadth and scope*** *of any expansion such as whether expansion should focus on any particular model, whether it should target specific regions of the country, and whether it should be expanded using voluntary or mandatory participation.*

Preliminarily, to put BPCI in context, it is important to note that the expansion of BPCI—regardless of how successful that expansion may be—has limited potential to reduce Medicare expenditures for those with multiple chronic conditions, a population comprising an estimated 5% of Medicare beneficiaries but consuming about 50% of Medicare costs. It is Philips' experience through the e-IAC program, which focuses on the management of patients with multiple chronic conditions, that the greatest potential for costs savings for this patient population results from more effective management of ambulatory care services, integrating psychosocial and other supports into a team-based ambulatory care model, that reduces inpatient admission rates. For this patient population, the primary focus should be on avoiding hospitalizations altogether and not necessarily on bundling payment for the various services provided during hospitalization and the immediate post-discharge period.

Even for those Medicare beneficiaries that do not have multiple chronic conditions, bundling approaches are of limited utility. Bundles are only useful for certain specialized service lines, but are not useful for managing a patient's overall care.

That having been said, bundled payment approaches may have a role in improvement of quality and reduction in costs for Medicare patients with acute conditions requiring relatively defined services during and immediately following a hospitalization. It would appear that Model 2 is the most likely BPCI model warranting potential expansion, since (unlike Model 3) it includes services provided during the hospitalization, and does not require the degree of integration necessary for effective implementation of Model 4. It is our experience that health care systems vary widely in the extent to which they are integrated, and that, even within health care systems, some service lines are more prepared to take on financial risk than others. Therefore, to the extent that CMS decides to proceed with the expansion of BPCI and similar bundled payment approaches, we urge the agency to do so on a voluntary basis and to give hospitals substantial flexibility in defining the episode of care.

- ***Episode Definition:*** *whether episode definitions and lengths should be modified or broadened.*

Based on its experience with the integration of telehealth across the care continuum, Philips believes that the most salient opportunities for care improvement and cost reduction derive from (a) patients with multiple chronic conditions, in the ambulatory care environment; and care in the ICU (b) for patients with more acute conditions, during the post-discharge phase of care (i.e. post-acute care). Under the BPCI, hospitals are provided an incentive to coordinate care and to achieve cost savings because their DRG payments are reduced: Hospitals must achieve cost savings simply to "break even" under the current BPCI models. We urge CMS to consult closely with the BPCI participants to more accurately pinpoint the phase of care (e.g. during the inpatient hospital stay or post-discharge) during which savings can be achieved and to ensure that the post-discharge period included in the episode is defined in a manner that facilitates cost savings and care coordination.

We understand that all of the BPCI options are triggered by an inpatient stay in a hospital and that purely ambulatory patients are not included. Nonetheless, it is our experience that substantial cost savings and quality improvements can be achieved through telehealth for patients with multiple chronic conditions in the ambulatory environment. We urge CMS to consider offering hospitals the opportunity to participate in a new bundled care model that focuses on care provided to Medicare patients with multiple chronic conditions, and that extends further than 90 days post discharge. In our view, this is a patient population that could benefit significantly from the enhanced care coordination and concerted patient management efforts that characterize bundled payment programs.

- ***Payment amounts:*** *whether payments should be set prospectively or based on regional episode experience; whether the same episode discount percentages should apply to all episodes or vary by episode.*

We believe that, in the event CMS decides to propose an expansion of BPCI, both prospective and retroactive payment models should be made available to participating providers. Perhaps the more critical issue is how to derive a bundled payment that accurately captures the costs involved. This can be especially difficult in the post-discharge phase of care delivery. Especially in the post-acute phase, the question remains how all the care for the patient will be captured. This includes not only physicians and nurses, but also ambulatory care providers, home health aides, case managers, and others whose costs are not captured in historic claims data.

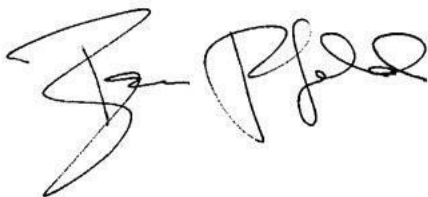
We also believe that a process should be put in place for hospital systems that participate in any expanded BPCI program to build into the episode payment at least some portion of the initial costs of installing new technology necessary for patient management and coordination. The costs of this technology are not included in the baselines used to determine the amount of the episode–based payment, and this inhibits the acquisition of technology that ultimately may result in substantial cost savings. For example, a process could be developed under which a hospital participating in a BPCI would be paid its full IPPS rates (rather than the reduced amount paid to other BPCI participating hospitals that do not acquire telehealth technology), but would be required to repay some of the amounts out of savings achieved, at the time of the reconciliation. Alternatively, we urge CMS to use its waiver authority to provide coverage to BPCI participants for telehealth (including telemonitoring) services that would not meet the current restrictive originating site and other requirements imposed on the telehealth benefit under fee-for-service Medicare.

- ***Quality Issues:*** *What quality measures could be applied to episodes and how value-based payment could be incorporated in the BPCI initiative?*

We strongly encourage CMS to include meaningful quality measures in any bundling methodology adopted in the Medicare Program, including, but not limited to, any expanded BPCI program. We firmly believe that any such program should be designed to improve health care outcomes in addition to improving cost efficiency.

In this regard, we urge CMS to consider quality measures that are specifically designed to identify the underutilization of health care services provided to patients whose admissions are subject to bundled payment. We are aware that many of the quality measures currently used for both hospitals and physicians are designed to identify the overutilization of services (e.g. imaging efficiency measures) and believe that these would be inappropriate for use under any expanded BPCI methodology. By contrast, the quality indicators developed for use in any expanded BPCI program should be condition-specific outcomes measures that are designed to ensure against inappropriate underutilization of health care services during the episode of care. Consideration should be given to whether some quality measures should extend beyond the termination of the episode, to ensure that beneficiaries do not incur long term health consequences as the result of underutilization of health care services during the episode.

We hope that these comments are helpful to you as you consider the potential expansion of the BPCI beyond the demonstration stage. If you have any questions regarding these comments or regarding the potential for telehealth to contribute significantly to CMS' health delivery system transformation efforts, please do not hesitate to contact Dr. Brian Rosenfeld at Brian.Rosenfield@philips.com or Laurel Sweeney at Laurel.Sweeney@philips.com.



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