PHILIPS

[CMS-2390-P]
RIN 0938-AS25
Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed
Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability

Dear Sir or Madam:

Philips would like to commend the Centers for Medicare and Medicaid Services for its Proposed Rule on Medicaid Managed Care (MMC) plans. We believe that many of the provisions of the Proposed Rule have the potential to significantly improve the quality of care provided to Medicaid patients throughout the country and to bring MMC requirements in line with the requirements for Qualified Health Plans (QHPs) to be accessible on the state and federal exchanges and the requirements applicable to Medicare Advantage Plans.

Our comments on the Proposed Rule address one of the few areas that does not appear to be addressed in a comprehensive fashion by the Proposed Rule: The requirements applicable to MMC plans with regard to Medicaid patients with multiple chronic conditions. Addressing the challenges of our citizens with chronic conditions is a daunting but critical national priority, and this area has received substantial attention by the Department of Health and Human Services, primarily as it relates to Medicare patients with multiple chronic conditions. It does not appear that the same level of attention has been focused on the development of programs to address the special needs of Medicaid patients who have multiple chronic conditions and who are not also eligible for Medicare (dual eligible). Since an estimated 75% of Medicaid patients receive care through MMC plans, we believe that it would be appropriate for the Proposed Rule to ensure that the managed care programs adopted by the states to serve Medicaid patients address the needs of this special population.

In this regard, a brief review of the available literature suggests that little is known regarding the quality of care received by Medicaid enrollees with multiple chronic conditions (MCCs) and whether quality is different for those with mental illness.[1] Medicaid beneficiaries with disabilities frequently have multiple chronic conditions, and very high rates of psychiatric and cardiovascular disease. One California study

[1] See "Heterogeneity in the quality of care for patients with multiple chronic conditions by psychiatric comorbidity",Domino ME[1], Beadles CA, Lichstein JC, Farley JF, Morrissey JP, Ellis AR, Dubard CA. http://www.ncbi.nlm.nih.gov/pubmed/24561748

released in 2009 suggested that 67% of Medicaid-only beneficiaries with disabilities have three or more chronic conditions. [2] And the HHS Initiative on Multiple Chronic Conditions indicates that one in 15 children has multiple chronic conditions. Since Medicaid is the primary payer for this special population, MMC plans have a special obligation to address the needs of this highly vulnerable group.

Recommendation

In light of our experience described further below, we strongly urge CMS to adopt special requirements for MMCs with regard to patients with multiple chronic conditions. Specifically, we urge CMS to:

- Require state submissions to specifically describe the requirements imposed on MMC programs with regard to the care of Medicaid patients with multiple chronic conditions;
- Ensure that the amounts paid by states to MMC programs take into account the true costs of caring for Medicaid patients with multiple chronic conditions;
- Ensure that the accessibility standards applied to MMC programs address the care coordination and health coach needs of these patients;
- Encourage states to adopt incentive-based programs that reward MMC programs for providing team-based, high touch/high tech programs to improve the quality of care provided to patients with multiple chronic conditions.

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[3], it is our experience in the provision of a comprehensive telehealth program to patients with multiple chronic conditions that is most germane to the Proposed Rule: Through the Philips **Intensive Ambulatory Care (eIAC) Program** and **the Philips eConsultant SNF programs**, Philips partners with providers to manage high-risk patients with multiple chronic conditions in the home and in skilled nursing facilities.

The eIAC Program

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.[4] Our experience with the eIAC program has taught us that 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. A one-page description of the program is included as Attachment A.

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

[2] http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/Executive_Summary_-_Faces_III.pdf.

[3] 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.

[4] 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.

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%.

This approach to the management of patients with multiple chronic conditions is supported in the clinical literature. 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 such for the remote care of patients in the home for congestive heart failure (CHF), chronic obstructive pulmonary disease (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, COPD, and stroke. 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.

The eConsultant SNF Program

The eConsultant_SNF program is designed to help maintain patients in the skilled nursing facility (SNF) setting throughout their treatment to maintain uninterrupted progress toward their goals and keep costs down. The program's aim is multifaceted, including but not limited to the avoidance of unnecessary emergency department transfer costs for the sole purpose of evaluation, the maintenance of the patient at the site of care to support the clinical progress and the integration of best practices in the continuum of care. By handling patient issues through the program, providers can also potentially reduce expenses associated with avoidable hospital readmissions, reduce unnecessary physician calls and increase efficiency

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 CMS will find helpful in determining the requirements that should be imposed on MMC plans serving these patients.

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 Philips 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 urge CMS to recognize that this issue of EHR interoperability is bound together with improving care for patients with multiple chronic care conditions.

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 among Medicaid patients with multiple chronic conditions.

We appreciate the opportunity to comment on the Proposed Rule. If you have any questions regarding Philips' experience in the care of patients with multiple chronic conditions or would like any further input

into how this experience could be incorporated into MMC plan requirements, please do not hesitate to contact either of us.

Sincerely yours,

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Attachment A: A Description of the eIAC Program

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:

- 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