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June 22, 2015

To: Chronic Care Working Group of the U.S. Senate Committee on Finance
The Honorable Orrin Hatch, Chairman
The Honorable Ron Wyden, Ranking Member
The Honorable Johnny Isakson
The Honorable Mark Warner

Re: Recommendations for Improving Care for Medicare Patients with Chronic Conditions

Submitted via email to chronic_care@finance.senate.gov

Kaiser Permanente appreciates the opportunity to provide this response to the Committee's May 22nd stakeholder letter requesting recommendations to improve care for Medicare patients with chronic conditions. As we discuss in detail below, Kaiser Permanente believes a key policy change that would improve the quality and enhance the availability of care for patients with chronic conditions is the expansion of telehealth and related technologies in Medicare. In particular, we request that the Committee pursue legislative action that would permit Medicare Advantage plans to offer enrollees the option of accessing covered services (e.g., physician office visits) by way of telehealth technologies as part of their basic Medicare coverage, rather than as a supplemental benefit.

We appreciate the Committee's consideration of the comments below.

Chronic Condition Management within Kaiser Permanente

As the largest private integrated health care delivery system in the country, Kaiser Permanente delivers health care to more than 10 million members in eight states and the District of Columbia, including approximately 1.3 million Medicare patients. Our mission is "To provide high-quality, affordable health care services and to improve the health of our members and the communities we serve." Since our founding in 1945, Kaiser Permanente has been innovating to provide our members the highest quality care in the way that optimally meets their clinical needs and care preferences, including a focus on prevention, primary care, and well-coordinated, continuously managed care for members with chronic conditions.

Kaiser Permanente has improved our effectiveness in preventing and managing chronic conditions by leveraging our integrated structure, our physician-led interdisciplinary teams, our advanced, shared electronic health record and associated digital tools, our commitment to evidence-based care, and our capitated payment model. Many of our initiatives and clinical programs for addressing chronic disease can be linked to lower rates of hospitalization and readmission, suggesting that they achieve the "triple aim" of improved care for populations as well as for individual patients, while making care more affordable. We have described several of these initiatives in the Appendix.

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By leveraging today's technologies, Kaiser Permanente's vision of "total health" for all our members is more achievable than ever before. As part of Kaiser Permanente's vision of total health:

- care is delivered across the entire landscape of settings and modalities to provide the right care at the right time in the right location;
- a member's health can be proactively managed through continuous communication with and access to his or her clinical team, ensuring that care is available and given when needed;
- patients are more highly engaged and take part in a greater degree of self-care, reducing the need for clinical interventions;
- care is coordinated among primary care providers, specialists and caregivers; and
- transitions between care settings are seamlessly managed.

Kaiser Permanente believes that leveraging telehealth and related technologies is integral to delivering on this vision of the medical care delivery model while ensuring efficient use of health care resources. For that reason, many of our physicians have been piloting and incorporating these technologies into their regular care delivery workflows. However, as discussed below, broad adoption and availability of telehealth-enabled care has been significantly stifled by outdated Medicare coverage and reimbursement policy.

Telehealth Enables Continuous, Coordinated, Patient-Centered Care for Chronic Conditions

Advances in technology over the last several years have enabled secure, reliable, real-time interactive communication and data transfer that were not possible in the past. In health care, a wide range of high-quality, HIPAA-compliant technologies have entered the market, and consumers are increasingly using mobile and personal devices and applications to manage their health and their interactions with the health care system. Technologies such as real-time interactive video and remote or home monitoring have been proven to be effective modalities of care delivery, with quality on par with that of care provided in traditional face-to-face settings. If these modalities and others can be deployed in strategic and clinically appropriate ways, health care providers can optimally meet patients' care needs and preferences and enhance patients' overall care experience.

Particularly for Medicare patients with one or more chronic conditions, the availability of technology-enabled care would mean:

- *Continuous care management*. For patients with chronic conditions, regular communication with members of the care team is critical in order to monitor progress and make adjustments to the care plan as needed. Video and telephone visits, as well as use of secure email, allow for more regular contact between patients and providers without necessitating an in-person visit each time.
- *Proactive care management*. Through remote monitoring technologies including home-based and personal or wearable devices, a patient's vital signs and other health data can be automatically recorded in his or her electronic health record and shared with members of the care team, allowing proactive intervention if a patient's condition changes.

- *Convenient access ensuring adherence to care plans*. Making care convenient and easily accessible to patients has been shown to improve patients' adherence to care plans and therapeutic regimens, ensuring that patients with chronic conditions remain stable or continue to make progress.
- *Facilitation of team-based care*. Video visit technology enhances coordination of care by streamlining consultation and collaboration between care providers and facilitating participation by patients' family members and caregivers.

The Committee Should Pursue Legislative Action to Promote the Use of Telehealth in Medicare

The most significant policy barrier to broad adoption and use of telehealth and related technologies is the very limited scope of telehealth services available to Medicare beneficiaries. With respect to telehealth and related services, without policy changes Medicare risks ceding its traditional role of strongly influencing commercial coverage policy by lagging behind the innovation occurring in care delivery. In addition, with the current trends in the marketplace, Medicare members will have fewer care delivery options than members with commercial and other sources of coverage.

While Medicare coverage lags far behind, the large majority of state Medicaid plans now provide some level of reimbursement for services provided via telehealth (primarily real-time interactive video visits); more than half of states have legislated mandates requiring varying levels of parity in their commercial insurance markets for coverage of services provided in person and those provided via telemedicine; and the Veterans Administration is widely recognized as a leader in the use of telehealth in care delivery, providing a substantial number and breadth of services via "Clinical Video Telehealth" and "home telehealth" (remote monitoring).

Under the Medicare statute, only beneficiaries located in rural or underserved areas of the country can receive certain Medicare-covered services via telehealth (real-time, interactive video), and only under specified circumstances. Further, only a very limited set of remote monitoring technologies are covered by Medicare, including monitoring of cardiac pacemakers. Although these requirements apply directly to the original fee-for-service Medicare program, and although CMS generally has significant flexibility in its administration of the Medicare Advantage program, CMS considers these fee-for-service limitations to be applicable within the Medicare Advantage program as well.

CMS generally has significant flexibility in its administration of the Medicare Advantage program and, furthermore, we believe the Medicare statute provides clear authority for the agency to deem telehealth-enabled care as equivalent to in-person care for purposes of the MA program. However, in the 2015 Medicare Advantage Call Letter, CMS opined that it does not have authority to allow plans to offer enrollees the option of receiving Medicare-covered services (e.g., physician office visits) by way of telehealth technologies as part of their basic Medicare coverage. Rather, CMS considers telehealth to be a separate, supplemental benefit for which the plan must use part of its rebate or the enrollee must pay an additional premium, both of which are disincentives to offer these services.

Medicare Advantage is an ideal program in which to expand the availability of telehealth-enabled care to millions more individuals without significant budgetary or fraud-and-abuse risk. Because Medicare Advantage plans accept full financial risk for the medical care of their enrollees, the risks of overutilization or fraudulent billing that exist in fee-for-service Medicare are minimized. In addition, the existing protections for ensuring quality of care (e.g., evidence-based standards of practice, state licensing laws, health plan accreditation requirements, standardized quality metrics) would apply equally to telehealth-enabled care as to face-to-face care. Furthermore, in the recently-finalized Medicare Shared Savings Program rule, CMS stated that the agency will test waivers of the telehealth rules for ACOs beginning in 2017. Given that MA plans bear full risk for the care of their members, MA plans should have at least the same level of flexibility in the use of telehealth as ACOs.

We request that the Committee consider the following legislative options to permit broader coverage of services provided via telehealth and related technologies in the Medicare Advantage program:

1. Through a letter to the Secretary of Health and Human Services, urge the Centers for Medicare & Medicaid Services (CMS) to leverage the full extent of its administrative authority to encourage broad adoption of telehealth and related technologies in care delivery for Medicare patients.
2. Pass a resolution or "Sense of the Congress" that the Medicare statute provides CMS significant regulatory flexibility in administering the Medicare Advantage program, such that the agency may permit plans to cover Medicare Parts A and B services that are provided through or enabled by telehealth and related technologies, consistent with state practice laws, as part of the basic Medicare benefit package.
3. Amend the Medicare statute to direct CMS to permit Medicare Advantage plans to cover Medicare Parts A and B services that are provided through or enabled by telehealth and related technologies, consistent with state practice laws, as part of the basic Medicare benefit package.

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Kaiser Permanente appreciates the opportunity to provide feedback in response to the Committee's request. We would be pleased to provide additional information or answer any questions the Committee may have. Please contact Laird Burnett at (202) 216-1900 or laird.burnett@kp.org with any questions.

APPENDIX
Chronic Care Initiatives across Kaiser Permanente

Kaiser Permanente has improved our effectiveness in preventing and managing chronic conditions by leveraging our integrated structure, our physician-led interdisciplinary teams, our advanced, shared electronic health record and associated digital tools, our commitment to evidence-based care, and our capitated payment model. Innovation is often generated and tested locally in a Kaiser Permanente region, and when evidence supports a new "best practice" the locally-developed innovations are adapted and spread across our regions. Many of our initiatives and clinical programs for addressing chronic disease can be linked to lower rates of hospitalization and readmission, suggesting that they achieve the "triple aim" of improved care for populations as well as for individual patients, while making care more affordable. We have described several of these initiatives below, which have been developed and demonstrated in one Kaiser Permanente region but adapted by others to address their local circumstances.

Medicare Advantage "Stars" Reward Effective Chronic Disease Management

The Medicare Advantage program reflects the alignment of incentives in our care system, and the Star Ratings system provides important metrics used to measure, evaluate and reward high performance. The Star Ratings measures include a number of the measures from the Healthcare Effectiveness Data and Information Set (HEDIS), which have been developed by the National Committee for Quality Assurance (NCQA). Many HEDIS measures capture chronic disease management, such as blood pressure and blood sugar (HbA1c) control in patients with heart disease and diabetes. As a program and in most of our regions, Kaiser Permanente scores at or above the 90th percentile in the HEDIS measures aimed at managing these chronic diseases.

Advances in digital health and alternative payment models make it possible for other organizations without Kaiser Permanente's scale or long history of integration to create similar tools and reliable care systems to improve the care of people with chronic conditions. Indeed, high-performing and innovative medical groups and care systems can be found or are emerging in all parts of the United States.

Hypertension

A recent study[1] published in *JAMA* demonstrated that Kaiser Permanente members with hypertension in Northern California were more likely to have their condition under control than patients in California with hypertension cared for outside of Kaiser Permanente, as well as when compared to a national sample of patients during the period studied from 2006 to 2009. Kaiser Permanente attributes our relatively faster rate of improvement in hypertension control to the development of evidence-based guidelines, the creation of a large patient registry, the development and sharing of performance metrics, the use of medical assistants on the care team for follow up, and the use of aspirin plus a single-pill combination therapy. Hypertension control rates have continued to improve after the study. The availability of electronic disease registries

[1] Jaffe et al., "Improved Blood Pressure Control Associated With a Large-Scale Hypertension Program," JAMA, 2013;310(7):699-705. Available at: http://jama.jamanetwork.com/article.aspx?articleid=1730511&resultClick=3.

enables physicians and care teams to be proactive and outreach to patients whose disease is not well-controlled, and design approaches that can reduce barriers patients may face.

Across all of Kaiser Permanente's eight regions, our electronic health record (known as KP HealthConnect) and associated patient tools include a portal that allows secure email with physicians and care team members, appointment booking, notification of lab results, prescription refill requests, mail-order medications, and patient education materials. These tools allow us to partner with our members in their own health, and monitor and prevent avoidable chronic disease progression. Kaiser Permanente offers patients a wide range of educational and support tools to promote member involvement in their own blood pressure control. These include classes in nutrition, smoking cessation, stress management, and chronic disease management skill-building; online resources such as videos, educational information, and interactive, tailored health questionnaires; and outreach through letters, secure e-mail, and phone contacts to remind patients to schedule appointments when their blood pressure is not at goal.

Kaiser Permanente's Mid-Atlantic Region (Maryland, Virginia, and District of Columbia) has improved hypertension control and hypertension control of patients with diabetes by deploying many of the same tools and techniques as those adopted in Northern California. The foundational principles for hypertension management include benchmarking, transparency, and reliability of clinical work flows. Workflow changes include taking and repeating blood pressure readings consistently at every primary care or specialty visit and following a protocol that includes same day referral or consultation for patients with an elevated blood pressure.

A number of approaches are used to support knowledge and skill development. Nurses and Medical Assistants must undergo an annual competency exam on blood pressure measurement and nurses must participate in motivational interview training. Physicians attend webinars, CME programs, and meetings that reinforce assertive BP management. Key peer-reviewed journal articles are shared with clinical teams.

"Academic detailing" is used to change clinician behavior by engaging the professional in a one-to-one discussion about a specific therapeutic topic or practice pattern. It is used to support a clinician who may have lower performance on clinical quality metrics to help him/her maximize use of tools and electronic support systems in practice.

Lessons Learned

- Involving physicians and staff at all levels and in all departments is a key factor in success:
    - Increases in awareness and buy-in
    - Improves interventions at the time of the visit
    - Greater patient volume screened
    - Members respond when multiple staff and departments address care gaps
    - Engage readiness to change assessment and motivational interviewing techniques
    - Support physician's approach to panel management
- Group appointment dynamics promoted and improved member behavior change

- Involving physician extenders (NP/pharmacist) for hard-to-reach members who hadn't benefited from care with traditional MD intervention shows results

Diabetes

A study of Kaiser Permanente members in California reported in *JAMA* in 2013 indicated that introduction of a shared electronic health record across our inpatient and outpatient settings enabled a decline in preventable emergency department visits and hospitalizations among patients with diabetes, and a modest associated decline in costs.[2] A similar study from Kaiser Permanente indicates that EHR use was associated with improved medication treatment rates of follow-up laboratory testing, and reductions in glycosylated hemoglobin and low-density lipoprotein levels.

Because a complete EHR system like the one in the study can be used in numerous ways to manage patients with diabetes, including many with multiple conditions, we believe that our finding of reduced ED visits and hospitalizations may represent not just improvements in diabetes care but also the cumulative effect of the EHR across many different care pathways and conditions. Also, our study found EHR-related improvement in care quality and outcomes without changes in office visit rates, which may reflect greater efficiency during visits or care delivery between visits.[3]

Kaiser Permanente has developed a program called ALL (aspirin, lisinopril, and lipid-lowering medication, as well as a beta blocker) which is informed by our own research showing this treatment reduces heart attacks and strokes in people with diabetes and heart disease. This initiative also highlights the importance of low cost generic medications in contributing to patient adherence and better outcomes. Kaiser Permanente published research in the Journal of General Internal Medicine[4] based on a large sample of our own members which indicated that it is necessary to control systolic blood pressure, low density lipoprotein cholesterol, and hemoglobin A1c in order to prevent adverse cardiovascular events and associated hospitalizations.

Osteoporosis

Our Southern California region's "healthy bones" program[5] is aimed at identifying members at risk of fractures and engaging our interdisciplinary teams in proactive care to screen for and prevent fractures. One-half of all women and one-third of all men will sustain a "fragility

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[2] Reed et al., Implementation of an Outpatient Electronic Health Record and Emergency Department Visits, Hospitalizations, and Office Visits Among Patients With Diabetes," *JAMA*, 2013;310(10):1060-1065. Available at: http://jama.jamanetwork.com/article.aspx?articleid=1737043&resultClick=3.

[3] See "In Preventing Diabetes-Related Heart Disease, Blood Pressure and Cholesterol Targets are Higher Priorities than Blood Sugar," Jan. 28, 2013. Available at: http://share.kaiserpermanente.org/article/in-preventing-diabetes-related-heart-disease-blood-pressure-and-cholesterol-targets-are-higher-priorities-than-blood-sugar/.

[4] Nichols et al., "Independent Contribution of A1c, Systolic Blood Pressure, and LDL Cholesterol Control to Risk of Cardiovascular Disease Hospitalizations in Type 2 Diabetes: An Observational Cohort Study," J Gen Int Med, May 2013. Available at: http://rd.springer.com/article/10.1007/s11606-012-2320-1.

[5] See Dell et al., "Osteoporosis Disease Management: The Role of the Orthopaedic Surgeon," J Bone Joint Surg Am, Nov. 2008. Available at: http://jbjs.org/content/90/Supplement_4/188.

fracture" in their lifetime. Osteoporosis is associated with high morbidity and mortality, as well as significant financial costs to Medicare. Our Southern California region set a clear goal of reducing hip fractures by 25 percent, and exceeded its goals and has spread its practice across Kaiser Permanente regions through the development of a clinical practice guideline to standardize the practice.

Lessons Learned

- Be a champion, set a specific goal, and identify high risk patients;
- Be proactive, make ordering scans and labs easy to do, make referrals to physical therapy and appropriate specialists;
- Engage patients through outreach, education, classes in fall prevention;
- Create discharge checklists for patients who sustain frailty fractures and arrange follow up prevention plan;
- Measure, measure, measure.

Complex Care Medical Home

Kaiser Permanente's Northwest region has pioneered a "complex care medical home" model that stratifies patients based on recent utilization, multiple chronic diseases, and risk factors identified in a Medicare total health assessment. An interdisciplinary care team collaborates with the patient to create a coordinated care plan. Many of these patients are eligible for care at home, and are supported in transitions of care and advanced care planning. Pharmacists, social workers, RNs, case managers, and care navigators all work together with primary care providers to carry out care plans. A care "bundle" has been developed to transition patients appropriately and safely from inpatient stays to other care settings. Members are identified for the complex care medical home because they have unmet needs, often are homebound, rely on a caregiver, need connections to community resources, and need conversations about their care goals. Compared to usual care, the patients in the complex care medical home have higher rates of advanced directives, care plans, total health assessments, and referrals to palliative care. Over time we will be measuring utilization measures such as ED visits and hospital admissions to evaluate the effectiveness of the complex care medical home.

Total Health Assessment Promotes Early Intervention

Kaiser Permanente's Colorado region has created PATHWAAY—Proactive Assessment of Total Health and Wellness to Add Active Years—which routinely screens Medicare members to identify risks for falls, urinary incontinence, malnutrition, pain, frailty, and mood disorders. Integrated with our electronic medical record, the survey responses trigger clinical workflows and interventions that are also captured for the member in a comprehensive prevention and care plan.

Outreach via the telephone and email allow us to work with member to fill out the assessment in advance of the office visit, and allows the care team to prepare the member and physician for the office visit by effectively beginning the visit by phone and targeting specific risk factors to discuss. The member is provided with appropriate referrals and follow up, and leaves the visit

with an after-visit summary and personal prevention plan. In a survey, Colorado members reported that the Total Health Assessment (KP's "health risk assessment) brought up issues for discussion and follow up with the physician and care team that the member might not have raised without the THA. The PATHWAAY program, already technology enabled, could be even more personalized with the addition of video to enhance the pre-visit preparation, post-visit follow up and monitoring, and perhaps even replace the office visit entirely at the member's request.