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House Committee on Energy and Commerce
Subcommittee on Health
Hearing on Examining Barriers to Expanding Innovative, Value-Based Care in Medicare
September 13, 2018

Thank you, Chairman Burgess, Ranking Member Greene, and members of the Subcommittee for the opportunity to speak to you today. I am speaking to you from the unique perspective of being both a physician who cares for Medicare patients and an entrepreneur challenging the status quo to actively deliver better care to patients. My testimony will focus on a new approach to incorporating innovation into the Medicare program that will both save taxpayers money and, most importantly, improve patient care. This is a model that provides a mechanism for Medicare to support value for the patient, their families and the system.

My story begins as a young attending Emergency Physician at Beth Israel Deaconess and Harvard Medical School who became frustrated that there was no mechanism – operationally or financially – to be with patients at their most vulnerable moments - the time of their emergencies. At this same time, telehealth was becoming more and more common as a way to help patients and physicians manage chronic conditions and members of this Subcommittee were forming work groups to champion telehealth policy. I thought – what if I could use technology in a different way - to be with patients at the time of their emergencies?

As I researched where the majority of emergencies happen, I found that 19 percent of transfers to the emergency department are from skilled nursing facilities (SNFs).[1] I then set out to develop an approach that paired emergency clinical skills with technology to scale a model that could replace 911 in nursing homes to treat Medicare's most vulnerable patient population: nursing home residents.

Many of us have experienced this issue first-hand with our loved ones and are not surprised by the statistics. The Centers for Medicare and Medicaid Services (CMS) states that 45 percent of hospital admissions from SNFs could have been avoided.[2] Further, approximately one in five patients admitted to a SNF are readmitted to a hospital within 30 days.[3] Because of this, nursing home residents are unnecessarily exposed to health risks such as falls, delirium, infections, adverse medication interactions, and post-hospital syndrome.[4][5]

To combat these issues, I founded and built Call9. Call9 turns this equation on its head to save lives that otherwise wouldn't be saved, improve care for patients who need it, and save millions for the healthcare system. By bringing the emergency room to the patient instead of the patient to the emergency room, Call9 is able to treat patients in place approximately 80 percent of the time. Anytime a patient has an acute change of condition, Call9 first responders – who are embedded 24/7 in the nursing home to complement the skills of existing nursing home staff – go to the bedside of the patient and connect via telehealth to our emergency physicians. The emergency

[1] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/Downloads/Report-To-Congress-September-2015.pdf

[2] https://innovation.cms.gov/initiatives/rahnfr/

[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5063303/

[4] http://www.medpac.gov/docs/default-source/reports/jun17_ch9.pdf?sfvrsn=0

[5] https://www.nejm.org/doi/full/10.1056/NEJMp1212324

physician then directs the care of the patient, which is delivered by the first responder and nursing home staff at the bedside of the patient. Our first responder and emergency physician then continue to monitor and care for the patient for days afterward until he or she returns to the baseline clinical state.

By replacing not only the emergency room visit, but also the subsequent hospitalization, Call9's data show that we are saving our commercial partners $8 million per 200 beds per year. I've included further data on our reduction in hospital transfers and patient quality in my written testimony.

Call9 currently operates in 10 nursing homes in New York state and partners with seven commercial payers; however, there is no way for Medicare to reimburse us for the care we deliver, which has severely limited our growth and ability to reach vulnerable patients – especially in rural areas. Call9 is lucky to have found investors who believe in the double bottom line – social good and profit – to invest in our model. To date, we have treated more than 3,500 Medicare Part B-enrolled patients at a financial loss to our company.

You may be asking – why didn't we go to CMS to secure reimbursement first? Unfortunately, Medicare only has two mechanisms under which to advance truly innovative models into the program – through a demonstration under the Centers for Medicare and Medicaid Innovation (CMMI) or through an act of Congress.

I fully support CMMI in their mission; however, it is constrained in both funding and flexibility. I'm sure a number of members of this Subcommittee have met with young entrepreneurs and we will likely all tell you the same thing – the success of any innovative company stems from the ability to fail fast, fail safely, learn from those failures, and correct the course. This mindset does not correlate to CMMI – who, rightly so – as stewards of taxpayer dollars, can only look at testing models that already have proven successes. While this works for some models, it cannot possibly work for all innovative models that could be beneficial for Medicare patients.

The alternate option for practitioners of truly innovative models is to work with you – Congress – to pass legislation to recognize new methods of care. Unfortunately, we all know that Congress does not move at the same pace as start-up funding timelines and many companies do not have the time nor resources to devote to passing legislation.

That is why we recommend Congress advance a third approach – Medicare value-based contracting. I could be asking you, like many others, to remove the current statutory restrictions (specifically 1834M) to reimbursement for telehealth under Medicare Part B. Many of my colleagues and members of this Subcommittee have fought for bills that would do just that, only to be met with unmanageable cost estimates from the Congressional Budget Office (CBO). While this is extremely frustrating to those of us who see the value of telehealth every day, it became clear to me that the problem wasn't telehealth, it is the reimbursement structure of Medicare Part B. There is a understandable case to be made that anytime you make it easier to access a service or add more services under a fee-for-service reimbursement structure, it will inherently cost more.

With this in mind, as members of the Health IT Now coalition we worked with forward-thinking staff from this Subcommittee, the Ways & Means Committee, and Representatives Griffith, Lujan, Smith, Black, and Crowley to craft legislation that would create a mechanism for CMS to enter into selective, voluntary value-based contracts with innovative physician groups, to be able to deliver care in new ways. The *Reducing Unnecessary Senior Hospitalization Act (RUSH) Act of 2018* was introduced on July 25, 2018 and would allow physician groups and the nursing homes they serve to contract with Medicare to use technology to reduce costly and harmful avoidable hospitalizations. If the program doesn't save money or quality metrics aren't met, CMS must end the program. If it does save money – and there are massive savings to be realized by avoidance of hospitalizations for this vulnerable population – the savings are shared with the physician group, nursing home, and Medicare. It aligns all incentives to deliver the best possible care to patients, all the while saving money.

As Jeff Lemieux, Chief Economist with Health IT Now, noted in his recent Health Affairs blog, Medicare's traditional approach to fee-for-service reimbursement has paid providers regardless of quality. CBO worries, as we all should, that if a new benefit is added and even low-quality providers are paid, Medicare's costs could expand quickly.[6] The solution is to reimburse for value, and Congress can create the mechanism for that solution.

Call9's motto is "do right by the patient and all else will fall into place," which is why we seek to enter into value-based arrangements with Medicare – it is right for the patient. I thank you for your attention and dedication to addressing the barriers that entrepreneurs, small businesses, health-care systems, nursing homes and others face in entering into these types of arrangements with Medicare and I look forward to answering your questions.

[6] https://www.healthaffairs.org/do/10.1377/hblog20180116.506486/full/

Addendum: Presentation on the *RUSH Act*

RUSH Act 2018

Reducing Unnecessary Senior Hospitalizations

THE PROBLEM

1.3 million patients suffer from transportation to the ED from nursing homes every year

Two-thirds of those ambulance trips are avoidable per CMS

$40 billion of unnecessary costs incurred by the healthcare system

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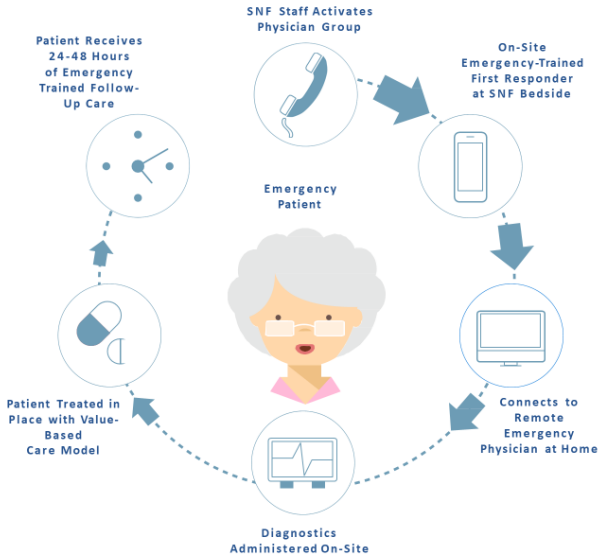
THE SOLUTION



BENEFIT TO STAKEHOLDERS:

Patients & Families
avoid harmful transfers and hospitalizations

CMS
share $15-30K of savings

SNFs
retain revenue, improve CMS five-star rating, share in savings

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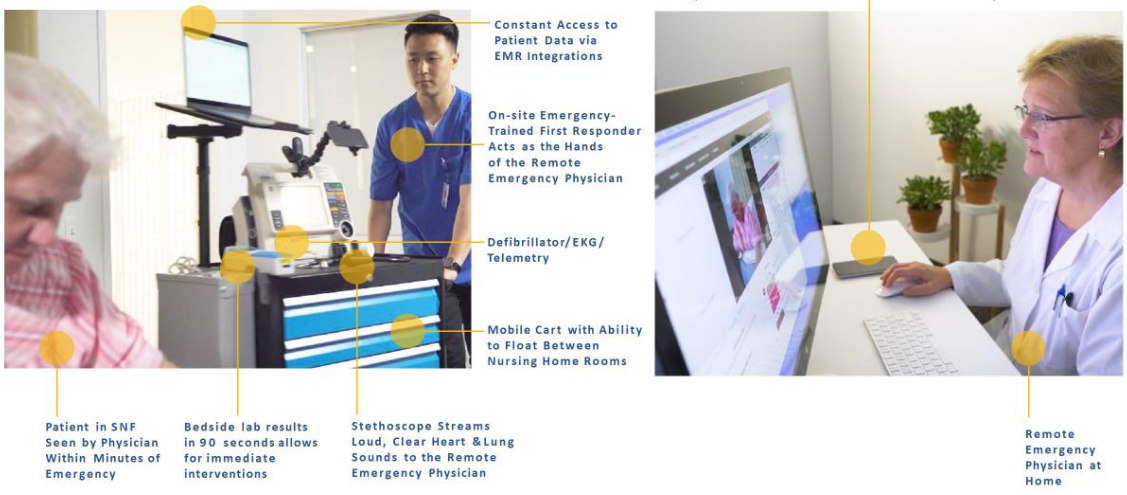
TECH-ENABLED BEDSIDE CARE DELIVERY



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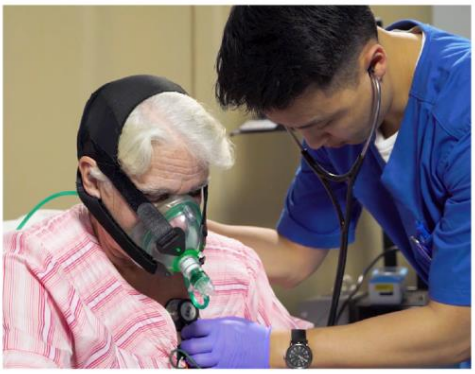
TECH-ENABLED EMERGENCY BEDSIDE CARE DELIVERY

On-Site Emergency First Responder, Employed by Physician Group, extends SNF staff bandwidth and skill set via:

- **Experience in emergency situations**
- **Delivery of IV fluids**
- **Delivery of breathing treatments**
- **Administration of point of care labs**
- **Operation of ultrasound technology**
- **Administration of breathing treatments**
- **Collection of intake forms to risk stratify patients**
- **Rounding on patients following acute events**



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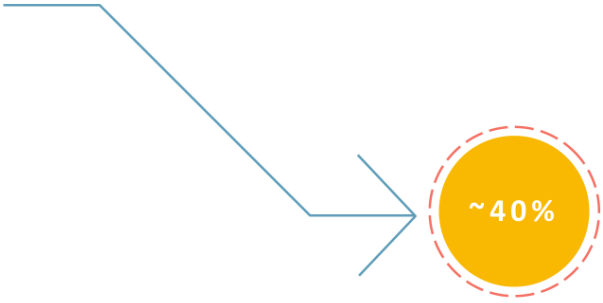
REDUCTION RATE

Data on 3,500+ Medicare patients has shown a **40%+ reduction of hospitalization transfers**



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RUSH ACT MODEL: 50 BED NURSING HOME

Present State:

11emergency events per month

Average cost: **$173,855**

Rush Act Model:

11emergency events per month

ED transfers avoided: **5**
Saving from avoided transfers: **$79,025**
Cost of physician group: **$15,390**
Total Savings: **$63,635**
Savings for Medicare: **$31,817**
Revenue for SNF: **$7,954**

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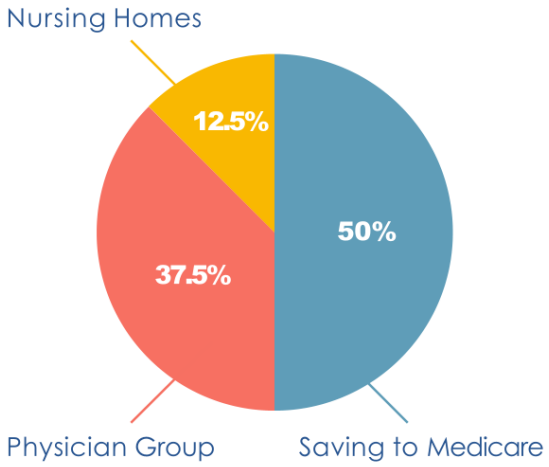
VALUE-BASED CARE

On-site first responder model has proven to deliver **$4M a year in savings per nursing home**. The RUSH Act will deliver massive savings to Medicare, while incentivizing 1) physician groups to deliver superior value-based care, and 2) SNFs to provide environments that attract patients that formerly lost them money.



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Thank You!