



## AMERICA'S ESSENTIAL HOSPITALS

January 26, 2016

The Honorable Orrin G. Hatch  
Chairman  
Committee on Finance  
United States Senate  
Washington, DC 20510

The Honorable Ron Wyden  
Ranking Member  
Committee on Finance  
United States Senate  
Washington, DC 20510

The Honorable Johnny Isakson  
Committee on Finance  
United States Senate  
Washington, DC 20510

The Honorable Mark R. Warner  
Committee on Finance  
United States Senate  
Washington, DC 20510

### **Ref: Bipartisan Chronic Care Working Group Policy Options Document**

Dear Chairman Hatch, Ranking Member Wyden, and Sens. Isakson and Warner:

America's Essential Hospitals welcomes the opportunity to contribute to the discussion on coordinating care and improving outcomes for Medicare beneficiaries with chronic health conditions. We appreciate the work of the Senate Committee on Finance chronic care working group toward identifying policies that will facilitate the provision of care for vulnerable beneficiaries with complex conditions. Essential hospitals are committed to providing high-quality care to their diverse patients, and we encourage the working group to consider the unique challenges that essential hospitals, with their limited financial resources, face in caring for these patients.

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. Our roughly 275 member hospitals provide access to high-quality health care for all patients and predominantly serve the uninsured and patients covered by public programs. Of the outpatient services our members provide, 21 percent are to Medicare beneficiaries, another 27 percent are to Medicaid recipients, and 24 percent are to uninsured patients.

Essential hospitals are leaders in managing chronic care for vulnerable populations. They treat more patients who are dually eligible for Medicare and Medicaid than the average hospital. These patients often have multiple comorbidities and chronic conditions and are among the most difficult to treat. Through their integrated health systems, essential hospitals offer comprehensive, coordinated care, including mental health services, substance abuse services, and wraparound services that vulnerable patients often need. Members of America's Essential Hospitals work

daily to improve care quality for chronically ill patients through a broad variety of initiatives—from reducing readmissions to preventing falls, blood stream infections, and other patient harm events. Essential hospitals also play a vital role in providing ambulatory care to their communities. They deliver ambulatory care services to schools and housing developments through mobile units, and many offer behavioral health support services, interpreters, and patient advocates for patients with complex medical and social needs. Our members provide care to these complex patients while operating on margins substantially lower than the rest of the hospital field—an aggregate operating margin of negative 3.2 percent, compared with positive 5.7 percent for all hospitals nationwide.<sup>1</sup>

We are encouraged that the working group is evaluating policy options tailored to the most vulnerable and clinically complex patients. Many of the policies under consideration by the working group would be positive steps that will remove barriers to the provider-patient relationship, such as by encouraging the use of supplemental services related to the social determinants of health or expanding the scope of Medicare-covered telehealth services. We urge the working group to turn this important work into legislation in the short term. Not only is there a need for comprehensive policy solutions to improve care for the chronically ill, there is an urgent need for public policy solutions for many of the issues the working group covered, for the good of all patients and the health care system as a whole.

In addition to the policy options put forth by the working group, we believe it is imperative that the working group place special emphasis on evaluating the needs of dual eligible beneficiaries and current deficiencies in care delivery for these patients. Due to distinct Medicare and Medicaid funding streams for dual-eligible beneficiaries and barriers to coordination between distinct coverage sources, dual eligible beneficiaries often face difficulty in receiving optimal care. More dual eligible patients suffer from chronic illness than other Medicare beneficiaries, and they also constitute a disproportionate share of Medicare spending.<sup>2</sup> As such, any discussion of coordination of care for chronically ill patients would be incomplete without particular focus on dual eligible beneficiaries.

It is true that advancements in Medicare policy often serve as signals to other payers, governmental or private, to follow the program's lead. To that end, we ask that the working group also look more broadly at policy options that can benefit all chronically ill beneficiaries, not just those under the care of providers in alternative payment models, such as an accountable care organization (ACO). Additional comments follow on specific content categories discussed in the policy document.

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<sup>1</sup> Reid K, Roberson B, Landry, C, Laycox S, Linson M. *Essential Hospitals Vital Data: Results of America's Essential Hospitals Annual Characteristics Survey, FY 2013*. America's Essential Hospitals. March 2015. <http://essentialhospitals.org/wp-content/uploads/2015/03/Essential-Hospitals-Vital-Data-2015.pdf>. Accessed January 12, 2016.

<sup>2</sup>Kasper J, O'Malley M, and Lyons B. *Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending*. Kaiser Commission on Medicaid and the Uninsured. July 2010. <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8081.pdf>. Accessed January 26, 2016.

## **Advancing Team-Based Care**

The working group presents policy options that it hopes will give providers incentives to use a team-based approach to treat patients with chronic conditions. The policies under consideration include expanding the scope of Medicare Advantage (MA) coverage by allowing end-stage renal disease beneficiaries to enroll in an MA plan and requiring MA plans to cover the hospice benefit. In addition, the working group is considering whether to reimburse for care management services and how to improve coverage for beneficiaries with behavioral health disorders.

Essential hospitals are actively developing initiatives that focus on patients with chronic conditions; therefore, we are pleased that the working group is moving in this direction. Essential hospitals, for example, provide lifesaving dialysis for diabetes patients, both in their hospitals and in designated chronic care dialysis centers. Often, they are the only source of this care in patients' communities. Further, these hospitals look for ways to expand their reach to manage the care of these patients, such as by providing home-based dialysis programs. One essential hospital in Florida developed an outreach initiative that connects patients with chronic health conditions to community-based medical homes, to provide care early and avoid unnecessary emergency department visits. Another essential hospital emphasizes the value of team-based care in a care transitions program that brings together a multidisciplinary team to reduce hospital admissions, emergency department visits, and costs. Policy changes that recognize these innovative approaches that often reach beyond a hospital's walls must play a key role in coordinating patients' health care.

We also appreciate that the working group recognizes the need for broader coverage of mental health and substance use disorder (MH/SUD) services. Members of America's Essential Hospitals understand the importance of these services and integrate MH/SUD services with primary care and other medical services. The working group points to the importance of integrating behavioral health and primary care to increase care coordination. Recognizing this, it should advance policy changes that will enable providers that offer a broad array of MH/SUD services to be appropriately reimbursed for these services.

**America's Essential Hospitals recognizes the value of team-based care as an important element for ensuring better patient outcomes, and we urge the working group to align Medicare payment policy with the broad scope of (often unreimbursed) services providers deliver to vulnerable beneficiaries.**

## **Expanding Innovation and Technology**

We support the working group's recommendation to increase the types of services that will be reimbursed when provided remotely as telehealth services. Currently, coverage of telehealth services is limited to a list of specified services and subject to geographical limitations on the telehealth patient's location (the "originating site") for the provider to receive Medicare reimbursement. The payment and policy landscape of telehealth continues to evolve, and recent legislative efforts in Congress

have focused on expanding the scope of reimbursable telehealth services.<sup>3</sup> In practice, there are a multitude of scenarios beyond those involving rural patients in which a patient might be unable to reach a hospital in time for needed care. This is particularly true of patients facing a lack of transportation and other barriers to mobility. For these patients, even if they live in urban areas, receiving a timely telehealth consultation or service from a physician can result in the early diagnosis of a life-threatening condition, such as stroke. **To this end, we support the working group’s recommendation to require Medicare reimbursement for certain stroke services regardless of originating site.** Furthermore, the working group's proposal to waive the originating site geographical restriction for other telehealth services provided by certain types of ACOs is a policy that will enable some providers to reach more patients in need of care at a time and place that works for the patient. To encourage providers to continue to provide coordinated care and reach the largest number of patients, we encourage the working group to study policies that will help bring Medicare policy in line with current provider practices.

**We encourage the working group to look beyond the ACO context for certain policies, such as lifting the geographical limitation on telehealth services.** While ACOs are a useful tool for some providers to coordinate patient care, the cost of participating in an ACO can be prohibitive for many providers. Some members of America’s Essential Hospitals are participating in alternative payment models, such as the Medicare Shared Savings Program, and have invested in becoming part of an ACO. However, while our members constantly look for ways to improve their organizations through technology upgrades, process redesign, care coordination, quality measurement, risk management, compliance, network development, governance, and legal restructuring, they often face challenges in finding the resources necessary to participate in an ACO.

In addition to their immediate implications for Medicare telehealth reimbursement and provider and patient access, policy changes will have downstream effects on other payers. As private payers and governmental agencies look to Medicare in determining what constitutes a patient-provider relationship, it will be important that Medicare not unreasonably restrict the scope of telehealth services.

**We also implore the working group to address the use of electronic health records (EHRs) in its work under the expanding innovation and technology category.** The use of EHRs plays a central role in managing patients’ care, and the working group should include ways to empower providers to use EHRs to engage patients in their health care and improve health outcomes. The vast majority of providers have implemented EHRs, but struggle with the regulatory requirements of the Medicare and Medicaid EHR Incentive Programs. While the ultimate goal of these programs is laudable, the constraints of Stage 2 and Stage 3 requirements often stand in the way of benefits to patients and their providers. We believe it will be of paramount importance to consider the role of the EHR Incentive Programs in

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<sup>3</sup>For example, this Congress has introduced a number of bills to broaden Medicare payment for telehealth (see, e.g., The TELEmedicine for MEDicare (TELE-MED) Act, S. 1778/H.R. 3081; Furthering Access to Stroke Telemedicine (FAST) Act, H.R. 2799; The Medicare Telehealth Parity Act of 2015, H.R.2948; Telehealth Enhancement Act of 2015, H.R.2066.

providing coordinated care to patients, and how to lift barriers to information exchange. The committee would be well-served to address current barriers in the EHR Incentive Programs, including the all-or-nothing construct and measures that impose unrealistically high thresholds that depend on patient action. **Health information technology (HIT) is a useful tool for coordinating and delivering high-quality care, and the working group should advance policy changes that will remove obstacles to HIT use.**

### **Identifying the Chronically Ill Population and Ways to Improve Quality**

The working group is considering requiring the Centers for Medicare & Medicaid Services (CMS) to develop quality measures focused on patients with chronic disease. In recommending that CMS develop additional measures, the working group should be cognizant of the current state of the quality measurement landscape, which includes a large number of measures across different quality reporting and pay-for-performance programs. **We believe any new measures should allow for increased transparency, accuracy, and consistency across the program. Furthermore, the working group should encourage CMS to eliminate duplicative reporting across programs and focus on a core set of relevant measures.** As highlighted by an Institute of Medicine panel—the Committee on Core Metrics for Better Health at Lower Cost—there is a need to reduce the burden of unnecessary and unproductive reporting by reducing the number, sharpening the focus, and improving the comparability of measures.<sup>4</sup> The committee set forth a measure set of “vital signs” for tracking progress toward improved health and health care in the United States. This measure set should emphasize the importance of streamlining measures to both promote greater alignment and harmonization and to reduce redundancies and inefficiencies in health system measurement.

Throughout the Policy Options Document, the working group recognizes the link between social factors and health, and we urge the committee to incorporate this linkage into quality measurement. **Risk adjustment for socioeconomic factors must be incorporated into any quality reporting framework underlying such payments to ensure that results are accurate and reflect patient population differences across hospitals.** Without proper risk adjustment, an essential hospital, serving a disproportionate share of low-income patients with confounding sociodemographic factors, will be unduly penalized for factors outside its control.

A growing body of literature shows that race, homelessness, cultural and linguistic barriers, low literacy, and other socioeconomic factors can skew performance on certain quality measures, such as those for readmissions. It is documented that patients who lack reliable support systems after discharge are more likely to be readmitted to a hospital or other institutional setting. These readmissions result from factors beyond the control of providers and health systems and do not reflect the quality of care provided. Hospitals should not be penalized for their readmission

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<sup>4</sup>Institute of Medicine Committee on Core Metrics for Better Health at Lower Cost. Blumenthal D, Malphrus E, McGinnis JM. Vital Signs: Core Metrics for Health and Health Care Progress. Washington, DC: The National Academies Press; 2015.

rates, especially given that high readmission rates are associated with lower mortality rates and good access to inpatient hospital care.

America's Essential Hospitals recognizes that risk adjustment is key for all payers and populations. The association strongly supports bipartisan bills that would require socioeconomic risk adjustment in the Medicare Hospital Readmissions Reduction Program, S. 688 and H.R. 1343, the Establishing Beneficiary Equity in the Hospital Readmission Program Act. These bills recognize the socioeconomic complexities of vulnerable populations when calculating quality measures to ensure that hospitals are assessed on the work they do, rather than on the patients they serve.

America's Essential Hospitals appreciates the opportunity to submit these comments, and we look forward to collaborating with the working group on policies that will improve care for chronically ill beneficiaries. If you have questions, please contact Director of Policy Erin O'Malley at [eomalley@essentialhospitals.org](mailto:eomalley@essentialhospitals.org) or 202-585-0127.

Sincerely,

/s/

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President and CEO