



**American Hospital  
Association.**

800 10th Street, NW  
Two CityCenter, Suite 400  
Washington, DC 20001-4956  
(202) 638-1100 Phone  
[www.aha.org](http://www.aha.org)

June 22, 2015

The Honorable Orrin Hatch  
Chairman  
Senate Finance Committee

The Honorable Ron Wyden  
Ranking Member  
Senate Finance Committee

The Honorable Johnny Isakson  
Co-chair  
Chronic Care Working Group

The Honorable Mark R. Warner  
Co-chair  
Chronic Care Working Group

Dear Chairman Hatch and Senators Wyden, Isakson and Warner:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and 43,000 individual members, the American Hospital Association (AHA) is pleased to provide feedback on ways to improve the provision of care for Medicare beneficiaries with chronic conditions. We applaud the creation of a bipartisan Senate Committee on Finance chronic care working group to examine opportunities to improve care for this vulnerable population.

Providing high quality, coordinated and cost efficient care for Medicare beneficiaries with multiple chronic conditions is a significant challenge facing the Medicare program. More than two-thirds of Medicare beneficiaries have at least two or more chronic conditions, which correspond to increased Medicare utilization and expenditures. Care that is coordinated across settings and over time is particularly important for patients with chronic conditions; however, the Medicare payment structure historically has not incentivized providers to coordinate care. This has led to a fragmented care system. In addition, regulatory barriers discourage health care providers from working together to improve patient care and prevent Medicare beneficiaries and providers from fully realizing the benefits offered by telehealth technologies.

The AHA applauds you and the other members of the Finance Committee chronic care working group for recognizing the need to tackle this significant and challenging issue. We look forward to working closely with the working group as it continues its deliberations. Our comments below address principles we urge members of the working group to consider as it develops proposals in this area. These principles include expanding access to telehealth, removing barriers to clinical integration, and better engaging Medicare beneficiaries.

## **EXPAND ACCESS TO TELEHEALTH FOR MEDICARE BENEFICIARIES**

Telehealth is vital to our health care delivery system, enabling health care providers to connect with patients and consulting practitioners across vast distances. Hospitals are embracing the use of telehealth technologies because they offer benefits such as virtual consultations with distant specialists, the ability to perform high-tech monitoring without requiring patients to leave their homes, and less expensive and more convenient care options for patients.

However, significant barriers to the expansion of telehealth exist, limiting its use and potential. Coverage and payment for telehealth services remains a major obstacle for providers seeking to improve patient care. Medicare, in particular, lags far behind other payers due to its restrictive statutes and regulations. Though the Medicare telehealth benefit was originally created to increase access to care in rural areas, telehealth technologies increasingly are useful regardless of geographic location – for example, to fill gaps in subspecialist care. Further, telehealth allows a patient to connect with a primary care physician or health system on a more flexible basis and often without an in-person visit.

Given the growing body of evidence that telehealth increases quality, improves patient satisfaction and reduces cost, we urge Congress to adopt a global approach to expanding Medicare coverage of telehealth. To modernize Medicare coverage and payment for telehealth, any legislative proposal should:

- **Eliminate geographic location and practice setting “originating site” requirements.** By statute, Medicare covers telehealth only for beneficiaries receiving services at an originating site listed in law, such as a hospital, skilled nursing facility or physician office. In addition, the originating site must be located in a rural area. As our nation’s telecommunications systems continue to improve, it is becoming increasingly possible to provide care safely to patients in other settings, including, potentially, the office, school or home. Further, while Medicare beneficiaries in rural areas may not have easy access to primary care or specialist services, patients in urban areas also face challenges due to physician shortages.
- **Expand the basis of covered services.** CMS approves new telehealth services on a case-by-case basis, with the result that Medicare pays for only 75 services when they are delivered via telehealth. This process should be changed so that Medicare-covered services are covered when delivered via telehealth, unless CMS determines on a case-by-case basis that such coverage is inappropriate.
- **Include services provided via store-and-forward technologies and remote patient monitoring as covered services.** Medicare covers telehealth services only when they are provided using an interactive audio and video telecommunications system that permits real-time communication between the practitioner, at the distant site, and the beneficiary, at the originating site. In contrast, store-and-forward technologies provide access to patient data – such as digital images, documents and pre-recorded videos – after they have been collected, and they are particularly beneficial to patients requiring specialty

care when providers are not otherwise available locally. Remote patient monitoring involves collection of a patient's personal health and medical data via electronic communication technologies. Once collected, the data are transmitted to a health care provider at a different location. This allows the provider to continue tracking the patient's data once the patient has been released to his or her home or another care facility.

### **REMOVE LEGAL BARRIERS TO INTEGRATED RELATIONSHIPS THAT FOSTER BETTER COORDINATED CARE**

As the health care field explores new payment and delivery system models that emphasize value over volume, hospitals are actively exploring clinical integration – a move away from working in silos and toward emphasizing teamwork to coordinate care. However, hospitals attempting to work with physicians and other health care professionals within and across sites of care to achieve such care coordination face significant legal barriers. Chief among these are outdated rules governing relationships between hospitals, physicians and other caregivers – portions of the Anti-kickback Statute and the Ethics in Patient Referral Act (also known as the “Stark law”). **The AHA recommends two specific changes to these laws that would enhance hospitals' ability to improve health and health care: creating an anti-kickback safe harbor for clinical integration programs, and refocusing the Stark law on its original intent.**

The anti-kickback law's main purpose is to protect patients and federal health programs from fraud and abuse. The law states that anyone who knowingly and willfully receives or pays anything of value to influence the referral of federal health program business, including Medicare and Medicaid, can be held accountable for a felony. However, the law has been stretched to cover any financial relationship between hospitals and doctors. For example, if a hospital rewards a physician for following evidence-based clinical protocols, the reward could be construed as violating the anti-kickback law, since such a reward could influence a physician's order for treatment or services. In acknowledgement that there are cases where the anti-kickback statute thwarts good medical practices, Congress has periodically created “safe harbors” to protect those practices. Consequently, Congress should create a safe harbor for clinical integration programs. The safe harbor should allow all types of hospitals to participate, establish core requirements to ensure the program's protection from anti-kickback charges, and allow flexibility in meeting those requirements so the programs can achieve their health goals.

The Stark law was originally enacted to ban physicians from referring patients to facilities in which they have a financial interest (known as self-referral). However, a tight web of regulations and other prohibitions that have grown around the law can now prevent arrangements that encourage hospitals and physicians to work together to improve patient care. Specifically, the law prohibits hospitals from making payments to physicians that are tied to achievements in quality and efficiency – rather, payments must be for hours worked only. For example, if a hospital pays a physician to help patients manage their diabetes according to a well-designed medical protocol, both the hospital and physician risk being in violation of the Stark law. Congress should return the Stark law to its original focus of regulating self-referral to physician-owned entities by removing compensation arrangements from the definition of “financial relationships” subject to the law.

## **PROVIDE ADEQUATE SUPPORT FOR DELIVERY SYSTEM REFORM EFFORTS TO BETTER COORDINATE CARE**

These reforms include forming accountable care organizations (ACOs), bundling services and payments for episodes of care, developing new incentives to better manage chronic conditions and care transitions, and testing payment alternatives for vulnerable populations. These initiatives show promise for the development of a more streamlined and coordinated system of care for Medicare beneficiaries, including those with chronic conditions. However, they require a significant up-front investment from participating providers, who must build the necessary infrastructure to engage in the resource-intensive activities – such as care management and data analytics – required to truly transform the delivery system. **While we support the aggressive evaluation and expansion of delivery reform models that have demonstrated success in reducing expenditures while enhancing the quality of care, it is critical that payment models recognize and adequately compensate providers for the time and resources invested in coordinating patient care. Further, payers, including Medicare, must ensure predictability and stability in payments while hospitals build the infrastructure necessary to redesign care.**

For example, our member hospitals and health systems have embraced the Medicare Shared Savings Program (MSSP) as one pathway to advance their ongoing efforts to transform care delivery. However, as currently designed, the MSSP places too much risk and burden on providers, with too little opportunity for reward in the form of shared savings. Though the Centers for Medicare & Medicaid Services (CMS) recently finalized technical changes that will improve the MSSP, we question whether these changes go far enough to make the program attractive to new applicants and existing ACOs. Instead, we urge structural modifications, such as altering the shared savings formula to allow providers to achieve a larger bonus or using quality performance to result in bonus payments, rather than resulting only in penalties, as is currently structured. Doing so could encourage additional providers – including small providers or those serving rural populations – to make the significant capital and upfront investments in their care coordination infrastructure required to be successful in the MSSP.

In addition, given the link between poverty and a high incidence of chronic conditions, we strongly urge Congress to incorporate socioeconomic adjustment into the Hospital Readmissions Reduction Program (HRRP) and other quality measurement programs so that hospitals caring for our nation's most vulnerable patients are not unfairly penalized. For example, since the HRRP's beginning, hospitals caring for the poorest patients have been significantly more likely to receive penalties. In fiscal year (FY) 2015, nearly 85 percent of hospitals in the highest quartile of disproportionate patient percentage (DPP) received a penalty, compared to 61 percent in the lowest DPP quartile (higher DPP quartiles indicate a poorer patient population). This is because the current HRRP fails to recognize that community factors outside the control of the hospital – such as the availability of primary care, mental health services, physical therapy, easy access to medications and appropriate food, and other rehabilitative services – significantly influence the likelihood of a patient's health improving after discharge from the hospital or whether a readmission may be necessary. These community issues are reflected in readily available proxy

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data on socioeconomic status, such as Census-derived data on income and education level, and claims-derived data on the proportion of patients dually eligible for Medicare and Medicaid.

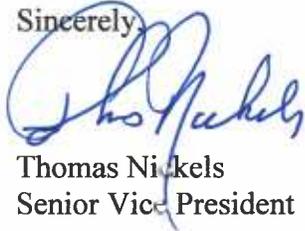
#### **PROMOTE ENGAGEMENT OF MEDICARE BENEFICIARIES IN THEIR HEALTH AND HEALTH CARE**

In addition to realigning provider incentives to better encourage coordinated care, it is important to identify and adopt strategies to engage Medicare beneficiaries in their own health and health care. One strategy could be to reward individuals who work to maintain or improve their health – such as receiving recommended screenings, immunizations and preventive services on a regular and timely basis; participating in disease, drug, or self-management programs (i.e., smoking cessation, diabetes management, weight reduction); or complying with individual care plans. Rewards could include varying Medicare co-payments and deductibles, or providing direct financial rewards such as tax credits or bonus payments.

In addition, the federal government could play a role in providing the public with easy-to-understand, accessible, and comprehensive information to better understand how to improve and maintain their health. For example, it could fund a “go-to” website for consumer-friendly information on physical, mental, and oral health, with free, basic information and fact sheets on both healthy and unhealthy behaviors related to issues such as nutrition, physical activity, tobacco and substance abuse, sleep and stress. Such information also should include educational tools for patients and families on chronic disease prevention and management.

Thank you again for considering our comments. We look forward to continued discussions on this important topic. If you have any questions or need further information, please contact Melissa Jackson at 202-626-2356 or [mjackson@aha.org](mailto:mjackson@aha.org).

Sincerely,

A handwritten signature in blue ink, appearing to read "Thomas Nickels". The signature is fluid and cursive, with the first name being the most prominent.

Thomas Nickels  
Senior Vice President