



**CALIFORNIA
HOSPITAL
ASSOCIATION**

*Providing Leadership in
Health Policy and Advocacy*

January 29, 2016

The Honorable Orrin G. Hatch
Chairman
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Johnny Isakson
Co-chair
Chronic Care Working Group

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

Subject: Bipartisan Chronic Care Working Group Policy Options Document, December 2015

Dear Chairman Hatch, Ranking Member Wyden, and Senators Isakson and Warner:

On behalf the California Hospital Association and our more than 400 hospital and post-acute care members, we are pleased to submit comments on the bipartisan Chronic Care Working Group's policy options document released in December. We wish to thank you for your leadership, dedication and prioritization of this important policy work over the last year. CHA is pleased to respond to the working group's request for input and looks forward to providing additional information to the committee as its deliberations continue.

The California Experience and Perspective

The prevalence and burden of multiple chronic conditions on our health care delivery system are of increasing concern to hospitals and our community partners. As you may know, California is currently home to the largest population of seniors in the country. In 2013, 4.8 million Californians — nearly 13 percent of the state's population — were age 65 or older. Due to the aging of the baby boomer generation and gains in life expectancy, California's senior population is projected to more than double to over 10 million people in 2040. This unprecedented growth will have a significant impact on the state's health care costs, as seniors use health care services at much higher rates than those under age 65.

The growing aging population in California's rural communities is particularly challenged, as seniors are faced with having to travel long distances for care, further impacted by seasonal weather conditions and a diminishing number of providers willing to serve the needs of this aging population in remote areas of the state.

An aging population is more likely to suffer from chronic disease, corresponding to a higher demand for health care services. Today, nearly 40 percent of California adults have one or more chronic diseases, and prevalence is increasing — from 34.9 percent in 2005ⁱ to 39 percent in 2014ⁱⁱ. About one in four California adults have high blood pressure. Fewer than one in 10 adults report having either asthma (8 percent), diabetes (8 percent), heart disease (6 percent) or serious psychological distress (8 percent) — but these percentages represent millions of Californians.

Delaying needed medical care can pose serious health consequences, especially for those with chronic medical conditions. California adults with serious psychological distress were more likely to report that

they delayed getting necessary medical care than those with other chronic conditions. Cost or lack of insurance was frequently cited as the reason for the delay. Given that the prevalence of serious psychological distress was nearly 1.5 times greater among those with Medi-Cal (the state's Medicaid program) than the uninsured, and more than twice as high as those with private insurance and Medicare, it is highly disconcerting that nearly one in five adults with serious psychological distress had no regular source of care.

Given these statistics, it is not surprising that an estimated \$98 billion is currently spent on treating chronic conditions in California. The average annual health care costs for a person with a chronic disease are approximately \$5,700 higher than those for a person without oneⁱⁱⁱ.

In addition to the aging population and prevalence of chronic disease, California's overall acuity has increased steadily over the last several years, as illustrated by its average case mix index. As Medicare and other payers move care to the outpatient arena, the sickest patients are admitted to the hospital. In addition, sicker hospitalized patients are also more likely to require post-acute services and coordination between multiple providers. The sicker a person, the more expensive their treatment.

Patients with chronic medical conditions have complex medical and behavioral health needs. In light of the significant burden of chronic conditions in California, hospitals and health systems are leading the way in transforming our health care delivery system to ensure integrated care delivery that promotes high-quality care and reduces unnecessary readmissions, which are often a result of poor management of multiple chronic conditions. California's hospitals have risen to the challenge of the Affordable Care Act and are committed to achieving the goals of the Triple Aim. We have looked beyond our walls and deeper into our communities to identify ways to further collaborate with our partners to identify and meet the needs of our patients and communities with an increased focus on population health.

We appreciate the committee's consideration of a number of policy options outlined in the working paper and its goals of increasing care coordination, streamlining Medicare payments to incentivize quality, and to reduce program spending. CHA shares these goals and offers the following specific comments for the committee's consideration. Due to time constraints and multiple competing policy priorities, we welcome the opportunity to expand on these comments at a later date following additional dialogue with our member hospitals and health systems.

Expanding Telehealth Services

A growing body of evidence indicates that telehealth, in particular, increases quality, improves patient satisfaction and reduces cost. However, significant barriers to telehealth expansion limit its use and potential. **At the federal level, comprehensive changes to the telehealth statute — such as eliminating the geographic location and practice setting “originating site” requirements, and removing restrictions on covered services and technologies (including store-and-forward technology and remote patient monitoring) — are needed to realize fully the promise of telehealth for Medicare beneficiaries.** These changes will lay the ground work for additional changes needed at the state level to promote and expand telehealth services.

CHA also encourages the working group to consider a cost-benefit analysis of telehealth. Although evidence of the quality and access benefits of telehealth continues to grow, there are insufficient studies on the cost-benefits of telehealth outside of certain services, such as telestroke. More and better research is needed for other conditions and newer technologies, such as remote monitoring of patients. Such research would help policymakers considering a broader expansion of telehealth benefits, providers considering adoption of telehealth to provide services, and Medicare beneficiaries considering whether to access services via telehealth.

Improving Care Management Services for Individuals with Multiple Chronic Conditions

The chronic care working group is considering establishing a new high-severity chronic care management code that clinicians could bill under the physician fee schedule. A new code would reimburse clinicians for coordinating care outside of a face-to-face encounter for Medicare's most complex beneficiaries living with multiple chronic conditions. The working group has solicited feedback on the patient criteria for this potential code, the types of providers who should be eligible to bill the code, methodologies to measure impact, and how the code should be implemented.

Overall, CHA supports Medicare payments to support care management for patients with multiple chronic conditions. Evidence shows the growing importance of clinicians — as well as other care givers, including social workers and case managers — in patient care across the continuum. While the working group raises a number of important questions about implementation, CHA is concerned about the level of specificity considered by the committee as part of their legislative framework. We believe the questions posed may be too narrow.

Rather, with the proliferation of alternative payment models, we believe the committee should set forward a framework of guiding principles that would give the Secretary of the Department of Health and Human Services discretion in developing the appropriate architecture for a payment flexible enough to be adopted in a number of payment models – from fee-for-service to other alternative payment models. While patient criteria are a critical component in such a framework, inflexibility may make it too prohibitive. Instead of a focus on the particular patient condition, we suggest the working group focus on alternative metrics such as time spent with the patient or the level of acuity of the patient. Further, we believe the working group should provide maximum flexibility for clinician eligibility to receive payment. In a patient-centered, team-based approach to providing chronic care management, a number of clinicians play a critical role in care management across the full continuum.

Addressing the Need for Behavioral Health Among Chronically Ill Beneficiaries

We appreciate the committee's acknowledgement of and continued work in addressing behavioral health as part of this important policy work, and we encourage additional dialogue on the matter. The working group is considering policies to improve the integration of care for individuals with a chronic disease combined with a behavioral health disorder. Policies would encourage care integration whether the beneficiary elects enrollment in traditional Medicare fee-for-service, a Medicare fee-for-service alternative payment model or a Medicare Advantage plan. As noted above, nearly one in five California adults with serious psychological distress had no regular source of care. These policies must be addressed in a comprehensive way.

CHA supports the working group's recommendation that the Government Accountability Office conduct a study on the current status of the integration of behavioral health and primary care among private sector accountable care organizations (ACOs), public sector ACOs and ACOs participating in the Medicare Shared Savings Program, as well as private and public sector medical homes. Additional information on this topic area will only improve understanding and help to illuminate best practices in the field. In addition, we believe the results of the Medicaid Institutions for Mental Disease (IMD) demonstration, currently operating in California, will show the growing need for removal of the IMD exclusion. We urge the committee's consideration of that important policy, which would improve access to care. We also encourage the working group to consider removal of the Medicare 190-day lifetime limit on inpatient psychiatric care, which disproportionately disadvantages chronically ill beneficiaries.

Meet the Needs of Chronically Ill Medicare Advantage Enrollees

The working group has solicited input on a number of important issues in addressing chronically ill Medicare Advantage enrollees. CHA generally supports innovation in plan design and payment models in

Medicare Advantage. Additional plan benefits and incentives for care coordination and disease management are important components in managing the chronically ill population. However, we believe that any changes should be tested and evaluated before being scaled nationally. Our experience implementing the duals demonstration in California has been mixed, suggesting that while the intent of many policies is to improve care coordination and efficiency, this is very difficult to achieve in practice. Unfortunately, without appropriate oversight, adequate payment and a robust provider and patient appeals process, these programs fall short of meeting their intended goals.

CHA urges CMS to fully consider the forthcoming evaluations of the state's dual eligible demonstrations in informing future changes to Medicare Advantage for chronically ill enrollees. We believe the experience of the demonstration should inform the policy discussion on this topic moving forward.

We appreciate the opportunity to share our initial thinking with the working group, and look forward to future dialogue on important policy areas worthy of further deliberation. If you have any questions, please do not hesitate to contact me at aorourke@calhospital.org or (202) 488-4494.

Sincerely,

Anne O'Rourke
Senior Vice President Federal Relations

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- i California HealthCare Foundation, (2010). Chronic Conditions of Californians, 2005 California Health Interview Survey and Discharge Data.
 - ii Brown, Paul M. Health Sciences Research Institute, UC Merced, *Cost of Chronic Disease in California*.
 - iii Brown, Paul M. Health Sciences Research Institute, UC Merced, *Cost of Chronic Disease in California*.
 - iv California Healthcare Foundation, (2006). Chronic Diseases in California: Facts and Figures, Average excess annual medical cost of an individual with heart disease, diabetes, hypertension, or chronic obstructive pulmonary disease/asthma was estimated approximately \$4,200 in 2002, which translates to approximately \$5,700 in 2010 dollars using a medical inflation rate of 4 percent.