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President and CEO

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The Honorable Orrin Hatch
Chairman, Senate Finance Committee
Washington, DC 20510

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

The Honorable Johnny Isakson
United States Senate
Washington, DC 20510

The Honorable Mark Warner
United States Senate
Washington, DC 20510

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

On behalf of the Federation of the American Hospitals and our more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States, we are delighted to provide our comments on ways to address chronic care. The FAH applauds the Senate Finance Committee for your attention to this critical important issue, and we look forward to working with you as your work proceeds.

Summary

Medicare beneficiaries with multiple chronic conditions are a growing population that have been gaining increasing attention from policymakers over the last decade due to their disproportionately high levels of health care needs and related spending on health care services. They represent an area of the health care system with great potential for improvements in the efficiency of health care delivery, as well as for the quality of services provided.

Both Congress and the Centers for Medicare & Medicaid Services (CMS) seek opportunities to improve the coordination of care for chronically ill beneficiaries through a range of policy reforms within the existing Medicare fee-for-service and managed care programs, as well as through alternative payment models (APMs). In support of these efforts, the Federal government will need to provide broader access to and use of data for quality improvement initiatives, develop payment systems that adequately cover the cost of infrastructure development and patient care management, and increase the flexibility of providers to deliver services,

whether through telehealth or through more fluid transition of Medicare beneficiaries across settings, particularly post-acute care settings, in the manner that is most clinically appropriate and efficient for this population.

Since the introduction of diagnosis-related groups (DRGs) by the Medicare program in inpatient hospitals over 30 years ago, CMS has spent a generation developing, implementing, and refining prospective payment systems for all Medicare-covered services. As a new generation of APMs are tested, many of which focus on patients with multiple chronic conditions, it is important to recognize that these initiatives will require sufficient time, broad-based experience, and significant investment by both the public and private sectors in order to succeed. If APMs are carefully developed and nurtured, longer term savings can be enhanced.

1) Improvements to Medicare Advantage for patients living with multiple chronic conditions

As the Medicare Advantage (MA) program currently represents approximately one-third of all Medicare beneficiaries, there are a number of policies that CMS could consider in order to improve care for chronic conditions. Most importantly, CMS could consider how collection and analysis of encounter data could directly impact care and outcomes for patients living with multiple chronic conditions, without unduly burdening providers of that care. Currently, encounter data is used by MA plans substantially for payment purposes, *i.e.*, plans submit the data to CMS to support risk adjustment scores to improve payment. Often, subsequent to the periodic release of the encounter data, MA plans make burdensome requests of providers' for comprehensive medical records. This has resulted in some abusive practices where plans request that providers submit within a couple of weeks many thousands of paper and electronic medical records. This type of burden increases system-wide costs and is for payment purposes only and bears, at best, a distant relationship to care and outcomes improvement.

Alternatively, existing encounter data could be considered for use in improving quality and process of care for the chronically ill, within certain guidelines:

- CMS should work with providers and other stakeholders at the front-end in developing methods for collecting and using encounter data in a manner that can assist in improving care for the chronically ill;
- The scope and secondary impact of data collection should be subject to a cost-benefit analysis which should include secondary effects on providers. Otherwise, excessive data requests could impose too great of a burden on providers without any corresponding benefit for improving care for the chronically ill, and increase administrative costs for the MA program overall, MA plans and providers.
- To promote transparency and usefulness of the data provided, while avoiding excessive data requests, MA plans should be required to furnish providers with documentation on the scope of the data request from CMS to clearly distinguish data requests required by CMS from those made by the MA plan.

CMS also could support the development and adoption of quality measures—recognized by a consensus-based multi-stakeholder entity (such as the National Quality Forum)—that relate to the provision of care coordination activities for beneficiaries with chronic illnesses. Examples of these types of quality measures could include the use of care transition coaches for beneficiaries to transfer between acute, post-acute, and community-based settings, as well as follow-up physician appointments, medication reconciliation, and adverse drug events.

In addition, CMS could commission a comprehensive environmental scan and qualitative assessment of the clinical interventions and other processes MA plans use to manage beneficiaries with chronic illnesses (including the investments required to develop the necessary care coordination infrastructure, and variable costs associated with staff, data analysis, and other aspects of care management). There are a variety of issues where little is known about MA plan behavior that would need to be explored in such an environmental scan, including (but not limited to):

- How to determine who the stakeholders are in the MA program;
- What role third-party companies, such as patient navigation contractors, play in the MA program and how they will be assessed;
- How to determine what the baseline is for current types and levels of care coordination provided by, or contracted out by, MA plans; and
- How MA plans use PAC settings, such as when a specific PAC setting is used for a particular type of patient.

Across the commercial insurance industry, health plans have increasingly implemented “narrow networks” in recent years in order to limit the number of providers with whom they contract. Medicare beneficiaries with multiple chronic conditions, who may require care from a variety of different physician specialties and other types of specialized providers, are particularly vulnerable to narrow networks that may not include the combination of providers necessary to treat their illnesses. To the extent MA plans are also implementing narrow networks, Congress should protect chronically ill beneficiaries and ensure that they are able to access and choose the providers and health care services they need.

Prior to enacting any major reforms to the MA program, with respect to managing patients with multiple chronic illnesses, Congress should proceed with caution and allow for current reform initiatives—such as the financial alignment demonstration for dual eligibles—to produce results and lessons learned that can be applied to future programs. The literature on Special Needs Plans (SNPs), which are a specific type of MA plan developed recently to improve care coordination for dual eligibles and other Medicare beneficiaries with chronic illnesses and/or functional limitations, should also be reviewed to inform any new policies made in this area.

2) Transformative policies that improve outcomes for patients living with chronic diseases either through modifications to the current Medicare Shared Savings ACO Program, piloted alternate payment models (APMs) currently underway at CMS, or by proposing new APM structures

Under the Medicare program, there are many APMs in various stages of implementation, operation, testing, and evaluation. These APMs, from the Medicare Shared Savings Program (MSSP) to the Bundled Payments for Care Improvement (BPCI) initiative, share many of the same goals, reflect many of the same incentives, and are being pursued by many of the same providers across the country. To better understand the relationship between APMs and Medicare beneficiaries with multiple chronic illnesses, Congress should first request information from CMS on how the various payment demonstrations, reform initiatives, and delivery models have affected access to services, health care spending, and patient outcomes for this population.

In considering modifications to any current initiatives or the establishment of new APMs, both Congress and CMS need to recognize that unintended consequences could follow if certain aspects of payment and delivery reform are not properly addressed, such as:

- *Provider investment and payment adequacy.* APMs need to cover the investment in infrastructure necessary for providers to coordinate and manage care for beneficiaries with chronic illnesses (e.g., clinical staff, case managers, upgrades in health information technology and exchange), while at the same time providing some level of predictability and certainty in prices and payments. Medicare beneficiaries with chronic conditions have an expectation that hospitals will continue to provide them with access to a broad range of services, and hospital investment in new infrastructure as well as the rehabilitation of aging infrastructure will be necessary in order for hospitals to continue serving the community adequately.
- *Transition period.* Transformative policies should be adopted incrementally, beginning with voluntary participation and broadening as more providers gain experience with managing financial risk and patient care across the continuum. The transition must be measured and orderly so that the marketplace can adjust to the new incentives of value-based purchasing and a culture oriented more towards social and community services and population health. The financial viability of providers participating in APMs needs to be protected through this transition in order to maintain beneficiary access to necessary care.
- *Flexibility.* APMs should continue to offer providers the flexibility to choose different levels of risk-taking—in terms of the types of patients and services at financial risk, the length of time over which care is delivered, and the amount of financial risk—in order to promote broad participation. In addition, CMS should also permit the testing of different options for prospective payment under APMs, such as for post-acute care services under Model 3 of the BPCI initiative. Under current prospective payment systems, certain post-acute care services—even when they are clinically appropriate and necessary—may trigger higher payments and therefore be discouraged under current regulations and use of retrospective reconciliation. The testing of new prospective APMs would produce very useful information about the use of different post-acute care services for beneficiaries

with multiple chronic conditions that might not otherwise be tested under a retrospective model, driven entirely by individual post-acute care prospective payment systems.

In addition, new APMs could provide greater incentives to better integrate providers into health systems, such as the integration of hospital care with medical and social services delivered in the community, in order to support more comprehensive population health initiatives. The relationship between hospitals and the community is changing in many ways as reform initiatives continue to roll out, but some hospital roles in the overall health care system—for example, forming a major component of the country’s emergency preparedness network and the provision of quaternary care—are necessary and need to be protected under APMs.

One model that holds promise and warrants special consideration is contained in S. 1932, The “Better Care, Lower Cost Act,” which was introduced in the Senate on January 15, 2014 by Senators Ron Wyden (D-OR) and Johnny Isakson (R-GA). “Better Care Programs” (BCPs), are enrollment-based, capitated programs intended to provide a full spectrum of care coordination limited to beneficiaries with chronic conditions. The bill establishes a BCP as another new and creative alternative model within Medicare. Hospitals have much to contribute to the potential success of the program and we believe the bill would benefit by including hospitals as a specified provider eligible to form and be certified as a qualified BCP. This recognition would properly acknowledge the vital role that hospitals and health systems play in serving the population health needs of communities. This recognition would properly acknowledge the vital role that hospitals and health systems play in serving the population health needs of communities.

There are many examples of hospital systems moving to transform health care delivery, with proven experience in all facets of what would make a BCP successful, for example: building care networks that provide and coordinate a continuum of care across medical and social services; managing risk; investing in infrastructure, including interoperable electronic health records and information technology; and, exceeding established quality performance standards. It seems logical, therefore, that the bill would recognize these successes and specifically invite hospitals to meet the challenge of chronic care management.

Regardless of the approach to chronic care management, there needs to be a level playing field for hospitals. Hospital systems have much to offer in terms of capital, post-acute care coordination (*e.g.*, nurse navigators, care managers), electronic medical records, outpatient rehabilitation therapies, diagnostic testing facilities, long-standing quality reporting and improvement initiatives, data analysis capabilities and comprehensive financial metrics. These unique clinical, functional and organizational strengths position hospitals to bring providers together and connect with the community in new payment and delivery arrangements that help ensure the best outcomes for patients and the Medicare program.

As Congress weighs new policy reform proposals, it will also be important to keep in mind the IMPACT Act of 2014. The IMPACT Act, which requires the development of uniform post-acute care quality measures, already sets in place a timeline for the implementation of a standardized functional assessment tool across post-acute care settings by 2019. In addition, the IMPACT Act requires that CMS and the Medicare Payment Advisory Commission (MedPAC) submit reports to Congress on new forms of prospective payment for post-acute care by 2022.

The post-acute care payment and delivery reform efforts already set in motion by the IMPACT Act could be jeopardized if new reforms are enacted before the tools necessary to implement them are fully developed and tested.

Ultimately, care transformation must be carefully considered and gradually implemented. It is essential that the base payment rates and savings generated adequately cover the costs of investing in and implementing changes in care delivery.

3) Reforms to Medicare’s current fee-for-service program that incentivize providers to coordinate care for patients living with chronic conditions

Existing Medicare prospective payment systems are important in underpinning a major component of the nation’s health care delivery system. Using prospective payment systems as a framework, CMS has introduced numerous initiatives to improve quality and value in the health care delivered to Medicare beneficiaries, and at the same time per capita Medicare spending has fallen over the last several years.¹ The prospective payment systems allow for predictability in pricing, are relatively simple to administer, and provide beneficiaries with flexibility in choice of providers as well as broad access to range a providers. Movement away from these known and reliable systems too quickly and without careful consideration of the complex issues in care delivery, pricing, administration, and patient access that must be addressed in payment bundling or other value-based payment systems could have unintended consequences for providers and patients alike.

However, within current “siloed” Medicare prospective payment systems, there are a number of reforms that could improve care for Medicare beneficiaries with chronic illnesses consistent with the CMS’s goals to improve the quality of patient care and reduce costs. Specifically, the easing of regulatory restrictions that differentially impact each post-acute care setting—home health agencies, inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), and skilled nursing facilities (SNFs)—could allow for providers to improve hospital discharge planning, more efficiently and appropriately place patients in and transition patients across settings, and develop patient-centered treatment plans that focus on the complex needs of beneficiaries with multiple chronic conditions. These restrictions do not make sense when APM policy aims to break down the “siloes” in which post-acute care services are currently delivered, and risk undermining the power of reforms to improve care coordination across the continuum.

For example, existing conditions of participation, such as the 3-hour therapy rule for IRFs, restrict fair competition across post-acute care providers. According to the 3-hour therapy rule, Medicare requires that at the time of admission, the patient must receive and benefit from three hours of therapy per day for at least five days per week.² If patients are unable to tolerate 3 hours of therapy for 5 days each week, they would not qualify for IRF care. Another example is that IRFs and LTCHs are required to have higher staffing ratios with more frequent patient contact by physicians than other post-acute care settings. In addition, IRFs and LTCHs must

¹ Dobson A, Berger G, Reuter K, DaVanzo J. Do structural changes drive the recent health care spending slowdown? *New Evidence*. Vienna, VA: Dobson | DaVanzo & Associates, February 2014. Available online at: <http://fah.org/upload/documents/Dobson-DaVanzo-Federation-Study.pdf>.

² Centers for Medicare and Medicaid Services. *Medicare Benefit Policy Manual Chapter 1 - Inpatient Hospital Services Covered Under Part A*. Accessed May 2015. <<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf>>.

meet stringent Federal hospital conditions of participation, among other strict Federal and state hospital licensing, and other regulatory requirements – other post-acute care settings do not.

Each post-acute care setting also has unique requirements for the proportion of patients with certain clinical conditions (*i.e.*, the IRF “60% Rule”) or level of clinical severity as measured by average hospital length of stay (*i.e.*, the LTCH 25-day average length of stay rule); home health requires a physician certification that the patient is “homebound” in order to be admitted for these services. Some of these regulatory requirements associated with prospective payment rules could be alleviated in the form of waivers under APMs. Without addressing the underlying difference in cost of providing care across post-acute care settings, reform efforts within existing prospective payment systems—such as the BPCI initiative—could preference some sites of service over others and simply encourage the placement of patients in the setting with the lowest spending, independent of clinical appropriateness. If left unaddressed, these regulatory differences have the potential to negatively impact patient referral patterns and patient access to clinically appropriate care in certain types of settings as well as restrict fair competition across post-acute care providers.

Another aspect of the traditional Medicare fee-for-service program that should be further explored is the development of Current Procedural Terminology (CPT) codes to promote the provision of care coordination services, particularly for beneficiaries with multiple chronic conditions. CMS should evaluate the adoption and financial adequacy of recent CPT codes that are meant to cover care coordination and care transitions activities, to determine whether these services can be provided in an effective and financially sustainable way under the existing fee-for-service system. In addition, CMS should consider whether these codes should be incorporated into the fee schedules of existing prospective payment systems, such as discharge planning from an inpatient hospital stay or emergency room visit, or if new codes could be created to reimburse providers for these currently unfunded services.

4) The effective use, coordination, and cost of prescription drugs

The prescription drug landscape overall is rapidly evolving, as older medications go off patent and new specialty drugs are released with previously unseen levels of price per treatment. In addition, recent consolidation in the generic drug market has led to shortages in supply of staple products (*e.g.*, saline solution) as well as financial burdens attributable to substantial price increases for medications that hospitals and other providers rely on to provide routine care. Although the majority of prescription drugs are sold as generics, the introduction of new brand name medications combined with restrictive formularies by health plans is placing a growing burden—both financial and for access—on consumers, including Medicare beneficiaries. This is coupled by the financial burden of significant price increases for many common generic drugs resulting from these current market forces.

Beneficiaries with multiple chronic conditions taking multiple prescription medications are disproportionately impacted by these trends. Additionally, the pricing for specialty drugs may be sufficiently high that overall population per-member per-month spending on health care is visibly and adversely affected, such that the affordability of both public and private health care plans is affected.

In order to improve coordination and use while decreasing spending on prescription drugs for beneficiaries with multiple chronic conditions, CMS should provide greater access to Medicare Part D prescription drug data. These data, which could be made available to researchers as well as providers, would allow for a better understanding of the relationship between medication use and utilization of other health care services. These data could also be disseminated to providers on a regular basis through a process similar to the distribution of Medicare Parts A and B claims data under the ACO and BPCI programs.

In addition, medication reconciliation—an important aspect of care coordination, particularly for Medicare beneficiaries with multiple chronic illnesses—and adverse drug events should be more broadly adopted as quality measures in payment reform initiatives. Any measure on medication reconciliation, prior to adoption, should be recognized by a consensus-based multi-stakeholder entity such as the National Quality Forum.

5) Ideas to effectively use or improve the use of telehealth and remote monitoring technology

Health care services and data collection provided via telecommunications are becoming more important to the health care delivery system over time, as improvements in technology reduce costs and increase speed and data storage capacity. These trends are occurring under the Medicare telehealth benefit—which covers “face-to-face” video consultation between patients and physicians—as well as remote-monitoring technologies, which collect and forward data to various types of providers for analysis of health behaviors and indications of changes in patient health status. For many beneficiaries, as well as providers, telehealth and remote monitoring allow for the delivery of more efficient and low-cost care, especially when patients may be homebound or live a far distance from providers they need to access.

However, the current Medicare coverage and payment rules for telehealth services create challenges for many providers seeking to improve access to and coordination of patient care through these technologies. Reforming the coverage and payment rules for telehealth and remote monitoring technologies would lead to improved access for beneficiaries in both rural and urban areas to primary as well as specialty and subspecialty care. By substituting video consultations for in-person visits, the telehealth benefit could also lead to reduced costs for the Medicare program and reduced burden on beneficiaries, particularly the chronically ill.

In order to promote care coordination for beneficiaries with multiple chronic conditions, Medicare coverage and payment for telehealth both need to be updated as follows:

- *Modify restrictions on the geographic location and practice setting “originating site.”* Medicare currently covers telehealth only for those beneficiaries receiving services at one of the originating sites listed in statute, such as a hospital, SNF, or physician office. In addition, the originating site must be located in a rural area. The restriction on practice setting limits the ability of beneficiaries to receive care, which can be provided safely, in other settings such as the office, school, or home. Furthermore, the restriction on geographic location limits the ability of urban Medicare beneficiaries—who may live in

areas with physician shortages, or lack certain specialists and subspecialists—to access the care they need.

- *Expand the basis of covered services.* Currently, Medicare only covers 75 services via telehealth, and CMS must approve new services for telehealth coverage on a case-by-case basis. Such restrictions limit the ability of providers to deliver a broad range of services to Medicare beneficiaries who lack access to care. The process of approving services for Medicare telehealth coverage should be simplified. For example, CMS could approve all Medicare-covered services for telehealth, unless services are determined inappropriate for the benefit on a case-by-case basis.

Beyond the telehealth benefit, Medicare should also consider covering services provided via store-and-forward or remote monitoring technologies. Such technologies allow for providers to continuously track and monitor patient behavior, vital signs, and other medical information in the community, and can lead to more timely and efficient clinical interventions. Chronically ill Medicare beneficiaries stand to benefit greatly from these technologies as they are more likely to experience complications from the complex interaction of multiple chronic conditions, some of which could be prevented through improved monitoring and early intervention.

Telehealth offers great promise in delivering efficient primary, specialty, and care coordination services for providers as well as Medicare beneficiaries, especially those with multiple chronic conditions. Addressing these significant barriers to expansion would increase health care access for many beneficiaries and could improve APM efficiency.

6) Strategies to increase chronic care coordination in rural and frontier areas

Beyond the policy recommendations on telehealth described above, there are additional strategies that could improve the coordination of care for beneficiaries with chronic illnesses in rural areas. First, CMS could focus specifically on and promote the integration of behavioral health providers and other specialists with primary care providers in rural areas. This could be done through the creation of patient-centered medical homes or primary care practices with behavioral health and other specialists embedded within them, or the creation of virtual specialist networks through telehealth consultations.

In addition, another strategy for expanding the telehealth infrastructure could be for CMS to pilot initiatives that expand investment in local workforce development as allied health professionals (e.g., technicians) to perform necessary telehealth functions. The loosening of restrictions on where telehealth services can be provided would allow for more flexibility in the types of health care professionals that connect beneficiaries with these services, and would therefore promote greater access to care for beneficiaries with chronic illnesses.

7) Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers

Ongoing CMS demonstrations, as well as initiatives underway in the employer-sponsored and commercial health insurance industries, have experimented with different patient

engagement strategies that could be applicable to Medicare beneficiaries with multiple chronic conditions. Numerous pilot programs being tested under the Center for Medicare and Medicaid Innovation (CMMI)—such as the Comprehensive Primary Care Initiative, Community-based Care Transitions Program, and Partnership for Patients—should be evaluated in order to determine what lessons learned can be applied to the Medicare program more broadly, or which successful programs can be implemented on a larger scale. CMMI is also seeking information from stakeholders to test new models of health care engagement among beneficiaries.

In addition, lessons learned from workplace wellness programs and other incentive-based private health insurance initiatives that promote healthy behaviors (e.g., smoking cessation, diet, regular exercise) may be applicable to the Medicare program, such that patients with chronic illnesses become more engaged in managing their conditions and health status. However, patients need to be protected from any penalty they could face that is tied to an outcome or event that is not necessarily preventable (e.g., inability to exercise due to recovery from surgery).

In addition, CMS could make information about community organizations and other local service providers that promote health more available to Medicare beneficiaries with chronic illnesses. This could be done at the agency level or at the provider level, specifically at the point of care. While there are numerous avenues through which CMS already communicates information to beneficiaries, such as the Medicare Handbook and other official Medicare publications, there may be other means of dissemination that have a greater impact on beneficiaries, particularly for the more technologically savvy Baby Boom generation (e.g., websites, smartphone apps, etc.)

8) Ways to more effectively utilize primary care providers and care coordination teams in order to meet the goal of maximizing health care outcomes for Medicare patients living with chronic conditions.

While CMS is currently undertaking many initiatives to improve the coordination and delivery of primary care with other types of services—such as patient-centered medical homes, primary care collaboratives, and ACOs—there are additional policies to consider. CMS could provide greater incentives to embed behavioral health providers and other non-physician specialties, such as diabetes educators and dietitians, in primary care offices in order to support a more comprehensive, population health-focused approach to primary care. CMS could also promote the reform of scope of practice laws, which currently restrict the ability of non-physician health care providers to deliver certain patient services, in order to improve efficiency and augment physician shortages through the use of mid-level health care professionals (e.g. nurse practitioners, licensed practical nurses, clinical nurse specialists, etc.).

Alternatively, CMS could support efforts to improve the access of primary care physicians themselves to specialist consultations (through telehealth or other means) in order to reduce unnecessary referrals and enhance primary care provision with input from other physicians.

Ultimately, CMS must ensure that APMs and other payment systems provide adequate financial incentives or reimbursement amounts to promote more efficient and effective provision of primary care. By removing barriers to accessing primary care and the ways that these services are delivered and paid for, CMS could greatly improve outcomes and reduce costs for beneficiaries with multiple chronic conditions—those who stand to benefit the most from better care coordination and patient management.

Thank you for the opportunity to submit these comments. If you have any questions, please feel free to contact me or Jeff Cohen, Executive Vice President Political & Public Affairs, at (202) 624-1500.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew M. Reinhart". The signature is fluid and cursive, with a large, sweeping initial "A" and a distinct "R" at the end.