Society of Hospital Medicine

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The Honorable Orrin Hatch
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219 Dirksen Senate Office Building
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The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
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The Honorable Johnny Isakson
Co-Chair
Senate Finance Committee
219 Dirksen Senate Office Building
Washington DC, 20510

The Honorable Mark Warner
Co-chair
Senate Finance Committee
219 Dirksen Senate Office Building
Washington DC, 20510

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

The Society of Hospital Medicine (SHM), appreciates the opportunity to provide comments to the chronic care working group. SHM shares the Senate Finance Committee's commitment to improving care for Medicare patients with chronic conditions, and supports the Committee's stated goals in increasing care coordination, incentivizing quality care while streamlining Medicare's current payment system and reducing growth in Medicare spending.

SHM represents the nation's more than 44,000 hospitalists who work primarily in acute care hospitals, as well as increasingly in post-acute facilities. Hospitalists are critical team leaders in coordinating care and are dedicated to providing the highest quality care for all hospitalized patients, which include a large number of Medicare beneficiaries, many of whom suffer from chronic conditions.

We offer the following suggestions for improved policies:

## Coordination of Care and Better Outcomes: The Right Care in the Right Setting

Patients with chronic conditions often face countless healthcare appointments with different healthcare providers and endless transitions to and from various facilities. For seamless transitions to occur, a clearly structured and well-communicated care plan and

coordination of that care among various caregivers is necessary. SHM strongly believes that an effective healthcare system can be built around ensuring patients are receiving the right care in the right setting. This requires policies to be structured to encourage the use of the appropriate care setting, while also ensuring that patients receive the highest quality care possible. SHM recommends that the Committee consider targeting existing policies and payment structures for updating and streamlining to account for the current capabilities of the healthcare system and the shifting demographics of Medicare beneficiary population.

One clear barrier to delivering "the right care in the right setting at the right time" is a direct result of observation status and Medicare's 3-day stay rule for SNF coverage. Many Medicare beneficiaries present to the hospital for minor complications associated with chronic conditions and do not necessarily require care at hospital level intensity, but would benefit greatly from a higher level of care than what is available in the community setting, such as a skilled nursing facility (SNF). However, Medicare does not cover a SNF stay unless the beneficiary has been admitted to the hospital as an inpatient for at least 3 days. This seemingly arbitrary requirement causes numerous obstacles for patients who end up being placed under observation status and for providers who know the patient cannot be safely sent home, but does not qualify for needed care at a step-down facility. If a beneficiary would clearly benefit from post-acute care after their hospital stay, but does not meet the 3 day inpatient requirement, they will often forego recommended SNF care to avoid paying the out-of-pocket fees. This foregone care can lead to otherwise preventable complications (i.e. dehydration, falls, etc.), and a readmission to the hospital – which drives up readmission rates, and has serious financial implications for both patients and Medicare.

In looking to solve this dilemma, at a minimum, the 3 Day Rule could be amended to include observation status toward the requirement for SNF care. An even more appealing option would be to allow direct transfer to an appropriate setting when the patient's physician feels that it is warranted. Both solutions would allow more patients to receive timely medically-appropriate care in a SNF, without financial uncertainty. However this issue is ultimately solved, SHM recommends the Committee take this opportunity to pursue an overhaul of observation status policy to align with clinical reality and better accommodate the care needs of Medicare beneficiaries. By systematically targeting and reforming these policies, the Committee should be able to ensure that the healthcare system is using its resources judiciously, while ensuring that patients with chronic conditions (and those without) are able to get the best care available.

**Reforms to Fee-For-Service and Effective use of Prescription Drugs through Alternate Payment Models**

Better coordination of care can also be found through the expansion of alternate payment models (APMs), bundling of care, and Accountable Care Organizations (ACOs). These options not only allow patients to receive care in an efficient, patient-centered way, but will also create a shared responsibility for physicians and facilities to better coordinate in creating optimal transitions and patient outcomes.

Bundling payments would be an avenue to consider for chronically ill patients, in that it encourages higher quality care at lower costs. A bundling example that would include Medicare Part D costs to utilize lower cost, yet equivalent drugs would benefit chronically ill patients especially, as they often have many prescribed

medications for their conditions. This option could also align with national initiatives to reduce the over-utilization of certain drugs such as antipsychotics and antibiotics.

ACOs present a unique opportunity to create alignment across the care continuum for patients. Although the payment structure is still new and its implications on the quality of care and costs for Medicare remain unclear, there is value to pursuing systems realignment on local and regional levels to ensure that all patients, especially those living with chronic conditions, can expect coordination across settings and providers. We encourage the Committee to consider how to expand and evolve ACOs to include and incentivize the participation of all providers, including those who practice at multiple locations.

Alternate payment models move the healthcare system away from fee-for-service payments, and into a more valued-based and efficient model, which will benefit the patients, stabilize Medicare payments, and give physicians more control over the way in which they are paid. These models also create an environment where providing the right care in the right setting is beneficial to all parties involved. However, proper risk adjustment and benchmark setting needs to be carefully considered and thoughtfully implemented within any alternative payment arrangements.

To address risk adjustment, we strongly support the concept of establishing an outlier pool and in keeping with a flexible approach, the work group should consider a process of analyzing risk thresholds separately based on participating provider, hospital, and patient characteristics (i.e., major teaching vs. community hospitals; high DSH vs. low DSH hospitals, prevalence of dual eligible population, etc.). To the extent that thresholds are materially different, separate thresholds could be instituted for different peer groups that emerge from this methodology.

Risk adjustment is absolutely necessary for providers to feel confident in participating in evolving payment settings and to protect against the incentive to exclude higher risk patients such as those with chronic conditions and their heightened care needs.

**Empowerment of Patient and Caregiver: Incentives for Active Participation**

To better include patients in the healthcare system, gainsharing incentives could be expanded. Gainsharing is structured to incentivize physicians to take part in higher quality, cost-conscious care, but at this point in time, does not include patients in these incentives. If patients were to also receive a reward in some form of gainsharing arrangements for maintaining their health and following the care their doctor prescribes (i.e. filling prescriptions, taking their blood pressure and reporting it to their doctor, showing up to follow-up visits), many more patients would actively participate in their care. Active participation would lead to better transitions between facilities, better coordination of care between doctor and patient, and a healthcare system that rewards patients for being mindful to their own care as much as their physicians. Patients with multiple chronic conditions may particularly benefit from this concept, as they are often taking multiple medications, visiting multiple facilities, and must be active in their healthcare based on their long-term condition and care needs. If patients are incentivized, and in turn more active and responsive to their own needs, physicians too will be more quickly informed and able to adjust their care/medications, and align the appropriate resources for the patient.

Managing chronic diseases requires all players to be invested and communicative throughout the spectrum of care – this includes the patient.

For providers, there are still barriers to developing fully coordinated and efficient systems, due to current gainsharing and anti-kickback statutes. There were steps taken to make some changes to the CMP law in the recently passed SGR legislation, but this change does not go far enough to allow gainsharing arrangements. While SHM recognizes the need to have safeguards for patients and for the Medicare Trust Fund, there need to be opportunities for the expansion of safe harbors and clear protections from penalties for providers who enter into gainsharing arrangements designed to improve care delivery, patient experience of care, and which in turn result in more efficient resource use and better health for patients.

The Society of Hospital Medicine appreciates the opportunity to provide feedback to the Senate Finance Committee, and hopes that these policy improvements will be helpful in establishing the working group's plan for patients with chronic diseases. We look forward to continued work with the chronic care working group as bipartisan legislative solutions are further developed.

For more information, questions or comments, please do not hesitate to reach out to Josh Boswell, SHM's Director of Government Relations at jboswell@hospitalmedicine.org.

Sincerely,

Robert Harrington, JR., MD, SFHM
President, Society of Hospital Medicine