



A Passionate Voice for Compassionate Care

March 1, 2019

Senator Lamar Alexander
Chairman, Committee on Health, Education, Labor and Pensions
United States Senate
Washington, DC 20510

Dear Chairman Alexander:

On behalf of the Catholic Health Association of the United States (CHA), the national leadership organization of more than 2,000 Catholic hospitals, nursing homes, indigent care clinics, long-term care facilities, systems, sponsors, and related organizations serving the full continuum of health care across our nation, I am pleased to offer the following thoughts and suggestions in response to your request for measures that can be taken to lower health care costs for individuals, families, providers and insurers.

The issue of access to quality affordable care has been at the heart of CHA's advocacy efforts for many years and remains our top legislative priority. Our Catholic health ministry believes that health care is a fundamental right for everyone in our nation, but unfortunately one that is too often denied due to prohibitive costs. We commend your leadership and the work being done by the Senate HELP Committee on this issue and welcome the opportunity to offer ideas that I hope will be useful as we continue to work with you in pursuit of accessible and affordable health care for everyone.

Improving Affordability in the Individual Marketplace

Improving affordability in the individual Marketplace will reduce health care costs throughout the system by enabling more individuals and families to afford, purchase and use coverage. This will allow them to receive preventative and primary care when needed and reduce dependency on hospital emergency rooms, the most expensive care setting. We were pleased to support the bipartisan ACA stabilization package that the HELP Committee considered during the last Congress and believe similar legislation is still needed. Specifically, **CHA recommends:**

- **Providing a reinsurance program** to help insurers manage large and unpredictable costs by sharing a portion or spreading the risk of insurer costs for their most expensive enrollees. The most common type of reinsurance allows insurers to draw on additional funding to help cover costs that exceed a certain threshold (e.g., a claim that exceeds a certain dollar amount or an enrollee with a defined health condition). This allows insurers to better manage their costs since the most expensive and difficult to predict medical care costs are offset by reinsurance. The federal government also saves money on premium tax credits as reinsurance lowers premiums.
- **Addressing what is known as the "family glitch"** to allow and assist three to six million more Americans to purchase health insurance coverage in the Marketplace, thereby expanding the risk pool and increasing stability. Under current rules, employer-sponsored insurance is deemed to be affordable if the cost of employee-only coverage is less than or

equal to 9.66 percent of family income in 2016. However, if one family member has an affordable offer of single coverage, then all family members are ineligible for tax credits to purchase Marketplace coverage, even if the cost of coverage for the whole family is greater than 9.66 percent of family income. While such families are not subject to penalties when the dependents go without coverage, these families lack an affordable option to cover all family members.

- **Ensuring continued investment in consumer information and outreach efforts** to create a sustainable risk pool, which raises awareness about coverage options and removes barriers to entry for individuals to enroll. The erosion of marketing and outreach efforts has had a negative impact on the risk pool and led to higher costs for consumers. Congress should provide serious oversight to make sure that funding intended to help individuals learn about and access coverage, known as “consumer information and outreach” funding, is fully restored and used as intended to appropriately educate the public about coverage options and encourage enrollment in the Marketplaces.

Palliative Care

Palliative care is the medical subspecialty focused on providing relief from the symptoms and stress of serious illness. The goal is to improve quality of life for both the patient and the family. Palliative care is appropriate at any age and at any stage of illness, can be provided along with all other medical treatments and is delivered by a team of doctors, nurses, social workers, chaplains and other specialists working together with a patient’s other doctors to provide an extra layer of support.

Studies show that palliative care improves quality of life for patients suffering from serious illness. In 2010 the *New England Journal of Medicine* published findings of a study that found lung cancer patients receiving palliative care showed improved quality of life and lower utilization. The patients receiving palliative care also lived longer than those receiving usual care. In September 2015, the *Journal of Pain and Symptom Management* published study findings that showed cancer patients receiving palliative care experienced better quality of life than those that did not receive palliative care. This in turn made the patients more likely to stay in clinical trials and complete their course of chemotherapy. **The use of palliative care has also been shown to result in reduced costs through more appropriate utilization of health care services:**

- In March 2011 *Health Affairs* published the results of a study that looked at how palliative care team consultations for patients enrolled in Medicaid impacted hospitals costs. The findings showed that on average, patients who received palliative care incurred \$6,900 less in hospitals costs than those who received usual care.
- A meta-analysis of six studies published in the June 2018 edition of *JAMA Internal Medicine* found that hospitals costs were lower for patients seen by a palliative care consultations team than for patients who did not receive this care. The authors of the study concluded that increasing palliative care capacity to meet national guidelines may reduce costs for hospitalized adults with serious and complex illnesses.

Catholic health care has been a leader in adopting palliative care programs. In 2016, over 90 percent of Catholic hospitals reported have a palliative care program as noted in the Supportive Care Coalition’s *2019 Mission Report*. Some examples from our health ministry show the benefits of these programs:

- Trinity Health, a Catholic health system with facilities in 22 states, has undertaken a system-wide palliative care redesign initiative increasing the access of palliative care services; addressing better health, better care and lower costs; and meeting national quality standards and evidence-based research. Trinity reports in its Policy and Story Card, [Sharing Our Palliative Care Story](#), that 78 percent of Trinity Health hospitals currently have access to a palliative care program. The results of their efforts are paying off in improved outcomes: 91 percent of patients report high satisfaction with palliative care services, 90 percent of uncontrolled pain and symptoms are addressed; and 72 percent have advance care plans and goals of care completed upon consultation. Trinity has also found that palliative care provides better care at lower cost, resulting in \$9.8 million in savings from FY2013-16.
- Bon Secours Richmond, part of the Bon Secours Mercy health system, was awarded the [2016 Circle of Life Award](#) in recognition of its high-quality palliative care services. This regional system's palliative care program, which is part of its medical group, follows patients and their families where they receive treatment, including hospitals, nursing homes, primary care practices and their own homes. The vast majority of the staff are palliative care certified and dedicated solely to palliative medicine. The program's model of caring proactively for patients in the setting of their choice allows the team to intervene before the patient enters the hospital, and/or prevent the admission from happening to begin with. Bon Secours has five ACOs and the palliative care model helps reduce unnecessary hospital admissions. The model is viewed as part of the reason the Bon Secours' Medicare shared savings plan's costs went down six percent in 2015.

Health care organizations recognize the benefits that palliative care programs can bring to their patients and their efforts to implement value-based health care. However, these programs cannot be improved or expanded without more health professionals trained in palliative care and evidence-based research specific to palliative care and symptom management. **CHA recommends:**

- Passage of the [Palliative Care and Hospice Education and Training Act](#) (HR 647). This bill addresses the workforce, education and research issues needed to build a strong palliative care infrastructure. A vital step in ensuring access to high-quality palliative care is to make sure there are enough trained health care professionals to meet patient demand, that the public educated about palliative care services and its benefits, and that there is a body of research that informs how palliative care needs to be delivered based on diagnosis, care setting and patient populations.

Telehealth Services

The wide array of connected health technologies available today – whether called “telehealth,” “ehealth,” “mHealth,” “store and forward,” “remote patient monitoring,” or other similar terms – offer great promise to expand access to care regardless of the patient’s location, improve patient care, reduce hospitalizations, help avoid complications, and improve patient engagement, particularly for the chronically ill. It can also mitigate workforce shortages and eliminate the need for patients to travel long distances for their care. In some rural communities, it can mean the difference between getting no care at all and getting the right care at the right time.

These technologies can also be a source of cost savings, for patients as well as for the overall health system. Patients who can consult doctors via telehealth can save on travel costs, avoid lost pay due to taking time off from work and, in some cases, have lower copays. Telehealth services that reduce hospitalizations and readmissions, coordinate care across settings and monitor care at home or in

post-acute settings can yield overall health system savings. Many of CHA's members are leaders in using telehealth to provide innovative solutions to their communities' care needs:

- The Mercy Virtual Care Center, launched in 2015, is a freestanding building dedicated to developing and delivering telehealth services. Physicians and other health providers at the center provide access to a full range of Mercy specialists for consult, including for stroke patients, trauma cases and others presenting at emergency rooms in remote or understaffed locations. Mercy Virtual also provides constant monitoring of critically ill patients to alert floor staff when a patient is about to have a medical crisis, as well as a host of other telehealth services.
- Avera Health's innovative eCARE program uses telehealth to provide around the clock access to care in areas such as ICU, emergency care, and behavioral health, with impressive results. Avera eCARE ICU has saved 187,060 hospital and ICU days and resulted in 11,188 fewer days on a ventilator since 2004. Their eLong Term Care program, which supports long-term care and skilled nursing facilities with access to an interdisciplinary team of geriatric-led clinicians, saved Medicare an estimated \$342 per beneficiary per month.

Such programs demonstrate the promise of telehealth for both providing better care for patients and lowering costs. However, significant challenges continue to stifle the promise of telehealth, for example, coverage and payment for telehealth series; licensing and credentialing across state lines; and on-line prescribing. **CHA recommends:**

- **Exploring how to make telehealth services more readily available under Medicare**, by expanding the types of technology that can be used as well as coverage for services that can safely be provided by telehealth.
- **Examining the limitations on the settings and geographical areas in which telehealth can be covered by Medicare**, to ease or eliminate current restrictions.
- **Encouraging additional research on the benefits of telehealth** services for patient access, quality and outcomes as well as cost-saving potential.

Age-Friendly Health System

An encouraging movement in health care is the Age-Friendly Health System project, an initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI) in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA). While designed to improve care for older patients, it is also focused on cost-saving potential. Costs may be reduced when:

- **Medications are properly prescribed.** Many medical emergencies and hospitalizations occur because high-risk drugs are prescribed or taken by older patient.
- **Delirium is averted or treated early.** According to Harvard Medical School professor Sharon Inouye, delirium is a serious and often fatal problem affecting up to 50% of hospitalized seniors and costing the U.S. over \$164 billion per year.
- **Paying attention to what matters to older patients.** Respecting their treatment choices is the most appropriate way to reduce health care costs by avoiding unwanted care. Research has shown that for older adults with multiple chronic conditions (the major users of health care) aligning care with individuals' goals reduces unwanted testing, procedures and potentially harmful medications.

CHA recommends the following to promote Age-Friendly Health Systems:

- Providing grants to health care organizations across the continuum to reach all older adults.
- Incorporating the “4Ms” of age-friendly care (What Matters, Medication, Mentation and Mobility) into quality measurement standards.

Substance Use Disorder Treatment

The existing system of requiring two separate sets of medical records for substance use disorder (SUD) treatment and other medical conditions has proven to be needlessly cumbersome and expensive for the many Catholic health care providers whose patients require SUD treatment and also have other medical conditions. CHA is committed to aligning the regulations for substance use disorder treatment records (known as 42 CFR Part 2) with the current regulations governing other medical records under HIPAA. This is absolutely essential for health care providers to have appropriate access to patient information in order to administer whole-person care, and would provide savings to the health care system by streamlining administrative procedures and reducing the time and expenses involved in maintaining two sets of records. **CHA recommends:**

- **Passing legislation to fully align Part 2 requirements with HIPAA to allow the use and disclosure of patient information for treatment, payment, and health care operations (TPO).** In the 115th Congress we supported H.R. 6082, the Overdose Prevention and Patient Safety Act (OPPS Act), which passed the House of Representatives by a bipartisan vote of 357-57. H.R. 6082 would align Part 2 with HIPAA for the purposes of TPO, while strengthening protections against the unauthorized use of addiction records.

Thank you for this opportunity to share with the Committee some of the wonderful work being done by the members of the Catholic health ministry to improve care and lower costs. We at CHA look forward to working with you on these initiatives, and if you have any questions about them please do not hesitate to contact me or another member of our advocacy staff.

Sincerely,



Sr. Carol Keehan, DC
President and CEO