THE
CATHOLIC HEALTH
ASSOCIATION
OF THE UNITED STATES

May 20, 2009

Senator Max Baucus
Chairman, Senate Finance Committee
U.S. Senate
Washington, D.C.

Senator Charles Grassley
Ranking Member, Senate Finance Committee
U.S. Senate
Washington, D.C.

Dear Chairman Baucus and Ranking Member Grassley:

On behalf of the Catholic Health Association of the United States, I am writing to you concerning the Senate Finance Committee's policy options paper, "Transforming the Health Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs." Let me first thank you for your leadership in the effort to improve health care in the United States and to ensure that quality, affordable care is available for everyone. We are grateful for the opportunity to offer our comments regarding the committee's delivery system reform proposals.

The Catholic Health Association of the United States (CHA) is the national leadership organization of the Catholic health ministry, representing the largest group of not-for-profit providers of health care services in the nation:

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- 1 in 6 patients in the United States is cared for in a Catholic hospital each year
- All 50 states and the District of Columbia are served by Catholic health care organizations.
- Over 600 hundred hospitals and more 800 post-acute care organizations provide the full continuum of health care.

By pursuing the priorities of the ministry, CHA and it members - more than 2,000 Catholic health care sponsors, systems, hospitals, long-term care facilities, and related organizations - are working to create health care that serves everyone. CHA's *Vision for U.S. Health Care* lays out the Catholic health ministry's principles for reforming the health care system. As a central component of our vision, we believe that health care should be patient centered, addressing health needs at all stages of life through services that are coordinated and integrated all along the continuum of care, with accountability for health outcomes. We also call for safe, effective health care delivered with the highest possible quality to achieve the best outcomes for patients.

We are pleased to see that these principles are reflected in many of the policy options included in the committee's health delivery system paper. CHA would like to offer support for several aspects of these policies, as well to share our concerns

relating to other aspects. Specifically, we would like to address the following sections of the committee's paper:

ESTABLISHMENT OF A HOSPITAL VALUE-BASED PROGRAM (VBP)
CHA endorses the development of a payment system that rewards providers for high-quality patient care and welcomes the committee's consideration of value-based purchasing (VBP) program for hospital Medicare reimbursement. The development of a VBP program should be guided by two key points. First, the *goal* of such a payment system must be to improve quality so that patients receive safe and effective care, not merely to produce federal savings. A VBP system should be designed so that all incentive funds are distributed to hospitals based on performance at least for the first year until we can demonstrate that there has been a significant reduction in charity care and bad debt as a result of the new health care reform program.

Second, great care must be taken to ensure that a VPB system does not negatively impact vulnerable populations or the hospitals that disproportionally serve them. Program elements including measurement selection should be designed to avoid unintended consequences, such as disadvantaging hospitals that serve sicker or lower income patients or exacerbating health care disparities among patient populations. We are pleased that the proposal calls for ongoing monitoring, and believe it is essential that such monitoring include attention to the effects of the VBP program on as disparities of care and on hospitals that disproportionately serve low-income Medicare beneficiaries.

The committee's VBP options include several elements which CHA supports, including implementing the program incrementally; rewarding hospitals for both improvement over time and attainment of high performance levels; improving the Hospital Compare website; and developing VBP demonstration projects for critical access hospitals and small hospitals.

We do have concerns about certain elements of the proposed VBP program for hospitals, including:

- Under the proposed VBP program, hospitals in the bottom quartile of performance would receive no payment incentive. If this means that there must always be a set percentage of hospitals that fail, we strongly urge you to reconsider. A hospital that achieves significant improvement but from a very low starting point so that it is still in the bottom quartile should not be automatically disqualified for a payment incentive. All hospitals should have the opportunity to earn an incentive.

- The incentive pool would be funded by reductions which rise from 2% in 2013 to 5% in 2016 and which would be applied to all MS-DRGs. We believe the scale of the proposed reductions is too aggressive, and that the reductions

should be applied only to those MS-DRGs that are related to the quality measures.

- Rather than calculating a total hospital performance score, hospital payment incentives should be based on condition-specific composite measures. Tying performance scores to relevant MS-DRGs will enhance the effect of the incentive, directly reflecting a hospital's high or low performance in specific areas, and will give consumers and patients more useful information about the hospital's strengths and weaknesses.

- The proposed program would initially use measures from the existing "pay for reporting" system, but beginning in 2013 the Secretary of Health and Human Services would have the authority to add additional measures. Selecting appropriate, tested, consensus-based measures is a crucial aspect of a VBP program. CHA believes that only measures endorsed by the National Quality Forum; supported by stakeholders, such as the Hospital Quality Alliance; and subjected first to field testing and reporting should be used in the VBP program.

We also support the committee's proposals to test VBP models for critical access hospitals and small hospitals; to develop VBP plans for home health agencies and skilled nursing facilities; and to begin quality reporting programs for inpatient rehabilitation and long-term care hospital providers.

PAYMENT FOR TRANSITIONAL CARE ACTIVITIES

The committee paper proposes to support integrated, transitional care management for chronically ill patients who experience hospitalization by reimbursing physicians for certain care management activities preformed by nurse care managers and other qualified non-physician professionals. CHA supports this provision but strongly believes that the proposal could be strengthened by recognizing additional providers of transitional care activities for payment and by broadening the definition of patients for whom the transitional care activities are reimbursed.

We would request that you expand eligibility for these transitional care payments to other types of providers including hospitals. In some communities (especially rural areas), the hospital is in the best position to create transitional programs and allocate the funds in a way that supports a full continuum of care. Many Catholic hospitals are already attempting to manage care for chronically ill patients through clinics, employed physicians, nurse practitioners and/or relationships with community physicians. Moreover, the hospital is sometimes best equipped to facilitate coordination because of their leadership in such areas as health IT (electronic health records) and care for the uninsured.

For example, one of our Catholic hospitals has been part of the Medicare Coordinated Care Demonstration (MCCD). In this demonstration project, the

hospital was responsible for providing the transitional care services and was reimbursed by Medicare for doing so. The care coordinators in the demo worked closely with the hospital, which provided them with timely information on patient hospitalizations and interacted informally on a regular basis with physicians. The demo was shown to reduce hospitalizations by more than 17% and its success was attributed to the high rates of in-person contact per month per patient. Including hospitals as providers eligible for transitional care activities would encourage more of the types of care management activities that connect patients with the appropriate follow-up services.

In addition, we believe transitional care payments should be available for care services provided to Medicare beneficiaries discharged from inpatient hospital stays and also from a hospital emergency department. Our experience has shown that there is a significant need for many beneficiaries who seek treatment in our hospital emergency departments (EDs) for the same conditions as listed in the proposal (e.g., COPD, asthma, diabetes, mental illness) to receive the same types of transitional care services. As front-line providers, EDs often see and treat those patients who might otherwise have to be hospitalized.

We recommend also that the program be expanded to include care coordination for beneficiaries with high cost, chronic illnesses who are at the highest risk for hospitalization, and not just those who have already been hospitalized. Transitional care activities can be most cost effective to the extent that they prevent the need for more costly services. Finally, we recommend that the types of services be expanded to include care that is not only provided to the patient in person but also through remote monitoring and such virtual technologies as phone and internet.

PRIMARY CARE AND GENERAL SURGERY BONUS

CHA supports the Committee's proposal to establish bonus payments for Medicare providers that provide primary care services. We are concerned that there are not sufficient primary care providers to meet the patient need. It is essential for the committee to include substantially improved payments for primary care providers if the goals for delivery system reforms as well as overall health care reform are to be achieved.

CMS CHRONIC CARE MANAGEMENT INNOVATION CENTER

CHA supports the committee's proposal to establish at CMS a Chronic Care Management Innovation Center (CCMIC) to test and disseminate payment innovations that foster patient-centered care coordination for high-cost, chronically ill Medicare beneficiaries. We also support the establishment and inclusion within CCMIC a Medicare Rapid Learning Network to evaluate emerging evidence-based care management models. CHA's *Vision For U.S. Health Care* calls for a health care system that ensures services are coordinated and integrated along the continuum of care and improves health outcomes. We believe the establishment of the CCMIC will help facilitate the development of chronic care management programs for Medicare beneficiaries.

HOSPITAL READMISSIONS

We agree that it is appropriate to implement payment policy changes to reduce unnecessary hospital readmissions. While many hospital readmissions are outside of the control or influence of hospitals, hospitals can do more to avoid preventable readmissions and many are already doing so. An important first step is gathering data about readmissions that will help hospitals to identify problem areas, as the committee paper proposes to do.

Yet it is also important to remember that physicians, other providers, patients themselves and their family members also play a role in decreasing or increasing the likelihood of readmission. Many factors contribute to whether a given readmission was in fact preventable or unnecessary, and not all of them are within the control of the hospital.

We welcome the proposal to risk-adjust readmission rates based upon clinical factors such as severity of illness and case type, but we believe any new policy in this area should acknowledge that social and economic conditions also affect readmission rates. For example, MedPAC in its June 2007 report noted studies showing that dually eligible beneficiaries are at higher risk for readmission. Cultural and language barriers, income level and the availability and affordability of appropriate post-discharge care can also affect whether a patient's readmission could have been avoided. Some discharged patients lack the family support, community services or economic resources they need to comply with their treatment plans and stay out of the hospital. A discharged low-income Medicare patient who cannot get to the pharmacy for medication or adequate nutrition, or cannot pay her heating bills, is at high risk for readmission to the hospital.

Policy designed to reduce readmissions must not penalize hospitals that serve disproportionate numbers of patients facing these challenges. We are concerned, however, that that could be an unintended result of the committee's proposal to prospectively withhold payment for initial admissions for hospitals with readmission rates in the top quartile. We ask that you consider revising this proposal to more accurately identify readmissions preventable by factors under the control of hospitals. We also suggest that the committee consider adjusting payment only after a preventable readmission has been identified, rather than reducing all payments for a certain condition in anticipation of a possible unnecessary readmission. The committee also should consider identifying and providing incentives for clinical practices and discharge procedures that reduce the likelihood of readmission.

BUNDLING

CHA strongly supports efforts to coordinate and integrate health care services all along the continuum of care, to ensure the best outcome for every patient. Bundling of Medicare payments is a promising approach to fostering collaboration among providers throughout the entire course of acute and post-acute care, and we are glad

the committee is exploring this policy option. But we are concerned that there is insufficient experience with bundling models to design and implement a national program. An aggressive program of voluntary testing and demonstrations of alternative models before beginning to phase-in a mandatory bundling policy is essential. For example, the committee paper does not include physicians in its bundling proposal. But physicians play a crucial role in health care decision-making, and the impact of including or excluding them should be understood before proceeding. Another concern is whether hospitals have the capacity and resources necessary to create and maintain contractual and administrative relationships with post-acute care providers, and are prepared to make post-acute care placement and payment decisions. Other issues to consider include the consequences of not having an available or willing appropriate post-acute provider; patient choice of provider; and how to ensure post-acute providers are paid fairly. It is crucial to get the design elements right, because the incentives created by bundling payments will drive whether patients get the right level of care in the right setting.

Finally, in addition to bundling of acute and post-acute payments, we suggest that you also consider bundling where there is no initial hospitalization. For example, the Program of All-Inclusive Care for the Elderly (PACE) and other integrated systems have demonstrated that they can manage the care and costs of beneficiaries and avoid costly hospitalization.

ACCOUNTABLE CARE ORGANIZATIONS

The committee paper proposes allowing groups of qualifying providers – such as individual physician practices, physician group practices, hospital-physician joint ventures and hospitals employing physicians – to voluntarily form ACOs and have the opportunity to share in the cost savings they achieve for the Medicare program. This policy will allow innovative providers to experiment with approaches to care coordination and other efficiency and quality improvement techniques. CHA believes ACOs offer an opportunity to improve integration of inpatient and outpatient care and promote joint accountability for care delivery across providers and across time. Especially important is the working relationship between hospitals and physicians, as well as other post-acute and community-based agencies.

EXTENSION AND EXPANSION OF THE MEDICARE HEALTH CARE QUALITY DEMONSTRATION PROGRAM

We strongly support the committee proposal to extend Section 646 demonstrations. This is a promising route to innovative and transformative approaches to coordinated care and improved health for communities. However, we urge you to modify the requirements of the Section 646 demonstrations so that providers can engage in these large-scale, aggressive experiments under a shared risk model. Several of our Catholic health systems and hospitals were very interested in pursuing bold new approaches for organizing and paying for care in their communities when the Medicare Modernization Act was passed, but concluded that they could not bear the full financial risk of such an effort to achieve budget neutrality as required. We believe that the likely advances that could be made in

communities across the nation would be worth at least some limit on the financial risk imposed on willing providers.

NURSING HOME TRANSPARENCY

The committee's draft proposes a number of changes aimed at skilled nursing facilities and nursing homes to improve transparency of information, enforce standards and rules and train staff. CHA supports many of the proposed provisions, including:

- Disclosure of ownership. We think this is an appropriate requirement and appreciate the provision that would allow tax-exempt organizations to make available information on their IRS form 990 to fulfill this requirement.
- Accountability and compliance. We believe it is reasonable to expect an organization to develop and implement compliance and ethics programs.
- Nursing Home Compare: We especially support the provision that the HHS Secretary establish a process to review the accuracy, clarity, timeliness and comprehensiveness of the information. We believe that would be a valuable resource for consumers and could be improved to more accurately present needed information. For example, the website should be refined to reflect the severity, frequency and degree of a given violation, in order to provide consumers with more accurate information and to more fairly represent the quality of the care provided in a given facility.
- Reporting staffing expenditures and other staffing data. We believe that this information will help government agencies and the public determine when costs are related to direct care staff as opposed to other costs.
- Standardized complaint form. We believe this is an excellent policy.
- Sixty-day notification of facility closure. We believe this is an important consumer protection.
- Using civil monetary penalties to fund activities that benefit long term care residents. We believe this policy would provide needed funding to improve facilities and care for long term care residents versus all penalties going into general funds.
- Dementia and abuse prevention training. We support these provisions and believe they are very much needed.
- Demonstration projects on culture change and information technology in nursing homes. We support and look forward to the findings of these demonstrations.
- Study and report on training required for certified nursing assistance and supervisory staff. We support and look forward to these findings as well.

On the other hand, we recommend changes in the following provision:

- Holding civil monetary penalties in escrow accounts until completion of an appeals process. CHA does not support holding civil monetary penalties in escrow. For many freestanding, non-chain facilities, this provision could create extreme financial hardship that could well make it impossible for them to continue functioning. This would be especially unfortunate if the facility is eventually found not to owe the penalty.

REDISTRIBUTION OF UNUSED GRADUATE MEDICAL EDUCATION (GME) SLOTS

The committee draft proposes to redistribute unused GME slots to increase access to primary care and general surgery. Specifically, it proposes to reallocate 80% of unused slots, and allows hospitals to request up to 50 new slots. Seventy-five percent of new slots would be designated for primary care or general surgery for five years. Slots would be redistributed based on a set of criteria, such as whether the receiving hospital is in a health professional shortage area.

We applaud efforts to expand the number of physicians to improve access and expand health coverage. We support the committee proposal to redistribute unused residency slots. Given that there are approximately 2,500 unused residency slots, we are pleased that these unused slots will be reallocated to hospitals that are already training physicians. This will help address a portion of the current need. However, given the enhanced need for resident slots coupled with the projected shortage of physicians in the future, CHA supports increasing the number of Medicare-supported training positions for medical residents, especially in primary care.

PHYSICIAN SELF REFERRAL

The committee paper proposes that the current "whole hospital" and rural exceptions be repealed under the *Ethics in Patient Referrals Act*, known as the "Stark" law. They would be replaced by an exception for physician-owned hospitals with a Medicare provider number as of July 1, 2009. These hospitals would be "grandfathered" and allowed to continue to self-refer, subject to certain conditions. This new grandfathering exception includes several conditions for those physician-owned hospitals, such as:

- Ethical investment practice rules to ensure bona fide investment and proportional returns on investment;
- Disclosure of physician ownership interests in hospitals to patients at the point of referral and again at the earliest point of an admission; to the public through notices on the hospital's website; and in reporting to CMS, which is charged with providing ownership information on their website;
- Patient safety requirements to ensure that such hospitals are capable of responding appropriately to complications or emergencies and safely transferring patients who need care beyond their ability, as well as patient disclosure at admission if the hospital does not have 24-hour/7-day onsite physician coverage; and
- Required approval by HHS of any increase in the number of operating rooms, procedure rooms and beds, as well restrictions on growth overall and conditions that must be met.

We applaud the committee for the inclusion of this important provision. While the proliferation of physician ownership of hospitals is stimulated by opportunities for

physicians to earn additional income and gain greater control over their operating environment, the effect on health care delivery and costs in communities can be devastating. CHA supports a ban on physician self-referral to limited-service hospitals with limited exceptions for existing facilities that meet strict investment and disclosure rules.

Thank you again for the opportunity to provide comments on these proposed policy options and for all the efforts of the Senate Finance Committee to improve the health care system. If we at CHA can provide any clarifications of these comments or be of any further assistance, please do not hesitate to contact me or a member of our advocacy staff.

Sincerely,

Sr. Carol Keehan, DC
President and CEO