



American Hospital
Association®

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November 22, 2016

The Honorable Orrin Hatch
Chairman
Committee on Finance
United States Senate

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate

The Honorable Johnny Isakson
Co-chair
Chronic Care Working Group

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

Dear Chairman Hatch and Senators Wyden, Isakson and Warner:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and 43,000 individual members, the American Hospital Association (AHA) applauds you and the other members of the Finance Committee Chronic Care Working Group (CCWG) on the release of your recent discussion draft addressing the significant and challenging issue of managing the care of Medicare beneficiaries with chronic conditions. We appreciate the deliberate and thoughtful process undertaken by the CCWG to solicit feedback from stakeholders, and are pleased to see many of our priorities for improving care for those with chronic conditions reflected in the discussion draft.

We believe the discussion draft represents an important step forward to address the needs of beneficiaries with chronic conditions. Below, we offer some suggestions for expanding the committee's proposals to even more effectively achieve this important goal:

- **Expanded Access to Telehealth:** We are pleased that the CCWG has proposed some expansions to the Medicare telehealth benefit, including coverage of consults for patients experiencing acute stroke symptoms and monthly clinical visits for patients undergoing home dialysis treatment. However, we continue to advocate for 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), which are necessary to realize fully the promise of telehealth.



- **Increased Flexibilities for Accountable Care Organizations (ACOs):** We support the flexibilities for Medicare Shared Savings Program (MSSP) ACOs that the CCWG has included in its discussion draft, including eliminating the geographic limitations on telehealth coverage for MSSP Tracks 2 and 3 ACOs, allowing Track 1 ACOs to select prospective assignment, and creating an option for Tracks 2 and 3 ACOs to provide beneficiaries with incentives to encourage primary care services. However, we continue to urge the CCWG to make these important tools available to all MSSP ACOs, rather than just those in a two-sided risk track, since ACOs that do not take on downside risk still are accountable for health outcomes and costs of their attributed beneficiaries.
- **Medicare Advantage (MA):** We are pleased that the CCWG incorporated provisions that would enable beneficiaries with end-stage renal disease to enroll in an MA plan; permanently authorize special needs plans; expand the Value-Based Insurance Design Model to further test tailored benefits for chronically ill MA enrollees; allow MA plans to offer a wider array of supplemental benefits to chronically ill enrollees; and allow plans to include certain telehealth benefits in its annual bid amount. Further, while we are encouraged that the discussion draft proposes refinements to CMS's Hierarchical Conditions Category (HCC) Risk Adjustment Model, the proposal does not go far enough to address the impact of socio-economic and socio-demographic factors on the cost of care. We strongly encourage the CCWG to expand its proposal to adjust rates by such factors, which will help support beneficiary access to care.
- **Independence at Home:** We support the proposal to extend the Independence at Home demonstration for an additional two years and increase the cap on the total number of participating beneficiaries, and urge the CCWG to consider expansion of the demonstration to a permanent, national program.

In addition, we recommend expanding the discussion draft to include proposals that address behavioral health needs. We support the integration of physical and behavioral health and urge the CCWG to continue to consider policy solutions to address this important area. Research studies have identified a strong association between mental health disorders, such as severe depression, and serious chronic physical diseases, including heart disease, cancer, and diabetes. Untreated mental health disorders can impair a patient's ability to seek or fully participate in recommended treatment for chronic diseases, impeding recovery and worsening outcomes. The AHA will also continue to urge Congress to lift Medicare's discriminatory 190-day lifetime limit on inpatient psychiatric care, which hurts chronically mentally ill patients the most. Also, we urge the continued support of efforts to modify the Medicaid Institutions for Mental Disease exclusion in order to improve access to care.

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Finally, we would like to update you on the work of our Task Force on Ensuring Access in Vulnerable Communities. In examining ways in which hospitals can help ensure access to health care services in vulnerable rural and urban communities, the Task Force has identified aging populations, high disease burdens and lack of primary care services as some of the defining characteristics of vulnerable communities – all relevant to the CCWG. Later this month the Task Force will release its final report that includes options that communities may adopt to preserve access to essential health care services. We look forward to sharing that report with the committee and working with you to advance payment and delivery models recommended by the task force.

Thank you again for considering our comments. Please contact me if you have questions or feel free to have a member of your team contact Melissa Myers at mmyers@aha.org or 202-626-2356.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President