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May 15, 2009

To: Senate Finance Committee

Re: **Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs**

Dear Staff:

Trinity Health supports health care reform and is pleased that the Finance Committee is moving aggressively to achieve coverage and access for all in a cost-effective system of care. **We are writing to express support for the overall direction of the delivery system options paper while making a number of suggestions for improvement.**

Trinity Health is this country's fourth largest Catholic health system and is devoted to a ministry of healing. Our ministry encompasses 44 hospitals (32 owned and 12 managed), 379 outpatient clinics/facilities, 19 long-term care facilities, numerous home health and hospice programs and senior housing communities in seven core states. We employ more than 44,000 full-time equivalents, and our medical staff exceeds 8,000 physicians.

In 2006, Trinity Health developed a discussion document that includes the "Essential Elements" needed to achieve "coverage and access for all" in a cost-effective system of care. These Essential Elements are very similar to the eight principles that the Administration has committed to use as they work with Congress to transform and modernize America's health care system.

Using these Essential Elements, Trinity Health has been urging our nation's leaders to make comprehensive health care reform their top priority. Through our *Find a Way* Campaign, Trinity Health doctors, nurses and staff – those on the front lines of health care – have been asking Members of Congress and the Administration to ensure that everyone has quality, affordable health coverage in a coordinated, cost-effective system of care. *Find a Way* continues to build public support and momentum for comprehensive health care reform and emphasizes that everyone has a role to play. This effort has been coordinated with similar initiatives by the Catholic Health Association and the American Hospital Association.

We believe that one of the roles that we have as a hospital system advocating for reform is to offer suggestions on your white paper, "Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs" from the operational perspective of our hospital leaders. It is our hope that these suggestions and questions will improve the policy as it is refined and developed into legislation. We would welcome more direct engagement with you around these suggestions, if you view that to be beneficial.

General Reaction and Recommendation

Regarding the paper as a whole, we are pleased the Committee is striving to rationalize the delivery system by better aligning incentives for primary care, coordination of care, better chronic disease management, and reductions in unnecessary clinical variation. The road to cost savings should be through these kinds of systemic changes in the way care is delivered rather than blunt cuts in provider payment. For this reason, we are especially supportive of the paper's positive incentives and pilot efforts designed to move the nation aggressively toward better and more efficient care, such as enhanced primary care payment, transitional care payment, the chronic care innovation center, accountable care organizations, and the health care quality demonstration program. Indeed, many of these initiatives mirror our own "Essential Elements" for reform.

As you refine these concepts, we hope you will shift your overall approach more toward these positive, pilot-oriented incentives, and away from some of the more punitive changes that will result in overall payment reductions to healthcare providers. The value-based payment and readmission proposals, for example, are based purely on reduced revenues for poor performers without counterbalancing supports for better systems of care.

In addition, we believe an aggressive and expansive approach to pilot initiatives – followed by rapid implementation of successful practices -- is a better way to achieve systemic change than the wholesale shift to an untested readmission/bundling methodology. While bundling is clearly a good idea, the number of regulatory obstacles, implementation unknowns, and long-standing fragmentation in health care will make the transition a daunting and potentially disruptive one unless it is preceded by a solid roadbed of tested concepts. By taking more time for pilots and more gradual implementation, Congress could also incorporate physician care – currently a troubling "missing link" -- into the readmission/bundling concept.

We outline some suggestions for this shift in emphasis below.

Section I.: Payment Reform – Options to Improve the Quality and Integrity of Medicare Payment Systems

Linking Payment to Quality Outcomes

Hospital Value Based Purchasing

We believe that a value based purchasing program to pay hospitals for their actual performance on quality measures, rather than just reporting of those measures, makes good sense. While it was unclear in the proposal whether the performance standards would be defined in legislation or in implementation, the following are some suggestions for consideration:

- Balance the weighting appropriately between attainment and improvement to ensure high quality performers are not "penalized" at the expense of lower quality performers that are improving.
- Ensure physician and hospital measures are aligned to drive the same high quality outcomes.
- Consider building in a true payment incentive for highest quality performers versus simply getting back to "being whole" after the withhold.

- Apply unused incentive pool funds to payments (such as above) or initiatives designed to accelerate better and more efficient care rather than returning them to the trust fund, a feature of the proposal that produces an overall cut in Medicare funding to hospitals. In other words, the methodology should be budget neutral. Savings to Medicare should be achieved through systemic change (as with some of the other concepts in the paper) not a punitive cut in overall revenues.
- Allow for a future transition of the program to normative standards of quality rather than relative standards. While it may make sense initially to withhold payment from the bottom quartile of performers, this relative scale will become less meaningful as hospitals improve and the "performance distribution" becomes tighter with time.

Physician Quality Reporting Initiative (PQRI) Improvements and Requirement
We support moving the PQRI from merely reporting to a value-based purchasing program. Again, as referenced above, it is our belief that the measures for physician and hospital quality outcomes need to be in alignment.

Transparency and Evidence-Based Decision-Making for Imaging Services. Transparency in Self-Referrals
We agree that physicians should disclose their financial interest in imaging services. It is our experience that patients are often unaware of the financial connection that physicians have to ancillary services. For example, if physicians are leasing space in a medical office building on the hospital campus and providing imaging services in their office, it is often the perception of the patient that the hospital is the provider of those services. The disclosure of a financial interest may prompt a patient to question the necessity of such services or to consider provider options for the services before they are provided.

Promotion of Adherence to Appropriateness Criteria for Imaging Services
We support the proposal to vary payment to physicians ordering imaging services according to the physician's adherence to appropriateness criteria for Medicare advanced diagnostic imaging services (ADIS).

<u>Primary Care</u>

Primary Care and General Surgery Bonus
Trinity Health is in agreement with the concept of providing additional reimbursement to primary care physicians and general surgeons. In many of our markets, we are experiencing shortages in primary care and general surgery. We recommend that this bonus also be provided to nurse practitioners and physicians assistants providing primary care services in the context of a Patient Centered Medical Home supervised by physicians as part of the health care team.

Payment for Transitional Care Activities
We support the proposal to reimburse physicians for certain care management activities performed by nurse care managers or other qualified non-physician professionals. We would request that you expand eligibility for these transitional care payments to other types of providers such as hospitals. In some of our markets (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, including physician offices. These hospitals

are often already attempting to manage care for chronically ill patients through clinics, employed physicians, and/or relationships with community physicians. Moreover, the hospital is sometimes best equipped to make maximum use of the payments because of their leadership in such areas as health IT (electronic health records) and care for the uninsured.

For example, one of our Trinity Health hospitals, Mercy Medical Center – North Iowa, has been part of the Medicare Coordinated Care Demonstration (MCCD). Our site in North Iowa was shown to reduce hospitalizations by more than 17%. The success of this particular site was attributed to the high rates of in-person contact per month per patient. As a result of participation in this program, patients associated with the demo had high rates of compliance around their medications. In addition, the care coordinators in our demo worked closely with the hospital, which provided the programs with timely information on patient hospitalizations. The case managers also interacted informally on a regular basis with physicians, another factor contributing to the program's success.

In the case of the described demonstration project, the hospital is responsible for providing the transitional care services and is reimbursed by Medicare for doing so. We recommend that you consider a more open model that would allow the transitional care services to be coordinated by providers other than simply physicians.

Section II: Long-Term Payment Reforms – Options to Foster Care Coordination and Provider Collaboration

Chronic Care Management

Similarly to our position on the transitional care proposal described above, Trinity Health is supportive of the proposal to establish a Chronic Care Management Innovation Center (CMIC).

We also support the Medicare Rapid Learning Network, which mirrors a concept that we have been recommending to members of Congress for the past two years. Based upon the experience derived in our Medicare Coordinated Care Demonstration (as described above), we worked with other participants in the larger demonstration to develop a proposal with specificity on how such a Learning Network could function. The proposal, which is attached, is called the "Medicare Chronic Care Practice Research Network." We and others in the original demonstration developed the proposal because we realized that the traditional CMS approach to demonstrations was inhibiting the ability of the various sites to apply lessons from their experience on a real-time basis and make mid-course corrections in their approach. The proposed network structure would support a more rapid learning process for achieving better care and Medicare cost savings. In fact, the network has already begun some of this work by building on the demonstration results with a one-time Congressional appropriation.

We recommend that you include the "Medicare Chronic Care Practice Research Network" in the reform bill as one specific rapid learning network that is already producing valuable lessons for care coordination and cost savings. This would not preclude other organizations from becoming or joining the rapid learning concept, but would "jumpstart" the idea with a ready-made network. With this addition to the bill,

actionable lessons and rapid-cycle testing could begin within weeks of the bill's passage. As described in the attached summary, the network would:

- Efficiently design, launch, conduct and evaluate a demonstration focused on care coordination interventions for fee-for-service Medicare beneficiaries with multiple chronic conditions.
- Provide a reproducible, reliable, and scalable framework to standardize and translate best practices for all applicable Medicare beneficiaries.
- Assist the Secretary in translating effective care coordination interventions into policy and practice

We welcome the opportunity to describe this idea further and to describe the success stories associated with our Demonstration project in Mason City, Iowa.

Hospital Readmissions and Bundling

Hospital Readmission and Post-Acute Bundling Policy

Trinity Health is supportive of the need to reduce unnecessary cost in the Medicare system, and certainly values the idea of thoughtful changes in payment incentives versus across-the-board cuts. Our readmission rates at our hospitals are significantly lower than national averages; thus we expect to fall below the 75th percentile proposed in the paper.

However, there are some points that we ask you to consider as you finalize the readmission rate withhold proposal. First, it is important to remember that a hospital's ability to reduce readmissions will depend on a range of factors well beyond inpatient care. We attribute much our success with readmissions to efforts that are not covered directly by Medicare payment such as implementation of an integrated electronic record, associated clinical support tools, case management programs designed to help keep the patient well once they leave the hospital, and other efforts to coordinate care with post-acute providers. These additional efforts should be encouraged and supported as part of the readmission policy. One way to do so would be to adopt the "reward and penalty" approach outlined by MedPac (June 2007) rather than the "penalty only" concept described in your paper. The resulting boost in payment for high-performing hospitals would give them some of the resources they need to help coordinate care beyond the hospital door.

Second, effective risk-adjustment will be critical to the success of a readmission policy. This is especially true for hospitals that serve high numbers of patients that need extra support services, such as low income populations or persons with cultural and language barriers to care.

Third, it is important to remember that physicians refer, admit and discharge patients. In most markets across the country, these physicians operate independently-owned practices and are not employees of the community hospitals. As written, the readmission penalties do not take into consideration the influence of the physicians.

The payment incentives for physicians and hospitals have a history of misalignment. In the current IPPS system, hospitals are paid on a DRG basis, which provides some incentive to minimize length of stay. However, in the current system physicians are reimbursed on a per diem basis for treating those same patients. This misalignment of

payment incentives drives conflicting behaviors, which does not always result in the highest quality, most cost-effective outcome for the patient or the Medicare system.

We recommend that as you consider proposals to reduce unnecessary readmissions to hospitals it be done in concert with an evaluation of the incentives embedded in the physician payment system.

Bundling Policy
As written, this proposal would bundle payment for hospitals and post-acute care services initiated within 30 days of discharge provided by home health organizations, skilled-nursing facilities, rehabilitation hospitals and long-term acute care hospital services. The concept is promising, but we have some concerns and suggestions.

Physician services are not included in the bundled payment proposal. With physicians as the drivers of many aspects of care including referrals to hospitals, home care and long-term care facilities, their absence in a bundled payment is concerning.

In addition, in the majority of markets across our nation, health care providers are not vertically integrated. Assuming that bundled payments are enacted, hospitals and other post-acute providers may begin to integrate to improve care coordination and share risk. Such integration would likely improve outcomes, reduce cost, and enhance usability. This will require, of course, significant changes in regulations and related barriers to integration. For example, it would be helpful if regulations that currently require patients to be provided with a complete list of post-acute providers could be relaxed to accommodate this potential shift to greater integration.

In addition, as described above, the local market dynamics of health care is likely to put post-acute providers in a vulnerable position as compared to the larger hospital entity that will be receiving the bundled payment. We would encourage policy makers to include mechanisms in the bundled payment structure to ensure that post-acute providers are paid fairly, and that patients are referred appropriately and in a timely manner to post acute care. Without such protection, these providers may be pushed out of the market place, thus reducing access to post-acute services for Medicare beneficiaries.

Another comment that we have pertains to the 30-day post acute timeframe specified in the proposal. In many instances we experience episodes of care to approximate 45-60 days in the post-acute arena. We would ask you to consider how those services outside that timeframe will be reimbursed as you advance the bundled payment proposal.

Finally, while the bundling concept certainly makes sense as a method for aligning incentives, the process of getting to a successful policy will not be easy. Providers have not had a history of coordinating well in most markets, and the range of regulatory barriers to collaboration is extensive. Questions about quality and effectiveness for patients will be paramount. We recognize that the 2014 start date will give providers some time to get ready for the change, but we strongly urge you to support an aggressive and extensive pilot program so that multiple sites around the country can test and refine the approach. This would also allow you to test ideas for including physicians. Based on the pilots, bundled payments could then be implemented gradually and on a timeline that ensures a successful national transition.

Moving from Fee-for-Service to Payment for Accountable Care

Medicare Shared Savings Program (i.e. Accountable Care Organizations)
We support the proposal to establish Accountable Care Organizations and would welcome the opportunity to participate in demonstration projects of such models in certain of our markets. We agree that legal and regulatory impediments will need to be addressed in order to facilitate such arrangements among health care providers.

Extension and Expansion of the Medicare Health Care Quality Demonstration
We strongly support your intention to expend 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 organizations were very interested in pursuing bold new approaches for organizing and paying for care in their communities when the MMA was passed, but we concluded that we could not bear the full financial risk of such an effort to achieve budget neutrality, as required by CMS. 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.

Section III: Health Care Infrastructure Investments – Tools to Support Delivery System Reform

Health IT

Encouraging Health Information Technology use and Adoption in Support of Delivery System Reform Goals
We are supportive of the proposal to expand eligibility for the EHR Medicare incentive payments to include nurse practitioners and physicians assistants under certain conditions. In certain of our communities it is common to use physician extenders to provide primary care services to our Medicare patients.

We also support the consideration that is being given to providing health IT incentives to post-acute service providers. Our post-acute providers operate at break-even margins, leaving few resources to invest in Health IT. Incentive payments would fund such investments. Health IT improvements that connect hospitals and post-acute providers will improve care coordination for Medicare beneficiaries with chronic conditions resulting in lower costs to the system. Connectivity would also improve providers' ability to manage a bundled payment.

We also encourage you to include hospital-sponsored clinics for underserved populations. These clinics are typically not FQHCs that currently qualify for health IT support, but they are frequently key components of the community safety net.

Comparative Effectiveness Research (CER)
We support the proposals around comparative effectiveness. We think it is important to note that among multi-state, community hospital systems, Trinity Health has the most advanced HIT platform in the nation, and can immediately analyze an existing 7 million patient records from hospitals in seven states and varied communities. We can also conduct "real time" testing of comparative procedures in the kinds of hospitals

(community hospitals rather than academic medical center) where most Americans receive their care.

We would request that you consider seeking our expertise in this area as you advance legislation, particularly in terms of CER scope. We believe that comparative effectiveness research should focus not just on drugs, devices, and treatments, but also on the care process inside the hospital and across clinical settings. For example, we were able to use our data repository to help us identify and replicate best practices that have now resulted in substantial decreases in pressure ulcers and patient falls across our hospital network. Our work comparing best treatments and the care process itself is already yielding better outcomes and savings.

At a minimum, we urge you to ensure that comparative effectiveness research is performed in the community hospital setting, where most Americans get their care. Right now this research is typically done in the academic medical centers, which are not representative of the typical community hospital setting.

Transparency

Physician-Owned Hospitals

We support the proposal to eliminate the “whole hospital” exception to ban on self-referral. We have been advocates in this regard for several years in partnership with the American Hospital Association and the Coalition of Full-Service Community Hospitals.

Self-referral creates a troubling and damaging conflict-of-interest for physician owners. MedPAC, CMS, and a number of academic studies have now documented the detrimental impacts. Unlike when this debate first began in Congress, we now know that limited-service hospitals:

- Specialize in a narrow range of services that are more profitable than the average mix of patients typically found in a full-service hospital,
- “Cherry pick” more profitable cases leaving the community hospital with the more expensive patients,
- Often have no emergency room, unlike most community hospitals, which are obligated to see all patients walking through the door,
- Are less likely to serve Medicaid and uninsured patients,
- Result in higher utilization of certain, highly reimbursed services, thereby exacerbating the problem of spiraling health insurance premiums for employers.

As you know, we and other full-service hospitals are more than willing to compete based on cost, quality, and efficiency. However, referring the most carefully selected, financially rewarding patients to facilities in which physicians have an ownership interest is not “fair competition.” It is anti-competitive.

We urge you to include this ban in delivery reform legislation.

Workforce

General Remarks

We believe that when our nation embraces universal coverage and provides access to all of its citizens that there is going to be a significant shortage in primary care providers,

nurses and other health professionals. We have seen this happen in states like Massachusetts as they have implemented their individual mandate and provided access to nearly all citizens of their state. We have concerns that this issue has not yet been adequately addressed with the proposals set forth in this discussion paper.

We would encourage you to prioritize this issue as you draft delivery reform.

Redistribution of Unused GME Slots to Increase Access to Primary Care and Generalist Physicians
Trinity Health supports the proposal to establish a redistribution of currently unused residency training slots as a way to encourage increased training, particularly in the areas of primary care and general surgery. We believe that it will be important to use a broad definition of primary care providers, which includes internal medicine and hospitalists. We expect to experience a shortage of such professionals, particularly as the baby boomers age and if universal coverage becomes reality.

Proposed development of a National Workforce Strategy
Trinity Health supports the establishment of a national health workforce commission that would be tasked with advising Congress and the Secretary on health care workforce policy and recommendations. At our hospitals, we have employed several successful strategies with our nursing workforce. These efforts have been rewarded with lower than average turnover and higher levels of satisfaction of our nursing staff. We would welcome the opportunity to share these ideas with your Committee or the Senate HELP Committee as legislation is formulated.

Section IV: Medicare Advantage – Options to Promote Quality, Efficiency and Care Management

As you refine Medicare Advantage policies, we encourage you to reinforce and reward plans that are actually helping to lead the way to health care reform today. We recognize that many MA plans are not coordinating care and achieving the kinds of outcomes envisioned when the program was started. But as payment reductions are implemented, they should be calibrated to encourage high-quality plans.

Trinity Health owns a plan in the Columbus, Ohio market that participates in the Medicare Advantage program. Our plan, called MediGold, provides value in the following ways:

- Medigold provides $150.62/month benefits over the standard Medicare benefit per Senior
- Seniors who participate in disease management programs like MediGold's spend 11% less for care after entering such programs
- Highest ranking in Ohio in terms of customer service, value and overall quality as ranked by CMS Senior satisfaction surveys
- "Medicare Made Easy" with low co-pays, no paperwork and dedicated service representatives to answer questions or concerns
- Ownership by a healthcare system with employed physicians creates opportunities for integrated and coordinated delivery of healthcare unavailable with other MA models
- Critical to our hospital's product portfolio that provides risk diversification supporting health care in neighborhoods with low access to critical healthcare services

Trinity Health supports reform to the Medicare Advantage Program and believes that it should include the following elements:

- Spread any reduction in payments over three years to allow Medicare Advantage plans to develop and implement measures (e.g., reduction in benefits and increased premiums) to effectively manage the impact on Seniors.
- Differentiate and support Medicare Advantage plans that add value or provide unique benefits from plans that do not:
    - Give "value add" plans more payment reduction transition time and cut them less to reinforce their contribution to better and more efficient care as part of health reform.
    - Let CMS define "value add" to include some combination of structural and performance criteria:
        - Structural Examples: Organized system of care; coordination of care; case management for chronic conditions; patient safety and quality provisions; health IT that includes clinical support tools.
        - Performance Examples: CMS five-star ranking in Senior satisfaction surveys; hospital readmissions for selected conditions; access to needed drug therapies.
- Recognize role of "value add" Medicare Advantage plans as partners with government in achieving health reform objectives

Concluding Remarks

In closing, we would stress the importance of making sure that the concepts outlined in the white paper are implemented in concert with the other critical elements of health care reform, especially coverage and access for all. As you know, the various elements of reform are interrelated. It will be critical in the coming months to ensure that final legislation is both comprehensive and integrated – and that it achieves the imperative for a health system that meets the needs of all Americans.

Trinity Health has been advocating for systemic health care reform for over two years. We believe that one of the roles that we have as a hospital system advocating for reform is to offer suggestions on your white paper, "Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs" from the operational perspective of our hospital leaders. It is our hope that these suggestions and questions will improve the policy as it refined and developed into legislation. We would welcome more direct engagement with you around these suggestions, if you view that to be beneficial.

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