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The Honorable Orrin Hatch
Chairman
Senate Finance Committee

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee

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) is pleased to provide additional feedback on ways to improve the provision of care for Medicare beneficiaries with chronic health conditions. We applaud you and the other members of the Finance Committee Chronic Care Working Group (CCWG) for recognizing the need to tackle this significant and challenging issue. We appreciate that the group has dedicated significant effort to considering stakeholder feedback on this issue, and are encouraged to see this work progress, as evidenced by the policy options document the CCWG released last month.

The AHA is pleased to see that the CCWG has included many of our priorities for improving care for those with chronic conditions, including the expansion of telehealth, improvements to accountable care models, and policies to increase Medicare beneficiary engagement. We also applaud its focus on behavioral health, although we encourage the CCWG to expand its focus to recognize that behavioral health conditions may themselves be chronic illnesses.

While our detailed comments on the CCWG's policy options follow, we would like to take this opportunity to highlight one specific effort that the AHA has underway: our Task Force on Ensuring Access in Vulnerable Communities. This Task Force is examining ways in which hospitals can help ensure access to health care services in vulnerable rural and urban communities. In its initial work, 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. As such, it is planning to explore the possibility of developing a new care delivery and payment model that addresses the needs of Medicare beneficiaries with multiple chronic conditions. As the development of this model advances, we will ensure that the CCWG is well-informed about our progress and pathway.

EXPANDED ACCESS TO TELEHEALTH FOR MEDICARE BENEFICIARIES

The AHA agrees with the CCWG that innovation in technology may increase Medicare beneficiaries' access to services that are critical to treating and managing chronic disease. A growing body of evidence indicates that telehealth, in particular, increases quality, improves patient satisfaction and reduces cost. Currently, more than half of U.S. hospitals connect with patients and consulting practitioners at a distance through the use of video and other technology. However, as we noted in our prior feedback to the CCWG, significant barriers to telehealth expansion exist, which limit its use and potential. **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) – are needed to realize fully the promise of telehealth for Medicare beneficiaries.** While we will continue to advocate for these broader changes, we also support and encourage adoption of the more incremental changes to current policies the CCWG has put forth for consideration.

In addition to the policies outlined by the CCWG, the AHA strongly urges Congress to provide dedicated funding to conduct research to determine the benefit of telehealth compared to its cost. Although evidence on the quality and access benefits of telehealth continues to grow, there are insufficient studies on the cost-benefits of telehealth outside of certain services, such as telestroke. More and better research is needed for other conditions and newer technologies, such as remote monitoring of patients. Such research would help policymakers considering a broader expansion of telehealth benefits, providers considering adoption of telehealth to provide services, and Medicare beneficiaries considering whether to access services via telehealth.

Expanding Access to Home Hemodialysis Therapy. The CCWG is considering expanding the definition of a telehealth originating site – the site where the Medicare beneficiary receiving telehealth services is physically located – to include freestanding renal dialysis facilities. Further, the CCWG is considering allowing renal dialysis facilities to serve as originating sites, regardless of geographic location. This would expand the locations from which Medicare beneficiaries who receive home hemodialysis therapy may access their required monthly clinical assessment.

The AHA supports allowing freestanding dialysis facilities to serve as originating sites and eliminating the geographic restriction with respect to those visits. However, we urge the CCWG to consider a more comprehensive approach of waiving the geographic restriction for the monthly clinical visit when provided at *any* authorized originating site, including hospitals and physicians' offices. This would provide the greatest flexibility for Medicare beneficiaries who choose to utilize telehealth for their monthly visit, and would prevent introducing a disparity among providers of dialysis services.

Increasing Convenience for Medicare Advantage (MA) Enrollees through Telehealth. The CCWG is considering allowing MA plans to submit costs associated with telehealth in their bid amounts. The CCWG also seeks input on what costs should be allowed.

The AHA supports allowing MA plans to submit costs associated with telehealth as part of their bid amounts. Reimbursing MA plans for telehealth will promote provider adoption of such technologies, ultimately improving both quality, efficiency and access to care. At the same time, the MA program requires that plans meet certain network adequacy standards, such as the maximum travel distance and travel time for enrollees to reach providers, as well as a minimum number of providers serving MA enrollees in that plan. While telehealth holds the promise of improving access to certain health care professional for MA enrollees, it should not be used to substitute for the provider ratio or time and distance criteria embedded in the MA plan network adequacy requirements. In addition, we encourage the CCWG to not limit MA plans to what is currently reimbursable under fee-for-service (FFS) Medicare. Current restrictions, including limitations based on geography and originating site of care and on some services and technologies, will limit the ability to leverage the benefits of telehealth, similar to what has happened in the FFS system. **Instead, we encourage the CCWG to revise current policy with respect to telehealth to allow reimbursement for a broader range of telehealth services, both within the traditional Medicare program and the MA program.** Such consistency will provide the greatest incentive to providers to adopt telehealth to delivery services safely and efficiently.

Providing ACOs the Ability to Expand Use of Telehealth. The CCWG is considering allowing Medicare Shared Savings Program (MSSP) accountable care organizations (ACOs) that participate in a two-sided risk model to request a waiver of the geographic limitation on the provision of telehealth services. The CCWG also solicits feedback on whether to lift the originating site requirement entirely for such ACOs, which would allow Medicare beneficiaries to receive telehealth services from their homes.

The AHA supports allowing MSSP ACOs to request waiver of the geographic limitations to the provision of telehealth. This would provide qualifying ACOs increased flexibility to address issues with access to primary care and specialty services, which exist in both urban and rural settings. We also support allowing CMS to waive the originating site requirements entirely for qualifying ACOs, which would increase their ability to provide telehealth services in Medicare beneficiaries' home, when clinically appropriate. However, we urge the CCWG not to limit such flexibilities to solely ACOs in a two-sided risk track.

Telehealth is an important tool to assist all ACOs, regardless of risk track, with providing quality, coordinated care to Medicare beneficiaries. We acknowledge the CCWG's concern about curbing the potential overutilization of telehealth services. However, Track 1 ACOs that have not accepted downside risk have an important incentive to prevent unnecessary utilization, in that they still are measured against a financial benchmark, and excess utilization that leads to increased spending would cut into any potential savings such ACOs could realize. Further, for these same reasons, we urge the CCWG to explore including telehealth waivers in all new Medicare payment and delivery models.

Expanding Use of Telehealth for Individuals with Stroke. The CCWG is considering eliminating the geographic restrictions on telehealth for the limited purpose of identifying and diagnosing strokes. The AHA supports this option, which would allow Medicare beneficiaries – whether in a

rural or urban location – to be evaluated for acute stroke by an offsite neurologist, resulting in more prompt provision of critical care. **Again though, we encourage the CCWG to revise current policy with respect to telehealth to allow adequate reimbursement for a broader range of telehealth services, as opposed to a condition-by-condition approach which only allows certain patients to benefit from access to telehealth.**

INCREASED FLEXIBILITY FOR MSSP ACOS

The CCWG has requested feedback on a number of enhancements to the MSSP. Many of our member hospitals and health systems participate in the MSSP as part of their ongoing efforts to transform care delivery through improved care coordination and financial accountability. However, as we previously expressed to the CCWG, we are concerned that the program does not adequately balance the risks and rewards for participating providers. Therefore, we continue to urge structural modifications, such as altering the shared savings formula, to allow providers to achieve a larger bonus, and using quality performance to result in bonus payments, rather than resulting only in penalties. That said, the AHA supports the changes discussed in the policy options document, which would provide increased flexibility that would enable ACOs to better coordinate and manage care.

Maintaining ACO Flexibility to Provide Supplemental Services. The CCWG is considering allowing MSSP ACOs to provide Medicare beneficiaries with certain services that are not covered by FFS Medicare, such as transportation, social services and remote patient monitoring services, in order to help ACOs best serve their patient populations.

The AHA conceptually supports this approach, as ACOs would appreciate increased flexibility to offer services that address the needs of the population they are managing. However, they are currently prohibited from doing so by civil monetary penalty (CMP) restrictions on patient incentives that could influence Medicare beneficiaries to seek services from a particular provider. Though the MSSP includes a waiver of the beneficiary inducement CMP, the waiver is limited to certain circumstances. If the CCWG clarifies that ACOs may provide such additional services, it must also clarify how the beneficiary CMP would apply to those services.

Providing Flexibility for Beneficiaries to be Part of an ACO. Currently, the Centers for Medicare & Medicaid Services (CMS) assigns beneficiaries to Track 1 and 2 MSSP ACOs at the end of a performance year, after evaluating where beneficiaries received most of their primary care in that performance year. The CCWG discusses the potential of instead allowing ACOs in MSSP Track 1 (the non-risk-bearing track) to choose whether their beneficiaries are assigned retrospectively or prospectively, at the beginning of the performance year. The group also discusses whether Medicare beneficiaries should be able to elect to be assigned to an ACO.

The AHA supports these policy options, and in fact urged CMS to adopt them through its 2015 rulemaking on the MSSP; however, the agency ultimately declined to do so. Specifically, we support allowing all MSSP ACOs to choose the assignment methodology that best fits their particular strategies. Prospective assignment could be attractive because it would increase certainty for the ACO and provide a more narrowly defined target population, which could

enable it to improve care management, identify and target services to high-risk individuals, develop specific outreach programs, and proactively work with patients and their families to establish care plans. In contrast, some ACOs might feel it is more beneficial to potentially add assigned beneficiaries over the course of the performance period through retrospective assignment. Lastly, it is unclear why the CCWG would limit this option to Track 1 ACOs; we urge extending this flexibility to all MSSP ACOs.

Additionally, we support allowing beneficiaries to elect voluntarily to be assigned to an ACO. This policy would balance the important considerations of beneficiaries' freedom to choose their providers with ACOs' interest in reducing churn among their assigned populations, which would help provide a more defined and stable beneficiary population up front. This, in turn, would allow ACOs to target more effectively their efforts to manage and coordinate care for beneficiaries for whose care they will ultimately be held accountable. In addition, allowing beneficiaries to attest to the provider they want to manage their care may help increase beneficiary engagement in that care. We also urge the CCWG to consider building in incentives that would encourage beneficiaries attributed to an ACO to seek care from within the ACO. This would give ACOs a powerful tool to better influence cost and quality outcomes.

Eliminating Barriers to Care Coordination under ACOs. The CCWG is considering allowing ACOs in two-sided risk models to waive beneficiary cost-sharing for items and services that treat a chronic condition or prevent the progression of a chronic disease. The AHA supports this approach, as it could help remove a financial barrier that may discourage beneficiaries with chronic conditions from seeking needed care, which, as the CCWG notes, ultimately, can lead to increased costs and poor health outcomes. Further, this policy may provide ACOs with a tool to encourage beneficiaries to seek care from ACO providers. **We urge the CCWG to consider allowing all MSSP ACOs, rather than just those in a two-sided risk track, to take advantage of this flexibility since, as noted above with respect to telehealth, ACOs that do not take on downside risk still are accountable for health outcomes and costs of their attributed beneficiaries.**

In addition, almost all of the alternative payment models (APMs) that CMS has implemented to date, including ACOs, utilize a retrospective payment methodology that is built upon the existing FFS payment system infrastructure and processes. While we are supportive of this pathway, we note that the use of a FFS foundation in APMs creates challenges that either did not exist or were not as problematic in the FFS system. For example, we continue to be concerned about additional barriers to care coordination that exist under ACOs and other alternative payment models. Allowing health care providers maximum flexibility to identify and place beneficiaries in the clinical setting that best serves their short- and long-term recovery goals is essential to ensuring that care is provided in the right place at the right time – an important goal for all beneficiaries, but perhaps even more so for those who are chronically ill. It is also a valuable tool to help increase quality and reduce unnecessary costs. **Therefore, we urge the CCWG to consider waiving additional regulatory barriers to care coordination, such as the long-term care hospital (LTCH) "25% Rule," the inpatient rehabilitation facility (IRF) "60% Rule," and the skilled nursing facility (SNF) "three-day rule," within APMs.**

Finally, the varying designs of the different FFS prospective payment systems create a new challenge under APMs. Specifically, many of them, such as the IRF PPS, make predetermined per-discharge payments based primarily on the patient's condition. Therefore, efficiencies achieved in these settings are not reflected in their payments. The only opportunity to achieve payment efficiencies in such settings may be to avoid them, which is, needless to say, not an ideal strategy for any party involved – particularly so for beneficiaries who are chronically ill. Therefore, we urge CMS to consider ways to allow for efficiencies that are achieved in provider settings, such as IRFs, to actually be reflected in their payments.

PAYMENT FOR CHRONIC CARE MANAGEMENT SERVICES

In the calendar year 2014 Physician Fee Schedule final rule, CMS established a policy to pay physicians and qualified non-physician practitioners explicitly for care management services provided to patients with two or more chronic conditions, effective Jan. 1, 2015. The CCWG discusses two options that would build on this payment for care management services.

Improving Care Management Services for Individuals with Multiple Chronic Conditions. The CCWG is considering establishment of a new high-severity chronic care management code under the Physician Fee Schedule. This code would be higher than the current chronic care management code to compensate providers who require significantly more than the 20 minutes of care management per month required to bill the current code.

The AHA supports creation of a new code to better compensate clinicians for circumstances where they spend substantially more time to manage an individual's chronic condition, as there is clearly a wide range of clinical severity levels within the chronic care patient population. However, we suggest the CCWG consider another metric – such as amount of time spent – rather than a beneficiary's number of chronic conditions – to determine when the code is applicable. It is feasible that in some cases a beneficiary with fewer, but more severe, conditions could take more time to manage. For example, the chronically *critically* ill patient population, which includes patients with chronic obstructive pulmonary disease and ESRD that are treated by LTCHs, have unique care management needs and access concerns. Specific care management protocols are likely appropriate for this segment of the chronically ill patient population, which may require much more time than would necessarily be indicated by the simple number of chronic conditions present. Focusing on time spent managing the condition, rather than a beneficiary-specific attribute, comes closer to reimbursing clinicians for the actual care they have provided. Alternatively, the CCWG could consider risk adjusting the code, which could provide a more precise relationship between payment and the severity of a beneficiary's conditions.

Encouraging Beneficiary Use of Chronic Care Management Services. Medicare beneficiaries must pay a copayment, currently around $8, each time their clinicians bill the chronic care management code. The CCWG is considering waiving the co-payment. The AHA supports this change, as any out-of-pocket expense can discourage a beneficiary from accessing services. This is particularly the case with a non face-to-face, less tangible service such as care management services. It likely is confusing to beneficiaries to receive a bill for a service that was not directly provided, and burdensome for clinicians to collect this co-payment. Waiving the co-payment

could increase beneficiaries' willingness to receive care management services and reduce provider burden. This could, in turn, help improve patient care transitions between different settings, including acute care, post-acute care and the community.

CHANGES TO MEDICARE ADVANTAGE (MA) PLANS

Providing MA Enrollees with Hospice Benefits. The AHA supports the CCWG's proposal to integrate hospice services into the MA benefit package. Today, hospice benefits for MA enrollees are coordinated and delivered by an integrated, interdisciplinary team, but services outside of the hospice benefit, e.g., treatment for conditions unrelated to the terminal illness, are managed separately by the MA plan. Integrating these two silos will create a better opportunity for enhanced, comprehensive care coordination.

We caution the CCWG, however, from pursuing this provision without adequate beneficiary safeguards in place. Plan rates will need to be adjusted to incorporate costs associated with the hospice benefit and we strongly encourage the CCWG to ensure that nothing in the integration of these services or in the development of the plan rates dismantles the important interdisciplinary structure of the hospice benefit, which includes social work, chaplaincy and family bereavement services in addition to the management of pain and other symptoms.

We also urge the CCWG to consider specific beneficiary protections to prevent delays in access to care and inappropriate denials. The MA reimbursement structure incentivizes plans to reduce inappropriate or unnecessary utilization. As such, plans often use prior authorization as one tool to determine whether a service is necessary. However, this process can lead to delays in care and some providers contracting with MA plans report high rates of coverage denials, which then require appeal. Individuals eligible for hospice services do not have the time or often the capacity to pursue lengthy prior approval or appeals processes. We strongly recommend that the CCWG incorporate safeguards for this unique benefit such as instant coverage determinations and expedited appeals processes for coverage denials.

Allowing End-stage Renal Disease (ESRD) Beneficiaries to Choose an MA Plan. The AHA supports the CCWG's proposal to allow individuals with ESRD to enroll in MA. There is significant opportunity to improve care coordination and management for individuals with ESRD.

Similar to our hospice comments above, given the medical severity of ESRD patients, we urge the CCWG to implement adequate beneficiary safeguards when pursuing this provision, again by implementing instant coverage determinations and expedited appeals processes to protect against delays in accessing care. We also stress that this is a high-need/high-cost population and plan rates will need to be adjusted to account for these costs. Because plans have not previously served many ESRD patients, we encourage the CCWG to provide FFS Medicare data to plans so that they have a full understanding of the cost of managing care for this population. Without adequate reimbursement, plans may struggle to contract with a sufficient number of providers to provide timely access to high-quality care, particularly in areas that may not have a large supply

of dialysis facilities, such as rural areas. The condition of ESRD patients, like hospice patients, cannot withstand delays in access to care.

Providing Continued Access to MA Special Needs Plans (SNPs) for Vulnerable Populations. The AHA recognizes the importance of offering tailored plans to individuals with special needs and supports an extension of SNPs. However, the need for SNPs may diminish if the CCWG pursues the enhanced flexibilities for traditional MA plans that it has also proposed. We recommend that the CCWG consider our comments on this provision in conjunction with our comments below related to those proposed flexibilities.

We encourage the CCWG to use the next extension of the SNP program to make critical program reforms. The excessive regulatory burden placed on SNP plans results in unnecessary administrative burden and health care utilization. For example, plans must make all services available to all enrollees, whether they are necessary and appropriate for a particular beneficiary nor not. This means that they have limited ability to tailor benefits to different enrollees within a SNP, an important shortcoming because despite sharing many common characteristics, no two enrollees are alike. We strongly encourage the CCWG to review the administrative burden associated with SNP plans and allow similar flexibilities as contemplated for all MA plans.

Adapting Benefits to Meet the Needs of Chronically Ill MA Enrollees/Expanding Supplemental Benefits to Meet the Needs of Chronically Ill MA Enrollees. The AHA encourages the CCWG to continue exploring flexibilities within the MA program that would allow plans to better meet the needs of chronically ill enrollees. **We are particularly encouraged by and strongly support the CCWG's interest in allowing plans to offer non-medical social services and additional services via telehealth. However, as mentioned above, we recommend that these same flexibilities be available to all Medicare beneficiaries – FFS Medicare as well as MA.** Many social, economic and demographic factors contribute to an individual's health status, such as secure and safe housing, transportation, assistance with activities of daily living, and adequate nutrition and physical exercise. These factors often cannot be addressed by medical services alone and can have a negative impact on health outcomes, patient experience of care, and total cost of care. MA plans currently have limited options for providing non-medical social services to help address these underlying social determinants of health.

In addition, we strongly encourage the CCWG to consider allowing plans to provide other supplemental services that will facilitate keeping individuals in their homes. Patients prefer to stay in their homes, and the home can be the most efficient site of care. Two examples of such services include personal care services for beneficiaries that do not have a need for skilled care and remote patient monitoring.

However, while the AHA believes that such flexibilities can help plans best manage their enrollees, they may create more administrative complexity and burden if not implemented carefully. If each plan's approach to supplemental benefits varies significantly, hospitals and other providers will be burdened with deciphering different benefit packages, billing plans appropriately, and educating beneficiaries about benefit options and cost-sharing, among other challenges. Therefore, we recommend that the CCWG iteratively implement additional

flexibilities. For example, it could identify an initial set of supplemental benefits that plans may offer and authorize CMS to develop a process to approve additional supplemental benefits over time, as well as issue guidance on how plans may market these benefits and how they should price them for purposes of submitting their bid amounts. Providers will benefit from the sharing of best practices and information on performance of similar programs.

Ensuring Accurate Payment for Chronically Ill Individuals. **The AHA strongly urges the CCWG to further explore refinements to the Hierarchical Condition Categories (HCC) risk-adjustment model.** We applaud the CCWG for identifying dual-eligible status, total number of conditions/cumulative impact of a large number of conditions, and the interaction between physical and behavioral health conditions as a potential modifiers to the HCC model. However, we encourage the CCWG to look further. Specifically, there is a strong and growing body of evidence that a number of patient characteristics impact health outcomes, health care utilization and cost of care. Just this month, the National Academies of Medicine (NAM) released its report, "Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors," which focuses on the social – not medical – factors that influence access to care, health care use, health outcomes and cost. NAM identified five domains of social risk: 1) socioeconomic position (SEP); 2) race, ethnicity and cultural context; 3) gender; 4) social relationships; and 5) residential and community context. These factors are not fully accounted for in the HCC risk-adjustment model, but should be considered as additional adjustments. Better accounting of sociodemographic information, where appropriate, will ensure that plans are adequately reimbursed for more complex patients. Failing to account for these issues when establishing reimbursement rates can harm patients and worsen health care disparities by diverting resources away from plans serving large proportions of disadvantaged patients and their network providers.

In addition, we again urge the CCWG to incorporate socioeconomic adjustment into the Hospital Readmissions Reduction Program (HRRP) and other quality measurement programs so that hospitals caring for our nation's most vulnerable patients are not unfairly penalized. The current HRRP fails to recognize that community factors outside the control of the hospital — such as the availability of primary care, mental health services, physical therapy, easy access to medications and appropriate food, and other rehabilitative services —significantly influence the likelihood of a patient's health improving after discharge from the hospital or whether a readmission may be necessary.

ADDRESSING THE NEED FOR BEHAVIORAL HEALTH AMONG CHRONICALLY ILL BENEFICIARIES

Expanding the CCWG's focus on behavioral health. **We applaud the CCWG's attention to behavioral health and believe that focus should be expanded further.** For example, the CCWG states that "[b]ehavioral health problems hinder the successful management of chronic conditions." While true, this statement overlooks the fact that behavioral health conditions may themselves be chronic, such as with schizophrenia or persistent depressive disorder. Therefore, we urge the committee to support policies that will provide access to treatment for those with chronic behavioral health conditions. We applaud the CCWG's leadership in passing the

Improving Access to Emergency Psychiatric Care Act (S. 599), but **we urge it also to lift Medicare's discriminatory 190-day lifetime limit on inpatient psychiatric care, which hurts chronically mentally ill patients the most.** In addition, we urge the continued support of efforts to modify the Medicaid Institutions for Mental Disease exclusion in order to improve access to care.

Supporting Integrated Approaches. We echo the CCWG's concern about the need for a more integrated behavioral and physical health care delivery system, which research demonstrates could improve outcomes and lower costs. Although health care providers are embracing new frameworks for behavioral and physical health care integration, many encounter a discouraging barrier: the lack of mental health care professionals – especially psychiatrists, but also psychologists, licensed clinical social workers, advanced practice nurses and physician assistants with training in addiction and psychiatry, as well as licensed mental health counselors and specialists. As the CCWG assesses policies to improve integration of behavioral and physician health care, we urge the CCWG to be mindful of this significant limitation and how such policies could address it.

EXPANDING THE INDEPENDENCE AT HOME (IAH) MODEL OF CARE

The AHA supports expansion of the IAH demonstration to a permanent, national program. Under the IAH model, a care team led by physicians or nurse practitioners provides primary care home visits tailored to the needs of Medicare beneficiaries with multiple chronic conditions and functional limitations. Several AHA members participate in this demonstration and have expressed enthusiasm for continuation and more widespread adoption of its home-based approach. As the CCWG notes, this effort has been successful so far – in the first performance year over 75 percent of participating organizations demonstrated an average savings per beneficiary, and all participating organizations showed improvement on specified quality measures. National and permanent expansion of this model would allow more providers to implement its home-based approach as part of their overall care redesign efforts and – more importantly – allow more Medicare beneficiaries to appreciate its benefits.

EXPANDING ACCESS TO DIGITAL COACHING

The AHA supports a requirement that CMS provide medically related information and educational tools on its website to help beneficiaries learn more about their health conditions and manage their own health. As we noted in our previous feedback to the CCWG, it is important to identify and adopt strategies to engage Medicare beneficiaries in their own health and health care. A good first step would be to provide the public with easy-to-understand, accessible and comprehensive information to better understand how to improve and maintain their health. Materials should be consumer-friendly and include information on physical, mental and oral health. For example, CMS could provide basic information and fact sheets on both healthy and unhealthy behaviors related to issues such as nutrition, physical activity, tobacco and substance abuse, sleep and stress. Such information also should include educational tools for patients and families on chronic disease prevention and management.

INCREASING TRANSPARENCY AT CMS

The AHA supports a requirement that CMS issue notice-and-comment rulemaking for all new mandatory delivery system and payment models. An innovation model that mandates provider participation substantively affects those providers' rights and imposes significant responsibilities on them. In some cases, it may effectively change the payment system with respect to a particular provider or set of services. As such, CMS should be required to provide the full details of any program, its rationale for making the proposal and any data it considered when developing the proposal, and an opportunity for the field to respond.

For example, the new Comprehensive Care for Joint Replacement (CJR) model mandated participation by hospitals in certain markets. In many cases, successful hospital participation in this program will require care redesign, which can come at a significant cost for the implementing providers. In addition, there is a real risk that some hospitals' payments for the procedures that fall under the new CJR bundle may be reduced. Although the AHA supports the program overall, based on our data analysis and member feedback we identified some needed improvements to the model's design – many of which CMS implemented in the final rule. Absent the rulemaking process and the opportunity to comment, CMS would have missed the benefit of feedback that will improve the model's likelihood of success.

Further, once a mandatory model is implemented, it is reasonable to expect that changes to the model will be made through notice-and-comment rulemaking. Again, such changes substantively affect the rights and responsibilities of participating providers, who often must invest significant resources to ensure success in these models. Notice-and-comment rulemaking would require CMS to provide adequate notice of any changes it is considering, as well as to consider any feedback from providers who have first-hand experience with the model. Though this might slightly constrain CMS's ability to tweak the model as it is ongoing, such constraints are a reasonable trade-off for CMS mandating provider participation.

Thank you again for considering our comments. We look forward to continued discussions on this important topic. If you have any questions or need further information, please contact Melissa Jackson at (202) 626-2356 or mjackson@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President