May 18, 2009

The Honorable Max Baucus
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Charles Grassley
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

Dear Chairman Baucus and Ranking Member Grassley:

The U.S. Chamber of Commerce, the world’s largest business federation representing more than three million businesses and organizations of every size, sector, and region, thanks you for your work toward overhauling America’s health care delivery system. We have reviewed the document titled “Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs,” and would like to offer our thoughts as detailed in the attached document.

The Chamber is committed to working with Congress to find policy solutions that work for business as we engage in a comprehensive overhaul of the health system. We support the processes established by the Senate Finance and HELP Committees and continue to hope for a bipartisan bill that is supported by a broad array of stakeholders.

The Chamber thanks you for this opportunity to share its thoughts about reforming the delivery system and looks forward to working with you to enact meaningful reform that will lower costs, increase quality, and expand coverage.

Sincerely,

R. Bruce Josten

Cc: The Members of the Senate Committee on Finance

Attachment
Below please find the comments of the U.S. Chamber of Commerce on “Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs.”

**Section I: Payment Reform – Improving Quality and Promoting Primary Care**

**Establishment of a Hospital Value-Based Program**

The Chamber supports making reported quality data available to the public, and fully supports the creation of this program. Further, we specifically support the creation of demonstration projects to broaden the reach of this program and to ensure that the incentives within the program are focused on quality rather than unintentionally penalizing hospitals and their patients who are trying to raise their level of quality. As payers, employers and employees need more information to make better health care decisions. We also believe it is imperative that we have an independent entity like the National Quality Forum coordinating these efforts.

**Physician Quality Reporting Initiative Improvements and Requirements**

We support realigning monies already within the system to drive participation in quality reporting.

**Transparency in Self-Referrals**

We support stricter requirements on self-referrals, and believe the proposed option laid out by the Committee is a step in the right direction, but incomplete – the Chamber is on record supporting repeal of exceptions to the ban. Specialty hospitals that cherry-pick the most valuable patients and procedures could lead to instability in the nation’s hospital system. We also believe that physician reporting of financial relationships should be regulated on the federal level, and state laws should be preempted. Reporting should include distributors as well as manufacturers and other companies.
Medicare Inpatient Rehabilitation Facility and Long-Term Acute Care Hospital Reporting

In light of the passage of Mental Health Parity legislation, this section is critical. We fully support implementation of robust quality and reporting programs for mental health, rehab, and long term care facilities to ensure that patients are receiving the best and most appropriate care available.

Primary Care and General Surgery Bonus

The Chamber fully supports increasing reimbursements to primary care providers, both to keep them in business, and to incentivize more medical students to choose this practice area. It is acceptable to fund this with money already within the Medicare system. Especially as the baby boomers retire, we desperately need more doctors in the primary care area of practice.

Payment for Transitional Care Activities

We fully support implementation of this section, and further, support expansion of this program to include high-cost beneficiaries with chronic conditions. This focus on chronic disease is a key element in the overall cost-control and quality improvement agenda.

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

CMS Chronic Care Management Innovation Center

The Chamber strongly supports creation of this Center. Further, we believe the Center should have authority, upon certification of savings by the Office of the Actuary and permission of the Secretary, to permanently implement successful programs throughout the entire Medicare population. There should be a streamlined process to allow this.

Other (Not Included) – ESRD Management

We support immediate implementation of an accountable care model for patients with end-stage renal disease (ESRD). Dialysis providers have been working with physician and patient groups to develop a model under which they would be held accountable for all of the cost and quality of care delivered to their patients. Particularly, we note that there is fundamental support from the Renal Physicians Association for a pilot of an accountable care model in kidney disease. This proposal is especially important because of the enhanced needs – and associated costs – of patients with ESRD.

This accountable care model for patients with ESRD reflects a step beyond existing approaches to bundling, shared savings, and other capitation-like incentive programs. As explained in more detail in attached documents, through the creation of a joint reserve account with CMS, participating providers would assume responsibility for all of the fee-for-service costs of their patients. Further, they would guarantee savings to Medicare by agreeing to specified “off the top” reductions in risk-adjusted payments to the account over time. In turn, providers will make
investments in care coordination, supplemental services, mid-level practitioners, and other strategies that have proven effective in improving quality outcomes, reducing avoidable hospital admissions, and controlling costs. This will address an extremely costly population, and innovative means of improving their care and controlling ESRD costs cannot wait until the establishment of CMIC.

**Hospital Readmissions and Post-Acute Bundling Policy**

The Chamber supports the proposed initiatives to reduce hospital readmissions and to begin bundled payments to hospitals.

**Sustainable Growth Rate**

Chamber members want an end to the SGR in its current incarnation. Congress must act now to eliminate the SGR, and develop a new, viable, sustainable formula to calculate Medicare reimbursements. If comprehensive health reform passes and a few years down the road physicians are back to the annual tradition of lobbying for “fixes” to their reimbursement rates, reform will have been incomplete. A comprehensive overhaul of the health system, and especially the Medicare and entitlement reform the President promised, must include a permanent fix to the SGR.

**Medicare Shared Savings Program**

The Chamber fully supports this proposal and sees the potential for vast savings in the Medicare program if it is successfully implemented.

**Extension and Expansion of the Medicare Health Care Quality Demonstration Program**

Permanent authorization of Section 646 is a positive step forward, and the proposed modifications will make the MHCQ program significantly more robust and effective.

**Other (Not Included) – Medical Liability**

One major way to reign in costs and also drive quality is to give special legal protection to care providers who follow evidence-based guidelines. If Congress is unwilling to remove medical claims from the general tort system, it should investigate creating legal mechanisms to allow providers to lower their insurance costs by making awards more predictable and safeguards more available. Further demonstration projects centered on specialized health courts could help provide expertise to the health care justice system and reduce the randomness of jury awards that has plagued the provider community.

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

**Encouraging Health Information Technology Use and Adoption in Support of Delivery System Reform Goals**
The Chamber supports providing incentive payments to care providers like nurse practitioners and physician assistants, especially as those providers may be the primary point of care for many in rural and low-provider areas.

**Improving Quality Measurement**

The Chamber supports this proposal, particularly the creation of multi-stakeholder group that will include employers and those in the business of health care. We suggest that Congress go further, enacting the Medicare Quality Enhancement Act of 2007, sponsored by Senators Clinton and Gregg. This would create Medicare Quality Reporting Organizations to drive quality in the program by giving more data to consumers and the government, as well as put to good use the large amount of Medicare claims data that is already aggregated.

**Comparative Effectiveness Research**

The Chamber supports comparative effectiveness research, and has concerns about housing this entity under the auspices of a federal agency, where it would be highly susceptible to lobbying and political forces. Employers should be a part of the stakeholder board that governs the entity. Funding for this entity must be consistent and not vulnerable during the political process – but a new premium tax is not a viable way to fund this research.

**Nursing Home Transparency**

We support the proposals for increased disclosure, standardized forms and processes, and demonstration projects to improve nursing home performance.

**Other (Not Included) – Retail Clinics**

Medicare should support retail and work-site clinics that help increase the points of care for individuals and workers. Multiple clinics can be overseen by a physician while the day-to-day operations are run by nurse practitioners and other health professionals that help to lower costs. These clinics improve convenience, reduce barriers to care, and free up doctors and hospitals by reducing their workloads, and public programs should work to fully integrate them into their ongoing efforts to care for beneficiaries.

**Workforce – In General**

The Chamber supports the included proposals to fund more primary care physicians, and mitigate the coming shortage. We believe Congress should go further, creating new visas to bring primary care physicians, internists, geriatricians, pediatricians, nurses, and other critically-needed health care professionals into the U.S.

**Section IV: Medicare Advantage – Options to Promote Quality, Efficiency, and Care Management**
Developing a More Efficient Payment Structure

The Chamber does not have a clear preference between the first and second approach proposed here. The first approach may be a way of drilling down to the regional variations that have for so long confounded health economists. The second approach could be very positive in terms of financial incentives for plans to implement evidence-based care management and quality improvements. However, the bidding proposal as laid out in the president’s budget might lead to a large amount of plan consolidation and loss of choice.

Pay for Chronic Care Management

The proposal to incentivize MA plans to implement chronic care management is critical to the overall effort to improve quality and control costs.

Section V: Public Program Integrity – Options to Combat Fraud, Waste and Abuse

Provider Screening

The Chamber urges Congress to enact a completely non-political means to deny participation by probable fraudulent actors. We fully support a large increase in screenings and physical site visits – in light of a recent GAO investigation that found it to be incredibly easy to defraud the program.

Data Base Creation and Data Matching

The creation of one comprehensive database (“One PI”) is a good idea that will help move government agencies forward in a more organized and timely manner.
ACCOUNTABLE CARE MODEL FOR KIDNEY FAILURE PATIENTS

Goals
• Create incentives for dialysis providers to coordinate all of the care their patients receive to improve health outcomes, forestall complications, and avoid hospitalization.
• Capitalize on encounters dialysis facilities have with patients – 3x/week for the rest of their lives (or until they receive a transplant).
• Guarantee savings to Medicare and the broader health care system.
• Establish a model to be adopted by other payers, including state Medicaid programs and private insurers.

Program Basics
• Pilot program, designed to apply to around 10,000 patients in the first few years, but that could be expanded more broadly if CMS deems it successful.
• Patients’ coverage, benefits, cost sharing, and choice of providers does not change. Other providers observe no change in their interaction with these patients or their claims filing/payment.
• Dialysis providers would join together to submit applications to be eligible for payment under the program and agree to submit to unprecedented transparency regarding cost and quality.
• Providers agree to take financial risk for all of the care their patients receive, exposing them to liability for costs up to 105% of their payments. They also submit to a cap on savings they generate equal to 15% of payments.

How it Works
• Medicare makes monthly, risk-adjusted payments to accounts established by participating providers to cover the cost of all Medicare Part A and B services patients are expected to receive. After three years, payments to the account are discounted by 1% of these expected costs – guaranteeing savings to the Medicare trust fund.
• An existing Medicare Administrative Contractor (MAC) coordinates the payment of claims for patients, drawing from providers’ accounts whenever necessary to pay other providers (docs, hospitals, etc.).
• Providers employ care coordination, patient engagement, HIT, interdisciplinary care teams and other techniques to improve quality and cut costs (primarily by avoiding hospitalizations). Initial infrastructure investments and increased care costs will be recouped over time as savings are generated.
• These techniques have been proven to reduce hospital admissions by 6%, readmissions by 40%, hospital days by 39%, and improve on vaccination rates and other quality indicators.\(^1\)
• Quality oversight and reporting of both outcomes and care processes would build on the existing regulatory regime governing dialysis services, including existing CMS clinical performance measures and oversight responsibilities of dialysis facility medical directors. Risk adjustment methodology would expand on the case-mix adjustors established under the new MIPPA bundled payment system. In other words, this is not an effort to recreate the wheel, but to expand on what works.

Scalability
• By sharing the administrative burden with CMS (via the designated Medicare MAC), small and medium-sized providers could successfully participate in the program.
• Private payers and state Medicaid programs could adopt this payment model (as they have adopted the composite payment model for dialysis services). In a reformed system, with a new national or state-based connector and regulatory regime, private payers could be required to adopt this program to ensure alignment of incentives and greater savings to the health care system.
• The central innovation of this reform proposal – the shared account between providers and CMS to bring capitation-like incentives to fee-for-service – could be applied to other providers and to patients with other chronic diseases.

\(^1\) Data is from the Medicare ESRD Disease Management Demonstration, which has been successful at reducing cost and improving quality, but is not a sustainable payment model over the long term.