

August 12, 2014

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The Honorable Ron Wyden, Chairman
Senate Finance Committee
219 Dirksen Senate Office Building
United States Senate
Washington, DC 20510

The Honorable Charles Grassley
135 Hart Senate Office Building
United State Senate
Washington, DC 20510

Dear Chairman Wyden and Senator Grassley:

On behalf of the American Health Care Association (AHCA), thank you for the opportunity to provide input on how to enhance the availability and utility of health care data. In your letter dated June 12, 2014, you requested “ideas that will enhance the availability and utility of health care data, while maintaining and strictly protecting patient privacy.”

Long term and post-acute care providers play a vital role in providing health care services for millions of Americans. Our providers agree that access to health care-related data across the care continuum is a critical tool to facilitate improvements in health care delivery and quality, including improved coordination of care. We are constantly seeking ways to innovate and improve so we can delivery higher quality care to those we serve.

With the shift from fee-for-service (FFS) to value-based payment and delivery models, such as bundled payments and accountable care organizations (ACOs), it creates an imperative for providers to be able to better coordinate and manage the care of their patients. Better access to health care data can allow providers to coordinate care across settings, establish and maintain helpful partnerships and reduce overall costs. Patients, families and health care providers all can benefit from continued improvements in access to good health care data.

Below we have provided thorough input in response to the questions posed in your letter. We have synthesized our feedback into four recommendations for your consideration:

1. CMS should remove barriers to accessing timely Medicare claims and MDS data;
2. CMS should ensure that MDS data systems meet certain standards of interoperability;

3. CMS should enhance its data collection and reporting efforts for the Medicare Advantage and Medicaid managed care programs.
4. The Congress should pass legislation providing incentive funding to post-acute and long term care providers for implementing electronic health records (EHRs).

We elaborate on each recommendation below. We thank you for your continued dedication to this very important issue, and we look forward to working with you and your staffs in developing and promulgating solutions. To schedule time for a discussion about this important topic, please contact my executive assistant, Carole Jones, at cjones@ahca.org or 202-898-6324.

Sincerely,

A handwritten signature in black ink, appearing to read "Mark Parkinson". The signature is fluid and cursive, with a large initial "M" and "P".

Mark Parkinson
President & CEO

AHCA'S RECOMMENDATIONS

1. *CMS should remove barriers to accessing timely Medicare claims and MDS data.*

CMS collects vast amounts of patient and provider data, some of which it makes publicly available, but at a significant cost. Two of the most important data sets to skilled nursing providers are Medicare claims data and Minimum Data Set (MDS) data, both of which it releases annually. However, by the time CMS has taken the necessary steps to clean and “scrub” the data for a given year, it is almost two years old. CMS typically makes a year’s worth of claims and MDS data available near the end of the following year. For example, CMS released 2012 claims data in November of 2013, long after that care had been provided.

AHCA believes that both providers and CMS would benefit from more timely access to MDS and claims data. As providers are embarking on new and innovative models to improve care and community and other organizations are working to assist with these efforts and measure and report improvement, access to timely data is critical. Providers and other stakeholders are more likely to embark on new models of care delivery if they are able to perform an analysis of how it might impact their business and operations, and access to claims data allows them to do this. However, the older the claims data, the more unlikely it is to be representative of their current environment. If, for example, a provider has implemented a new quality improvement initiative within the last year, they would not be able to assess the impact of that initiative for several years, when the claims data finally becomes available. This lag in availability of data likely dissuades many providers from developing and implementing new innovative models of care.

AHCA recognizes and appreciates CMS’ efforts to speed up the availability of claims data within some of their demonstration models. In the Bundled Payments for Care Improvement (BPCI) initiative, CMS provides more up-to-date claims data to demonstration participants. We have learned, through AHCA members who are also BPCI participants, that CMS has drastically cut the lag time for claims data, down from two years to between six and nine months. While a significant improvement, AHCA believes that CMS should do so for *all* de-identified Medicare claims data, not just for those providers participating in demonstration models.

However, CMS should go beyond providing these data more quickly; they should also remove the exorbitant, prohibitive costs to purchase them for providers who are not granted access via participation in a demonstration. Only large providers with ample resources are able to purchase these data, locking out an entire segment of the provider community, including most small regional providers and independent operators. Large and small providers alike must be able to perform the appropriate analyses to help them plan for and adapt to new payment and care delivery environments. Without transparent and easy access to this data, most providers will remain wary of new payment models, choosing instead to maintain status quo operations.

2. *CMS should ensure that MDS data systems meet certain standards of interoperability.*

Skilled nursing providers currently collect and report a wealth of information and data related to patient function and outcome through the Minimum Data Set (MDS), the skilled nursing providers' patient assessment instrument. This data is essential in determining the reimbursement to providers for delivering care to patients, but currently little else can be done with this data. The MDS data system is not interoperable with other systems, meaning it cannot easily be transmitted and shared between different providers or entities, representing a huge missed opportunity.

AHCA believes that CMS should ensure that MDS data systems meet certain HIT standards of interoperability. As ACOs and managed care organizations (MCOs) expand their reach, they are looking to define their preferred networks of post-acute and long term care providers, and they are targeting those providers that are more easily able to transmit and share data with them. AHCA believes a huge opportunity exists for providers to utilize and share assessment data with other entities in efforts to improve care coordination and transitions, but they are limited by the fact that assessment data are not interoperable.

As an interim step, CMS should provide technical assistance to post-acute and long term care providers on how to fully utilize Direct Secure Messaging to connect to ACOs and MCOs and other network providers. CMS should allow the systems cost and the operational cost of participating in a local HISP and utilizing Direct Secure Messaging for transitions of care and care delivery as an allowable Medicare expense for purposes of reimbursement.

3. *CMS should enhance its data collection and reporting efforts for the Medicare Advantage and Medicaid managed care programs.*

Managed care is rapidly gaining popularity in both Medicare (through the Medicare Advantage program) and Medicaid (through expanded use of Medicaid managed care plans). In 2014, 30 percent of Medicare beneficiaries were enrolled in a Medicare Advantage plan, and 74.2 percent of Medicaid enrollees were enrolled in a managed care plan¹. For representing such a significant portion of Medicare and Medicaid populations, researchers have surprisingly very little access to any data that explains the care that managed care plans provide to their beneficiaries and what it costs. This lack of access is counterintuitive to CMS' efforts to improve the transparency of health care cost data, and AHCA believes that CMS should require the reporting, and then make public, claims information from all managed care plans.

The concept of managed care has tremendous political support, yet there is very little research that truly explains or quantifies either the cost or quality benefits of it over

¹ Data from the Kaiser Family Foundation, available at <http://www.kff.org>, accessed August 4, 2014.

traditional fee-for-service. Unlike Medicare fee-for-service (FFS) claims data, CMS does not collect and release managed care claims data. As a result, researchers are unable to adequately compare managed care programs against FFS, which is especially challenging in an environment where new delivery system and payment reforms are quickly taking hold. Of the limited research comparing managed care to FFS, the results are mixed.

AHCA believes that CMS should enhance its data collection and reporting efforts in all managed care programs so that it is better able to compare FFS approaches to managed care. AHCA believes CMS has several options should it move to release managed care claims data. They could release claims data in the form of public use files, as it does for traditional FFS Medicare claims. Alternatively, Congress could require that CMS provide Medicare claims to states that are developing all-payer databases. This latter approach would solve many of the problems researchers currently encounter when trying to compare different payers or when trying to analyze patients who utilize more than one payer. AHCA would support any efforts CMS might make to improve the transparency of managed care claims data.

4. The Congress should pass legislation providing incentive funding to post-acute and long term care providers for implementing electronic health records (EHRs).

AHCA has long maintained that Congress missed a huge opportunity when it passed the Health Information Technology for Economic and Clinical Health (HITECH) Act in 2009. The HITECH Act, which provided incentive funding to hospitals and physician groups who implemented health information technology (HIT), completely excluded post-acute and long term care providers from participating. HIT is integral to the widespread adoption of population health management, upon which many of the new delivery system and payment reforms are based. AHCA believes that without adequate support and participation from post-acute and long term care providers, these new systems (such as ACOs) being implemented throughout the country will struggle to succeed.

Absent incentive funding the adoption of HIT among post-acute and long term care providers is likely lag far behind other providers. This lag has been well documented already. Compared to the 59% of hospitals and 79% of office-based physicians that have implemented fully-function EHR systems, the statistics for post-acute and long term care providers lag far behind:

- Six (6%) of long-term acute care hospitals, four percent (4%) of inpatient rehabilitation hospitals, and 2% percent of psychiatric hospitals have a basic electronic health record (EHR) system.² Rates are higher among home health, hospice, and nursing facilities (SNF/NFs) (43%).³

² EHR Payment Incentives for Providers Ineligible for EHR Payment Incentives and Other Funding: Study -- <http://aspe.hhs.gov/daltcp/reports/2013/ehrp.html>; Wolf L, Harvell J, Jha A.; Hospitals Ineligible For

- Thirty percent (30%) of all Medicare beneficiaries discharged from acute care hospitals are discharged to post-acute and long term care settings.
- Post-acute and long term care facilities have little capacity to support HIE across settings.⁴

To exacerbate this problem, post-acute and long term care providers continue to endure a barrage of cuts to their reimbursements, making independent investment in these systems nearly impossible for the vast majority of providers.

AHCA recommends that the Congress develop and pass legislation that would provide incentive funding to post-acute and long term care providers to implement HIT, and that doing so would foster the healthy development and growth of the value-based reimbursement models that are being tested.

CONCLUSION

At AHCA we remain committed to our mission of improving lives by delivering solutions for quality care. We stand ready to assist Members of Congress and their staffs in developing smart legislative proposals to address many of the challenges explained above. We firmly believe that with dedicated efforts to expand the availability and usability of existing health care data, and making strides to collect and release data not currently available, long term and post-acute care providers will embrace new payment and delivery system reforms and help them to succeed.

Federal Meaningful-Use Incentives Have Dismally Low Rates Of Adoption Of Electronic Health Records (March 2012) <http://content.healthaffairs.org/content/31/3/505.full>.

³ Resnick, H.E., Alwan, M. "Use of Health Information Technology in Home Health and Hospice Agencies: United States, 2007." *Journal of the American Medical Informatics Association (JAMIA)*, 2010, 17: 389-395. Abstract available online at: <http://jamia.bmj.com/content/17/4/389.abstract>; Resnick, H.E., Manard, B.B., Stone, R.I., Alwan, M. "Use of Electronic Information Systems in Nursing Homes: United States, 2004." *Journal of the American Medical Informatics Association (JAMIA)*, 2009, 16: 179-186. Abstract available online at: <http://jamia.bmj.com/content/16/2/179.abstract>.

⁴ *Id.*