COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

TESTIMONY OF

THE FEDERATION OF AMERICAN HOSPITALS

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Presented by:

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Chairman Rangel, Ranking Member Camp, and other distinguished Members of the Committee, on behalf of the Federation of American Hospitals (FAH), I appreciate the opportunity to offer our views on the House of Representatives' Tri-Committee Health Reform discussion draft. The FAH is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include general community hospitals and teaching hospitals in urban and rural America as well as inpatient rehabilitation, long term acute care, psychiatric and cancer hospitals.

It is gratifying for me to come before the Committee today. President Obama, the Congress, and the members of this Committee are right to place health reform at the top of the domestic agenda. In my view, we are at one of those inflection points in history when health reform is not only possible but desperately needed because too many Americans lack access to affordable, quality health care. Beyond the tragedy of the almost 50 million uninsured Americans and despite the best efforts of so many, all of us experience a health care system that spends too much and is not as effective and efficient as it should be. The time for action has come, and the FAH looks forward to participating in the development of constructive change that will bring better, more affordable health care to all Americans.

For a task so momentous, it is appropriate that the Congress approach this priority with due care. The ambitious and comprehensive Tri-Committee Health Reform discussion draft presents a good starting point for health reform. The draft raises all the right issues. It gives us a roadmap to affordable, quality health care for all Americans. At the same time, we recognize that the Committee has offered the draft as a work in progress. It is meaningful to the FAH, and to all of us who care so deeply about health care in America, that we can today offer our observations and

recommendations. We look forward to working with the Committee and the rest of the Congress as the draft legislation evolves from its current form to enacted law.

COVERAGE

The FAH is particularly pleased that the primary goal of the Tri-Committee Health Reform discussion draft is to ensure that affordable health coverage is available for all Americans. More than two years ago, the members of the FAH set the same goal as our highest priority and released our own proposal, the "Health Coverage Passport" (HCP) to illustrate how universal health coverage could be obtained in the context of the American health care system.

The FAH based the HCP on four guiding principles to achieve universal coverage: (1) to assure low income coverage there must be sufficient subsidies; (2) to expand coverage based on the current avenues to coverage available for Americans; (3) to reform the insurance system where necessary; and, (4) to recognize a responsibility for all Americans to obtain coverage.

In general, the draft meets these principles. It provides the subsidies that Americans lacking sufficient disposable income will need to obtain coverage; it builds on the current employer-based system; it addresses the need for insurance reform; and it includes a requirement that will ensure that coverage is obtained by all Americans.

Americans have said repeatedly that they want to build on the current health care system. Clearly, the draft honors this principle. It aims to preserve what works in our current system, allowing Americans to keep the coverage they have, and provides the building blocks for the support others need to attain health coverage. These include sliding scale subsidies for purchasing health insurance, reforms to private insurance and efforts to limit cost growth.

The ingredients for coverage expansion are present in the draft. However, the draft wavers somewhat from our prescription for reform in its construct of insurance reform. We called for reforms that would assure ready access to private health insurance for Americans who are not eligible for employer-based coverage or the existing public programs. We also recognized that there might need to be structures at the state level where these Americans could purchase affordable coverage, similar to the health insurance exchanges in the draft. In our model, we assumed that a reformed private health insurance market with guarantee issue, guarantee renewability, modified community rating, and market protections would suffice. We did not envision a government-run public option as presented in the draft.

In our view, the public option is not necessary to achieve successful reform. We feel very strongly that a private market can best serve those eligible Americans without the need for government intervention. We further feel that the stability of the critically important employer-based health insurance market depends on a vibrant private health insurance industry.

We do understand, however, that President Obama and many of you feel strongly that there needs to be an alternative to the current private insurance carriers available in the health insurance exchanges proposed in this draft, where so many Americans will purchase their coverage. The FAH does not disagree that such an alternative could be beneficial. If the Committee agrees an alternative is a necessary feature of the exchanges, we ask the Committee

to consider a non-governmental, non-profit or co-op model that would offer eligible consumers another choice without forming a new government-run insurance plan.

The governmental construct, from the view of the FAH, is problematic for many reasons. We believe it will eventually result in government price setting for most, if not all, health care settings. We feel strongly that a mixed system of payment built on private negotiation will serve the consumer well and keep providers and clinicians viable and available to serve patients and their communities.

The FAH fears that the draft leans in a different direction and, instead, would create an insurance system dependent on Medicare payment in the near term and over time. For the first few years, the public plan option would require Medicare payment rates and over time would give the Secretary of HHS total administrative authority to set the rates that would be paid. This is unfortunate because, as critical as both the Medicare and Medicaid programs are to so many Americans, for providers and clinicians, these programs chronically underpay for services. To assume that either model would become predominate is to raise real concerns that insufficient resources will be available to provide the care Americans expect and deserve.

There has been a legitimate debate in recent months about the sufficiency of Medicare payments to hospitals. MedPAC has asserted that such payment is all that is necessary for the maintenance of an efficient hospital. The FAH does not agree with this analysis, but even accepting the merits of the Medicare argument, the draft expands Medicaid significantly so that hospitals would potentially be subject to a Medicare-Medicaid payment mix with an expansive public option that was not envisioned in the the MedPAC analysis. Additionally, the draft includes reductions in Medicare payment that may further exacerbate the vast expansion of the Medicare-Medicaid payment proportion of hospital payment.

While we welcome what would appear to be the draft's intent not to require hospitals to participate in the public option, hospitals are there to serve their communities and the option not to serve is, in fact, no option at all.

Further, we find that the draft assumes a level of authority over pricing and payment methodology that is even more extensive than the level under the current Medicare program. Section 223 of the draft clearly gives the Secretary of HHS authority to establish payment rates and Section 224 permits the Secretary to "modernize" payment. Under Section 224, the Secretary would have the authority, absent Congressionally-mandated and reviewed demonstrations or pilots, to develop payment policies to include value-based purchasing, accountable care organizations, bundled payments, and adjustment of payments to address geographic variation.

While we applaud and support some of these initiatives, we have concerns about others, and would be extremely apprehensive to have them applied by Secretarial authority without sufficient review. While Section 224 pertains only to the coverage offered under the public option, we are concerned that the exercise of reform through administrative action implied here would not allow for sufficient vetting of policy and clearly lacks any semblance of the negotiation and engagement that is so essential to the operation of a viable and competitive

health insurance market. We do not believe government has a monopoly on "good ideas" about cost containment and delivery reform and, considering past experience with Medicare, are concerned this approach will not result in the best outcome for patients or those who serve them.

The FAH feels strongly that the only way to avoid the issues related to the exercise of administrative authority through the public option is to remove it from governmental authority and stick to the draft's newly restructured and highly regulated private health insurance market.

Finally, despite the enforcement of the individual and employer mandates in the draft, hospitals will invariably be faced with uninsured patients who have avoided health insurance. The FAH urges the inclusion of a mechanism under which hospitals would be enabled to automatically enroll uninsured patients. Enrollment could take many forms - it might look like current presumptive enrollment in Medicaid, or use some type of default mechanism to coverage in the new health insurance exchange. Whatever the approach, it is essential that under full implementation of the envisioned coverage expansion that anyone who seeks care at a hospital and who does not have health coverage can be enrolled in coverage at the hospital.

We realize the Congress is going to call upon hospitals to contribute financially to health coverage expansion. A key tenet of the FAH "shared sacrifice" policy is that any reimbursement reductions should be calibrated to and triggered by associated increases in coverage. Hospitals are under significant financial pressure, and before essential resources are removed, it is critical to assess the actual coverage expansion. For example, if the Committee chooses to target a certain portion of the hospital market basket, the FAH believes that such reductions should only occur once the CMS Actuary determines that certain increased coverage goals have been attained. The FAH seeks to work with the Congress on ensuring this critically important and fundamentally fair policy is part of this health reform legislation.

In addition, the draft exercises appropriate restraint by calling for the Secretary to submit a report to Congress in 2016 with recommendations on what, if any, changes to DSH may be warranted going forward at that time. As you know, DSH payments are absolutely vital to maintaining the fragile health care safety net, especially considering well-documented Medicare and Medicaid payment shortfalls. This will remain so, for the foreseeable future, and likely under virtually any level of coverage expansion. The Committee demonstrates great wisdom in waiting until coverage expansions and broader health reforms take hold and can be fully evaluated before considering changes to the DSH program.

The FAH, however, does recommend one immediate change to DSH policy in the interim – equity for rural hospitals. For reasons that are unclear from a policy perspective, the statutory formula for determining DSH payments to hospitals provides lower payments to rural hospitals treating the same proportion of indigent patients than it does for larger urban hospitals. Rural hospitals anchor health care delivery in their communities, and a key goal of health reform must be to strengthen these institutions to enable them to continue to treat the growing number of indigent patients in rural areas. We urge the Committee to establish DSH payment equity for rural hospitals.

REFORMING DELIVERY & REDUCING COSTS

- **Self-Referral Ban to Physician-Owned Hospitals**

Rising costs remain the most menacing health care issue for most Americans. Reducing those costs and appropriately aligning incentives begins with inclusion of Section 1156, the self-referral ban to physician-owned hospitals. The FAH remains appreciative of this Committee's longstanding support for this policy. In the last two years, the House of Representatives has passed similar legislation three times, and the Senate has passed it once. The Obama Administration also included this policy in its FY10 Budget Proposal, recognizing it as an important policy objective which has the added benefit of being an offset to health reform. Additionally, the Congressional Budget Office (CBO) has concluded that self-referral to physician-owned hospitals raises health care costs by increasing utilization. Now is the time to pass this legislation once and for all.

Section 1125 is compromise legislation: it is prospective in application, protects current physician ownership arrangements, and allows existing facilities to grow if they meet certain requirements. This policy will benefit patients and communities, save taxpayer money, end a serious conflict of interest that can affect patient care, and allow full-service community hospitals to provide vital care for all those in need.

- **Readmissions**

The FAH supports the principle of decreasing potentially preventable hospital readmissions and appreciates the direction of several key elements of the draft's readmissions policy. However, we are concerned the key measure of performance – the "excess readmissions ratio" – creates the potential for large, counterproductive payment reductions. Large cuts through this policy would substantially undermine hospitals' ability to invest in and adopt systems changes that would minimize preventable readmissions.

While we are troubled with these potential payment reductions, we are pleased that the draft recognizes the need to adopt readmission performance measures that have been endorsed by a multi-stakeholder consensus group, such as the National Quality Forum. We also appreciate that the draft would exclude readmissions that are unrelated to the prior discharge. We would urge that any expansion of conditions be linked to the national priorities as defined in Section 1441. In addition, the Committee takes an important step forward by offering financial assistance to certain DSH hospitals to help with addressing patient noncompliance issues, a key factor in hospital readmissions. We strongly recommend, however, that, at a minimum, all DSH hospitals be eligible for this assistance, not just those with $10 million in DSH payments as transitional care and patient compliance are readmissions issues for all hospitals.

The FAH also commends the Committee for recognizing the central role of physicians and others throughout the continuum of care in admitting, discharging and providing continuing care for patients. For readmissions policy to achieve its goal, hospital and physician incentives must be aligned. The Committee is correct to pursue a readmissions policy that would align incentives for clinicians and hospitals.

Regarding post-acute care providers, however, the bill prematurely applies an arbitrary interim policy that reduces their payments when a patient is readmitted to a hospital within 30 days of discharge, even if the readmission was clinically necessary and unrelated to the care provided in the post-acute setting. It makes little sense, then, to subject post-acute providers to payment reductions based on such an arbitrary policy, especially since the draft correctly calls for the development of more carefully calibrated measures governing readmissions from post-acute providers.

- **Post-Acute Payment Reform**

The draft steers just the right course in directing the Secretary, in a reasonable time frame and with the input of stakeholders, to develop a detailed plan to reform post-acute payments, and then authorizing the Secretary to conduct demonstrations, including, as appropriate, a variety of bundling approaches, to test what works and what doesn't. Clearly, the Committee recognizes the enormous complexities of reforming these payments with minimal disruption to patients. The list of issues that the Secretary's detailed plan must consider is appropriately exhaustive, including whether payment for physician services should be included in the bundle. As a result, the bill adopts the patient and thoughtful approach that is necessary.

- **Accountable Care Organizations (ACO)**

The FAH supports initiatives that focus on new methods of furnishing quality medical care to patients through integration. Creating greater accountability in the delivery of care through payment incentive arrangements is a positive and important step toward this goal. Section 1301 seeks to reach this goal, but does so in a way that would limit access regarding who can submit proposals to participate as a pilot program. Physicians will be an important part of any successful ACO, but hospitals should be afforded the opportunity to take leadership roles in establishing a pilot ACO and guiding care integration with physicians, especially when the focus is on controlling both Medicare Part A and Part B costs.

- **No "Super-MedPAC"**

The FAH is appreciative that the draft proposal does not contain a policy under discussion by certain policymakers to change the mission of the Medicare Payment Advisory Commission (MedPAC) from a congressional advisory body to an Executive Branch decision-making entity. Since its inception in 1997, MedPAC has fulfilled a key function for helping guide Medicare policy for Congress. Health care policy naturally is complex and can impact constituencies in unintended or unexpected ways. MedPAC has functioned appropriately in advising Congress on policy options and recommendations, and this Committee, in particular, has taken its advice seriously but not without using its independent judgment as it seeks to clarify how its recommendation would impact real people. The FAH believes it is the purview of Congress to legislate on significant health care policy changes and believe the traditional role of MedPAC should be maintained.

IMPROVING QUALITY

- **Establishment of National Priorities and Performance Measures for Quality Improvement**

The FAH is pleased that the Committee recognizes the importance of national quality measurement in numerous sections of the legislation. The FAH is a member of "Stand For Quality," a nationwide 200 plus multi-stakeholder coalition representing patients, consumer advocates, labor, clinicians, hospitals, employers, purchasers, researchers, and more, who have all come together to improve health care quality and delivery.

Quality health care happens at the bedside, not in Baltimore at CMS. The quality of care delivered to patients improves fastest and most efficiently through a coordinated multi-stakeholder approach that is patient-centered.

We appreciate the Committee recognizing that performance measurement is a key building block to quality improvement and must be supported by a strong national infrastructure linked to a set of national priorities established by the Secretary. By building on the current public-private initiatives, we can create a sustainable infrastructure to support high quality, affordable health care for all.

To make this happen, the FAH and Stand for Quality recommends the draft legislation focus on six clearly established goals:

- Setting national priorities to guide reporting and improvement activities and assess progress.
- Endorsing and maintaining measures for national use through a multi-stakeholder consensus process.
- Developing measures to fill identified gaps in priority areas.
- Strengthening a public-private stakeholder consultation process.
- Providing a national strategy for the collection, aggregation and public reporting of quality measures
- Identifying, developing, testing and disseminating innovative methodologies for improvement in quality of health care.

Unfortunately, the Committee draft falls short of these goals. While the draft recognizes the importance of priority setting and development of new measures, Subtitle C does not clearly define how the national priorities are linked to identifying gaps in useable quality measures, the use of measures in a wide variety of public and private payment programs, the process for collecting, aggregating and publicly reporting on measures.

We believe that Subtitle C would be enhanced by adding several sections including a section that would link the definition of "multi-stakeholder" already in the legislation to the consultative process. The consultative process provides input to the Secretary of HHS and CMS on the establishment of priorities, the endorsement of quality measures, the use of quality measures, and identification of gaps in quality measurement, and the aggregation of quality data for public

reporting. The consultative process does not take authority or power away from the Secretary or CMS, it merely provides the Secretary with options informed by patients and those providing care to them.

Throughout the draft, there are distinct references to quality measurement in a variety of Subtitles and across health care sectors such as Medicare Advantage Plans, prevention and wellness. We believe that overall national quality would be greatly enhanced if the use of quality measures required for implementation and quality improvement in other sections of the bill would build on the national priorities established by the Secretary, by creating a specific legislative link to an enhanced Subtitle C. Such a linkage would harmonize the information provided to the public and facilitate a process that focuses every element of the health care system on the key factors that will improve patient care.

The FAH is pleased to see Sec. 2401, "Implementation of Best Practices in the Delivery of Health Care." Quality improvement must focus on research on the factors that facilitate the behavior change necessary to improve quality and foster an environment of continuous improvement.

The FAH believes that quality improvement happens most efficiently when reliable methodologies are developed to quickly disseminate information to clinicians, patients and providers. We believe the Agency for Healthcare Research and Quality (AHRQ) is the correct entity to carry out this task, and would urge the Committee to reassess the quality improvement language already in the draft to focus on the outcomes of the quality improvement process including the provision of technical assistance and learning aids for health care organizations to disseminate what's learned through QI efforts. We believe that good science and methodologies for improving patient care can be more effectively and efficiently distributed than under the current system.

Section 1709 establishes a new Assistant Secretary for Health Information responsible for ensuring the collection, collation, reporting and publishing of statistics on key health indicators which will include the development of standards for the collection of data on health and health care. The FAH believes strong consideration should be given to the role that increased use of electronic health records will play in the collection of health information in the future. While we support the requirement for the Assistant Secretary to coordinate with the Office of the National Coordinator for Health Information Technology (ONC) to carry out these duties, we are concerned about the potential overlap between the responsibilities of the Assistant Secretary and the responsibilities of the National Coordinator for Health IT as the collection of health information becomes increasingly automated.

While the draft calls for the Assistant Secretary to consult with offices and agencies within HHS and the heads of other appropriate federal departments, there is no requirement for the Assistant Secretary to undertake a multi-stakeholder consultation process. The FAH believes that consultation with both public and private stakeholders will ensure a more streamlined process for the collection of health information that takes into account the operational challenges faced by those health organizations, including hospitals, that generate these data.

We appreciate the draft bill designating Trust Fund dollars to support the establishment of national priorities that would be implemented across all programs. However, we believe that the national goal setting, measure use, measure endorsement and consultative processes would require more than the annual $7 million currently in the draft legislation. The FAH would suggest that to effectively accommodate the complexity of establishing a national infrastructure to measure and report quality across the health care spectrum that the Committee consider increasing the Trust Fund allocation.

The FAH is willing to work with the Committee on the development of language to support initiatives to define the consultative process, the use of quality measures and the identifications of gaps in the measurement development process.

OFFSETTING HEALTH REFORM

The FAH recognizes the importance of shared sacrifice, but we need to be very careful that health reform legislation does not arbitrarily reduce hospital revenue. Hospitals are facing serious financial burdens now and for the foreseeable future that place significant pressure on our ability to meet community health care needs. Thankfully, the Tri-Committee draft rejects many of the hospital reimbursement cuts proposed by the Administration. We are particularly pleased that this legislation does not impose cuts to Medicare and Medicaid Disproportionate Share (DSH) payments to hospitals.

There is no doubt that health coverage expansion done right could lead less uncompensated care to hospitals. However, it is next to impossible to predict the impact of reform and the potential utilization that would result from such dramatic changes in the marketplace, which are without precedent. It also is worth noting that a key source of revenue for hospitals is reimbursement from the individual health insurance market, which is often at beneficial rates for hospitals. The draft legislation targets this population for the health insurance exchange and (with or without the public option) would naturally result in reduced revenues to hospitals.

As Congress addresses hospital reimbursement, we also urge you to keep in mind that:

- Hospitals are estimated to have a -6.9% overall Medicare margin this year;
- The FY2010 proposed Medicare inpatient payment rule would cut hospital payments an estimated $41 billion over 10 years; and
- Medicare and Medicaid payment shortfalls to hospitals are chronic and well-documented.

- **Market Basket Updates**

The FAH opposes incorporating productivity adjustments as a permanent, arbitrary reduction to hospital market basket updates. Acute care hospital Medicare margins have been negative and falling for seven years, beginning in 2003. MedPAC projects that the overall Medicare hospital margin will reach negative 6.9 percent in 2009. This is an unsustainable path. Imposing additional, annual reductions, currently estimated at 1.3 percent, will exacerbate an already intolerable burden on hospitals struggling to meet the health care needs of seniors.

In addition, productivity adjustments as described in the bill are largely inapplicable to hospitals. The hospital market basket is structured specifically to capture the costs hospitals incur in providing a unit of inpatient care. Yet, the proposed productivity adjustment measures efficiency gains for the broader economy, virtually exclusive of hospitals, which remain extremely labor intensive among other differences. Indeed, the cuts that this adjustment would impose would make it that much more difficult for hospitals to make the investments necessary to achieve the very gains in efficiency that are cited as justification for this productivity adjustment.

Finally, it would be imprudent to adopt, permanently, the same productivity adjustment that MedPAC has, for the last three years, rejected when issuing its recommendations for a full hospital market basket update.

Apart from productivity adjustments, the FAH recommends that inpatient rehabilitation facilities (IRF) receive a payment update in 2010. IRF margins are deteriorating, volume is declining, patient acuity is increasing, and this hospital sector, like all hospital sectors, has suffered from the collapse of the general economy. In addition, IRFs have been subject to an update freeze that began during FY08 and continues through the remainder of FY09. It is unreasonable to deny these critical facilities an update for FY10 as well.

FRAUD AND ABUSE

The Tri-Committee's draft contains a number of proposals aimed at reducing fraud, abuse, and waste in government programs. Many of the proposals are sound and target areas of the health care continuum in which fraudulent activities have been rampant and require better detection and prosecution. Other proposals, however, may be subject to restrictive interpretation resulting in greater burden to health care providers than real benefit to the federal programs.

- For example, Section 1641 requires repayments of Medicare and Medicaid overpayments within sixty days of identification. A sixty-day time frame for repayment may often be insufficient to complete an internal review of a potential overpayment, verify whether an overpayment exists, and take required action to repay the monies with the required written explanation. We urge the Committees to consider requiring a 60-day timeframe that is triggered when an overpayment is identified and then verified by internal review.

The FAH believes the Committees should also consider adding exceptions to the self-referral statute and safe harbors for the anti-kickback statute to protect certain payment incentive and shared savings arrangements. The draft contains a number of other policies that focus on payment incentives as a way better to integrate care and control costs. Thus, these fraud and abuse statutes should not stand in the way as a barrier to implementing these types of policies through negotiated programs involving hospitals and physicians.

OTHER ISSUES

In closing, there are several other issues in the draft that are of significant importance to our member companies that we would like to briefly address.

- **Investor-Owned Hospitals Parity – Access to Grants to Improve Delivery and Outcomes**

FAH member hospitals, like all community hospitals, play a vital role in the communities we serve, and in some circumstances, investor-owned hospitals are the primary access point to essential health care services. While not necessarily within this Committee's jurisdiction, we are troubled that the grants throughout Title II aimed at improving the health care workforce and access to health care are limited to nonprofit hospitals. We urge the Congress to open up access to grants based on need, not on tax status.

- **Administrative Simplification**

The FAH strongly supports administrative simplification, but recommends that Sec. 501 of the draft legislation be amended to require the Secretary to seek guidance on administrative simplification standards from existing public and private standard setting entities and then develop regulations in consultation with professional organizations representing entities and constituencies referenced in SSA Section 1172(a) - HIPAA. We also recommend that all regulations be subject to Notice of Proposed Rulemaking.

- **Psychiatric Hospital Stays and Mental Health Parity**

The FAH supports the provision in the discussion draft eliminating the 190-day lifetime limit on psychiatric hospital stays. Furthermore, we appreciate that the draft extends the mental health parity requirement as an essential benefit.

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Thank you for the opportunity to testify before this esteemed Committee on this critically important piece of legislation. The FAH stands ready to assist Congress as it moves through its consideration of the many issues that are important to all Americans and the hospitals that serve them in their time of need.