Federation of American Hospitals®

Charles N. Kahn III
President and CEO

January 21, 2015

Chairman Fred Upton
House Energy and Commerce Committee
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Ranking Member Frank Pallone
House Energy and Commerce Committee
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Subcommittee Chairman Joe Pitts
House Energy and Commerce Committee
Subcommittee on Health
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Ranking Member Gene Green
House Energy and Commerce Committee
Subcommittee on Health
U. S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Upton, Subcommittee Chairman Pitts, Ranking Member Pallone, and Subcommittee Ranking Member Green:

The Federation of American Hospitals ("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 teaching and non-teaching hospitals in urban and rural parts of the United States, as well as inpatient rehabilitation, psychiatric, long-term acute care, and cancer hospitals. The FAH welcomes the opportunity to submit our views concerning the sustainable growth rate ("SGR") reform, and commends the Subcommittee's leadership in addressing this problem. We also applaud the Subcommittee's interest in building upon the bipartisan, bicameral agreement on policy reached in the 113th Congress and discussing options to permanently resolve this issue in a fiscally responsible manner.

In order to serve our patients' needs, America's hospitals rely on the quality and professionalism of their medical staffs. The partnership we have long shared with physicians has ensured that seniors and patients in communities across America have access to the medical care they need when they need it. Going forward, we will strengthen this partnership to improve the performance of hospitals and the health care system more generally, and expand access and deliver higher quality care more efficiently – goals we all share. One of the greatest threats to this partnership and achievement of these goals, however, is the lack of fair and predictable Medicare payment for physicians. That is why the FAH remains deeply concerned with the problems plaguing the SGR formula.

The FAH strongly supports fixing Medicare's flawed physician payment system, and as the Subcommittee moves forward to address the SGR, the FAH urges that a new approach include the principles outlined below.

KEY PRINCIPLES FOR REFORMING PHYSICIAN PAYMENT AND THE SGR

- ***The SGR Fix Should Not Be Funded with Cuts in Payments for Hospital Services***

The FAH vigorously opposes funding the SGR fix with cuts in payments for critical hospital services. Should Congress determine that offsets are needed for an SGR fix, we strongly encourage the Subcommittee to look at other sources of savings to cover the cost of a Medicare physician payment solution**.**

Stable and adequate Medicare payment, for both physicians and hospitals, is essential to sustain this partnership and our shared goals of broad access to high quality care, as well as to align incentives in a new world of greater care coordination and integration. It is counterintuitive to reduce Medicare or Medicaid payments to hospitals, which already fall far below the cost of care, to offset the costs of fixing the SGR. Robbing hospital Peter to pay physician Paul is bad public policy and severely undermines the Subcommittee's expressed goal of resolving this issue in a fiscally responsible manner. Since 2010, hospitals have been hit with $121.9 billion in federal Medicare and Medicaid payment cuts, which will occur over ten years. Last year, the Medicare Payment Advisory Commission ("MedPAC"), which advises Congress on Medicare payment policy, projected that hospitals would experience the lowest Medicare margin in history for 2014: negative 8 percent. And just last month, MedPAC delivered even more sobering news: for 2015, MedPAC now projects that Medicare hospital margins will set a new low of negative 9 percent. At a time when health care spending is experiencing an unprecedented slowdown, enough is enough. Hospitals are working diligently to protect patient access to care, and we cannot do that in an environment of continued cuts.

Further, these cuts have occurred at the same time as the underlying cost drivers of hospital care continue to climb. It is unfair and unwise to expect the health care system or one element of the system, such as hospitals that already suffer from chronic federal underfunding, to finance the cost of past policy mistakes.

- ***Ensure Fair and Equitable Payment***

We agree with many in the physician community that an adequately funded Medicare physician payment system is needed, while creating incentives for physician participation in an array of alternative payment models focusing on value rather than volume. This will provide the basis for a new payment and delivery system that improves quality and increases efficiency.

Congress must recognize, however, that adequate funding for physician services depends on the setting in which those services are furnished. Such funding should not jeopardize access to hospital services, which have intrinsically higher costs due to the need for round-the-clock, comprehensive emergency care every day of the year for patients who often are sicker and suffer with higher average risk for complications than patients treated in a physician's office.

- ***A Flexible Transition Period Is Needed***

In developing a new Medicare physician payment system, the FAH supports a transition period during which physician practices have the opportunity to adopt varying new payment and delivery models, scalable to their practice, and at an appropriate pace. This will provide physician practices with the flexibility needed to plan for infrastructure and other changes, and join new care delivery models as the practice becomes ready.

- ***Timely Data and Feedback is Needed***

The FAH supports requiring the Centers for Medicare and Medicaid Services ("CMS") to provide timely feedback, at least quarterly, and actionable, real time and relevant data to physicians that will assist physicians in making necessary adjustments in their medical practice to improve patient care. We also generally support expanded use of Medicare data for physician performance improvement, as this will help physicians better incorporate practice improvements, so long as appropriate safeguards are present to ensure, for example, that data are adequately risk-adjusted and appropriately attributed to those who have provided the medical care.

- ***Align Incentives to Encourage Coordinated Care***

The FAH supports continued efforts to align incentives for coordinated care across providers. Effective coordination and collaboration among hospitals, physicians and other providers will help achieve higher quality of care with better outcomes, and for better value, in a more seamless manner.

- ***Assess Payment and Delivery Development Efforts to Ensure Proper Long-Term Implementation***

As numerous innovative payment and delivery models get underway, it is critical to assess "best practices" over time and build upon the experience of successful payment and delivery models. Therefore, the FAH supports an ongoing assessment of efforts to develop new payment and delivery models, including annual reports to Congress. It would be short-sighted to jump to long-term payment and policy decisions without the benefit of knowledge and "lessons learned" from the testing phase of various new payment and delivery models. There are many initiatives currently underway by CMS's Center for Medicare & Medicaid Innovation and in the private sector that hopefully will provide a base of data and experience to help craft appropriate, permanent policies.

- ***Quality Measures Should be Reviewed and Developed through a National, Multi-Stakeholder Consensus Process***

For more than a decade, the FAH has been working side-by-side with other stakeholders toward three quality goals: improving quality of care; making provider performance more transparent; and improving the value of health care services as measured by both cost and quality. More specifically, the FAH has been engaged in multi-stakeholder collaborative processes to develop, evaluate, endorse, and recommend performance measures for use in federal and private quality reporting and payment programs. These processes include purchasers, payers, providers, consumers, employers, physicians, researchers,

governments and other stakeholders to support improvement in health care quality and outcomes while achieving better value for the services provided. These groundbreaking efforts, over many years, have produced a reliable multi-stakeholder, consensus-based quality framework designed to address national goals and priorities outlined in the federal government's National Quality Strategy ("NQS").

The NQS reflects the multi-stakeholder consensus that a patient-centered health care system will lead to improved population health, with more efficient care delivery, at a lower cost. To help achieve the NQS, the National Quality Forum ("NQF") convenes multi-stakeholder consensus development committees for evaluating, endorsing, and recommending quality measures for use in public reporting and payment programs. The NQF quality measure endorsement process ensures that measures are vetted through a multi-stakeholder process that assesses the importance of topics to measure, and the scientific soundness, reliability, and feasibility to collect and report the data. In order to drive transparent quality improvement, metrics must be understandable to patients and their families and providers, instead of just a matter of academic interest.

The NQF also convenes the Measure Applications Partnership ("MAP"), a separate multi-stakeholder process. The purpose of the MAP is to provide advice and assess specific quality measures for their readiness for specific federal public reporting and payment accountability programs prior to the measures being included in a proposed rulemaking issued by HHS. The pre-rulemaking review makes the rulemaking process more efficient and gives clinicians and providers the opportunity to better prepare for the implementation of new quality measures.

To be effective, quality measures must produce results that are meaningful for patients, payers, providers, clinicians and other quality enterprise stakeholders. The measure endorsement and pre-rulemaking review process for appropriate use of measures in specific quality programs is critical for ensuring alignment of public quality reporting and payment programs across various providers, as well as the reliability, validity and usefulness of quality measures. The consensus-based review process also influences the private sector use of quality measures.

Both the NQF measure endorsement process and the MAP provide proven processes for engaging strong multi-stakeholder efforts and consensus building. Involving multiple stakeholders in the approval process creates a level playing field, reduces reporting burden, helps assure broad acceptance of the measures for use by both public and private payers and by consumers and patients, and creates efficiencies by minimizing duplication of effort. Without these processes, the system risks returning to fragmented past practices with less consensus and alignment among quality programs in both the public and private sectors.

The bipartisan, bicameral agreement on physician payment policy reached in the 113th Congress proposes streamlining existing physician quality programs, and the FAH supports such streamlining in concept. ***Yet, it is critical that the development of a new streamlined program, whether a VBP or other quality program, incorporate existing quality infrastructures, such as the NQF and the MAP, that have been so instrumental in facilitating Medicare quality programs and streamlining measures for all providers. We urge the Subcommittee to ensure that quality measures used in any quality or VBP program are those that are endorsed through the NQF.*** Further, the HHS Secretary's annual

solicitation of recommended measures for inclusion in the VBP program should utilize the existing MAP process.

Additionally, the FAH has concerns about proposals involving physician-endorsed measures and allowing individual physician specialties to develop measures, which may not necessarily be reviewed and endorsed through the national NQF and MAP consensus processes. We caution the Subcommittee that permitting various stakeholders to individually develop and use their own measures without having those measures reviewed by an impartial multi-stakeholder entity would lead to questions about the validity, reliability and usefulness of the data produced. It could also create a proliferation of inconsistent, conflicting, and duplicative measures that will be burdensome, confusing and even harmful to patients and health care providers who need to rely on consistent and accurate data at the point of care. It certainly would add to the overall costs in the health care system and undermine the goals of improved health, improved care delivery and lower costs.

While it is critical that physicians be involved with the development of the measures on which they will be evaluated, it is equally critical that physician measures reflect the goals of the NQS and that the process for developing, endorsing and implementing quality measures involve a broad range of health care stakeholders. Consistency of measurement across providers and settings will be jeopardized without the use of measures endorsed through a multi-stakeholder process, such as the NQF. All stakeholders should have the opportunity to review any quality measure for its scientific validity, feasibility, reliability and importance to measurement. Such a process ensures that quality measures used for public reporting and payment will be valid for purposes of accountability and comparison.

Both the NQF and the MAP provide a proven process for engaging strong multi-stakeholder efforts and consensus building. These processes permit wide vetting of the measures by multiple stakeholders based on criteria for importance, validity, reliability, solid evidentiary base, and usability. Involving these multiple stakeholders in the approval process creates a level playing field, reduces reporting burden and helps assure broad acceptance of the measures for use by both public and private payers and by consumers. Without these processes, we risk returning to fragmented past practices that had less consensus and alignment among quality programs in both the public and private sectors.

Also, because the NQF and MAP processes promote achieving consensus on measures at the front-end, providers have more time to plan how to implement and use measures. This means that when measures are ready for implementation, this can be achieved in a more efficient and meaningful manner.

Further, the FAH recommends that as measures are developed and endorsed through a multi-stakeholder consensus process, the measures should be specified to coding systems that are expected to be in use during the time period for which the measures will be effective. This will help ease administrative difficulties in aligning measures to appropriate coding systems, which will further ensure the availability of a measure.

With respect to the development of measures, we support additional funding for measures, and also urge that continued funding be provided for the measure endorsement and MAP pre-rulemaking processes as well.

Finally, the FAH also cautions the Subcommittee concerning the use of registries. We recognize that there is valuable role for registries, but we urge the Subcommittee to ensure that registry measures are required to be reviewed and endorsed through a multi-stakeholder consensus process. Further, because registries are expensive to develop and maintain, participation in a registry should be optional. We urge the Subcommittee also to keep in mind that registries may take many years to develop, and the promise of their ultimate long-term functionality and financial sustainability remains to be seen. Therefore, the Subcommittee should consider the return on investment when developing proposals involving registries and ensure that other alternative avenues are available to participate in quality programs.

****

We thank the Subcommittee for its leadership and efforts to address these important Medicare physician payment matters. We look forward to continuing our work with the Subcommittee and Congress to meet the challenge of ensuring adequate payments for physicians and to strengthen, not weaken, the ability of hospitals to sustain America's fiscal and public health, while providing patient-centered quality of care.

Sincerely,



750 9th Street., NW, Suite 600 Washington, DC 200041• 202-624-1500 • FAX 202-737-6462 • www.fah.org