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Testimony
of the
American Hospital Association
before the
House Democratic Steering and Policy Committee
on
Health Care Reform
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Good morning, Madam Speaker. I am Tom Priselac, president and CEO of Cedars-Sinai Health System in Los Angeles, and chairman of the board of trustees of the American Hospital Association (AHA). I am pleased to be here today to represent the AHA's nearly 5,000 member hospitals, health systems and other health care organizations, its 40,000 individual members, and the dedicated hospital leaders, doctors, nurses, pharmacists and other health care workers who care for patients in our hospitals.

The people of America's hospitals are on the front lines of health care in this country. They see every day how good our health care system can be, and the miracles that happen because of dedicated, caring, highly trained people using the latest in technology. They also see the system's shortcomings: how the uninsured come to us in much worse shape than they should because they don't have access to primary care, for example; or how someone who thinks they have coverage ends up not having coverage for a particular treatment. While the answers to health care reform are as complex as its problems, at the heart of the reform effort should be one very simple maxim: getting people the care they need, when they need it. That is why the hospital field supports meaningful reform.

INCREASED COVERAGE

With respect to coverage, we commend the House committees for their expansion of health care coverage for the uninsured. To us, meaningful reform, first and foremost, expands coverage to at least 95 percent of all those residing in the U.S. Accomplishing this goal requires a shared responsibility among all stakeholders. This includes an individual mandate, employer responsibility, and government subsidies for those who need financial assistance. We applaud the House leadership for working to pass legislation that seeks to achieve the fundamental goal of expanded coverage. We acknowledge that 100 percent coverage is unlikely … there always will be some who fall through the cracks, and funding mechanisms must be preserved to deal with those individuals.

But a broad expansion of coverage is critical to successful and meaningful reform, and we share your commitment to it.

We applaud that the legislation restricts the ability of physicians to self-refer to hospitals in which they have an ownership interest, and imposes growth limits for those facilities that are grandfathered. As we saw in a recent *New Yorker* article by Dr. Atul Gawande, areas where physician-owned facilities flourish – such as McAllen, Texas – tend to have significantly higher health care spending levels. We believe that decisions about a patient's care should be based on what is best for the patient, and that by addressing the self-referral issue you have taken a major step toward ensuring that these important decisions are not based on financial interest.

We also are very appreciative that the House legislation includes no cuts to graduate medical education, including the indirect medical education adjustment, which helps train the next generation of doctors.

Again, Madam Speaker, we applaud the House leadership for your commitment to meaningful reform. We do have several concerns about other proposals in the legislation.

DISPROPORTIONATE SHARE HOSPITALS

The legislation calls for, beginning in Fiscal Year (FY) 2017, a 10.2 percent reduction over four years in Medicare Disproportionate Share Hospital (DSH) payments if there is a significant decrease in the number of uninsured. Medicare DSH payments could be partially restored for some hospitals based on the amount of uncompensated care the hospital provides. Medicaid DSH payments to states would be reduced by $6.4 billion, beginning in FY 2017.

It is absolutely critical, Madam Speaker, that that 95 percent coverage target be reached if DSH payments are to be adjusted. There will always be a need for DSH support for hospitals, because, as I mentioned, there will always be uninsured people, and we appreciate that the House bill recognizes this need. No matter how successful health care reform is, there will always be a need to keep the safety net strong, and DSH provides the strength of that safety net.

MEDICAID

Madam Speaker, we also applaud the committees for expanding Medicaid to help those in need receive care. But we urge you to keep in mind that hospitals provide care to all patients who come through their doors, regardless of ability to pay. Overall, hospitals, in 2007, provided care at a cost of $34 billion for which no payment was received.

Hospitals experience severe payment shortfalls when treating Medicaid patients. On a national level the Medicaid payment shortfall amounted to $10.4 billion in 2007. While we support expanded coverage through Medicaid and subsidies, we note that Medicaid paid only 88 cents for every dollar spent treating Medicaid patients. At the same time,

state budgets are being squeezed and many states are reducing Medicaid payment rates to hospitals and other providers.

We urge the committee to consider carefully how hospitals' ability to care for ever-expanding numbers of patients could be compromised by the perpetuation of Medicaid underpayment for hospital services.

THE PUBLIC OPTION

The legislation creates a government-run, public insurance plan option under the premise of offering consumers greater choice, more competition and affordability in health plans. While the AHA believes the public option in the Energy & Commerce Committee version of H.R. 3200 is an improvement, we still have concerns about the public option:

- In general, HR 3200 includes an expansive public plan that is available on day one of the national health insurance exchange and can be offered only through the exchange. In the first two years the exchange is operational, the public plan is limited to the uninsured, self-employed, and small businesses. Beginning in year three of the exchange, the public plan could be expanded to large employers as defined by the exchange commissioner. We believe the public plan should be limited permanently to the uninsured, self-employed and small businesses – those most in need of help to purchase health care coverage.

- The Ways & Means and Education & Labor public plan relies on Medicare rates for hospital payment, while the Energy & Commerce legislation creates a range of payments, with Medicare rates as a floor. These are the differences among the bills:

  - In the Ways & Means and Education & Labor versions, the Secretary of HHS would establish a rate-setting process for hospitals, but such rates could not be more than the Medicare rates used in the first three years of the exchange.

  - The Energy & Commerce version would require that, beginning in year four, the Secretary establish a process where rates are negotiated with hospitals, but those negotiated rates are constrained by a floor and ceiling. The negotiated rates could be no lower, in the aggregate, than Medicare rates and no higher, in the aggregate, than the average rates paid by the health plans operating within the exchange.

Madam Speaker, while the Energy & Commerce bill provides a range, we are concerned that the Secretary would have little incentive to pay more than Medicare rates. Tying public plan payment rates to Medicare, which already pays less than the cost of care, could result in significant losses to hospitals, as individuals and employers choose to enroll in the public plan because of the lower premiums made possible by the existing underpayment of providers.

Also, the Medicare Payment Advisory Commission projects that hospitals will have a *negative* 6.9 percent Medicare margin in 2009 – down from a *positive* 6.2 percent

Medicare margin in 1999 – the lowest level in more than a decade. According to AHA annual survey data, a staggering 58 percent, or 2,840 hospitals, lost money serving Medicare patients in 2007. Any public-sponsored insurance option should require that provider payments be based on negotiated rates with no link to Medicare payment rates.

ACOs

House legislation permits Medicare to pilot programs in which accountable care organizations (ACOs) are paid to manage the health care of defined populations beginning in January 2012. ACOs are defined by the House as groups of physicians or physician organizational models that:

- Have a legal structure that would enable the group to receive payments and distribute incentives;
- Have a sufficient number of primary care providers to serve the population for which they are assuming accountability;
- Collect and report on quality data and other information specified by the Secretary of HHS to enable the evaluation of the success of the pilot;
- Notify the applicable beneficiaries as determined appropriate by the Secretary;
- Contribute to a "best practices" Web site specified by the Secretary for sharing of effective strategies for improving care and efficiency;
- Use patient-centered care processes; and,
- Meet other criteria set by the Secretary.

We strongly believe the legislation should include an ACO pilot that allows groups of qualifying providers – including hospitals, hospital-physician joint ventures and hospitals employing physicians – to voluntarily form ACOs and share in the cost savings they achieve for Medicare. The leadership of an ACO should not be limited to physician groups and physician organizational models, as it is in the House legislation.

ACOs offer an opportunity to improve integration of inpatient and outpatient care and promote joint accountability for care delivery across providers and across time. Hospitals and health care systems are well-positioned to provide the organizational structure and leadership that underlies the functioning of a successful ACO.

READMISSIONS

The policy in the House reform bill would link hospital performance on readmissions to Medicare payments, and represents a potential cut of $19 billion dollars to America's hospitals over 10 years. Beginning in FY 2012, it would reduce payments to hospitals, including critical access hospitals, with higher-than-expected 30-day readmission rates for heart attack, heart failure and pneumonia. This payment cut would apply to all Medicare discharges – not just cases involved in a readmission.

- In FY 2012, the largest reduction for a hospital would be 1 percent, with the reduction growing to 5 percent in FY 2015 and beyond. In 2013, the Secretary of HHS would have authority to expand the policy to an unlimited number of other conditions.

- Post-acute care providers, including skilled nursing facilities, inpatient rehabilitation facilities, long-term care hospitals and home health agencies, would experience reduced payments for readmissions starting in FY 2012.

Madam Speaker, we believe that this proposal is overly aggressive. Hospitals' actual readmission rates would be compared to their expected readmission rates for the three conditions, and any hospital with even *one* readmission more than expected would be financially penalized. These penalties would be significant, applied to *every single* Medicare discharge, not just discharges for heart attack, heart failure and pneumonia.

Preventing unnecessary hospital readmissions is a complex, system-wide goal that involves hospitals, physicians and other providers who manage patients' care, as well as patients and their families. Hospitals have an important role in preventing unplanned readmissions that are related to the initial admission, but other sectors of the health care system also must do their part.

The examination of hospital readmissions data is relatively new and more work is needed to determine how to effectively reduce inappropriate readmissions. The proposed policy would financially punish hospitals without attempting to fix other shortcomings of the health care system. In addition, the provision would give the Secretary the ability to rapidly expand the program.

The goal of any effort to reduce hospital readmissions should be to improve patient care. Therefore, policies that seek to provide incentives to hospitals to reduce readmissions should focus on the group of unplanned readmissions that are related to the initial admission and for which the greatest opportunity exists for hospitals to take actions that may prevent their occurrence. To center efforts on those areas where hospitals could prevent inappropriate readmissions most directly, public policy efforts should focus on preventable complications of care for which evidence-based practices exist that, when followed, can prevent the occurrence of those complications and readmissions associated with them.

For example, readmissions caused by preventable complications associated with non-emergent, major surgical procedures, such as hip or knee replacements, would be an appropriate category of readmissions. In addition, there are certain types of admissions that, because of their characteristics, should be excluded from a readmissions payment policy. Specifically, planned admissions, admissions that are part of the natural disease or treatment progression, and admissions that are mostly influenced by non-hospital community factors, such as patients' characteristics and home environments should be excluded.

GEOGRAPHIC VARIATION
The House bill includes two Institute of Medicine (IOM) studies: one on geographic variation and growth in intensity and services in per capita health spending, and another on whether payment systems should be modified to incentivize "high value" care, including consideration of the adoption of a "value index."

On the first, while we appreciate that the bill provides $8 billion over a two-year period, we are disturbed that there would be significant redistribution among hospitals when that funding elapses.

On the second, we are concerned that the bill would mandate a fast-track process for secretarial and congressional review and adoption of possible payment system changes, again resulting in significant redistribution.

This is a complex issue, and the field is looking into how to best address it. Moreover, as it stands in the House legislation, we are concerned about the power given the Secretary to affect payment changes.

CONCLUSION
Madam Speaker, while there is still much work to be done in Washington, all stakeholders – insurers, suppliers, unions, employers, providers and individuals - must step forward and do their part if we going to achieve meaningful reform. Additionally, it is critical that any health reform bill be based on expanding coverage to at least 95 percent of those residing in the U.S., and must ensure that our hospitals remain strong and able to provide care to patients and communities.

Again, we appreciate this opportunity to share our views on meaningful health care reform. You have our commitment to work with you on reform that truly makes health care better for the patients and communities hospitals serve.