PREMIER

13034 Ballantyne Corporate Pl.
Charlotte, NC 28277

T 704 357 0022
F 704 357 6611

444 N Capitol Street NW
Suite 625
Washington, DC 20001-1511

T 202 393 0860
F 202 393 6499

premierinc.com

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January 31, 2012

The Honorable David Camp
Chairman
House Ways and Means Committee
United States House of Representatives
341 Cannon House Office Building
Washington, DC 20515

Dear Chairman Camp:

On behalf of the Premier healthcare alliance, uniting more than 2,500 leading not for-profit hospitals and health systems and 81,000-plus other healthcare sites, we are writing to urge you to reject policies that will be detrimental to Medicare beneficiaries and the transformation of our healthcare system as the conference committee deliberates on the Temporary Payroll Tax Cut Continuation Act of 2011 (H.R. 3630).

The Premier healthcare alliance supports your work to prevent the 27.4 percent scheduled cut in physician payments and address the flawed Medicare sustainable growth rate (SGR) formula. However, we strongly oppose ANY additional Medicare or Medicaid cuts to hospitals to finance the physician payment fix and urge Congress to seek alternative sources of funding. The fact is Medicare spending growth is already constrained. CBO has projected that for 2012-2021, Medicare spending per beneficiary will grow 0.4 percentage points less than GDP per capita.

Moreover, we have clear evidence that hospitals have contributed significantly to the recent decline in healthcare spending. While some have attributed the decline to the recession, we are confident that changes hospitals have been making to measurably improve quality and reduce costs have helped to bend the cost curve. The Premier alliance's work by our QUEST®: High Performing Hospitals collaborative has achieved a reduction in costs of $4.5 billion in 2010, a substantial increase in evidence-based care to all patients and a reduction in harm. These real advances have resulted from substantial new investments by hospitals. Hospitals will continue to make this progress, but they cannot transform healthcare while they are being cut. **Congress should be recognizing and encouraging this progress, not cutting payments that fund this needed work**.

Hospitals are already facing $155 billion in Medicare and Medicaid cuts enacted in the healthcare reform law. This has been compounded by an additional 2 percent Medicare cut – approximately $40 billion – in 2013 due to automatic sequestration resulting from the Budget Control Act. Additional cuts are both unjustified and foolish. Hospitals have already taken huge cuts; these new reductions will undermine the real progress that has been made to improve quality and reduce costs, and further cuts will stunt needed changes as we transition from our fee-for-service system.

Reductions in hospital outpatient department payments for evaluation and management services

Specifically, Premier urges conferees to reject the provision contained in the House-passed bill, which would reduce payments for evaluation and management (E&M) services when provided in hospital outpatient departments. The bill would cut $6.8 billion from payments for outpatient E&M services by "equalizing" outpatient payment rates with the rates for the same services provided in physician offices.

In addition to understanding the current economic context for hospitals, we ask Congress to consider that this policy:

- Fails to recognize that **hospitals are already losing money providing outpatient services** to Medicare beneficiaries and there is little to no room for cost-shifting. According to Medicare Payment Advisory Commission (MedPAC)'s latest estimates, hospital Medicare margins for outpatient services were -9.6 percent in 2010. MedPAC's estimate that leveling payment for E&M services across sites would reduce *overall* payments for *all* hospitals by 0.6 percent is not reflective of the true impact on hospitals. The negative impact to *outpatient* departments – especially for certain hospitals such as teaching or safety net hospitals that provide many of these services – will be <u>much</u> greater. Furthermore, the argument that the overall impact on hospitals is not that great since hospitals have latitude in how they allocate costs between the inpatient and outpatient setting does not hold water. MedPAC also reports that Medicare *inpatient* margins in 2010 were negative, which leaves hospitals no room to absorb additional cuts.

- Fails to recognize the **substantial difference in resource use and costs** to furnish E&M services in the hospital outpatient department versus a physician office, including: the cost of caring for the uninsured and underinsured; the higher costs that hospitals incur meeting complex licensing, accreditation and regulatory requirements such as Medicare conditions of participation that are not required of physician offices; and other overhead costs such as access to crucial 24/7 "standby capacity" care, pharmacy, diagnostic testing

and care management. Unlike the physician fee schedule, the hospital outpatient payment system "packages" the cost of providing certain ancillary supplies and services, such as drugs, with the primary service, which makes office-based E&M services and outpatient-based services incomparable.

- Will **disproportionately impact hospitals that serve as a safety net for vulnerable Medicare beneficiaries** that rely on outpatient departments and hospital-based clinics for their primary source of care. Access to the wide range of services offered at a hospital-based clinic for all patients is particularly critical in urban and rural communities, where the majority of the population is enrolled in Medicaid, Medicare or is uninsured and financing care is challenging at best. Reducing Medicare payment for primary care in the hospital outpatient setting may leave some communities with very limited access, due to the lack of private practice physician alternatives for patients. Even MedPAC recognized the severe hit this would have on these hospitals by moderating its initial recommendation by capping losses to disproportionate share hospitals.

- Will **disproportionately impact integrated health systems and academic medical centers**. This will significantly stall movement toward health system integration and coordination of care, which represent the main approach for reducing costs and improving quality without harming access for patients. Integrated health systems, for example, generally invest in care managers despite the fact that Medicare offers no specific reimbursement for these critical services. The facility fee attached to hospital-based clinic services, including primary care, currently provides some financing for these, and other services, which are typically not provided in a physician's office.

- Was **recommended by MedPAC without in-depth data analysis** – as MedPAC traditionally undertakes – to substantiate its claim that there is a direct link between the growth in outpatient E&M services and hospital employment of physicians. MedPAC's recommendation largely reflects a belief that the trend of hospitals purchasing physician practices is driving increased patient visits to hospital-based clinics for primary care services. The undertone is that hospitals are buying up physician practices in order to bill Medicare at the higher facility-based rate without any changes to the healthcare model. This presumed "gaming" of the system is almost impossible given the latest criteria CMS uses prior to granting provider-based status to any entity. These include requirements on integration, compliance with outpatient rules such as patient anti-dumping, and a host of other very specific requirements that align with the outpatient setting. Before making a reimbursement policy change of this magnitude, careful analyses should be conducted of this claim, the true cost of providing E&M services in outpatient departments and the potential impact if access to those services is reduced.

- **Assumes that reimbursement for physicians for E&M services is "correct."** While outpatient payment system rates are based on hospitals' cost reports and claims data, the Medicare physician fee schedule rate for E&M services is based on voluntary surveys of physicians and has been held steady for years as a result of the stop-gap "fixes" to the

sustainable growth rate. Clearly, making payments for E&M services "site neutral" does *not* move us toward more accurate reimbursement rates.

Decreasing payment for bad debt and Medicaid DSH

Premier strongly opposes several other provisions in the House-passed bill. Cutting hospital payments for bad debt, as the bill would do, is tantamount to an across-the-board reduction that hurts all community hospitals and the seniors they serve. The purpose of these payments is to reimburse the costs of care that seniors receive, but only when they cannot meet their cost-sharing obligations. With the faltering economy, more and more seniors are struggling to fulfill their payment obligation, which leaves hospitals in the untenable position of providing an increasing level of uncompensated care. Hospitals are required to provide emergent care to all patients regardless of ability to pay. There are no comparable requirements on physicians and other providers.

Hospitals that serve a disproportionate share of Medicaid patients will already see cuts as a result of the $14 billion reduction in federal Medicaid DSH allotments to states as a result of the Affordable Care Act. The House-passed bill would pile on an additional $4.1 billion in reductions to these hospitals by rebasing Medicaid DSH allotments in FY 2021. These two policies will impact many of the same institutions that will be hit by a change in reimbursement policy for outpatient E&M services. If Congress imposes any further cuts, it will have a direct and adverse impact on the communities and Medicare beneficiaries hospitals serve.

Achieving long-term savings through payment and delivery system reforms

We hope that the conferees can work together to develop a politically feasible solution that will provide physicians serving Medicare patients with a stable stream of reimbursement that protects Medicare beneficiaries' access to care. On a broader scale, we urge the conferees to take advantage of all providers' efforts to reduce spending so as to spur the advancement of changes that will fix the perverse incentives in the payment system. The current fee-for-service payment system is misaligned with healthcare provider's attempts to achieve coordinated and cost-effective healthcare. It is critical that new delivery system models and programs give providers levers to achieve real, long-term savings for the government. This will encourage those providers who are taking meaningful and measurable steps to reduce healthcare costs and manage care to move in that direction. We recommend that:

- Organizations that are participating in programs that are designed to share savings with the government or offer a discount from current payment levels should be given credit for attained reductions in spending for the government. To that end, savings achieved for the government by providers that are building shared savings programs or participating in bundled payment programs with discounted payments should be recognized as already "contributing" to sequestration or other proposed cuts. Specifically, we recommend that

every dollar saved by the providers and accrued to CMS that are beyond the confidence interval or offered as specific payment reductions should offset on a dollar-for-dollar basis any sequestration or other proposed payment cuts. This reform will create a significant incentive for providers to work aggressively to both build coordinated care programs as well as reduce healthcare spending.

- The Center for Medicare and Medicaid Innovation has tested a number of bundled payment initiatives. The most recent initiatives require interested organizations to bid discounted prices at or below a minimum level of savings, with no opportunity for providers to share in the savings achieved beyond the minimum level of savings. The lack of shared savings increases the risk to providers with little business case to do so for the average hospital system. So as to improve the business case, encourage far more organizations to take part in these programs, increase the pace of adoption, and set more organizations onto the path of accountable care organizations that will save even more in the future, a broad-scale national voluntary bundled payment program, rather than a pilot program, should be implemented that allows providers to share in the savings with the Medicare program.

- To increase the success and, by extension, the savings potential of Medicare shared savings programs, these programs must allow for incentives that encourage beneficiary participation, loyalty and engagement. Providers participating in these programs should be allowed to offer items and/or services that promote better preventive care, encourage patients' compliance with their treatment plans and generate increased participation by the beneficiary. Such items or services could be free screenings or wellness items and services, co-pay and deductible waivers, as well as transportation vouchers. Without an Anti-Kickback Statute waiver to permit the furnishing of these types of services by participants of shared savings programs, participating providers are constrained in what they can provide to beneficiaries that will provide additional value and help them become more engaged as a healthcare consumer. Allowing providers to use such levers drawn from evidence-based care guidelines to influence beneficiaries will undoubtedly increase the effectiveness of the model and generate greater savings for the government.

- Medicare shared saving programs should also be structured in a way that allows participants to drive care where it is most appropriate and to the highest quality and most effective sites of service. Accountable care organizations, for example, will be mindful of care patterns that ultimately result in higher Medicare spending, as it will reduce the annual bonus, and the quality measurement process will ensure that the quality of care is maintained. Accordingly, payment policies should not be applied that penalize providers for directing the setting of care where appropriate. As long as the ultimate outcome is measurably higher quality, cost-effective care, participants should be able to direct patients to the appropriate setting without reduced payment.

QUEST is but one example of how Premier is working to fix healthcare from the inside. Many Premier hospitals are undertaking efforts to reduce readmissions and healthcare-acquired infections, and improve coordination of care and overall health outcomes for their patients. Savings achieved from these innovative initiatives are a result of real investments by hospitals. Federal healthcare policy should credit hospitals for the recent slowdown in healthcare spending, rather than further cutting the resources hospitals need to build on these successes.

Extending expiring Medicare provisions

We also urge conferees to include in any final bill an extension of expiring Medicare provisions through the end of the year, which are critical to hospitals, including:

- Extending the Section 508 Program,
- Extending the outpatient hold-harmless payments for small rural hospitals and sole community hospitals,
- Continuing payment for the technology component of physician pathology services furnished to hospital patients,
- Protecting reasonable cost-based payment for clinical lab tests in small hospitals located in qualified rural areas, and
- Continuing ambulance add-on payments.

In closing, we appreciate the challenges facing the conferees in identifying how to pay for the considerable cost of stabilizing Medicare physician payments. However, cutting hospitals' payments would harm the very patients we are trying to help by ensuring access to physician services. Hospitals in the Premier healthcare alliance are moving forward with cost-saving initiatives while shouldering significant reductions in Medicare and Medicaid payments. We urge the conferees to adopt other financing mechanisms to fix a system which is widely acknowledged to be flawed.

Sincerely,

Blair Childs
Senior Vice President, Public Affairs
Premier healthcare alliance