Federation of American Hospitals®

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President and CEO

June 10, 2013

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

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

Dear Chairman Upton and Subcommittee Chairman Pitts:

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 House Energy and Commerce Committee's draft legislative proposal to reform Medicare physician payment and the sustainable growth rate ("SGR") formula.

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 care they need when they need it. Going forward, we will strengthen this partnership to improve the performance of hospitals and the health 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 current SGR formula. We applaud the Committee's interest in a long-term resolution to the fundamental SGR flaw and providing fair and predictable Medicare payment, especially as new payment and delivery models are developed to form the basis for a new Medicare physician payment system. The FAH strongly supports fixing Medicare's flawed physician payment system, and we believe the Committee's legislative proposal is a step in the right direction.

We have several concerns, however, particularly concerning the quality improvement provisions and believe the Committee's proposal may undermine existing long-standing efforts that were developed to ensure alignment and standardization of quality improvement programs, as discussed further below. In addition, in March, we submitted the attached letter to the Committee, in which the FAH urged the Committee to incorporate various key principles into any final SGR reform proposal. We summarize and reiterate those key principles 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. Instead, we strongly encourage the Committee to look at other sources of savings to cover the entire cost of a physician payment fix.

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, especially as hospitals come to grips with the cumulative impact of nearly $95 billion in cuts since 2010, including sequestration, in addition to more than $320 billion in cuts under the *Patient Protection and Affordable Care Act* ("ACA"), according to the Congressional Budget Office. 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 as an array of new payment and delivery reform models are developed and tested in the search of a suitable, sustainable alternative payment 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, and 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 would have the opportunity to adopt varying new payment and delivery models, scalable to their practice, and at an appropriate pace.

Timely Data and Feedback is Needed

The FAH supports requiring the Centers for Medicare and Medicaid Services (CMS) to provide timely feedback 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.

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, including annual reports to Congress.

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

The FAH long has been engaged in multi-stakeholder collaborative processes to develop, evaluate, endorse, and recommend performance measures for use in federal quality reporting and payment programs. These efforts have included purchasers, payers, providers, consumers and other stakeholders to support improvement in health care quality and outcomes while achieving better value for the services provided. These groundbreaking efforts have produced, over many years, a reliable multi-stakeholder, consensus-based quality infrastructure designed to address national goals and priorities outlined in the 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, and at lower cost. To help achieve the NQS, the National Quality Forum ("NQF") convenes a multi-stakeholder consensus development process for evaluating, endorsing and recommending quality measures. The NQF also convenes the Measure Applications Partnership ("MAP"), a pre-rulemaking advisory process that provides perspective on whether measures are appropriate for specific quality programs and meaningful for patients, payers, providers and the private sector. These processes are critical for ensuring alignment of quality programs as well as the reliability, validity and usefulness of quality measures.

We are concerned that the Committee's legislative proposal would create new, yet duplicative quality programs and processes that diverge from these existing infrastructures that have been so instrumental in aligning Medicare quality programs and streamlining measures for all providers. Specifically, the Committee's proposal would allow individual physician specialties to develop measures, which may not necessarily be reviewed and endorsed through the NQF and MAP consensus processes.

Permitting various stakeholders to individually develop and use their own measures without having those measures reviewed by an impartial multi-stakeholder entity, such as the NQF, 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 will 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, as occurs through the NQF. Further, measures should support achievement of the NQS strategy, rather than potentially creating a new framework based on "core competency categories," as proposed in the legislation. For example, measures designed to achieve a patient-centered focus would assess attributes (such as care coordination, patient experience of care, and functional status) that cut across all physician specialties. Focusing on a "core competency" framework may undermine patient need and a more evolved delivery system based on care coordination.

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. 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, 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.

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.

Finally, the FAH also cautions the Committee concerning the use of registries. We recognize there may be a valuable role for registries, but we urge the Committee 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 Committee to also keep in mind that registries may take many years to develop, and the promise of their ultimate long-term functionality remains to be seen. Therefore, the Committee should consider the return on

investment when developing proposals involving registries and ensure that other avenues are available to participate in quality programs.

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Thank you for your leadership and efforts to address these important health care issues, and for your attention to our concerns. We look forward to continuing our work together 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,