



Minnesota Hospital Association

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May 15, 2009

The Honorable Max Baucus
Chair
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Charles Grassley
Ranking Member
Senate Finance Committee
219 Senate Office Building
Washington, DC 20510

Dear Chairman Baucus and Ranking Member Grassley:

On behalf of the 149 hospitals and 17 health system members of the Minnesota Hospital Association (MHA), we appreciate the opportunity to comment on the Senate Finance Committee's "Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs." MHA appreciates the chance to offer input at the early stages of the legislative process and encourages the Committee to allow for similar opportunities as health reform legislation moves forward.

Minnesota's hospitals, health systems, policy makers and residents are proud of our state's nation-leading efforts to develop a high-quality, low-cost, accessible health care delivery system. Over the years, studies have documented our providers' high quality, safety and efficiency. This is coupled with our relatively low percentage of uninsured individuals, which has resulted in the high quality of life and health status of our population.

Moreover, Minnesota receives a disproportionately small share of federal health care spending. Our Medicaid programs receive the lowest match of federal funds in the country and our per capita reimbursements from Medicare are at or near the bottom as well.

While we are proud of our achievements, we recognize that health care reform is essential for the long-term sustainability and vitality of our nation's health care system. As Congress embarks on the challenging task of federal health care reform, MHA asks you to consider policies that do not disadvantage low-cost, high-quality providers for their historical efficiency.

In attempting to address and modify the practices in other areas, we hope that Congress will not focus on financial withholds and penalties that allow the best providers to achieve nothing more than avoiding financial penalties. Instead, we encourage Congress to develop incentives that allow the best providers to recover more than their withhold so that the programs create positive incentives and rewards for stellar care that are in the best interests of our patients.

Hospital Value-Based Program

MHA supports the Committee's position to implement a value-based program (VBP) in a manner that would not impact inpatient prospective payment system (IPPS) add-on payments including disproportionate share hospital payments, indirect medical education payments, low-volume adjustment payments and outlier payments.

The proposal does not address how the measures and thresholds for VBP will be developed. MHA urges the Committee to require their development through a consensus-based process, such as those administered by the National Quality Forum and the Hospital Quality Alliance.

It is unclear in the VBP proposal description whether the best performing providers would receive incentive payments that exceed the amount of their initial withholds. If legislation is developed, it should clarify that the top quartile of hospitals would receive incentive payments that would exceed the amount of their withholds to provide a positive, net gain for high achievement. Other payments, specifically those to hospitals falling between 25% and 75%, could be structured so that the Medicare trust fund continues to achieve a savings from the withhold of the lowest performing hospitals. Without this positive incentive, the VBP becomes a no-win program in which providers can suffer financial penalties or break-even with no upside.

Similarly, the improvement- or attainment-based rewards are an appropriate way to encourage both excellence and significant gains toward excellence. MHA encourages the committee to ensure that the rewards are calculated in a manner that avoids an unintended consequence of putting above-average facilities in a bind where they do not have enough room for growth to obtain improvement-based rewards and yet are too far from attainment-based rewards to feel that investments in improvement have a realistic chance of reaching the thresholds necessary.

MHA encourages the Committee to reconsider the amount of the proposed withholds, especially in the out years. Without knowing more specifics about the program and the MS-DRGs that will be subject to the withholds, 3-5% withholds might be unduly harsh and actually serve to deprive those facilities most in need of the resources for improvements thereby undermining the goal of higher quality and safety the Committee wants to foster.

MHA suggests that the VBP incentives are available for a facility's performance with respect to each measure involved rather than basing all of a facility's withhold or bonus on a cumulative score. A composite score approach makes it more difficult for hospitals to identify the most meaningful changes they can make to improve their blended-performance score, thereby undermining the public policy goal of motivating hospitals to target practices that could move them from good to great facilities.

The proposal indicates that the methodology and subjective weighting of the various measures would be immune from appeals by providers. However, hospitals facing significant risks under a new formula that includes discretionary decisions to weight the factors used in the calculation, should have the opportunity to contest and appeal based on the methodology used and not merely on the outcome of the methodology.

As MHA assesses its future positions regarding this proposal, it would be helpful if the Committee would specify the payment methodology that would be used to calculate reimbursements for those hospitals excluded from the program.

Because many critical access and small hospitals have an interest in documenting and demonstrating their quality and outcomes for the communities they serve, MHA supports the Committee's intention to develop demonstration projects tailored to these hospitals rather than implement untested programs. MHA urges the Committee to ensure that any such demonstration projects continue to protect the ongoing viability of these essential aspects of our health care system.

MHA, in collaboration with other health care stakeholders and the Minnesota Department of Health, is developing standardized rural-relevant quality measures for critical access and small hospitals this year. We believe the outcomes of our efforts could serve as a useful guide for developing national measures for these hospitals.

Primary Care and General Surgery Bonus

Minnesota's hospitals and health systems, especially those in the rural communities throughout the state, struggle to recruit and retain the primary care physicians and general surgeons they need. MHA supports and applauds the Committee's recognition of this significant challenge and its approach to providing bonus payments for those physicians practicing in rural and underserved areas.

MHA looks forward to further clarification of the process the Committee intends to be used to establish "newly defined rural scarcity areas."

MHA prefers that these well-intentioned and needed bonus payments are funded through the appropriation process or other sources rather than from across-the-board cuts in payments for services under other codes.

Chronic Care Management Innovation

MHA is concerned about the confining parameters placed on expanding the duration and scope of care coordination projects. As proposed, a project could not be expanded unless it reduced costs without decreasing quality or improved quality without increasing costs. These parameters preclude expansion of projects that demonstrate significant or even dramatic improvements in patient care if there is a corresponding minimal increase in cost. While it is understandable that the Committee seeks to avoid significant cost increases, improving patient care should be the primary objective and innovations that can dramatically improve care and quality of life should not be precluded merely because they are associated with minimal cost increases. Accordingly, MHA encourages the Committee to reconsider the limitations it proposed on future expansions of care coordination projects.

Evidence that care coordination could improve patient care and achieve cost savings lead to the conclusion that the Committee's limitation of care coordination projects to patients with multiple chronic conditions is too restrictive. Projects in Minnesota have demonstrated that patients with chronic conditions, not necessarily with multiple chronic conditions, benefit from more coordinated care and, consequently, require fewer hospital admissions and health care resources. By expanding the types of patients for whom care coordination projects could be designed, future legislation would accelerate and amplify the learnings, savings and improved patient care that the proposal aims to achieve.

Perhaps the most significant unknown associated with this proposal is the accompanying reimbursement for providers who take on the tasks of intensive care coordination. The Committee's proposal and vision for care coordination will require providers to make a significant investment of time, resources, training and administrative management to implement. If reimbursement levels for the coordinated services are insufficient, the projects will not make the impact desired and resources and critical time will be squandered.

Hospital Readmissions

MHA supports the Committee's approach of addressing avoidable and preventable readmissions. Some readmissions are unavoidable; some are even expected. Health care providers' financial incentives should be targeted to modify behaviors and results that are within the providers' control and not those that are unavoidable. Accordingly, in addition to cancer, burn and trauma care, and scheduled surgeries, which the Committee appropriately identified as not preventable, there are other types of readmissions, such as psychoses, maternity and neonatal, and end-stage renal disease, that should be explicitly excluded from the readmission policy.

Likewise, MHA supports the Committee's decision to set readmission incentives based on a national benchmark. Current Medicare payment methodologies result in inequitable geographic disparities. Regional benchmarks would threaten to solidify existing disparities or create new disparities in Medicare payments.

The proposal's description raises several concerns that the Committee should address before drafting legislation. As discussed earlier, the proposal is unclear whether the highest performing hospitals could earn payment bonuses that exceed the amount of their withholds. As stated above, a payment incentive plan that includes the potential for loss and penalties but offers no upside gains, fails to reward providers who excel at patient safety and quality. Accordingly, the Committee should clarify that incentives could reward providers with a return of their withhold plus an additional bonus for high achievement or improvement.

The proposal's description raises several concerns that the Committee should address before drafting legislation. MHA suggests that the Committee consider revising the proposal to appropriately recognize that responsibility for preventable readmissions often falls on multiple parties. Hospitals, clinics or physicians providing follow-up care, and patients themselves, often share responsibility for the miscommunications, poor coordination and noncompliance that so often results in otherwise avoidable readmissions. Yet, the Committee's proposal places financial risk solely on one actor in the equation. Instead, MHA suggests that the financial risk be shared among hospitals and the other providers involved in post-acute care so that there is alignment of responsibility, risk and reward across the continuum.

A 20% prospective withhold is an unreasonably severe financial risk. Admittedly, the proposed percentage carries a strong message to those hospitals falling in the bottom quartile, its ramifications could result in unintended consequences that ultimately lead to reduced access to safe care for patients. Those hospitals most in need of resources to improve patient safety will instead be faced with unpredictable and diminished payments. Furthermore, this level of an automatic withhold is particularly problematic for small and rural hospitals that have limited cash flow and a high proportion of Medicare patients.

One suggestion for improvement is that reimbursement for the original MS-DRG be reduced only *after* a readmission occurs. This would improve cash flow issues for hospitals and provide them with an opportunity to challenge withholds for individual patients, especially those readmitted to different facilities.

In addition, the proposal lays out a complex and costly payment methodology for Medicare to implement and for hospitals to track. Individual patient tracking of withholds and readmissions adds a significant layer of clinical and administrative data management coupled with payment processes. Likewise, a hospital providing care will have no way of knowing whether it has received appropriate reimbursement of its withhold because it will not know if the patient was readmitted to a different facility. As a result, hospitals will be unable to contest unreimbursed withholds and, instead, have no recourse but to blindly trust that the system and payments are accurate. MHA believes a simpler, more accountable and low-cost incentive program could be brought forward to achieve the Committee's underlying policy objectives.

Bundling Policy

MHA appreciates the goal of creating payment mechanisms that foster more care coordination across multiple providers and supports the theory of episode-based payments for those instances in which best-available science identifies an effective, safe and appropriate care regimen. Minnesota hospitals are currently participating in a pilot project of the PROMETHEUS Payment approach in hopes of contributing to the advancement of episode-based or bundled payment methodologies.

Based on our members' limited experience in the pilot project, MHA believes that Congress should pursue federal pilot projects in a variety of markets before implementing a new payment methodology nation-wide. In particular, bundled payments as described create an implicit incentive for providers to reduce, withhold or delay care, at least until day 31, which does not align with the patient's best interest. Before embarking on a bundled payment system, MHA encourages Congress to further develop, test and study ways to ensure the payment mechanism used truly aligns reimbursement with the patient's best interest, that reimbursements are sufficient to maintain and foster high-quality care, and that evidence-based care protocols exist to appropriately define the care that falls within or outside the scope of the bundle.

Furthermore, the specific proposal set forth by the Committee raises serious concerns. Most significantly, the exclusion of physician services from the bundled payment undermines the integrity and equity of the proposed policy. Physicians hold the most control and exercise the most discretion over what services and treatments a patient receives. If their services are not included in the bundled payment, the other providers operating within the parameters of the bundled payment have little if any ability to control the costs, utilization and care strategies that ultimately determine whether the bundled payment is sufficient.

A number of legal and regulatory barriers would need to be removed to allow greater care coordination and management of patients by both hospitals and physicians. Under the Committee's proposal, CMS would waive certain laws to ensure patients receive appropriate services and that access to care is maintained. CMS would examine payment rules in the existing post-acute payment system to determine if modifications are needed to allow proper coordination and care management of patients. MHA supports this aspect of the Committee's approach because providers' ability to respond to bundling payment incentives currently is

significantly hampered by multiple laws and regulations. In addition to the antitrust laws, four federal statutes have a significant impact on hospitals' ability to form financial relationships with physicians: the *Ethics in Patient Referrals Act*, also known as the "Stark law;" the anti-kickback statute; the Civil Money Penalty (CMP) law; and the tax-exemption provisions of the Internal Revenue Code. These regulations restrict a hospital's ability to respond to the incentives of a bundled payment system.

Existing regulations also inhibit care coordination and would need to be reformed or withdrawn to achieve the goals of bundling. For example, today's requirement that hospitals provide a list of all local home health providers to patients at the point of discharge would need to be eliminated. In a new bundled payment system, hospitals, working in collaboration with physicians and post-acute providers, will need the ability to choose the post-acute setting that is appropriate for patient care. The inpatient rehabilitation facility "60% Rule," long-term care hospital "25% Rule," and the skilled nursing facility "3-day Inpatient Stay Rule" would also inappropriately hamper care management and should be rescinded under a bundled payment system.

Accountable Care Organizations (ACOs)

Beginning in 2012, groups of qualifying providers – such as individual physician practices, physician group practices, hospital-physician joint ventures and hospitals employing physicians – with large volumes of Medicare patients could voluntarily form ACOs and have the opportunity to share in cost savings they achieve for the Medicare program. The ACO proposal is aimed at improving integration of inpatient and outpatient care, promoting joint accountability for care delivery across providers and across time, and instilling a financial motivation to hold down costs to Medicare.

However, as with other aspects of the proposal, the ACO recommendations would disadvantage providers that already offer high-quality, low-cost care. Because the calculation of Medicare savings is based on an individual ACO's improvement against its own historical costs, today's low-cost providers have less opportunity for shared savings incentives as high-cost providers with significant windows for improvement. In other words, the ACO proposal starts with existing inequities as the baseline for calculating future savings and imbeds those inequities in the amount of potential incentives providers can obtain by becoming an ACO: today's high-cost, inefficient providers could realize significant financial gains while our already low-cost, efficient providers have less margin for improvement and, consequently, less potential reward in the ACO system. To alleviate this concern, MHA suggests that the Committee use national, risk-adjusted benchmarks of costs to calculate the savings generated by an ACO.

Also, as described in the policy option paper, many providers in Minnesota's rural communities would be ineligible to participate in the ACO program because they could not meet the minimum 5,000 beneficiary requirement. While recognizing that an ACO must have a sufficient patient population over a period of time to have the necessary scale and impact to generate cost savings, MHA encourages the Committee to consider authorizing CMS to create pilot projects that would explore payment methodologies that allow providers in rural communities to enjoy financial incentives for delivering longitudinal health care to a population in a manner that reduces Medicare's overall costs.

Sustainable Growth Rate (SGR)

The Committee offers two options to fix the SGR problem under the physician fee schedule (PFS). MHA supports AHA's recommendation that Congress fix the PFS by providing physicians with a positive update in calendar years 2010 and 2011, and that a permanent fix to the SGR is needed.

Health Information Technology

MHA appreciates Congressional efforts to include investments in health information technology (HIT) in the American Recovery and Reinvestment Act (ARRA) enacted earlier this year and the Committee's willingness to explore expanding HIT investments to nurse practitioners, physician assistants and post-acute care providers. The promises of HIT – improved quality, reduced unnecessary utilization, and improved care coordination – require implementation among the breadth of providers in the entire continuum of care.

At the same time, MHA encourages the Committee to explore ways to further supplement and expand investments in hospitals' HIT needs. Some of Minnesota's hospitals remain ineligible for the ARRA funds because of their structural relationships and integration with their physicians, yet their need for support of HIT costs remains daunting. Likewise, it is important to emphasize that hospitals pursuing installation of HIT systems also incur significant operating costs, especially in the early years and transition periods during implementation, which are not supported by ARRA funds or other sources. MHA hopes that the Committee will pursue reforms to reimbursement mechanisms, grants or other methods of providing further support for hospitals' HIT implementation and operation efforts.

Physician-Owned Hospitals

MHA supports a ban on physician self-referral to hospitals in which they have an ownership interest. The American Hospital Association (AHA) has long advocated for such a ban because of the potential for self-referral to cause a conflict between the needs of the patient and the financial interests of the physician. MHA supports AHA's position on this issue.

Patients rely heavily on the advice of their physicians when making decisions about where to have a medical procedure. Real choice means knowing that the physician's motivation for referring a patient to a specific facility is not based on financial self-interest, but rather on the best interest of the patient.

Physician-owned, limited service hospitals exercising patient selection tactics may yield attractive profits for physician investors, but this comes at the great expense of the community hospital and the overall cost of health care. Too often, a nearby full-service community hospital is left with a higher mix of emergency cases with low reimbursement, strained resources and lost efficiencies. And, ultimately those attractive profits for individual physicians accrue to our society's rising health care costs.

Redistribution of Unused Graduate Medical Education (GME) Slots

The Committee proposes to reallocate 80 percent of unused slots and allow hospitals to request up to 50 new slots. Seventy-five percent of new slots would be designated for primary care or general surgery for five years. Slots would be redistributed based on a set of criteria, such as whether the receiving hospital is in a health professional shortage area.

MHA supports efforts to increase the number of physicians practicing in our communities, as well as proposals aimed at generating more physicians serving in our rural communities. MHA also echoes AHA's recommendation to increase the number of Medicare-supported training positions for medical residents by 15,000 slots.

MHA appreciates the opportunity to offer these comments at this stage in the legislative process and looks forward to future opportunities to respond to other proposals from the Committee, as well as the ultimate bills and amendments aimed at enacting the best ideas for improving Americans' health and America's health system. If you have any questions regarding these comments, please contact Ann Gibson, director of federal relations at (651) 603-3527 or anngibson@mnhospitals.org.

Sincerely,

A handwritten signature in black ink, appearing to read 'Matthew L. Anderson', with a long horizontal flourish extending to the right.

Matthew L. Anderson, J.D.
Vice President, Regulatory/Strategic Affairs