



**Federation of  
American  
Hospitals™**

Charles N. Kahn III  
President

December 22, 2008

The Honorable Thomas Daschle  
Health and Human Services Secretary-Designate

Dear Secretary-Designate:

Thank you very much for the opportunity to meet with you on November 24<sup>th</sup> on behalf of the members of the Federation of American Hospitals (FAH). Your thoughtfulness and steady vision of a high quality health care system with universal insurance coverage will be critically important for President-Elect Obama's Administration and the American people. As I previously expressed to you, the nation's approximately 1,000 investor-owned and managed hospitals, serving health care needs for patients in communities across America, 24/7, are eager to contribute to your efforts to meet your important mission to foster positive health care change for America.

The transition staff asked for the FAH's input on a number of issues affecting community hospitals and health systems. Specifically, we were asked to provide our: 1) short term health policy priorities/goals, and 2) long term health policy priorities/goals. Additionally, our views were requested on: a) the mechanisms for achieving these goals (i.e., executive order, regulation, guidelines, policy change or legislation); and b) any budgetary or appropriations concerns or impact.

It is my pleasure to respond to this query, but before doing so I would like to provide a brief economic environmental assessment of the hospital industry to set the context for our comments.

### **Environmental Assessment**

The deepening economic recession has not spared the hospital sector, and the effects on hospitals will grow worse over time. Recovery in the sector likely will lag behind a prolonged recovery in the broader economy, which many believe will not take place until at least 2010. Analysts expect that the full impact of the economic meltdown on the hospital industry will not be known for at least another 12-24 months as the cycle of consumers losing jobs and health coverage runs full-circle. Until this happens, more and more people will postpone health care, so that when they do seek care, often in distress in an already overburdened hospital emergency



room, their health status will have deteriorated and their condition will be more acute, requiring more intensive and expensive medical intervention.

Increasing unemployment, loss of health insurance and lack of consumer confidence already is affecting the number and mix of patients seeking care, adding pressure to hospitals with fewer than expected admissions and a growing caseload of uninsured patients and uncompensated care. The crisis in the credit markets already has forced hospitals to abandon or postpone indefinitely critical capital infrastructure projects to replace obsolete facilities, deploy life-advancing technologies and modernize health care delivery systems with, for example, health information technologies that promise to increase efficiency and improve quality. Hospitals have been one of the few, sustained engines of economic activity in communities. However the layoffs and downsizing hospitals that are experiencing, in addition to fewer capital projects and purchases, will exacerbate economic hardships that communities are suffering and, arguably, prolong the time before the beginning of a broader economic recovery.

Medicare and Medicaid underpayments are contributing to hospitals' mounting financial challenges. Earlier this month, Medicare Payment Advisory Commission (MedPAC) reported that overall Medicare hospital operating margins continue to fall, and remain deeply negative. In 2007, Medicare hospital margins were negative 5.9 percent. Non-teaching hospitals experienced a Medicare margin of negative 9.3 percent in 2007. MedPAC projects that hospital Medicare margins in 2009 will continue to fall further, to a negative 6.9 percent. This would be the seventh consecutive year of negative and falling margins.

Hospitals are entering uncharted territory, and it is critically important that health care policy and legislation reflect and respond to the unprecedented challenges facing hospitals as our members strive to meet the needs of the communities that they serve.

### **Health Policy Priorities/Goals in the Short Term**

#### **State Children's Health Insurance Program (SCHIP)**

The FAH strongly supports the expansion and rapid reauthorization of SCHIP. The FAH supported the reauthorization of SCHIP passed by the Congress in 2007 and would like to see it enacted quickly in 2009.

#### **Ban on Self-Referral to Physician-Owned Hospitals**

One of the unfinished pieces of legislative business from the 110<sup>th</sup> Congress is the ban on self-referral to physician-owned specialty hospitals.

According to the Congressional Budget Office (CBO), significant Medicare savings would be generated by banning self-referral to new physician-owned specialty hospitals. In addition, there are patient safety and quality of care concerns for many of these facilities, particularly regarding the emergency health care needs of their patients who might experience complications from the procedures performed on them. In addition, self-referral has a profound negative effect on community hospitals as physician-owned specialty hospitals leave the more



costly, complex, uninsured, underinsured and indigent patients to be treated by the full-service community hospitals in the same market.

The Congress has recognized that banning self-referral to hospitals promotes patient safety and raises significant Medicare savings. This is why, in the 110<sup>th</sup> Congress, the House twice passed legislation (H.R. 3162 and H.R. 1424) that included language to prohibit self-referral, and the Senate passed it once (H. R. 2642). The FAH urges the inclusion of this provision in legislation at the earliest opportunity. Furthermore, as I mentioned to you at our meeting, we recommend the inclusion of the ban in your Administration's version of the FY10 Federal Budget.

### **Medicaid Regulations**

The FAH strongly supports the Congressionally-mandated moratoria on the six Medicaid regulations issued by the Bush Administration. As you know, the moratoria expire in the first quarter of 2009, allowing the Medicaid regulations to take effect. Therefore, the FAH hopes that the Obama Administration will withdrawal these ill-conceived regulations, which would compromise Medicaid beneficiary access to vital hospital services.

### **Health Information Technology**

Broad adoption of interoperable health information technology (HIT) should be a national priority. Making this priority a reality should include three basic elements: 1) broad adoption of HIT; 2) standards for interoperability; and 3) service providers or health information exchanges to enable interoperability. We believe interoperability is attainable with federal leadership and funding. We appreciate Congress' commitments to make HIT funding available as well as to encourage faster diffusion of interoperable health care information. We further support the President-elect's leadership in calling for the inclusion of funding for HIT in the anticipated Economic Stimulus Package.

By providing appropriate financial incentives and establishing needed policies, the Federal government can assume a pivotal role in ensuring that all hospitals and clinicians are well positioned to use HIT to improve the quality and coordination of patient care and help lower health care costs.

In the context of the Economic Stimulus initiative, the Federation of American Hospitals (FAH) prefers HIT provisions consistent with the following principles:

- **HIT Funding:** Hospitals and clinicians should be eligible for incentive funding for HIT if the technology employed by them meets the criteria established by the statute and the Secretary of HHS for technology that is interoperable.
- **Interoperability standards:** The HHS Secretary shall create standards that enable interoperability. When possible, standards will be based on currently accepted standards already harmonized by the Health Information Technology Standards Panel (HITSP) and approved by the Secretary. And, HHS policy should allow for flexibility in determining



whether the products, as certified by the Certifying Commission for Health Information Technology (CCHIT), meet these standards; and should accommodate, to the extent possible, legacy systems that may already be in place.

- **Connectivity:** The federal government will contract for and fund the development and operation of necessary service providers or health information exchanges to enable and maintain HIT interoperability between and among health care providers and clinicians.
- **Priorities for Interoperability:** Establishing full working interoperability will not be simple. Beyond limited regional activities, there is no working system or model that will ensure interoperability between health care providers and clinicians even if each facility has HIT capacity. To get the interoperability started, we propose that initial efforts focus on making full medication histories, laboratory results and radiologic images available (electronically?). Additionally, new rules should enable e-prescribing for all FDA-approved drugs.
- **Privacy:** Rules regarding protections and record security for confidentiality and privacy are essential to realize the full potential for electronic interoperability. However, there is not sufficient time to adjudicate policy in this area for fast tracked legislation. Therefore, we believe that privacy and security should be addressed as it was under HIPAA with the Secretary making any necessary changes to the Privacy Rule and record security through notice and comment rulemaking.

## **Health Policy Priorities/Goals in the Long Term**

### **Health Care Coverage/Access**

Increasing access to affordable, quality health care coverage is the FAH's number one priority. The FAH and its members are encouraged that the Congress and President-elect Obama are committed to comprehensive health reform. It is a national disgrace that 45 million Americans lack health care coverage, and we believe that renewed energy and leadership is crucial in this area.

This is why, in February 2007, the FAH issued a universal coverage proposal called the Health Coverage Passport (HCP). The HCP is based upon the following key principles:

1. universal coverage leveraged through an individual mandate;
2. income-based subsidies for those who need it;
3. expansion of the employer-based coverage model; and
4. insurance reforms that guarantee access, affordability and portability

It is vitally important, however, that health insurance reform be done with the least disruption to those who currently have access to private health insurance. The HCP plan, in part, through the creation of a reformed individual market (e.g., guarantee issue at community rates, etc.), demonstrates that it is possible to provide access to quality health care coverage without turning the current system upside down.



Efforts to expand public programs, if not done with great care, could lead to crowd-out of the private health insurance coverage that works for millions of Americans. Additionally, the private health insurance marketplace typically more fully compensates hospitals and physicians for the cost of care. Without the private market rates to help offset Medicare and Medicaid reimbursement that often is well below cost, hospitals and physicians could face tens of billions of dollars in payment reductions per year which would reduce our the ability of providers to provide services to the newly insured as well as many who will slip through the cracks and not have insurance.

We deeply appreciate your commitment to health insurance reform and look forward to working with you as partners in this area.

### **Lack of Available On-Call Physicians**

One of the most critical operational issues facing community hospitals today is the challenge to ensure access to specialty physician services when patients require emergency services. In recent years, many physicians have been less willing to provide on-call services to hospital emergency departments. This has occurred partly because of HHS policies which have allowed physicians to sidestep their ethical responsibilities to their local communities to provide specialty services, as well as their traditional obligations as members of a voluntary hospital medical staff. The issue raises broader policy concerns about the availability of essential services that should be considered in health care reform, but in the interim there are a number of areas where HHS can adopt policies that would help to reverse this alarming trend and ensure needed patient access to essential medical services.

### **Health Care Delivery Reform**

Medicare can be an important lever in promoting change that encourages more efficient use of limited resources and improved quality.

#### Medicare Reimbursement & Rural Equity

First, as mentioned in my environmental overview, Medicare payment on average is penalizing hospitals. For hospitals to continue to provide the quality of care that seniors expect and deserve, it is critical to address this systematic underpayment.

Second, as you know all too well, modest reimbursement improvements are critical to providing quality care in rural areas. One such area in which the FAH would like to see improvement is the Medicare rural Disproportionate Share (DSH) program – a critical safety-net program that provides badly-needed, supplementary funding for hospitals treating a disproportionate share of indigent, often-uninsured Americans. When DSH was enacted, separate payment formulas were established that, for no sound policy reason, discriminated against rural hospitals. It was more difficult for rural hospitals to become eligible for DSH payments, and, even if eligibility was attained, the payment they would receive was lower, even if their indigent caseload was identical to that of a larger urban hospital. The payment formula was patently discriminatory against rural hospitals.



Congress recognized this inequity in recent years and has taken steps to remedy it. The eligibility threshold was leveled, and, over time, DSH payment amounts for rural hospitals have modestly improved. Yet, an inequity still exists because the DSH payment amount for rural hospitals is artificially suppressed, even when they experience indigent caseload percentages equal to large urban hospitals. Rural communities suffer financial strains just as much as larger urban hospitals from serving low income Americans and meeting the crisis of the uninsured. We urge the Administration to propose and support legislation that would remove the current cap on DSH payments to rural hospitals and ensure that payment policies for rural hospitals treating a disproportionate share of indigent patients are level with those of larger urban hospitals.

Third, another area ripe for Medicare hospital payment reform in rural America is the Medicare outlier program. By law, CMS must set aside between five and six percent of short-stay acute hospital inpatient payments to fund an outlier pool, which is intended to help defray hospital costs associated with unusually high-cost cases. Current law also requires CMS to finance the outlier pool through a uniform offset, or “flat tax”, applied to the base payment for all MS-DRGs. CMS sets the pool at 5.1 percent, which means that the base payment for every hospital inpatient is reduced 5.1 percent.

The reality is that this policy is unfair to rural hospitals because they seldom treat the kinds of high-cost cases that qualify for outlier payments. As a result, rural hospitals are forced to pay a 5.1 percent “outlier tax”, but receive on average only about 2 percent in outlier payments. In short, rural hospitals suffer a “silent cut” of three percent on all of their Medicare hospital cases to fund an outlier pool from which they will derive little subsidy, while at the same time subsidizing care in other hospitals.

MedPAC has proposed an important and fair reform in the way that outlier cases would be funded, and we urge the Administration to support it. Instead of applying a five percent reduction to the base payment for every Medicare hospital discharge, MedPAC has proposed adjusting MS-DRG weights to reflect differences in the frequency of outliers across all patient categories. We would term this an outlier “user tax” and believe it is a much more equitable way for all hospitals to fund an outlier pool.

We also believe that the size of the outlier pool needs to be reexamined in light of the more accurate payments that have resulted from the implementation of DRG payment reforms (MS-DRGs) and cost-based weights. These fundamental changes in the way weights are determined ensure that payments are more closely correlated with the costs of care, diminishing the need for outliers to help hospitals with high-cost cases, because those high-cost cases will now receive higher payments. A smaller outlier pool, set at an amount no larger than is necessary to help defray the costs only of extraordinarily high cost cases, which will be a fraction of the current outlier caseload, may well be warranted.

The FAH looks forward to discussing this issue with you further early next year.



## Quality Enterprise

FAH members strongly support endeavors to improve the quality and outcome of patient care across all clinical providers of health care, and we have taken a leadership role in the development of quality measurement and public reporting of quality measures to drive improvement in patient care.

A national quality enterprise has developed and continues to evolve. The FAH encourages continued federal support for this enterprise, which is described below. There is a distinct role for the Department of HHS to strengthen this enterprise through targeted funding and infrastructure support. Key to the success of the quality enterprise and the evolving programs today is the collaboration between the public and private stakeholders. While this enterprise is due for reconsideration and refinement, we believe that currently, it has key elements necessary for moving forward with material improvement of care in this country. In our view, focused federal support of several key areas will significantly improve the delivery and efficiency of quality patient care

The current quality enterprise assists in the implementation of a number of federal statutes and regulations. The key entities involved in quality measurement are the Agency for Healthcare Research and Quality, the Centers for Medicare & Medicaid Services, the National Quality Forum (NQF), and a series of quality alliances including the Hospital Quality Alliance (HQA), and others in the physician and pharmacy sectors. Each entity plays a unique role and the AHRQ and CMS sit on the boards of each of these entities. The NQF and the quality alliances are public-private partnerships, which have been essential for fostering quicker and more meaningful quality measurement both at the national and local levels.

Several steps are needed for quality improvement efforts to continue to improve patient care and efficiencies in the health care system.

- Begin Secretarial consideration of NQF's quality priorities, as called for in the Medicare Improvements for Patients and Providers Act of 2008.
- Provide new funding for AHRQ to further the development of quality measures to meet the national priorities.
- Continue the collaboration with national quality alliances, specifically HQA, on recommendations for the adoption of measures for use in federal quality reporting, and ultimately, payment-related programs for hospitals. It is essential that the NQF-endorsed measures be evaluated for their applicability to a specific setting before the measures are included in a public payment program. In the hospital community, the HQA serves this function and adopts measures that can be recommended to CMS for use in the hospital payment programs. The role of the HQA should be recognized in the national quality enterprise.
- Enhance the government infrastructure to support quality measurement through an enhanced Hospital Compare web site and funding to the QIOs implementing the public programs.



We recognize that quality measurement informs quality improvement and should drive delivery changes and the development of best practices at the local level to improve the care delivered to patients. It is important that additional research be conducted to better understand what is working and how we can better measure patient outcomes.

### Pay for Performance

Federal payment policy for hospitals currently focuses on pay-for-reporting. As you consider the next possible step, pay-for-performance, we recommend that the following key elements be included in any pay-for-performance program:

- Measure and reward both improvement and attainment of national benchmarks. Measures should be included in a pay-for-reporting program before being moved into a pay-for-performance program. Clinical process measures should be weighted more heavily than patient experience of care measures.
- Financing
  - *Source of funds* – Adopt conceptual MedPAC recommendation.
  - *Relevant DRGs* – Funds to create the payment pool should come only from the DRGs relevant to the measures in the system.
  - *Size of performance pool* – No more than 1.0 percent phased-in over a four year period of time with assessment and Congressional reconsideration after two years of implementation.
  - *Unspent funds* - Distribute unspent performance pool funds back to all hospitals participating in the program to assist them.
  - *System Savings* - Any system savings identified should be distributed back to all participating hospitals.
- Measure Submission – any hospital wishing to participate should be able to do so.
- Support of Administrative CMS Infrastructure – the reliability and accuracy of the data in a pay-for-performance environment are essential. Support infrastructure fund enhancements for data collection, warehousing, processing and the public web site. Additionally, the consumer satisfaction with the usability of Hospital Compare should be assessed and changes made quickly to facility its use as the authoritative hospital quality source.

### Healthcare Associated Conditions

The Department has developed quality assessment programs beyond the current pay-for-reporting program as part of its value based purchasing program. Most notable is the Healthcare Associated Condition program. The FAH agrees that preventable adverse events, where there is clear clinical evidence of best practices for preventing adverse outcomes, should be a focus of attention. However, before expanding the current program to new conditions or settings, we suggest that the Department evaluate the current program and assess whether there have been



unintended consequences of including conditions for which there is no clear clinical evidence to prevent adverse events.

### IMD Issue

Another issue ripe for reform is an amendment to federal law to allow for Medicaid reimbursement for the stabilization of emergency medical conditions by non-publicly owned or operated Institutions for Mental Diseases (IMDs), generally known as psychiatric hospitals.

As you know, Federal law allows states to use matching federal Medicaid funds to pay for inpatient psychiatric care. However, there is a key exception that poses dangerous risk both to patients in need of services and the facilities that serve them. Federal law does not permit the use of federal matching funds to provide acute inpatient psychiatric services at non-public Institutes for Mental Disease (IMDs) for patients between the ages of 21 to 64 who are Medicaid recipients.

Therefore, if a mental health patient is sent to a non-public IMD for emergency care, the facility is not reimbursed. This is an anachronism in the law that fails to recognize the current configuration of mental health care delivery today and legal obligations that apply to all hospitals.

For example, under the Emergency Medical Treatment and Active Labor Act (EMTALA), both general and psychiatric hospitals are required to stabilize any patient who comes to an emergency room in a health crisis regardless of ability to pay. Stabilization of psychiatric emergencies often requires admission to ensure that patients are not a danger to themselves or others. However, because of the IMD exclusion, non-public, psychiatric hospitals cannot receive Medicaid reimbursement if the patient is between the ages of 21 through 64. The exclusion is harmful to both patients and to the specialized facilities that provide this essential care.

Legislation to allow for such Medicaid reimbursement has been introduced previously by both Rep. Tom Allen (D-ME) and Senator Olympia Snowe (R-ME), but no further action has occurred. We look forward to working with you on this important issue.

### Conclusion

Thank you for taking the time to consider the views of community hospitals as you proceed with both short and long-term health care reform. We hope you will continue to consider us as a resource.



The FAH and its members look forward to your leadership and to working with you. If you have any questions, please do not hesitate to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Chris". The signature is written in a cursive style with a horizontal line underneath the name.