



**American Hospital
Association**

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

April 29, 2011

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

Dear Chairman Upton and Members of the Committee:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and 40,000 individual members, the American Hospital Association (AHA) is writing in response to your request for ideas for solutions to the current problems with the Medicare payment system for physician services. Thank you for seeking our input.

In communities across America, hospitals provide the most sophisticated and advanced health care in the world 24 hours a day, seven days a week, 365 days a year. Hospitals are increasingly working more closely with physicians, including a growing trend of employing physicians.

The ideas we present below may, in some cases, require additional explanation as you analyze how they fit into a legislative solution. We look forward to continuing to work together, and are available for additional consultation as this process proceeds.

We present ideas in three areas: medical liability reform; pay for performance via physician-hospital shared incentives; and possible value-based payment or a bonus payment structure.

The AHA recognizes the high CBO score associated with maintaining current physician payment rates, but paying for preventing such reductions by making drastic cuts solely from providers such as hospitals that are already seeing negative Medicare margins could endanger beneficiary access to those providers. As Senator Jon Kyl (R-AZ) has stated publicly on the subject of offsetting physician payment reform, "it is not something that should be collected from the very people you're trying to keep in business to treat Medicare patients."



MEDICAL LIABILITY REFORM

The high costs associated with the current medical liability system not only harm hospitals and physicians, but also patients and their communities. Across the nation, access to health care is being negatively impacted as physicians move from states with high insurance costs or stop providing services that may expose them to a greater risk of litigation. The increased costs that result from the current flawed medical liability system not only hinder access to affordable health care, they also threaten the stability of the hospital field, which employed 5.3 million people in 2009, and continues to be one of the largest sources of private-sector jobs. An estimated \$50 to \$100 billion is spent annually on defensive medicine – services not provided for the primary purpose of benefiting the patient, but rather to mitigate the risk of liability. To help make health care more affordable and efficient, the current medical liability system must be reformed.

There are proven models of reform enacted in several states across the country, and in fact California's model has previously been the core of legislation passed by the United States House of Representatives. The AHA supports this legislation. This and other legislative proposals will likely be considered during this 112th session of Congress, and we applaud your Committee for the work and leadership you've shown on the issue thus far this year. The AHA and its members have examined additional approaches that could create a legal environment that fosters high-quality patient care. The result is a "Framework for Medical Liability Reform," which is outlined below:

Proposal

An administrative compensation system (ACS) would be created to compensate patients for injuries that could have been avoided during medical care. Decisions would be made using nationally developed evidence-based clinical guidelines and schedules for compensation amounts. The system would be part of a comprehensive approach to address injuries sustained during care. Robust regulatory and oversight activities would complement the system to protect patients from individual practitioners who may place their safety at risk.

Expected Benefits of this System.

Quality and patient safety improvements – Providers would have additional incentives to adhere to clinical protocols and evidence-based care; the focus would be on quality and safety, not defensive medicine.

Broader access to compensation – The system would reach all eligible patients, not just a few; the amounts would be more consistent across similar cases, and awards would be reasonably predictable for patients; both the process and compensation would be faster.

Reasonable compensation – Patients should be made "whole" for the economic and non-economic costs of injuries.

The Honorable Fred Upton

April 29, 2011

Page 3 of 5

A more efficient system – The claims process for patients would be simpler and less adversarial; compensation would be delivered with lower transaction costs; liability insurance should become more affordable.

What an ACS Might Look Like. Claims for injury during medical care would be handled through an administrative process administered by the states and could not be brought directly to the courts. Intentional injuries and criminal acts would remain in the courts, outside of this system.

Compensation would be provided for those injuries that could have been avoided and that meet a minimum threshold of harm. The standard would be whether the injury was avoidable; the negligence standard would not apply.

Patients who believe they have been injured during medical care would submit a claim to a local panel that, using explicit nationally established decision guidelines and schedules, would make an initial decision about whether an injury was eligible for compensation and, if so, offer compensation. Hospitals, physicians and other providers could take the initiative before a claim is filed and offer compensation using the guidelines and schedules.

Patients who question the local panel's decision could bring their claim to an expert panel or administrative law judge who is part of a state system. Patients could ultimately seek review of the decision in court.

Reduction of costs via medical liability reform will have a direct and indirect impact on Medicare payment on physicians: directly, the component of the Medicare physician payment rate formula that includes medical liability insurance will be reduced; also directly, as CBO has found when it scored H.R. 5 as saving \$54 billion over 10 years, decreased utilization will yield a savings to the program. Indirectly, medical liability reform increases physician net income via reduced medical liability insurance costs, reduced individual (and practice) exposure to a liability judgment, and reduced time practicing defensive medicine thus freeing that time for other endeavors.

We recognize the history of medical liability reform in the Congress, which is why we are presenting additional ideas in the spirit of your request letter; but we do not want the presentation of these ideas to in any way obscure unwavering support for H.R. 5 by our members, who looks forward to working with the Committee and the Congress to enact meaningful medical liability reform legislation.

PAY FOR PERFORMANCE VIA PHYSICIAN-HOSPITAL INCENTIVES

For previous short-term Medicare physician payment “fixes,” the Congress has required some return on its increased investment – for example, the Physician Quality Reporting System was attached to Sustainable Growth Rate legislation.

Pay for performance via physician-hospital incentives would serve the purpose of both enabling a performance-based payment program and reducing Medicare spending. It also would allow physicians to earn more without increasing Medicare spending. For example, the Medicare Gainsharing Demonstration program in New Jersey, the average physician incentive was approximately \$5,000, while another gainsharing program in New York averaged over \$9,000 per physician. These are significant amounts as you consider how to pay physicians more than under current law.

A gainsharing arrangement is relatively simple, but is blocked by existing regulatory barriers, specifically in Civil Monetary Penalty, Anti-kickback, and “Stark” physician self-referral laws. The Medicare Gainsharing Demonstration program in New Jersey (as originally authorized under Section 5007 of the *Deficit Reduction Act of 2005*) tested and evaluated methods by which hospitals and physicians, paid via fee-for-service, can share in cost savings as a result of improved quality and efficiency of care provided to Medicare beneficiaries. The 12 participating hospitals have 1,500 physicians participating voluntarily and, so far, the demonstration is yielding positive results: there have been 52,000 discharges (60 percent of Medicare admissions), and average incentive payments in the first year averaged approximately \$5,000 per participating physician (with higher admitting physicians surpassing \$10,000).

Participating hospitals are reporting:

- Physician/hospital integration and dialogue has improved significantly;
- Medicare length of stay is down;
- Group practices are coordinating their care, rounds and on-site coverage;
- Hospital savings are covering the cost of the physician incentives and other costs associated with running the demonstration;
- Physicians are actively seeking input on care delivery changes that will improve their incentive opportunities and lower hospital costs;
- Significant savings opportunity still remains; and
- Quality has been maintained or improved.

None of the physicians or hospitals have left the program because they see it as beneficial.

The demonstration closes in June, but other incentive programs would also benefit the Medicare program if the legal and regulatory barriers were removed. This program is evidence of what an incentive program can accomplish.

VALUE-BASED PAYMENT OR BONUS PAYMENT STRUCTURE

Just as the hospital field has been required to implement a number of value-based components to its Medicare reimbursement policy (such as readmissions policy, payment reductions for hospital-acquired infections, and the Hospital Value-Based Purchasing Program), physician payment could be tied to value. Recognizing that hospitals and physicians have to work together

The Honorable Fred Upton

April 29, 2011

Page 5 of 5

in these endeavors – to improve care coordination, efficiency and quality – now may be the time for physicians to move forward in this area.

Given that physician payment is schedule to be cut by approximately 30 percent on January 1, this drastic cut provides an opportunity to innovate. A payment system with a value-based component would reward individual positive practice patterns. A monetary incentive to provide high-quality, coordinated, efficient care will yield paying for value over volume. Some possible items to include in this pursuit are paying for: (1) additional quality reporting and improvements; (2) delivering coordinated care – i.e., via participation in a medical home, gainsharing, ACO or other care coordination initiative; (3) efficiency practices, such reduced physician hospital readmission rates, usage of an imaging order-entry tool to reduce unneeded utilization, or counseling of high-cost patients to reduce their high utilization.

The balance of how much of payment to subject to a value-basis is impossible to suggest without more specifics. As the Committee investigates these ideas, and if it decides to legislate in this area, early and frequent input from stakeholders will be vital to finding a workable value-basis level.

Thank you for giving the AHA an opportunity to provide you with ideas on Medicare physician payment. If you have additional questions or would like to discuss policy options at length, please feel free to contact me or Erik Rasmussen, AHA senior associate director, at (202) 626-2981 or erasmussen@aha.org.

Sincerely,

/s/

Rick Pollack

Executive Vice President