

**Statement
of the
American Hospital Association
to the
Senate Finance Committee
Roundtable on Health Care Delivery System Reform
Washington, DC**

April 21, 2009

The American Hospital Association (AHA), on behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 38,000 individual members, appreciates the opportunity to share its views on America's health care delivery system and the need for comprehensive health care reform.

It is often said that the U.S. has the best health care in the world, and indeed there is much of which we can be proud. But, for all its strengths, the system of delivering and paying for care that has evolved over the decades is in need of change. The health care system of today prevents patients, providers and others from experiencing what could and should be a much more coordinated system of care. The payment system, as currently designed, discourages care coordination by creating silos of care that reward volume instead of quality.

A Framework for Change

America's hospitals are committed to health care reform that is achieved in a bipartisan manner, and the time for that reform is now. For the past three years, the AHA has led a discussion among disparate fields, including health care, business, insurance, labor, consumers and others, about what kind of change will best serve America now and in the future. The AHA Board of Trustees convened hundreds of hospital leaders in addition to leaders from nearly 100 different organizations to develop policy ideas to lead the effort.

The result: *Health for Life: Better Health. Better Health Care. Health for Life* centers on five pillars of reform upon which we must build:



- **Health Coverage for All, Paid for by All.** Everyone – individuals, businesses, insurers and government – must play a role in expanding and paying for health coverage for all. Coverage for all will be our toughest challenge, politically and financially. There are many ways to accomplish this goal; we must remain firm on the objective but flexible on how to achieve it.
- **Focus on Wellness.** Good health – physical, mental and oral – is essential for a productive and vibrant America. A focus on wellness must be integrated into the lifecycle, from birth to death, and be encouraged in our homes, schools, workplaces and communities.
- **Most Efficient, Affordable Care.** Reform must include efforts to make the costs of insurance and health care more affordable. We need to better manage chronic disease; spend limited resources on care, not paperwork; and address the growing shortage of well-trained health care workers. And, useful information on quality and pricing must be made public, so that patients, providers and payers have the information they need to make informed decisions.
- **Highest Quality Care.** The best care is provided when caregivers and patients work as a team to make the right decisions with the best possible information. We need to invest in research that will identify the best treatments, technologies and protocols, and then reward providers who use them. We must coordinate the treatment of physical and behavioral health needs; reward care outcomes, not the number of patients seen; and make palliative care more available and better understood. And we have to ensure that we have enough trained health care workers to deliver the care communities need.
- **Best Information.** Good information is the gateway to good care and good research. We have to accelerate the adoption of health information technology by addressing financial, regulatory and technological barriers, including inter-operability and standardization.

Components of Change

Policy decisions affecting the health care of Americans should be made explicitly by Congress. We urge Congress to offer robust, detailed proposals that are then subject to the input of the public and others. We urge Congress to determine specifically how savings are to be achieved in financing health reform. Proposals that leave too much discretion to implementing agencies, or self-implement policies, to achieve savings without the direct input of Congress are not acceptable or appropriate.

When it comes to reform, policymakers have many options. But success will require balancing the desire for sweeping reform with some measure of stability – to ensure that patients have access to care that continually improves, consumers and employers have health coverage with manageable costs, and providers remain financially able to handle the demand for care. To achieve this, we need reform that is thoughtful, deliberate and

gradual. Several areas of our health delivery system need to be addressed as we look to reform.

Financing

Consumers, providers, employers, payers and government should share in the responsibility to achieve comprehensive reform that leads to coverage for all. This means fair and balanced reform that considers all funding options, including new revenues or taxes. Reform should reflect both the immediate need for change and the long-term savings reform can bring. We support a flexible approach to financing that recognizes the need for up-front investment to set the health system on the path toward significant long-term savings and improvement in the long-term fiscal health of the nation. The Congress' recent investment of \$19 billion in health information technology in the *American Recovery and Reinvestment Act* is a perfect example of the type of investment needed to spur innovation and improvement.

Administrative Simplification

Even limited reductions in administrative costs could yield significant savings. The Congressional Research Service estimated the administrative costs of private insurance and government programs last year alone at about \$465 billion – not including the administrative costs borne by health care providers to comply with those entities' requirements. Most estimates cite administrative requirements as accounting for a quarter of total hospital spending; physicians' offices spend a little more.

An AHA task force that looked at the issue of administrative simplification came up with several recommendations to improve the delivery system by decreasing costs and making it easier for patients to navigate care. Several changes are needed to our insurance system, including standardizing and simplifying:

- access to up-to-date eligibility and enrollment information, benefits, coverage and cost sharing information;
- elements of the billing, claims processing and adjudication processes; and
- collection and reporting of clinical information for quality measures.

Coverage and Social Responsibility

The AHA believes that everyone deserves health care coverage that provides the right care, at the right time, in the right place. Health coverage for all, paid for by all is an essential element of health reform supported by the AHA. The economic recession gripping the nation has brought into sharp focus the need for health care reform so that the many millions uninsured will have health care coverage and access to health services.

Coverage also is key to cost control. Health care costs are higher when patients don't receive care at the right time or in the right setting. Many uninsured people delay needed care until it is an emergency. And the costs of the uninsured are reflected in higher health insurance premiums for those purchasing insurance. Providing coverage to all will help mitigate the "cost shift" that moves the financial burden of non-coverage from public to private payers. The AHA supports enhanced access to affordable private health

insurance, but is concerned that implementing another public program could continue the under-payment of providers.

In addition, both Medicare and Medicaid have in place hospital funding mechanisms designed to mitigate the financial stress faced by hospitals serving a disproportionate burden of poor and uninsured patients, and to provide support for the training of future physicians and other practitioners. While the Medicare and Medicaid disproportionate share hospital (DSH) programs differ in scope and size, they serve as the nation's primary source of support for safety-net hospitals providing health care to the most vulnerable populations – Medicaid beneficiaries, low-income Medicare beneficiaries, the uninsured and the underinsured.

The DSH program funds are the health care safety net for millions of people. Even as universal coverage is achieved, there will be populations that will remain uncovered and hospitals will be asked to bear the burden of their health care and essential community services. As a result, until universal coverage is fully achieved, no reductions should be made in the DSH program.

Another societal good is the clinical training of our nation's health professionals. Both the Medicare and Medicaid programs have recognized this important need since their 1965 inception. Medicare's payments for the direct cost of graduate medical education and payments for the higher operating costs of teaching hospitals, the indirect medical education (IME) adjustment, are crucial to the ability of teaching hospitals to carry out their academic missions of education, research and high-intensity patient care. These payments fund a social good that benefits all Americans and should not be reduced. A strong clinical workforce, including the need for additional primary care providers, must be the foundation upon which reform is built. The AHA urges Congress to make the investments necessary to ensure a strong and sustained primary care workforce.

Improving the Delivery System

Patients often find themselves filling out clinical and insurance forms multiple times because information is not easily transferred from one caregiver to the next, even within the same organization. They are unsure about who is in charge of their care. This lack of coordination can mean necessary steps to prevent illness and restore wellness may be missed, diagnostic tests may be redone, health problems may go unnoticed or unaddressed, and mistakes may be made in care.

Barriers to Care Coordination

Bringing physicians, hospitals and others together to coordinate care with the patient and the patient's family is critical to the success of any care coordination program. While some payment reforms may hold promise, the ability to respond to payment incentives is hampered significantly by multiple laws and regulations. Many were developed to address problems created by our system's traditional payment silos. In a new system, with payment reforms that provide incentives for hospitals, physicians and other

providers to work together, these laws and regulations must be removed or modernized to recognize a new model of care delivery.

Hospitals have been working to improve clinical integration with physicians, but the existing barriers limit their abilities. To address the regulatory impediments to clinical integration, the AHA provided to its members *Guidance for Clinical Integration*, a document we hope the antitrust agencies will use to provide guidance to hospitals and doctors on establishing clinical integration programs.

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*, known as the "Stark law;" the antikickback statute; the Civil Money Penalty (CMP) law; and the tax-exemption provisions of the Internal Revenue Code. Each has a unique purpose, and is implemented largely independently of the others.

Each of these statutes creates a tension around hospital and physician financial relationships. Under the Stark and antikickback laws, payments from hospitals to physicians are often seen by policymakers as a means to induce referrals, interfere with clinical decisions, or increase payments from federal health care programs. Under the CMP law, the concern is that hospitals might encourage doctors to limit or reduce services provided to program beneficiaries by offering a share of the resulting financial gains. Under the Internal Revenue Code, the suspicion is that payments to physicians will be for the private benefit of the physicians and not to advance the charitable purpose of the hospital.

Congress and regulatory agencies should change laws and regulations to allow physicians, hospitals and others to work together as teams, and to use financial incentives to reduce costs and improve care. Such changes should include:

- Establish a simpler, consistent set of federal rules for how hospitals, physicians and others may construct their financial and contractual relationships;
- Provide clearer guidelines under federal antitrust law to enable clinical integration and joint hospital-physician contracting with payers to ensure aligned performance incentives;
- Amend the CMP law to allow implementation of best practices and clinical protocols by only prohibiting incentives for physicians to withhold medically necessary care;
- Provide a "safe harbor" under federal laws and regulations to encourage the development of real or virtual delivery "networks" (such as accountable care organizations); and
- Reevaluate the impact of state laws governing the corporate practice of medicine on the ability of providers to collaborate.

Policymakers are looking for strategies that will both improve the quality of care patients receive and reduce costs. Among the more recent ideas to promote better coordination of care: value-based purchasing; bundled payments; accountable care organizations; and reductions in payments for avoidable readmissions.

Value-based Purchasing

A number of public and private payers are testing “incentive payments” to reward provider performance. In late 2007, the Centers for Medicare & Medicaid Services (CMS) issued a report to Congress outlining options for a value-based purchasing incentive program that would reward hospitals for meeting certain performance thresholds.

Since 2002, the Hospital Quality Alliance (HQA), a public-private partnership of hospitals, consumer groups, labor, business and government agencies such as CMS and the Agency for Healthcare Research and Quality (AHRQ), has enabled hospitals to share reliable, credible and useful information on hospital quality with the public. As a result of this volunteer partnership, hospitals are far ahead of other provider groups in reporting quality information and having their payments tied to quality measures. In 2003 Congress recognized the importance of this initiative and began requiring hospitals to submit the quality data to Medicare in order to receive a full market basket update for their hospital inpatient payments. The quality improvement effort has expanded to include new measures each year. Today, 4,900 hospitals voluntarily report their quality data on the HospitalCompare Web site.

Hospitals currently face multiple requests for quality data from insurers, employer groups, accreditors and government agencies. Rather than helping to illuminate key aspects of quality, these myriad demands create confusion and frustration for hospitals and the public alike. Hospitals strongly urge that quality data should be reported in just one way to just one place.

The HQA provides a firm foundation for further transparency and for what may be the next step in the national quality movement – pay-for-performance programs that reward providers with payment incentives for demonstrating excellence in patient safety and effective care. For these programs to be successful, they must be implemented in a budget-neutral manner. They can reduce health care spending, but those savings should be the result of better and safer care, not across-the-board budget reductions. To be successful, pay-for-performance approaches should:

- align hospital and physician incentives to encourage all to work towards effective and appropriate care;
- be developed collaboratively with all stakeholders;
- focus on improving quality, not act as a cost cutting mechanism;
- provide rewards that will motivate change;
- be implemented incrementally;
- recognize and reward both high levels of performance and substantial improvements;
- use measures that are developed in an open and consensus-based process and selected to streamline performance measurement and reporting;
- use measures that are evidence-based, tested, feasible, statistically valid and recognize differences in patient populations; and
- be designed carefully so as not to perpetuate disparities in care.

Bundled Payments

Policymakers have shown significant interest in the idea of bundling payments for an episode of care. While bundling may improve care coordination and quality, and reduce health care costs, CMS should establish a reliable evaluation system to assess bundling's impact and report back to Congress on the approaches that warrant broader consideration.

Therefore, bundling payments should not be automatically implemented by law or regulation. A variety of demonstration projects with proper evaluation is needed to determine what best serves patient needs. For example, in some cases, the bundle could consist of only acute hospital and physician services. Others have proposed a bundled payment for hospital and post-acute care services. A third model could bundle only the post-acute services. Those approaches that create greater integration across the health care system should be eligible for greater rewards.

At this time, there is no common assessment tool to evaluate patients across care settings after a hospitalization. CMS is currently running the CARE Tool demonstration program, which is testing a common assessment instrument, but results are not yet available.

As it appears in the administration's budget outline, bundling of hospital and post-acute payments is problematic. The AHA encourages Congress to take an incremental approach by testing different models of bundling to determine what works and what doesn't before broad adoption. For example, starting with a subset of high-volume/high-cost diagnoses or procedures, Congress could allow different organizational entities to receive the bundled payments, such as health systems, hospitals that employ physicians, physician-hospital organizations, and multispecialty group practices or designated "medical homes."

Proposals to bundle Medicare payments for general acute hospital and post-acute care (PAC) services call for a paradigm shift in health service delivery. Numerous regulations would need to be revised or withdrawn since their policy rationale would be eliminated. These regulations were put in place to manage the silo approach to care that dominates our delivery and payment systems today. 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. Otherwise providers' ability to manage care with the patient would be severely hampered. Other examples of needed regulatory change are elimination or modification of the many rules constraining where patients may receive post-acute care.

A similar approach should be applied to "accountable care organizations" (ACOs). ACOs offer an opportunity to improve integration of inpatient and outpatient care and promote joint accountability for care delivery. AHA supported a similar concept of care delivery in the early 1990s called Community Care Networks and we believe there should be opportunities to test the ACO approach today.

Hospital Readmissions

Readmission policies should distinguish between factors that are within the control of the hospital and those that are not. Policies that seek to provide incentives to hospitals to reduce readmissions should begin by focusing on the group of unplanned readmissions that are related to the original admission. These unplanned yet related readmissions offer the greatest opportunity for hospitals to take actions that may prevent readmissions. Our understanding of the causes of hospital readmissions is still in its early stages, but some things are clear. First, some readmissions are planned because they are needed to get the patient the best care. Any proposal that does not separate these planned readmissions from unplanned readmissions may penalize hospitals and doctors for providing appropriate services for patients in need of re-hospitalization.

Among the unplanned readmissions, there are some factors that are within the control of the hospital, and holding hospitals accountable for these factors through the payment system may be appropriate. For example, hospitals should ensure that timely information about the patient's care is communicated to post-acute providers when the patient is discharged. However, other factors are outside the control of the hospital, such as patients' ability to access necessary post-hospitalization care, patients' willingness and ability to adhere to recommended treatment and lifestyle changes, the presence of family and other support systems, and other factors that may affect patients' conditions. Regardless, the goal of all efforts to reduce hospital admissions should be to improve patient care. Readmission policies should not simply be used as a blunt cost-cutting tool.

Policies to reduce the occurrence of hospital readmissions also should recognize differences among hospitals, their communities and the patients they serve. The limited availability of important post-acute and ambulatory health care services in some communities, the level of poverty of hospitals' patients, and the availability of community services could affect a hospital's performance on readmission measures and should be addressed in any measurement process.

Transparency in Health Care

Hospitals have made significant efforts to be more transparent about the cost and quality of care. The HCAHPS has worked for more than five years to publish hospital quality data. And more than 40 states report hospital pricing information to consumers. CMS also released pricing information based on Medicare data for all hospitals as part of the hospitalcompare.hhs.gov Web site. Similar transparency efforts should be adopted for physicians and other providers, pharmaceuticals, devices and insurance plans and premiums. Public release of information is not only helpful to consumers, it also drives improvement activities.

Transparency efforts should also include measures to understand the comparative effectiveness of drugs, devices and services. The AHA strongly supports comparative effectiveness research (CER) that provides clinicians, patients and others with valid and reliable information about the relative effectiveness of various treatment alternatives. CER is an important step in reforming the nation's health care delivery system, and will be a key mechanism to improve health care quality, eliminate variation in care, and

reduce health care costs. Additionally, it will provide credible information allowing patients, clinicians and others to make better medical decisions.

Conclusion

Now is the time to enact major health care reform, and America's hospitals are committed to change that is thoughtful and achieved in a bipartisan manner. While some reform measures are ready for broad-scale adoption, other options require more study. What's clear is that change must include all stakeholders, and be started as soon as possible.