



Charles N. Kahn III
President

January 4, 2010

The Honorable Nancy Pelosi
Speaker of the House
U.S. Capitol
Washington, DC 20515

The Honorable Harry Reid
Majority Leader, U.S. Senate
U.S. Capitol
Washington, DC 20510

Dear Speaker Pelosi and Majority Leader Reid:

As you prepare to complete work on a comprehensive health reform measure, I want to thank you, on behalf of the Federation of American Hospitals (FAH) and our nearly 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Both of you have provided leadership on this critically important issue for the American people. The health reform bills from both chambers move the nation towards universal coverage while reforming health care delivery and financing. It is important in our view that both bills embrace the current employer-based system and market-based solutions, and at the same time contribute to improving the efficiency of the delivery of health care that will increase access to high quality, lower cost care.

We are proud to have been supportive of Congressional efforts to reform America's health care coverage, delivery and financing by building on what works and reforming what does not. While we recognize there are differences in the approaches each bill takes in pursuing our shared goals, we remain confident that these differences will be reconciled swiftly, bringing us ever closer to the day when Americans can attain true health security, knowing that they will have access to the coverage and care that they need, when they need it.

As you move forward in this next, critical stage of policy development, the FAH would like to make the following recommendations where we believe the best of both bills could be combined, or enhanced, to meet the goals of health reform for Americans as well as best enable hospitals to serve our society and meet the mission of serving the health care needs in communities across America.

Key FAH Recommendations:

- Attain health care coverage for 94 percent of non-elderly U.S. residents, an achievement of the House-passed bill. The Senate bill only reaches 92 percent coverage of non-elderly U.S. residents, a difference of five million covered lives;
- Drop the House public option provision in favor of the Senate approach for market-based exchanges that will offer consumers more than sufficient cost-effective coverage choices through the private sector, making the insurance market more accessible, robust and competitive;
- Calibrate hospital payment reductions to attainment of health care coverage policy goals as included in the Senate-passed bill, especially with respect to the market basket update;
- Limit hospital payment reductions from Medicare and Medicaid to no more than \$155 billion over 10 years, and lower these levels of reductions if health coverage expansions are not projected to achieve at least 94 percent of non-elderly U.S. residents;
- Set a 2013 effective date for the implementation of the major coverage expansion provisions consistent with the House bill, and if this is not possible, lower the Medicare reductions that occur prior to a later startup date for the major coverage expansion effort;
- Drop the Senate bill's Independent Payment Advisory Board (IPAB) provisions. However, if a House-Senate compromise includes the IPAB, maintain the Senate provision that recognizes the significant, permanent reductions already agreed to by hospitals and therefore precludes the IPAB from mandating additional payment rate reduction policies affecting hospitals until 2020. Further, focus the IPAB on the challenges surrounding Medicare, and limit its authority accordingly;
- Keep the House and Senate provisions prospectively banning self-referral to physician-owned hospitals with the House bill's effective date;
- Include the Senate bill's hospital value-based purchasing program should a final bill include such a program;
- Refine both House and Senate hospital readmissions policies to focus hospital payment reductions only on readmissions that are preventable or avoidable;
- Include the Senate bill's quality infrastructure policy with the House bill's funding levels;
- Do not include the House bill's new, open-ended HHS Secretarial payment restructuring authority to implement Institute of Medicine report recommendations regarding payment variation;
- Include the Senate bill's long-term acute care hospital MMSEA extension; and

- Improve access to emergency community inpatient psychiatric care for adult Medicaid recipients by including the Senate bill's version of the three-year IMD demonstration program.

Health Care Coverage

Last July, hospitals agreed to contribute \$155 billion in Medicare and Medicaid payment reductions towards achieving the goal of near-universal coverage. Hospital support for payment reductions came despite the fact that MedPAC continues to document negative and declining Medicare operating margins that now reach historic lows.

Funding for hospital patient care must be sustained overall as these reductions are made in Medicare and Medicaid. Such payment reductions only can be justified, considering the precariousness of current hospital finance, in the context of health reform designed to come as close as possible to universal coverage.

Ultimately, the success of health reform, to a great extent, hinges on achieving universal coverage. To make the insurance market reforms work and to transform health care delivery, everyone should be in the system on an equal basis. This will minimize distortions related to the coverage crisis that undermine effective, durable reform, such as uncompensated care that leads to cost-shifting and higher premiums for the insured population and other imbalances. It will help insurers pool and distribute risk more efficiently, reduce the incentive for adverse selection, and widen access to preventive and primary care leading to better health outcomes, a more productive population, and lower health costs.

According to the Congressional Budget Office (CBO), the House bill would achieve coverage levels of 94 percent of non-elderly U.S. residents, compared to 92 percent of non-elderly U.S. residents under the Senate bill -- a significant difference that equates to approximately five million U.S. residents. For this reason, the FAH strongly supports the coverage levels in the House bill and urges you to agree on a compromise that includes the House coverage levels as a minimum.

The FAH has long advocated market-based approaches for health care delivery and finance, and applauds both the House and Senate measures for significant reliance on reforms of the private insurance marketplace to increase coverage and insurance choices for consumers. Both bills create health insurance exchanges that should make the insurance market more accessible, robust and competitive.

The FAH believes the exchanges can offer consumers essential cost-effective coverage choices through the private sector as included in the Senate bill. Thus, we strongly oppose an unnecessary "public plan" administered by the Department of Health and Human Services.

In addition, while the FAH accepts the need to expand Medicaid as one means to reduce the number of uninsured Americans, we believe that such an expansion should be limited to the Senate bill's 133 percent of the Federal poverty level. As much as Medicare suffers from chronic underpayment, the Medicaid program is worse and falls well short of covering the costs of hospital care for its recipients. Expanding Medicaid coverage beyond 133 percent of the Federal poverty level as a substitute for subsidized private coverage provided through the

exchanges would further weaken rather than strengthen hospitals' fiscal foundations for providing patient care.

Hospital Payment Reductions

A key element of the willingness of hospitals to accept payment reductions in Medicare and Medicaid to contribute to the financing of new health care coverage is an understanding that reductions in disproportionate share hospital payments (DSH) and a portion of the Medicare updates would correspond closely to actual progress in expanding health care coverage. This calibration of reductions is necessary to ensure that hospitals have the resources to continue to care for seniors and everyone else who relies on hospitals for their care. Hospitals already absorb annually some \$35 - \$40 billion in uncompensated care costs, and Medicare and Medicaid chronic underpayment will continue. Between the House and the Senate bills, the Senate-passed bill better calibrates payment reductions to progress on coverage, especially with its timing of much lower market basket reductions in the first few years. The House-Senate compromise measure should include the Senate's approach on calibration of payment reductions. However, the final bill should ensure that the hospital market basket update in a given year does not fall below zero.

Regarding DSH payment reductions, while both bills recognize a critical link to coverage expansion, the Senate bill provides more clarity for hospitals under its framework for distributing DSH funds, and appropriately ties a hospital's Medicare DSH payment to its relative level of uncompensated care, which should include bad debt as well as charity care.

It is important to remember, regardless of the progress made by health reform, that the CBO estimates that there would be a substantial pool of uninsured residents under the Senate and House bills -- 23 million and 18 million, respectively -- even when health reform is fully phased-in. Significant reductions in the number of uninsured residents do not occur until 2014 in the Senate bill and 2013 in the House bill. DSH payments will remain a crucial source of funds for hospitals to help defray what are certain to be significant levels of residual uncompensated care, particularly if the lower coverage levels of the Senate bill prevail.

Independent Payment Advisory Board

The FAH recognizes that "bending the health care cost curve" is an important goal of health care reform, and in this context, the hospital industry's agreement to accept \$155 billion in Federal payment reductions constitutes an important contribution to this goal. It is imperative to understand that these reductions reflect the maximum level that community hospitals can reasonably tolerate while sustaining the patient care mission. This is the primary reason why the FAH remains deeply opposed to including hospitals within the scope of the authority of the Senate's IPAB to reduce payment rates prior to 2020.

Additionally, the FAH believes that payment reduction policymaking should remain within and be set by the Congress and that the usefulness of MedPAC to provide advice and guidance to policymakers actually would be undermined by the envisioned IPAB, where an

outside group would make Federal payment policy based on arbitrary goals. Health care policy naturally is complex and can impact delivery and financing in unintended or unexpected ways. The Congress is accountable for its decisions, and therefore best positioned to fulfill this critical function.

Since its inception in 1997, MedPAC has performed a crucial role in advising Congress on policy options and recommendations, and Congress has taken its advice seriously, but not without exercising its independent judgment as it seeks to clarify how its recommendations would impact real people. The FAH believes the traditional respective roles of MedPAC and Congress should be continued.

Finally, the IPAB's mandate regarding Medicare is both challenging and demanding of its full attention. Diverting resources and focus beyond that mission would weaken its ability to respond effectively. Therefore, should final legislation include the IPAB, its authority should be limited to the Medicare program.

Medicare Delivery Reform Policy

Prospective ban on self-referral to physician-owned hospitals: The FAH has long expressed concern about the conflict of interest inherent in self-referral to physician-owned hospitals, the deleterious impacts of which are well documented. CBO, MedPAC and independent researchers have found that self-referral results in higher utilization of services and higher costs to Medicare. Further, data clearly show that self-referral to physician-owned hospitals results in patient cherry-picking and raises patient safety concerns. Therefore, we appreciate that both the House and Senate have included appropriately strong measures to effectively limit this practice. However, we are troubled by continued efforts to provide loopholes and/or to postpone the effective date for the prospective ban on self-referral to new physician-owned hospitals, which are increasing at a rapid rate.

For almost every new physician-ownership arrangement, there is a community hospital nearby struggling to provide care to all patients in its community. For each delay, it is the Medicare B premium payers as well as the taxpayer who shoulder the cost. According to the CBO, the self-referral ban contained in the House-passed CHAMP Act in 2007 would have generated nearly \$3 billion in savings, while the most recent Senate-passed ban in H.R. 3590 would result in \$500 million in savings. The FAH strongly supports a prospective ban and urges negotiators to adopt the House date for the prospective ban to take effect.

Value Based Purchasing (VBP): The FAH can support budget-neutral policies to reward quality performance and promote the delivery of high value care. Since its inception years ago, the pay for reporting program currently in place for acute hospitals clearly has effected quality improvement in hospital care for a wide variety of conditions as well as in patient perception of care. The FAH can support the expansion of reporting to the payment incentive approach included in the Senate bill. And, we agree with the Senate provision that removes readmission measures from the VBP program, since other sections of the legislation address readmissions.

In particular, we are supportive of the focus on the enhancement of the Hospital Compare website to facilitate use of the information generated by the program. We believe the proposed VBP demonstration projects for other venues will provide valuable additional information.

Hospital Readmissions: The FAH sees the justification of properly focused, well-designed policies effecting hospital readmissions that are both preventable and avoidable. However, the FAH has concerns about the potential for new readmission policy to be punitive and arbitrary in punishing hospitals for circumstances that currently are beyond their control.

Unfortunately, the readmission policy included in both the House and Senate bills suffers by not focusing solely on preventable and avoidable readmissions, and creates the potential for payment reductions that result from readmissions that are beyond the ability of hospitals to prevent or avoid. Policy causing such arbitrary cuts would be counterproductive and could substantially undermine hospitals' ability to invest in and adopt systems changes that would reduce preventable readmissions.

Policy options that would focus readmission policy appropriately are available and could be implemented.

In addition, the House bill would apply to post-acute hospitals an arbitrary, premature interim readmission policy that reduces payments when a patient is readmitted to a hospital within 30 days of discharge, even if the readmission is clinically necessary and unrelated to the care provided in the post-acute hospital. This policy should not be included in final legislation.

Finally, both the House and Senate bills include policies that would affect readmissions in other payment systems beyond Medicare. The resulting efforts would be uncoordinated and result in confusion and probably inhibit rather than enhance improvement of patient care.

Pilots & Demonstrations: The FAH endorses the underlying premise of both bills that there are no quick fixes or "one-size-fits all" formulas to transform health care delivery, and that we are very much in the discovery phase that needs active experimentation. The FAH supports initiatives that focus on new methods of furnishing quality medical care to patients through increased integration of care.

The reliance on voluntary demonstrations and pilot programs throughout the House and Senate bills (for example, the proposed CMS Center for Medicare and Medicaid Innovation, the National Pilot Program on Bundling, and the Accountable Care Organization Pilot Program) is both prudent and necessary.

However, the FAH recommends clarifying language to indicate that Secretarial authority to expand pilots does not alter the underlying intent that provider participation is voluntary. Further, regarding the accountable care organization (ACO) pilot, the FAH strongly endorses the Senate version, which includes an option for hospitals to assume a leadership role in organizing an ACO.

Health Care Associated Infections (HAIs): The FAH understands and shares the Congress's interest in reducing the incidence of HAIs. The FAH opposes, however, the

provision in the Senate bill that would apply arbitrary, punitive and unnecessary payment penalties to hospitals. It is important that provisions in the House and Senate bills regarding HAIs are melded together in such a way to assure that new policy designed to reduce HAIs will be coordinated in the Medicaid and Medicare programs and will be implemented in a manner that enables hospitals to take action to reduce HAIs. It is particularly important that provisions that require publicly reporting the incidence of HAIs are designed to mandate only reportable data that are actionable and truly useful and can be collected in a consistent and validated manner. The method that is called for under the House bill for data collection of HAIs does not meet this standard.

Quality Infrastructure: The FAH appreciates that both the House and Senate bills address many of the elements necessary for a coordinated, well-researched and well-funded national healthcare quality infrastructure in the multi-stakeholder proposed Stand for Quality initiative.

Both the House and Senate measures make use of existing and proven public-private sector structures. The FAH believes the Senate bill most succinctly organizes the needed quality infrastructure, though it can be improved with a few technical modifications related to funding and by linking quality measurement programs for insurance plans to the overall national quality infrastructure. The House bill includes the funds needed to strengthen and streamline the quality enterprise.

Institute of Medicine Studies: The FAH strongly opposes provisions in the House bill that basically mandate the Secretary of HHS to make major payment changes in Medicare based on IOM study recommendations. Such changes in the past have been directed by the Congress, and we believe this precedent should be maintained in the future. However, under the House bill these changes could occur without explicit Congressional direction. The Secretary could make new payment policy based nominally on recommendations issued by the Institute of Medicine regarding changes to the geographic adjustment factors in Medicare as well as changes to the overall Medicare payment system to reward “value and quality.” If such recommendations have merit, they should be fully considered and directed by the Congress through its regular legislative process.

Additional Provisions

Rural Policy: The FAH supports the extension of expiring rural hospital provisions including Section 508 wage index reclassifications, outpatient hold-harmless payments, and the Medicare Dependent Hospital program. The FAH also supports provisions in the Senate bill seeking to protect hospitals in Frontier states.

Long-Term Acute Care Hospitals: The FAH supports the Senate’s temporary, two year extension of provisions in the Medicare, Medicaid and SCHIP Extension Act of 2007 regarding payment rules and a moratorium on long-term acute care hospitals. This extension would ensure regulatory stability for these crucial facilities and provide the additional time necessary to develop patient and facility criteria.

Medical Device Tax: The FAH prefers the Senate approach to imposing a tax on medical devices and opposes the “first taxable sales” mechanism included in the House bill. The FAH is concerned that, under the House bill, this tax would be passed-through directly to hospitals.

Price Transparency: The FAH believes that health care consumers should have access to useful pricing information. Many states already have taken the initiative to develop and implement programs to provide consumers average or common prices for the most frequent medical (including hospital) procedures. Further, many insurers currently are providing their enrollees with the up-front, real-time comparative cost information that matters most (and which insurers are best-positioned to provide) -- expected out-of-pocket costs -- including co-pay and deductible amounts. Hospitals routinely make available to the general public prices as well as various discount programs and available charity policies.

The FAH believes that any new federal policy neither should interfere with, nor penalize, current state efforts. In addition, it should focus on generating information that is meaningful for consumers, for example, insurers providing expected out-of-pocket costs and hospitals providing a range of prices for the most common procedures. Most importantly, should Congress pursue policy in this area, it must not require the submission, or enable the disclosure, of privileged information, which could undermine the competitiveness of the private health care marketplace.

Medical Liability: The FAH strongly supports comprehensive medical liability reform. Effective reform, however, must include such items as caps on non-economic damages, joint and several liability reform, and caps on attorneys' fees, as well as other reforms on which CBO recently based its estimate of a net reduction in the Federal deficit of \$54 billion. We urge the negotiators to include such meaningful liability reforms in the final health reform measure.

Self-referral disclosure protocol: We are pleased that both bills provide for a self-disclosure protocol that would grant the Secretary of HHS authority to compromise on penalties related to self-referral violations. We support the additional language included in the House provision.

Stabilization of Emergency Medical Conditions by Institutions for Mental Disease: The FAH applauds both the House and Senate for including provisions that would require the Secretary to establish a three-year demonstration under which states would apply to pay institutions of mental disease for stabilizing adult Medicaid recipients with an emergency medical condition. However, the FAH strongly supports the Senate proposal which would appropriately limit the demonstration to non-governmental, community psychiatric hospitals. One policy intent is to help compensate community psychiatric hospitals for the treatment provided to adult Medicaid patients. Unlike governmental or state mental hospitals which receive millions of dollars through Medicaid DSH, non-governmental community psychiatric hospitals generally do not receive any other federal or state funding to offset the cost of treating these adult Medicaid recipients.

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Again, the FAH commends and thanks you for your strong and steady leadership in advancing health reform. It is our hope that the process of melding the House and Senate bills will produce landmark health reform that patients and the hospitals that serve them can count on.

We believe that the House and Senate measures are major legislative accomplishments, and we and our nearly 1,000 community hospitals and health systems stand ready to contribute to the enactment of this historic health reform legislation.

Sincerely,

A handwritten signature in black ink, appearing to read "Nightingale", written over a horizontal line.

cc:

Majority Leader Hoyer
Majority Whip Clyburn
Democratic Caucus Chair Larson
Democratic Caucus Vice Chair Becerra
Chairman Rangel
Chairman Waxman
Chairman Stark
Chairman Pallone
Chairman Miller
Minority Leader Boehner
Minority Whip Cantor
Ranking Member Camp
Ranking Member Herger
Ranking Member Barton
Ranking Member Deal
Ranking Member Kline
Majority Whip Durbin
Chairman Baucus
Chairman Dodd
Chairman Harkin
Chairman Conrad
Senator Schumer
Minority Leader McConnell
Minority Whip Kyl
Ranking Member Grassley
Ranking Member Enzi
Republican Conference Chair Alexander
White House Chief of Staff Rahm Emanuel
Deputy Chief of Staff Jim Messina
Director, OMB, Peter Orszag
Director, White House Office for Health Reform, Nancy-Ann DeParle
Director, National Economic Council, Larry Summers