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QUALITY &
PAYMENT REFORM

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The Honorable Fred Upton, Chairman
The Honorable Joseph R. Pitts, Chairman, Subcommittee on Health
Committee on Energy and Commerce
House of Representatives
Congress of the United States
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Chairman Upton and Subcommittee Chairman Pitts:

Thank you for the opportunity to provide input to the Committee on Energy and Commerce as it considers better ways to pay hospitals and other healthcare providers for the services they deliver.

Congress is to be commended for including Section 603 in the Bipartisan Budget Act of 2015. It established a much-needed "timeout" for hospital acquisitions of physician practices that are driven by disparities in payment rates for services delivered in hospitals versus physician practices. However, Section 603 can only be considered a temporary solution, since it does not correct problems that developed prior to November 2 and it does not correct the underlying structural problems with payments to hospitals and other providers.

Problems with the Ways Hospitals Are Paid and Potential Solutions

It is clear that the differences in the amounts that Medicare pays for the same service in hospital outpatient departments, physician offices, and other settings have caused a number of serious problems. Independent physician practices have been unable to sustain their operations due to payment rates that do not cover their costs. Multi-specialty physician groups and independent practice associations that are trying to deliver more coordinated, high-value care to their patients are seeing their physicians lured away by hospitals that can afford to pay dramatically higher salaries using the revenues generated by higher payment rates. Both Medicare beneficiaries and working age adults and families are paying more than is necessary or appropriate for many of the healthcare services they need, and their choices of where to get those services are narrowing.

A major reason these problems have persisted is that the solution is not as simple as requiring "site-neutral payments." The problem with Medicare's current payments is not that the amounts paid for the same service are *different* for different providers, but that both the *methods* of payment and the *amounts* of payment Medicare uses do not properly address the *legitimate differences* in costs between hospitals and other settings. In order to effectively solve the problems, the Committee will need to pursue more comprehensive reforms in the payment systems for hospitals and physicians.

As the Committee knows very well, hospitals argue strongly that payment rates for services delivered in hospitals need to be higher than payment rates for the same services delivered in other settings

because of higher standards and expectations that are placed on hospitals. It is true that hospitals are required or expected to incur costs that physician practices and ambulatory surgery centers are not, because of statutory mandates (such as EMTALA) and performance standards and goals (such as speed of treatment for heart attacks and strokes). However, this does not mean that the hospital should be paid more for *every* service the hospital delivers, regardless of how many or what types of services are delivered, as happens today in Medicare's payment systems. Medicare payments should be designed to pay hospitals in ways that will provide adequate financial support to cover the extra costs the hospitals are expected to incur without creating problematic incentives to deliver services in the hospital that could and should be delivered in lower-cost settings.

The first step is to explicitly identify each of the types of costs hospitals are either required or expected to incur that other providers and sites of service are not. Payment methodologies should then be designed to adequately support each of those types of costs without encouraging either overuse or underuse of services.

1. Standby Services

Hospitals are required or expected to be prepared to provide certain types of services on a round-the-clock basis whether they have any patients who need those services or not. In particular, the hospital's emergency room, the cardiac catheterization suite, the surgical suite, and key laboratory and imaging services are all expected to be available to address emergencies, heart attacks, trauma, childbirth, epidemics, and other conditions with as little delay as possible.

However, Medicare does not directly pay hospitals to support these standby services. Instead, Medicare pays for the services only when they are used, which encourages the hospital to deliver as many services as possible in order to ensure it has enough revenue to support the otherwise-unfunded standby capacity.

The hospital's standby capacity is a form of health insurance for a community; the residents of the community benefit significantly from having the hospital ready to provide services whether the residents use them or not. Consequently, payment to support standby capacity should be based in part on the *number of individuals who benefit from having that capacity available*, not based solely on the number of individuals who actually *use* the services. This means that Medicare should pay for the *fixed cost* of a hospital's standby services based on the number of beneficiaries living in the communities that rely on those standby services, since that is the cost the hospital has to support regardless of whether anyone uses the services or not. Medicare should also continue to pay an additional amount to the hospital each time a standby service is actually delivered to a Medicare beneficiary; however, the amount of the additional payment should be based on the *marginal cost* of that service (i.e., the out-of-pocket cost the hospital incurs when an additional patient is evaluated or treated), not the *average* cost (as it is today). If payments are restructured in this way, the hospital can reliably support the cost of its standby services regardless of how many patients it actually treats, and it will have no financial incentive to deliver unnecessary services, because any additional revenues from delivering more services would be offset by the additional costs of delivering the services.

2. Medical Education and Research

Hospitals serve as one of the principal venues for preparing future generations of physicians to practice successfully and for developing new approaches to treating serious illnesses. The costs of supporting these activities do not depend in any significant way on the number or types of services the hospital delivers. Yet Medicare ties its payments for graduate medical education to the number

and types of services the hospital delivers. This means that the hospital cannot support the costs of its medical education program unless it delivers a sufficient number of services to patients, and it also means that physicians' efforts to keep patients healthy and reduce hospitalizations will make it more difficult for a teaching hospital to sustain a successful medical education program.

A better approach would be to simply pay teaching hospitals directly for the cost of their medical education program. Rather than basing payments on the number of services the hospital delivers to patients, payments could be tied to the number of residents being trained and other factors affecting the cost of medical education.

3. Care for the Uninsured

Hospitals are expected to provide basic care for patients even if the patients cannot pay for it. The actual cost to the hospital of delivering care to those who cannot pay depends not just on the number of uninsured patients, but on how many patients there are who cannot pay *relative to* the number of patients who *can* pay. This is because the majority of a hospital's costs are fixed, i.e., the costs do not change depending on how many patients the hospitals has (within the range of patient volume the hospital's capacity can support). Once the hospital has cared for enough paying patients to generate sufficient revenue to cover its fixed costs, the marginal cost of serving additional patients is simply the additional out-of-pocket spending the hospital incurs when it treats an additional patient. Today, however, hospitals get paid the same amount per patient regardless of the volume of services they deliver, so additional patients beyond the number needed to cover fixed costs generate profit margins. The more paying patients the hospital has, the higher its margins, and the better its ability to provide some of those services for free. This means that the cost of caring for uninsured patients is *inversely related* to the volume of care delivered to patients who can pay, i.e., the more paying patients the hospital has, the less expensive it will be for the hospital to care for the uninsured patients. Paying more to the hospital for each service it delivers has the exact opposite result – it encourages the hospital to deliver more services to paying patients, not to deliver more services to patients who cannot pay, and it means that initiatives to help insured patients avoid unnecessary hospitalizations reduce the hospital's ability to care for patients without insurance.

The best solution to covering hospitals' costs for treating patients who cannot pay is to simply pay the hospitals for those costs, either by providing insurance to the patients or by paying the hospital for all or part of the cost of the services delivered to those patients. However, if the solution is going to be an increase in the payments to the hospital for services that are delivered to patients who do have insurance, then the amount of the payment differential should be based on the proportion of the services that are, in fact, delivered to the uninsured, i.e., hospitals who care for a higher proportion of uninsured patients would receive higher Medicare payments. Moreover, the payment differential need only be enough to cover the cost of delivering the care to the uninsured; for example, if the insured subset of the hospital's patients receiving the service is sufficiently large to enable the hospital to cover its fixed costs, then the cost of serving the uninsured is equal to the marginal cost of the service, not the average cost. Also, if payment adjustments are going to be made to support all or part of the costs of serving the uninsured, the adjustments should be specific to individual types of services based on the proportion of uninsured patients receiving those specific services, in order to avoid creating incentives to over-provide services.

4. Cross-Subsidized Services

Many hospitals use higher-than-cost payments on some services to cross-subsidize other services where their payments are below cost. Ideally, this problem would be addressed by having all payers

pay the right amount for each service. However, an alternative would be similar to the approach described above for addressing the cost of serving the uninsured: adjustments to the payment amount for a service could be made based on the proportion of patients receiving that service whose insurance pays less than the cost of the service. Here again, if possible, the payment adjustments should be targeted to the services that require cross-subsidization, rather than to all services, in order to avoid creating incentives to over-provide unrelated services.

5. Services for Complex and High-Risk Patients

In many cases, it will cost more to deliver the same procedure to patients who have more complex conditions or more risk factors than to patients who are less complex and lower-risk. Because the hospital delivers a full range of emergency and procedural services, it will be better equipped to handle many kinds of complex and high-risk patients than a physician practice or ambulatory surgery center. It would be inappropriate to pay the hospital and the physician practice the same amount for delivering a service to two patients with very different needs, because the two providers are really providing different services when the patients' needs are very different. The converse of this, however, is that it is inappropriate to pay the hospital more for delivering the same service to patients who have the same characteristics that a physician practice or ambulatory surgery center can care for successfully at lower cost.

Rather than simply paying the hospital more for a service regardless of the types of patients who are receiving the service, the right approach is to pay both the hospital and other providers more for services delivered to patients who have greater complexity or risk than for the "same" service delivered to patients with lower complexity and risk. If only the hospital delivers a service to the higher-risk patients, then the hospital will receive higher payments than other providers, but if the hospital is delivering the service to the same kinds of patients as other providers, then the hospital's payment would be the same. Medicare pays hospitals different amounts for inpatient procedures based on differences in the characteristics of the patients, and there is no reason why it could not do the same thing for outpatient procedures.

Site-Neutral Payment Amounts After Other Reforms Are Made

Once payments are being made to directly support the types of costs hospitals uniquely incur, and once payment differentials are created based on differences in patient needs, all other aspects of services can be paid for on a site-neutral basis. For example, there would be no need to pay a hospital more than a physician practice for performing routine screening colonoscopies for low-risk patients.

It should not be assumed, however, that the correct site-neutral payment is equal to the amount Medicare currently pays for services delivered in a physician's office or other setting. Hospitals are acquiring physician practices not only because the higher amounts Medicare pays for hospital-based services allow the hospitals to pay physicians more than the physicians can earn in a community practice, but also because Medicare payments to physicians for many services have been inadequate to enable them to cover the costs of delivering those services in the community. Consequently, it is essential that payment rates be set at levels that are adequate to enable them to be delivered in a high-quality fashion in a non-hospital setting if that setting is appropriate.

Changes in Hospital Payments Needed to Support Broader Payment Reforms

The problems with Medicare payment systems are not limited to the amounts paid for services. A more serious problem is that healthcare providers are paid based on the number and types of services

they deliver rather than the outcomes they achieve. If physicians and hospitals work together to successfully keep patients healthy, the patients will need fewer services and both the physicians and the hospitals will earn less. A payment system that penalizes providers financially for keeping patients healthy will never be sustainable, so more fundamental reforms in payment are needed.

Unfortunately, many of the "payment reforms" that are currently being implemented by CMS and private payers do not solve the problems with current fee-for-service structures, and in some cases, they make them worse. In particular, the "shared savings" methodology that CMS has used to pay Accountable Care Organizations has also created problematic incentives for hospitals to acquire physician practices. Some of the biggest opportunities for ACOs to reduce healthcare spending are associated with helping patients avoid hospitalizations and unnecessary outpatient procedures. However, when there are fewer admissions to a hospital, the hospital's revenues will decrease more than its costs, causing financial problems for the hospital. Although a "shared savings" payment could help to offset these losses, the CMS methodology attributes all "savings" attributed to primary care physicians, even if the hospital made the changes in care that created the savings. Consequently, many hospitals feel compelled to acquire physician practices in order to ensure they receive a share of these savings to cover their standby costs (or in some cases to discourage the physicians from doing anything to generate savings).

The types of reforms to hospital payments described earlier would not only mitigate these problems but facilitate true payment reforms in physician payment as well. The types of physician-focused alternative payment models encouraged by the Medicare Access and CHIP Reauthorization Act will be more feasible and more sustainable if hospitals are paid in ways that enable them to cover the costs of their standby services when physicians redesign care in ways that reduce hospital admissions and procedures.

I hope these recommendations are helpful to you as you pursue your efforts to address these important issues. I would be happy to answer any questions you may have or to provide any additional information or assistance that would be helpful to you in implementing them.

Sincerely,

Harold D. Miller
President and CEO

cc: The Honorable Frank Pallone, Jr., Ranking Member
The Honorable Gene Green, Ranking Member, Subcommittee on Health
The Honorable Tim Murphy
James Paluskiewicz
Josh Trent
Adrianna Simonelli