

May 15, 2009

The Honorable Max Baucus, Chairman
The Honorable Charles Grassley, Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Baucus and Ranking Member Grassley:

The Florida Hospital Association, on behalf of its member hospitals and health systems, appreciates the opportunity to comment on the Senate Finance Committee's Description of Policy Options in Transforming the Health Care Delivery System. In summary, we believe that the Committee proposals will make significant strides in improving the quality and efficiency of our healthcare system. As you draft the legislation with further specificity, we urge your recognition of the unique challenges of states like Florida with very high Medicare, dual eligible and uninsured populations and limited numbers of primary care physicians in transitioning to new payment methodologies.

Overall, Florida's healthcare system is shaped by certain demographic trends and economic challenges, which, in combination, disproportionately affects the State:

- One in four Floridians under the age of 65 has no health insurance – nearly 10 percent of the nation's uninsured reside in Florida.
- Florida is home to the nation's largest elderly population.
- There is a significant shortage of patient care physicians in Florida, with patient care physicians per 100,000 residents at 225 compared to 239 nationally.
- Florida has 3,065 residency positions or 16.9 residents per 100,000 population, compared to 35.6 per 100,000 nationally and 81 per 100,000 in New York, 77.5 in Massachusetts, 28.7 in Texas, and 25.7 in California.

In addition, Florida's Medicare population includes:

- Over 3.1 million beneficiaries, second only to California, and representing 17 percent of the state's total population.
- Approximately 18 percent of beneficiaries are eligible for both Medicare and Medicaid.
- Nearly 44 percent of Medicare enrollees are below 200 percent of the Federal Poverty Level (FPL) and 16 percent are under 100 percent of FPL.
- Ten percent of Florida's Medicare beneficiaries are age 85+ and 43 percent of enrollees are over age 75.

The FHA agrees with the need and supports efforts to increase efficiency and improve quality within the current Medicare fee-for-service (FFS) payment system. In assessing the policy options presented by the Committee, we support the move to performance-based, rather than volume-based, payment. The current Medicare FFS payment methodology is not conducive to care coordination and is just moving to a focus on quality, albeit quality reporting and not quality outcomes. We support the Committee's work to create a new Medicare payment methodology that rewards the efficient use of services and encourages the effective integration and coordination of care. Florida's hospitals remain committed to providing high-quality and effective healthcare for all Floridians. FHA's members are currently engaged in a number of patient safety initiatives and other collaboratives to reduce readmissions and hospital-acquired infections.

The Committee's policy options related to value-based purchasing, readmissions, post-acute bundling, and redistribution of unused residency slots will address the limitations of the current program and improve access and efficiency of care in the long-term. It will be very important, however, for states like Florida which have unique challenges relative to the Medicare population, that as further specificity is developed, these proposals should also address the unique characteristics of Florida's Medicare beneficiaries.

Value-Based Purchasing (VBP). VBP programs are typically designed to measure provider performance through standard quality measures. Providers that meet thresholds related to the standards are rewarded with incentive payments that are intended to drive quality improvement and spur efficiencies. All providers should fund the pool from which incentive payments are drawn, along with additional federal funding to reward the top performers. Providers should be able to receive more than they paid into the incentive pool. Overall program savings should be accomplished through greater efficiencies in the delivery of care and assuring that the right care is provided in the right setting.

In addition to budget neutrality, any VBP program should:

- Ensure that implementation of a VBP program would be transparent and predictable for hospital budgeting purposes and avoid any unintended consequences that may adversely affect hospitals and the patients they serve.
- Tie incentive payments as closely as possible to hospitals' most recent performance.
- Be built on quality measures developed and approved by the Health Quality Alliance and the National Quality Forum.
- Provide that the dollars flowing into the incentive pool are taken as a percentage of payments for the DRGs associated with the quality measures rather than all DRGs to ensure that low-volume hospitals are not disadvantaged.
- Reward both attainment of specific quality benchmarks and improvement from a baseline.
- Have a fair and timely appeals process.

Further, FHA strongly urges that while any VBP program should be phased in, those providers in the lowest quartile of current performance should be allowed an expanded transition period. It is vital that poor performers, both from the provider and state perspective, have the needed

financial resources and technical assistance for improvement and not experience immediate reductions in Medicare payments

Readmissions. Based on findings from MedPAC that approximately 18 percent of Medicare patients discharged from hospitals were readmitted within 30 days, at a cost of \$15 billion to the Medicare program in 2005, the Committee has proposed the identification of the eight conditions with the highest volume and highest rates of readmission and the development of national readmission benchmarks for each of the selected conditions. FHA provides the following specific thoughts and recommendations.

First, readmission policies should distinguish between factors that are within the control of the hospital and those that are not. We agree with the proposal that the policy exclude those readmissions that are planned or unrelated to the initial admission and to focus on those readmissions that are potentially preventable. This is most applicable to states such as Florida with more than 10 percent of our Medicare beneficiaries over 85 years of age and with multiple chronic conditions. About 60 percent of FFS Medicare beneficiaries have two or more chronic conditions and the percentage increases with age.

States such as Florida with a large number of dual eligibles – those eligible for both Medicare and Medicaid – will see a higher volume of readmissions due to patients’ non-compliance with discharge instructions, medication, and recommended follow-up care, including access to a primary care physician and lack of support services through a competent home caregiver. Most dual eligibles are very low income individuals with substantial health needs – 77 percent have annual income below \$10,000 and over half are in fair or poor health, twice the rate of others in Medicare. Any readmissions policy that is adopted must take into consideration the needs of this special population by assuring continuity of care that is both affordable and accessible to all.

FHA would like to make the Committee aware that in Florida's experience in developing methods to prevent unnecessary readmissions, a focus on the first 15 days following the admission was deemed to be within greater control of the hospital, rather than a full 30 days. Florida was one of the first states in the country to make available on Florida’s consumer Web site, www.floridahealthfinder.gov, information on readmission rates for 54 conditions and procedures using a methodology developed by 3M Health Information Systems that focuses on “potentially preventable” readmissions. Through discussions with key stakeholders, including hospitals, physicians, health plans, the business community and consumers, Florida’s Agency for Health Care Administration decided to focus on readmissions within 15 days of the initial admission, since these were determined to be more within the control of the hospital. Many felt there were other outside factors beyond the hospital’s control that could occur in 30 days. The data are severity-adjusted, which is another important factor to consider when measuring readmission rates, given the higher likelihood of sicker patients being readmitted.

FHA would also call to your attention, that in addition to public reporting of readmission rates, Florida hospitals have joined together in a collaborative to gain a better understanding of readmissions and to identify initiatives that could reduce the likelihood of a patient being rehospitalized soon after a hospital stay. The focus of the collaborative is on five high volume conditions: congestive heart failure, heart attack, pneumonia, coronary artery bypass surgery and hip replacement surgery. Strategies being discussed and tested include improving patient and

caregiver communication through techniques such as “teach back;” improving communication with other providers such as the patient’s physician, home health agencies, and nursing homes; assessing the home environment to determine additional needs that would reduce the chances of rehospitalization; improving medication reconciliation processes; developing patient assessment forms to determine the risk of rehospitalization; scheduling follow-up appointments with the patient’s physician; and improving the discharge process through improved instruction and tools.

Second, it is important that any readmissions policy be tied to changes in the law to support gainsharing (shared accountability) to allow hospitals and physicians to share in the resultant savings of adoption of a focused plan to reduce readmission rates. Hospitals should be able to financially reward physicians for helping to reduce readmission rates.

Third, reductions in payment for high rates of readmissions should be phased-in, rather than starting with a 20 percent withhold in payments. Hospitals are working diligently to address their readmission rates but have found it difficult to afford the additional expense of new programs. A phase-in of any readmissions payment reductions would provide hospitals the time needed to put new protocols, staffing, and systems in place.

Finally and more specifically, any readmissions policy adopted by the Congress for the Medicare program should address the following:

- Use a 15-day focus instead of 30-day since readmissions during this time are more within the control of the hospital.
- Readmission rates must be severity-adjusted to factor in the higher likelihood that a more acutely ill patient with multiple chronic conditions will be readmitted.
- Additional adjustments should be made to account for low-income level and dual eligible enrollees, as well as those with an underlying mental health issue.
- The role and payment incentives of those outside the hospital involved in the patient’s care, including the patient’s physician, must be addressed to assure the appropriate follow-up care is provided.
- It is vital that prescription medications and home health and caregiver services be both available and accessible to individuals in all geographic areas and at all income levels.
- Hospitals and physicians should be allowed to share in the savings of coordinated activities aimed at reducing readmission rates.

Post-Acute Bundling. The Committee proposes that, beginning in fiscal year 2015, acute inpatient prospective payment system hospitals and post-acute care services (defined as home health, skilled nursing facilities, inpatient rehabilitation services, long-term acute care services, and readmissions) occurring within 30 days of discharge be paid through a bundled payment.

Implementation of bundled payments would require that potential legal and regulatory barriers at the state and federal level be carefully addressed. The referral to a post-acute level of care is made by the physician and not the hospital. If hospitals are to develop relationships with post-acute care providers, they must be given a greater voice in the coordination of patient care and even allowed to recommend specific downstream providers.

Continuity of care without a truly integrated delivery system for Florida's "snowbirds" and dually eligible population is problematic. To date, CMS has conducted two demonstrations related to bundling, but both involved bundling hospital and physician payments, and not post-acute care providers. The FHA urges completion of a post-acute care bundling demonstration prior to adoption of a new national policy to ensure that when bundling is implemented to include post-acute providers, access throughout the continuity of care is not inadvertently impeded. Such a demonstration program should address the availability of post-acute care services for dual eligibles and the relationship of providers in different geographic areas, such as post-acute services received in another state from the hospital discharge for seasonal residents.

Graduate Medical Education. The FHA commends the Committee's efforts to address the critical workforce challenges facing our nation. The Committee proposes redistribution of currently unused residency slots, particularly in the areas of primary care and general surgery. While reallocation of these slots will provide the opportunity for increased residents within the state, the FHA supports the creation of new residency programs in primary care and general surgery. All of the Committee's efforts to incentivize preventive care, disease management and more appropriate utilization will be challenged without a sufficient number of physicians to care for and provide effective medical homes for Medicare patients, particularly those with multiple conditions and over 85 years of age.

Florida is facing a physician shortage which threatens to limit access to physicians, jeopardize quality and accelerate cost increases. Florida is among the states with the slowest growth in physician supply, with the ratio of physicians to population growth only 3.2 percent from 1999 to 2003, compared to 13 percent growth nationally. Additionally, over 25 percent of the physicians practicing in Florida are over the age of 60. A recent study by the Association of American Medical Colleges ranks Florida 43rd among states with federally-funded medical residency positions, with 17 residents per 100,000 people. Because physicians tend to remain in the area where they train, increasing the number of physicians-in-training in Florida is essential to increasing the physician workforce. As such, FHA supports efforts to ensure the number and geographical distribution of federally-supported medical residents reflects recent population growth in states such as Florida.

Again, the Florida Hospital Association appreciates the opportunity to provide these comments on the proposed policy options and we look forward to working with the Congress, the Administration, and the Centers for Medicare & Medicaid Services on changes to the Medicare payment system.

Sincerely,

A handwritten signature in black ink, appearing to read "Bruce J. Rueben". The signature is fluid and cursive, with the first name "Bruce" and last name "Rueben" clearly distinguishable.

Bruce J. Rueben
President