hfma
healthcare financial management association

April 10, 2013

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Dave Camp
Chairman
Committee on Ways and Means
1102 Longworth HOB
Washington, DC 20515

The Honorable Joe Pitts
Chairman
Subcommittee on Health
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Kevin Brady
Chairman
Subcommittee on Health
Committee on Ways and Means
1102 Longworth HOB
Washington, DC 20515

Re: Request for Feedback on Second Draft of Sustainable Growth Rate (SGR) Repeal and Reform Proposal

Dear Chairman Upton, Chairman Camp, Chairman Pitts, and Chairman Brady:

The Healthcare Financial Management Association (HFMA) would like to thank you for the opportunity to provide feedback on the draft Sustainable Growth Rate (SGR) Repeal and Reform Proposal. We salute your leadership in working to preserve seniors' access to health care and the stability of the delivery system by better aligning the Medicare physician reimbursement system to support high quality, low cost care.

HFMA is a professional organization of more than 39,000 individuals involved in various aspects of healthcare financial management. HFMA is committed to helping its members improve the

management of healthcare delivery systems, comply with the numerous rules and regulations that govern the industry, and further the principles of administrative simplification.

Background

In 2008, HFMA convened a group of healthcare stakeholders representing payers, providers, employers, and patients to define the key principles that a reformed payment system must achieve. The group came to consensus around five key principles, which are discussed briefly below:[1]

- **Quality:** Payments should encourage and reward high-quality care and discourage medical errors and ineffective care. Wherever possible, payments should reward positive outcomes, rather than adherence to processes. In the absence of outcome measures, payment systems should reward the use of accepted practice and evidence-based processes and protocols that meet or exceed standards of quality and safety to promote optimal outcomes. Payers should not be responsible for payment to cover costs directly related to serious preventable medical errors.

- **Alignment:** Payments should align incentives among all stakeholders to maximize the efficiency and coordination of health services based on accepted practice and evidence-based delivery models and protocols. Payment systems should stimulate and reward healthful behavioral choices and selection of value-based services by consumers related to prevention, primary care, acute care, and chronic disease management. Care decisions should be made through a shared decision-making process in which patients' values and preferences are identified and respected.

- **Fairness/Sustainability:** Payment systems should balance the needs and concerns of all stakeholders. Payments should recognize appropriate total costs for the efficient delivery of healthcare services that are necessary and consistent with evidence-based care, high-quality/low-cost provider benchmarks, and the advancement of medical science. Payment systems should accommodate payers' and purchasers' needs to allocate funds in a predictable, manageable fashion. In addition, consumers should have financial incentive to select high-quality, efficient care without being discouraged from seeking necessary and appropriate services. Finally, the payment system should be sustainable, providing a stable funding stream in the face of competing claims on public and private capital.

- **Simplification:** Payment processes should be simplified, standard, and transparent. All parties should use payment methodologies, standardized at the national level, to reduce complexity. The payment methodologies should be transparent to those affected by them, and comply with privacy, security, and antitrust laws and regulations.

- **Societal Benefit:** The resources needed to support broad societal benefits (i.e. medical education and research, indigent care) should be paid for explicitly. Similarly, payment systems should reward innovators who develop technologies, services, processes, and procedures that enhance safe, high-quality, and efficient care.

[1] Healthcare Financial Management Association, *Healthcare Payment Reform – From Principles to Action*, September 2008

Introduction

HFMA has long supported the development of an alternative to the SGR that is better aligned with our payment reform principles. At the level of detail that is presented in the second draft, we believe your proposal has the potential to meet these principles. Based on our membership's experience with ongoing efforts to better align payment systems to support the provision of high-quality, low-cost care, HFMA offers the following comments. They are organized according to the payment reform principle that they seek to reinforce.

Quality

HFMA strongly supports basing physician payment on quality and outcome measures and applauds the approach taken in the proposed draft. We believe the strength of this proposal lies in its flexibility (allowing physicians to choose a payment methodology that best fits their practice) and its measured approach. We agree the phased approach is necessary to better understand which payment models are more likely to produce the desired outcomes.

1) Risk-Adjustment for Quality Measures:
   HFMA supports using quality measures endorsed by the NQF and other accrediting bodies. However, we believe it is crucial that any quality measure include an adequate risk adjustment mechanism to ensure that providers are appropriately held accountable only for circumstances within their control.

   In many instances, NQF-endorsed measures (for example, measures related to hospital readmissions) lack a sufficient mechanism to account for a patient's economic circumstances. Numerous studies have shown that economic factors, which are beyond the control of providers, contribute significantly to patient outcomes.[2]

   Recommendation: We strongly urge that legislation implementing a physician reimbursement system based on quality and outcome measures include language specifying that the risk-adjustment mechanism include factors that account for a patient's economic circumstances.

2) Preference for Outcome Based Measures:
   Outcome-based measures are best suited to achieving the desired goal of improving patient quality. They are preferable in that they establish a goal for providers and then allow them the latitude to pursue the process improvement activities best suited to achieving the desired outcome based on the given patient population and clinical circumstances.

   However, in the absence of a meaningful, widely-accepted outcome measure, process-based measures can be useful if they are supported by analysis of best practice initiatives that are shown to drive the change necessary to achieve desired patient outcomes.

   Recommendation: Where meaningful, widely accepted outcomes metrics are available, we strongly urge that the legislation favor the use of outcome over process metrics. In instances where the measures are process-based, we believe the Secretary should be instructed to

[2] S. Jencks et al., "Rehospitalizations"
[2] http://www.kaiserhealthnews.org/Stories/2011/December/20/Readmissions-Methodology.aspx
[2] Kansagara, D., Englander, H., Salanitro, A., Kagen, D., Theobald, C., Freeman, M., Kripalani, S. "Risk Prediction Models for Hospital Readmission: A Systematic Review." *JAMA*, October 19, 2011

annually reexamine the available metric set and replace process with outcome metrics as meaningful, widely accepted outcome metrics become available for a given specialty or provider type.

Alignment

HFMA believes the proposal as drafted has the potential to align economic incentives for physicians with the goal of high-quality, low-cost care. However, the proposal is silent on a number of issues, which leaves us concerned that any legislation based on the framework could further entrench existing provider silos. If this occurred, it would prevent collaboration across the care continuum and leave beneficiaries unengaged in their care. The net effect would cause the proposal to miss its full potential of delivering high-quality, low-cost care to all Americans.

1) Align Metrics with Other Payers:
   Both public and private payers have developed various quality reporting requirements that are reported through various submission mechanisms or claims-based measures to support initiatives such as quality report cards, medical homes, and other pay-for-performance programs.

   One of the findings from our Value Project (http://www.hfma.org/Content.aspx?id=1135) research indicates that 55 percent of our members believe that quality measures are inconsistently defined across the various public and private payers. The likelihood that a provider reports that quality metrics are inconsistently defined appears to be positively correlated to the amount of revenue at risk under value-based reimbursement arrangements. This misalignment across payers (for what should be a similar set of metrics) does not benefit patients in any manner while increasing administrative costs and inhibiting quality improvement activities.

   Recommendation: We strongly urge that the legislation provide for development of a mechanism that enables the Secretary of Health and Human Services to work with other state, federal, and commercial payers to develop a common set of metrics for each type of provider.

2) Align Metrics Across the Care Continuum:
   Currently, the lack of quality and efficiency-based reimbursement mechanisms across the care continuum serves to reinforce the existing silos that exist within the care continuum. HFMA believes the development and implementation of a properly constructed value-based reimbursement system for physicians would be a significant step toward achieving the goals of high-quality, low-cost coordinated care that reduces readmissions and ultimately improves patients' outcomes.

   Recommendation: We strongly urge that the legislation—where possible based on clinical pathways and existing measures—align metrics between physicians and hospitals. Further, we urge Congress to use its authority to expedite the development of quality-based reimbursement systems for other types of providers so that all components of the delivery system are incented to collaborate and provide high-quality, cost-efficient, patient-centric care.

3) Providing Beneficiaries with Incentives to Identify and Use High-Value Providers:
HFMA believes that a significant design weakness inherent in many of CMS's value-based payment mechanisms is that they fail to engage beneficiaries in their care. We believe there are multiple benefits from helping beneficiaries indentify and receive their care from high-quality, low-cost providers. These include but are not limited to:

- Providing positive economic incentives for patients to develop deeper relationships with high-value providers. This will foster greater compliance with evidence-based care plans that will improve quality and reduce cost.
- Creating greater urgency among providers to increase quality while reducing cost. While basing per-unit reimbursement on quality and efficiency measures is a necessary step, we are concerned it is not sufficient. Incenting beneficiaries to seek care from high-value providers will have a "multiplier effect" as demand for high-value providers will increase, and with it the economic incentives to provide high-value care. This will have the further benefit of ameliorating the economic challenges high-value providers could face when they make investments to identify and eliminate inappropriate utilization.

Recommendation: In order to engage Medicare beneficiaries in their care, the legislation should include the following provisions:

- Provide means to improve the CMS Physician Compare website so that it creates the transparency necessary for engaged beneficiaries. In addition to improvements to Physician Compare, the legislation should create other avenues to provide beneficiaries with cost and quality data for the providers in their community.
- Allow high-quality providers to market themselves as CMS "Quality Centers" for any condition where they are a high-value provider in their community/market.
- Reduce or waive beneficiary cost-sharing requirements for those beneficiaries who elect to receive care from high-value providers, similar to an effective strategy being deployed in the private sector**.**

Fairness/Sustainability

HFMA supports repealing and replacing the SGR in a fiscally responsible manner. Doing so otherwise would only jeopardize beneficiaries and the stability of the delivery system in the long-term.

According to MedPAC's most recent analysis, hospitals' overall Medicare margin declined from -4.5 percent in 2010 to -5.8 percent in 2011.[3] Compounding this, projected reductions in Medicare and Medicaid reimbursement resulting from the Affordable Care Act (ACA), Budget Control Act, and American Taxpayer Relief Act exceed $360 billion over the next 10 years.

Therefore, we are deeply concerned about the financial viability of hospitals and health systems over the long-term. These concerns are supported by future projections of hospitals' financial performance from the CMS Actuary. According to estimates, by 2019 15 percent of hospitals will have *negative total margins* as a result of the payment update productivity cuts included in the Affordable Care Act.[4] This

[3] http://medpac.gov/chapters/Mar13_Ch03.pdf
[4] http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/2010TRAlternativeScenario.pdf

analysis does not include the effects of sequestration or offsets from prior fixes to the SGR, which will exacerbate the problem.

Simplicity

In order for the new payment system to achieve Medicare's goal of high-quality, low-cost care, there are several administrative barriers that need to be addressed.

1) Legal Obstacles to Provider Collaboration:
   The thicket of laws regulating behavior and relationships among providers was developed as a result of the unintended incentives embedded in the fee-for-service reimbursement system. However, in order for providers to become accountable for the care provided to Medicare beneficiaries, they must establish a greater level of clinical and financial integration than is currently permitted.

   Recommendation: HFMA strongly recommends that the proposal include provisions updating Stark, anti-kickback, civil monetary penalty, anti-trust, and tax-exempt statutes to better reflect the operational environment that will exist under value-based reimbursement mechanisms. These provisions should be less onerous than what providers face today when they attempt to form clinically integrated networks. Instead of requiring significant scrutiny and prior approval of arrangements, the proposal should require that various regulatory bodies develop standard guidelines for acceptable arrangements that provide safe harbor if followed. Also, where there are instances of regulatory authorities with overlapping jurisdiction, the proposal should assign jurisdiction to a single agency.

2) Access to Beneficiary Claims Data:
   In instances where provider reimbursement will be based on quality and efficiency measures, caregivers will need access to timely beneficiary claims data to understand utilization patterns and identify opportunities within their practices and the care continuum to improve quality and reduce cost. However, few physician practices have access to the necessary human and technological resources to convert high volumes of claims data into actionable information in a timely manner. Additionally, investments in the capabilities to do this are subject to significant economies of scale. It is not practical or economically efficient to have thousands of providers across the country replicating this capability.

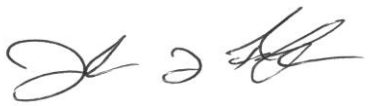
   Recommendation: HFMA recommends that the proposal include a mechanism to process the data for providers and generate reports that organizations can use to improve quality and the efficiency of care delivery.

   To ensure that the reports are actionable, CMS should convene meetings with all stakeholders to understand the data requirements and formats that are most beneficial. This will ensure that all physicians have access to timely, actionable patient level utilization data.

HFMA looks forward to any opportunity to provide assistance or comments to support Congress's efforts to repeal and replace the SGR. As an organization, we take pride in our long history of providing balanced, objective financial technical expertise to Congress, CMS, and advisory groups.

We are at your service to help Congress gain a balanced perspective on this complex issue. If you have additional questions, you may reach me or Richard Gundling, Vice President of HFMA's Washington, DC, office, at (202) 296-2920. The Association and I look forward to working with you.

Sincerely,



Joseph J. Fifer, FHFMA, CPA
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About HFMA

The Healthcare Financial Management Association (HFMA) provides the resources healthcare organizations need to achieve sound fiscal health in order to provide excellent patient care. With more than 39,000 members, HFMA is the nation's leading membership organization of healthcare finance executives and leaders. HFMA helps its members achieve results by providing education, analysis, and guidance, and creating practical tools and solutions that optimize financial management. The organization is a respected and innovative thought leader on top trends and challenges facing the healthcare finance industry. From addressing capital access to improved patient care to technology advancement, HFMA is the indispensable resource for healthcare finance.