January 29, 2015

The Honorable Kevin Brady  
Chairman  
U.S. House Committee on Ways and Means, Subcommittee on Health  
Attention: Ms. Lisa M. Grabert, Professional Staff Member  

Re: Hospital Improvements for Payment (HIP) Act of 2014 Discussion Draft  
Submitted via HDDWAMR@mail.house.gov  

Dear Chairman Brady,

Trinity Health appreciates the work of the Ways and Means Health Subcommittee to acknowledge the complex nature of our current reimbursement system and recognize the need for a comprehensive solution to address many of its inherent problems. Trinity Health believes that any solution needs to move us toward a system that advances better health, better care, and lower costs.

Trinity Health is one of the largest multi-institutional Catholic health care delivery systems in the nation. It serves people and communities in 21 states with 86 hospitals, 128 continuing care facilities and home health and hospice programs that provide nearly 2.8 million visits annually. With annual operating revenues of about $13.6 billion and assets of about $19.3 billion, the organization returns almost $900 million to its communities annually in the form of charity care and other community benefit programs. Trinity Health employs about 89,000 people, including 3,300 employed physicians.

Trinity Health is encouraged by the Committee’s interest in addressing several perplexing issues with Medicare hospital prospective payment systems. However, we have substantial concerns about the proposed short-stay approach. We support the following policy elements in the Committee’s discussion draft:

- Repeal of the 0.2 percent payment reduction that accompanied the two-midnight rule;
- Six-month continuation of the enforcement delay of the two-midnight policy;
- Transition period for developing a short-stay policy solution;
- Continued reforms to the Recovery Audit Contractors (RACs) program;
- Extension of the moratorium on enforcement of the direct supervision requirements for outpatient therapeutic services furnished in Critical Access Hospitals (CAHs);
- Removal of the 96-hour criterion of the physician certification requirement as a condition of payment for CAHs;
- Incorporation of an adjustment for sociodemographic factors in the Hospital Readmissions Reduction Program;
- Establishment of a comprehensive, voluntary bundled payment program in Medicare;
- Update to CMS regulations regarding pass-through dollars for hospital-based nursing schools;
• Changes to allow nurse practitioners, clinical nurse specialists, physicians assistants or certified nurse midwives to meet documentation requirements for ordering a hospital stay; and
• Enhancements to the availability of Medicare data to qualified entities.

Trinity Health strongly opposes the Committee’s proposal to weaken the prohibition on physician self-referral to new physician-owned hospitals and loosen the restrictions on the growth of grandfathered hospitals that were set forth in the Affordable Care Act (ACA).

Remarks Specific to the Proposed New Short Stay Payment Methodology

Trinity Health agrees with the concerns included in comments offered by the American Hospital Association (AHA) and Premier, specifically as they pertain to:

• The complexity of establishing a new short-stay payment system;
• Paying hospitals in a site neutral manner (i.e., not making IME and DSH payments to eligible hospitals);
• Not specifying whether the new payment system would be budget neutral;
• Use of a new wage index based upon BLS data;
• Dual submission of claims in order to build HPPS;
• The lack of clarity in the proposed per diem payment structure;
• New regulatory burdens that would arise from having to submit multiple claims; and
• RAC reform that does not extend far enough to address the significant administrative and financial burden on hospitals.

Trinity Health believes that changes to the existing Inpatient Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS) could be made to address short stays and overnight observation cases. Separate MS-DRG weights could be established for short stay cases in selected MS-DRGs. By having two weights to choose from, a discharge could be assigned to one weight if it was short stay and a different weight if it exceeded the short stay threshold. Another option would base short-stay policy on post-acute care transfer policy, which reimburses hospitals a graduated per-diem rate rather than a full DRG payment rate. CMS could develop a payment amount that is empirically based on actual charges in short-stay cases compared to actual charges for all cases in the MS-DRGs to which the policy would apply. An empirically based formula would ensure that the payment is adequate to cover the cost of the services provided. This is very similar to the per diem proposal in this discussion draft. Under either of these alternative methods, changes must be made in a budget neutral manner.

The establishment of an altogether new payment system adds complexity and tightens linkage of acute care payment to fee-for-service reimbursement at a time when the industry, including commercial payers, is moving toward reimbursement for value and outcomes. For this reason, we encourage the Committee to, instead, explore changes to the Medicare program that would hasten progress toward bundled payment programs, accountable care models and quality and outcomes-based payment. Trinity Health is a member of the Health Care Transformation Task Force (Task Force), which brings together patients, plans, providers and purchasers to align private and public sector efforts to clear the way for a sweeping transformation of the U.S. health care system in the next five years. Trinity Health and the other Task Force members believe that our country cannot continue down the path of fee-for-
service medicine that has made health care costly and made patient care fragmented, duplicative and oftentimes unsafe.

Members of the Task Force are committed to rapid, measurable change, both for ourselves and our country. Our plan and provider members have committed to put 75 percent of their business into value-based payment arrangements by 2020 and call on the rest of the health system to achieve the same objective. And our purchaser and patient members commit to creating and sustaining the demand, support and education of their constituencies necessary to reach this goal.

In close, we are grateful for the opportunity to review the discussion draft and to submit these comments for your consideration. Trinity Health looks forward to continuing to work with Congress on these important concerns and issues. If you have any questions about our comments, please feel free to contact me at 734.343.0824 or wellstk@trinity-health.org.

Sincerely,

Tonya K. Wells
Vice President, Public Policy & Federal Advocacy
Trinity Health