American Hospital Association

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October 27, 2016

United States Senate
Washington, DC 20510

Dear Senator:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, I am writing to share the American Hospital Association's (AHA) legislative priorities for the remainder of this session of Congress.

America's hospitals appreciate the leadership and support many in Congress have shown this year on numerous issues important to patients and the hospitals and health systems that serve them. As the Congress considers year-end legislation, there are five issues in particular where we urge you to take immediate action. They are:

1. Addressing the consequences of the Bipartisan Budget Act on Medicare outpatient payment to hospital-based clinics that were under development at the time of passage;
2. Establishing a socioeconomic adjustment in the readmissions program;
3. Extending the Rural Community Hospital Demonstration Program;
4. Addressing "25% Rule" relief for long-term care hospitals; and
5. Ensuring flexibility in physician supervision for critical access hospitals.

All of these priorities would have a meaningful impact on access to care and are included in legislation that has been introduced this session; some have already passed one body of Congress. Our concerns are detailed below.

HOSPITAL OUTPATIENT DEPARTMENTS UNDER DEVELOPMENT

Many in Congress clearly understand the unintended consequences of a provision in last year's Bipartisan Budget Act (BiBA) that severely impacted hospital outpatient facilities under development at the time of enactment and jeopardized access to patient care. Under current law, facilities operating before Nov. 2, 2015 are "grandfathered" and can continue to be paid at the hospital outpatient department (HOPD) rate, while new facilities opening after Nov. 2, 2015 are capped at the lower Physician Fee Schedule rate. But the BiBA did not provide for HOPDs that had already begun planning and construction and invested millions of dollars and countless man hours to build facilities based on the prior reimbursement amounts. In addition, the way BiBA was developed, with no hearings or committee consideration and with legislative text released

approximately one week before it was signed into law, put those HOPDs in an unfair and untenable situation.

This concern is addressed in the Helping Hospitals Improve Patient Care Act of 2016, H.R. 5273, by moving the grandfather date from Nov. 2, 2015 to Dec. 31, 2016, or 60 days after enactment, whichever is later. This will allow HOPDs that narrowly missed the November 2015 deadline, but will open shortly, to qualify for the higher HOPD rate. For those select HOPDs that would qualify, this legislation provides significant relief, and we are supportive of the legislation on their behalf. Unfortunately, because hospital construction projects take a long time to bring to completion, some HOPDs that were underway on Nov. 2, 2015 will not be completed by Dec. 31, 2016 in order to qualify for the grandfather. We would like to continue to work with the Congress to find additional ways to address the issue. At the same time, we recognize that H.R. 5273 is a necessary action.

SOCIOECONOMIC STATUS IN THE MEDICARE READMISSIONS PROGRAM

We also support the policy in Section 102 of H.R. 5273, "Establishing Beneficiary Equity in the Medicare Hospital Readmission Program," which recognizes that measures used in Medicare's Hospital Readmissions Reduction Program need to be adjusted to account for socioeconomic status. Under this section, there would first be a transitional risk adjustment based on the proportion of patients a hospital treats that are dually eligible for Medicare and Medicaid. The Secretary would be able to permanently substitute a more refined methodology following the analysis required by the Improving Medicare Post-Acute Care Transformation Act of 2014. We greatly appreciate the inclusion of this provision in the legislation.

EXTENSION OF THE RURAL COMMUNITY HOSPITAL (RCH) DEMONSTRATION PROGRAM

We also are supportive of the inclusion of Section 103 of H.R. 5273, the "Five-Year Extension of the Rural Community Hospital Demonstration Program." This provision requires the Secretary to extend the current-law RCH demonstration for an additional five years. This program has become vital to participating hospitals and is providing valuable data on potential new models for these vulnerable hospitals.

'25% RULE' RELIEF FOR LONG-TERM CARE HOSPITALS (LTCHS)

For LTCH referrals that exceed a specified threshold, the "25% Rule" policy reduces the Medicare payment from the LTCH rate to a far lower amount that is equivalent to an inpatient prospective payment system payment. This policy arbitrarily penalizes LTCH admissions based on the origin of an LTCH referral, with complete disregard for the patient's medical necessity for LTCH services. The rule was intended to reduce "inappropriate" admissions to LTCHs; however, its focus on referral source rather than a patient's clinical status means that the Centers for Medicare & Medicaid Services (CMS) would reduce LTCH payments for medically-appropriate care in the LTCH setting.

The 25% Rule is wholly outdated given the major LTCH transformation underway due to the BiBA's implementation of site-neutral payment. As of October 2015, this payment change is

reshaping the LTCH field by reducing payment by 73 percent for one out of every two LTCH cases. Given the magnitude of this payment cut, further 25% Rule burdens have become even more inappropriate.

For these reasons, we urge your support for H.R. 5713, The Sustaining Healthcare Integrity and Fair Treatment Act of 2016. Your support of regulatory relief from the 25% Rule is vital, especially given the level of change LTCHs currently face. We look forward to working with you to pass this important legislation so that meaningful relief can be achieved.

SUPERVISION OF HOSPITAL OUTPATIENT THERAPEUTIC SERVICES

As of Jan. 1, 2016, CMS contractors are permitted to enforce the direct supervision policy on all hospitals and critical access hospitals (CAHs). Given the shortage of medical professionals, this policy may force small and rural hospitals and CAHs to limit their hours of operation or cut services to comply with the provision, resulting in reduced access to outpatient care in communities across America. The AHA continues to urge Congress to provide relief from this short-sighted policy by enacting bipartisan legislation (S. 1461/H.R. 2878) that would temporarily extend the enforcement delay through the end of 2016. We also support the Protecting Access to Rural Therapy Services Act of 2015 (S. 257/H.R. 1611), which would provide permanent relief from this flawed policy by:

- Adopting a default standard of "general supervision" for outpatient therapeutic services and supplement with a reasonable exceptions process with provider input to identify those specific procedures that require direct supervision;
- Ensuring that, for CAHs, the definition of "direct supervision" is consistent with the CAH conditions of participation that allow a physician or non-physician practitioner to present within 30 minutes of being called; and
- Prohibiting enforcement of CMS's retroactive reinterpretation that the "direct supervision" requirements applied to services furnished since Jan. 1, 2001.

We appreciate your willingness, as well as that of the committees of jurisdiction and their staffs, to work with the hospital field to find solutions during the last weeks before adjournment and we appreciate the opportunity to continue that work as legislation moves to floor consideration.

Please contact me if you have questions or feel free to have a member of your team contact Erik Rasmussen, vice president for legislative affairs, at erasmussen@aha.org or (202) 626-2981.

Sincerely,

//s//

Thomas P. Nickels
Executive Vice President