

**Testimony
of the
American Hospital Association
before the
Committee on Ways and Means,
Subcommittee on Health
of the
United States House of Representatives**

“Expiring Medicare Provider Payment Provisions”

September 21, 2011

Good morning, Mr. Chairman and distinguished members of the Committee. I am Richard Umbdenstock, president and CEO of the American Hospital Association (AHA). On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 42,000 individual members, the AHA appreciates the opportunity to testify regarding certain expiring Medicare provider payment provisions and their importance to Medicare beneficiaries, and we applaud the Committee for holding this hearing.

SECTION 508

The area wage index is greatly flawed in many respects. It is highly volatile from year to year, is self-perpetuating (in that hospitals with low wage indexes are unable to increase wages to become competitive in the labor market) and is based on unrealistic geographic boundaries. These fundamental problems warrant a full and comprehensive re-evaluation and redesign of a system that CMS itself acknowledges is burdensome and of questionable integrity.



In an attempt to introduce more equity into a system that is so flawed, certain exceptions to the wage index have been created. One example is Section 508 of the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003*, which allows certain qualifying hospitals to receive wage index reclassifications and assignments that they otherwise would not have been eligible to receive. About 100 hospitals are reclassified under Section 508. The program was originally effective for discharges beginning April 1, 2004, and ending March 31, 2007, but has been extended several times and is now scheduled to end October 1, 2011.

The Section 508 program provides critical help to hospitals with wages that are not representative of their area, but that slip through the cracks of the current reclassification criteria. Specifically, many hospitals apply each year to the Medicare Geographic Classification Review Board (MGCRB) for reclassification to another area to receive a higher area wage index. The current criteria for reclassification require a hospital to be in close geographic proximity to the area to which it wants to reclassify and to have wages that are a certain amount higher than hospitals in its own area, but comparable to the hospitals in the area to which it seeks reclassification. The 508 criteria were designed to accommodate categories of hospitals that, based on CMS experience, fall just beyond the current regulatory reclassification criteria. The program provides them with the resources necessary to be able to attract and retain a sufficient workforce and best serve their beneficiaries.

LOW-VOLUME ADJUSTMENT

The ACA improved the low-volume adjustment for fiscal years 2011 and 2012. For these years, a low-volume hospital is defined as one that is more than 15 road miles (rather than 35 miles) from another comparable hospital and has up to 1,600 Medicare discharges (rather than 800 total discharges). An add-on payment will be given to qualifying hospitals, ranging from 25 percent for hospitals with fewer than 200 Medicare discharges to no adjustment for hospitals with more than 1,600 Medicare discharges. About 500 hospitals are receiving the low-volume adjustment in FY 2011.

Medicare seeks to pay efficient providers their costs of furnishing services. However, certain factors beyond providers' control can affect the costs of furnishing services, Patient volume is one such factor and is particularly relevant in small and isolated communities where providers frequently cannot achieve the economies of scale possible for their larger counterparts. Although a low-volume adjustment had existed in the inpatient prospective payment system (PPS) prior to FY 2011, CMS had defined the eligibility criteria so narrowly that only two to three hospitals qualified each year. The improved low-volume adjustment better accounts for the relationship between cost and volume and helps level the playing field for low-volume providers and also sustains and improves access to care in rural areas. If it were to expire, these providers would once again be put at a disadvantage and have severe challenges serving their communities.

MEDICARE-DEPENDENT HOSPITAL PROGRAM

The network of providers that serves rural Americans is fragile and more dependent on Medicare revenue because of the high percentage of Medicare beneficiaries who live in rural areas. Additionally, rural residents on average tend to be older, have lower incomes and suffer from higher rates of chronic illness than their urban counterparts. This greater dependence on Medicare may make certain rural hospitals more financially vulnerable to prospective payment.

To reduce this risk and support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges, Congress established the Medicare-dependent hospital (MDH) program in 1987. The approximately 200 MDHs are paid for inpatient services the sum of their PPS payment rate plus three-quarters of the amount by which their cost per discharge exceeds the PPS rate. These payments allow MDHs greater financial stability and leave them better able to serve their communities.

OUTPATIENT HOLD-HARMLESS PAYMENTS FOR SMALL RURAL HOSPITALS AND SOLE COMMUNITY HOSPITALS

When the outpatient prospective payment system (OPPS) was implemented, Congress made certain rural hospitals with 100 or fewer beds eligible to receive an additional payment adjustment, referred to as “hold harmless” transitional outpatient payments (TOPs). “Hold harmless” TOPs were intended to ease their transition from the prior reasonable cost-based payment system to the OPPS system. That provision originally expired on January 1, 2004; however, because of concerns about the financial stability of these small rural hospitals, Congress has extended the provision every year since and has subsequently expanded it to apply to equally vulnerable sole community hospitals (SCHs).

Under this provision, the hospital’s Medicare outpatient payment is increased by 85 percent of the amount of the difference between the aggregate reasonable cost-based payment the hospital would have received prior to the enactment of the *Balanced Budget Act of 1997* (i.e., “pre-BBA amount”) and the aggregate payments the hospital received under the OPPS. In 2010, 258 small rural hospitals and SCHs received \$93.7 million in “hold harmless” TOPs¹. Due to the expiration of legislative authority, these hospitals will cease to be eligible for TOPs on December 31, 2011.

The AHA is concerned that the small rural hospitals and SCHs that are currently eligible for TOPs will be significantly harmed if the policy is allowed to expire. The average amount that eligible hospitals received in 2010 under this provision was \$363,194. While this amount may seem small, the impact of these payments on the hospitals is significant. Hospitals that receive TOPs already have Medicare payments that are well below their Medicare costs, with payments averaging about 82 percent of costs. By contrast, other hospitals have a significantly higher payment-to-cost percentage – about 91 percent. In fact, 96 percent of all TOPs-eligible hospitals have payment-to-cost percentages that are below the national average. If TOPs were to expire, TOPs-eligible hospitals would see their payment-to-cost percentage plummet to 75 percent. This would represent a cut of about 16 percent to Medicare outpatient payments for these hospitals. With such a large gap between payments and costs, it would be difficult for these vulnerable

hospitals to continue to provide access to critical outpatient services, such as emergency department services and chemotherapy.

PAYMENT FOR THE TECHNICAL COMPONENT OF PHYSICIAN PATHOLOGY SERVICES FURNISHED TO HOSPITAL PATIENTS

Medicare has long paid independent laboratories directly under the physician fee schedule for both the preparation (technical component) and interpretation (professional component) of patient specimens obtained from hospital inpatients and outpatients. They did so because many hospitals do not have the capacity to furnish these services within their in-house labs and therefore contract with independent labs for their pathology services.

In 1999, CMS proposed eliminating direct Medicare payments to labs for the technical component (TC) services. This proposal was based on questionable assumptions and would have created significant hardships for both labs and the hospitals they serve. At the request of stakeholders, CMS delayed implementation of the policy for one year to allow sufficient time for hospitals and independent labs to negotiate arrangements. Subsequent congressional action over the last 11 years has allowed for the continuation of separate billing for TC services for a large number of hospitals that had arrangements with independent labs in place prior to CMS' 1999 proposal. Most recently, under the *Medicare and Medicaid Extenders Act* (MMEA), Congress extended the "grandfathering" of these hospital arrangements through December 31, 2011.

This grandfather provision allows independent labs to bill Medicare directly for physician pathology TC services provided to hospital patients. In the absence of this provision, these services would be subject to the Medicare hospital prohibition against unbundling payments, which would require hospitals to provide directly, or under arrangement, all services furnished to hospital patients and bill Medicare directly for these services.

The history of the development of the hospital PPS systems and CMS' guidance on physician pathology TC costs makes it clear that the independent laboratory TC costs have never been included in the MS-DRGs. If the grandfather provision is allowed to expire, the increased costs that hospitals will bear will never be compensated through the regular budget neutral re-weighting of hospital DRGs.

Further eliminating direct payment to independent labs would be especially burdensome for small and rural hospitals, which often lack the surgical volume necessary to support in-house services and instead rely heavily on independent labs for physician pathology services. These hospitals would have to establish costly and administratively complex new billing systems and procedures, stretching already scarce resources and potentially forcing them to reduce the variety of services they provide. Further, the hospitals would also have to pay the independent labs directly for their services, despite the fact that Medicare DRG payments do not include these costs.

REASONABLE COST BASED PAYMENT FOR OUTPATIENT CLINICAL LAB TESTS IN SMALL HOSPITALS LOCATED IN QUALIFIED RURAL AREAS

The *Medicare Modernization Act of 2003* (MMA) included a provision requiring reasonable cost reimbursement for outpatient clinical laboratory tests furnished by hospitals with fewer than 50 beds in certain “qualified rural areas” for cost reporting periods beginning on July 1, 2004, through 2008. A “qualified rural area” is defined as an area with a population density in the lowest quartile of all rural county populations, a designation that CMS refers to as “super rural.” The subsequent enactment of the ACA and the MMEA re-instituted and extended the reasonable cost reimbursement provisions for cost reporting periods beginning on or after July 1, 2010, through June 30, 2012. In the absence of this provision, reimbursement for hospital outpatient clinical lab services in these “super rural” communities would revert to the rates under the Clinical Laboratory Fee Schedule (CLFS).

Extending this provision has critical implications for patients and hospitals located in sparsely populated rural areas. Despite their small size and their smaller base of patients, these hospitals still have to maintain a broad range of basic services, including laboratory services, to meet the health care needs of their communities. In fact, in these communities, the hospital may be the only source of clinical laboratory testing services for miles. Laboratory tests provide critical information on which sound medical decisions can be made. It has been estimated that 70 percent of all medical decisions are based on laboratory testing.

Congress initially enacted reasonable cost reimbursement for outpatient clinical lab tests in these small rural hospitals because they have fewer patients over which to spread fixed expenses and therefore costs per case tend to be higher. Payment under the CLFS is clearly inappropriate for these extremely vulnerable hospitals. Clinical laboratory testing has been subject to significant payment freezes and cuts over the last decade. Medicare payment amounts for clinical laboratory services have been reduced by about 40 percent in real (inflation-adjusted) terms over the past 20 years. In fact, since 1997, CLFS payments have been increased only twice, in 2003 (by 1.1 percent) and 2009 (by 4.5 percent). As required by legislation, in 2010 and 2011 the CLFS payments were actually reduced, by 1.9 percent and 1.75 percent, respectively. The laboratory-specific cut and the productivity adjustment included in the ACA is estimated to result in a cumulative 20 percent cut over 10 years.

Allowing the reasonable cost reimbursement provision to expire would put critical lab testing at these hospitals at risk and would create serious access problems for vulnerable seniors whose health depends on lab testing. Hospitals are already being underpaid for laboratory services under the current CLFS. Extending the applicability of this provision will help ensure patients’ ability to get the testing they need.

AMBULANCE ADD-ONS PAYMENTS

Small patient volumes and long distances put tremendous financial strain on ambulance providers in rural areas. To help alleviate this situation and ensure access to ambulances for patients in rural areas, the *Medicare Prescription Drug, Improvement, and Modernization Act*

increased payments by 2 percent for rural ground ambulance services and also included a super rural payment for counties are in the lowest 25% in population density. Congress, in the *Medicare Improvements for Patients and Providers Act (MIPPA)*, raised this adjustment to 3 percent for rural ambulance providers.

Congress appropriately decided that these additional rural payments were necessary and important because rural ambulance providers incur higher per-trip costs because of longer travel distances and fewer transports of patients. These provisions ensure that ambulance services are more appropriately reimbursed and that beneficiaries in rural and super rural areas will have access to emergency transport services.

COST REDUCING POLICIES

As the Committee is examining these policies and their impact on costs and on Medicare beneficiaries, there are a number of proposals that AHA supports that would reduce Medicare spending and could be included in year-end Medicare legislation. While there are a number of policies AHA supports or is willing to discuss, including restructuring components of the Medicare program, I would like to specifically highlight long-term care hospital criteria, 340B drug pricing, and medical liability reform.

Long-Term Care Hospital Criteria

Establishing facility criteria for long-term care hospitals would both define the care delivered in these facilities as well as reduce costs to Medicare. S. 1486, the *Long-Term Care Hospital Improvement Act of 2011*, accomplishes this.

As you know, LTCHs provide hospital care for a specific patient population – medically complex, long-stay patients. LTCHs include both free-standing facilities and facilities co-located within hospitals, and treat a wide variety of conditions such as respiratory failure with ventilator dependency, infections, patients with complex wounds and trauma patients.

The Medicare Payment Advisory Commission and other policymakers have called for new LTCH patient and facility criteria as the best policy approach to ensure the right patients are treated in LTCHs. To do this, Congress should establish comprehensive patient and facility criteria to distinguish LTCHs from all other provider settings. S. 1486 was developed with carefully considered input from hospitals and clinicians who work in this medically complex area and would accomplish this goal.

The legislation implements patient criteria, facility criteria and the retrospective test to ensure that LTCHs are focused on treating high-acuity patients. The patient criteria standard ensures all potential LTCH patients are screened prior to admission through a standardized process that is overseen by a physician, with new patients examined by an LTCH physician during the first 24 hours to assess whether LTCH-level care is reasonable and necessary. The legislation's facility criteria would establish common requirements for the programmatic, personnel and clinical operations of an LTCH.

Additionally, LTCHs should demonstrate that 70 percent of LTCH cases meet criteria that demonstrate that LTCHs focus on treating medically complex patients and patients requiring extended stays.

In the absence of LTCH criteria, CMS instituted the “25% Rule” in 2004 to reduce access to LTCHs based on a patient’s prior site of care. The 25% Rule is a blunt payment policy necessitated by the lack of criteria based on the clinical needs of patients; the very short-stay outlier (VSSO) policy and CMS’s planned budget neutrality adjustment were in turn necessitated as blunt payment containment policies. This legislation replaces these policies with patient and facility criteria that clarify a specific and unique role for LTCHs in the continuum of care, ensure patients are admitted based on their medical needs, and bring uniformity and cost containment to the LTCH field.

Congress should support criteria that ensure LTCHs provide quality hospital care to the appropriate patients. Furthermore, in concert with establishing facility and patient criteria, Congress should repeal the 25% Rule, budget-neutrality adjustment, and VSSO policies. The Moran Company scored the proposal as saving \$500 million over 10 years.

340B Drug Discount Program

In 1990, Congress established the Medicaid drug rebate program, which requires drug manufacturers to enter into and have in effect a rebate agreement with the Secretary of the Department of Health and Human Services. The rebate agreement requires that pharmaceutical manufacturers supply their products to state Medicaid programs at the manufacturer's "best price" – that is, the lowest price offered to other purchasers.

Section 340B of the *Public Health Service Act* expanded the program. It requires pharmaceutical manufacturers participating in Medicaid to sell outpatient drugs at discounted prices to taxpayer-supported health care facilities that care for uninsured and low-income people. Covered entities include community health centers, children’s hospitals, hemophilia treatment centers, and public and nonprofit disproportionate share hospitals (DSH) that serve low-income and indigent populations.

The AHA supports extending the 340B discounts to the purchases of drugs used during inpatient hospital stays for safety-net hospitals. Many of these hospitals are in urban settings and are the health care safety net for their communities. This would allow these hospitals to further stretch their limited resources and relieve them of the burden of carrying two separate inventories and pricing structures for inpatient and outpatient drugs.

The AHA also supports extending the 340B drug program discounts to critical access hospitals (CAHs), sole community hospitals (SCHs), rural referral centers (RRCs) and Medicare-dependent hospitals for inpatient stays. Currently, CAHs, and SCHs and RRCs with a DSH adjustment equal to or greater than 8 percent are eligible for the outpatient discount. These hospitals serve low-income patients in rural areas by providing emergency and health care services and are the sole source of care for patients in their communities.

This program is a “win-win” for taxpayers, as well as for hospitals. The 340B program generates savings for the Medicaid program and also reduces Medicare costs, as CAHs are paid 101

percent of their inpatient and outpatient costs by Medicare, and the 340B pricing mechanism will lower their drug costs.

Medical Liability Reform

The high costs associated with the current medical liability system not only harm hospitals and physicians, but also patients and their communities. Across the nation, access to health care is being negatively impacted as physicians move from states with high insurance costs or stop providing services that may expose them to a greater risk of litigation. The increased costs that result from the current flawed medical liability system not only hinder access to affordable health care, they also threaten the stability of the hospital field, which employed 5.3 million people in 2009, and continues to be one of the largest sources of private-sector jobs.

An estimated \$50 to \$100 billion is spent annually on defensive medicine – services not provided for the primary purpose of benefiting the patient, but rather to mitigate the risk of liability. To help make health care more affordable and efficient, the current medical liability system must be reformed.

There are proven models of reform enacted in several states across the country, and in fact California’s model has previously been the core of legislation passed by the United States House of Representatives. The AHA supports this legislation, H.R. 5, the *Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011*. This and other legislative proposals will likely be considered during this 112th session of Congress, and we applaud the work and leadership Members of this Committee have shown on the issue thus far.

Reduction of costs via medical liability reform will have a direct and indirect impact on Medicare payment on physicians: directly, the component of the Medicare physician payment rate formula that includes medical liability insurance will be reduced; also directly, as CBO has found when it scored H.R. 5 as saving \$62 billion over 10 years, decreased utilization will yield a savings to the program. Indirectly, medical liability reform increases physician net income via reduced medical liability insurance costs, reduced individual (and practice) exposure to a liability judgment, and reduced time practicing defensive medicine thus freeing that time for other endeavors.

CONCLUSION

Over the years, Congress has enacted several provisions to address the special challenges rural hospitals encounter in delivering health care services to the communities they are committed to serving. The American Hospital Association urges the Committee to recognize that the circumstances that necessitated these provisions continue to exist, and therefore it is appropriate that they be extended.

ⁱ The Congressional Budget Office estimate for the cost of this provision is \$200 million. We believe that this amount is too high in that it erroneously takes into account hold-harmless TOPs payments for cancer hospitals and children’s hospitals, which are accorded a permanent hold-harmless status under the Social Security Act. Our estimate is that the provision costs approximately \$100 million.