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**Statement  
of the  
American Hospital Association  
before the  
Health Subcommittee  
of the  
Committee on Ways and Means  
of the  
U.S. House of Representatives**

**“Hearing on the President’s and Other Bipartisan Proposals to Reform  
Medicare Post-Acute Care Payments”**

**June 14, 2013**

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates this opportunity to provide input on proposals to reform Medicare’s post-acute care payment systems. While the AHA supports efforts to bring meaningful reform to the post-acute care field, many of the proposals highlighted in the president’s fiscal year (FY) 2014 budget proposal, and the proposals and research currently under development by the Medicare Payment Advisory Commission (MedPAC) and the Centers for Medicare & Medicaid Services (CMS), include arbitrary cuts that would threaten patients’ access to post-acute care services.

Our detailed concerns follow.



## THE PRESIDENT'S FY 2014 BUDGET

### Market Basket Update

In recent years, post-acute care providers have faced congressional scrutiny that has resulted in substantial payment cuts. Regulatory and statutory payment reductions and restrictions have been considerable for all four post-acute care sectors – long-term care hospitals (LTCH), inpatient rehabilitation facilities (IRF), skilled nursing facilities (SNF) and home health (HH) providers. *The Patient Protection and Affordable Care Act of 2010* (ACA) included productivity offsets and other reductions to updates, quality reporting requirements and significant HH cuts. Additionally, CMS has implemented further major payment and operational changes. Most recently, post-acute care providers have endured reductions as a result of the *Budget Control Act's* sequestration.

Despite these numerous payment reductions, the president's FY 2014 budget proposal calls for an additional market basket reduction for all post-acute care providers that would result in a \$79 billion payment cut over 10 years. **Given the number and magnitude of the cuts already faced by the post-acute sector, the AHA opposes these additional market basket cuts.**

### IRF 60% Rule

The "60% Rule" helps define IRFs by requiring that 60 percent of cases have one of 13 qualifying medical conditions. **The AHA opposes the president's FY 2014 budget proposal to return the threshold for this rule to the 75-percent level.** The president's budget proposal overlooks the fact that IRFs continue to treat sicker patients every year and simultaneously produce better outcomes. Increasing the threshold is also unnecessary, as IRFs already face stringent admission controls, which were tightened in 2010, and yield a distinct IRF patient population. Finally, it would impose a barrier to IRF services that is excessive and unwarranted.

### IRF-SNF Site Neutral Payments for Certain Procedures

The president's FY 2014 budget proposal also proposes to reduce IRF payments to a SNF-comparable rate for three conditions. **The AHA opposes this effort because IRFs and SNFs are not comparable settings.** IRFs exclusively treat patients who require both hospital-level care and intensive rehabilitation after an illness, injury or surgery, and are prohibited from treating SNF-level patients. Only in an IRF do beneficiaries receive three-plus hours of therapy per day as part of a plan of care that is developed and overseen by a specialty physician and carried out by an inter-disciplinary medical team. As a result, the patient population and scope of services found in IRFs are unique from those found in SNFs and other settings. In addition, IRFs are required to submit data that show that IRF patients are continuing to produce improved functional outcomes – even as the overall severity of IRF patients increases. Finally, CMS reported in the August 2011 SNF final rule that IRFs have a far higher rate of discharging patients to the community (IRFs: 81 percent; SNFs: 46 percent), and a far lower readmission rate (IRF: 9.4 percent; SNF: 22.0 percent).

## **CMS's FY2014 LTCH PROPOSED RULE**

The AHA is extremely concerned about two provisions in CMS's LTCH prospective payment system (PPS) proposed rule for FY 2014 – CMS's plans to allow the current "25% Rule" relief to expire, and its current research on major reforms for the LTCH PPS. Both of these changes would inhibit the ability of LTCHs to continue to treat the sickest patients – a role that is notably distinct from other provider settings. They are overly drastic and ill-timed given the fundamental transformation of the delivery system that is in process.

LTCHs are adapting to a wide array of regulatory demands, including the rollout of the LTCH quality reporting program, the transition to ICD-10, implementation of electronic health records, and efforts to integrate with other providers and payers in their communities. These adaptations, when paired with the pending paradigm shift toward paying for value instead of volume, present LTCHs with substantial regulatory fluctuation. Given this environment, the AHA urges CMS to avoid further exacerbating this demanding period of transitions and instead maintain the current 25% Rule relief.

In addition, CMS is researching a policy that would shift payments for a majority LTCH patients from the LTCH PPS to the inpatient PPS. CMS estimated that, under this research, 67 percent of LTCH cases would be subject to inpatient PPS-level payments. The remaining patients – those whom CMS would deem chronically, critically ill (CCI) – are a subset of the highest-acuity patients treated in LTCHs and their cases would continue to be paid under the LTCH PPS. The agency defines CCI patients as those who received eight or more days of intensive care unit (ICU) services during the prior stay in a general acute care hospital, and having a qualifying medical condition.

This policy would be a draconian way to achieve CMS's prior goals for the LTCH PPS, as stated in 2012 and before, of establishing criteria to more clearly define the types of patients admitted to LTCHs. We are deeply concerned that CMS has not adequately justified the need for such extreme reforms. High-acuity beneficiaries treated in LTCHs receive a very focused scope of clinical service that is uniquely concentrated on this population, and which should be preserved. **Therefore, the AHA will urge the agency to reconsider the extreme scope of its current research and instead concentrate on less severe means of raising the minimum clinical standards for LTCHs.**

## **MEDPAC RESEARCH**

At MedPAC's April meeting, staff discussed reform approaches that would eliminate the LTCH PPS and make all payments for LTCH services under the inpatient PPS. These reforms define a new subcategory of patients – CCI patients – a subset of the high-acuity for whom LTCHs would receive an increased inpatient PPS payment. MedPAC defines CCI patients as patients receiving eight or more days of ICU services in either an LTCH or during an immediately prior stay in a general acute hospital. MedPAC estimated that 40 percent of LTCH patients meet the CCI definition.

The AHA agrees with MedPAC's long-standing calls for more stringent LTCH patient and facility criteria, and we support policies that redirect to other settings LTCH patients who do not represent high-acuity, long-stay cases. However, MedPAC's current research is a notable

departure from its prior goal for the LTCH PPS, as stated in 2012 and before, of establishing criteria to identify the types of patients who would benefit from the unique services LTCHs provide. This research makes a dramatic and unfounded leap beyond addressing the problem of LTCHs treating patients who are not both long-stay and high-complexity cases. The options emanating from this research could dramatically lower payments for high-severity cases that do not fall into the CCI category, and potentially lower payments substantially, even for CCI cases.

**We are deeply concerned that the commission has not adequately justified the need for such extreme reforms, especially considering how drastically they differ from its prior goal of using criteria to define the type of patient who is appropriate for admission to an LTCH. Rather than continuing on this radical path toward elimination of the LTCH PPS, we urge consideration of more reasonable reforms that would maintain the LTCH PPS for a narrower range of appropriate cases.**

## **MEANINGFUL REFORM PROPOSALS**

### **Criteria**

The AHA supports legislative efforts to raise minimum standards for LTCH admissions. In the 112<sup>th</sup> Congress, Senator Pat Roberts of Kansas and Senator Bill Nelson of Florida introduced S. 1486, *the Long-Term Care Hospital Improvement Act*. This bill would have established both patient and facility criteria for LTCHs in order to make the LTCH setting even more distinct by further concentrating services on treating the sickest beneficiaries. *The Long-Term Care Hospital Improvement Act* sought to proactively define LTCHs and ensure LTCHs concentrate on the highest-complexity, long-stay patients. The AHA continues to advocate for the passage of this important reform proposal. This legislation is an important step toward delivery system reform since it distinguishes a unique LTCH role in communities that are reshaping their local delivery system.

### **Other Solutions to Improve Care**

The AHA believes we need real reform, not the further ratcheting of post-acute care provider payments as outlined in the president's budget proposal, and by CMS and MedPAC. Please find attached a bipartisan list of alternatives to cutting payments for hospital services. Some options Congress should consider specific to post-acute care providers include:

- Develop programs to coordinate care across settings for individuals eligible for both Medicare and Medicaid
- Eliminate barriers to developing integrated care models, such as the LTCH 25% Rule, the IRF three-hour rule and the SNF three-day stay requirement
- Improve programs to enhance care at the end of life

# Deficit Reduction Alternatives in Health Care

## Summary of the Issue

Measures to curb federal spending by trimming Medicare and Medicaid payments are options in the current deficit reduction environment. Providers already face billions of dollars in Medicare and Medicaid payment cuts. Efforts to further cut Medicare and Medicaid payments to providers jeopardize access to high quality health care services for America's seniors and the poor. True entitlement reform and approaches to change the health care delivery system are needed – not provider cuts.

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As congressional leaders and the administration have debated deficit reduction, several “plans” and proposals have emerged. These include:

- President Obama's budget proposals
- House Budget Chairman Paul Ryan's budget proposal
- The Congressional Budget Office's report on options for reducing the Federal deficit
- The National Commission on Fiscal Responsibility and Reform (Simpson-Bowles)
- The Debt Reduction Task Force (Rivlin-Domenici)
- The “Gang of 6” US senators that developed a bipartisan plan to reduce the deficit
- House Majority Leader Eric Cantor's list of spending reductions

**These various plans proposed many types of deficit reduction provisions including across-the-board reductions or sequestration, formulaic and deadline-based “triggers” of budgetary action, and specific policy alternatives. Among these options, there are many health care policy alternatives that could be used to support deficit reduction that don't simply cut Medicare and Medicaid payments. The following alternatives should be discussed and thoughtfully considered in any deficit reduction debate:**

- Modernizing cost sharing for Medicare and Medicaid
- Increasing the eligibility age for Medicare
- Increasing the FICA tax to support Medicare Part A spending
- Implementing enhanced comparative effectiveness research and programs
- Improving programs to improve care at the end of life
- Developing programs to coordinate care for individuals eligible for both Medicare and Medicaid
- Applying Medicare reforms in the ACA (such as accountable care organizations, medical homes, bundling) to Medicaid
- Increasing use of generic drugs and biologicals
- Modernizing the Medicaid long-term care benefit
- Medical liability reform
- Taxing Cadillac health plans
- Taxing junk foods and sugary drinks

These types of reforms can be used to reduce spending, improve quality, better coordinate care, enhance personal responsibility, and modernize Medicare, Medicaid and the entire health care system.

# Health Care Alternatives for Deficit Reduction

The following table provides more detail describing health care alternatives that were included in one or more of the various deficit reduction proposals and should be considered for deficit reduction.

Option	Description	Plans that include option	10-Year Savings
Medical Liability Reform	<p>Three of the plans included caps on non-economic and punitive damages. The most developed proposal in the CBO Options document would impose certain nationwide curbs on medical malpractice torts, capping non-economic damages to \$250,000; punitive damages at \$500,000 or two times the value awards for economic damages (whichever is greater); impose a "fair –share" rule (replacing joint-and-several liability); impose a statute of limitations for one year from the date of injury discover for adults; 3 years for children.</p> <p>Modify collateral source rule; impose a statute of limitations; replace joint-and-several liability with a fair-share rule; and create specialized "health courts," allow safe havens for providers who follow best practices.</p>	<p>CBO Options Ryan Budget Rivlin-Domenici</p> <p>Simpson-Bowles</p>	<p>\$62.4 Billion (CBO proposal)</p> <p>\$17 Billion</p>
Reduce Medicare Costs by Changing Cost-Sharing Structures for Medicare Part A and B	<p>Establish a single combined annual deductible for Part A and B, along with a 20 percent coinsurance for spending above deductible up to a certain amount.</p> <p>Increase the basic premium for Medicare Part B from 25% to 35% of the Program's cost. When Part B began in 1966, the premium was intended to finance 50% of the Part B costs per enrollee.</p> <p>Prohibit Medigap plans from covering the first \$550 of an enrollee's cost-sharing liabilities and limit coverage to 50% of the next \$5000 in Medicare cost-sharing.</p>	<p>Simpson-Bowles CBO Options</p> <p>CBO Options Rivlin-Domenici</p> <p>Simpson-Bowles CBO Options Cantor List</p>	<p>\$32.2 Billion</p> <p>\$241.2 Billion</p> <p>Up to \$53 Billion</p>
Raise the Age of Eligibility for Medicare to 67	Raise the age of eligibility for Medicare by 2 months every year beginning with people who were born in 1949 until the eligibility age reached 67.	Ryan Budget CBO Options	\$124.8 Billion
Pharmaceutical Pricing	<p>Require manufacturers of brand-name drugs to pay the federal government a rebate on drugs purchased by enrollees in the low-income subsidy program. The program would reflect the current rebate system for Medicaid.</p> <p>Speed up availability of generic biologics, and prohibit brand-name companies from entering into a "pay for delay" agreements with generic companies. Implement Medicaid management of high prescribers and users of prescription drugs.</p> <p>Use Medicare's buying power to increase rebates from pharmaceutical companies.</p>	<p>CBO Options Obama Budget Simpson-Bowles</p> <p>Obama Budget</p> <p>Obama Budget Rivlin-Domenici</p>	\$112.0 Billion
Slow the Growth of Federal Contributions for the Federal Employees Health Benefits Program (FEHBP)	Limit the federal government's contribution to \$5,000 towards the cost of an individual premium or \$11,000 for a family premium beginning on 1/1/13. The federal contribution would then increase annually at the rate of inflation as measured by the CPI for all urban consumers, rather than at the average weighted rate of change in FEHBP premiums. Simpson-Bowles plan would include a similar pilot program for FEHBP.	CBO Options Simpson-Bowles Cantor List	\$31.5 Billion in Mandatory Spending; \$41.9 Billion in discretionary spending
Health Care-Related Revenues	<p>Standardize the base on which the federal excise tax on alcohol is levied by using the proof gallon as the measure for all alcoholic beverages.</p> <p>Replace the 0.9% surtax on high-income taxpayers with a 1.0 percentage point increase in the total HI tax on all earnings. The HI tax rate for both employers and employees would increase by 0.5 percentage points to 1.95%, resulting in a combined rate of 3.9%.</p> <p>Impose a federal excise tax of 3 cents per 12 ounces of "sugar-sweetened" beverage.</p> <p>Impose the excise tax on employment-based health care coverage above certain limits beginning in 2014 instead of in 2018.</p>	<p>CBO Options</p> <p>CBO Options</p> <p>CBO Options Rivlin/ Domenici</p> <p>CBO Options</p>	<p>\$59.9 Billion</p> <p>\$650.8 Billion</p> <p>\$50.4 Billion</p> <p>\$310 Billion</p>
Base Social Security COLAs and Other Entitlements on the Chained CPI-U	Some policymakers have discussed changing the measure of inflation for Social Security COLAs (CPI-W) and other entitlement program COLAs currently based on CPI-U to the "chained" CPI-U. Social security COLAs are currently based on the CPI-W (consumer price index for urban wage earners and clerical workers). The chained CPI-U (C-CPI-U) is an alternative measure of inflation (also calculated by the Bureau of Labor Statistics) that more fully incorporates the effects of changes in patterns of spending and which most economists and analysts believe more accurately reflects the actual increase in the cost of living.	CBO options (Social Security only)	<p>\$112 Billion (Social Security only)</p> <p>Effect on other entitlements unknown</p>