

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

“The Current Status of the Medicare Program, Payment Systems, and Extenders”

May 18, 2017

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 the opportunity to comment for the record regarding expiring Medicare provisions of importance and other Medicare payment issues.

A number of critical Medicare payment policies that were extended in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) face expiration this year. We appreciate the Committee’s attention to these important matters and their impact on millions of Americans.

LOW-VOLUME ADJUSTMENT AND MEDICARE-DEPENDENT HOSPITAL PROGRAM

Low-volume Adjustment

Medicare seeks to pay efficient providers their costs for furnishing services. However, certain factors beyond providers’ control can affect these costs. 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 existed in the inpatient prospective payment system (PPS) prior to fiscal year (FY) 2011, the Centers for Medicare & Medicaid Services (CMS) had defined the eligibility criteria so narrowly that only two to three hospitals qualified each year.



The Affordable Care Act (ACA) improved the low-volume adjustment for FYs 2011 and 2012, and MACRA extended the adjustment through the end of FY 2017. 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 is 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 currently receive the low-volume adjustment. This 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. In addition, 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; MACRA extended this program until Oct. 1, 2017. 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.

The AHA supports the Rural Hospital Access Act of 2017 (S. 872/H.R. 1955), which would make permanent both the MDH program and the enhanced low-volume Medicare adjustment for PPS hospitals, which are vital programs for rural hospitals and the patients and communities they serve. We appreciate the leadership of Congressman Tom Reed of the Committee in introducing this legislation.

AMBULANCE ADD-ON 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 ambulance services 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 that are in the lowest 25 percent in terms of population density. Congress, in the Medicare Improvements for Patients and Providers Act (MIPPA), raised this adjustment to 3 percent for rural ambulance providers, and MACRA extended this policy until Dec. 31, 2017. Congress appropriately decided that these additional rural payments were necessary and important because rural ambulance providers incur higher per-trip costs due to longer travel distances and fewer transports of patients.

The AHA supports the Medicare Ambulance Access, Fraud Prevention and Reform Act of 2017 (S. 967), which would provide for a permanent increase in Medicare payment rates for ground ambulance services. In addition to protecting access to ambulance services through adequate payment, this legislation directs the Secretary of Health and Human Services to study how the additional payments should be modified (if at all) to account for the costs of providing ambulance services in urban, rural and super rural areas. This would ensure that federal payments are aligned with appropriate data and utilization patterns.

IMPACT ACT IMPLEMENTATION

Standardization and Interoperability of Measures

The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 requires that CMS adopt the same measurement domains for all post-acute care Quality Reporting Programs, and that the measures be “standardized and interoperable” across post-acute care facilities. However, the statute does not provide specific operational definitions of these two terms. We believe how CMS interprets these terms will have significant implications for post-acute care providers.

The AHA cautions that “complete” standardization and interoperability of measures – i.e., using the exact same measure specifications, data definitions and data collection tools across all post-acute care settings – may not always be possible, as some measures do not work well across all four settings. CMS could instead focus on achieving “topical” standardization in which all four post-acute care provider types report on the same measure topics, but using data collection instruments and definitions (e.g., rating scales) that may vary. To fulfill the requirement of “interoperability,” CMS could develop mechanisms to ensure the data are routinely shared across post-acute settings with crosswalks or other explanations of how the data from each setting are defined.

We urge Congress to help us minimize the burden of collection and reporting requirements. Post-acute care providers must balance numerous reporting requirements from CMS, private payers and others. CMS should ensure any new requirements add value and are not unnecessarily duplicative with existing reporting requirements.

The AHA believes it is time to streamline and focus the measures used in national quality measurement programs on those that truly matter for driving better outcomes and health for the patients we serve. As we progress through implementation of the IMPACT Act, we hope that CMS and Congress will be mindful of what truly matters to patients and not abandon these tenets in service of statutory compliance.

Mandate for a New Post-acute Care Payment System

The IMPACT Act also authorized the implementation of a common Medicare payment system for post-acute care (PAC) provider types: home health agencies (HHAs), skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs).

This policy development process is presently underway through a collaboration by the Medicare Payment Advisory Commission (MedPAC), CMS and the Assistant Secretary for Planning & Evaluation. The first stage of work was completed with MedPAC's submission of a June 2016 report to Congress, which presented a prototype of the new PAC PPS. More recently, MedPAC approved a recommendation for Congress to implement the PAC PPS by 2021, which would accelerate the current timeline by more than four years.

While we appreciate the thoughtful work MedPAC has completed thus far on PAC PPS development, it remains unclear how policymakers could eliminate four to five years from the IMPACT Act's timeline to build a PAC PPS and still produce an accurate and reliable payment system. Specifically, considering MedPAC's estimate that their truncated timeline would require the introduction of a proposal to Congress in 2018 or 2019, MedPAC staff should be called upon to articulate the currently planned policy development steps that could be eliminated to meet their truncated deadline, and explain how, in their view, the shorter process is feasible and would not affect the quality of the resulting PAC PPS policy. As a point of reference, CMS recently spent five years to develop a re-tooled payment system for the SNF PPS – a process that is still underway. In other words, building complex payment systems requires extensive and thoughtful analyses and stakeholder input – and rushing through building a PAC PPS would likely threaten the dependability of the resulting policy.

Post-acute Care Value-based Purchasing

During the previous Congress, the House introduced, H.R. 3298, the Medicare Post-Acute Care Value-Based Purchasing (PAC VBP) Act of 2015, which would repeal the FY 2018 market-basket update cap for post-acute care providers mandated by MACRA and replace it with a PAC VBP program. **In concept, the AHA agrees with the potential for pay-for-performance to accelerate improvements in post-acute care. However, we urged a number of improvements to the PAC VBP legislation due to concerns the bill too narrowly focuses on reducing provider payment rather than promoting “value” – that is, the delivery of consistently high-quality care at a lower cost.**

Should the Ways and Means Committee consider similar legislation this Congress, we urge that any PAC VBP proposal be budget neutral within each PAC setting. Subsequent versions of the PAC VBP bill released for comment in 2016 included budget-neutral language across all PAC settings. Individual providers could earn back some or all of the withheld funds – but not within PAC settings. In other words, the ranking methodology may result in the withheld being earned back only by IRFs, for example. This holds the clear potential to pit PAC providers against each other, when the bill purports to drive collaboration across setting types.

Moreover, we urge that any new PAC VBP effort use quality and resource use measures that are fully developed and found to be valid. AHA members are deeply engaged in efforts to provide more accountable care that delivers greater value. The AHA believes pay-for-performance programs should include both cost and quality measures to ensure that the reward system encourages both high-quality care and lower costs. While the 2016 discussion draft of the legislation amended the 2015 bill by adding discharge to community and all-condition risk-adjusted potentially preventable hospital readmissions, the specifications of these measures must

undergo further development before they incur significant payment adjustments.

The 2016 discussion draft proposed a ranking methodology that would have inherently resulted in comparisons between post-acute care setting types, which is inappropriate given the vastly different environments in these settings. The language in the draft attempted to assuage these concerns by emphasizing that scores for these providers would be based solely on their performance in setting-specific standards, but the AHA is troubled that the draft suggested ranking all providers against each other. This is imprecise and would mislead consumers looking for the best providers; just because a SNF is ranked higher than an IRF does not mean that the SNF is the appropriate setting for a particular patient. The AHA urges Congress to consider a different manner of determining comparative value across PAC settings that would avoid these unintended consequences.

Current Pause of the Home Health Pre-claim Review Demonstration

The AHA supports CMS's current pause of its five-state demonstration, through which the agency implemented Medicare pre-claim review in August 2016, which applied to every home health agency and home health claim in Illinois. While the demonstration had not expanded to the remaining states (FL, MA, MI and TX) prior to the recent pause, because of its misguided and excessive scope, we are confident that, based on the Illinois experience, a better approach exists to address CMS's goal for the demonstration, which is to reduce Medicare payment errors and fraud and abuse.

To raise awareness of our Illinois members' grave concerns over the demonstration, the AHA has weighed in at length with the Government Accountability Office's Senate Finance Committee-initiated examination of the demonstration experience in their state. Based on this member feedback, we are confident that CMS's goals would be more effectively and fairly achieved through targeted education interventions that focus on agencies and/or types of claims experiencing payment errors – especially errors associated with the statutorily mandated face-to-face encounter requirement. Despite extensive efforts by both CMS and the field, compliance with this policy remains very time consuming and, in some cases, seemingly impossible given the policy's design and structural limitations associated with hospital and home health transitions. Further, HHAs that demonstrate no problems with either payment accuracy or fraud should not be subject to extra compliance interventions.

Long-term Care Hospital '25% Rule'

The AHA supports the current statutory relief from full implementation of the LTCH "25% Rule" that was provided by Congress in MACRA. The relief extends through Sept. 30, 2017. We have long viewed the 25% Rule as a misguided and arbitrary policy that reduces access to care for clinically appropriate patients – including those deemed appropriate for the LTCH setting by the Bipartisan Budget Act of 2013 (BiBA). However, with the implementation of LTCH site-neutral payment in October 2015, as mandated by BiBA, the purpose of the 25% Rule diminished even further. The LTCH site-neutral policy, unlike the 25% Rule, categorizes LTCH patients based on their medical complexity and reduces payment for only those with lower medical acuity. As such, we have called for the 25% Rule, with its non-clinical criteria, to be

withdrawn by CMS under its own authority. **With this in mind, we strongly endorse the agency's recent proposal for an additional 12-month pause on the full 25% Rule, from October 2017 through September 2018, and again urge the agency to permanently rescind the 25% Rule.**

CONCLUSION

The AHA and the hospital field appreciate your recognition of the need to examine and extend the Medicare payment systems that are the topic of this hearing, and to continue to improve these payment policies. We look forward to working with the Committee this year on legislation to accomplish these goals and urge Congress and the Administration to act on legislation in a timely manner to provide certainty for patients and the hospitals who treat them.