American Hospital Association

Legislative Advisory

May 27, 2016

House Ways and Means Committee Passes 'Hospital Bill'

At a Glance

At Issue

The House Ways and Means Committee on May 24 approved by voice vote the AHA-supported Helping Hospitals Improve Patient Care Act (H.R. 5273), which contains numerous provisions affecting hospitals. Of particular note, a provision of the bill would revise Section 603 of the Bipartisan Budget Act of 2015 to allow off-campus hospital outpatient departments (HOPDs) that were under development when that law was enacted on Nov. 2, 2015, to qualify as "grandfathered." As a result, these HOPDs could bill as provider-based departments of the hospital under the outpatient prospective payment system, rather than under the physician fee schedule. Specifically, this legislation would allow to qualify as "grandfathered" those off-campus HOPDs that attest to meeting provider-based requirements by Dec. 31, 2016 (or, if later, 60 days after enactment), are included on their parent facilities' Medicare enrollment form and had a binding written agreement with an outside unrelated party for the actual construction of the HOPD prior to Nov. 2, 2015.

The bill also would require the Centers for Medicare & Medicaid Services (CMS) to make an adjustment to the Hospital Readmissions Reduction Program (HRRP) to account for the socioeconomic status of the patients in a hospital's community. Specifically, in fiscal years (FYs) 2019 and 2020, CMS would compare hospitals' readmissions performance to others serving a similar proportion of patients that are dually eligible for Medicare and Medicaid. Beginning in FY 2021, CMS could modify its socioeconomic adjustment approach. The legislation also would extend the Rural Community Hospital Demonstration Program for five years and expand the program to rural areas in all states.

Our Take:

For those select HOPDs that would qualify for the revised grandfather provision, this legislation provides significant relief. Unfortunately, because hospital construction projects take a long time to bring to completion, some HOPDs that were underway on Nov. 2, 2015 will not qualify for the grandfather. We will to continue to work with the Congress to find additional ways to address the issue.

We are pleased that the bill recognizes that measures used in the HRRP need to be adjusted to account for socioeconomic status and are supportive of the extension of the Rural Community Hospital Demonstration Program. At the same time, we will continue to work with the Committee to ensure that long-term care hospitals obtain "25% Rule" relief as found in H.R. 4650, the Preserving Patient Access to Post-Acute Hospital Care Act of 2016.

Further Questions:

If you have questions, please contact AHA Member Relations at 1-800-424-4301.

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HOUSE WAYS AND MEANS COMMITTEE PASSES 'HOSPITAL BILL'

BACKGROUND

The House Ways and Means Committee on May 24 approved by voice vote the AHA-supported Helping Hospitals Improve Patient Care Act (H.R. 5273), which contains numerous provisions affecting hospitals. Of particular note, a provision of the bill would revise Section 603 of the Bipartisan Budget Act of 2015 to allow off-campus hospital outpatient departments (HOPDs) that were under development when that law was enacted on Nov. 2, 2015, to qualify as "grandfathered." As a result, these HOPDs could bill as provider-based departments of the hospital under the outpatient prospective payment system (OPPS), rather than under the physician fee schedule (PFS).

The bill also would require the Centers for Medicare & Medicaid Services (CMS) to make an adjustment to the Hospital Readmissions Reduction Program (HRRP) to account for the socioeconomic status of the patients in a hospital's community. Specifically, in fiscal years (FYs) 2019 and 2020, CMS would compare hospitals' readmissions performance to others serving a similar proportion of patients that are dually eligible for Medicare and Medicaid. Beginning in FY 2021, it could modify its socioeconomic adjustment approach. The legislation also would extend the Rural Community Hospital (RCH) Demonstration Program for five years and expand the program to rural areas in all states.

A section-by-section summary of the most relevant parts of the bill follows.

AT ISSUE

Development of HCPCS Version of MS-DRG Codes (Sec. 101)

The bill would require, no later than Jan. 1, 2018, the creation of a crosswalk between HCPCS codes (outpatient) and ICD-10-PCS codes (inpatient) for no fewer than 10 surgical Medicare-Severity diagnosis-related groups (MS-DRGs). CMS would be required to develop a HCPCS MS-DRG definitions manual and software for ICD-10-PCS codes for these 10 DRGs. It would be required to be posted on the CMS website and available for public use/redistribution without

charge. In doing this, the bill states that CMS should consult with the Medicare Payment Advisory Commission (MedPAC) and consider the analysis MedPAC did related to short inpatient stays (i.e., translating outpatient surgical claims into inpatient surgical MS-DRGs).

Establishing Beneficiary Equity in the Medicare Hospital Readmission Reduction Program (HRRP) (Sec. 102)

The legislation includes a modified version of the Establishing Beneficiary Equity in the Hospital Readmission Program Act of 2015 (H.R.1343/S. 688), which would make an adjustment to the HRRP to account for the socioeconomic status of the patients in a hospital's community. The legislation would require CMS to employ a "transitional" adjustment approach in FYs 2019 and 2020 in which it would assign hospitals to groups based on the proportion of their patients dually eligible for Medicare and Medicaid. Hospitals would have their performance compared to others within their dual-eligible grouping. In developing its approach, the agency would be required to consult with MedPAC. After this "transitional" adjustment, CMS could modify its socioeconomic adjustment approach and, in doing so, would be required to consider the findings of the two reports on socioeconomic adjustment in Medicare mandated by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014.

The legislation also requires MedPAC to submit a report to Congress by June 2017 that assesses whether changes in readmission performance are related to changes in the utilization of emergency department (ED) services and observation status.

The legislation retains several requirements of H.R. 1343/S. 688, including:

- Budget-neutral implementation of the socioeconomic adjustment;
- Starting in FY 2018, a requirement that CMS assess whether it can use V-codes and other ICD codes to exclude non-compliant patients from the calculation of readmissions performance; and
- Starting in FY 2018, a requirement that CMS assess whether it should exclude burns, trauma, psychosis, end-stage renal disease and substance abuse patients from the calculation of hospital readmission performance.

Five-year Extension of the Rural Community Hospital (RCH) Demonstration Program (Sec. 103)

Section 103 would extend the RCH Demonstration for an additional five years and expand the program to rural areas in all states. This program, which allows hospitals with fewer than 51 acute care beds to test the feasibility of cost-based reimbursement, was established under the Medicare Prescription Drug, Improvement and Modernization Act. The Affordable Care Act (ACA) extended the program an additional five years, increased the maximum number of participating hospitals from 15 to 30, and expanded the eligible sites to rural areas in 20 states with low population densities. Under this bill, the ACA limit for the

maximum number of participating hospitals – 30 – would remain in place. The legislation also would require a report to Congress evaluating the impact of the demonstration be submitted no later than Aug. 1, 2018.

Regulatory Relief for Long-term Care Hospitals (LTCHs) (Sec. 104)

The legislation would retroactively expand the exceptions to the statutory moratorium on new LTCH hospitals or satellites to include new LTCH beds. To offset the cost of this change, the bill would reduce the LTCH high-cost outlier pool from 8.0 percent to 7.975 percent, for FY 2018 and beyond. The moratorium and its exceptions were originally established under the Medicare, Medicaid, and SCHIP Extension Act of 2007 and later amended by the Pathway for SGR Reform Act of 2013 and the Protecting Access to Medicare Act of 2014.

Savings from IPPS MACRA Pay-for Through Not Applying Documentation and Coding Adjustment (Sec. 105)

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) spread the restoration of coding cuts required by the American Taxpayer Relief Act of 2012 over six years. Specifically, it restored 3.0 percentage points over a six-year period by adding 0.5 percentage point to the inpatient hospital update in each of FYs 2018 through 2023. This bill would implement a cut of 0.041 percentage points in FY 2018 to offset the changes to Section 603 of the Bipartisan Budget Act of 2015, discussed below. As a result, the increase set forth in MACRA would be adjusted to be an increase of 0.459 percentage points rather than 0.5 percentage points.

Changes to the Bipartisan Budget Act of 2015 (Sec. 201)

The bill would make adjustments to Sec. 603 of the Bipartisan Budget Act of 2015 in order to allow some HOPDs that were under development when that law was enacted to bill as provider-based departments of the hospital under the OPPS, rather than under the PFS. Specifically, for purposes of items and services furnished in 2017, if CMS received an attestation from a provider prior to Dec. 2, 2015 indicating that their department was a provider-based department of the hospital, the HOPD would be fully grandfathered, even if they were not providing services and billing Medicare under the OPPS before Nov. 2, 2015, the date of enactment of Sec. 603.

For purposes of items and services furnished in 2018 and beyond, an HOPD would be grandfathered if:

- CMS received an attestation from the hospital prior to Dec. 31, 2016 (or, if later, 60 days after the date of the enactment of this bill), indicating that its department met the Medicare provider-based requirements (as described in 42 CFR 413.65);
- the provider updated its Medicare enrollment form to include the HOPD; and

- prior to Nov. 2, 2015, the provider had a binding written agreement with an outside unrelated party for the actual construction of the HOPD (referred to in the bill as the "mid-build requirement") and the Secretary of Health and Human Services receives from the hospital's CEO or COO a written certification that the HOPD met the mid-build requirement no later than 60 days after the bill is enacted.

In addition, CMS would audit each of the HOPDs that were grandfathered under this bill for compliance with these provisions by Dec. 31, 2018. No administrative or judicial review of the determinations made in the audits are permitted. The bill also provides for $10 million to fund these activities at CMS.

Grandfathering Dedicated Cancer Center HOPDs (Sec. 202)

Under the legislation, a new off-campus HOPD of a dedicated cancer center would receive an exemption from the site-neutral payment changes in Section 603 of the Bipartisan Budget Act of 2015 and would be able to bill under the OPPS if:

- For departments of such a dedicated cancer centers that became HOPDs between Nov. 1, 2015 and the date of enactment of this bill, CMS receives from the center an attestation within 60 days of enactment of this bill.
- For departments of such a dedicated cancer center that became HOPDs after the date of enactment of this bill, CMS receives from the center an attestation within 60 days of the department becoming an HOPD.

CMS would be required to audit the HOPDs of these dedicated cancer centers for compliance with these provisions within two years of the date that it receives the attestation. No administrative or judicial review of the determinations made in the audits are permitted. The bill provides for $2 million to fund these activities at CMS. To fully offset the cost of this exemption, the bill requires CMS to reduce the dedicated cancer centers' target payment-to-cost ratio adjustment by at least 1 percentage point.

Ambulatory Surgery Centers (ASCs) (Sec. 203)

The bill includes language that would exempt ASCs from penalties in the electronic health records (EHRs) meaningful use program in 2017 and 2018 and continue the protections under the new Medicare merit-based incentive program that begins in 2019. Those protections would sunset three years after the Secretary determines, through notice-and-comment rulemaking, that certified EHR technology applicable to ASCs is available. This language previously was included in a stand-alone measure (H.R. 887).

Temporary Delay in Termination of Medicare Advantage (MA) Plans Due to Low Star Ratings (Sec. 301)

The legislation would delay CMS's authority to terminate MA plans on the basis of low quality star ratings until the end of plan year 2018, allowing time for CMS to continue

to investigate and obtain input on issues related to socioeconomic status and dual-eligible status.

Requirement for Enrollment Data Reporting for Medicare (Sec. 302)

The bill requires the Secretary to provide the House Ways and Means and the Energy and Commerce Committees with a report on Medicare beneficiary enrollment data by congressional district and state and in such a way that distinguishes those enrolled under fee-for-service and those enrolled under Medicare Parts C and D.

Updating the "Welcome to Medicare" Package (Sec. 303)

Within a year of enactment, the Secretary would have to update the "Welcome to Medicare" package to include clear information about MA plans under Part C and prescription drug plans under Part D, in addition to information about the original Medicare fee-for-service program under Parts A and B. In addition, not later than six months after enactment, the Secretary would be required to request input and recommendations from stakeholders on the information included in the "Welcome to Medicare" package.

FURTHER QUESTIONS

Please contact AHA Member Relations at 1-800-424-4301.