

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

**" Payments to Certain Medicare Fee-for-Service Providers "
May 15, 2007**

Good afternoon, Mr. Chairman. I am Rich Umbdenstock, President and CEO of the American Hospital Association (AHA). On behalf of the AHA's nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, I appreciate the opportunity to testify before you today about payments to hospitals.

HOSPITALS – BUILDING BETTER LIVES AND COMMUNITIES

Hospitals are cornerstones of their communities. The doors of the local hospital are open 24 hours a day, seven days a week, every week of the year. The women and men of these hospitals take care of all who walk through the hospital doors, regardless of their ability to pay for that care. Our doctors, nurses and other professionals take care of people at all stages of life, from birth until old age. Hospitals stand ready to respond in the wake of a catastrophic event, whether caused by man, like a bioterrorism attack, or nature, like floods and tornadoes. And hospitals work not just to mend bodies, but also to make the entire community healthier. Their work extends far beyond the four walls of a brick building and includes bringing free clinics, job training, smoking cessation classes, back-to-school immunizations, literacy programs and so many other resources, often with little fanfare, directly to the people of the community.

At the same time, the local hospital is more than a place where people go to get well. Hospitals are employers, providing good wages and stimulating other areas of business throughout the community. Hospitals employ nearly five million people, rank second as



a source of private sector jobs, directly or indirectly support one of every nine jobs in the U.S., remain a stable source of employment, even during times of economic stress; and support other businesses when they purchase the goods and services needed to provide care. The well-being of a local hospital can cause ripple effects on the economic health of a community.

And that well-being is at risk. To meet the unique needs of their communities, hospitals face unique challenges. More than 115 million people are treated in our emergency departments each year; more than 35 million patients are admitted each year. Hospitals are the primary place of care for many of the nation's 45 million uninsured people. In 2005, hospitals provided \$29 billion of uncompensated care. We must be prepared to respond to any threat to the community, and we must invest in newer cutting edge technologies and facilities in order to keep up with soaring demand. Yet more than half of our patients are covered by government programs – Medicare and Medicaid – that pay us far less than the cost of caring for those patients.

PROPOSED MEDICARE AND MEDICAID CUTS

Despite these demands and challenges, the Administration's fiscal year (FY) 2008 budget proposal seeks more than \$100 billion in overall cuts to Medicare and Medicaid over the next five years, a significant portion from hospital services. Cuts of this magnitude would not only affect the hospital services that Medicare and Medicaid beneficiaries rely on, they would affect services for all Americans in all communities.

Fortunately, Congress disagrees with these proposed cuts. A bipartisan group of 223 House lawmakers, led by Reps. Richard Neal (D-MA) and Phil English (R-PA), and 43 senators, led by Sens. Blanche Lincoln (D-AR) and Pat Roberts (R-KS), signed letters to budget leaders calling for Congress to protect hospital services under Medicare. In late March, both the Senate and House rejected Medicare cuts to hospital services when they passed their budget resolutions. The threat of cuts to hospital services for beneficiaries will exist throughout the year. We urge you to continue to reject any effort to cut Medicare or Medicaid payments for the hospital services that America's children, disabled and seniors rely on.

We also appreciate and support, Mr. Chairman, your efforts to do away with the 45 percent rule. This rule triggers a warning when the amount of general revenue needed to finance Medicare is projected to top 45 percent of the program's outlays for a second year in a row. It then requires the President to propose legislation to respond to the issue within 15 days following the release of the Fiscal Year 2009 Budget, which will be released in early February, 2008. The law requires Congress to consider the President's proposals on an expedited basis.

The 45 percent threshold misdefines the basic challenge facing Medicare: how much the program is expected to cost, not what share of that cost comes from any given revenue source. What the millions of people who rely on Medicare need is a broader look at ways to keep Medicare strong for years to come, not arbitrary budget triggers. Cuts based on arbitrary triggers are misguided and simply won't work.

MEDPAC'S RECOMMENDATIONS

The Medicare Payment Advisory Commission (MedPAC) recently agreed that the challenges facing hospitals are serious. MedPAC recommended that Congress grant a full market basket update for hospital inpatient and outpatient prospective payment systems (PPS) in Fiscal Year 2008. We encourage Congress to follow MedPAC's recommendation.

We appreciate MedPAC's recognition of the need to ensure that Medicare reimbursement keeps pace with inflation and the changing needs of our health care system. Americans depend on hospitals to be there, ready to serve, 24 hours a day, 365 days a year. Reversing the dramatic decline in hospitals' Medicare margins is essential to ensuring hospitals' ability to fulfill this expectation.

Here are just some of the pressures and challenges that bolster the case for a full update for hospitals:

- MedPAC projects overall Medicare margins to continue to fall, from *negative* 3.3 percent in 2005 to *negative* 5.4 percent in 2007 – a 10-year low.
- Sixty-five percent of hospitals are paid less than the cost of services provided to Medicare patients, a shortfall that exceeds \$15 billion.
- We continue to face a severe shortage of workers to meet increased demands for care. For example, there is expected to be a shortage of more than 1 million nurses by 2020. Training and retaining skilled workers of all types requires considerable investment.
- Spending on health IT systems is high and growing. The median capital spending per bed for system implementation was \$5,556 in 2006. The median operating costs to cover ongoing expenses were \$12,060 per bed, a 4.5 percent increase over 2005.

Indirect Medical Education (IME). In January, the commission recommended that Congress reduce the indirect medical education adjustment in FY 2008 by 1 percentage point – from 5.5 percent to 4.5 percent – concurrent with CMS' efforts to implement a payment system based on severity-adjusted diagnosis related groups (DRGs). The AHA strongly opposes this recommendation, as a one percentage point reduction equates to a 20 percent cut in indirect medical education payments.

The indirect medical education adjustment helps compensate teaching hospitals for the higher operating costs associated with training physicians, research-related patient care costs, treating sicker patients and providing more complex and costly services. Many teaching hospitals have trauma centers and transplantation services, and most use cutting-edge new technologies.

Targeting indirect medical education payments for across-the-board reductions may lead to reduced access to high-caliber medical education settings for our future physicians. We urge Congress to consider the benefits provided by teaching hospitals and reject any cuts to indirect medical education.

THE CMS INPATIENT RULE

CMS' proposed Medicare inpatient rule for FY 2008 includes dramatic cuts – \$25 billion over the next five years – to services that are needed by America's seniors and disabled. It does this in large part by imposing a 2.4 percent, across-the-board cut, in each of the next two years, in anticipation of the coding changes it says hospitals *might* make under a new severity DRG system and by cutting important capital payments.

The “Behavioral Offset.” The proposed rule calls for refinement of the DRGs, which will result in changes to Medicare payments. The AHA continues to analyze the new DRGs and their ability to improve the accuracy of Medicare payments. But the 2.4 percent “behavioral offset” is a key misstep. The \$24 billion cut over five years to capital and operating payments is based on CMS' apparent belief that, with implementation of its Medicare Severity Diagnosis-Related Groups (MS-DRGs), the changes hospitals will make in coding practices will result in higher payments. CMS maintains that under a “new” system of DRGs hospitals will change coding behavior. Yet, even during the initial years of the inpatient PPS, when hospitals moved from a cost-based system to a prospective DRG system, we did not see coding changes of the magnitude that CMS anticipates in attempting to justify this dramatic cut. MS-DRGs are based on the existing DRG system and are simply a refinement of a classification system that hospitals have been using for 23 years. Hospital personnel already are coding experts with DRGs and are using coding forms and practices that have been in place for a long time.

CMS also cites as rationale for the cut the transition of hospitals in Maryland to a completely new coding system called All Patient Refined DRGs. But this rationale also is flawed. Maryland's hospitals are paid under a state rate-setting system. Historically, coding in the Maryland hospital payment system was not a significant factor in determining hospital payments. The classification system recently adopted by Maryland is much more complicated than what CMS has proposed and, in fact, completely changed the coding incentives for Maryland's hospitals. Applying the Maryland experience to the rest of the nation's hospitals is an inappropriate apples-to-oranges comparison.

There is no precedent in other payment systems for making a prospective adjustment of this magnitude without any evidence of actual and measurable changes in coding. While CMS has made adjustments for coding in the implementation of new payment systems, these changes have been based on actual experience. When the new physician fee schedule was implemented in 1992, CMS imposed a behavioral offset based on predicted increases in the volume of services physicians would provide. It was later learned that the estimated offset cut much more payment than necessary, yet the funding was never returned to physicians who were adversely affected by those cuts.

Capital Cuts. CMS is required by law to pay for a portion of the capital-related costs of inpatient hospital services. These costs include depreciation, interest, taxes, insurance and similar expenses for new facilities, renovations, expensive clinical information systems and high-tech equipment like MRIs and CAT scanners. This is done through a separate capital PPS. Since the PPS for inpatient capital costs uses DRGs in its payment formula, the 2.4 percent cut already reduces payments for urban and rural hospitals.

CMS's proposed rule also would eliminate the annual update for capital payments for all hospitals in urban areas and would eliminate additional capital payments made to hospitals in large urban areas. In addition, CMS is considering discontinuing the IME and DSH adjustments to capital payments. Eliminating the update and the loss of the additional large-urban hospital payments would cost those hospitals \$880 million over the next five years.

These proposed cuts to capital payments would make it more difficult to purchase the advanced technology, equipment and clinical information systems that consumers have come to expect and could have the effect of slowing clinical innovation. Capital cuts of this magnitude will disrupt the ability of urban hospitals to meet their existing long-term financing obligations. Hospitals have committed to these improvements under the expectation that Medicare's prospective payment system for capital-related costs would remain a stable source of income. Reducing capital payments creates significant financial difficulties for many of our nation's innovative and cutting edge hospitals.

CMS cites as its rationale that financial margins for capital are excessive in hospitals in urban areas. It is important to note, however, that actual overall Medicare margins for these hospitals averaged -3.3 percent in 2005, according to MedPAC. In addition, taken by themselves, capital margins don't reflect the cyclical patterns of capital investment by which hospitals replace facilities, purchase and improve information systems or update clinical technologies. Indeed, the very nature of a PPS is to provide a consistently reliable flow of funding so that hospitals can plan their capital expenditures – in times of high or low capital costs.

We believe CMS went well beyond its charge by recommending both of these arbitrary and unnecessary changes. They will deplete scarce resources, ultimately making hospitals' mission of caring for patients even more challenging. The Federation of American Hospitals, the Association of American Medical Colleges, the National Association of Public Hospitals and Health Systems, Premier, Inc., and VHA Inc., along with the AHA, recently sent a letter to Acting CMS Administrator Leslie Norwalk urging her to eliminate the two provisions from the rule.

Two members of the Ways & Means Committee, Reps. John Lewis (D-GA) and Jerry Weller (R-IL), are circulating a Dear Colleague letter with the same purpose. The letter also will be sent to Acting Administrator Norwalk.

The cuts clearly fly in the face of congressional intent. As stated above, 43 senators and 223 representatives recently signed letters opposing budget cuts to Medicare and Medicaid. Nowhere are the cuts CMS is proposing mandated by the Congress. At a time when Medicare must be strengthened to meet soaring demand for its services, CMS is instead sapping its strength, and the ability of hospitals to meet the needs of patients will be sapped as well. We urge you to insist that CMS remove these unwarranted and unwise cuts from the proposed rule.

INPATIENT REHABILITATION HOSPITALS AND UNITS

Inpatient rehabilitation facilities treat seriously ill and injured patients, but restrictive Medicare policies, such as the 75% Rule and stringent definitions of “medical necessity,” are making it more difficult for these patients to get the care they need. The 75% Rule is one of the criteria an inpatient rehabilitation facility must satisfy to be eligible for Medicare reimbursement under the inpatient rehabilitation PPS. When fully phased in, 75 percent of patients discharged must be treated for one of 13 conditions in order to qualify for rehabilitation-specific payments.

Currently, the patient threshold is set at 60 percent, but it is set to rise to 65 percent in July 2007 and 75 percent in July 2008. The Moran Group, a Washington, DC-based health care research and consulting firm, recently found that nearly 88,000 patients were unable to receive care in rehabilitation hospitals and units during the first two years of the 75% Rule phase-in – an assessment that far exceeds CMS’ estimate that only 7,000 fewer patients would be treated. CMS’ policies have severely reduced, beyond what was intended, access to the medical rehabilitation care that patients need, and the AHA opposes moving to the 65 percent threshold in July.

The AHA is equally concerned that many Medicare fiscal intermediaries (FIs) have further restricted the number of patients who can be treated at inpatient rehabilitation hospitals and units by establishing local coverage determinations (LCDs) based on overly stringent definitions of “medical necessity.” As a result, patients who should be eligible for rehabilitation care are being turned away. And, because no uniform standards exist, some FIs are employing far more restrictive standards than others, creating an unfair competitive environment for inpatient rehabilitation hospitals and units that are located in the same community but have to follow the disparate rules of different FIs.

The AHA supports removing overly restrictive LCDs and ensuring that all FIs use the national guidelines currently in place for medical necessity. We urge Congress to pass the *Preserving Patient Access to Inpatient Rehabilitation Hospitals Act of 2007* (H.R. 1459), introduced by Reps. John Tanner (D-TN), Kenny Hulshof (R-MO), Nita Lowey (D-NY), and Frank LoBiondo (R-NJ). The bill would freeze the 75% Rule at the current 60 percent level and address inconsistent and harsh LCDs.

In addition, the 75% Rule, even at a transitional level, has already changed the course of inpatient rehabilitation facility payment by creating significant instability. To avoid further erosion of beneficiary access to quality inpatient rehabilitation care, a full market basket update is warranted.

LONG-TERM CARE HOSPITALS

In FY 2005, CMS implemented the 25% Rule for long-term care hospitals (LTCHs) that were co-located within acute care hospitals. When fully phased in, this policy, currently at 50 percent, would require that only 25 percent of admissions to the LTCH can be patients who were previously admitted to the co-located acute care hospital. For LTCHs exceeding this 25 percent patient threshold, CMS will reimburse the LTCH at the lower

payment rate for general acute care hospitals. CMS' rate year 2008 final rule for LTCHs recommends several troubling changes – most notably CMS' plan to extend the 25% Rule to all LTCHs, including freestanding and satellite facilities, as well as LTCHs that were exempted from the original 25% Rule. This expansion of the 25% Rule, phased in over three years, would reduce payments to LTCHs by \$406 million over the next three years.

The AHA supports efforts to more specifically define patient and facility criteria for LTCHs. However, the 25% Rule misses the mark by arbitrarily limiting the number of patients who can be admitted, rather than focusing on patients' clinical characteristics and their need for long term care. LTCHs provide intense care to patients who require longer lengths of stay than typical patients in a general acute care hospital, such as those on ventilators or burn victims. Any proposed policy regarding LTCHs should ensure access for patients for whom LTCH care is medically appropriate – a view supported by MedPAC.

Last year, CMS released a report by the Research Triangle Institute (RTI) that identified patient and facility criteria that would help distinguish LTCHs from other acute care facilities. However, CMS has not yet used the report to produce specific policy recommendations. Rather than limiting access to LTCH services through payment cuts, we urge CMS to stop the proposed rule and work with the RTI and LTCH providers to develop appropriate facility and patient-centered criteria to determine the types of patients that should be treated in LTCHs.

RURAL HOSPITALS

Rural hospitals provide essential health care services to nearly 54 million people, including 9 million Medicare beneficiaries. Because of their small size, modest assets and financial reserves, and higher percentage of Medicare patients, these hospitals face enormous pressures as government payments decline. Yet, Medicare margins are the lowest for rural hospitals, with the smallest hospitals having the lowest margins.

Tremendous diversity exists among rural hospitals and different approaches are needed to reach the common goal of providing access to high quality care for Medicare beneficiaries who live in rural areas. National payment policies, specifically prospective payment systems, often fail to recognize the special characteristics and unique circumstances of small rural hospitals. Some rural hospitals are too large to qualify for status as a Critical Access Hospital (CAH) but too small to absorb the financial risk associated with PPS programs. As a result, the AHA supports the following legislation, which was introduced earlier this year:

The Sole Community Hospital Preservation Act (H.R. 1177) – Introduced by Reps. John Tanner (D-TN) and Sam Graves (R-MO), this bill would extend permanently the outpatient PPS payment protection for sole community hospitals – the “hold harmless” – and permit the use of a more current year to allow re-determination of the hospital target amount.

The Physician Pathology Services Continuity Act (H.R. 1105) – This bill, introduced by Reps. John Tanner (D-TN) and Kenny Hulshof (R-MO), would permanently extend current law to allow Medicare to continue to make direct payments to certain independent laboratories for the technical component of pathology services.

The AHA also supports the extension of expiring legislative provisions affecting rural hospitals, including a rural home health 5 percent add-on, cost-based payment for rural laboratory services provided by hospitals with fewer than 50 beds, and ambulance mileage bonuses for transport of rural patients in low-population density areas. We support extension of Section 508, which allows geographic reclassification of certain hospitals.

In addition, we support the expansion of existing cost-based payment to home health and skilled nursing facility settings for CAHs, and to rural hospitals with 25-50 beds for inpatient and outpatient services. We also support allowing flexibility in the relocation of CAHs, allowing CAHs to be used as reference labs to provide services to beneficiaries. We also need to ensure that CAHs are paid at least 101 percent of costs by Medicare Advantage plans. H.R. 2159, introduced by Reps. Ron Kind (D-WI) and Cathy McMorris-Rodgers (R-WA), aims to correct the inequity of how rural hospitals are paid by Medicare Advantage plans.

PHYSICIAN-OWNED, LIMITED SERVICE HOSPITALS

Although a congressional moratorium and subsequent Department of Health and Human Services administrative action from late 2003 to mid-2006 was supposed to hold in check the expansion of physician-owned, limited service hospitals, their growth is on the rise. Many public and private studies conducted during the moratorium found that physician-owned, limited-service hospitals:

- Reduce patient access to specialty and trauma care at community hospitals;
- Damage the financial health of full-service hospitals and lead to cutbacks in services;
- Reduce efficiency of full-service hospitals that must maintain stand-by capacity for emergencies, even as they lose elective cases;
- Increase utilization rates and costs;
- Are not more efficient and do not provide better quality;
- Use physician-owners to steer patients;
- Provide limited or no emergency services; and
- Select the most profitable patients by:
 - Avoiding low-income populations, both uninsured and Medicaid;
 - Offering the most profitable services; and
 - Serving less sick patients within case types.

The proliferation of physician ownership of limited-service hospitals is stimulated by opportunities to earn additional income and gain greater control over their operating environment. However, the effect on health care delivery and costs in communities can be devastating, especially when self-referral is involved.

To help ease the effects of these and other issues surrounding limited-service hospitals, the AHA supports a permanent congressional ban on physician self-referrals to limited-service hospitals, with limited exceptions for existing facilities that meet strict investment and disclosure rules. We urge Congress to act this year.

MEDICARE ADVANTAGE

The Medicare Advantage (MA) program made major changes in the types of private health plan options available to Medicare beneficiaries. In addition to the traditional coordinated care plans, beneficiaries now have access to regional preferred provider organization (PPO) plans, private fee-for-service (PFFS) plans, and Medical Savings Account (MSA) plans. Implementation of Medicare Part D drug coverage has changed the dynamics of the program as well. Changes in MA plan payments have also led to higher payments to plans, and changes regarding where new plans are being offered and where the growth in new enrollment is concentrated.

With MA plans in place for several years, we now have some experience with the changes that have resulted. The AHA has identified four specific areas of concern that are causing difficulties for hospitals, especially rural hospitals, and for the Medicare beneficiaries they serve.

Elimination of IME payments. We are strongly opposed to a provision in the Administration's FY 2008 budget that would eliminate the indirect medical education (IME) payment made to teaching hospitals on behalf of MA enrollees when they receive care in a teaching hospital. This proposal would save approximately \$5 billion over the next five years. MA plans, however, would continue to receive funding for costs related to indirect medical education even though they do not pass those payments on to teaching hospitals. It is outrageous to eliminate payments to hospitals that are providing Medicare beneficiaries with future generations of physicians, while at the same time protecting payments to plans that rarely, if ever, pass those payments on to the teaching hospitals that need them, as the plans are not required to do so. We ask that the subcommittee protect these much-needed payments to teaching hospitals. And we suggest that a prime source of legitimate savings in the Medicare program would be removing IME payments from the MA rates, while continuing to make IME payments directly to teaching hospitals when they serve MA enrollees.

Underpayment of Rural and Critical Access Hospitals. Federal law requires that MA plans pay out-of-network providers what they otherwise would have been paid under the traditional Medicare program. For PFFS plans, this requirement applies to "deemed providers" who are presumed to have accepted the plan's terms and conditions for payment without a contract. Traditional Medicare pays CAHs 101 percent of costs. As a matter of convenience for MA plans, CMS allows them to pay CAHs a proxy amount or interim payment rate. But, interim rates are based on the prior year's costs. Unlike traditional Medicare, where there is a year-end settlement based on actual costs, MA plans are not required to reconcile these proxy payments with actual amounts due to CAHs. This is also true for sole community providers, rural health clinics (RHCs), and

others paid on a cost-related basis. Recognizing the inequity of this situation, legislation has been introduced in the House (H.R.2159, by Reps. Ron Kind (D-WI) and Cathy McMorris-Rodgers (R-WA)) that would require all MA plans to pay CAH and rural health center services, at minimum, their interim rate with year-end cost reconciliation, or 103 percent of interim rates without reconciliation. AHA supports these legislative efforts. Given that MA plans are paid substantially more than traditional Medicare costs, rural health care providers should not pay the price for MA plan convenience.

Questionable Marketing Practices. Based on beneficiary complaints and congressional hearings, it is clear that some Medicare beneficiaries are sold MA plans without good information about important issues like how those plans operate, access to providers and copayments. This is especially true with PFFS plans, which have been characterized by some as being no different from the traditional Medicare program with full access to all Medicare-certified providers. While CMS has said it will increase oversight of PFFS plans, the agency's plan to do so misses a key complaint: beneficiaries seeking to enroll in a part D drug benefit plan who are instead enrolled in a PFFS MA plan. These beneficiaries are asking for one thing and getting another. Those who are unaware that they have signed up for an MA plan present their old Medicare cards to providers, and it is not until the provider's claims are rejected that either the beneficiary or the provider is aware of their actual plan coverage. As a result, beneficiaries may be unwittingly subject to a higher copayment for failing to notify the plan before their admission, and higher copayments than the traditional Medicare program. CMS needs to put a stop to misleading or fraudulent marketing practices and ensure that Medicare beneficiaries can return to the traditional Medicare program without any penalty or loss of supplemental coverage.

Confusing Plan Variations and Poor Plan Administration. Differences among MA plans, the sheer number of plans available in some areas, and the fact that MA plans are not required to follow state insurance regulations is causing confusion among providers as well as beneficiaries. PFFS plans present some of the worst administrative problems, especially for rural providers. The "deemed provider" approach is most problematic. If a hospital serves a Medicare PFFS enrollee, the hospital is deemed to accept the PFFS plan's terms and conditions unless it is providing emergency care. PFFS plans enter rural markets and enroll beneficiaries without any notification to the area's health care providers. Providers have no opportunity to review the plan's terms and conditions and must make on-the-spot decisions when new enrollees begin to seek services. In the absence of contracts with these plans, providers have no ability to negotiate terms and conditions. Simplification of administrative requirements and an overhaul – if not elimination – of the "deemed provider" concept must be considered.

In those instances where plans are providing actual care management services, like those provided by Kaiser Permanente, Sentara, and Providence Health System, payments above fee-for-service may be appropriate. However, as stated above, we are hearing from our rural members that private fee-for-service plans, in addition to the problems outlined above, provide little care management but still receive additional payments, and are creating difficulties for rural hospitals. Consequently, we ask that the subcommittee

further investigate the activities of private fee-for-service plans, and make adjustments to their payments if they are found not to provide true care management for beneficiaries, and are not working with hospitals that are so vital to health care in their rural communities.

CONCLUSION

Mr. Chairman, the women and men of our hospitals face significant challenges as they strive to provide the best care possible to their friends and neighbors in communities across our nation. But, while the challenges are complex, their mission is simple: Get people the right care, at the right time, in the right place. You have our pledge to work with you to address these complex challenges in a way that helps us accomplish that goal.