Written Testimony

of the

Arizona Hospital and Healthcare Association

to the

Committee on Ways and Means, Subcommittee on Health

of the

House of Representatives

"Expiring Medicare Provider Payment Provisions"

September 26, 2011

On behalf of the Arizona Hospital and Healthcare Association's (AzHHA's) 102 member hospitals, I appreciate the opportunity to comment on the expiring Medicare provider payment provisions and their importance to Arizona's small rural hospitals and the Medicare beneficiaries they care for.

Low Volume Adjustment

The *Affordable Care Act* (*ACA*) improved the low-volume adjustment (LVA)for fiscal years 2011 and 2012. For these two 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. According to the American Hospital Association (AHA), about 500 hospitals are receiving the low-volume adjustment in FY 2011. AzHHA is aware of just one hospital that receives this adjustment in Arizona—La Paz Regional Hospital in Parker, Arizona—but the importance of the adjustment to this hospital cannot be understated.

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 such as Parker, which lack the economies of scale that can be found in larger cities. It is important to note that La Paz Regional Hospital, with under 40 beds, serves not just the town of Parker, but it is the only community hospital in the County of La Paz, which covers more than 4000 square miles. With a 59 percent Medicare utilization rate, it is crucial that La Paz receive adequate reimbursement to provide for its patients. Without the LVA and sole community hold harmless payments, services provided by La Paz are at risk.

Outpatient Hold Harmless Payments

When the outpatient prospective payment system (OPPS) was implemented, Congress made small rural hospitals with 100 or fewer beds eligible for a payment adjustment, referred to as "hold harmless" transitional outpatient payments (TOPs). "Hold harmless" TOPS were intended to ease these hospitals' 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 and has subsequently expanded it to apply to equally vulnerable sole community hospitals (SCHs).

Under the "hold harmless" 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 Arizona, 10 hospitals in rural areas of the state are classified as small rural and SCHs and eligible for hold harmless payments. Due to the expiration of legislative authority, these hospitals will cease to be eligible for TOPs on December 31, 2011.

AzHHA 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. According to the AHA, 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 hold harmless payments in Arizona have Medicare payments well below their Medicare costs, with payments averaging about 83 percent of costs based on 2008 data. By contrast, the statewide average payment-to-cost percentage is about 91.7 percent.

According to the AHA, 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 across the country would see their payment-to-cost percentage fall 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 hospitals to continue to provide access to critical outpatient services, such as emergency department services and chemotherapy.

Reimbursement for Technical Component of Physician Pathology Services

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 rural hospitals throughout Arizona, 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 and Small Rural Hospitals

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 rural Arizona. Despite their small size and their smaller number of patients, these hospitals still have to maintain a certain 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 many miles. Laboratory tests provide critical information on which sound medical decisions can be made.

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 Medicare beneficiaries who depend on lab testing provided by their community hospital. 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.

Thank you for the opportunity to provide written testimony on the expiring Medicare provider payment provisions.

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